**COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

**IN THE MATTER OF**
**A HEARING UNDER *THE HEALTH PROFESSIONS ACT,***

**AND IN THE MATTER OF A HEARING REGARDING**
**THE CONDUCT OF LILIBETH OLANIRAN**

# DECISION OF THE HEARING TRIBUNAL
# OF THE
# COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

**IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF LILIBETH OLANIRAN, LPN #34453, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")**

**DECISION OF THE HEARING TRIBUNAL**

## (1) Hearing

The hearing was conducted remotely via videoconference using Zoom on June 29, 2020 with the following individuals present:

**Hearing Tribunal**:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Jan Schaller, LPN
Marg Hayne, Public Member

**Staff**:
Evie Thorne, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

**Investigated Member**:
Lilibeth Olaniran, LPN ("Ms. Olaniran" or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

## (2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

## (3) Background

Ms. Olaniran was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Olaniran was initially licensed as an LPN in Alberta on February 9, 2012.

On May 1, 2019, the College of Licensed Practical Nurses of Alberta (“CLPNA”) received a complaint dated May 1, 2019, (the “First Complaint”) from Ms. Laine Cholak, Community Manager, Extendicare Eaux Claires, pursuant to s. 57 of the Act. The First Complaint stated Ms. Lilibeth Olaniran, LPN, had received a three-day suspension of her employment at Extendicare Eaux Claires as a result of a number of medication administration errors.

The Complaints Director delegated her authority under Part 4 of the Act to Ms. Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act, for the First Complaint.

In accordance with s. 55(2)(d) of the Act, Ms. Blatz determined she would conduct an investigation into the First Complaint. Ms. Olaniran received notice of the First Complaint and notice that Ms. Blatz would conduct an investigation by letter dated May 9, 2019.

On June 17, 2019, the CLPNA received a further complaint via email dated June 17, 2019 (the “Second Complaint”) from Ms. Robin Brooks, Community Manager at Extendicare Eaux Claires pursuant to s. 57 of the Act. The Second Complaint stated that Ms. Olaniran had been terminated as a result of a number of medication errors by Ms. Olaniran.

The Complaints Director determined that she would conduct an investigation into the Second Complaint. Ms. Olaniran received notice of the Second Complaint and the preliminary investigation by letter dated June 18, 2019.

On July 4, 2019, the Complaints Consultant requested that Jeanne Weis, Executive Director for the CLPNA, impose a condition of supervised practice on Ms. Olaniran’s practice pursuant to s. 65(1)(a) of Act due to the number of medication errors complaints made against Ms. Olaniran and that it was in the best interests of public safety.

Ms. Olaniran received Notice of the Complaints Consultant’s request for a condition on her practice permit by letter dated July 4, 2019.

By letter dated July 12, 2019, Ms. Weis granted the request for a condition of supervision on Ms. Olaniran’s practice permit and notified Ms. Olaniran accordingly.

On December 31, 2019, Ms. Blatz concluded the investigation into the First and Second Complaint.

Following the Investigation, the Complaints Consultant determined there was sufficient evidence that the issues raised in the First Complaint and Second Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Olaniran received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and Investigation Report, on March 30, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Olaniran under cover of letter dated May 19, 2020.

## (4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are:

1. On or about May 2, 3, and 4, 2018 administered Codeine 30 mg at 2000 hours to client GR when the Codeine 30 mg had been discontinued on May 1, 2018.

2. On or about August 21, 2018 did one or more of the following with regards to client MN:

    a) Failed to ensure medications were consumed;
    b) Left the medications unattended in client MN's room.

3. On or about January 10, 2019 left the medication cart unlocked and unattended.

4. On or about April 4, 2019 failed to correctly document the addition of Belladonna/Morphine Suppositories on the Daily Narcotic & Controlled Drug Administration record.

5. On or about April 10, 2019 left the medication cart unlocked and unattended with the Medication Administration Record binder open on top of the medication cart.

6. Between April 1, 2019 and April 24, 2019 administered Apo-Levocarb 25/200 mg on or around 1700 hours to client CB without witnessing client CB consume the medication.

7. On or about May 7, 2019, did one or more of the following with regards to client DP:

    a) Failed to document on the Medication Administration Record the administration of Apo-Oxycodone HCL/Acetaminophen TA 5 mg at 2100 hours;
    b) Failed to document the reason for the removal of Percocet from the Narcotic & Controlled Drug Administration record at 2000 hours.

8. On or about May 12, 2019, failed to document the reason for the removal of Oxyneo 10 mg from the Narcotic & Controlled Drug Administration record at 2100 hours.

9. On or about May 7, 2019, documented on the Medication Administration Record for the administration of Coumadin 2.5 mg at 1700 hours on the discontinued order as well as the current order for client BH, making it appear as if client BH received a double dose of Coumadin at 1700 hours.

10. On or about May 8, 2019 failed to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar 100 Unit/ml at 2100 hours to client IM.

11. On or about May 12, 2019 did one or more of the following with regards to client HW:

    a) Failed to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar 100 Unit/ml at 2100 hours;
    b) Failed to document on the Medication Administration Record the administration of Cotazym Ecs 20 and Magnesium 250 mg at 1700 hours.

12. On or about May 12, 2019, did one or more of the following with regards to client IM:

    a) Failed to document on the Medication Administration Record the administration of Apo-Metroprolol 25 mg, Metformin FC 500 mg, Teva-Magnesium 100 mg/ml, and Xarelto 20 mg at 1700 hours and Voltaren Emulgel Extra Strength, Apo-Acetaminophen 500 mg and Lantus Solostar 10 units at 2100 hours;
    b) Failed to document on the Medication Administration Record the water flushes at 1600 hours and 2000 hours.

13. On or about May 20, 2019 failed to document the administration of one or more of the following medications on the client's Medication Administration Record:

    a) Pentoxifylline SR 400 mg and Lantus Solostar 20 units at 2100 hours for client WR;
    b) Apo-Levocarb 25/100 mg at 1900 hours and 2200 hours and Artificial Tears Opht and Sennosides at 2200 for client GG;
    c) Isopto Tears Opht Drops at 1700 hours for client FF;
    d) Mylan-Mirtazapine 15 mg at 2000 hours for client MG;
    e) Sennosides 8.6 mg at 1700 hours for client RC;
    f) Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA;
    g) Metformin FC 50 mg at 1700 hours, Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 8.6 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW.

14. On or about May 21, 2019, failed to document the administration of one or more of the following medications on the client's Medication Administration Record:

    a) Acetaminophen 650 mg at 1900 hours and Sennosides 17.2 mg at 2100 hours for client MH;
    b) Mirtazapine 7.5 mg at 2100 hours for client AS;

c) Apo-Acetaminophen 650 mg at 1700 hours and Atrac Tain CR 10%, Vitamin A Acid 0.025% at 2100 hours for client WR;
d) Lantus Solostar 20 units at 2100 hours for client WR;
e) Apo-Levocarb 25/100 mg at 1900 hours and 2200 hours and Artificial Tears Opht and Pms-Sennosides at 2200 hours for client GG;
f) Acetaminophen 650 mg and Isopto Tears Opht Drops at 1700 hours for client FF;
g) Resource 120 ml and Rex Naal Mist Saline at 1700 hours and Mylan-Mirtazapine 15 mg and Vagifem 10 mcg at 2000 hours for client MG;
h) Metformin FC 500 mg and Duotrav PQ at 1700 hours for client RC;
i) Peg 17 g at 1700 hours, Apo-Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA;
j) Resource 60ml, Tamsulosin CR 0.4 mg, Apo-Acetaminophen 650 mg, Ferrous Fumarate 300(100) mg and Metformin FC 500 mg at 1700 hours and Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 17.2 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW;
k) HDC N/S 50 cc/hr at 2100 hours for client LB;
l) Apo-Acetaminophen 500 mg at 1700 hours, Apo-Levocarb 25/100 mg at 2055 hours and Pms-Sennosides 17.2 mg at 2100 hours for client CF;
m) Rex Fibre Laxative at 1700 hours, Dilantin 50 mg, Pms-Sennosides 8.6 mg and Pms_Valproic Acid 250 mg/5 ml at 2100 hours for client HT.

15. On or about May 21, 2019, documented on the Medication Administration Record the administration of Pentoxifylline SR 400 mg, Apo-Acetaminophen 650 mg and Sdz-Carbamazepine CR 200 mg at 2100 hours for client WR when the medications were found in the medication cart in the medication pouch.

## (5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Ms. Olaniran acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Consultant submitted, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

## (6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3: Joint Submission on Penalty

## (7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #1.

## (8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Lilibeth Olaniran's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Lilibeth Olaniran.

Allegation 1

Lilibeth Olaniran admitted on or about May 2, 3, and 4, 2018, she administered Codeine 30 mg at 2000 hours to client GR when the Codeine 30 mg had been discontinued on May 1, 2018.

Ms. Olaniran provided care to client GR on May 2, 3, and 4, 2018.

On April 25, 2018, client GR was ordered to receive Codeine 30mg PO QHS x 1 week. As per client GR's Physician's Order, the last date of administration on the Medication Administration Record (MAR) was May 1, 2018.

Despite the above, on May 2, 3 and 4, 2018, at approximately 2000 hours, Ms. Olaniran recorded removal of Codeine 30mg on the Daily Narcotic and Controlled Drug Administration record for client GR and administered the same on those days.

Ms. Olaniran failed to check client GR's MAR and administered Codeine 30mg to client GR on three additional dates after the Order had been discontinued.

Sheeja Velayudan, LPN discovered that additional medication had been administered to client GR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 1 did in fact occur.

Ms. Olaniran displayed a lack of knowledge or skill and judgement by not checking client GR's Medication MAR on May 2, 3, or 4, 2018. This is one of the fundamental "rights" of medication administration. The result of this was that client GR received medication for three days after the attending Physician ordered that it discontinue. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation which can cause a reduction of trust in LPNs overall. This could have been avoided if Ms. Olaniran had used client GR's MAR when doing her medication pass on the above-mentioned dates. Ms. Olaniran's conduct also constitutes a breach of the Code of Ethics and Standards of Practice for the reasons discussed below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 2</u>

Lilibeth Olaniran admitted on or about August 21, 2018, she did one or more of the following with regards to client MN:

a) Failed to ensure medications were consumed;
b) Left the medications unattended in client MN's room.

On August 21, 2018, Ms. Olaniran provided care to client MN.

While providing care to client MN, a healthcare aide outside the room called for assistance with another client. Ms. Olaniran left client MN's room to assist the healthcare aide. Ms. Olaniran failed to return to client MN's room to ensure she consumed her medication.

At approximately 2345 hours on the same date, Esperance Mambu-Konde, LPN discovered the medication on client MN's bedside table.

On August 29, 2018, a Letter of Expectation was issued to Ms. Olaniran relating to the August 21, 2018 incident.

Ms. Olaniran failed to make sure that client MN took her medications. Ms. Olaniran placed the medications on client MN's beside table but did not return to make sure that MN did indeed consume the medications.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 2 did in fact occur.

Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation. Ms. Olaniran should have taken the medication out of client MN's room when she was leaving and then returned at a later time to administer MN's medications. Failing to do so could lead to a member of the public concluding that LPNs do not provide proper care to clients and conclude that LPNs are not deserving of self-regulation. This conduct displayed a lack of skill. Moreover, Ms. Olaniran did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 3</u>

Lilibeth Olaniran admitted on or about January 10, 2019, she left the medication cart unlocked and unattended.

On January 10, 2019, Ratibha Sirajuddin, RN, Community Manager, was conducting a shift observation of Ms. Olaniran from approximately 1500 hours to 2315 hours due to ongoing concerns with medication management and time management.

While Ms. Olaniran was completing her medication pass, Ms. Sirajuddin observed Ms. Olaniran leaving the medication cart unlocked and unattended outside several residents' rooms.

A summary of Ms. Sirajuddin's observations was submitted into evidence before the Hearing Tribunal. The summary stated that a Performance Improvement Plan was to be created by the end of January, with goals being met by the end of February 2019.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 3 did in fact occur.

Ms. Olaniran left the medication cart unlocked and unattended outside several of the residents' rooms. This posed a risk to, not only Ms. Olaniran, but to the residents as well. This is not standard protocol of medication administration and Ms. Olaniran was aware of the proper protocol at Eaux Claires with regards to medication administration but did not follow it. In doing so, she failed to demonstrate the application of her professional skill and judgment. Ms. Olaniran harmed the integrity of the profession by not doing what another LPN would do if placed in the same position. It is expected that the medication cart, when not in view of the LPN, is locked to prevent any harm to the residents. By not doing this, Ms. Olaniran placed herself, the residents, and the profession at risk. Ms. Olaniran also failed to follow the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 4</u>

Lilibeth Olaniran admitted on or about April 4, 2019, she failed to correctly document the addition of Belladonna/Morphine Suppositories on the Daily Narcotic & Controlled Drug Administration record.

On April 4, 2019, Ms. Olaniran failed to correctly document the addition of 12 Belladonna/Morphine Suppositories on the Daily Narcotic and Controlled Drug Administration record.

On the Daily Narcotic and Controlled Drug Administration record, at approximately 1930 hours, the total Belladonna/Morphine suppositories were recorded as 4.

If additional medication is received, it should be recorded on a separate line indicating the time, origin and amount of additional medication received.

At approximately 2000 hours, Ms. Olaniran recorded the total number of Belladonna/Morphine suppositories as 16. Ms. Olaniran failed to record a separate entry indicating the time and origin of the additional 12 suppositories.

Sharon Wharton, RN, Director of Care discovered the error during a routine narcotic audit on May 8, 2019.

On June 10, 2019, at approximately 2300 hours, Ms. Wharton, Robin Brooks, Prisca Ryan and Ms. Olaniran met to discuss recent errors that had been found, including the failure to document additional suppositories on the Daily Narcotic and Controlled Drug Administration record.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 4 did in fact occur.

Ms. Olaniran failed to correctly put in additional Belladonna/Morphine Suppositories on the Daily Narcotic and Controlled Drug Administration record. Instead of putting in that there were twelve medications added Ms. Olaniran only wrote in the total of 16. This caused the narcotic count to be incorrect and this shows a lack of knowledge and skill on the part of Ms. Olaniran. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do which would be to add the medication to the count sheet in the proper manner as this is a basic task within medication administration for an LPN. Ms. Olaniran also contravened the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 5

Lilibeth Olaniran admitted on or about April 10, 2019, she left the medication cart unlocked and unattended with the Medication Administration Record binder open on top of the medication cart.

On April 10, 2019, Ms. Olaniran was working an evening shift at household 34/3300.

Shortly before 1600 hours, Ms. Olaniran was preparing medications for her medication pass. After hearing a noise in another client's room, Ms. Olaniran left to assist and left the medication cart unattended in the hallway.

Cindy Mucha, RN, and Ms. Cholak came upon the unattended medication cart. It was unlocked and the Medication Administration Records containing confidential client information was left open on top of the medication cart. After it was discovered, the medication cart was taken to the 'neighbourhood' office as Ms. Cholak was unable to lock the cart herself. After approximately five minutes, Ms. Olaniran arrived. The keys for the unattended medication cart were with Ms. Olaniran.

On April 10, 2019, at approximately 1630 hours, Ms. Cholak interviewed Ms. Mucha regarding the incident.

On April 17, 2019, at approximately 1300 hours, Ms. Cholak interviewed Ms. Olaniran regarding the incident.

As a result of the incident, on April 30, 2019, a Counselling Memorandum was issued to Ms. Olaniran and she was suspended for three (3) shifts, April 30, May 1 and May 2, 2019, without pay. Ms. Olaniran's Counselling Memorandum was included in the evidence before the Hearing Tribunal.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 5 did in fact occur.

Ms. Olaniran left the medication cart unlocked and unattended. This posed a risk to, not only Ms. Olaniran, but to the residents as well. Ms. Olaniran also left the Medication Administration Record Binder open on top the Medication Cart. This posed risk for the breach of confidentiality. In doing this, Ms. Olaniran displayed a real lack of judgment. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation because medication administration is a basic fundamental for an LPN and it is an expectation that LPNs will adhere to the fundamentals of medication administration as well as adhere to site policies. Finally, this conduct constitutes a breach of the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 6

Lilibeth Olaniran admitted between April 1, 2019 and April 24, 2019, she administered Apo-Levocarb 25/200 mg on or around 1700 hours to client CB without witnessing client CB consume the medication.

From April 1, 2019 to April 24, 2019, Ms. Olaniran worked the evening shift and provided care for client CB.

Client CB was ordered Apo-Levocarb 25/100mg to be taken at 1800 hours.

During this time, Ms. Olaniran typically took her break around 1800 hours. Due to client CB's preference to take his medication at exactly 1800 hours, Ms. Olaniran left the Apo-Levocarb on client CB's table at approximately 1730 hours, to allow client CB to take the medication at 1800 hours. Client CB took Apo-Levocarb 25/200mg without Ms. Olaniran witnessing him consuming it.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 6 did in fact occur.

On April 25, 2019, at approximately 1400 hours, Ms. Brooks, Ms. Ryan, Ms. Cholak and Ms. Olaniran met to discuss the incident. Ms. Olaniran displayed a lack of knowledge, skill or judgment by not witnessing client CB take his medication. Ms. Olaniran should have remained with client CB instead of going for her break. Ms. Olaniran showed a lack of judgement by leaving the medications and going for her break and this lack of judgment is inconsistent with being a member of a self-regulated profession. Ms. Olaniran's actions harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation which would be to stay with client CB while he took his medication to ensure that client CB did in fact take his medication. LPNs enjoy self-regulation because they are trusted members of the health care team and the public need to be able to trust that LPNs will provide quality care. Ms. Olaniran engaged in conduct that erodes that confidence and in turn harms the integrity of the LPN profession. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 7

Lilibeth Olaniran admitted on or about May 7, 2019, she did one or more of the following with regards to client DP:

a) Failed to document on the Medication Administration Record the administration of Apo-Oxycodone HCL/Acetaminophen TA 5 mg at 2100 hours;
b) Failed to document the reason for the removal of Percocet from the Narcotic & Controlled Drug Administration record at 2000 hours.

On May 7, 2019, Ms. Olaniran provided care to client DP. Ms. Olaniran administered Apo-Oxycodone HCL/Acetaminophen 5mg at 2100 hours to client DP, but failed to document administration of the same on client DP's MAR.

At approximately 2000 hours, Ms. Olaniran removed Percocet from the Narcotic and Controlled and Drug Administration record for client DP.

Ms. Olaniran failed to document on client DP's Pain Flow Record and/or Progress Note the Percocet removed from the Narcotic and Controlled Drug Administration record at 2000 hours

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 7 did in fact occur.

Ms. Olaniran failed to document on client DP's Medication Administration Record the medications that she administered, nor did she document the removal of medications from the Narcotic and Controlled Drug Administration Record. In doing so, she failed to demonstrate the skill expected of an LPN in relation to the administration of medications. Ms. Olaniran's conduct did not reflect what another LPN would do in a similar situation and so displayed conduct which reflected poorly on all LPNs and thereby harmed the integrity of the profession. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.
b) Contravention of the Act, a code of ethics or standards of practice.
c) Conduct that harms the integrity of the regulated profession.

Allegation 8

Lilibeth Olaniran admitted on or about May 12, 2019, she failed to document the reason for the removal of Oxyneo 10 mg from the Narcotic & Controlled Drug Administration record at 2100 hours.

On May 12, 2019, Ms. Olaniran provided care for client DP. At approximately 2100 hours, Ms. Olaniran removed Oxyneo 10mg from the Narcotic and Controlled Drug Administration record for client DP.

Ms. Olaniran failed to document the administration of Oxyneo 10mg at 2100 hours on client DP's MAR.

Ms. Olaniran failed to document on client DP's Pain Flow Record the Oxyneo 10mg removed at 2100 hours.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 8 did in fact occur.

Ms. Olaniran displayed a lack of knowledge by failing to document the reason for the removal of the Oxyneo 10 mg from the Narcotic and Controlled Drug Administration for client DP. Medication administration is a fundamental core competency for LPNs. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation which undermines the public's view of the profession as one of skilled and knowledgeable professionals working competently to provide healthcare. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 9

Lilibeth Olaniran admitted on or about May 12, 2019, she failed to document the reason for the removal of Oxyneo 10 mg from the Narcotic & Controlled Drug Administration record at 2100 hours.

On May 7, 2019, Ms. Olaniran provided care to Client BH. Client BH's order of Coumadin 2mg alternation with 2.5mg daily was discontinued on May 7, 2019. A new order was started on the same date.

Ms. Olaniran administered Coumadin 2.5mg to client BH at 1700 hours. Ms. Olaniran initialed for the administration on both the current and discontinued order on the MAR. This made it appear that client BG had been administered a double dose of Coumadin, which is a high-risk medication, at 1700 hours.

The error was discovered by Ms. Brooks on June 4, 2019.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 9 did in fact occur.

Ms. Olaniran displayed a lack of knowledge when she documented on the Medication Administration Record the administration of Coumadin 2.5 mg at 1700 hours on the discontinued order, as well as, the current Medication Administration Record for client BH. By documenting on the two different Medication Administration Records this gave the appearance that client BH received two doses of Coumadin which could have resulted in significant harm to the client. Members of the public rely on LPNs to carry out the administration of medications with care and accuracy and by failing to do this Ms. Olaniran's behaviour undermined this trust and consequently the integrity of the profession. Finally, Mr. Olaniran's conduct breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 10</u>

Lilibeth Olaniran admitted on or about May 8, 2019, she failed to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar 100 Unit/ml at 2100 hours to client IM.

On May 8, 2019, Ms. Olaniran provided care to client IM. On or around 2100 hours, Ms. Olaniran administered Lantus Solostar 100 unit/ml to client IM.

As Lantus Solostar 100 unit/ml is a high alert medication, a seconded independent check is required prior to administration. As Ms. Olaniran was in a hurry, she failed to follow correct protocol for a second independent check for insulin administration as no second signature was recorded on the MAR for client IM.

Ms. Brooks discovered the error on June 4, 2019, during a medication audit.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 10 did in fact occur.

Ms. Olaniran displayed a lack of judgment by failing to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar to client IM. This was in violation of Eaux Claires' policy which Ms. Olaniran should have known as she was not a new employee to the facility. Medication administration is a core competency of LPNs and it must be executed properly. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation which undermines the profession as a whole. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 11</u>

Lilibeth Olaniran admitted on or about May 12, 2019, she did one or more of the following with regards to client HW:

a) Failed to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar 100 Unit/ml at 2100 hours;
b) Failed to document on the Medication Administration Record the administration of Cotazym ECS 20 and Magnesium 250 mg at 1700 hours.

On May 12, 2019, Ms. Olaniran provided care to client HW. On or around 2100 hours, Ms. Olaniran administered Lantus Solostar 100 unit/ml to client HW.

As Lantus Solostar 100 unit/ml is a high alert medication, a second independent check is required prior to administration. Ms. Olaniran failed to follow correct protocol for a second independent check for insulin administration as no second signature was recorded on the MAR for client HW.

Ms. Olaniran failed to document the administration of Cotazym ECS 20 and Magnesium 250mg at 1700 hours on client HW's MAR.

Ms. Brooks discovered the lack of a second independent check of Lantus Solostar 100 units/ml on June 4, 2019, during a medication audit.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 11 did in fact occur.

Ms. Olaniran displayed a lack of judgment by failing to document on the Medication Administration Record a second independent check for the administration of Lantus Solostar to client IM. This was in violation of Eaux Claires' policy which Ms. Olaniran should have known as she was not a new employee to the facility. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation. Medication administration is a core competency of LPNs so when it is not done properly it calls into question all members of the profession and the practice of LPNs. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

<u>Allegation 12</u>

Lilibeth Olaniran admitted on or about May 12, 2019, she did one or more of the following with regards to client IM:

a) Failed to document on the Medication Administration Record the administration of Apo-Metroprolol 25 mg, Metformin FC 500 mg, Teva-Magnesium 100 mg/ml, and Xarelto 20 mg at 1700 hours and Voltaren Emulgel Extra Strength, Apo-Acetaminophen 500 mg and Lantus Solostar 10 units at 2100 hours;
b) Failed to document on the Medication Administration Record the water flushes at 1600 hours and 2000 hours.

On May 12, 2019, Ms. Olaniran provided care to client IM. On that date, Ms. Olaniran administered Apo-Metroprolol 25 mg, Metformin FC 500mg, Teva-Magnesium 100 mg/ml, and Xarelto 20 mg at 1700 hours and Voltaren Emulgel Extra Strength, Apo-Acetaminophen 500 mg and Lantus Solostar 10 units at 2100 hours to client IM. Water flushes were also to be performed at 1600 hours and 2000 hours to client IM.

On that date, Ms. Olaniran failed to document on the MAR the administration of Apo-Metroprolol 25 mg, Metformin FC 500 mg, Teva-Magnesium 100 mg/ml, and Zarelto 20mg at 1700 hours and Voltaren Emulgel Extra Strength, Apo-Acetaminophen 500 mg and Lantus Solostar 10 units at 2100 hours.

Ms. Olaniran failed to document on client IM's MAR water flushes at 1600 hours and 2000 hours.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 12 did in fact occur.

Ms. Olaniran displayed a lack of knowledge of or lack of skill or judgment by failing to document on the Medication Administration Record for client IM. Medication administration is a core competency for an LPN. Ms. Olaniran also failed to perform the proper checks for medication administration. Ms. Olaniran failed to follow the "rights" of medication administration and in doing so called into question the administration of medication by all LPNs. As such, Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.
b) Contravention of the Act, a code of ethics or standards of practice.
c) Conduct that harms the integrity of the regulated profession.

Allegation 13

Lilibeth Olaniran admitted on or about May 20, 2019, she failed to document the administration of one or more of the following medications on the client's Medication Administration Record:

a) Pentoxifylline SR 400 mg and Lantus Solostar 20 units at 2100 hours for client WR;
b) Apo-Levocarb 25/100 mg at 1900 hours and 2200 hours and Artificial Tears Opht and Sennosides at 2200 for client GG;
c) Isopto Tears Opht Drops at 1700 hours for client FF;

d) Mylan-Mirtazapine 15 mg at 2000 hours for client MG;
e) Sennosides 8.6 mg at 1700 hours for client RC;
f) Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA;
g) Metformin FC 50 mg at 1700 hours, Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 8.6 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW.

On May 20, 2019, Ms. Olaniran provided care for client WR, client GG, client FF, client MG, client RC, client HA, and client PW.

On May 20, 2019, Ms. Olaniran administered but failed to document the administration of medication for the aforementioned seven (7) clients including:

a. Pentoxifylline SR 400 mg and Lantus Solostar 20 units at 2100 hours for client WR;

b. Apo-Levocarb 25/100 mg at 1900 hours and 2200 hours and Artifical Tears Opht and Sennosides at 2200 hours for client GG;

c. Isopto Tears Opht Drops at 1700 hours for client FF;

d. Mylan-Mirtazapine 15 mg at 2000 hours for client MG;

e. Sennosides 8.6 mg at 1700 hours for client RC;

f. Apo-Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA;

g. Metformin FC 50 mg at 1700 hours, Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 8.6 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW.

Ms. Brooks discovered the errors on May 22, 2019, after completing a medication audit.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 13 did in fact occur.

Ms. Olaniran failed to document the administration of medication for at least nine clients in a single day. This shows a real lack of knowledge, skill and judgment on the part of Ms. Olaniran. Ms. Olaniran harmed the integrity of the profession by not doing what another reasonable LPN would do in a similar situation. Ms. Olaniran repeatedly failed to follow the rights of medication administration which fails to demonstrate to the public that LPNs are skilled professionals who can be trusted to undertake medication administration. Ms. Olaniran's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 14

Lilibeth Olaniran admitted 0n or about May 21, 2019, she failed to document the administration of one or more of the following medications on the client's Medication Administration Record:

a) Acetaminophen 650 mg at 1900 hours and Sennosides 17.2 mg at 2100 hours for client MH;
b) Mirtazapine 7.5 mg at 2100 hours for client AS;
c) Apo-Acetaminophen 650 mg at 1700 hours and Atrac Tain CR 10%, Vitamin A Acid 0.025% at 2100 hours for client WR;
d) Lantus Solostar 20 units at 2100 hours for client WR;
e) Apo-Levocarb 25/100 mg at 1900 hours and 2200 hours and Artificial Tears Opht and Pms-Sennosides at 2200 hours for client GG;
f) Acetaminophen 650 mg and Isopto Tears Opht Drops at 1700 hours for client FF;
g) Resource 120 ml and Rex Naal Mist Saline at 1700 hours and Mylan-Mirtazapine 15 mg and Vagifem 10 mcg at 2000 hours for client MG;
h) Metformin FC 500 mg and Duotrav PQ at 1700 hours for client RC;
i) Peg 17 g at 1700 hours, Apo-Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA;
j) Resource 60ml, Tamsulosin CR 0.4 mg, Apo-Acetaminophen 650 mg, Ferrous Fumarate 300(100) mg and Metformin FC 500 mg at 1700 hours and Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 17.2 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW;
k) HDC N/S 50 cc/hr at 2100 hours for client LB;
l) Apo-Acetaminophen 500 mg at 1700 hours, Apo-Levocarb 25/100 mg at 2055 hours and Pms-Sennosides 17.2 mg at 2100 hours for client CF;
m) Rex Fibre Laxative at 1700 hours, Dilantin 50 mg, Pms-Sennosides 8.6 mg and Pms_Valproic Acid 250 mg/5 ml at 2100 hours for client HT.

On May 21, 2019, Ms. Olaniran provided care to client MH, client AS, client WR, client GG, client FF, client MG, client RC, client HA, client PW, client LB, client CF, and client HT.

Ms. Olaniran administered, but failed to document the administration of medication, for the twelve (12) aforementioned clients including:

a. Acetaminophen 650 mg at 1900 hours and Sennosides 17.2 mg at 2100 hours for client MH.

b. Mirtazapine 7.5 mg at 2100 hours for client AS.

c. Apo-Acetaminophen 650 mg at 1700 hours and Atrac Tain CR 10%, Vitamin A Acid 0.025% at 2100 hours for client WR.

d. Lantus Solostar 20 units at 2100 hours for client WR.

e. Apo-Levocarb 25/100mg at 1900 hours and 2200 hours and Artificial Tears Opht and Pms-Sennosides at 2200 hours for client GG.

f. Acetaminophen 650 mg and Isopto Tears Opht Drops at 1700 hours for client FF.

g. Resource 120 ml and Rex Nasal Mist Saline at 1700 hours and Mylan-Mirtazapine 15 mg and Vagifem 10 mcg at 2000 hours for client MG.

h. Metformin FC 500 mg and Duotrav PQ at 1700 hours for client RC.

i. Peg 17 g at 1700 hours, Apo-Acetaminophen 650 mg and Artificial Tears Opht at 2100 hours for client HA.

j. Resource 60 ml, Tamsulosin CR 0.4 mg, Apo-Acetaminophen 650 mg, Ferrous Fumarate 300 (100) mg and Metformin FC 500 mg at 1700 hours and Melatonin TB 5 mg at 2000 hours and Pms-Sennosides 17.2 mg and Apo-Acetaminophen 650 mg at 2100 hours for client PW.

k. HDC N/S 50 cc/hr at 2100 hours for client LB.

l. Apo-Acetaminophen 500 mg at 1700 hours, Apo-Levocarb 25/100mg at 2055 hours and Pms-Sennosides 17.2 mg at 2100 hours for client CF.

m. Rex Fibre Laxative at 1700 hours, Dilantin 50 mg, Pms-Sennosides 8.6 mg and Pms-Valproic Acid 250 mg/5ml at 2100 hours for client HT

These errors were discovered during a medication audit by Ms. Brooks.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 14 did in fact occur.

On May 21, 2019, Mr. Olaniran failed to document the administration of medication for at least 12 patients which demonstrates a serious lack of skill and judgment in her work. In failing to carry out fundamental tasks to this degree she cast a shadow over the work of all LPNs and harmed the integrity of the profession. Finally, her conduct breached the Code of Ethics as well as the Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

Allegation 15

Lilibeth Olaniran admitted on or about May 21, 2019, she documented on the Medication Administration Record the administration of Pentoxifylline SR 400 mg, Apo-Acetaminophen 650 mg and Sdz-Carbamazepine CR 200 mg at 2100 hours for client WR when the medications were found in the medication cart in the medication pouch.

On May 21, 2019, Ms. Olaniran provided care for client WR. At 2100 hours, Ms. Olaniran documented the administration of Pentoxifylline SR 400 mg, Apo-Acetaminophen 650 mg and Sdz-Carbamazepine CR 200 mg at 2100 hours for client WR.

On May 22, 2019, despite Ms. Olaniran's documentation of administration, Natasha Ng, LPN, located WR's above mentioned medications in the medication pouch in the medication room. Client WR did not receive the medications despite Ms. Olaniran's documentation that she gave the medications to WR.

The error was discovered by Natasha Ng and brought to the attention of Ms. Brooks. Ms. Ng also completed a Medication Incident Report.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Olaniran's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit 2 prove that the conduct for Allegation 15 did in fact occur.

Ms. Olaniran displayed a lack of knowledge, lack of skill and judgment by failing to document on the Medication Administration Record the administration of client WR's medications which were found in the medication pouch in the medication cart. Ms. Olaniran documented that the medications were given to client WR when they were not. Medication administration is a core competency of being an LPN and Ms. Olaniran should have given WR the medications and witnessed WR take them prior to signing them as being given on the Medication Administration Record. By failing to administer medication despite indicating that it had in fact been administered, Ms. Olaniran called into question the work of all LPN's and harmed the integrity of the profession. This conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

b) Contravention of the Act, a code of ethics or standards of practice.

c) Conduct that harms the integrity of the regulated profession.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics" and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice").

CLPNA Code of Ethics

Ms. Olaniran acknowledges her conduct breached one of more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

a. Principle 1: Responsibility to the Public – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:

    - 1.1 Maintain standards of practice, professional competence and conduct.

    - 1.2 Provide only those functions for which they are qualified by education and experience.

    - 1.5 Provide care directed toward the health and well-being of the person, family, and community.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

    - 2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.

    - 2.8 Use evidence and judgement to guide nursing decisions.

    - 2.9 Identify and minimize risks to clients.

c. Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

    - 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

    - 3.3 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

d. Principle 4: Responsibility to the Profession – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically provides that LPNs:

    - 4.2 Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families and communities.

e. Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

    - 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

    - 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

Ms. Olaniran's conduct by improperly administering medication, failing to follow medication administration policies and protocols, and in numerous errors in regard to administering medication improperly shows a serious failing to the public to provide safe care which accords with professional competence. Each occasion of error also represents a failure to the particular client affected and could well undermine the trust these clients placed in her. Leaving records available for review by passersby undermined the requirement to maintain the confidence of private information. She also failed her profession by engaging in repeated failures of a completely avoidable nature and in relation to fundamental skills of any LPN. Finally, she failed herself as an LPN in failing to operate according to her training and professional competence. As such, the conduct set out above constitutes a series of breaches of the Code of Ethics to such an extent that constitutes an unprofessional conduct.

<u>CLPNA Standards of Practice</u>

Ms. Olaniran acknowledges that her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

a. Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

    - 1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.

- 1.4 Recognize their own practice limitations and consult as necessary.

- 1.6 Take action to avoid/or minimize harm in situations in which client safety and well-being are compromised.

- 1.7 Incorporate established client safety principles and quality assurance/improvement activities into LPN practice.

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

b. Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

    - 2.1 Possess current knowledge to support critical thinking and professional judgement.

    - 2.7 Demonstrate understanding of their role and its interrelation with clients and other health care colleagues.

c. Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

    - 3.6 Demonstrates an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

d. Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

    - 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.

    - 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

    - 4.9 Support and contribute to healthy and positive practice environments.

- 4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

Ms. Olaniran's repeated errors relating to all aspects of medication administration constitute breaches of the Standards of Practice. Ms. Olaniran failed in professional accountability and responsibility by failing to practice in a manner consistent with her obligations. She also acted in a manner which undermined the creation of an environment to promote safe and effective practice and which did not accord with an understanding of the privileges of self-regulation. Finally, her conduct did not accord with the high standards of ethical practice expected of all members of the CLPNA.

**(9) Joint Submission on Penalty**

The Complaints Consultant and Ms. Olaniran jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Olaniran shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months from service of letter advising of final costs.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Olaniran shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Olaniran shall provide a signed written declaration to Susan Blatz, Complaints Consultant, within **(30) days** of service of the Decision, attesting she has reviewed CLPNA's documents:

    i. Code of Ethics for Licensed Practical Nurses in Canada;

    ii. Standards of Practice for Licensed Practical Nurses in Canada;

    iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

    iv. CLPNA Practice Policy: Documentation;

    v. CLPNA Practice Guideline: Medication Management;

    vi. CLPNA Competency Profile A1: Critical Thinking;

    vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

viii. CLPNA Competency Profile A3: Time Management; and

ix. CLPNA Competency Profile U: Medication Management.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

4. Ms. Olaniran shall complete, at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Olaniran shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Ms. Olaniran shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Olaniran shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Lilibeth Olaniran's practice permit shall be subject to a condition that she practice medication administration under supervision for a period of 200 hours, and that:

   a) She must provide any person supervising (the "Evaluator") her medication administration practice with a copy of the Medication Administration Competency Skills Evaluation Tool;

   b) Following the completion of 200 hours of supervised medication administration practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

   c) Following the completion of 200 hours of supervised medication administration practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. The orders set out above at paragraphs 2-5 will appear as conditions on Ms. Olaniran's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial activities outlined at paragraphs 2-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Olaniran's practice permit and the Public Registry until the below orders have been satisfactorily completed;

   i. Read and review CLPNA documents;

   ii. NURS 0161 Medication Management;

   iii. Nursing Documentation 101.

b) The requirement to practice subject to medication administration supervision will continue to appear on Ms. Olaniran's practice permit and the Public Registry until she provides proof to the Complaints Consultant that she has successfully completed the requirements set out above at paragraph 6; and

c) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Ms. Olaniran's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Ms. Olaniran's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 7.

9. Ms. Olaniran shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Olaniran will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Ms. Olaniran be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Ms. Olaniran fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

    a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    b) Treat Ms. Olaniran's non-compliance as information for a complaint under s. 56 of the Act; or

    c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Olaniran's practice permit until such costs are paid in full or the Complaints

Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

Legal Counsel for the Complaints Consultant submitted the primary purpose of orders from the Hearing Tribunal is to protect the public. The Hearing Tribunal is aware that s. 82 of the Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Olaniran and the Complaints Consultant.

## (10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Olaniran has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances

- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

- **The nature and gravity of the proven allegations:** This is a significant factor as the allegations are concerning violations of workplace policy, medication administration, and medication administration. Ms. Olaniran did not adhere to the basic rights of medication administration to which is expected that an LPN will adhere to. These allegations are quite serious in nature as these allegations go against the basic skills and core competencies that is expected of an LPN regardless of their experience and are basic requirements upon graduation.

- **The age and experience of the investigated member:** Ms. Olaniran was initially registered with the CLPNA on February 9, 2012. Ms. Olaniran graduated as an LPN in 2010 in Vancouver, BC. After moving to Edmonton, she began working at Extendicare Eaux Claires in a full-time position. Medication administration is a core competency of an LPN regardless of their experience level.

- **The age and mental condition of the victim, if any:** the clients that were in Ms. Olaniran's care were clients were elderly patients who relied on Ms. Olaniran to give them their medications in a timely manner.

- **The number of times the offending conduct was proven to have occurred:** There were fifteen (15) allegations that occurred over a one-year time period with ten (10) of the allegations occurring within a one (1) month time period. In respect to allegations thirteen (13) there were seven (7) medication errors and in respect to allegation fourteen (14) there were thirteen (13) medication errors made on each shift. This shows to the Hearing Tribunal that there is a pattern by the number of allegations that were presented to the Hearing Tribunal, as well as, the number of medication errors that Ms. Olaniran had made and the fact that there were 27 medication errors made on two different shifts was a substantial factor and raised serious concern for the Hearing Tribunal.

- **The role of the investigated member in acknowledging what occurred:** Ms. Olaniran did acknowledge each of the allegations that were presented to the Hearing Tribunal and she did cooperate with both the CLPNA as well as her AUPE representative by providing the Hearing Tribunal with an Agreed Statement of Facts.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Ms. Olaniran was placed on an unpaid suspension for three (3) days and then was terminated from her position at Extendicare Eaux Claires.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** Regarding specific deterrence there is a need to impose sanctions on Ms. Olaniran as she should be aware that this type of behavior of an LPN is not acceptable and falls below the expectations of an LPN. Regarding general deterrence, the public should also be made aware that this type of behavior will not be tolerated by the CLPNA and that the behavior will be dealt with in a serious manner. CLPNA does have a discipline process which helps to ensure that LPNs are competent and self-regulated professionals and the public needs to be reassured that this standard is upheld.

- **The need to maintain the public's confidence in the integrity of the profession:** The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the Act, the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

## (11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Ms. Olaniran shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months from service of letter advising of final costs.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Olaniran shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website

http://www.clpna.com/ under "Governance" and will be provided. Ms. Olaniran shall provide a signed written declaration to Susan Blatz, Complaints Consultant, within **(30) days** of service of the Decision, attesting she has reviewed CLPNA's documents:

i. Code of Ethics for Licensed Practical Nurses in Canada;

ii. Standards of Practice for Licensed Practical Nurses in Canada;

iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

iv. CLPNA Practice Policy: Documentation;

v. CLPNA Practice Guideline: Medication Management;

vi. CLPNA Competency Profile A1: Critical Thinking;

vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

viii. CLPNA Competency Profile A3: Time Management; and

ix. CLPNA Competency Profile U: Medication Management.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

4. Ms. Olaniran shall complete, at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Olaniran shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Ms. Olaniran shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Olaniran shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Lilibeth Olaniran's practice permit shall be subject to a condition that she practice medication administration under supervision for a period of 200 hours, and that:

   a) She must provide any person supervising (the "Evaluator") her medication administration practice with a copy of the Medication Administration Competency Skills Evaluation Tool;

b) Following the completion of 200 hours of supervised medication administration practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

c) Following the completion of 200 hours of supervised medication administration practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. The orders set out above at paragraphs 2-5 will appear as conditions on Ms. Olaniran's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial activities outlined at paragraphs 2-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Olaniran's practice permit and the Public Registry until the below orders have been satisfactorily completed;

        i. Read and review CLPNA documents;

        ii. NURS 0161 Medication Management;

        iii. Nursing Documentation 101.

    b) The requirement to practice subject to medication administration supervision will continue to appear on Ms. Olaniran's practice permit and the Public Registry until she provides proof to the Complaints Consultant that she has successfully completed the requirements set out above at paragraph 6; and

    c) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Ms. Olaniran's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Ms. Olaniran's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 7.

9. Ms. Olaniran shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Ms. Olaniran will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Ms. Olaniran be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Ms. Olaniran fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

    a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    b) Treat Ms. Olaniran's non-compliance as information for a complaint under s. 56 of the Act; or

    c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Olaniran's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a),(b) and 87(2) of the Act, the Investigated Member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

**DATED THE 20th DAY OF JULY 2020 IN THE CITY OF EDMONTON, ALBERTA.**

**THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

Kelly Annesty, LPN
Chair, Hearing Tribunal