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 MICHELLE MONTPETIT

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 MICHELLE MONTPETIT, LPN #28161, 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 using Zoom on July 23, 2020 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Angelica de Vera, LPN
Nancy Brook, Public Member

Staff:
Ayla Akgungor, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Michelle Montpetit, LPN ("Ms. Montpetit or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Montpetit was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Montpetit was initially licensed as an LPN in Alberta on October 13, 2005.

On August 9, 2018, the CLPNA received a complaint from Eva Hart, Care Manager at Good Samaritan Society ("GSS") CHOICE Program in Edmonton, Alberta (the "Complaint"). The

Complaint was made pursuant to s. 57(1) of the Act, and advised that Ms. Montpetit, LPN had received an (8) eight-day suspension as a result of performance concerns related to medication administration.

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

In accordance with section 55(2)(d) of the Act, the Complaints Consultant conducted a preliminary investigation into the Complaint.

On August 10, 2018, Ms. Montpetit received notice of the Complaint and the investigation by letter.

On September 19, 2018, the CLPNA received a second letter of complaint from Ms. Hart at GSS CHOICE Program in Edmonton, Alberta (the "Second Complaint"). The Second Complaint was made pursuant to s. 57(1) of the Act and advised that Ms. Montpetit had been terminated as a result of further performance concerns relating to medication administration and documentation practices.

In accordance with section 55(2)(d) of the Act, the Complaints Consultant conducted a preliminary investigation into the Second Complaint.

Ms. Montpetit received notice of the Second Complaint and the investigation by letter dated October 4, 2018.

On February 5, 2019, Ms. Montpetit received notice that the complaints would be referred for further investigation and in accordance with s. 55(2)(d) of the Act, the Complaints Consultant appointed an Investigator, Kerry Palyga ("the Investigator"), to conduct an investigation into the First and Second Complaints.

On September 23, 2019, the Investigator concluded the investigations of the First and Second Complaints and submitted the Investigation Report to the CLPNA.

Following the Investigation Report, the Complaints Consultant determined there was sufficient evidence that these matters should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Montpetit received notice that the matters were referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated April 6, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Montpetit under cover of letter dated June 8, 2020.

(4) Allegations

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

It is alleged that **MICHELLE MONTPETIT, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about July 13, 2018 did one or more of the following with regards to client RF:
    a) On the Medication Administration Record changed Sinemet 100/25 (1) tab at 1300 hours to 1500 hours initially without a physician's order;
    b) Incorrectly changed the time of administration on the Medication Administration Record for Sinemet 100/25 (1) tab from 1300 hours to 1500 hours by writing a "5" over the "3";
    c) Incorrectly transcribed a verbal order onto the Physician's Order and Progress Record, received at 1345 hours, for Sinemet by failing to include the dosage, number of tablets and route for the medication to be administered at 1500 hours;
    d) Failed to document on the Medication Administration Record the administration of Calcium 500 mg/Vitamin D 125 IU at 1200 hours;
    e) Failed to document on the Medication Administration Record the administration of Novorapid Insulin 6 units at 1200 hours.
2. On or about July 4, 6, 9, 11, and 13, 2018 failed to document on the Medication Administration Record the administration of and/or the reason for not administering Sinemet 100/15 at 1300 hours to client RF.
3. On or about June 13, 2018 did one or more of the following with regards to client RF:
    a) After administering Prolia injection 60 mg/ml on January 5, 2018 failed to update the Medication Administration Record to indicate the next dose to be given was July 5, 2018;
    b) Administered Prolia injection 60 mg/ml 2 weeks ahead of the ordered date of July 5, 2018;
    c) Failed to check the Medication Administration Record for client RF to confirm when the Prolia injection was due prior to administering the Prolia injection 60mg/ml;
    d) Failed to complete an incident report as requested by RN.
4. On or about September 7, 2018 did one or more of the following with regards to client VA:
    a) Administered Eliquis 2.5 mg at 0800 hours when the medication had been discontinued on August 30, 2018;
    b) Failed to document the administration of the Eliquis 2.5 mg at 0800 hours on VA's Medication Administration Record;

c) Failed to check the medications contained in VA's bubble pack against VA's Medication Administration Record.

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

   a) Failed to document her entry on September 10, 2018 as a "late entry";

   b) Documented information in the Interdisciplinary Progress Notes that was not appropriate to be documented in the Interdisciplinary Progress Notes.

(5) Admission of Unprofessional Conduct

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

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

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

must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

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

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

Allegation 1

Michelle Montpetit admitted on or about July 13, 2018, she did one or more of the following with regards to client RF:

a) On the Medication Administration Record changed Sinemet 100/25 (1) tab at 1300 hours to 1500 hours initially without a physician's order;

b) Incorrectly changed the time of administration on the Medication Administration Record for Sinemet 100/25 (1) tab from 1300 hours to 1500 hours by writing a "5" over the "3";

c) Incorrectly transcribed a verbal order onto the Physician's Order and Progress Record, received at 1345 hours, for Sinemet by failing to include the dosage, number of tablets and route for the medication to be administered at 1500 hours;

d) Failed to document on the Medication Administration Record the administration of Calcium 500 mg/Vitamin D 125 IU at 1200 hours;

e) Failed to document on the Medication Administration Record the administration of Novorapid Insulin 6 units at 1200 hours.

On June 27, 2018, it was noticed the timing of client RF's administration of Levocarb (Sinemet) 100/25mg was amended from 0700, 1100, 1500 and 1900 hours to Levocarb 100/25mg PO TID at 0700, 1100, 1300 and Levocarb 100/25mg 1.5 tablets at 1900 hours. Levocarb is used to treat tremors related to Parkinson's Disease.

On July 13, 2018, Ms. Montpetit worked a dayshift from 0700 hours until 1515 hours at GSS. At around 1300 hours, Ms. Montpetit told the Unit Clerk, Sukhvir Sandhu, that Ms. Sandhu had made an error on client RF's Medication Administration Record ("MAR") when transcribing on June 27, 2018. Ms. Montpetit told Ms. Sandhu that she had transcribed the wrong time for the Levocarb 100/25 and that client RF should receive the dose at 1500 hours and not at 1300 hours as Ms. Sandhu had written.

After spotting the alleged error, Ms. Montpetit wrote a 5 over the 3 on client RF's MAR changing the administration time from 1300 hours to 1500 hours.

Ms. Sandhu reviewed client RF's Physician Order and Progress Record and confirmed that she had transcribed the order correctly as 1300 hours and alerted Ms. Montpetit of this.

Ms. Montpetit phoned client RF's wife who advised Ms. Montpetit that client RF's Levocarb had previously been given at 1500 hours, not 1300 hours and client RF's wife preferred that the Levocarb continued to be administered at 1500 hours. Client RF's wife had been administering the Levocarb at 1500 hours when client RF was at home. Ms. Montpetit was advised by Terri-Lynn Weber, RN, to phone the doctor on call for direction as a result of the discrepancy.

Ms. Weber advised Ms. Montpetit that a new medication order was needed to be written with the times corresponding to the exact direction received from the doctor and that client RF's wife needed to be updated as to the correct administration time. Dr. M. Manning gave a verbal order to Ms. Montpetit over the phone to continue with Levocarb 100/25mg PO TID at 0700, 1100, and 1500 hours.

Ms. Montpetit transcribed on client RF's chart "continue to give levocarb at 1500 hours, Dr. Fillion to follow up on Monday", but failed to specify the dosage, the number of tablets and route for the medication.

On the same date, Ms. Montpetit administered Calcium 500mg/Vitamin D 125 IU to client RF at 1200 hours but failed to document the same on client RF's MAR.

Ms. Montpetit administered Novorapid Insulin to RF at 1200 hours but failed to document the same on client RF's MAR.

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

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

> (i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) Contravention of the Act, a code of ethics or standards of practice;
>
> (xii) Conduct that harms the integrity of the regulated profession.

Ms. Montpetit displayed a lack of knowledge and or lack of skill by not confirming with the client's MAR to confirm which medication was supposed to be given and at what time. Ms. Montpetit also spotted an error in the documentation of RF's medication and instead of adding

a new entry she wrote on top of the existing order. Ms. Montpetit did not properly transcribe the verbal order that she was given by Dr. Fillion to RF's MAR. If Ms. Montpetit was unsure of how to do the verbal order, she should have asked for assistance. Ms. Montpetit was, at the time of the allegations, an LPN with approximately 13 years of experience and should have been familiar with the rights of medication administration.

Ms. Montpetit did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her 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.

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

CLPNA Code of Ethics

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

> **Principle 1**: Responsibility to the Public - Licensed Practical Nurses, as self-regulating professionals, commit to provide safe, effect, compassionate and ethical care to members of the public. Principle 1 states that LPNs:
>
> - 1.1 Maintain standards of practice, professional competence and conduct.
> - 1.2 Provide only those functions for which they are qualified by education and experience.
> - 1.5 Provide care directed toward the health and well-being of the person, family, and community.
>
> **Principle 2**: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for clients. Principle 2 states that LPNs:
>
> - 2.8 Use evidence and judgement to guide nursing decisions.
> - 2.9 Identify and minimize risk 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 states 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 recognize and function within their personal and professional competence and value systems. Principle 5 states that LPNs:

- 5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgement.

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

CLPNA Standards of Practice

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

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 states that LPNs:

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

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

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

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

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

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

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

- 2.2 Apply knowledge from nursing theory and science, other disciplines evidence to inform decision making and LPN practice.

- 2.11 Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

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 states that LPNs:

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

- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury.

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

Ms. Montpetit harmed the integrity of the regulated profession by not doing what another LPN would have done in a similar circumstance. Ms. Montpetit should have confirmed client RF's medications against his MAR. The failure by an experienced LPN of failing to follow basic principles of medication administration and charting harm the integrity of the profession.

Allegation 2

On July 4, 6, 9, 11 and 13, 2018 Ms. Montpetit provided care for client RF.

Michelle Montpetit admitted on or about July 4, 6, 9, 11, and 13, 2018, she failed to document on the MAR the administration of and/or the reason for not administering Sinemet 100/15 at 1300 hours to client RF.

On July 13, 2018, Eva Hart, RN Care Manager at GSS, reviewed the MAR for client RF. Ms. Hart noted Levocarb 100/15, scheduled to be administered to RF at 1300 hours, had not been signed off on the MAR. Ms. Montpetit was the LPN responsible for client RF during this time period.

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

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Montpetit displayed a lack of skill or judgement by failing to document and sign off the medication for RF that was scheduled to be administered at 1300 hours.

Ms. Montpetit did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her 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 in Allegation 1.

Ms. Montpetit harmed the integrity of the regulated profession by not doing what another LPN would have done in a similar circumstance. Ms. Montpetit should have documented that she administered client RF's medications on the MAR at the time that they were administered.

<u>Allegation 3</u>

Michelle Montpetit admitted on or about June 13, 2018, she did one or more of the following with regards to client RF:

a) After administering Prolia injection 60 mg/ml on January 5, 2018 failed to update the Medication Administration Record to indicate the next dose to be given was July 5, 2018;

b) Administered Prolia injection 60 mg/ml 2 weeks ahead of the ordered date of July 5, 2018;

c) Failed to check the Medication Administration Record for client RF to confirm when the Prolia injection was due prior to administering the Prolia injection 60mg/ml;

d) Failed to complete an incident report as requested by RN.

On June 13, 2018, Ms. Montpetit worked from 0700 hours to 1515 hours and provided care for client RF.

Client RF was ordered Prolia injection 60 mg/ml subcutaneously every 6 months. Client RF was ordered Prolia injection 60mg/ml on January 5, 2018. Ms. Montpetit administered Prolia injection 60mg/ml on January 5, 2018 to client RF.

The next administration was scheduled for July 5, 2018. Ms. Montpetit failed to update client RF's MAR to indicate when the next dose was due and the June MAR incorrectly stated, "Next due: Jan 5/18". This obvious error should have prompted Ms. Montpetit to confirm the correct date for the next dose.

On or around June 13, 2018, Prolia injection was delivered from the pharmacy for client RF.

On client RF's "To-Do" list, it indicated client RF had been administered Prolia on "Jan 13/2018" and it was "Due July 17".

Ms. Montpetit failed to check client RF's To-Do List MAR prior to the administration to confirm the correct date for client RF's Prolia injection and instead administered it early on June 13, 2018, when it arrived from the pharmacy.

Ms. Montpetit realized her error and stated she reported the same to Dr. Mariette Fillion, and clinical pharmacist Michael Newman. Dr. Fillion indicated that no interventions were required as a result of the early Prolia injection.

Ms. Montpetit asked Tammy Row, RN if she should complete an incident report. Ms. Row directed that she should. Despite that direction, Ms. Montpetit did not complete an incident report regarding the early administration.

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

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Montpetit displayed a lack of knowledge and judgment by failing to properly document the Physician's Order with respect to Client RF's Prolia which was supposed to be ordered subcutaneously every 6 months. Ms. Montpetit also failed to document properly when the next dose was due for client RF. Ms. Montpetit failed to check RF's To-Do List MAR prior to the administration of Prolia. These are core rights of medication administration that Ms. Montpetit should have been aware of with her experience. Ms. Montpetit was also instructed as a result of this to do an incident report, which she did not do, regarding the administration of the medication.

Ms. Montpetit did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her 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 in Allegation 1.

Ms. Montpetit harmed the integrity of the regulated profession by not doing what another LPN would have done in a similar circumstance. Ms. Montpetit should have confirmed client RF's medications against his MAR. Ms. Montpetit should have been more careful when she was marking down when the next dose of the Prolia was to be given and, if she was not sure, then she should have had an independent double check with another health care provider.

Allegation 4

Michelle Montpetit admitted on or about September 7, 2018, she did one or more of the following with regards to client VA:

a) Administered Eliquis 2.5 mg at 0800 hours when the medication had been discontinued on August 30, 2018;

b) Failed to document the administration of the Eliquis 2.5 mg at 0800 hours on VA's Medication Administration Record;

c) Failed to check the medications contained in VA's bubble pack against VA's Medication Administration Record.

On September 7, 2018, Ms. Montpetit worked from 0700 hours until 1515 hours and provided care to client VA.

On August 30, 2018, Eliquis 2.5mg was discontinued for client VA. Despite the Eliquis 2.5mg being discontinued, the medication bubble pouch for September 7, 2018 still contained Eliquis 2.5mg in the pouch for client VA. Ms. Montpetit failed to check the medication pouch against client VA's MAR.

On that day, Ms. Montpetit administered Eliquis 2.5mg to client VA at 0800 hours despite it being discontinued. Ms. Montpetit failed to document the administration on client VA's MAR.

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

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Montpetit displayed a lack of knowledge and a lack of skill by administering medications to client VA that were discontinued more than a week prior to Ms. Montpetit administering the medications to client VA. Ms. Montpetit failed to check client VA's MAR to ensure that she was giving the correct medication at the correct time, which is a fundamental to basic mediation administration.

Ms. Montpetit did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her 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 in Allegation 1.

Ms. Montpetit harmed the integrity of the regulated profession by not doing what another LPN would have done in a similar circumstance. Ms. Montpetit should have confirmed client VA's medications against his MAR.

<u>Allegation 5</u>

Michelle Montpetit admitted on or about September 10, 2018, she did one or more of the following with regards to client VA:

a) Failed to document her entry on September 10, 2018 as a "late entry";

b) Documented information in the Interdisciplinary Progress Notes that was not appropriate to be documented in the Interdisciplinary Progress Notes.

On September 10, 2018, Ms. Montpetit worked from 0700 hours until 1515 hours and provided care to client VA.

The September 7, 2018 medication administration error for client VA by Ms. Montpetit (Eliquis 2.5mg) was discovered by Susan Christensen, LPN on the September 7, 2018 evening shift. Ms. Christensen notified the on-call RN, Adriene Arbuckle, as well as the on-call physician. Ms.

Arbuckle removed Eliquis from the remaining medication pouches and noted the same on client VA's Choice Physician's Order and Progress Record.

On September 10, 2018, Ms. Montpetit was made aware of the medication administration error. At approximately 0915 hours, Ms. Montpetit entered a note on client VA's Interdisciplinary Progress Note. Ms. Montpetit did not note that it was a "late entry".

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

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

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

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

Ms. Montpetit displayed a lack of knowledge or skill by not realizing the error that she made in respect to client VA and the administration of VA's medication earlier then it should have been. Ms. Montpetit did not notify anyone of the error as it was found in an audit by Ms. Susan Christensen on September 7, 2018. When Ms. Montpetit was notified of the error, she did document on client VA's Interdisciplinary Progress Notes; however, she did not note that it was a late entry. Both medication administration and documentation are core competencies of an LPN regardless of their experience.

Ms. Montpetit did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her 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 in Allegation 1.

Ms. Montpetit harmed the integrity of the regulated profession by not doing what another LPN would have done in a similar circumstance. Ms. Montpetit should have noticed the error when she was administering the medications to client VA as she should have been referring to the MAR. Once Ms. Montpetit was made aware of the error, she should have documented the entry into VA's Interdisciplinary Progress Notes as a late entry.

Summary

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

(9) Partial Joint Submission on Penalty

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

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

2. Ms. Montpetit shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Montpetit shall provide a signed written declaration to the Complaints Consultant, within **30 days** of service of the Decision, attesting that she 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 Practice Guideline: Medication Management;

    f) CLPNA Competency Profile A1: Critical Thinking; and

    g) CLPNA Competency Profile A2: Clinical Judgment and Decision Making.

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

3. Ms. Montpetit shall complete, at her own cost, the following course: **NURS 0161 Medication Management** offered on-line by MacEwan University. Ms. Montpetit 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.

4. Ms. Montpetit shall complete, at her own cost, the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Michelle Montpetit shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

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

5. Ms. Montpetit shall pay, in full, a portion of the investigation and hearing costs to the CLPNA. The portion of the investigation and hearing costs to be paid to the CLPNA by Ms. Montpetit and the timeframe in which the portion of costs must be paid shall be determined by the Hearing Tribunal on hearing the submissions of the parties on costs.

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

   a) The requirement to complete the readings and courses outlined at paragraphs 2-4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Montpetit's practice permit and the Public Registry until the following orders have been satisfactorily completed;

      i. Read and Review of CLPNA documents;

      ii. NURS 0161 – Medication Management; and

      iii. Nursing Documentation 101.

   b) The requirement to pay costs will appear as "Conduct Cost/Fines" on Ms. Montpetit's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 5.

7. The conditions on Ms. Montpetit's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.

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

9. Should Ms. Montpetit 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.

10. Should Ms. Montpetit 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 the Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

    b. Treat Ms. Montpetit's non-compliance as information under s. 56 of the Act; or

    c. In the case of non-payment of the costs described in paragraph 5 above, suspend Ms. Montpetit's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payments agreed to by the Complaints Consultant.

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

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

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

However, Ms. Montpetit and the Legal Counsel for the Complaints Consultant did not make joint submissions on the costs payable by Ms. Montpetit as a result of the hearing, and the Hearing Tribunal considered those submissions as well.

(10) Submissions by Complaints Consultant as to Costs

Submissions were made by the Legal Counsel for the Complaints Consultant. The submission made was that presently, the hearing costs for CLPNA Legal Counsel were at $15,000.00, not

including any of the other costs that are related to the hearing. The request of CLPNA Legal Counsel was 25% of the costs to be paid by Ms. Montpetit, with payments being made over a time period of 36 months to the CLPNA.

(11) Submissions on behalf of Ms. Montpetit as to Costs

Submissions were made by Ms. Montpetit's AUPE Representative, Ms. Drennan, and the Hearing Tribunal was presented with Ms. Montpetit's monthly budget to take into consideration, although this was not entered into evidence. Ms. Montpetit also provided the Hearing Tribunal with a letter that was dated May 19, 2020 that spoke to her financial situation, which was also not entered into evidence. These documents were reviewed by the Hearing Tribunal but neither were taken into consideration in the ultimate decision on costs. The Hearing Tribunal was made aware by Ms. Drennan that Ms. Montpetit is a single wage earner and making approximately 32% of her usual earnings, in her current employment of working as a Pharmacy Technician at the Glenrose Hospital. Ms. Drennan asked the Hearing Tribunal to consider a one-time payment of $2,000.00 by Ms. Montpetit over the next 36 months to the CLPNA.

(12) Decision on Penalty and Conclusions of the Hearing Tribunal

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

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

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

The nature and gravity of the proven allegations: This was a significant factor as Ms. Montpetit demonstrated a lack of skill, knowledge and judgement in relation to these allegations. The allegations dealt with medication administration and documentation errors, which are basic core competencies of what is expected of an LPN.

The age and experience of the investigated member: Ms. Montpetit was initially registered with the CLPNA on October 13, 2005. Ms. Montpetit worked at the GSS CHOICE Program in Edmonton at the time of the allegations. Ms. Montpetit had been practicing as an LPN in Alberta for approximately thirteen (13) years, and therefore she should have been experienced enough and skilled enough to avoid the errors that were made.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not made aware of any previous complaints or convictions in respect to Ms. Montpetit.

The number of times the offending conduct was proven to have occurred: This was a significant factor as there were repeated instances of the errors that occurred with respect to Ms. Montpetit. There were five (5) allegations presented to the Hearing Tribunal with sub-allegations within these. The allegations took place over a time period of June 13, 2018 to September 10, 2018 (3 months).

The role of the investigated member in acknowledging what occurred: Ms. Montpetit did acknowledge the allegations that were brought forward by her employer to the CLPNA. Ms. Montpetit also did cooperate with both the CLPNA and she did provide the Hearing Tribunal with an Agreed Statement of Facts, which demonstrates that she took some responsibility for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Montpetit did receive an eight (8) day suspension as a result of the allegations. Ms. Montpetit served her suspension on August 10, 13, 14, 15, 16, 17, 20 and 21, 2018. Ms. Montpetit was subsequently terminated from her position on September 19, 2018.

The impact of the incident(s) on the victim: The Hearing Tribunal was not made aware of any impact to any of the clients that were in Ms. Montpetit's care during the time of the allegations, however the potential of harm to these clients existed, as the allegations all deal with medication administration and documentation errors, which can have significant effects on clients in the care of Ms. Montpetit.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware of any mitigating circumstances.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: Specific deterrence is required to keep Ms. Montpetit from repeating the same conduct in the future. General deterrence is required to ensure that other members in the LPN profession do not engage in this type of conduct and to make it known that this type of conduct will not be tolerated by the CLPNA. LPNs are recognized as independent and capable members of the healthcare team and are self-regulating and the public needs to be reassured that this standard is upheld.

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

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

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

On the matter of costs, where the parties did not make a joint submission, the Hearing Tribunal orders that Ms. Montpetit shall be required to pay 25% of the hearing costs, with payments being made over a time period of 36 months to the CLPNA.

(13) Orders of the Hearing Tribunal

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

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

2. Ms. Montpetit shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Montpetit shall provide a signed written declaration to the Complaints Consultant, within **30 days** of service of the Decision, attesting that she 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 Practice Guideline: Medication Management;

f) CLPNA Competency Profile A1: Critical Thinking; and

g) CLPNA Competency Profile A2: Clinical Judgment and Decision Making.

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

3. Ms. Montpetit shall complete, at her own cost, the following course: **NURS 0161 Medication Management** offered on-line by MacEwan University. Ms. Montpetit 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.

4. Ms. Montpetit shall complete, at her own cost, the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Michelle Montpetit shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

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

5. Ms. Montpetit shall pay twenty-five (25%) percent of the hearing costs of the CLPNA, in full, with payments being made over a time period of 36 months to the CLPNA.

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

   a) The requirement to complete the readings and courses outlined at paragraphs 2-4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Montpetit's practice permit and the Public Registry until the following orders have been satisfactorily completed;

i. Read and Review of CLPNA documents;

ii. NURS 0161 – Medication Management; and

iii. Nursing Documentation 101.

b) The requirement to pay costs will appear as "Conduct Cost/Fines" on Ms. Montpetit's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 5.

7. The conditions on Ms. Montpetit's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.

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

9. Should Ms. Montpetit 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.

10. Should Ms. Montpetit 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 the Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

b. Treat Ms. Montpetit's non-compliance as information under s. 56 of the Act; or

c. In the case of non-payment of the costs described in paragraph 5 above, suspend Ms. Montpetit's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payments agreed to by the Complaints Consultant.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 12 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 9th DAY OF SEPTEMBER 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal