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 RANDI BURNETT

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 RANDI BURNETT, LPN #40405, 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 on December 17, 2020 with the following individuals present:

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

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Kevin Oudith, Complaints Consultant, CLPNA

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

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Burnett 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. Burnett was initially licensed as an LPN in Alberta on May 12, 2015.

The CLPNA received a complaint dated October 17, 2019 (the "Complaint") from Wyona Sargent, Manager, at the Lacombe Hospital and Care Centre (the "Facility") in Lacombe, AB, pursuant to s. 57 of the Act. The Complaint stated Ms. Burnett, LPN, had received a one-day suspension of her employment at the Facility.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, the Complaints Director of the CLPNA (the "Complaints Director") appointed Judy Palyga, Investigator for the CLPNA (the "Investigator"), to investigate the Complaint. At this time, the Complaints Director delegated her authority and powers under Part 4 of the Act to Kevin Oudith, Complaints Consultant for the CLPNA (the "Complaints Consultant") pursuant to s. 20 of the Act.

By way of letter dated October 21, 2019, the Complaints Director provided Ms. Burnett with notice of the Complaint and of the appointment of the Investigator.

On July 28, 2020, the Investigator concluded the investigation into the Complaint and submitted an Investigation Report to the Complaints Consultant.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Burnett received notice the matter was referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report on October 26, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Burnett under cover of letter dated November 23, 2020.

(4) Allegations

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

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

1. On or between September 18, 2019 to September 19, 2019, did one or more of the following with respect to client WBN:

   a) Discontinued intravenous (IV) fluids of ½ NS D5W at 80 ml/hr without a physician's order;

   b) Failed to accurately document the care provided, including the reason why the IV fluids of ½ NS D5W at 80 ml/hr were discontinued;

   c) Failed to adequately document in the Progress Notes the amount of sanguineous discharge noted in WBN's foley catheter at 0445 hours;

d) Failed to report the change in WBN's condition to the Charge RN and/or physician in a timely manner;

e) Failed to complete Vital Signs every one-hour as ordered."

(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. Burnett 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 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. Burnett'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. Burnett.

Allegation 1

Ms. Burnett admitted that on or between September 18, 2019 to September 19, 2019, she did one or more of the following with respect to client WBN:

a) Discontinued intravenous (IV) fluids of ½ NS D5W at 80 ml/hr without a physician's order;

b) Failed to accurately document the care provided, including the reason why the IV fluids of ½ NS D5W at 80 ml/hr were discontinued;

c) Failed to adequately document in the Progress Notes the amount of sanguineous discharge noted in WBN's foley catheter at 0445 hours;

d) Failed to report the change in WBN's condition to the Charge RN and/or physician in a timely manner;

e) Failed to complete Vital Signs every one-hour as ordered.

Ms. Burnett worked a night shift at the Facility as an LPN from 2300 hours on September 18, 2019 to 0715 hours on September 19, 2019 and was assigned to patient WBN. WBN was a 77 year old patient who had been admitted to the Facility for pneumonia. WBN was not eating well and had an acute kidney injury with deteriorating kidney function.

On September 18, 2019, WBN had a physician's order to receive intravenous (IV) with "½ NS D5W @ 80ml/hr" to be continued overnight. The physician's order also required that WBN's vital signs be taken every hour. At approximately 2320 hours on September 18, 2019, Ms. Burnett stopped the administration of IV fluids to WBN which had been ordered to continue overnight. Ms. Burnett did not document in the Medical Surgical 24-Hour Flow Record the reason why the IV fluids of ½ NS D5W at 80 ml/hr were discontinued. Ms. Burnett also failed to document in WBN's Progress Notes that she discontinued the IV fluids.

In addition, Ms. Burnett did not immediately notify any physician or the Charge RN that she had stopped the administration of IV fluids for WBN. It is necessary to have a physician's order for an LPN to discontinue the administration of fluids by IV to a patient. Ms. Burnett discontinued the administration of IV fluids of ½ NS D5W at 80 ml/hr to WBN on September 18, 2019 without a physician's order or any direction from a physician.

Ms. Burnett did not complete and document WBN's vital signs at 0100 hours or 0300 hours as ordered. As a result of Ms. Burnett discontinuing the administration of IV fluids, WBN became hypotensive. At 0445 hours, Ms. Burnett documented in WBN's Progress Notes "Sang noted drainage from catheter". Ms. Burnett did not document the amount of sanguineous discharge noted in WBN's foley catheter. The sanguineous discharge noted in WBN's foley catheter was a significant change in WBN's condition considering the diagnosis of dehydration and acute kidney injury and should have been immediately reported to the Charge RN or physician. The lowering of WBN's blood pressure should have also been immediately reported.

At approximately 0600 hours, Ms. Burnett advised the Charge RN that WBN's blood pressure had dropped to 67/36 and that there was blood in WBN's catheter tubing. The Charge RN advised Ms. Burnett to call the on-call physician. Ms. Burnett failed to document in the Progress Notes that she consulted with the Charge RN at 0600 hours on September 19, 2020.

Ms. Burnett contacted the on-call physician by phone at approximately 0627 hours, after the on-call physician had left the Facility and was at home, to advise of the change in WBN's condition. The on-call physician had been at the Facility until 0500 hours. Ms. Burnett should have advised her of the change in WBN's condition prior to the 0627 hours call, as WBN had a low blood pressure reading and was in respiratory distress prior to 0600 hours.

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. Burnett's conduct displayed a significant lack of judgement and knowledge by failing to adhere to the principles of physical assessment, reporting and documentation as well as failing to follow physician's orders.

By failing to follow physician's orders to keep WBN's IV running @ 80ml/hr, and instead discontinuing the fluids, she caused the patient to become physically unstable. As a direct result of this discontinuance of fluids, patient WBN became significantly hypotensive. Ms. Burnett also failed to properly document the fact she discontinued the IV fluid and rationale as to why she discontinued it.

Ms. Burnett also failed to follow the order to complete Vital Signs every hour, thereby missing WBN's blood pressure dropping. Ms. Burnett failed to report changes in WBN's condition to the charge nurse and physician in a timely manner. The changes to WBN's blood pressure and

the sanguineous discharge noted in WBN's catheter were significant changes and needed to be reported immediately.

The result of Ms. Burnett's actions created a risk of harm to WBN. WBN was known to have an acute kidney injury and deteriorating kidney function and Ms. Burnett's actions potentially caused further impairment as indicated by the decrease in blood pressure and the sanguineous discharge in the catheter.

Ms. Burnett harmed the integrity of the profession by failing to perform her duties in the same manner as other LPNs in the same or similar circumstances would do. She should have followed the physician's orders and not taken it upon herself to discontinue the IV fluids. An LPN cannot make a decision to discontinue IV fluids; this can only be done under the direction of a physician. Ms. Burnett also failed to properly document critical information in relation to WBN. The public needs to have confidence that LPNs will work within their scope of practice and follow physician's orders.

There was also an expectation that she would follow the physician's order to assess the patient's Vital Signs every hour. She failed to follow through on that order by failing to obtain WBN's Vital Signs at 0100 hours and 0300 hours. In doing so, Ms. Burnett failed to perform her duties as other LPNs would do in the same or similar circumstances.

Upon assessing a change in WBN's condition, Ms. Burnett failed to notify both the charge nurse and physician in a timely manner. As per the documents provided, as well as Ms. Burnett's own admission, she noted sanguineous discharge from WBN's catheter @ 0445 hours; however, she failed to notify her charge nurse until 0600 hours. Furthermore, she failed to inform the physician until 0627 hours, and by this time, the patient's blood pressure had dropped significantly. Ms. Burnett's charting was vague and only noted there was sanguineous discharge in the catheter without providing details about what she observed. As such, she further failed to perform her duties as other LPNs would do in the same or similar circumstances. Documentation and charting are a fundamental skill of all health care providers; by failing to properly document, she caused harm to the integrity of the profession and placed a patient at risk.

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 provides that LPNs:

- 1.1 Maintain standards of practice, professional competence and conduct.
- 1.2 Provide only those functions for which they are qualified by education or experience.

- o 1.5 Provide care directed to the health and well-being of the person, family, and community.
- o 1.6 Collaborate with clients, their families (to the extent appropriate to the client's right to confidentiality), and health care colleagues to promote the health and well-being of individuals, families and the public.

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

- o 2.8 Use evidence and judgement to guide nursing decisions; and
- o 2.9 Identify and minimize risks to clients.

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

- o 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- o 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.
- o 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

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

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

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

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

- o 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 provides that LPNs:

- o 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.
- o 1.4 Recognize their own practice limitations and consult, as necessary.
- o 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.
- o 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.
- o 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 provides that LPNs:

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

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

- o 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice.
- o 3.5 Provide relevant and timely information to clients and co-workers.
- o 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

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

- o 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.
- o 4.7. Communicate in a respectful, timely, open and honest manner.
- o 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.
- o 4.9 Support and contribute to healthy and positive practice environments.

Ms. Burnett breached the aforementioned provisions of the Code of Ethics and Standards of Practice. Ms. Burnett's conduct, in failing to follow physician's orders, adequately document, and report the changes in the patient's condition in a timely manner breached her responsibility to the public in that she did not provide care that maintained the standards of practice and professional competence. By failing to provide appropriate care, as mentioned above, she did not practice ethical practice; she failed to provide safe, effective and ethical care to her patient, she lacked skill, judgement and knowledge and failed to act in a manner in which the public expects LPNs to practice.

9) Joint Submission on Penalty

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

1. The Hearing Tribunal's written reasons for decision (the "Decision") shall serve as a reprimand.
2. Ms. Burnett shall pay 25% of the costs of the investigation and hearing to be paid over a period of **thirty-six (36) months** from service of the Decision.
    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.
3. Ms. Burnett 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. Burnett shall provide 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 **30 days** of service of the Decision:
        i. Code of Ethics for Licensed Practical Nurses in Canada;
        ii. Standards of Practice for Licensed Practical Nurses in Canada;

iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

iv. CLPNA Practice Policy: Documentation;

v. CLPNA Competency Profile A1: Critical Thinking;

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

vii. CLPNA Competency Profile B1: Assessment;

viii. CLPNA Competency Profile B2: Nursing Diagnosis;

ix. CLPNA Competency Profile B3: Planning;

x. CLPNA Competency Profile B4: Implementation;

xi. CLPNA Competency Profile B5: Evaluation;

xii. CLPNA Competency Profile C2: Licensed Practical Nurse Scope of Practice;

xiii. CLPNA Competency Profile: C5: Accountability and Responsibility; and

xiv. CLPNA Competency Profile: D3: Legal Protocols, Documenting and Reporting.

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

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

5. Ms. Burnett shall complete the **LPN Ethics Course** available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics. Ms. Burnett shall provide the Complaint Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

6. Ms. Burnett shall complete, at her own cost, the **Augmented LPN Practice Course** available online at https://www.jcollinsconsulting.com/index.php/courses-modules/licensed-practical-nurse. Ms. Burnett shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (6) months** of service of the Decision.

7. Ms. Burnett shall complete, at her own cost, the **Improving Critical Thinking, Clinical Reasoning, and Clinical Judgment Course** available online at https://www.nurse.com/ce/improving-your-ability-to-think-critically. Ms. Burnett shall

provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (6) months** of service of the Decision.

8. If any of the required courses set out at paragraphs 5-7 becomes unavailable, Ms. Burnett shall request, **in writing prior to the deadline**, to be assigned an alternative course. The Complaints Consultant shall, in his sole discretion, reassign the education. Ms. Burnett will be notified by the Complaints Consultant in writing, advising of the new required course.

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

    (a) The requirement to complete the remedial education and reading/reflect paper outlined at paragraphs 3-7 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Burnett's practice permit and the Public Registry until the below orders have been satisfactorily completed;

        i. CLPNA Readings/Reflection Paper;

        ii. LPN Ethics Course;

        iii. Augmented LPN Practice Course; and

        iv. Improving Critical Thinking, Clinical Reasoning, and Clinical Judgment Course.

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

10. The conditions on Ms. Burnett's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

11. Ms. Burnett 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. Burnett will keep her contact information current with the CLPNA on an ongoing basis.

12. Should Ms. Burnett 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.

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

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

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

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

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

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Burnett 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

1) **The nature and gravity of the proven allegations:** Ms. Burnett's actions were serious. By failing to follow the orders of the physician she caused WBN to have a significant change in both vital signs and sanguineous drainage from the catheter. The Hearing Tribunal was made aware that subsequent actions were needed to stabilize WBN's blood pressure by means of a bolus but was not given further information on further effects on WBN.

2) **The age and experience of the investigated member:** Ms. Burnett became a regulated member of the CLPNA in 2015. While she didn't start working at the Acute care unit at Lacombe Hospital until February 2019, she had enough experience to have the appropriate skill, knowledge and judgement to know her actions were not in line with the expectations of both the public, as well as the College.

3) **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 prior complaints or convictions.

4) **The age and mental condition of the victim:** The Hearing Tribunal heard that WBN was a 77-year-old patient who was admitted with pneumonia. The patient also had an acute kidney injury, decreased kidney function and was not eating well. WBN was dependent on Ms. Burnett to provide safe, effective and competent care.

5) **The number of times the offending conduct was proven to have occurred:** The Hearing Tribunal was only made aware of the one incident during Ms. Burnett's night shift September 18-19, 2019.

6) **The role of the investigated member in acknowledging what occurred:** Ms. Burnett acknowledged and admitted to the allegations. She was cooperative in bringing forth the Agreed Statement of Facts and the Joint Submission on Penalty.

7) **Whether the investigated member has already suffered other serious financial or other**
penalties as a result of the allegations having been made: The member did have a one-day suspension following an investigation conducted by her employer.

8) **The impact of the incident(s) on the victim:** Apart from hearing the patient required a bolus and close monitoring after Ms. Burnett's actions, the Hearing Tribunal was not made aware of any further impact on the victim.

9) **The presence or absence of any mitigating circumstances:** As per Ms. Burnett, it was a chaotic shift, apart from that the Hearing Tribunal was not made aware of any mitigating circumstances.

10) **The need to promote specific and general deterrence and, thereby to protect the public**
and ensure the safe and proper practice: It is imperative the penalty demonstrates the College takes allegations such as these serious. The penalty needs to provide both specific deterrence to the member involved, as well as general deterrence to the other members of the College. The penalty must demonstrate that acts such as these will not be tolerated and will be dealt with in an appropriate manner. The Hearing Tribunal believes the penalties suggested in this case do provide both a specific and a general deterrence.

11) **The need to maintain the public's confidence in the integrity of the profession:** The public needs to trust the regulated members of the CLPNA. The penalties in this case are intended, in part, to demonstrate to the public that the College takes such matters seriously and to ensure the public is protected.

12) **The range of sentence in other similar cases:** While the Hearing Tribunal was not provided with specific cases, we believe the penalties assessed in this case are in the range of other sentences in similar cases.

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

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

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Burnett shall pay 25% of the costs of the investigation and hearing to be paid over a period of **thirty-six (36) months** from service of the Decision.

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

3. Ms. Burnett 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. Burnett shall provide 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 **30 days** of service of the Decision:

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

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

    iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

    iv. CLPNA Practice Policy: Documentation;

    v. CLPNA Competency Profile A1: Critical Thinking;

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

    vii. CLPNA Competency Profile B1: Assessment;

    viii. CLPNA Competency Profile B2: Nursing Diagnosis;

    ix. CLPNA Competency Profile B3: Planning;

    x. CLPNA Competency Profile B4: Implementation;

    xi. CLPNA Competency Profile B5: Evaluation;

    xii. CLPNA Competency Profile C2: Licensed Practical Nurse Scope of Practice;

    xiii. CLPNA Competency Profile: C5: Accountability and Responsibility; and

    xiv. CLPNA Competency Profile: D3: Legal Protocols, Documenting and Reporting.

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

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

5. Ms. Burnett shall complete the **LPN Ethics Course** available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics. Ms. Burnett shall provide the Complaint Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

6. Ms. Burnett shall complete, at her own cost, the **Augmented LPN Practice Course** available online at https://www.jcollinsconsulting.com/index.php/courses-modules/licensed-practical-nurse. Ms. Burnett shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (6) months** of service of the Decision.

7. Ms. Burnett shall complete, at her own cost, the **Improving Critical Thinking, Clinical Reasoning, and Clinical Judgment Course** available online at https://www.nurse.com/ce/improving-your-ability-to-think-critically. Ms. Burnett shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **six (6) months** of service of the Decision.

8. If any of the required courses set out at paragraphs 5-7 becomes unavailable, Ms. Burnett shall request, **in writing prior to the deadline**, to be assigned an alternative course. The Complaints Consultant shall, in his sole discretion, reassign the education. Ms. Burnett will be notified by the Complaints Consultant in writing, advising of the new required course.

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

    (a) The requirement to complete the remedial education and reading/reflect paper outlined at paragraphs 3-7 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Burnett's practice permit and the Public Registry until the below orders have been satisfactorily completed;

        i. CLPNA Readings/Reflection Paper;

        ii. LPN Ethics Course;

iii. Augmented LPN Practice Course; and

iv. Improving Critical Thinking, Clinical Reasoning, and Clinical Judgment Course.

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

10. The conditions on Ms. Burnett's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

11. Ms. Burnett 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. Burnett will keep her contact information current with the CLPNA on an ongoing basis.

12. Should Ms. Burnett 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.

13. Should Ms. Burnett 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:

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

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

    (f) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Burnett'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 balance the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

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

> "87(1) An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

(a) identifies the appealed decision, and
(b) states the reasons for the appeal.
(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated. person."

DATED THE 25th DAY OF JANUARY 2021 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz
Michelle Stolz, LPN
Chair, Hearing Tribunal