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 REBECCA TROUT

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 REBECCA TROUT, LPN #37905, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference using Zoom on May 26, 2021 with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Jeff Bell, LPN
James Lees, Public Member
Doug Dawson, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Officer, CLPNA
Caitlyn Field, Legal Counsel for the Complaints Officer, CLPNA
Kevin Oudith, Complaints Officer

Investigated Member:
Rebecca Trout, LPN ("Ms. Trout" or "Investigated Member")

(2) Preliminary Matters

The hearing was open to the public.

When the hearing began, the Chairperson of the Hearing Tribunal advised the Investigated Member she had the right to legal counsel under section 72(1) of the Health Professions Act ("the Act"). The Investigated Member confirmed she wished to proceed with the hearing without legal counsel.

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.

(3) Background

Ms. Trout was an LPN within the meaning of the Act at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Trout was initially licensed as an LPN in Alberta on February 14, 2014.

By letter dated July 29, 2019, the CLPNA received a complaint (the "First Complaint") from Mr. Rahul Bhatti, Unit Manager for Unit 32 at the Foothills Hospital, Calgary, AB (the "Facility") pursuant to s. 57 of the *Health Professions Act* (the "Act"). The First Complaint stated that Ms. Rebecca Trout, LPN, received a one-day suspension for arriving to work late, falling asleep while on shift, and for incomplete and inaccurate clinical documentation.

By way of letter dated August 2, 2019, the Complaints Director provided Ms. Trout with notice of the Complaint and notified Ms. Trout that she was delegating her powers under Part 4 of the Act to Kevin Oudith, Complaints Consultant (the "Complaints Consultant") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Trout that she had appointed Phil Northrup, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

Prior to completion of the investigation into the First Complaint, by letter dated November 21, 2019, the CLPNA received a further complaint (the "Second Complaint") from Mr. Bhatti, pursuant to s. 57 of the Act, stating that Ms. Trout had received a three-day suspension for improper medication administration, not following physician orders, and lack of proper clinical documentation.

By way of letter to Ms. Trout, dated November 22, 2019, the Complaints Director notified Ms. Trout that she had delegated her authority to the Complaints Consultant and that she had appointed the Investigator to investigate the Second Complaint.

Prior to completion of the investigation into the First and Second Complaints, by letter dated December 2, 2019, the CLPNA received a further complaint (the "Third Complaint") from Mr.

Bhatti, pursuant to s. 57 of the Act, stating that Ms. Trout had received a five-day suspension for conduct which occurred on November 13, 2019 regarding the failure to provide basic care to a client post-fall, not following MD Orders, and failing to complete proper documentation.

By way of letter to Ms. Trout, dated December 4, 2019, the Complaints Director notified Ms. Trout that she had delegated her authority to the Complaints Consultant and that she had appointed the Investigator to investigate the Third Complaint.

After receiving three complaints within a short period of time, the Complaints Consultant had concerns that Ms. Trout may have been incapacitated. Following a conversation with Mr. Bhatti and Ms. Trout regarding these concerns, the Complaints Consultant ordered Ms. Trout to cease to practice pursuant to s. 118 of the Act. Ms. Trout received notice of the Direction to Cease Practice pursuant to s. 118 by letter dated December 4, 2019.

By way of letter to Ms. Trout, dated February 21, 2020, the Direction to Cease Practice pursuant to s. 118 was lifted by the Complaints Consultant. Following this date, a number of conditions were imposed on Ms. Trout's permit to practice, including that she be restricted to evening shifts only, continue a program of treatment with a psychologist, and provide confirmation of fitness to practice at 6 and 12 month intervals.

The Investigator investigated the First, Second, and Third Complaints together. This investigation was completed and submitted to the CLPNA on March 2, 2020.

Following the completion of the investigation into the First, Second, and Third Complaints, by letter dated May 20, 2020, the CLPNA received a further complaint (the "Fourth Complaint") from Dianne Benner, Manager of Units 18/32/46 at Foothills Medical Centre, pursuant to s. 57 of the Act, stating that Ms. Trout had been terminated from her employment at the Facility.

The Complaints Director delegated her authority to the Complaints Consultant and determined that Katie Emter, CLPNA Investigator, would investigate the Fourth Complaint. Ms. Trout received notice of the Fourth Complaint and the investigation by letter dated May 22, 2020.

In August 2020, the Investigator concluded the investigation into the Fourth Complaint and the Complaints Consultant determined there was sufficient evidence that the matters arising from all four complaints should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Trout received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated December 2, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Trout under cover of letter dated March 18, 2021.

(4) Allegations

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

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

1. On or between July 5, 2019 to July 8, 2019 fell asleep while on shift, including:
    a) On or about July 5, 2019, falling asleep in the back room from approximately 0030 to 0130 hours;
    b) On or about July 7, 2019 falling asleep at the nursing station for approximately 15-30 minutes;
    c) On or about July 8, 2019, falling asleep at the nursing station;
    d) On or about July 8, 2019, sleeping in an over-crowded bed for approximately an hour and twenty minutes.

2. On or between July 13, 2019 to July 14, 2019 removed a syringe and needle from the Facility for personal use, without authorization.

3. On or about July 5, 2019 inaccurately documented on client PLS's Medication Administration Record (MAR) the administration of Hydromorphone 3 mg at 0044 hours, rather than at approximately 0004 hours as administered.

4. On or about July 7, 2019 did one or more of the following with regard to client PLS:
    a) Inaccurately documented on PLS's Medication Administration Record (MAR) the administration of Hydromorphone 3 mg at 0045 hours;
    b) Inaccurately documented on PLS's MAR the administration of Fentanyl 25 mcg at 0054 hours;
    c) Inaccurately documented on PLS's MAR the administration of Hydromorphone 3 mg at 0455 hours.

5. On or about July 13, 2019 incorrectly documented the administration of Hydromorphone 3 mg IVPB on client PLS's Medication Administration Record (MAR) at 0530 hours, when in fact the medication was never removed from the narcotics cupboard or administered.

6. On or about July 13, 2019 failed to assess and/or document client PP's vital signs at 0400 hours, as ordered.

7. On or about July 14, 2019 did one or more of the following:
    a) Failed to document in the Sunrise Clinical Manager (SCM) electronic record, the end of shift report for client PP, as required;
    b) Failed to document in the SCM electronic record, the end of shift report for client KC, as required;
    c) Incorrectly documented in the SCM electronic record, the end of shift report for client MG by copying and pasting the shift report entered by the previous shift.

8. On or about August 5, 2019, incorrectly administered Vancomycin 1 gram IV to client JXL, instead of to client H.

9. On or about August 6, 2019, incorrectly set up a primary infusion of Normal Saline 0.9% with 40 mmol/L of Potassium Chloride, by attaching the Normal Saline 0.9% with 40 mmol/L of Potassium Chloride to the Y-Site connector as a piggyback to intravenous solution D5W 0.45% instead of by primary line.

10. On or about August 27, 2019, failed to follow proper medication administration process by administering Ceftriaxone IV to client FM, instead of Cefazolin 2 grams IV.

11. On or about August 26, 2019, failed to administer Metoclopramide 10 mg IV to client PLS by not opening the roller clamp on the intravenous tubing, as required.

12. On or about September 1, 2019 did one or more of the following with regards to client JC:
    a) Failed to document on the Sunrise Clinical Manager (SCM) electronic record, the Intake and Output section for client JC, the amount of urine emptied from JC's bladder, as required;
    b) Failed to assess and/or document vital signs q4h, as ordered.

13. On or about November 13, 2019 did one or more of the following with regards to client PJA:
    a) Failed to assess and/or document vital signs, as ordered;
    b) Failed to assess and/or document a head to toe assessment, as required;
    c) Failed to document on the Sunrise Clinical Manager (SCM) electronic record, the end of shift report, as required.

14. On or about November 13, 2019 failed to discharge client CT in a timely manner.

15. On or about November 13, 2019 did one or more of the following with regards to client MMH:

a) Failed to assess and/or document a head to toe assessment on the Sunrise Clinical Manager (SCM) electronic record, as required;
b) Failed to assess and/or document vital signs q4h on the SCM electronic record, as ordered;
c) Failed to document an End of Shift report on the SCM electronic record, as required.

16. On or about April 20, 2020 did one or more of the following with regard to client MB:
    a) Incorrectly documented on client MB's Medication Administration Record (MAR) the administration of Furosemide 40 mg PO and Gabapentin 100 mg PO at 1500 hours, when they were not administered;
    b) Incorrectly documented on client MB's MAR the administration of Apixaban 2.5 mg PO, Duloxetine DR 30 mg PO, Gabapentin 100 mg PO, Metoprolol 50 mg PO, and Pramipexole 0.25 mg PO at 2200 hours, when they were not administered.

17. On or about April 21, 2020 did one or more of the following with regard to client WC:
    a) Falsely documented on client WC's Medication Administration Record (MAR) the administration of Acetaminophen 1000 mg PO at 1600 hours, when it was not administered;
    b) Falsely documented on client WC's MAR the administration of Acetaminophen 100 mg PO, Levetiracetam 500 mg PO, and Metoprolol 12.5 mg PO at 2100 hours, when they were not administered.

18. On or about April 25, 2020 failed to document on client AR's Medication Administration Record (MAR) the administration of Ativan 3 mg at 2058 hours.

19. On or about April 30, 2020 failed to obtain a physician order to hold client NT's evening dose of Lantus 14 units Insulin, as required.

20. On or about April 21, 2020 failed to provide report on assigned clients, prior to leaving the hospital, to the Charge RN, as required.

(5) Admission of Unprofessional Conduct

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

Ms. Trout acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and she 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: Sanctions being sought by the CLPNA

(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. Trout'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. Trout.

Allegation 1

Ms. Trout admitted that on or between July 5, 2019 to July 8, 2019, she fell asleep while on shift, including:

a) On or about July 5, 2019, falling asleep in the back room from approximately 0030 to 0130 hours;
b) On or about July 7, 2019 falling asleep at the nursing station for approximately 15-30 minutes;
c) On or about July 8, 2019, falling asleep at the nursing station;
d) On or about July 8, 2019, sleeping in an over-crowded bed for approximately an hour and twenty minutes.

On or about July 5, 2019, Ms. Trout worked at the Foothills Hospital (the "Facility"). While on shift, Ms. Trout fell asleep in the back room from approximately 0030 to 0130 hours. Ms. Trout was awoken to address calls from clients who required care. On or about July 7, 2019, Ms. Trout worked at the Facility. While on shift, Ms. Trout fell asleep at the nursing station for approximately 15-30 minutes. Ms. Trout fell asleep on two separate occasions. On or about July 8, 2019, Ms. Trout worked at the Facility. While on shift, Ms. Trout fell asleep at the nursing station. Subsequently, Ms. Trout took a break for approximately one hour and twenty minutes, during which she slept in an "OC-2", or patient overflow bed. Ms. Trout had to be woken by another staff member. During this time, Ms. Trout was experiencing sleep deprivation as she had recently been prescribed sleeping pills and was adjusting to her new medication.

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. Trout displayed a complete lack of judgement and knowledge by falling asleep at work multiple times. This conduct fails to uphold the Standards of Practice and the Code of Ethics as set out below.

By falling asleep multiple times she failed to be responsible to the public, the clients under not only her care, but other clients on the unit. She failed to be responsible to her profession as it is extremely unprofessional to fall asleep when she was to be attending to her clients, as well as,

failing to be responsible to her colleagues. Such behaviour harms the integrity of the profession as the expectation is she will not be sleeping when she is on shift and was supposed to be providing nursing care to her clients. The public expects that nurses will be awake and provide competent care during their shifts, not sleeping.

Allegation 2

Ms. Trout admitted that on or between July 13, 2019 to July 14, 2019, she removed a syringe and needle from the Facility for personal use, without authorization.

On or between July 13, 2019 to July 14, 2019, Ms. Trout worked at the Facility. Ms. Trout worked a shift from 2300 hours on July 13 to 0715 hours on July 14. At or about 0230 hours on July 14, 2019, Ms. Trout's colleague LM, LPN, observed Ms. Trout holding a syringe with a needle and a blunt needle. Ms. Trout put the needles and syringe into her bag and removed them from the Facility. Ms. Trout removed the needles and syringe for her personal use as she intended to use them for an upcoming vaccination. Ms. Trout did not have authorization to remove the syringe and needle from the Facility.

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. Trout displayed a lack of judgement by stealing from her employer. She should have known that theft of any kind from her employer was wrong and is a direct contravention of the Health Profession Act. It also goes against the Code of Ethics and Standards of Practice set forth by the CLPNA for the reasons discussed below. The integrity of the profession could significantly be harmed by someone stealing supplies that are for the clients. The public does not expect that employees will be stealing supplies from healthcare facilities.

Allegation 3

Ms. Trout admitted that on or about July 5, 2019, she inaccurately documented on client PLS's Medication Administration Record (MAR) the administration of Hydromorphone 3 mg at 0044 hours, rather than at approximately 0004 hours as administered.

On or about July 5, 2019, Ms. Trout worked at the Facility and provided care to client PLS. Ms. Trout gained access to the narcotic cupboard at 0004 hours and removed 2 vials of Hydromorphone 2mg/ml, 1ml in order to administer 3 mg of Hydromorphone to client PLS. Despite removing the Hydromorphone at 0004 hours, Ms. Trout inaccurately recorded the administration of Hydromorphone at 0044 hours on client PLS's Medication Administration Record ("MAR").

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.

According to the evidence provided to the Hearing Tribunal, it is evident that Ms. Trout displayed a lack of knowledge, lack of skill or judgement by failing to accurately document the administration of a narcotic. By failing to adhere to the basics of medication administration and documentation, Ms. Trout displayed actions that contravene the Health Professions Act, as well as the Code of Ethics and the Standards of Practice as set out by the CLPNA for the reasons discussed below. Proper documentation and administration of medications, especially narcotics, can cause detrimental consequences for the client but also significantly harm the integrity of the profession; there is an expectation that LPNs will properly engage in medication administration.

<u>Allegation 4</u>

Ms. Trout admitted that on or about July 7, 2019, she did one or more of the following with regard to client PLS:

a) Inaccurately documented on PLS's Medication Administration Record (MAR) the administration of Hydromorphone 3 mg at 0045 hours;
b) Inaccurately documented on PLS's MAR the administration of Fentanyl 25 mcg at 0054 hours;
c) Inaccurately documented on PLS's MAR the administration of Hydromorphone 3 mg at 0455 hours.

On or about July 7, 2019, Ms. Trout worked at the Facility and provided care to client PLS. At 0045 hours, Ms. Trout was granted access to the narcotics cupboard and signed out Hydromorphone 3mg. Also at 0045 hours, Ms. Trout documented the administration of Hydromorphone 3 mg on

client PLS's Medication Administration Record, despite the fact that it was removed from the narcotics cupboard at the same time and it would not be possible to administer the medication immediately. At 0053 and 0054 hours, Ms. Trout was granted access to the narcotics cupboard and signed out Fentanyl 25 mcg. Also at 0054 hours, Ms. Trout documented the administration of Fentanyl 25 mcg on client PLS's Medication Administration Record, despite the fact that it was removed from the narcotics cupboard at the same time and it would not be possible to administer the medication immediately. At 0456 hours, Ms. Trout was granted access to the narcotics cupboard and signed out Hydromorphone 3 mg. Despite recording accessing the narcotics cupboard at 0456 hours, Ms. Trout documented the administration of Hydromorphone 3 mg on client PLS's MAR at 0455 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.

After reviewing the evidence provided to the Hearing Tribunal, it is evident that Ms. Trout displayed a lack of knowledge, skill or judgement by failing to adhere to the basic medication administration procedures. The Hearing Tribunal finds this allegation amounts to unprofessional conduct for essentially the same reasons as detailed in Allegation 3.

Allegation 5

Ms. Trout admitted that on or about July 13, 2019, she incorrectly documented the administration of Hydromorphone 3 mg IVPB on client PLS's Medication Administration Record (MAR) at 0530 hours, when in fact the medication was never removed from the narcotics cupboard or administered.

On or about July 13, 2019, Ms. Trout worked at the Facility and provided care to client PLS. At 0530 hours, Ms. Trout documented the administration of Hydromorphone 3 mg on client PLS's Medication Administration Record. Despite recording the administration of Hydromorphone 3 mg at 0530 hours, the medication was in fact not removed from the narcotics cupboard or administered to client PLS.

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.

After reviewing the evidence provided to the Hearing Tribunal, it is apparent that Ms. Trout displayed a lack of knowledge, skill or judgement by again failing to adhere to the basics of medication and narcotic administration and documentation. The Hearing Tribunal has concluded this for the same reasons as set out in Allegations 3 and 4. Ms. Trout's actions also breached the Code of Ethics and Standards of Practice for the reasons discussed below.

Allegation 6

Ms. Trout admitted that on or about July 13, 2019, she failed to assess and/or document client PP's vital signs at 0400 hours, as ordered.

On or about July 13, 2019, Ms. Trout worked at the Facility and provided care to client PP. A physician's order for client PP required vital signs to be assessed every four hours. On or about July 13, 2019, Ms. Trout assessed client PP and documented client PP's vital signs at 0000 hours. However, Ms. Trout failed to assess and/or document client PP's vital signs at 0400 hours. Client PP's vital signs were not assessed and recorded again until 0732 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.

As per the evidence provided, Ms. Trout failed to follow orders provided by a physician to assess the client's vital signs every 4 hours. By failing to properly assess the client as ordered, she neglected to ensure the client had safe competent care which may have led to serious consequences. As such, Ms. Trout demonstrated a lack of knowledge, skill and judgement and also violated multiple aspects of the Code of Ethics and Standards of Practice as discussed below. Ms. Trout's actions failed to meet the obligations of the regulated profession as well as failed to reflect the privilege of self regulation. In this way her conduct harmed the integrity of the profession.

Allegation 7

Ms. Trout admitted that on or about July 14, 2019, she did one or more of the following:

a) Failed to document in the Sunrise Clinical Manager (SCM) electronic record, the end of shift report for client PP, as required;
b) Failed to document in the SCM electronic record, the end of shift report for client KC, as required;
c) Incorrectly documented in the SCM electronic record, the end of shift report for client MG by copying and pasting the shift report entered by the previous shift.

On or about July 14, 2019, Ms. Trout worked at the Facility and provided care to clients PP, KC, and MG. As part of providing client care, LPNs and RNs at the Facility are expected to complete in Sunrise Clinical Manager reporting an end of shift report for each client they provided care for. Normally, these reports include a brief report on whether the notes relate to day or night shift, how the client slept, whether they ate, if they had any notable treatments, and whether the client has been discharged or transferred. End of shift reports also indicate which care provider is taking over responsibility for each client and ensures continuity of care. While providing care to client PP, Ms. Trout failed to document an end of shift report in relation to client PP. While providing care to client KC, Ms. Trout failed to document an end of shift report in relation to client KC. When documenting the end of shift report for client MG, Ms. Trout copied the previous entry by her EC, RN. Ms. Trout did not document her own independent shift report for client MG.

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.

The Hearing Tribunal was provided with evidence that demonstrated significant errors in documentation as well as omissions in documentation. Ms. Trout failed to provide an end of shift report on multiple clients. These actions can have detrimental effects on those clients. Clear and concise communication between health care providers is essential to provide safe, effective and competent care. By failing to provide report on the clients she potentially caused unnecessary risk to those clients and displayed a lack of knowledge, skill and judgement.

These failures also harm the integrity of the profession since documentation is central to an LPN's role in the overall care of clients. Where documentation fails, all health care providers relying on

that information are unable to make appropriate decisions based in evidence --- because the evidence is flawed.

This conduct also constitutes a breach of the Code of Ethics and Standards of Practice for the reasons discussed below.

Allegation 8

Ms. Trout admitted that on or about August 5, 2019, she incorrectly administered Vancomycin 1 gram IV to client JXL, instead of to client H.

On or about August 5, 2019, Ms. Trout worked at the Facility and provided care to clients JXL and H. At 0600 hours, Ms. Trout's colleague, SC, RN and Clinical Nurse Educator, noticed that 1 g Vancomycin IV had been administered to client JXL. Client JXL had a physician's order for Vancomycin IV 750 mg. Ms. Trout incorrectly administered client H's dose of Vancomycin 1 gram IV to client JXL, rather than to client H, as ordered.

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.

Based on the evidence provided, Ms. Trout made a significant medication error by providing the wrong client with another client's medication. For reasons stated previously in Allegations 3, 4 and 5, medication administration is a basic skill that all LPNs are expected to have. Ms. Trout neglected the basic "Rights" of medication administration including "right patient". As such, Ms. Trout demonstrated a lack of skill, judgement and knowledge. Medication errors have the potential to cause significant consequences to clients. The public has the expectation that members of the regulated profession will be competent in the basic skills of medication administration. As such, this conduct harms the integrity of the profession.

In addition to this, the conduct constitutes a breach of the Code of Ethics and Standards of Practice as discussed below.

Allegation 9

Ms. Trout admitted that on or about August 6, 2019, she incorrectly set up a primary infusion of Normal Saline 0.9% with 40 mmol/L of Potassium Chloride, by attaching the Normal Saline 0.9% with 40 mmol/L of Potassium Chloride to the Y-Site connector as a piggyback to intravenous solution D5W 0.45% instead of by primary line.

On or about August 6, 2019, Ms. Trout worked at the Facility and assisted her colleague, SF, LPN, to provide care. While assisting SF, Ms. Trout administered an infusion of Normal Saline 0.9% with 40mmol/L of Potassium Chloride by attaching it to the Y-Site connector as a piggyback to intravenous solution D5W 0.45%. The Normal Saline 0.9% with 40 mmol/L of Potassium Chloride should have been administered by primary line. SF checked on Ms. Trout's medication administration and found that Ms. Trout had improperly set up the primary infusion. SF immediately stopped the infusion. SF completed an incident report relating to the administration of 40mmol/L of Potassium Chloride.

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.

As per the evidence provided, Ms. Trout displayed a significant lack of skill, judgement and knowledge. By improperly setting up a primary infusion as well as committing yet another medication error she demonstrated a pattern of conduct showing a lack of understanding of the privilege of self-regulation. In failing to adhere to basic medication principles, Ms. Trout improperly administered a critical medication that could have many different consequences to the client, some of them potentially life threatening. This unskilled practice also harmed the integrity of the profession since LPNs are expected to engage in their practice for the purpose of limiting harm to their clients not introducing it.

Ms. Trout's actions failed to meet multiple Standards of Practice and Code of Ethics, again, for the reasons discussed below.

Allegation 10

Ms. Trout admitted that on or about August 27, 2019, she failed to follow proper medication administration process by administering Ceftriaxone IV to client FM, instead of Cefazolin 2 grams IV.

On or about August 27, 2019, Ms. Trout worked at the Facility and provided care to client FM. At or about 0652 hours, Ms. Trout documented the administration of 2g Cefazolin IV to client FM, as ordered. However, Ms. Trout in fact administered Ceftriaxone IV to client FM. The Ceftriaxone IV was labelled to be administered to a different client, and client MF was wearing an allergy band advising of his allergy to Ceftriaxone. The administration of Ceftriaxone IV was stopped at 0715 hours by Ms. Trout's colleague, SC, RN. SC completed an Incident Report and documented that client FM did not experience any shortness of breath, rashes, itchiness, or facial swelling.

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.

As per the evidence provided to the Hearing Tribunal, Ms. Trout's actions in this allegation again demonstrate a lack of skill, knowledge and judgement. In this allegation however, there was a potentially severe risk of an adverse effect caused by Ms. Trout's inability to adhere to the basic "Rights" of medication administration, again for the reasons discussed in regard to Allegations 3, 4, 5 and 8.

Ms. Trout's actions in regard to medication administration errors go against multiple Standards of Practice and Code of Ethics as discussed below.

Allegation 11

Ms. Trout admitted that on or about August 26, 2019, she failed to administer Metoclopramide 10 mg IV to client PLS by not opening the roller clamp on the intravenous tubing, as required.

On or about August 26, 2019, Ms. Trout worked at the Facility and provided care to client PLS. At 0524 hours, Ms. Trout administered Metoclopramide 10 mg IV to client PLS, as ordered. At or about 0710 hours, Ms. Trout's colleague, SC, RN, received client PLS into her care. At this time, SC noticed that Ms. Trout had failed to open the roller clamp on the intravenous tubing, as required, and the Metoclopramide 10 mg IV had not been properly administered to client PLS.

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.

The Hearing Tribunal was provided with evidence that showed Ms. Trout failed to follow proper medication administration procedures by neglecting to open the clamp on the IV tubing and administering Metoclopramide to the client. As per the reasons provided above in relation to Allegations 5, 8, and 10, Ms. Trout's failure to follow proper medication administration procedures demonstrates a lack of skill, judgement and knowledge. Further, her conduct harmed the integrity of the profession as medication administration is a skill central to LPNs' practice and where a basic skill is not carried out correctly it suggests a lack of training in the profession overall. Further, as previously noted, where conduct moves from a one-off or a 'slip' towards a pattern, it suggests a lack of care about the outcomes for clients and for the privilege of self-regulation.

Finally, for the reasons set out below, this conduct also breached the Code of Ethics and Standards of Practice.

Allegation 12

Ms. Trout admitted that on or about September 1, 2019, she did one or more of the following with regard to client JC:

a) Failed to document on the Sunrise Clinical Manager (SCM) electronic record, the Intake and Output section for client JC, the amount of urine emptied from JC's bladder, as required;
b) Failed to assess and/or document vital signs q4h, as ordered.

On or about September 1, 2019, Ms. Trout worked at the Facility and provided care to client JC. While providing care to client JC, Ms. Trout did not record the urine emptied from client JC's bladder in the Intake and Output section of the Sunrise Clinical Manager electronic record, as required. Ms. Trout failed to assess and/or document the assessment of client JC's vital signs.

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.

As per the evidence provided to the Hearing Tribunal, Ms. Trout displayed a lack of knowledge, skill or judgement by failing to document the client's output on the appropriate form as well as failed to assess/document the client's vital signs. Proper assessment and documentation of assessments are basic nursing skills that LPNs are expected to possess. Failing to adhere to these basic nursing practices breach both the Standards of Practice and Code of Ethics for the reasons set out below. Clear, concise communications between health care providers ensures competent care is provided to clients.

This conduct also undermines the integrity of the profession since it leaves all others relying on documentation in good faith, in a position where they are unable to make an informed decision about care due to a lack of evidence.

Allegation 13

Ms. Trout admitted that on or about November 13, 2019, she did one or more of the following with regards to client PJA:

a) Failed to assess and/or document vital signs, as ordered;
b) Failed to assess and/or document a head to toe assessment, as required;
c) Failed to document on the Sunrise Clinical Manager (SCM) electronic record, the end of shift report, as required.

On or about November 13, 2019, Ms. Trout worked at the Facility and provided care to client PJA. At or about 0750 hours, client PJA had an unwitnessed fall while trying to move from the chair to his bed. Ms. Trout was informed by her colleagues of the fall and attended to provide care to client PJA. Client PJA was agitated and had bleeding from his forehead. Ms. Trout failed to complete a head to toe assessment of client PJA, and/or failed to document a head to toe assessment of PJA, as required. An existing order required that client PJA's vital signs be taken every eight hours, while awake. While providing care to client PJA, Ms. Trout failed to assess and/or document client PJA's vital signs. Lastly, Ms. Trout failed to document her end of shift report in relation to client PJA, as required.

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.

Based on the information provided, it is evident that Ms. Trout displayed a lack of knowledge, skill and judgement. She failed to properly assess the client following a fall as per policy. It is basic nursing practice to complete a thorough head to toe assessment following an unwitnessed fall and to document such. The client had a visible injury due to the fall. Ms. Trout also failed to follow orders when she did not take the client's vital signs every eight hours. This could have caused significant but avoidable harm to the client. Her failure to properly assess clients and failure to document are a contravention of the Act as well as the Code of Ethics and Standards of Practice for the reasons discussed below. It also harms the integrity of the profession as it suggests LPNs cannot be trusted to adhere to policies and basic principles of their practice.

Allegation 14

Ms. Trout admitted that on or about November 13, 2019, she failed to discharge client CT in a timely manner.

On or about November 13, 2019, Ms. Trout worked at the Facility and provided care to client CT. A discharge order for client CT was issued at 0846. Ms. Trout failed to discharge client CT in a timely manner, in spite of medical clearance being provided for the discharge. Client CT was ultimately discharged in the afternoon of November 13, 2019.

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.

The Hearing Tribunal was provided with evidence showing Ms. Trout failed to discharge the client in a timely manner despite being medically cleared to be discharged. Ms. Trout's decision to delay the discharge displayed a lack of knowledge, skill and judgement. It also undermined the integrity of the profession in that it demonstrated an arbitrary approach to someone under her care.

Ms. Trout's actions displayed unprofessional conduct and thereby contravened the Code of Ethics and Standards of Practice for the reasons set out below.

Allegation 15

Ms. Trout admitted that on or about November 13, 2019, she did one or more of the following with regards to client MMH:

a) Failed to assess and/or document a head to toe assessment on the Sunrise Clinical Manager (SCM) electronic record, as required;
b) Failed to assess and/or document vital signs q4h on the SCM electronic record, as ordered;
c) Failed to document an End of Shift report on the SCM electronic record, as required.

On or about November 13, 2019, Ms. Trout worked at the Facility and provided care to client MMH. As part of providing care to client MMH, there was an expectation that Ms. Trout would perform at least one head to toe assessment of MMH while on her shift. Ms. Trout failed to complete a head to toe assessment of client MMH, and/or failed to document a head to toe assessment of MMH. An existing order required that client MMH's vital signs be taken every four hours. While providing care to client MMH, Ms. Trout failed to assess and/or document client MMH's vital signs. Lastly, Ms. Trout failed to document her end of shift report in relation to client MMH, as required.

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.

Once again, the Hearing Tribunal was provided with evidence demonstrating Ms. Trout's inability to maintain Standards of Practice and the Code of Ethics by failing to do proper assessments on clients which includes taking vital signs as ordered and for other reasons set out below. By failing to follow orders on clients there is a significant possibility of something detrimental happening to the clients. Basic nursing practices include the ability to complete thorough head to toe assessments. It is an expectation of the public that LPNs follow orders as part of their ability to be a part of a self-regulated profession. Where that does not happen, it undermines the integrity of the profession and demonstrates a lack of skill.

Allegation 16

Ms. Trout admitted that on or about April 20, 2020, she did one or more of the following with regard to client MB:

a) Incorrectly documented on client MB's Medication Administration Record (MAR) the administration of Furosemide 40 mg PO and Gabapentin 100 mg PO at 1500 hours, when they were not administered;
b) Incorrectly documented on client MB's MAR the administration of Apixaban 2.5 mg PO, Duloxetine DR 30 mg PO, Gabapentin 100 mg PO, Metoprolol 50 mg PO, and Pramipexole 0.25 mg PO at 2200 hours, when they were not administered.

On or about April 20, 2020, Ms. Trout worked at the Facility and provided care to client MB. Ms. Trout's colleague, AV, RN, prepared medication for client MB and placed MB's evening and night medication in her medication drawer. Ms. Trout documented on the Medication Administration Record ("MAR") that she administered all of MB's medications, including Furosemide 40 mg PO and Gabapentin 100 mg PO at 1500 hours. Subsequently, Ms. Trout documented on the MAR that she administered MB's medications, including Apixaban 2.5 mg PO, Duloxetine DR 30 mg PO, Gabapentin 100 mg PO, Metoprolol 50 mg PO, and Pramipexole 0.25 mg PO at 2200 hours. However, when AV provided care to client MB the following morning on April 21, 2020, she discovered that client MB's 1500 and 2200 hours medication was still in the medication drawer and had not been administered. Ms. Trout incorrectly documented on client MB's MAR the administration of Furosemide 40 mg PO and Gabapentin 100 mg PO at 1500 hours, when they were not administered. Ms. Trout incorrectly documented on client MB's MAR the administration of Apixaban 2.5 mg PO, Duloxetine DR 30 mg PO, Gabapentin 100 mg PO, Metoprolol 50 mg PO, and Pramipexole 0.25 mg PO at 2200 hours, when they were not administered.

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.

As per the evidence provided to the Hearing Tribunal, Ms. Trout inaccurately documented that she had administered medication when in fact she had not. For the same reasons in allegations 3,4,5,8 and 10, Ms. Trout demonstrated a complete lack of skill, judgement and knowledge and thereby harmed the integrity of the profession. Failure to administer medications and

inaccurately documenting the medication had been given has the potential for serious consequences for the clients.

Finally, this conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

Allegation 17

Ms. Trout admitted on or about April 21, 2020, she did one or more of the following with regard to client WC:

a) Falsely documented on client WC's Medication Administration Record (MAR) the administration of Acetaminophen 1000 mg PO at 1600 hours, when it was not administered;
b) Falsely documented on client WC's MAR the administration of Acetaminophen 100 mg PO, Levetiracetam 500 mg PO, and Metoprolol 12.5 mg PO at 2100 hours, when they were not administered.

On or about April 21, 2020, Ms. Trout worked at the Facility and provided care to client WC. Ms. Trout's colleague, AV, RN, prepared medication for client WC and placed WC's evening and night medication in the medication drawer. Ms. Trout documented on the Medication Administration Record ("MAR") that she administered all of WC's medication, including Acetaminophen 1000 mg PO at 1600 hours. Subsequently, Ms. Trout documented on the MAR that she administered WC's medication, including Acetaminophen 100 mg PO, Levetiracetam 500 mg PO, and Metoprolol 12.5 mg PO at 2100 hours. However, when AV provided care to client WC the following morning on April 22, 2020, she discovered that client WC's 1600 and 2100 hours medication was still in the medication drawer and had not been administered. Ms. Trout incorrectly documented on client WC's MAR the administration of Acetaminophen 1000 mg PO at 1600 hours, when they were not administered. Ms. Trout incorrectly documented on client WC's MAR the administration of Acetaminophen 100 mg PO, Levetiracetam 500 mg PO, and Metoprolol 12.5 mg PO at 2100 hours, when they were not administered.

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.

As per the reasoning already discussed in regard of multiple allegations above, Ms. Trout's repeated failures to properly administer and document medication displays a lack of knowledge, skill and judgment and also undermines the integrity of the profession. Further, her conduct breached the Code of Ethics and Standards of Practice for the reasons set out below.

Allegation 18

Ms. Trout admitted that on or about April 25, 2020, she failed to document on client AR's Medication Administration Record (MAR) the administration of Ativan 3 mg at 2058 hours.

On or about April 25, 2020, Ms. Trout worked at the Facility and provided care to client AR. Ms. Trout documented on client AR's Multidisciplinary Progress Notes that she administered Ativan 3 mg to client AR. However, Ms. Trout failed to document the administration of Ativan 3 mg at 2058 hours on client AR's MAR.

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.

The Hearing Tribunal was provided with evidence that demonstrated Ms. Trout failed to properly document the administration of Ativan to the client. Although she documented in the Multidisciplinary Progress Notes that she administered the medication, she failed to document on the MAR. Proper documentation of medication administration is not only a basic nursing skill but also is part of being a member of a self-regulated profession. For the same reason listed in Allegations 3,4,5,8, 16 and 17 (and others), Ms. Trout's conduct demonstrated a lack of skill, knowledge or judgement and also harmed the integrity of the profession. Once again, the Hearing Tribunal notes the pattern of conduct which tends to demonstrate a lack of understanding of the responsibility of self-regulation and therefore harms the integrity of the profession.

For the reason set out below this conduct also breached the Code of Ethics and Standards of Practice.

Allegation 19

Ms. Trout admitted that on or about April 30, 2020, she failed to obtain a physician order to hold client NT's evening dose of Lantus 14 units Insulin, as required.

On or about April 30, 2020, Ms. Trout worked at the Facility and provided care to client NT. Client NT had been scheduled for a PEG insertion and had an order that he was not to receive anything by mouth. Client NT suffered from diabetes and required doses of Lantus Insulin to manage his blood glucose levels. Client NT did not receive a PEG insertion, and Ms. Trout received direction from her colleague, BJ, Charge RN, to provide client NT's tube feed at 2200 hours. Ms. Trout provided the tube feeding to Client NT. In spite of providing nutrition to client NT, Ms. Trout held client NT's evening does of Lantus 14 units Insulin. Ms. Trout did not obtain a physician's order to hold NT's insulin, as required.

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.

As per the evidence provided to the Hearing Tribunal, Ms. Trout demonstrated an absolute lack of skill, judgement or knowledge by taking it upon herself to hold Insulin from the client. Ms. Trout did not obtain a physician's order to hold the Insulin. Insulin is a life saving drug and failure to administer it can have significant implications. Medication administration is a privilege allotted to LPNs being part of a self regulated profession. Failure to adhere to the protocols of medication administration and obtaining orders for the same demonstrated a lack of knowledge and serious lack of judgment. Acting outside of her scope of practice also undermined the integrity of the profession. For the reasons supplied below, this conduct also constituted a breach of the Code of Ethics and Standards of Practice.

Allegation 20

Ms. Trout admitted that on or about April 21, 2020, she failed to provide report on assigned clients, prior to leaving the hospital, to the Charge RN, as required.

On or about April 25, 2020, Ms. Trout worked at the Facility and provided care to clients. Ms. Trout was scheduled to work from 1500 hours to 2315 hours on April 21, 2020. However, nearing the end of her shift at or about 2115 hours, Ms. Trout had to leave her shift early due to feeling

ill. Prior to leaving work, AW, RN, instructed Ms. Trout to report to her team lead and the Charge RN before she went home. Despite these instructions, Ms. Trout failed to report to the Charge RN on assigned clients prior to leaving the hospital.

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.

The Hearing Tribunal was provided with evidence that Ms. Trout failed to follow proper protocols by failing to report to her team lead and Charge Nurse prior to leaving. It is imperative that health care providers provide report on their clients and failure to do so can lead to errors provided to clients. Neglecting to provide report on her clients displayed a lack of judgment. It also left her colleagues in a position where they were unable to carry on with the care previously provided and therefore undermined the integrity of the profession. This conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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

a. Principle 1: Responsibility to the Public- LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to the members of the public. Principle 1 specifically provides that LPNs:
    1.1 Maintain standards of practice, professional competence, and conduct.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
    2.8 Use evidence and judgement to guide nursing decisions.
    2.9 Identify and minimize risks to clients.

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

3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
3.3 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

d. Principle 5: Responsibility to Self - Licensed Practical Nurses recognize and function within their personal and professional competence and value systems.

5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.
5.5 Inform the appropriate authority in the event of becoming unable to practice safely, competently and/or ethically.

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

a. Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

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

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

1.5. Identify and report any circumstances that potentially impede professional, ethical or legal practice.

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

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

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

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

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

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

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

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

    4.7. Communicate in a respectful, timely, open and honest manner.

In Allegation 1, Ms. Trout attended to work when she was unfit to practice and, as a result, she fell asleep while on shift multiple times. In doing so, Ms. Trout breached the Code of Ethics by failing in her commitment to providing safe and effective care to those clients depending on her to provide care during those shifts. It is obvious that Ms. Trout provided no care while she was sleeping on shift. Furthermore, she placed her clients at risk by not being responsive and attentive as she would need to be when on shift in order to provide appropriate care. In attending to work when she was so fatigued, Ms. Trout also failed to practice in a manner as expected of a regulated professional. The privilege and responsibility to self-regulation calls on practitioners to recognize when they are not fit to practice --- even if by reason of fatigue.

This conduct also breached the Standards of Practice for substantially similar reasons. Ms. Trout failed to recognize her own limitations, to act to avoid or minimize potential harm to those in her care, she failed her in team in not providing the full support of a member on shift and did not practice in a manner consistent with an understanding of self-regulation.

In regard of Allegation 2 which involved the removal of healthcare supplies for personal use, this conduct also breached both the Code of Ethics and Standards of Practice. At its heart this conduct constitutes a theft from Ms. Trout's workplace. Certainly, in this action Ms. Trout failed to conduct herself in a manner which was consistent with an understanding of the privilege and

responsibility of self-regulation. Regulated professionals must trade on trust and where a professional acts in this manner that trust is broken and difficult to rebuild.

Ms. Trout made numerous medication documentation errors (see Allegations 3, 4, 5, 16, 17, and 18). This conduct breaches the Code of Ethics in that it fails to maintain a standard of professional competence. LPNs are expected to faithfully document medications removed from inventory (in some cases) and administered (in all cases) and where this does not occur an LPN has failed to perform a fundamental function of their role. In failing in this manner an LPN also creates risk for clients whose MARs cannot be relied on for accuracy which might lead to a compounding effect of multiple dosages or to a client suffering for want of a painkiller not actually administered. Members of the public who become aware of such conduct would, rightfully, have less trust in LPNs as a result. This is especially the case where there are so many repetitive instances of this conduct. For these same reasons, Ms. Trout breached the Standards of Conduct especially in regard of minimizing harm and in providing relevant and timely information to co-workers.

In addition to medication documentation errors, there were numerous medication administration errors. The potential for harm where medication is administered in a manner other than as prescribed by a physician is great. The multiple instances of these errors are a clear breach of both the Code of Ethics and the Standards of Practice. This shows a lack of competence in nursing, introduces rather than reduces harm, and is inconsistent with the profession's values of service to clients and the public. Further, such conduct diminishes the integrity of the profession which is founded in safe and effective practice by skilled and knowledgeable members.

On numerous occasions, Ms. Trout failed to assess a client as circumstances required her to do (Allegations 6, 12, 13, and 15). Assessment of clients is necessary to establishing a portrait of their health or time and a critical tool to identifying concerns so they can be monitored or treated before they worsen or progress. In failing to perform these assessments as required, Ms. Trout created a situation of risk for those in her care, failed to support the entire team involved in the circle of care, and did not meet the requirements of competent practice. Moreover, the repetition of this conduct demonstrated that she did not appreciate and learn from past mistakes as one would expect of a professional with an understanding of the privilege of self-regulation.

Multiple times Ms. Trout failed to adequately and accurately document information, or to document information at all with regard to her client. Documentation is essential in health care because it provides everyone in the circle of care with the evidence needed to make informed decisions. Such documentation is relied upon for numerous reasons which all point back to informing others on the health care team of critical information relating to a person's health be

that as a matter of knowing what happened in the prior shift or in order to permit an assessment of health outcomes over time. In failing to so document, Ms. Trout did not provide timely and complete information to her colleagues, did not act in the best interests of clients, and did not act in a manner which upholds the integrity of the profession. Accordingly, this conduct was clearly a breach of both the Code of Ethics and the Standards of Practice.

In regard of Allegation 20 she failed to communicate information to her coworkers when she left early from a shift which constitutes substantially the same breaches as failing to document since the results are the same.

On two occasions (Allegations 9 and 11) Ms. Trout demonstrated unskilled practice by incorrectly administering an IV to a client. This conduct is also a breach of both the Code of Ethics and the Standards of Practice as this is a fundamental skill which LPNs are expected to execute without issue.

As such, Ms. Trout breached multiple provisions of the Code of Ethics and Standards of Practice on multiple occasions.

(9) Submission on Penalty

Complaints Consultant's Submissions

The Complaints Consultant requested that the Hearing Tribunal impose the following orders pursuant to s. 82of the HPA:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.
2. Ms. Trout shall pay 25% of the costs of the investigation and hearing to be paid in equal monthly installments over a period of 36 months subject to the following:
    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.
    (b) The first payment will be due within 30 days after Ms. Trout is provided with the letter advising of the final costs.
3. Ms. Trout will not be eligible to apply for registration or reinstatement until she has complied with the following:
    (a) Ms. Trout 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. Trout 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 their professional practice:

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 D1: Communication and Collaborative Practice;
xiii. CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting;
xiv. CLPNA Competency Profile U2: Medication Preparation and Administration;
xv. CLPNA Competency Profile V1: Principles and Administration of Infusion Therapy.

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

(b) In the event the reflective paper referred to at paragraph 3(a) is not satisfactory to the Complaints Consultant, Ms. Trout 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 his sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

(c) Ms. Trout shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Ms. Trout shall provide the Complaints Consultant with a certificate confirming successful completion of the course.

(d) Ms. Trout shall complete, at her own cost, **Medication Errors: Causes and Prevention v2.5** available online at https://ncsbn-external.myabsorb.com. Ms. Trout shall provide the Complaints Consultant, with a copy of certification confirming successful completion of the course.

(e) Ms. Trout shall complete the Infusion Therapy Self-Study Course available online at https://www.clpna.com/members/continuing-education/study-with-clpna/. Ms. Trout shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

(f) Ms. Trout shall complete **the Medication Administration Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/. Ms. Trout shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

(g) Ms. Trout shall complete the **Nursing Documentation Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/. Ms. Trout shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

4. Should any of the above course(s) referred to above at paragraph 3 become unavailable, then Ms. Trout shall request in writing to be assigned an alternative course. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Trout will be notified by the Complaints Consultant, in writing, advising of the new course required.

5. Once Ms. Trout has completed the requirements set out in paragraph 3, and provided that she is not in default of the requirements to pay costs as set out in paragraph 2, she will be eligible to apply for registration.

6. If, upon receiving her application for registration, the Registrar determines that Ms. Trout meets the CLPNA's requirements for registration, Ms. Trout's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, except that medication administration must be under direct supervision, subject to the following:

(a) She must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;
(b) Following the completion of 150 hours of supervised practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

(c) Following the completion of 150 hours of supervised practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. If, following the completion of 150 hours of supervised medication administration practice, the Evaluator is unable to indicate that Ms. Trout is deemed knowledgeable or competent as set out above at paragraph 6(b):
   (a) The condition requiring Ms. Trout to practice under supervision will remain on Ms. Trout's practice permit for an additional 150 hours;
   (b) During the additional 150 hours of supervised practice Ms. Trout may practice under indirect supervision except that medication administration must be performed under direct supervision; and
   (c) Following the completion of the additional 150 hours of supervised practice, she must provide proof to the Complaints Consultant that she has successfully completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

8. In the event that the Evaluator does not deem Ms. Trout knowledgeable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 150 hours of supervised practice, the matter may be remitted to the Hearing Tribunal for further consideration.

9. The condition requiring Ms. Trout to practice under supervision will continue to appear on her practice permit and the public registry until she has successfully completed the period of supervised practice as outlined above, and will be removed upon successful completion of the period of supervised practice. Until the conditions are removed, her practice permit and the public registry will state the following:
   (a) Condition – supervised practice (indirect) – practice
   (b) Condition – supervised practice (direct) – medication administration

10. Ms. Trout 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. Trout will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms. Trout 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.

12. Should Ms. Trout 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. Trout non-compliance as information for a complaint under s. 56 of the Act; or
    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Trout 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

Investigated Member's Submissions

Ms. Trout did not provide any written submissions and did not make any specific verbal submissions. She did however take the opportunity to state that she was embarrassed about the allegations and admits that her "actions were not o.k.". Ms. Trout was in agreement with the majority of the sanctions being proposed by the CLPNA Complaints Director however she was concerned about the financial sanction being sought. She stated she is currently on EI and is suffering financially.

(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 Rebecca Trout 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:** The allegations collectively are very serious in nature. They demonstrate a repetitive pattern that shows significant deficiencies in basic nursing competencies. These deficiencies are in areas of medication administration, communication, IV administration therapy principles, professional judgement as well as multiple offences in professional responsibility and accountability.

2) **The age and experience of the investigated member:** Ms. Trout has been a regulated member of the CLPNA since 2014. She was not a new member of the profession and the expectation is that she would have been proficient in all areas of her practice.

3) **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Prior to the allegations in this hearing, there have been no other complaints or convictions against Ms. Trout.

4) **The age and mental condition of the victim(s), if any:** The Hearing Tribunal was not provided with any adverse effects suffered by the clients involved.

5) **The number of times the offending conduct was proven to have occurred:** There are multiple allegations against Ms. Trout. Despite being served with suspensions by her employer, the pattern of neglectful behavior continued and eventually escalated to her termination.

6) **The role of the investigated member in acknowledging what occurred:** Ms. Trout has acknowledged all of the allegations in this hearing.

7) **Whether the investigated member has already suffered other serious financial penalties as a result of the allegations having been made:** Ms. Trout was suspended three separate times by her employer and then terminated.

8) **The impact of the incidence(s) on the victims:** The Hearing Tribunal was not made aware of any impacts on the victims in this case.

9) **The presence of absence of any mitigating circumstances:** Ms. Trout stated she was dealing with significant mental health issues including but not limited to an inpatient admission on a mental health unit. She continues to struggle with her mental health and is being followed by a psychologist at this time. The Hearing Tribunal placed a significant amount of weight on this factor when we determined sanctions.

10) **The need to promote both specific and general deterrence and, thereby, to protect the public and ensure safe and proper practice:** It is imperative that the sanctions imposed by the Hearing Tribunal promote both specific and general deterrence. The members of the CLPNA need to be made aware that the proven allegations in this hearing will not be tolerated and will be dealt with quickly and strictly. Ms. Trout also needs to be made aware that the College will not tolerate the behavior displayed and will hold her accountable to ensure that the public is protected.

11) **The need to maintain the public's confidence in the integrity of the profession:** The sanctions that are handed down to Ms. Trout must demonstrate to the public that we take the allegations very seriously.

12) **The range of sentences in similar sentences:** The sanctions being sought after in this case are in line with other cases that are similar in nature.

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.

(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. Trout shall pay 25% of the costs of the investigation and hearing to be paid in equal monthly installments over a period of 36 months subject to the following:

    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.
    (b) The first payment will be due within 90 days after Ms. Trout is provided with the letter advising of the final costs.

3. Ms. Trout will not be eligible to apply for registration or reinstatement until she has complied with the following:

    (a) Ms. Trout 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. Trout 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 their professional practice:

        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 D1: Communication and Collaborative Practice;
        xiii. CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting;

xiv. CLPNA Competency Profile U2: Medication Preparation and Administration;
xv. CLPNA Competency Profile V1: Principles and Administration of Infusion Therapy.

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

(b) In the event the reflective paper referred to at paragraph 3(a) is not satisfactory to the Complaints Consultant, Ms. Trout 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 his sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

(c) Ms. Trout shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses. Ms. Trout shall provide the Complaints Consultant with a certificate confirming successful completion of the course.

(d) Ms. Trout shall complete, at her own cost, **Medication Errors: Causes and Prevention v2.5** available online at https://ncsbn-external.myabsorb.com. Ms. Trout shall provide the Complaints Consultant, with a copy of certification confirming successful completion of the course.

(e) Ms. Trout shall complete the Infusion Therapy Self-Study Course available online at https://www.clpna.com/members/continuing-education/study-with-clpna/. Ms. Trout shall provide the Complaints Consultant, with a certificate confirming successful completion of the course.

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4. Should any of the above course(s) referred to above at paragraph 3 become unavailable, then Ms. Trout shall request in writing to be assigned an alternative course. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Trout will be notified by the Complaints Consultant, in writing, advising of the new course required.

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6. If, upon receiving her application for registration, the Registrar determines that Ms. Trout meets the CLPNA's requirements for registration, Ms. Trout's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, except that medication administration must be under direct supervision, subject to the following:

    (a) She must provide any person supervising ("Evaluator") her with a copy of the Medication Administration Competency Skills Evaluation Tool;

    (b) Following the completion of 150 hours of supervised practice, she must be deemed knowledgeable and/or competent by the Evaluator in every competency listed in the Medication Administration Competency Skills Evaluation Tool;

    (c) Following the completion of 150 hours of supervised practice, she must provide to the Complaints Consultant a completed copy of the Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

7. If, following the completion of 150 hours of supervised medication administration practice, the Evaluator is unable to indicate that Ms. Trout is deemed knowledgeable or competent as set out above at paragraph 6(b):

    (a) The condition requiring Ms. Trout to practice under supervision will remain on Ms. Trout's practice permit for an additional 150 hours;

    (b) During the additional 150 hours of supervised practice Ms. Trout may practice under indirect supervision except that medication administration must be performed under direct supervision; and

    (c) Following the completion of the additional 150 hours of supervised practice, she must provide proof to the Complaints Consultant that she has successfully

completed a second Medication Administration Competency Skills Evaluation Tool signed by the Evaluator(s) and herself.

8. In the event that the Evaluator does not deem Ms. Trout knowledgeable and/or competent in every competency listed in the Medication Administration Competency Skills Evaluation Tool following the additional 150 hours of supervised practice, the matter may be remitted to the Hearing Tribunal for further consideration.

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    (a) Condition – supervised practice (indirect) – practice

    (b) Condition – supervised practice (direct) – medication administration

10. Ms. Trout 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. Trout will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms. Trout 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.

12. Should Ms. Trout 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. Trout non-compliance as information for a complaint under s. 56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Trout practice permit until such costs are paid in full or the Complaints

Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant

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

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

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 1st DAY OF SEPTEMBER 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz
Michelle Stolz, LPN
Chair, Hearing Tribunal