COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA
(CLPNA)

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF MYRSA PENA

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 MYRSA PENA, LPN #33695, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES ("CLPNA") OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta in Edmonton, Alberta on July 31, 2019 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN"), Chairperson
Christine Buck, LPN
Johanne Chicoine, LPN
Hugh Campbell, Public Member

Staff:
Tessa Gregson, Legal Counsel for the Complaints Director/Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Myrsa Pena, LPN ("Ms. Pena" or "Investigated Member")
Kathie Milne, 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, along with additional submissions on costs by the Complaints Consultant.

(3) Background

Myrsa Pena was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Myrsa Pena was initially licensed as an LPN in Alberta on June 6, 2011.

On August 27, 2018, the CLPNA received a complaint from Patricia Compton, Assistant Director of Care at Extendicare, Michener Hill (the "Facility") in Red Deer Alberta (the "Complaint"). The Complaint was sent pursuant to s. 57 of the Act notifying that Ms. Pena, LPN had been suspended for three (3) days due to errors in medication administration.

Sandy Davis, Complaints Director for the CLPNA delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act. Further, in accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Kathryn Emter, Investigator for the CLPNA (the "Investigator") to conduct an investigation into the Complaint. Ms. Pena received notice of the Complaint and notice of investigation by letter dated August 28, 2018.

On November 20, 2018, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

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

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Pena under cover of letter dated May 31, 2019.

(4) Allegations

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

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

1. On or about June 1 and/or 6, 2018, documented on the Medication Administration Record resident JH's refusal to have Diclo 10%, Gabapentin 5%, Lidocaine 5% cream applied to her feet when she was not working on those days.

2. On or about June 30, 2018 did one or more of the following with regards to resident JH:

    a) Failed to administer Spironolactone 25 mg and Synthroid 200 mg at the scheduled time of 0800 hours;

    b) Administered Spironolactone 25 mg and Synthroid 200 mg at 1445 hours despite being instructed to hold the medication;

    c) Documented on the Medication Administration Record as having administered the Spironolactone 25 mg and Synthroid 200 mg at 0800 hours instead of the actual time of 1445 hours; and

d) Failed to document on the Resident Progress Notes, in a timely manner, the reason for administering the Spironolactone 25 mg and Synthroid 200 mg at 1445 hours.

3. On or about July 6, 2018 failed to follow proper medication administration procedures by failing to document on the Medication Administration Record at the time of administration but rather documented the administration of numerous residents' medications on the Medication Administration Record at the same time.

4. On or about July 6, 2018 did one or more of the following with regards to resident SS:

    a) In the morning, pre-poured Oxycodone 5 mg/325 mg tablet scheduled for administration at 1400 hours; and

    b) Failed to document on the Narcotic Count Record the date and time the Oxycodone 5 mg/325 mg tablet was removed.

5. On or about May 7, 2018 left the medication cart unsecured and unattended, with medications left out on top of the cart.

6. On or about May 17, 2018 failed to follow proper medication administration procedures by doing one or more of the following:

    a) Leaving resident DM's 0800 hours medications on the dining room table unattended; and

    b) Failing to ensure resident DM consumed his 0800 hours medications.

7. On or about June 14, 2018 documented on resident JH's Medication Administration Record as having administered the following medications at 0800 hours instead of the actual time of 1200 hours: Furosemide 20 mg; Metoprolol 100 mg; Brilinta 90 mg; Isdn 30 mg; Mylan-Pantoprazole T 40 mg; Praxis ASA EC 81 mg; Ramipril 2.5 mg; Synthroid 200 mcg; Teva-Spironolactone 25 mg; vitamin D 1,000U; Mylan-Nitro 0.2 mg/hr; and Gabapentin 300 mg."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits a 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. Pena 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 Director/Consultant submitted that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

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

In addition to the Exhibits entered above, Ms. Pena put forth information about her current financial situation, which was not formally entered as an Exhibit, but was taken into account by the Hearing Tribunal.

(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. Pena'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. Pena.

Allegation 1

Ms. Pena admitted on or about June 1 and/or 6, 2018, she documented on the Medication Administration Record resident JH's refusal to have Diclo 10%, Gabapentin 5%, Lidocaine 5% cream applied to her feet when she was not working on those days.

In May 2018, Ms. Pena had been counselled by Ms. Sandi Engi, a Nurse Practitioner that if resident JH refused to have medicated cream applied to her feet, then the refusal needed to be documented on the Medication Administration Record ("MAR"). This is further reflected in the Facility's Medication Management Policy which requires nursing staff to immediately document all medication administered, refused or omitted after administration on the MAR. A copy of the Medication Management Policy was provided in the Agreed Statement of Facts in Tab 8.

Ms. Pena did not work a shift at the Facility on June 1 or June 6, 2018. Rather, Ms. Amanda Sugrue, LPN worked on June 1 and June 6, 2018. A copy of Ms. Pena's June 2018 shift schedule was provided in the Agreed Statement of Facts under Tab 5.

On both June 1 and June 6, 2018, Ms. Sugrue asked resident JH if she wanted the Diclo 10%, Gabapentin 5%, Lidocaine 5% cream applied to her feet at 0800 hours and then again at 1200 hours as ordered. Resident JH refused both applications indicating she would rather have the cream applied in the evenings. Ms. Sugrue failed to document the refusals on the MAR for both June 1 and June 6, 2018.

Despite not having worked on June 1 or June 6, 2018, Ms. Pena documented a "1" on resident JH's MAR, indicating that resident JH refused the medicated cream on both days. A copy of resident JH's MAR was provided in the Agreed Statement of Facts under Tab 6.

Ms. Sugrue did not ask Ms. Pena to document the refusals for June 1 or June 6, 2018 and Ms. Pena did not ask Ms. Sugrue if she wanted Ms. Pena to document the refusals for those days.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pena'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 considered the following definitions of unprofessional conduct found in s. 1(1)(pp) of the Act:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct clearly displayed a lack of judgment in the provision of professional services as it demonstrated carelessness toward the accurate charting of resident JH's medications. The conduct also 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:

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 states that LPNs:

1.1 Maintain standards of practice, professional competence and conduct.

1.5 Provide care directed to 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 states that LPNs:

2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities;

2. 8 Use evidence and judgement to guide nursing decisions; and

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 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 specifically states that LPNs:

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:

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:

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

1.2 Engage in ongoing self-assessment of their professional practice and competence and seek opportunities for continuous learning.

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 LPNs.

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.

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

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

The Hearing Tribunal accepted Ms. Pena's admission of unprofessional conduct. The failure to document medication properly is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, her

failure to follow policies and procedures put patient safety at risk as those are developed to assist the care team in ensuring competent and consistent care.

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

Allegation 2

Ms. Pena admitted on or about June 30, 2018, she did one or more of the following with regards to resident JH:

a) Failed to administer Spironolactone 25 mg and Synthroid 200 mg at the scheduled time of 0800 hours;

b) Administered Spironolactone 25 mg and Synthroid 200 mg at 1445 hours despite being instructed to hold the medication;

c) Documented on the Medication Administration Record as having administered the Spironolactone 25 mg and Synthroid 200 mg at 0800 hours instead of the actual time of 1445 hours; and

d) Failed to document on the Resident Progress Notes, in a timely manner, the reason for administering the Spironolactone 25 mg and Synthroid 200 mg at 1445 hours.

Ms. Pena worked a day shift at the Facility on June 30, 2018. During the shift, she provided care to resident JH.

Resident JH was set to receive Spironolactone 25mg and Synthroid 200mg at 0800 hours. However, Ms. Pena failed to administer the Spironolactone and Synthroid during the 0800 hours medication pass as directed. A copy of resident JH's MAR was provided in the Agreed Statement of Facts under Tab 6.

Ms. Pena injured herself at the Facility and left to see a physician. Upon Ms. Pena's return to the Facility at around 1430 hours, Ms. Helen Bentir, RN informed Ms. Pena that she found resident JH's 0800 hours Spironolactone and Synthroid intact. Ms. Bentir instructed Ms. Pena to hold the medications.

Despite Ms. Bentir's instructions not to administer the Spironolactone and Synthroid, Ms. Pena administered the medications to resident JH at 1445 hours. Ms. Pena then documented on resident JH's MAR that she administered the Spironolactone and Synthroid at 0800 hours rather than the actual administration time of 1445 hours.

Ms. Pena failed to document anything about the late administration of Spironolactone and Synthroid in the resident's Progress Notes on June 30, 2018. Rather, this was not documented until July 2, 2018 at 1400 hours when Ms. Pena included a late entry in the Progress Notes. A

copy of the relevant portion of resident JH's Progress Notes was provided in the Agreed Statement of Facts under Tab 7.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pena'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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the HPA], a code of ethics or standards of practice.

The conduct clearly displayed a lack of judgment in the provision of professional services as it demonstrated carelessness toward the accurate charting of resident JH's medications. The conduct also breached the following principles and standards set out in CLPNA's Code of Ethics and CLPNA Standards of Practical Nurses of Canada;

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

The Hearing Tribunal accepted Ms. Pena's admission of unprofessional conduct. The failure to document medication properly is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, her failure to follow policies and procedures put patient safety at risk as those are developed to assist the care team in ensuring competent and consistent care.

Although there was no evidence of harm to the patient, there was a potential for harm and such conduct could have led to the clients, who are being cared for by Ms. Pena, to have very serious safety issues. In this case, it could have caused confusion about JH's medications and the possibility of JH taking her medication improperly. The Hearing Tribunal also finds the conduct breached the Code of Ethics and Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal also finds the conduct breached the Code of Ethics and Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 3</u>

Ms. Pena admitted on or about July 6, 2018, she failed to follow proper medication administration procedures by failing to document on the Medication Administration Record at the time of administration but rather documented the administration of numerous residents' medications on the Medication Administration Record at the same time.

Ms. Pena worked the day shift on July 6, 2018 at the Facility. During this shift, Ms. Pena administered medications to the residents at the Facility.

The Facility's Medication Management Policy mandates that nursing staff:

a) Ensure the resident information on each medication dispenser corresponds identically with the resident's MAR;
b) Administer medications following the 8 "Rights" of medication administration, including right resident, right drug, right dose, right time, right route, right reason, right response, and right documentation;
c) Immediately document all medication administered, refused or omitted after the administration on the MAR (emphasis added).

A copy of the Facility's Medication Management Policy was attached in the Agreed Statement of Facts under Tab 8.

Despite these requirements, Ms. Pena failed to follow proper medication administration procedures. She failed to document on the residents' MAR at the time of administration. Rather, Ms. Pena documented numerous medication administrations for multiple residents while in the medication room after completing the entire medication pass.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pena'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 accepted Ms. Pena's admission of unprofessional conduct. The failure to complete proper documentation is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, her failure to follow policies and procedures put patient safety at risk as those are developed to assist the care team in ensuring competent and consistent care.

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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

Allegation 4

Ms. Pena admitted on or about July 6, 2018, she did one or more of the following with regards to resident SS:

a) In the morning, pre-poured Oxycodone 5 mg/325 mg tablet scheduled for administration at 1400 hours; and

b) Failed to document on the Narcotic Count Record the date and time the Oxycodone 5 mg/325 mg tablet was removed.

As above, Ms. Pena worked a day shift on July 6, 2018. During this shift, she provided care to resident SS.

Resident SS was scheduled to receive Oxycodone 5mg/325mg at 0200, 0800, 1400 and 2000 hours. A copy of Resident SS's MAR was provided in the Agreed Statement of Facts under Tab 9.

Just before lunchtime on July 6, 2018, having misread the dosage time on the MAR, Ms. Pena incorrectly pre-poured resident SS's dose of Oxycodone scheduled for 1400 hours. Ms. Pena realized her error and placed the pre-poured Oxycodone dosage in the top drawer of the medication cart.

While Ms. Pena documented withdrawing the Oxycodone dose scheduled for 1400 hours on the Narcotic Count Record, she failed to record the date and time in which she removed the medication. A copy of the Narcotic Count Record was provided in the Agreed Statement of Facts under Tab 10.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pena'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 accepted Ms. Pena's admission of unprofessional conduct. The failure to complete proper documentation is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, in this case there was carelessness demonstrated with narcotics that could have harmed patients in the Facility had it been mishandled.

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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

Allegation 5

Ms. Pena admitted on or about May 7, 2018, she left the medication cart unsecured and unattended, with medications left out on top of the cart.

Ms. Pena worked the day shift on May 7, 2018 at the Facility. The Facility's Medication Management Policy requires nursing staff to ensure the medication cart is locked when unattended or out of sight.

During a medication pass on this shift, Ms. Pena left the medication cart in the dining room of the Facility unsecured and unattended. At that time there were cups containing medication on top of the medication cart.

Ms. Engi, Nurse Practitioner, found the unsecured and unattended medication cart and filled out an incident report. A copy of the Medication Incident Report was provided in the Agreed Statement of Facts under Tab 11.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Pena'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 accepted Ms. Pena's admission of unprofessional conduct. Leaving a medication cart unattended in a space where medications could possibly be removed or used by residents is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, her failure to follow policies and procedures put patient safety at risk.

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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

Allegation 6

Ms. Pena admitted on or about May 17, 2018, she failed to follow proper medication administration procedures by doing one or more of the following:

a) Leaving resident DM's 0800 hours medications on the dining room table unattended; and

b) Failing to ensure resident DM consumed his 0800 hours medications.

Ms. Pena worked the day shift at the Facility on May 17, 2018, and provided care to resident SDM, who went by the name DM.

Ms. Pena performed the 1200 hours medication pass in the dining room of the Facility. During this pass, Ms. Pena prepared resident DM's 1200 hours medications, which were Calcium Carbonate 500mg and Metoclopramide HCL 5mg. A copy of resident DM's MAR was provided in the Agreed Statement of Facts under Tab 12.

The Facility's Medication Management Policy mandates that nursing staff "observe medication for ingestion otherwise it cannot be considered administered".

Despite this, on May 17, 2018, Ms. Pena prepared resident DM's 1200 hours medications and then left the medications on the dining room table. Ms. Pena failed to remain at the table and ensure that DM consumed the medications she prepared for him.

As a result, another resident, resident KJ who was sitting next to resident DM thought the medications on the table were for him and accidentally consumed resident DM's 1200 hours medications. Ms. Pena realized this error when resident KJ asked her why his medications had changed.

Ms. Bentir, a RN completed a Medication Incident Report regarding the medication error. A copy of the report was provided in the Agreed Statement of Facts under Tab 13.

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

The Hearing Tribunal accepted Ms. Pena's admission of unprofessional conduct. Leaving medications unattended where another individual could, and did, consume them improperly is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services. In addition, her failure to follow policies and procedures put patient safety at risk.

Although there was no evidence of harm to the patients, there was a potential for harm to both DM, who missed the medication, and to KJ, who improperly took DM's medication and such

conduct could have led to the clients, who are being cared for by Ms. Pena, to have very serious safety issues.

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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

Allegation 7

Ms. Pena admitted on or about June 14, 2018, she documented on resident JH's Medication Administration Record as having administered the following medications at 0800 hours instead of the actual time of 1200 hours: Furosemide 20 mg; Metoprolol 100 mg; Brilinta 90 mg; Isdn 30 mg; Mylan-Pantoprazole T 40 mg; Praxis ASA EC 81 mg; Ramipril 2.5 mg; Synthroid 200 mcg; Teva-Spironolactone 25 mg; vitamin D 1,000U; Mylan-Nitro 0.2 mg/hr; and Gabapentin 300 mg.

Ms. Pena worked the day shift at the Facility on June 14, 2018 and provided care to resident JH.

Resident JH was set to receive the following medications at 0800 hours: Furosemide 20mg; Metoprolol 100mg; Brilinta 90mg; Isdn 30mg; Mylan-Pantoprazole T 40mg; Praxis ASA EC 81mg; Ramipril 2.5mg; Synthroid 200mcg; Teva-Spironolactone 25mg; vitamin D 1,000U; Mylan-Nitro 0.2mg/hr; and Gabapentin 300mg. A copy of resident JH's MAR was provided in the Agreed Statement of Facts under Tab 6.

Ms. Pena attempted to administer resident JH's 0800 hours medications to JH in the morning. However, JH refused to take the medications as JH was leaving the unit. Ms. Pena then administered JH's 0800 hours medications to JH at 1200 hours. A copy of JH's progress notes with Ms. Pena's entry of July 14, 2018 was provided in the Agreed Statement of Facts under Tab 7.

Despite administering the 0800 hours medications to resident JH at 1200 hours, Ms. Pena documented on resident's JH's MAR that the medications were administered at 0800 hours.

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

The Hearing Tribunal accepted Ms. Pena's admission of unprofessional conduct. The failure to complete accurate documentation and to misstate when a patient has taken medication is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of professional services.

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 considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
ii. Contravention of this Act [the Act], a code of ethics or standards of practice.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics and Standards of Practical Nurses in Canada:

CLPNA Code of Ethics: 1.1, 1.5, 2.4, 2.8, 2.9, 3.1, 3.3, and 5.3.

CLPNA Standards of Practice: 1.1, 1.2, 1.6, 1.7, 1.9, 1.10, 2.1, 2.2, 2.11, 3.3, 3.4, 3.6, and 4.1.

Summary

In summary, the Hearing Tribunal considered the evidence put forth in Exhibit #2, and the documents included in Exhibit #2, and concluded that each of the Allegations against Ms. Pena were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act and the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Ms. Pena 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. Pena made a partial joint submission with respect to penalty, which was entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

2. Ms. Pena 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. Ms. Pena shall provide to the Complaints Consultant, a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA

documents will impact her professional practice within **90 days** of service of the Decision:

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 E1: Critical Thinking and Critical Inquiry;

f. CLPNA Competency Profile E2: Clinical Judgment and Decision Making; and

g. CLPNA Competency Profile U: Medication Administration.

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

3. In the event the reflective paper referred to in paragraph 2 above is not satisfactory to the Complaints Consultant, Ms. Pena shall within **two (2) weeks** of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Pena shall complete the following course: **Documentation 101** offered on-line by CLPNA at www.clpna.com. Ms. Pena shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **90 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. Pena shall complete, at her own cost, the following course: **NURS 0161 – Medication Management** offered on-line by MacEwan University. Myrsa Pena shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **9 months** of service of the written decision.

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

6. Ms. Pena shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her

current employment information. Ms. Pena will keep her contact information current with the CLPNA on an ongoing basis.

7. Should Ms. Pena 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.

8. Should Ms. Pena 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; or

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

Legal Counsel for the Complaints Director/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 that 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, that 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/Consultant to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns.

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

(10) Additional Order sought by Complaints Consultant Regarding Costs

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

1. Ms. Pena shall pay 25% of the costs of the hearing to a maximum of $3,500.00 to be paid in equal monthly installments over a period of 36 months from service of the Hearing Tribunal's written reasons for decision.

2. In the case of non-payment of the costs described in paragraph 1 above, the Complaints Consultant may suspend Ms. Pena's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

(11) 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 order imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Pena has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in the decision of *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. Pena displayed a lack of skill, knowledge and judgement in relation to core competencies of an LPN. These allegations deal with core competencies of an LPN with regards to medication administration, documentation, leaving medication unattended, failing to follow policies and proper charting procedure, which are basic nursing skills in which Ms. Pena was not upholding.

The age and experience of the investigated member: Ms. Pena was initially registered with the CLPNA on June 6, 2011 and has been continually registered from that time. At the time that these allegations took place, Ms. Pena had approximately seven (7) years' experience as an LPN in Alberta and therefore should have known better than to commit the basic errors that she has admitted occurred in the Allegations.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The CLPNA is not aware of any previous complaints with regards to Ms. Pena.

The number of times the offending conduct was proven to have occurred: The seven (7) allegations took place over a time period of approximately three (3) months, so this was not an isolated incident and could demonstrate a pattern of careless conduct.

The role of the investigated member in acknowledging what occurred: Ms. Pena did acknowledge her role in respect to these allegations and did provide the Hearing Tribunal with an Agreed Statement of Facts and Admission of Unprofessional Conduct, which she worked on with both the CLPNA and AUPE.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: As a result of these allegations being made Ms. Pena did receive a three (3) day suspension without pay from the Facility.

The impact of the incident(s) on the victim: The Hearing Tribunal was not made aware of any impact on the residents that were in Ms. Pena's care at the time of the allegations, however with respect to the allegations with medication errors and the lack of documentation there was a potential of harm to take place. There is evidence, however, that Ms. Pena's actions were reckless as to the care of vulnerable patients in her care. The potential of impact to these residents was very serious.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: With regard to specific deterrence, there is a need to impose sanctions on Ms. Pena. She needs to be aware that this type of behavior is not acceptable of an LPN, nor will it be tolerated by the CLPNA and that this type of behavior is dealt with in a serious manner. The sanctions that are imposed with regards to Ms. Pena will also act as a deterrent to other LPNs by CLPNA acknowledging the seriousness of these breaches and responding with appropriate orders.

The need to maintain the public's confidence in the integrity of the profession: CLPNA deals with the actions of the members when they conduct themselves in a way that is not becoming to the LPN profession. LPNs are trusted caregivers for populations that are often vulnerable and require attentive, careful care. The public's trust must be maintained by demonstrating that the CLPNA will deal with any breaches in the Act, Code of Ethics and Standard of Practice in a manner that the reflects the seriousness of this conduct.

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 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 Partial Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

In addition, the Hearing Tribunal has considered the submissions of the Complaints Consultant for the additional orders requested, respecting costs, and finds that they are also appropriate and reasonable and therefore the Hearing Tribunal also makes the orders requested regarding costs, as set out below.

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Pena 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. Ms. Pena shall provide to the Complaints Consultant, a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice within **90 days** of service of the Decision:

    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 E1: Critical Thinking and Critical Inquiry;

    f. CLPNA Competency Profile E2: Clinical Judgment and Decision Making; and

g. CLPNA Competency Profile U: Medication Administration.

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

3. In the event the reflective paper referred to in paragraph 2 above is not satisfactory to the Complaints Consultant, Ms. Pena shall within **two (2) weeks** of being notified by the Complaints Consultant the reflective paper is not satisfactory, or such longer period as determined by the Complaints Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

4. Ms. Pena shall complete the following course: **Documentation 101** offered on-line by CLPNA at www.clpna.com. Ms. Pena shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **90 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. Pena shall complete, at her own cost, the following course: **NURS 0161 – Medication Management** offered on-line by MacEwan University. Myrsa Pena shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **9 months** of service of the written decision.

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

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

7. Should Ms. Pena 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.

8. Should Ms. Pena 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; or

b. Treat Ms. Pena's non-compliance as information for a complaint under s. 56 of the Act.

9. Ms. Pena shall pay 25% of the costs of the hearing to a maximum of $3,500.00 to be paid in equal monthly installments over a period of thirty-six (36) months from service of the Hearing Tribunal's written reasons for decision.

10. In the case of non-payment of the costs described in paragraph 9 above, the Complaints Consultant may suspend Ms. Pena's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

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

Under Part 4, sections 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 13TH DAY OF AUGUST 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal