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 LORNE BASCOM

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 LORNE BASCOM, LPN #46864, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference in using Zoom on July 29, 2020 with the following individuals present:

Hearing Tribunal:
Kimberley Chin, Licensed Practical Nurse ("LPN") Chairperson
Michelle Stolz, LPN
James Lees, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Consultant, CLPNA
Kevin Oudith, Complaints Consultant, CLPNA

Investigated Member:
Lorne Bascom, LPN ("Mr. Bascom or "Investigated Member")
Lee Watson, 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

Mr. Bascom 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. Mr. Bascom was initially licensed as an LPN in Alberta on September 21, 2018.

By letter dated July 5, 2019, the CLPNA received a complaint (the "Complaint") from Ms. Lori Sanford ("Ms. Sanford"), Manager for Garden Vista Magrath, the Good Samaritan Society pursuant to s. 57 of the Act. Ms. Sanford stated that Mr. Bascom, LPN, was terminated following an investigation regarding allegations that Mr. Bascom failed to administer medication, improperly processed physicians' orders, failed to assess and or document assessments of clients, and failed to follow medication administration procedures, among other allegations.

By way of letter dated July 9, 2019, Ms. Sandy Davis, Complaints Director for the CLPNA, provided Mr. Bascom with notice of the Complaint. The Complaints Director delegated her powers under Part 4 of the Act to Kevin Oudith, Complaints Consultant (the "Complaints Consultant") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

On October 1, 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. A Notice of Hearing was served upon Mr. Bascom under cover of letter dated June 20, 2020.

(4) Allegations

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

"It is alleged that Lorne Bascom, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about March 2, 2019 failed to document on SP's Medication Administration Record (MAR) the administration of Amoxi-Clav 875/125mg tablet at 1700 hours, as required.

2. On or between April 2, 2019 to April 3, 2019 failed to complete required steps when processing physician orders for client LR by:
    a) Failing to document on Prescriber's Order and Progress Record the order was verified, as required;
    b) Failing to remove package of Risperidone 0.25 mg tablet from LR's medication pouch.

3. On or between April 16, 2019 to April 17, 2019 failed to complete required steps when processing physician orders for client PK by:
    a) Failing to document on Prescriber's Order and Progress Record the order was verified;

b) Failing to document on the Medication Administration Record (MAR) Amlodipine 5mg was discontinued at 0755 hours.

4. On or between April 25, 2019 to April 26, 2019 failed to assess and/or document Neuro Vital Signs (NVS) on client DV, as required.

5. On or between April 30, 2019 to May 1, 2019 failed to complete required steps when processing client AO's physician orders by incorrectly updating Betahistine 16mg to be administered at 0755 hours on AO's Medication Administration Record (MAR) instead of 0800 hours, as required.

6. On or between May 3, 2019 to May 4, 2019 did one or more of the following with regard to client NW:

    a) Failed to clarify Dilantin Infantabs 50 mg order in a timely manner;

    b) Directed an HCA to hold Dilantin Infantabs 50 mg at 2055 hours.

7. On or between May 4, 2019 to May 5, 2019 did one or more of the following with regard to client EH:

    a) Failed to assess and/or document on the progress notes the reason for administering PRN Acetaminophen 500mg 2 tabs on May 4, 2019 at 2100 hours, as required;

    b) Failed to assess and/or document on the progress notes the reason for administering PRN Acetaminophen 500mg 2 tabs on May 5, 2019 at 2245 hours, as required.

8. On or between May 13, 2019 to May 14, 2019 failed to update client RM's Medication Administration Record (MAR) by not updating the order from Butran 10 Patch 10mcg/hr to Butran 5 Patch 5mcg/hr, as required.

9. On or between May 19, 2019 to May 20, 2019 did one or more of the following with regard to client KR:

    a) Failed to notify KR's physician of significant changes to KR's neurological status; as required;

    b) Failed to provide further assessments and/or documentation of further assessment based on KR's significant change in neurological status, as required.

10. On or between May 19, 2019 to May 20, 2019 did one or more of the following with respect to client FG:

    a) Failed to assess and/or document a post fall assessment(s), as required;

    b) Failed to notify an RN and/or a physician of the fall, as required;

    c) Failed to complete an incident report, as required.

11. On or between May 23, 2019 to May 24, 2019 failed to document which medication he administered to client DV at 2100 hours on client DV's progress notes, as required.

12. On or between May 28, 2019 to May 29, 2019 failed to assess and/or document the assessment of client IL's bypassing urinary catheter, as required.

13. On or between June 11, 2019 to June 12, 2019 failed to complete the required steps when processing physician orders for client GD by failing to sign GD's MAR Update Communication Form.

14. On or about June 23, 2019 failed to follow proper medication administration practices by administering Tramadol 20mg two tablets to client RM instead of Tramadol 20mg one tablet as ordered.

15. On or about June 23, 2019 failed to follow proper medication administration practices by doing one or more of the following with regard to client IK:

    a) Failed to safely handle a narcotic/controlled drug by delegating a Health Care Aide (HCA) to administer Oxyneo 10mg tablet;

    b) Falsely documented the administration of Oxyneo 10mg tablet at 0800 hours on IK's Medication Administration Record (MAR) indicating that he had administered it when it was administered by an HCA.

16. On or about June 23, 2019 failed to follow safe medication administration practices by doing one or more of the following:

    a) Delegated a Health Care Aide (HCA) to administer Ciprofloxacin 250mg tablet to client DV;

    b) Falsely documented the administration of Ciprofloxacin 250mg tablet at 0755 hours on client DV's Medication Administration Record (MAR) when it had been administered by an HCA;

    c) Delegated a Health Care Aide (HCA) to administer Ciprofloxacin 500mg tablet to client LP;

    d) Falsely documented the administration of Ciprofloxacin 500mg tablet at 0800 and 1200 hours on client LP's Medication Administration Record (MAR) when it had been administered by an HCA.

17. On or about June 25, 2019 failed to complete required steps when processing physician orders for client KM by not updating Ventolin Inhaler two ii puffs QID PRN with mask aerochamber on KM's Medication Administration Record (MAR), as required.

18. On or about June 25, 2019 failed to complete the required steps when processing physician orders for client ES by:

a) Inaccurately updating client ES's Medication Administration Record (MAR) by writing over existing tablet quantity instead of applying new label to MAR, as required;

b) Failing to complete/sign client ES's MAR Update and Communication Form, as required.

(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.

Mr. Bascom acknowledged unprofessional conduct to all the allegations as evidenced by his 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: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2: 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 #1 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Mr. Bascom'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 Mr. Bascom.

Allegation 1

Lorne Bascom admitted on or about March 2, 2019, he failed to document on SP's Medication Administration Record (MAR) the administration of Amoxi-Clav 875/125mg tablet at 1700 hours, as required.

By way of background, Mr. Bascom worked at the Good Samaritan Society from 0700 hours to 1900 hours on March 3, 2019 and was assigned to provide care to client SP.

Mr. Bascom administered Amoxi-Clav 875/125mg to client SP at 1700 hours. However, Mr. Bascom failed to document the administration of Amoxi-Clav 875/125mg tablet on client SP's MAR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Medication administration and documentation is a basic nursing principle. Mr. Bascom's lack of skill and judgment with regard to his medication documentation demonstrated his inadequacies with his understanding of the importance of medication administration and documentation principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail below. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the

CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct.

(xii) Conduct that harms the integrity of the regulated profession.

Errors in medication administration and documentation are in contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors severely affect the confidence of the public in LPNs. Mr. Bascom failed to document the administration of Amoxi-Clav 875/125mg, which puts the patient at risk for medication errors. This conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care.

Allegation 2

Lorne Bascom admitted on or between April 2, 2019 to April 3, 2019, he failed to complete required steps when processing physician orders for client LR by:

a) Failing to document on Prescriber's Order and Progress Record the order was verified, as required;

b) Failing to remove package of Risperidone 0.25 mg tablet from LR's medication pouch.

On April 2, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on April 3, 2019. During this shift, Mr. Bascom provided care to client LR.

On April 2, 2019, the physician for client LR ordered that LR's prescription for Risperidone be discontinued. Mr. Bascom received this order and noted on client LR's MAR that LR's prescription for Risperidone 0.25 mg was discontinued. Mr. Bascom failed to indicate on client LR's Prescriber's Order and Progress Record that the order was verified, as required.

At 0800 hours on April 3, Ms. Brenda Sweetgrass, Health Care Aide ("HCA") provided care to client LR. Ms. Sweetgrass noticed that the contents of client LR's medication strip pouch did not match the MAR for client LR. Client LR's medication strip pouch contained a dose of Risperidone 0.25 mg, in spite of the order to discontinue this dosage.

Although Mr. Bascom was aware that Risperidone had been discontinued, when processing the physician's order for client LR, Mr. Bascom failed to remove the package of Risperidone 0.25 mg from client LR's medication pouch.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

Mr. Bascom showed a lack of knowledge, skill and judgment with his medication administration practices for client LR. Medication administration is a basic nursing skill, and Mr. Bascom demonstrated inadequacies with his understanding of the importance of medication administration principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out below under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. These errors severely affect the confidence of the public in LPNs and competent care providers.

(xii) Conduct that harms the integrity of the regulated profession.

This conduct directly affects the integrity of the regulated profession in that it does not provide confidence to the public that members of the profession are competent and provide competent care. This is shown by the carelessness of Mr. Bascom with processing the physician's orders and his failure to remove the previous package of medication from the medication pouch.

Allegation 3

Lorne Bascom admitted on or between April 16, 2019 to April 17, 2019, he failed to complete required steps when processing physician orders for client PK by:

a) Failing to document on Prescriber's Order and Progress Record the order was verified;

b) Failing to document on the Medication Administration Record (MAR) Amlodipine 5mg was discontinued at 0755 hours.

By way of background, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours from April 16, 2019 to April 17, 2019. During this shift, Mr. Bascom provided care to client PK.

On April 16, 2019, client PK's physician ordered to reduce client PK's dose of Amlodipine to 2.5mg daily. Prior to this order, client PK had received Amlodipine 5mg both in the morning at 0755 hours, and in the evening at 2055 hours.

Mr. Bascom received this order and noted on client PK's MAR that PK's prescription for Amlodipine 5mg was discontinued at 2055 hours. Mr. Bascom failed to document the discontinuation of client PK's Amlodipine 5mg at 0755 hours. Mr. Bascom noted on client PK's Progress Notes that her dose of Amlodipine was to be "decreased at bedtime", without consideration of the discontinuance of the dose at 0755 hours.

On client PK's Medication Administration Record Update Communication Form, Mr. Bascom indicated that he had completed the required documentation to verify the change on the physician's order sheet. However, Mr. Bascom failed to verify the physician's order on the Prescriber's Order and Progress Record**.**

On April 17, 2019, Ms. Sweetgrass, HCA provided care to client PK. Ms. Sweetgrass noticed that client PK's previous dose of Amlodipine at 0755 hours was still present on client PK's Medical Administration Record, in spite of its removal from the medical administration pouch and physician's order to discontinue that dose.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Mr. Bascom incorrectly transcribed and documented the decrease in the client's medication. Medication administration and documentation is a basic nursing skill, and medication errors such as this show a severe lack of knowledge, skill and judgment in the provision of professional services. This also demonstrated inadequacies with his understanding of the importance of transcription and medication administration practice.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. These errors severely affect the confidence of the public in LPNs and competent care providers.

(xii) Conduct that harms the integrity of the regulated profession.

This conduct directly harms the integrity of the profession, in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr. Bascom failed to process and document the physician's order properly for client PK, and errors such as these do not promote confidence in the provision of nursing as an LPN.

Allegation 4

Lorne Bascom admitted on or between April 25, 2019 to April 26, 2019, he failed to assess and/or document Neuro Vital Signs (NVS) on client DV, as required.

By way of background, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours from April 25, 2019 to April 26, 2019. During this shift, Mr. Bascom provided care to client DV.

On April 25, 2019, Client DV suffered a fall. As a result of the fall, Client DV required ongoing monitoring and assessments.

At 0055 hours on April 26, 2019, Mr. Bascom noted on client DV's Neurological Vital Signs Record that client DV was sleeping. Mr. Bascom failed to wake client DV to assess his neurological vital signs, as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Mr. Bascom displayed a grave lack of knowledge, skill and judgment with regard to client DV. If client DV had a change in his neurological status while he slept, Mr. Bascom would have been unaware until the morning, this poses a grave risk to the client.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct.

Patient assessment is a basic nursing skill that Mr. Bascom should have been thoroughly and competently performing on clients. His actions were in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and providing competent care. Failure to assess and document an assessment post-fall for a resident put DV at risk for further complications from this event, and actions such as these do not ensure confidence in the provision of nursing for LPNs.

Allegation 5

Lorne Bascom admitted on or between April 30, 2019 to May 1, 2019, he failed to complete required steps when processing client AO's physician orders by incorrectly updating Betahistine 16mg to be administered at 0755 hours on AO's Medication Administration Record (MAR) instead of 0800 hours, as required.

By way of background, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on April 30, 2019 to May 1, 2019. During this shift, Mr. Bascom provided care to client AO.

While processing an order, Mr. Bascom recorded on client AO's MAR that Betahistine was to be administered at 0755 hours.

On the MAR, the notes indicate that medications ordered for times ending in ":55" are crushable, whereas times ending in ":00" are not crushable. The Medication Administration Pouch for Client AO shows that client AO's Betahistine prescription was to be administered at 0800 hours, and therefore was not crushable. Mr. Bascom failed to complete the required steps by incorrectly documenting that client AO's order for Betahistine be administered at 0755 hours, instead of 0800 hours as ordered.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Medication documentation is a basic nursing skill and Mr. Bascom showed a severe lack of knowledge, skill and judgment with regard to his transcription and processing of physician's orders, which demonstrated the inadequacies with his understanding of the importance of medication administration principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Medication errors such as those performed by Mr. Bascom are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors have the potential to negatively affect the confidence the public has towards LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

This conduct directly harms the integrity of the profession and put client AO at risk of receiving a medication error. Mr. Bascom's behaviour with incorrectly processing medication orders did not ensure confidence that the members of the profession are competent and provide competent care.

Allegation 6

Lorne Bascom admitted on or between May 3, 2019 to May 4, 2019, he did one or more of the following with regard to client NW:

a) Failed to clarify Dilantin Infantabs 50 mg order in a timely manner;

b) Directed an HCA to hold Dilantin Infantabs 50 mg at 2055 hours.

On May 3, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 4, 2019. During this shift, Mr. Bascom provided care to client NW.

On May 3, 2019, client NW received an order for Dilantin Infantabs 50mg, to be administered daily at four times throughout the day, including at 2055 hours. Mr. Bascom processed the order sometime after 2055 hours, and updated client NW's MAR.

Due to the fact that Mr. Bascom processed the order after 2055 hours, the correct clinical approach on whether or not to still administer the 2055 hours dose was not clear and required clarification. Mr. Bascom did not contact either client NW's physician or the pharmacy to clarify

the order and the appropriate course of action for client NW's dose of Dilantin Infantabs 50 mg which was to be administered at 2055 hours.

Instead, Mr. Bascom told the assisting Health Care Aide to hold client NW's dose of Dilantin Infantabs 50 mg from 2055 hours. The Progress Notes Summary for client NW indicates that the dose of Dilantin Infantabs 50 mg from 2055 was put in the medication waste container rather than administered to client NW, as ordered.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Mr. Bascom showed a lack of knowledge, skill and judgment in the provision of professional services when he did not clarify the order from the physician regarding the course of action with client NW's medication. Medication administration and documentation is a basic nursing skill to be performed by nurses in a competent manner.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors have the potential to negatively affect the confidence the public has towards LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's actions directly harm the integrity of the profession in that they are not ensuring confidence that members of the profession are competent and provide competent care. His actions also put client NW at risk for adverse medical consequences due to the missed medication.

Allegation 7

Lorne Bascom admitted on or between May 4, 2019 to May 5, 2019, he did one or more of the following with regard to client EH:

a) Failed to assess and/or document on the progress notes the reason for administering PRN Acetaminophen 500mg 2 tabs on May 4, 2019 at 2100 hours, as required;

b) Failed to assess and/or document on the progress notes the reason for administering PRN Acetaminophen 500mg 2 tabs on May 5, 2019 at 2245 hours, as required.

On May 4, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 5, 2019. During this shift, Mr. Bascom provided care to client EH.

Client EH had an order for Acetaminophen 500 mg to be taken, as needed, for pain. Mr. Bascom gave client EH a dose of Acetaminophen at 2100 hours on May 4, 2019.

Mr. Bascom made an entry in client EH's Progress Notes indicating that the resident "request pain med" and that Acetaminophen was administered at 2100 hours. However, other than the reference to pain, Mr. Bascom did not record the reason for administering Acetaminophen to client EH or his assessment of client EH's pain.

Mr. Bascom gave client EH a further dose of Acetaminophen at 2245 hours on May 5, 2019. Mr. Bascom made an entry in client EH's Progress Notes regarding the administration of Acetaminophen at 2245 hours. Mr. Bascom made an entry indicating that "patient requested pain med" but did not record the reason for administering Acetaminophen to client EH or his assessment of client EH's pain.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Nursing assessment for medication administration and documentation is a basic nursing skill. Mr. Bascom showed grave lack of knowledge, skill and judgment with regard to not assessing client EH for pre- or post-analgesic administration.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in nursing assessment and documentation are serious in nature and are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and providing competent care to members of the public. This is shown in the lack of assessment and documentation for the reason for administering analgesics to resident EH.

Allegation 8

Lorne Bascom admitted on or between May 13, 2019 to May 14, 2019, he failed to update client RM's Medication Administration Record (MAR) by not updating the order from Butran 10 Patch 10mcg/hr to Butran 5 Patch 5mcg/hr, as required.

On May 13, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 14, 2019. During this shift, Mr. Bascom provided care to client RM.

On May 9, 2019, client RM's physician provided an order that from May 14th, 2019 onwards, client RM's prescription for a Butran Patch was reduced to a Butran 5 patch 5mcg/hr.

Mr. Bascom processed the order and completed client RM's MAR Update Communication Form on May 13, 2019. Mr. Bascom indicated that he updated client RM's MAR to reflect the new order. Mr. Bascom made an entry in client RM's Progress Notes that he verified the physician's order to decrease the Butran patch to 5mcg/hr.

However, Mr. Bascom failed to update client RM's MAR, as required, and the previous order for Butran 10 patch 10mcg/hr was not removed and replaced with Butran 5 patch 5mcg/hr.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 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;

Medication administration, documentation and transcription are basic nursing skills. Mr. Bascom showed a lack of knowledge, skill and judgment when he incorrectly completed client RM's medication change, demonstrating his inadequacies with his understanding of the importance of medication administration principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration, documentation and transcription are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

This conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr. Bascom was careless with updating the medication administration record for client RM, which could have resulted in RM receiving an incorrect dose of Butran.

Allegation 9

Lorne Bascom admitted on or between May 19, 2019 to May 20, 2019, he did one or more of the following with regard to client KR:

a) Failed to notify KR's physician of significant changes to KR's neurological status; as required;

b) Failed to provide further assessments and/or documentation of further assessment based on KR's significant change in neurological status, as required.

On May 19, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 20, 2019. During this shift, Mr. Bascom provided care to client KR.

On May 19, 2019, client KR suffered a fall as she slipped out of a reclining chair. In accordance with post-fall assessment requirements, client KR required ongoing monitoring assessment. Mr. Bascom performed three assessments of client KR, at 1900 and 2000 hours on May 19, 2019, and

0400 hours on May 20, 2019. Each assessment indicated that client KR scored between an 8 and 9 on the Glasgow Coma Score, which indicated client KR may have suffered severe brain injury.

In spite of client KR's Glasgow Coma Score results, Mr. Bascom failed to notify client KR's physician of the significant changes to her neurological status. Mr. Bascom also failed to perform or document further assessments based on client KR's significant change in neurological status, as exemplified by the decrease in her Glasgow Coma Score, which was previously in the range of 11-15.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 9 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;

Nursing assessment and documentation are a primary vital skill of nurses. Mr. Bascom did not demonstrate his ability to be a knowledgeable, skilled nurse during his assessment of client KR.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Assessment and documentation errors are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics.

(xii) Conduct that harms the integrity of the regulated profession.

As a self-regulated professional, Mr. Bascom's gaps in knowledge with his nursing assessment skills put client KR at risk. Errors such as this gravely affect the confidence of the public in the care that they would receive from LPNs.

<u>Allegation 10</u>

Lorne Bascom admitted on or between May 19, 2019 to May 20, 2019, he did one or more of the following with respect to client FG:

a) Failed to assess and/or document a post fall assessment(s), as required;

b) Failed to notify an RN and/or a physician of the fall, as required;

c) Failed to complete an incident report, as required.

On May 19, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 20, 2019. During this shift, Mr. Bascom provided care to client FG.

At approximately 2100 hours, client FG suffered a fall which was witnessed by a co-resident. In accordance with post-fall assessment requirements, client FG required ongoing monitoring assessment.

Mr. Bascom provided care to client FG and noted that the client denied any pain following the fall. Mr. Bascom failed to assess or document the post-fall assessment of client FG, failed to notify an RN or physician of the fall, and failed to complete an incident report relating to the fall.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 10 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;

Nursing assessment and documentation are basic vital nursing skills. Mr. Bascom showed a lack of knowledge, skill and judgment with his carelessness of not performing an assessment post-fall on client FG.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in nursing assessment and documentation can be serious for clients and are in direct contravention of the CLPNA Standards of Practice, and the CLPNA Code of Ethics.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct with regards to neglecting to document and report the assessment of client FG post-fall puts FG at risk of complications from this same event. Further, he then did not document or notify the physician or RN of the incident, which continued to put client FG at risk, if he were to have any complications afterwards.

Allegation 11

Lorne Bascom admitted on or between May 23, 2019 to May 24, 2019, he failed to document which medication he administered to client DV at 2100 hours on client DV's progress notes, as required.

On May 23, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 24, 2019. During this shift, Mr. Bascom provided care to client DV.

Client DV's MAR indicates that Mr. Bascom administered a syringe of Tinzaparin Sodium at 2100 hours on May 23, 2019.

On May 24, 2019, Mr. Bascom wrote that client DV was drowsy following receiving an injection at approximately 2100 hours in client DV's progress notes. Mr. Bascom failed to document which medication was administered.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 11 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;

Medication administration and documentation is a basic nursing skill. Mr. Bascom displayed a lack in knowledge, skill and judgment within the provision of nursing in medication administration and documentation that demonstrated inadequacies with his understanding of the importance of medication administration principles within patient care standards. These errors directly put client DV at risk.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts

and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct.

(xii) Conduct that harms the integrity of the regulated profession.

Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. Errors such as these directly harm the integrity of the profession and affect the confidence of the public in LPNs. Mr. Bascom did not properly document a medication that was administered to a resident in his care, and these actions put DV at risk, especially because the administered medication was making DV drowsy.

Allegation 12

Lorne Bascom admitted on or between May 28, 2019 to May 29, 2019, he failed to assess and/or document the assessment of client IL's bypassing urinary catheter, as required.

On May 28, 2019, Mr. Bascom worked at the Good Samaritan Society from 1900 hours to 0700 hours on May 29, 2019. During this shift, Mr. Bascom provided care to client IL.

Client IL had a urinary catheter, which required assessments to ensure that it remained correctly placed.

At 0603 hours on May 29, 2019, Beverly Hoek, HCA, noted in client IL's Progress Notes that client IL had been incontinent and that urine had bypassed her urinary catheter. Ms. Hoek also noted that she had informed Mr. Bascom.

At 0635 hours, Mr. Bascom recorded that he was aware of urine on client IL's urine pad, and that this indicated urine had bypassed her urinary catheter. Mr. Bascom failed to assess or document the assessment of client IL's catheter, and instead informed the day shift nurse of client IL's status rather than providing care himself in spite of the fact he became aware of the potential bypass during his shift.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 12 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;

Mr. Bascom displayed a lack of judgment when he neglected to assess and document the incontinence with client IL's urinary catheter. This places IL at a risk of complications. Assessment skills are a basic nursing skill and Mr. Bascom demonstrated gaps in his knowledge and skill in understanding the importance of this within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Neglecting the assessment and care of a patient is in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors directly affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

The conduct of Mr. Bascom with regard to client IL directly harms the integrity of the profession in that it is not ensuring the confidence that members of the profession are competent and providing competent care. Mr. Bascom did not provide competent care to client IL, leaving them incontinent in urine from their bypassing catheter. This was not compassionate or good nursing practice.

Allegation 13

Lorne Bascom admitted on or between June 11, 2019 to June 12, 2019, he failed to complete the required steps when processing physician orders for client GD by failing to sign GD's MAR Update Communication Form.

On June 11, 2019, Mr. Bascom worked at the Good Samaritan Society from 0700 hours to 0900 hours, and 2100 hours to 0700 hours on June 12, 2019. During this shift, Mr. Bascom provided care to client GD.

On June 11, 2019, client GD's physician provided an order for Diclo 10% cream to be applied to both of client GD's knees. Mr. Bascom verified the order on June 11, 2019 and initialed the Prescriber's Order and Progress Record. On June 12, 2019, Mr. Bascom wrote that he verified the physician's order and that the Diclo 10% cream for client GD was ordered.

Mr. Bascom completed part of the MAR Update Communication Form for client GD but failed to complete all required steps by failing to complete the required update to client GD's MAR and failing to sign GD's MAR Update Communication Form.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 13 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;

Administering medication and documentation is a basic nursing skill. Mr. Bascom displayed a lack of knowledge, skill and judgment with regard to his medication administration and documentation practices. This conduct demonstrated inadequacies with his understanding of the importance of medication administration and documentation principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr Bascom's careless nature with the important task of properly processing physician orders directly harms the integrity of the profession for the competence to perform this task.

<u>Allegation 14</u>

Lorne Bascom admitted on or about June 23, 2019, he failed to follow proper medication administration practices by administering Tramadol 20mg two tablets to client RM instead of Tramadol 20mg one tablet as ordered.

On June 23, 2019, Mr. Bascom worked at the Good Samaritan Society from 0700 hours to 1900 hours. During this shift, Mr. Bascom provided care to client RM.

Client RM had an order for Tramadol 20 mg one tablet which was administered only as needed. Mr. Bascom administered Tramadol to client RM on June 23, 2019. On client RM's PRN Documentation form, Mr. Bascom recorded that he administered Tramadol 20mg two tablets on June 23, 2019, rather than the one tablet ordered.

Mr. Bascom further recorded on client RM's progress notes that he administered Tramadol 20mg two tablets, again rather than the one tablet ordered.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 14 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;

Administering medication and documentation is a basic nursing skill. Mr. Bascom displayed a lack of knowledge, skill and judgment with regard to his medication administration and documentation practices. That demonstrated inadequacies with his understanding of the importance of medication administration and documentation principles within patient care standards

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr. Bascom did not properly check the medications and

the orders for client RM, and in not doing this, it resulted in RM receiving a later dose of the medication that they were not ordered to take. Errors such as these directly harm the integrity of the profession.

Allegation 15

Lorne Bascom admitted on or about June 23, 2019, he failed to follow proper medication administration practices by doing one or more of the following with regard to client IK:

a) Failed to safely handle a narcotic/controlled drug by delegating a Health Care Aide (HCA) to administer Oxyneo 10mg tablet;

b) Falsely documented the administration of Oxyneo 10mg tablet at 0800 hours on IK's Medication Administration Record (MAR) indicating that he had administered it when it was administered by an HCA.

On June 23, 2019, Mr. Bascom worked at the Good Samaritan Society from 0700 hours to 1900 hours. During this shift, Mr. Bascom provided care to client IK.

Client IK had an order for Oxyneo 10mg, which was administered twice daily at both 0800 and 2100 hours. Mr. Bascom initialed that he personally administered client IK's 0800 hours dose on June 23, 2019.

However, Mr. Bascom delegated the administration of Oxyneo 10mg to Alicia Anderson, HCA. In fact, Ms. Anderson administered Oxyneo 10mg to client IK. Health Care Aides are not permitted to administer narcotics.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 15 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;

Administering medication and documentation is a basic nursing skill. Mr. Bascom displayed a lack of knowledge and skill with regard to his medication administration and documentation practices. This conduct demonstrated inadequacies with his understanding of the importance of medication administration and documentation principles within patient care standards. Mr. Bascom also showed a grave lack of judgment by instructing an HCA to administer a narcotic medication that is not within their scope of practice.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. Mr. Bascom's choice to delegate the administration of narcotic medications to an HCA is also in direct contravention of the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. Delegating an HCA to administer narcotic medications is very inappropriate as this skill is not within their scope of practice. Mr. Bascom's actions directly harm the integrity of nursing by failing to provide a safe working environment for their colleagues and clients.

Allegation 16

Lorne Bascom admitted on or about June 23, 2019, he failed to follow safe medication administration practices by doing one or more of the following:

a) Delegated a Health Care Aide (HCA) to administer Ciprofloxacin 250mg tablet to client DV;

b) Falsely documented the administration of Ciprofloxacin 250mg tablet at 0755 hours on client DV's Medication Administration Record (MAR) when it had been administered by an HCA;

c) Delegated a Health Care Aide (HCA) to administer Ciprofloxacin 500mg tablet to client LP;

d) Falsely documented the administration of Ciprofloxacin 500mg tablet at 0800 and 1200 hours on client LP's Medication Administration Record (MAR) when it had been administered by an HCA.

On June 23, 2019, Mr. Bascom worked at the Good Samaritan Society from 0700 hours to 1900 hours. During this shift, Mr. Bascom provided care to clients DV and LP.

Client DV had an order for Ciprofloxacin 250mg tablet, to be administered twice daily at 0655 hours and 1855 hours. Mr. Bascom initialed that he personally administered client DV's 0755 hours and 1855 hours doses on June 23, 2019.

However, Mr. Bascom delegated the administration of Ciprofloxacin 250mg to Ms. Anderson, HCA. In fact, Ms. Anderson administered Ciprofloxacin 250 mg tablet to client DV. Health Care Aides are not permitted to administer antibiotics.

Client LP had an order for Cephalexin 500mg tablet, to be administered three times daily at 0800 hours, 1200 hours, and 2100 hours. Mr. Bascom initialed that he personally administered client LP's 0800 hours and 1200 hours doses on June 23, 2019.

However, Mr. Bascom delegated the administration of Cephalexin 500mg to Ms. Anderson, HCA. In fact, Ms. Anderson administered Cephalexin 500mg to client LP. Health Care Aides are not permitted to administer antibiotics.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 16 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;

Administering medication and documentation is a basic nursing skill. Mr. Bascom displayed a lack of knowledge and skill with regard to his medication administration and documentation practices. This conduct demonstrated inadequacies with his understanding of the importance of medication administration and documentation principles within patient care standards. Mr. Bascom also showed a grave lack of judgment by instructing an HCA to administer an antibiotic medication that is not within their scope of practice.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are in direct contravention of the CLPNA Standards of Practice and code of ethics. Mr. Bascom's choice to delegate the administration of antibiotic medications to an

HCA is also in direct contravention of the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. The administration of antibiotic medications is outside of the scope of practice for HCAs, and Mr. Bascom demonstrated a severe lack of judgement in requesting this of an HCA. This directly harms the integrity of the profession by failing to provide a safe working space for colleagues and clients.

Allegation 17

Lorne Bascom admitted on or about June 25, 2019, he failed to complete required steps when processing physician orders for client KM by not updating Ventolin Inhaler two ii puffs QID PRN with mask aerochamber on KM's Medication Administration Record (MAR), as required.

On June 25, 2019, Mr. Bascom worked at the Good Samaritan Society from 0000 hours to 0700 hours, and 1900 hours to 1159 hours. During this shift, Mr. Bascom provided care to client KM.

On June 25, 2019, client KM's physician provided an order for a Ventolin Inhaler two ii puffs to be used with a mask aerochamber. Mr. Bascom signed the Prescriber's Order and Progress Record indicating that he verified the order. Mr. Bascom signed the MAR update form indicating that he updated client KM's MAR with the new order.

However, Mr. Bascom failed to update client KM's MAR to include the order for Ventolin Inhaler two ii puffs OID PRN with mask aerochamber as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 17 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;

Medication administration and documentation are a basic nursing skill. Mr. Bascom's lack of knowledge, skill and judgment with regard to his medication administration and documentation practice demonstrate inadequacies with his understanding of the importance of these practice principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in medication administration and documentation are a direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession, in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr. Bascom did not properly process medications that were to be administered to resident KM. As this is a basic nursing skill, it harms the integrity of the regulated profession when an LPN does not properly perform these tasks.

Allegation 18

Lorne Bascom admitted on or about June 25, 2019, he failed to complete the required steps when processing physician orders for client ES by:

a) Inaccurately updating client ES's Medication Administration Record (MAR) by writing over existing tablet quantity instead of applying new label to MAR, as required;

b) Failing to complete/sign client ES's MAR Update and Communication Form, as required.

On June 25, 2019, Mr. Bascom worked at the Good Samaritan Society from 0000 hours to 0700 hours, and 1900 hours to 1159 hours. During this shift, Mr. Bascom provided care to client ES.

On June 26, 2019, client ES's physician provided an order to reduce client ES's order for Trandate from 1-200 mg tab to ½-100mg tab. Mr. Bascom signed the Prescriber's Order and Progress Record indicating that he verified the order.

Mr. Bascom began filling out client ES's MAR Update Communication Form but failed to complete the MAR update section and failed to sign the form.

On client ES's MAR, Mr. Bascom changed the existing order from "1" to "1/2" instead of creating a new line on the MAR, as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Bascom's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 18 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;

Medication documentation and transcribing physician orders is an important nursing skill. Mr. Bascom's lack of knowledge, skill and judgment with regard to his documentation practice demonstrates the inadequacies with his understanding of the importance of documentation principles within patient care standards.

(ii) Contravention of the Act, a code of ethics or standards of practice;

Mr. Bascom did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out under Allegation 18 and that such breaches are sufficiently serious to constitute unprofessional conduct. Errors in documentation are in direct contravention of the CLPNA Standards of Practice and the CLPNA Code of Ethics. These errors affect the confidence of the public in LPNs.

(xii) Conduct that harms the integrity of the regulated profession.

Mr. Bascom's conduct directly harms the integrity of the profession in that it is not ensuring confidence that members of the profession are competent and provide competent care. Mr. Bascom's conduct with regard to medication order processing directly harms the integrity of the profession because this is a basic nursing skill that places clients at risk if it is not done properly.

<u>CLPNA Code of Ethics</u>

Mr. Bascom acknowledges that his conduct breached one or more of the following requirements in the CLPNA Code of Ethics, which states as follows:

- 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.

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

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

    - 2.8: Use evidence and judgment to guide nursing decisions.

    - 2.9: identify and minimize risks to clients.

- 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.

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

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

Mr. Bascom acknowledges that his 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 state as follows:

- 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.

    - 1.6. Take action to avoid and/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.

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

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

    - 2.13. Modify and communicate to appropriate person changes to specific interventions based on the client's responses.

- 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:

    - 3.3: Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

    - 3.5. Provide relevant and timely information to clients and co-workers.

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

- 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.

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

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Bascom jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. 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. Mr. Bascom shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** subject to the following:
    a. Mr. Bascom will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter");
    b. Payments of costs will not commence until the first of the month after he has secured employment; and
    c. Should Mr. Bascom secure employment prior to service of the Costs Letter, payment of costs shall commence on the first of the month following service of the Costs Letter
3. Mr. Bascom shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Mr. Bascom shall provide to the Complaints Consultant, a signed declaration within **thirty (30) days** of service of the Decision, attesting he has reviewed the following CLPNA documents:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. CLPNA Practice Policy: Professional Responsibility & Accountability;
    d. CLPNA Practice Policy: Documentation;
    e. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;
    f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
    g. CLPNA Competency Profile B1: Assessment;
    h. CLPNA Competency Profile B2: Nursing Diagnosis;
    i. CLPNA Competency Profile B3: Planning;
    j. CLPNA Competency Profile B4: Implementation;
    k. CLPNA Competency Profile C4: Professional Ethics;
    l. CLPNA Competency Profile C5: Accountability and Responsibility;
    m. CLPNA Competency Profile C9: Informal Leadership; and
    n. CLPNA Competency Profile U2: Medication Preparation and Administration;

    If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.
4. Mr. Bascom shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Mr. Bascom shall provide the Complaints

Consultant with a certificate confirming successful completion of the course within **thirty (30) days** of service of the Decision.

If the course becomes unavailable, then Mr. Bascom shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Consultant shall, in his sole discretion, reassign a course. Mr. Bascom will be notified by the Complaints Consultant, in writing, advising of the new course required.

5. Mr. Bascom shall complete the CLPNA's **Health Assessment Self-Study Course** available online at https://studywithclpna.com/healthassessment/. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **thirty (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. Mr. Bascom shall read and view **Neurological Assessments and GCS Video** available online at https://www.ausmed.com/cpd/articles/neurological-assessment-gcs. Mr. Bascom shall provide the Complaints Consultant with a signed declaration attesting he has read and viewed the above noted video within **sixty 60 days** of the 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.

7. Mr. Bascom shall, at his own cost, complete MacEwan University's **Medication Management (NURS 0161)** available online at https://www.macewan.ca/wcm/SchoolsFaculties/CentreforProfessionalNursingEducation/Courses/NURS0161. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

8. Mr. Bascom shall, at his own cost, complete NCSBN Learning Extension **Sharpening Critical Thinking Skills** available online at https://ncsbn-external.myabsorb.com/#/public-dashboard. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

9. Mr. Bascom shall, at his own cost, complete NCSBN Learning Extension **Medication Errors: Causes & Prevention v2.5** available online at https://ncsbn-external.myabsorb.com/#/public-dashboard. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

10. Mr. Bascom will be required to submit performance appraisal(s) from his immediate supervisor(s) at all facilities where he is employed, subject to the following terms and conditions:

    a) The supervisor(s) will provide written confirmation that they have reviewed a copy of the Decision;

    b) The supervisor will provide the CLPNA with a performance evaluation, indicating whether they have any concerns with respect to Mr. Bascom's performance, and in particular in reference to the conduct found to constitute unprofessional conduct by the Hearing Tribunal in its Decision;

    c) The performance evaluation must be provided within three months of the date of service of the Decision on Mr. Bascom;

    d) If the performance evaluation(s) are not satisfactory, the Complaints Consultant may, in his discretion, request a further performance evaluation from Mr. Bascom's employer(s) which will be due three months after the first performance evaluation was provided;

    e) If at any time the supervisor(s) identify concerns regarding Mr. Bascom's performance, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

11. The condition requiring Mr. Bascom to practice subject to supervision will remain in place until Mr. Bascom provides proof to the Complaints Consultant that he has successfully completed the requirements set out above at paragraphs 3-10.

12. The orders set out above at paragraphs 2-11 will appear as conditions on Mr. Bascom's practice permit and the CLPNA's Public Registry subject to the following:

a) The requirement to complete the courses, quizzes, performance evaluation and self-reflection outlined at paragraphs 3-10 will appear as "monitoring orders (conduct)" on Mr. Bascom's practice permit and the Public Registry until the orders below have been satisfactorily completed:

    a. Reading/Reflective Paper;

    b. LPN Ethics Course;

    c. Professionalism in Nursing Course;

    d. CLPNA's Health Assessment Self-Study Course;

    e. Neurological Assessments and GCS Video;

    f. Medication Management (NURS 0161);

    g. Sharpening Critical Thinking Skills;

    h. Medication Errors: Causes & Prevention v2.5; and

    i. Performance evaluation.

b) The requirement to practice subject to supervision will continue to appear on Mr. Bascom's practice permit and the Public Registry until he provides proof to the Complaints Consultant that he has successfully completed the requirements in paragraphs 3-11; and

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

13. The conditions on Mr. Bascom's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 12.

14. Mr. Bascom shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Bascom will keep his contact information current with the CLPNA on an ongoing basis.

15. Should Mr. Bascom 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.

16. Should Mr. Bascom 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 Mr. Bascom'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 Mr. Bascom 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.

17. The parties agree that the Agreed Statement of Facts and Acknowledgement may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

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 Mr. Bascom 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 Mr. Bascom 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 conduct of Mr. Bascom is significant. The errors that he was performing are fundamental errors for safe and competent nursing in the areas of medication administration, documentation and medication transcription, as well as delegating tasks to other professions that were outside of their scope of practice;

- **The age and experience of the investigated membe**r: Even though Mr. Bascom was a new nurse (September 2018), the errors that were made were of the nature of basic competencies that are expected at all nursing levels;

- **The number of times the offending conduct was proven to have occurred:** From March 2 to the end of June is the time period that the Allegations took place. Mr. Bascom had several incidences that were repeated multiple times with various patients, suggestive of a pattern of issues as opposed to one specific incident;

- **The role of the investigated member in acknowledging what occurred:** The Hearing Tribunal would like to commend Mr. Bascom for acknowledging his conduct and cooperating with the College during the investigation;

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Mr. Bascom is not currently working as an LPN.

- **The impact of the incident(s) on the victim, and/or:** There is no evidence of specific harm to clients;

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** The Hearing Tribunal considered specific deterrence in respect of Mr. Bascom and concluded that the sanctions proposed bring home to him the seriousness of the Allegations and serve as a sufficient specific reprimand with appropriate remedial action. In addition, the proposed sanctions promote general deterrence by existing as a significant and thorough response to the finding of unprofessional conduct in this case, which the Hearing Tribunal found to include concerning and serious conduct on the part of Mr. Bascom;

- **The need to maintain the public's confidence in the integrity of the profession:** The proposed sanctions will demonstrate to the public that the profession is working to

address concerns within its membership and work towards ensuring all members are highly skilled and practicing ethically.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the 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.

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. Mr. Bascom shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** subject to the following:
    a. Mr. Bascom will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter");
    b. Payments of costs will not commence until the first of the month after he has secured employment; and
    c. Should Mr. Bascom secure employment prior to service of the Costs Letter, payment of costs shall commence on the first of the month following service of the Costs Letter
3. Mr. Bascom shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Mr. Bascom shall provide to the Complaints Consultant, a signed declaration within **thirty (30) days** of service of the Decision, attesting he has reviewed the following CLPNA documents:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;

c. CLPNA Practice Policy: Professional Responsibility & Accountability;
d. CLPNA Practice Policy: Documentation;
e. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;
f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
g. CLPNA Competency Profile B1: Assessment;
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i. CLPNA Competency Profile B3: Planning;
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l. CLPNA Competency Profile C5: Accountability and Responsibility;
m. CLPNA Competency Profile C9: Informal Leadership; and
n. CLPNA Competency Profile U2: Medication Preparation and Administration;

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

4. Mr. Bascom shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **thirty (30) days** of service of the Decision.

   If the course becomes unavailable, then Mr. Bascom shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Consultant shall, in his sole discretion, reassign a course. Mr. Bascom will be notified by the Complaints Consultant, in writing, advising of the new course required.

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

7. Mr. Bascom shall, at his own cost, complete MacEwan University's **Medication Management (NURS 0161)** available online at https://www.macewan.ca/wcm/SchoolsFaculties/CentreforProfessionalNursingEducation/Courses/NURS0161. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

8. Mr. Bascom shall, at his own cost, complete NCSBN Learning Extension **Sharpening Critical Thinking Skills** available online at https://ncsbn-external.myabsorb.com/#/public-dashboard. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

9. Mr. Bascom shall, at his own cost, complete NCSBN Learning Extension **Medication Errors: Causes & Prevention v2.5** available online at https://ncsbn-external.myabsorb.com/#/public-dashboard. Mr. Bascom shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (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.

10. Mr. Bascom will be required to submit performance appraisal(s) from his immediate supervisor(s) at all facilities where he is employed, subject to the following terms and conditions:

    a) The supervisor(s) will provide written confirmation that they have reviewed a copy of the Decision;

    b) The supervisor will provide the CLPNA with a performance evaluation, indicating whether they have any concerns with respect to Mr. Bascom's performance, and

in particular in reference to the conduct found to constitute unprofessional conduct by the Hearing Tribunal in its Decision;

c) The performance evaluation must be provided within three months of the date of service of the Decision on Mr. Bascom;

d) If the performance evaluation(s) are not satisfactory, the Complaints Consultant may, in his discretion, request a further performance evaluation from Mr. Bascom's employer(s) which will be due three months after the first performance evaluation was provided;

e) If at any time the supervisor(s) identify concerns regarding Mr. Bascom's performance, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

11. The condition requiring Mr. Bascom to practice subject to supervision will remain in place until Mr. Bascom provides proof to the Complaints Consultant that he has successfully completed the requirements set out above at paragraphs 3-10.

12. The orders set out above at paragraphs 2-11 will appear as conditions on Mr. Bascom's practice permit and the CLPNA's Public Registry subject to the following:

    a) The requirement to complete the courses, quizzes, performance evaluation and self-reflection outlined at paragraphs 3-10 will appear as "monitoring orders (conduct)" on Mr. Bascom's practice permit and the Public Registry until the orders below have been satisfactorily completed:

        a. Reading/Reflective Paper;

        b. LPN Ethics Course;

        c. Professionalism in Nursing Course;

        d. CLPNA's Health Assessment Self-Study Course;

        e. Neurological Assessments and GCS Video;

        f. Medication Management (NURS 0161);

        g. Sharpening Critical Thinking Skills;

        h. Medication Errors: Causes & Prevention v2.5; and

        i. Performance evaluation

b) The requirement to practice subject to supervision will continue to appear on Mr. Bascom's practice permit and the Public Registry until he provides proof to the Complaints Consultant that he has successfully completed the requirements in paragraphs 3-11; and

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

13. The conditions on Mr. Bascom's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 12.

14. Mr. Bascom shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Bascom will keep his contact information current with the CLPNA on an ongoing basis.

15. Should Mr. Bascom 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.

16. Should Mr. Bascom 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 Mr. Bascom'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 Mr. Bascom 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.

1. The parties agree that the Agreed Statement of Facts and Acknowledgement may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original

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 23rd DAY OF OCTOBER 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kimberley Chin, LPN
Chair, Hearing Tribunal