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 LISA MANTON (BARBER)

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 LISA MANTON (BARBER), LPN #29533, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta in Edmonton, Alberta on September 30, 2019 with the following individuals present:

Hearing Tribunal:
Patricia Standage, Licensed Practical Nurse ("LPN") Chairperson
Doris Kuelken, LPN
Jan Schaller, LPN
Marg Hayne, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant CLPNA

Investigated Member:
Lisa Manton (Barber), LPN ("Ms. Manton" 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 Partial Joint Submission on Penalty.

(3) Background

Ms. Manton 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. Manton was initially licensed as an LPN in Alberta on May 28, 2007.

By letter dated November 6, 2018, the CLPNA received a complaint (the “Complaint”) from Shauna Greenough, Unit Manager, Unit 38, Peter Lougheed Hospital in Calgary, Alberta, pursuant to s. 57 of the Act stating that Ms. Lisa Manton, who professionally goes by the name Lisa Barber, LPN had been suspended.

In accordance with s. 55(2)(d) of the Act, Sandy Davis, Complaints Director for the CLPNA, appointed Kathryn Emter, Investigator for the CLPNA (the “Investigator”), to conduct an investigation into the Complaint. Ms. Manton received notice of the Complaint, the investigation, and the appointment of the Investigator by letter dated December 12, 2018.

Subsequently, the Complaints Director delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act.

On February 11, 2019, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Manton received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated May 10, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Manton under cover of letter dated July 10, 2019.

(4) Allegations

The Allegations in the Statement of Allegations (the “Allegations”) are:

“It is alleged that LISA MANTON (BARBER), LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about August 31, 2018 did one or more of the following with regards to client RM:
    a) Failed to document the administration and/or disposal of Hydromorphone 2 mg removed at 0830 hours from the Record of Narcotic and Controlled Drugs;
    b) Failed to document the administration and/or disposal of Hydromorphone 2 mg removed at 1050 hours from the Record of Narcotic and Controlled Drugs; and
    c) Removed Hydromorphone 2 mg at 1600 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1700 hours.

2. On or about September 10, 2018 did one or more of the following with regards to client AA:

    a) Failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1220 hours from the Record of Narcotic and Controlled Drugs; and
    b) Removed Hydromorphone inj 2 mg at 0850 hours from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record.

3. On or about September 11, 2018 did one or more of the following with regards to client GM:

    a) Failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1900 hours from the Record of Narcotic and Controlled Drugs and;
    b) Removed Hydromorphone 0.5 mg at 1900 hours from the Record of Narcotic and Controlled Drugs when the order was for Hydromorphone 1 – 2 mg.

4. On or about September 11, 2018 failed to document, separately, the administration and/or disposal of Hydromorphone 0.5 mg removed at 1820 hours and 1822 hours from the Record of Narcotic and Controlled Drugs for client GM.

5. On or about September 17, 2018 did one or more of the following with regards to client GM:

    a) Failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 0820 hours from the Record of Narcotic and Controlled Drugs;
    b) Failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 1800 hours from the Record of Narcotic and Controlled Drugs; and
    c) Failed to document and/or account for the remaining 1 mg of Hydromorphone removed at 1800 hours from the Record of Narcotic and Controlled Drugs.

6. On or about September 29, 2018 at 0850 hours removed from the Record of Narcotic and Controlled Drugs 3 vials of Hydromorphone 2 mg/ml, when only 2 vials were necessary, for the administration of 3 mg of Hydromorphone at 0856 hours for client JR.

7. On or about October 6, 2018 did one or more of the following with regards to client DL:

    a) Removed Hydromorphone inj 2 mg at 0805 hours from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record;
    b) Documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2 mg at 0805 hours; and

c) Removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours.

8. On or about October 10, 2018 failed to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for client MW."

(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. Manton 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:	Partial Joint Submission on Penalty
Exhibit #4:	Additional Order Sought by the Complaints Consultant Regarding Costs

(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 #2.

(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 Ms. Manton'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 Ms. Manton.

Allegation 1

Lisa Manton (Barber) admitted on or about August 31, 2018, she did one or more of the following with regards to client RM:

a) Failed to document the administration and/or disposal of Hydromorphone 2 mg removed at 0830 hours from the Record of Narcotic and Controlled Drugs;
b) Failed to document the administration and/or disposal of Hydromorphone 2 mg removed at 1050 hours from the Record of Narcotic and Controlled Drugs; and
c) Removed Hydromorphone 2 mg at 1600 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1700 hours.

Ms. Manton worked a day shift from 0715 to 1930 hours and provided care to client RM on August 31, 2018. Ms. Manton documented the removal of Hydromorphone 2 mg at 0830 hours for RM on August 31, 2018.

Ms. Manton failed to document the administration and/or disposal of the Hydromorphone 2 mg removed at 0830 hours on August 31, 2018.

Ms. Manton documented the removal of Hydromorphone 2 mg at 1050 hours for RM on August 31, 2018.

Ms. Manton failed to document the administration and/or disposal of Hydromorphone 2 mg removed at 1050 hours on August 31, 2018. A copy of RM's Medication Administration Record is attached at TAB 7 indicating the same.

Ms. Manton removed Hydromorphone 2 mg at 1600 hours for RM on August 31, 2018.

Ms. Manton documented the administration of Hydromorphone 2 mg at 1700 hours on August 31, 2018.

RM's Hydromorphone 2 mg was ordered every 3 hours PRN. PRN medication administration must be documented accurately and in a timely manner due to the frequency they can be administered. If times are not documented accurately and in a timely manner, there is a

potential of overdosing a patient. Administration time must correlate with the removal time on the Record of Narcotic and Controlled Drugs.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:**

   a. Ms. Manton displayed a lack of knowledge by failing to document the administration and /or disposal of Hydromorphone 2 mg removed at 0830 hours from the Record of Narcotic and Controlled Drugs;

   b. Ms. Manton displayed a lack of knowledge by failing to document the administration and/or disposal of Hydropmorphone 2mg removed at 1050 hours from the Record of Narcotic and Controlled Drugs; and

   c. Ms. Manton displayed a lack of knowledge when she removed and administered Hydromorphone 2mg at 1600 hours, and failed to document on the Record of Narcotic and Controlled Drugs that she had done so until 1700 hours.

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in 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"):

   a. Standard 1 (Professional Accountability and Responsibility), as indicated by failing to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies (Standard 1.10) by failing to document the removal and administration of Hydromorphone 2 mg on the Record of Narcotic and Controlled Drugs on August 31 at 0830 hours, and 1050 hours and failing to document the administration of Hydromorphone 2 mg on the Record of Narcotic and Controlled Drugs until 1700 hours when it was removed at 1600 hours;

   b. Standard 3 (Service to Public and Self-Regulation), as indicated by the fact that she failed to document the removal and administration of Hydromorphone 2 mg on the Record of Narcotic and Controlled Drugs on August 31 2018 at 0830 hours, and 1050 hours and failing to document the administration of

Hydromorphone 2 mg, on the Record of Narcotic and Controlled Drugs until 1700 hours when it was removed at 1600 hours, she failed to provide relevant and timely information to co-workers (Principle 3.5) and failed to demonstrate self-regulation by not following the CLPNA Standards of Practice and other regulatory requirements (Principle 3.6);

c. Code of Ethics, Principle 3 (Responsibility to the Profession), as indicated by failing to practice in a manner that is consistent with the privilege and responsibility of self-regulation (Principle 3.3) by failing to document the removal and administration of Hydromorphone 2 mg on the Record of Narcotic and Controlled Drugs on August 31 2018 at 0830 hours, and 1050 hours and failing to document the administration of Hydromorphone 2 mg on the Record of Narcotic and Controlled Drugs, until 1700 hours when it was removed at 1600 hours; and

d. Code of Ethics, Principle 3 (Responsibility to the Profession) as indicated by failing to promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable for (Principle 3.4) by failing to document the removal of and administration of Hydromorphone 2mg on the Record of Narcotic and Controlled Drugs, on Aug 31 2018 at 0830, 1050, and failing to document the administration of Hydromorphone 2mg on the Record of Narcotic and Controlled Drugs, until 1700 hours when it was removed at 1600 hours.

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 2

Lisa Manton (Barber) admitted on or about September 10, 2018, she did one or more of the following with regards to client AA:

a) Failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1220 hours from the Record of Narcotic and Controlled Drugs; and
b) Removed Hydromorphone inj. 2 mg at 0850 hours from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record

Ms. Manton worked an eight-hour day shift from 0715 to 1530 hours and provided care to client AA on September 10, 2018. Ms. Manton stated she received a verbal order from a resident to administer 2 mg of Hydromorphone. The resident failed to confirm the order in writing or digitally. No formal order was in place.

Ms. Manton removed Hydromorphone inj 2 mg for client AA when there was no order in place and without checking it against the Medication Administration Record at 0850 hours on September 10, 2018.

Ms. Manton removed Hydromorphone 0.5 mg at 1220 hours for AA on September 10, 2018.

Ms. Manton failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1220 hours on September 10, 2018.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

   a. Standard 1 (Professional Accountability and Responsibility): On September 10, 2018, Ms. Manton failed to avoid and/or minimize harm in a situation which client safety and well-being are compromised, by failing to both document the administration and/or disposal of Hydromorphone 0.5 mg at 1220 hours from the Record of Narcotic Controlled Drugs, and by removing Hydromorphone inj. 2 mg without verifying Physician's orders or the Medications Administration Record for client AA (in particular, Standard 1.6);

   b. Standard 1 (Professional Accountability and Responsibility): Ms. Manton failed to incorporate established client safety principles and quality assurance improvement practices into LPN practice when she failed to verify with the Physician's Order or the Medication Administration Record for client AA and removed Hydromorphone inj. 2 mg at 0850 hours on September 10, 2018 from the Record of Narcotic and Controlled Drugs (in particular, Standard 1.7);

   c. Standard 1 (Professional Accountability and Responsibility): Ms. Manton failed to document on September 10, 2018 with regards to client AA, the administration and/or disposal of Hydromorphone 0.5 mg at 1220 hours from the Record of Narcotic and Controlled Drugs by not maintaining documentation and reporting according to established legislation, regulations, laws, and employer policies. (Standard 1.10); and

   d. Code of Ethics (Responsibility to the Profession): On September 10, 2018, Ms. Manton failed to practice in a manner that is consistent with the privilege and

responsibility of self-regulation, when she both failed to document the administration and/or disposal of Hydromorphone 0.5 mg at 1220 hours from the Record of Narcotic Controlled Drugs and by removing Hydromorphone inj. 2 mg without verifying Physician's orders or the Medication Administration Record for Client AA (in particular, Principle 3.3).

The Hearing Tribunal finds the conduct contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 3

Lisa Manton (Barber) admitted on or about September 11, 2018, she did one or more of the following with regards to client GM:

a) Failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1900 hours from the Record of Narcotic and Controlled Drugs and;
b) Removed Hydromorphone 0.5 mg at 1900 hours from the Record of Narcotic and Controlled Drugs when the order was for Hydromorphone 1 – 2 mg.

Ms. Manton worked a 12-hour day shift from 0715 to 1930 hours and provided care to client GM on September 11, 2018.

At 1900 hours, Ms. Manton documented on the Record of Narcotic and Controlled Drugs that she removed 2 mg of Hydromorphone for GM, with 0.5 mg to be administered to client GM and 1.5 mg wasted. However, at the time of this removal, the order was for client GM to receive 1-2 mg of Hydromorphone.

Ms. Manton failed to document the administration and/or disposal of Hydromorphone 0.5 mg removed at 1900 hours for GM on September 11, 2018.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton displayed a lack of knowledge on September 11, 2018, by failing to document the administration and/or disposal of Hydromorphone 0.5 mg that she removed at 1900 hours from the Record of Narcotic and Controlled Drugs and, and when she removed Hydromorphone 0.5 mg at 1900 hours from the Record of Narcotic and Controlled Drugs when the order was for Hydromorphone 1-2 mg; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

   a. Standard 1 (Professional Accountability and Responsibility), as indicated by failing to maintain and report according to established legislation, regulations, laws and employer policies (Standard 1.10) by failing to document the administration and/or disposal of Hydromophone 0.5 mg removed at 1900 hours from the Record of Narcotic and Controlled Drugs; and

   b. Principle 3 (Responsibility to the Profession) as indicated by failing to practice in a manner that is consistent with the privilege and responsibility of self-regulation, when on September 11, 2018 she removed Hydromorphone 0.5 mg at 1900 hours from the Record of Narcotic and Controlled Drugs when the order was for Hydromorphone 1-2 mg (in particular, Principle 3.3).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 4</u>

Lisa Manton (Barber) admitted on or about September 11, 2018, she failed to document, separately, the administration and/or disposal of Hydromorphone 0.5 mg removed at 1820 hours and 1822 hours from the Record of Narcotic and Controlled Drugs for client GM.

Ms. Manton worked from 0715 to 2030 hours and provided care to client GM, a different client from client GM noted in Allegation 3, on September 11, 2018.

Ms. Manton documented on the Record of Narcotic and Controlled Drugs that she withdrew Hydromorphone 0.5 mg at 1820 hours. At 1822 hours, Ms. Manton documented withdrawing a second 0.5 mg dose of Hydromorphone to “top up” the first dose.

Ms. Manton documented on client GM’s Medication Administration Record that she administered only one dose of 1 mg of Hydromorphone.

Ms. Manton should have documented two separate entries as two separate doses were removed from the Record of Narcotic and Controlled Drugs sheet.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton failed to document separately the administration and/or disposal of Hydromorphone 0.5 mg removed at 1820 hours and 1822 hours from the Record of Narcotic and Controlled Drugs for client GM on or about September 11 2018; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

   a. Standard 1 (Professional Accountability and Responsibility), as indicated by her failure to maintain and report according to established legislation, regulations, laws and employer policies (Standard 1.10) by failing to document the administration and/or disposal of Hydromophone 0.5 mg removed at 1900 hours from the Record of Narcotic and Controlled Drugs; and

   b. Standard 1 (Professional Accountability and Responsibility), when she failed to maintain documentation and reporting according to established legislation, regulations, laws and employer policies, as indicated by the fact that she failed to document separately the administration and/or disposal of Hydropmorphone 0.5 mg removed at 1820 hours and 1822 hours from the Record of Narcotic and Controlled Drugs for client GM on or about September 11, 2018 (in particular, Standard 1.10).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 5

Lisa Manton (Barber) admitted on or about September 17, 2018, she did one or more of the following with regards to client GM:

a) Failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 0820 hours from the Record of Narcotic and Controlled Drugs;

b) Failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 1800 hours from the Record of Narcotic and Controlled Drugs; and

c) Failed to document and/or account for the remaining 1 mg of Hydromorphone removed at 1800 hours from the Record of Narcotic and Controlled Drugs.

Ms. Manton worked from 0715 to 1930 hours and provided care to client GM on September 17, 2018. Ms. Manton was assigned to a "care hub" for ten patients along with Ashnoor Dhalla, RN, and Nicole Searle, LPN. Ms. Manton was responsible for the primary care of five patients, including GM.

Ms. Manton removed Hydromorphone 1 mg at 0820 hours for GM on September 17, 2018.

Ms. Manton failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 0820 hours on September 17, 2018.

Ms. Manton documented the removal of Hydromorphone 1 mg at 1800 hours on September 17, 2018 for client GM. Ms. Manton did not document on the Record of Narcotic and Controlled Drugs sheet the remaining/wasted Hydromorphone 1 mg, as Hydromorphone is supplied as 1 vial which contains Hydromorphone 2 mg/ml.

There is no corresponding entry on client GM's Medication Administration Record of receiving a 1 mg dose of Hydromorphone at 1800 hours on September 17, 2018. Ms. Manton failed to document the administration and/or disposal of Hydromorphone 1 mg removed at 1800 hours on September 17, 2018.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton displayed a lack of knowledge on or about September 17, 2018 when she failed to document the administration and or/disposal of Hydromorphone 1 mg removed at 0820 hours, and twice at 1800 hours from the Record of Narcotic and Controlled Drugs with regards to client GM; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

    a. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about September 17, 2018, with regards to client GM, she failed to incorporate established client safety principles into her LPN practice when she failed to document the administration and/or disposal of Hydromorphone 1 mg which was removed at 0820 hours, and twice at 1800 hours from the Record of Narcotic and Controlled Drugs (in particular, Standard 1.7); and

b. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about September 17, 2018, with regards to client GM, she failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies, when she failed to document the administration and/or disposal of Hydromorphone 1 mg which was removed at 0820 hours, and twice at 1800 hours from the record of Narcotic and Controlled Drugs (in particular, Standard 1.10).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 6

Lisa Manton (Barber) admitted on or about September 29, 2018 at 0850 hours, she removed from the Record of Narcotic and Controlled Drugs 3 vials of Hydromorphone 2 mg/ml, when only 2 vials were necessary, for the administration of 3 mg of Hydromorphone at 0856 hours for client JR.

Ms. Manton worked a day shift from 0715 to 1930 hours and provided care to client JR on September 29, 2018. At 0850 hours, Ms. Manton withdrew three vials of Hydromorphone 2 mg for administration to client JR.

Ms. Manton recorded administering 3 mg of Hydromorphone at 0856 hours to client JR. Ms. Manton wasted 3 mg of Hydromorphone after withdrawing the three vials.

Hydromorphone is supplied as a vial which contains Hydromorphone 2 mg/ml. Ms. Manton would have only needed 2 vials and should have only wasted 0.5 ml for the ordered dose of 3 mg.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton's admission to 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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton displayed a lack of knowledge on or about September 29, 2018, by removing from the Record of Narcotic and Controlled Drugs 3 vials of Hydromorphone 2 mg/ml, when only 2 vials were necessary, for the administration of 3 mg of Hydromorphone at 0856 hours for client JR; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

a. Standard 2 (Knowledge-Based Practice), as indicated by failing to possess current knowledge to support critical thinking and professional judgment, when on or about September 29, 2018 at 0856 hours she removed from the Record of Narcotic and Controlled Drugs 3 vials of Hydromorphone 2 mg/ml, when only 2 vials were necessary for the administration of 3 mg of Hydromorphone, for client JR (in particular, Standard 2.1); and

b. Standard 2 (Knowledge-Based Practice), as indicated by not applying knowledge from nursing theory and science, and other disciplines, evidence to inform her decision making in her LPN Practice, when on or about September 29, 2018, at 0856 hours she removed from the Record and Controlled Drugs 3 vials of Hydromorphone 2 mg/ml when only 2 vials were necessary for the administration of 3 mg Hydromorphone for client JR (in particular, Standard 2.2).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 7

Lisa Manton (Barber) admitted on or about October 6, 2018, she did one or more of the following with regards to client DL:

a) Removed Hydromorphone inj 2 mg at 0805 hours from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record;

b) Documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2 mg at 0805 hours; and

c) Removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours.

Ms. Manton worked a 12 hour dayshift from 0715 to 1930 hours and provided care to client DL on October 6, 2018.

Ms. Manton removed Hydromorphone inj 2 mg at 0805 hours from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record. When Ms. Manton realized that there was no order for this dose of Hydromorphone, she wasted the entire amount.

Ms. Manton improperly documented the removal of Hydromorphone 2 mg at 0805 hours as Hydromorphone 2 ml. The vial removed did not contain 2 ml.

Ms. Manton removed Hydromorphone 4 mg at 0807 hours for client DL on October 6, 2018. Ms. Manton did not document the administration of Hydromorphone 4 mg until 1230 hours on October 6, 2018.

The Hydromorphone 4 mg was a PRN medication. PRN medication administration must be documented accurately and in a timely manner due to the frequency they can be administered. If times are not documented accurately and in a timely manner, there is a potential of overdosing a patient. Administration time must correlate with the removal time on the Record of Narcotic and Controlled Drugs.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton displayed a lack of knowledge on or about October 6, 2018, at 0805 hours when she removed Hydromorphone inj. 2 mg, from the Record of Narcotic and Controlled Drugs, without verifying the order with a Physician Order or the Medication Administration Record and documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2mg. At 0807 hours on or about October 6, 2018 Ms Manton displayed a lack of knowledge when she removed Hdromorphone 4 mg from the Record of Narcotic and Controlled Drugs, and failed to document the administration until 1230 hours for client DL; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in the CLPNA Code of Ethics and CLPNA Standards of Practice:

    a. Standard 1 (Professional Accountability and Responsibility), as indicted by the fact that she failed to take action to avoid and/or minimize harm in a situation in which client safety and well-being was compromised, when on or about October 6, 2018 she removed Hydromorphone inj. 2 mg at 0805 hours from the Record of Narcotic and Controlled Drugs for client JR, without verifying the order with a Physician Order or the Medication Administration Record, and at 0805 hours documented the removal of Hydropmorphone 2 ml instead of Hydromorphone 2 mg and removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours for client DL (in particular, Standard 1.6);

b. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about October 6, 2018, at 0805 hours she failed to incorporate established client safety principles and quality assurance/improvement activities into her LPN practice when she removed Hydromorphone inj. 2 mg for client JR, from the Record of Narcotic and Controlled Drugs without verifying the order with a Physician Order or the Medication Administration Record, and at 0805 hours she documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2 mg and removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours for client DL (in particular, Standard 1.7);

c. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about October 6, 2018, at 0805 hours she failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies, when she removed Hydromorphone inj. 2 mg from the Record of Narcotic and Controlled Drugs for client JR, without verifying the order with a Physician Order or the Medication Administration Record, and at 0805 hours she documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2 mg and removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours for client DL (in particular, Standard 1.10);

d. Code of Ethics, Principle 3 (Responsibility to the Profession) as indicated by the fact she failed to practice in a manner that is consistent with the privilege and responsibility of self-regulation, when on or about October 6, 2018 at 0805 hours she removed Hydromorphone inj. 2 mg from the Record of Narcotic and Controlled Drugs for client JR, without verifying the order with a Physician Order or the Medication Administration Record, and at 0805 hours she documented the removal of Hydromorphone 2 ml instead of Hydromorphone 2 mg and removed Hydromorphone 4 mg at 0807 hours from the Record of Narcotic and Controlled Drugs but failed to document the administration until 1230 hours, for client DL (in particular, Principle 3.3).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 8</u>

Lisa Manton (Barber) admitted on or about October 10, 2018, she failed to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for client MW.

Ms. Manton worked an eight-hour dayshift from 0745 to 1515 hours and provided care to client MW on October 10, 2018.

According to the Record of Narcotic and Controlled Drugs, Ms. Manton withdrew 12.5 mcg Fentanyl at 1017 hours for client MW. Ms. Manton did not chart the administration and/or disposal of the 12.5 mcg Fentanyl in client MW's Medication Administration Record.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Manton'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.

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:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services:** Ms. Manton displayed a lack of knowledge by failing to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for client MW, on or about October 10, 2018; and

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Manton breached the following principles and standards set out in in CLPNA Code of Ethics and CLPNA Standards of Practice:

   a. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about October 10 2018, Ms. Manton failed to take action to avoid and/or minimize harm in a situation in which client safety and well-being was compromised, when she failed to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours for client MW from the Record of Narcotic and Controlled Drugs (in particular, Standard 1.6);

   b. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about October 10, 2018, Ms. Manton failed to incorporate established client safety principles and quality assurance activities into her LPN practice, by failing to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for client MW (in particular, Standard 1.7);

   c. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that on or about October 10, 2018, Ms. Manton failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies when she failed to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for client MW (in particular, Standard 1.10);

d. Code of Ethics, Principle 3 (Responsibility to the Profession), as indicated by the fact that on or about October 10, 2018, Ms. Manton failed to practice in a manner that is consistent with the privilege and responsibility of self-regulation when she failed to document the administration and/or disposal of Fentanyl 12.5 mcg removed at 1017 hours from the Record of Narcotic and Controlled Drug for Client MW (in particular, Principle 3.3).

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA Code of Ethics and CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Summary

In summary, the Hearing Tribunal considered the evidence put forth in Exhibit #2, and the documents included in Exhibit #2, and concluded that each of the Allegations against Ms. Manton were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act, the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Ms. Manton as an LPN, the Hearing Tribunal found that for each allegation, unprofessional conduct had occurred.

(9) Partial Joint Submission on Penalty

The Complaints Consultant and Ms. Manton made a partial joint submission with respect to penalty, which was entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

2. Prior to reinstatement of her practice permit, Ms. Manton shall:

   (a) Read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide a signed, written declaration to the Complaints Consultant confirming that she has reviewed the documents:

      (i) Standards of Practice for Licensed Practical Nurses in Canada;

      (ii) Code of Ethics 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 E1: Critical Thinking and Critical Inquiry;

(vii) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

(viii) CLPNA Competency Profile U: Medication Administration; and

(ix) CLPNA Competency Profile W: Professionalism.

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

(b) Complete, at her own cost, **NURS 0161 - Basic Medication Administration**, offered online by MacEwan University, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If the course should become unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

(c) Complete the **Nursing Documentation 101** course offered online by the CLPNA at the CLPNA website at www.clpna.com, and provide the Complaints Consultant with a certificate confirming her successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

3. Upon her return to practice as an LPN, Ms. Manton's practice permit will be subject to a condition of supervised practice for a period of 300 hours with the following conditions:

(a) Prior to the commencement of the supervised practice, Ms. Manton shall:

(i) Provide the Complaints Consultant with the name of her supervisor(s);

(ii) Provide her supervisor(s) with a copy of the Decision in this matter; and

(iii) Provide the Complaints Consultant with a written acknowledgment signed by her supervisor(s) confirming receipt of a copy of the Decision.

(b) The supervisor(s) must provide direct supervision of Ms. Manton with respect to medication administration.

(c) Upon completion of the 300 hours of supervised practice, Ms. Manton shall provide the Complaints Consultant with an evaluation completed by her supervisor(s) confirming the completion of the supervised practice and advising whether the supervisor(s) had any concerns related to the issues identified in the allegations and findings in the Decision.

(d) If the supervisor's report identifies concerns with Ms. Manton's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the *Health Professions Act*.

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

5. Should Ms. Manton 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.

6. Should Ms. Manton 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, one or more of the following steps may occur:

   (a) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty; and

   (b) the Complaints Consultant may treat Ms. Manton's non-compliance as information under s. 56 of the *Health Professions Act*.

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 partial 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.

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

(11) Additional Order Sought by Complaints Consultant

In addition to the Partial Joint Submission on Penalty outlined above, the Complaints Consultant sought the following two orders relating to the costs of the hearing:

1. Lisa Manton shall pay $3,500.00 in costs of the investigation and hearing with such costs to be paid in equal monthly installments over a period of 24 months from service of the Hearing Tribunal's written reasons for decision.

2. In the case of non-payment of the costs described in paragraph 1 above, the Complaints Consultant may suspend Ms. Manton'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 also took into account this additional request by the Complaints Consultant as to cost. Ms. Manton was provided with an opportunity to speak to this additional order and her response was that she is currently unable to work, as she is on maternity/parental leave.

(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 Lisa Manton (Barber) 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 hearing Tribunal carefully considered the above factors in coming to its decision on penalties and found that Ms. Manton clearly demonstrated unprofessional conduct.

The nature and gravity of the proven allegations: The nature and gravity of the allegations were found by the Hearing Tribunal to be great, as it related to clients in the care of Ms. Manton who were elderly, and highly dangerous narcotic drugs, which have a high potential of harm if they are not handled carefully.

The age and experience of the investigated member: The Hearing Tribunal took into consideration that Ms. Manton has been a practicing LPN since 2007, and therefore was an 11-year veteran of the profession. Ms. Manton had a complaint-free history until November of 2018, when she was given a 2 week casual shift blackout suspension, as a result of the investigation which lead to the allegations. The Hearing Tribunal also took into consideration that Ms. Manton was not taking her ADHD medication, due to pregnancy, resulting in many of her errors.

The number of times the offending conduct was proven to have occurred: The number of allegations against Ms. Manton was also a factor considered by the Hearing Tribunal, as there were eight in total.

The role of the investigated member in acknowledging what occurred: The Hearing Tribunal does recognize that Ms. Manton admitted to her errors, and did not contest the hearing, instead opting for an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: The Hearing Tribunal did take into consideration that Ms. Manton was suspended from her casual status for 2 weeks, and stated that she has not been offered any shifts since this suspension, and therefore has not worked as an LPN since. She did state that she was able to find some alternate work.

The impact of the incident(s) on the victim: There is no evidence of actual harm to any of the patients in her care; the risk of harm was a serious factor considered by the Hearing Tribunal. All the allegations involved narcotics, which have a high potential for harm to patients.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and CLPNA 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.

The need to maintain the public's confidence in the integrity of the profession: CLPNA deals with the actions of the members when they conduct themselves in a way that is not becoming to the LPN profession. The CLPNA will deal with any breaches in the HPA, the CLPNA Code of Ethics and the CLPNA Standards of Practice in a manner that the CLPNA deems acceptable.

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

In considering the additional Order regarding costs, submitted by the Complaints Consultant, the Hearing Tribunal does feel in this instance that costs should be levied against Ms. Manton. Although Ms. Manton did provide an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, there was still a requirement for a hearing and costs incurred as a result of her conduct.

(12) 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. Prior to reinstatement of her practice permit, Ms. Manton shall:

   (a) Read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide a signed, written declaration to the Complaints Consultant confirming that she has reviewed the documents:

      (i) Standards of Practice for Licensed Practical Nurses in Canada;

      (ii) Code of Ethics 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 E1: Critical Thinking and Critical Inquiry;

      (vii) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

      (viii) CLPNA Competency Profile U: Medication Administration; and

      (ix) CLPNA Competency Profile W: Professionalism.

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

   (b) Complete, at her own cost, **NURS 0161 - Basic Medication Administration**, offered online by MacEwan University, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If the course

should become unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

(c) Complete the **Nursing Documentation 101** course offered online by the CLPNA at the CLPNA website at www.clpna.com, and provide the Complaints Consultant with a certificate confirming her successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

3. Upon her return to practice as an LPN, Ms. Manton's practice permit will be subject to a condition of supervised practice for a period of 300 hours with the following conditions:

   (a) Prior to the commencement of the supervised practice, Ms. Manton shall:

      (i) Provide the Complaints Consultant with the name of her supervisor(s);

      (ii) Provide her supervisor(s) with a copy of the Decision in this matter; and

      (iii) Provide the Complaints Consultant with a written acknowledgment signed by her supervisor(s) confirming receipt of a copy of the Decision.

   (b) The supervisor(s) must provide direct supervision of Ms. Manton with respect to medication administration.

   (c) Upon completion of the 300 hours of supervised practice, Ms. Manton shall provide the Complaints Consultant with an evaluation completed by her supervisor(s) confirming the completion of the supervised practice and advising whether the supervisor(s) had any concerns related to the issues identified in the allegations and findings in the Decision.

   (d) If the supervisor's report identifies concerns with Ms. Manton's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the *Health Professions Act*.

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

5. Should Ms. Manton 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.

6. Should Ms. Manton 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, one or more of the following steps may occur:

(c) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty; and

(d) the Complaints Consultant may treat Ms. Manton's non-compliance as information under s. 56 of the *Health Professions Act*.

7. Lisa Manton shall pay $3,500.00 in costs of the investigation and hearing with such costs to be paid in equal monthly installments over a period of 24 months from service of this decision. The first installment will start on Oct 1, 2020, to allow Ms. Manton to find work after her maternity leave.

8. In the case of non-payment of the costs described in paragraph 7 above, the Complaints Consultant may suspend Ms. Manton'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 26th DAY OF NOVEMBER, 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Patricia Standage, LPN
Chair, Hearing Tribunal