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 SANDRA ROBLES

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 SANDRA ROBLES, LPN #36960, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Videoconference using Zoom on July 22, 2020 with the following individuals present:

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

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

Investigated Member:
Sandra Robles, LPN ("Ms. Robles" or "Investigated Member")
David Cavilla, 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. Robles was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Robles was initially licensed as an LPN in Alberta on July 3, 2013.

On February 14, 2018, the CLPNA received a complaint from Sherry Irwin, RN, Resident Care Manager at St. Michael's Health Care ("St. Michael's") in Lethbridge, Alberta (the "First Complaint"). The First Complaint was made pursuant to s. 57(1) of the *Health Professions Act* (the "Act"), and advised that Ms. Robles, LPN had received a five-day suspension as a result of performance concerns related to medication administration.

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

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

Ms. Robles received notice of the First Complaint and the investigation by letter dated February 21, 2018.

On March 1, 2018, the CLPNA received a second letter of complaint from Llan Baceda, RN, Program Manager at St. Michael's (the "Second Complaint"). The Second Complaint was made pursuant to s. 57(1) of the Act, and advised that Ms. Robles, LPN had received a second five-day suspension as a result of further performance concerns relating to medication administration and documentation practices.

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

Ms. Robles received notice of the Second Complaint and the investigation by letter dated March 15, 2018.

On August 15, 2018, the CLPNA received a third letter of complaint from Llan Baceda, RN, Program Manager at St. Michael's (the "Third Complaint"). The Third Complaint was made pursuant to s. 57(1) of the Act, and advised that Ms. Robles, LPN had been terminated from her employment following a threatening exchange with a co-worker.

In accordance with s. 55(2)(d) of the Act, the Complaints Consultant appointed an Investigator to conduct an investigation into the First, Second and Third Complaints.

Ms. Robles received notice of the Third Complaint and the investigation by letter dated August 23, 2018.

On March 5, 2019, the Investigator concluded the investigations of the First, Second and Third Complaints and submitted the Investigation Report to the CLPNA.

Following the Investigation Report, the Complaints Consultant determined there was sufficient evidence that these matters should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Robles received notice that the matters were referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated August 7, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Robles under cover of letter dated February 6, 2020.

(4) Allegations

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

It is alleged that SANDRA ROBLES, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about February 3, 2018 failed to follow proper medication administration practices by doing one or more of the following:
    a) Failed to document the removal of Codeine 15 mg at 2000 hours from client ED's Narcotic Control Record at the time of the removal; and
    b) Failed to properly document on client ED's Narcotic Control Record the removal of Codeine 15 mg at 2000 hours by writing over a previous entry.
2. WITHDRAWN
3. On or about February 21, 2018 documented on the Medication Administration Record indicating she administered Acetaminophen 650 mg at 1200 hours to client RT, when, in fact, she failed to administer Acetaminophen 650 mg at 1200 hours to client RT as scheduled.
4. On or about February 22, 2018 failed to follow proper medication administration practices by doing one or more of the following with regards to client AP:
    a) Failed to ensure AP consumed his medications; and
    b) Inappropriately delegated, to the HCA, the responsibility to ensure AP drank his orange juice with medication in it.
5. On or about February 22, 2018 failed to administer ferrous gluconate 300 mg and Cholestyramine Resin 4 gm to client AC at 1200 hours, as scheduled.
6. On or about February 22, 2018 did one or more of the following with regard to client AS:
    a) Failed to administer Lisinopril 10 mg, Phenytoin Sodium 200 mg, Amolodipine Besylate 5 mg, Carvedilol 6.25 mg, Vitamin D 1000 IU, Polyethylene Glycol 3350, and Trazodone HCI 12.5 mg at 0800 hours, as scheduled; and
    b) Failed to administer Trazodone HCI 25 mg at 1200 hours, as scheduled.
7. On or about February 22, 2018 failed to perform and/or document an assessment of client JQ after she complained of pain in her lower legs.

8. On or about July 10, 2018 failed to utilize effective interpersonal communication skills when speaking with a co-worker by pointing her finger at the co-worker and/or invading the co-worker's personal space.

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Ms. Robles' 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. Robles.

Allegation 1

Ms. Robles admitted that on or about February 3, 2018, she failed to follow proper medication administration practices by doing one or more of the following:

a) Failed to document the removal of Codeine 15 mg at 2000 hours from client ED's Narcotic Control Record at the time of the removal; and

b) Failed to properly document on client ED's Narcotic Control Record the removal of Codeine 15 mg at 2000 hours by writing over a previous entry.

On February 3, 2018, Ms. Robles worked a shift at St. Michael's. At approximately 2000 hours, Ms. Robles removed a Codeine 15 mg tablet from the narcotics cupboard. Ms. Robles failed to document the removal of this Codeine tablet on the Narcotic Control Record for ED at the time of the removal.

At 2300 hours, Ms. Robles and another staff performed the count of ED's narcotics. Due to the failure to record the removal of the Codeine tablet at the relevant time, the count was recorded at "9" tablets of Codeine.

The next morning, the following shift performed the count and discovered it was out by one Codeine tablet. To account for the error, Ms. Robles was asked if she administered a Codeine tablet at 2000 hours the previous evening. In response, Ms. Robles wrote over the count performed at 2300 hours to then document her removal of the Codeine tab at 2000 hours the evening before. The Narcotic Control Record may not be altered in this manner. A copy of client ED's Medication Administration Record is found in **Exhibit #2**. A copy of the altered Narcotic Control Record is also in **Exhibit #2.**

Proper and careful administration of medication is a key and foundational skill in nursing. The recording of the administration of medication provides a record of care that informs other nurses who take over the care of a client and maintains continuity of care. This is basic and critical nursing. In this case, other nursing staff were not clear on whether the client was properly medicated or not. Continuity of care was jeopardized.

In addition, Ms. Robles went back and modified the Medication Administration Record regarding the dispensing of a narcotic. Not only is this an unacceptable practice to alter the record after the fact, but it is dishonest in that it is trying to hide the mistake in charting from the previous day. Being trustworthy is a foundational principle for an LPN.

When Ms. Robles failed to properly record the administration of a narcotic on the Medication Administration Record, and then wrote on the existing record to correct it in a later shift, is a

clear demonstration of poor judgment, as well as an act of deception which violates the expected trustworthiness and practice of Ms. Robles. Therefore the Hearing Tribunal deems this to be unprofessional conduct.

Ms. Robles' conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

For these reasons, 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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 2

WITHDRAWN

Allegation 3

Ms. Robles admitted that on or about February 21, 2018, she documented on the Medication Administration Record indicating she administered Acetaminophen 650 mg at 1200 hours to client RT, when, in fact, she failed to administer Acetaminophen 650 mg at 1200 hours to client RT as scheduled.

On February 21, 2018, Ms. Robles worked a shift at St. Michael's.

As part of his medications, client RT was to receive Acetaminophen 650 mg at 1200 hours on February 21, 2018.

At the start of his shift **JL** the evening shift LPN, found client RT's lunchtime (1200 hours) medication pouch containing Acetaminophen 650 mg still in the medication cart. **JL** checked the Medication Administration Record for client RT and noted Ms. Robles had signed it to indicate that she had administered Acetaminophen 650 mg at 1200 hours.

Ms. Robles signed the Acetaminophen 650 mg for client RT but did not administer the Acetaminophen 650 mg. The Medication Administration Record for client RT is found in **Exhibit #2**.

The correct administration of medications and recording of same is critical and basic to proper continuity of nursing care for a client. Without this care, a client could be harmed in that they suffer without their medication. Also, other staff will not know for sure that the client has received proper medication. The evidence provided to the Hearing Tribunal clearly shows that Ms. Robles did not administer medications, but recorded that she had.

The failure to administer Acetaminophen 650 mg to RT and then adjusting the Medication Administration Record to show that it had been given, covered up the error and is a demonstration of a lack of skill and judgment. This behavior of Ms. Robles falls well below the acceptable Standards of Practice for an LPN. Therefore, the Hearing Tribunal finds that Ms. Robles' conduct in this allegation is unprofessional conduct. Further, this conduct constitutes a breach of the Code of Ethics and Standards of Practice for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 4

Ms. Robles admitted that on or about February 22, 2018, she failed to follow proper medication administration practices by doing one or more of the following with regards to client AP:

a) Failed to ensure AP consumed his medications; and
b) Inappropriately delegated, to the HCA, the responsibility to ensure AP drank his orange juice with medication in it.

On or about February 22, 2018, Ms. Robles worked a shift at St. Michael's.

At breakfast time, Ms. Robles administered medication to client AP by adding powder from a medication package to AP's glass of orange juice. Ms. Robles did not observe AP drink the juice.

Ms. Robles asked HCA **DP**, who was in the room actively engaged in other duties, to ensure client AP drank all his juice.

According to the evidence provided to the Hearing Tribunal, it is clear that Ms. Robles failed to carry out her duties in supervising client AP to ensure he took his medication. It is also unacceptable practice to ask a busy HCA to ensure AP drank his juice with the medication in it.

In failing to carry out her responsibility to supervise her client taking his medication, Ms. Robles demonstrated a lack of knowledge and judgment. Her actions fell well below the Standards of Practice and the requirements of the Code of Ethics for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 5

Ms. Robles admitted that on or about February 22, 2018, she failed to administer ferrous gluconate 300 mg and Cholestyramine Resin 4 gm to client AC at 1200 hours, as scheduled.

On or about February 22, 2018, Ms. Robles worked a shift at St. Michael's.

On this day, **LB**, RN Program Manager, reviewed the Medication Administration Record of client AC. **LB** noted the medications scheduled to be administered to AC at 1200 hours had not been signed off in the Medication Administration Record.

Ms. Robles was the LPN responsible for client AC during this time period. The Medication Administration Record for client AC is in **Exhibit #2**.

The evidence in **Exhibit #2** shows Ms. Robles failed in her duty and responsibility to sign AC's Medication Administration Record for medications he should have been given at 1200 hours. This can be a rather dangerous oversight or mistake because another nurse taking over AC's care would not know whether the signature has been forgotten or the medications were not given. This is a serious incident and falls below competent nursing practice.

By failing to sign the Medication Administration Record, Ms. Robles demonstrated a lack of skill and judgment. Also, failing in basic charting skills reflects poorly on the nursing profession. Further, Ms. Robles' conduct fell below the expectations found in the Code of Ethics and Standards of Practice for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 6

Ms. Robles admitted that on or about February 22, 2018, she did one or more of the following with regard to client AS:

a) Failed to administer Lisinopril 10 mg, Phenytoin Sodium 200 mg, Amolodipine Besylate 5 mg, Carvedilol 6.25 mg, Vitamin D 1000 IU, Polyethylene Glycol 3350, and Trazodone HCI 12.5 mg at 0800 hours, as scheduled; and

b) Failed to administer Trazodone HCI 25 mg at 1200 hours, as scheduled.

On or about February 22, 2018, Ms. Robles worked a shift at St. Michael's.

On this day, **LB**, RN Program Manager, reviewed the Medication Administration Record of client AS. **LB** noted that the following medications scheduled to be administered to AS at 0800 hours had not been signed off on the Medication Administration Record: lisinopril 10 mg, Phenytoin Sodium 200 mg, Amolodipine Besylate 5 mg, Carvedilol 6.25 mg, Vitamin D 1000 IU, Polyethylene Glycol 3350, and Trazodone HCI 12.5 mg.

LB further noted that the following medication scheduled to be administered to AS at 1200 hours had not been signed off on the Medication Administration Record: Trazadone HCI 12.5 mg.

Ms. Robles was the LPN responsible for client AS during this time period. The Medication Administration Record for client AS is found in **Exhibit #2**.

The Hearing Tribunal reviewed the evidence in Exhibit #2, and agrees that Ms. Robles failed to administer the medications, lisinopril 10 mg, Phenytoin Sodium 200 mg, Amolodipine Besylate 5 mg, Carvedilol 6.25 mg, Vitamin D 1000 IU, Polyethylene Glycol 3350, and Trazodone HCI 12.5 mg at 0800 hours, as scheduled. She also failed to administer Trazodone HCI 25 mg at 1200 hours, as scheduled. These are serious failures and fall well below nursing standards for an LPN. These failures had the potential to harm the client although, the Hearing Tribunal was not offered any evidence that harm occurred.

Ms. Robles, in failing to provide medications as scheduled, displayed a lack of skill and judgment. Failing to administer medications, as required by the orders, is a serious failure in an LPN's practice. In failing to provide this care, Ms. Robles contravened the Code of Ethics, and Standards of Practice for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 7

Ms. Robles admitted that on or about February 22, 2018, she failed to perform and/or document an assessment of client JQ after she complained of pain in her lower legs.

On or about February 22, 2018, Ms. Robles worked a shift at St. Michael's.

On this date, **MB**, HCA, reported to Ms. Robles that client JQ cried out in pain while **MB** was applying cream to her legs. **MB** then asked Ms. Robles to assess JQ. **MB's** chart entry for client JQ is found in **Exhibit #2**.

While Ms. Robles noted on the LPN report sheet that client JQ complained of pain in her lower legs, there is no documentation in JQ's client chart for the date of February 22, 2018 which reflects that an assessment was performed.

Ms. Robles, according to the evidence provided in Exhibit #2, failed to perform and/or document an assessment of client JQ after JQ complained of pain in her lower leg. It is the responsibility of the LPN to make an assessment of a client's pain and complaints and then record the same. In this situation, Ms. Robles' failure to do so is a failure to perform her responsibilities, and this falls below an LPN's standard of practice. In failing to assess and/or document JQ pain in her lower legs, Ms. Robles' conduct could have lead to more serious health outcomes. It threatened continuity of care and did not communicate with other staff members about the client's condition.

Ms. Robles' failure to assess and/or document JQ's condition is clearly demonstrating a lack of skill and knowledge, as well as being a violation of standards of practice for LPNs. There is an expected level of performance for an LPN and Ms. Robles practice fell below that expected level of practice. Further, her conduct falls below the requirements of the Code of Ethics and Standards of Practice for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

Allegation 8

Ms. Robles admitted that on or about July 10, 2018, she failed to utilize effective interpersonal communication skills when speaking with a co-worker by pointing her finger at the co-worker and/or invading the co-worker's personal space.

On or about July 10, 2018, while giving shift report in the break room, on or around 2300 hours, Ms. Robles, when referring to client CS stated that the doctor had not made any changes.

In response, **HW**, LPN, reminded Ms. Robles that the doctor had ordered olanzapine.

At this point, Ms. Robles pointed a finger at **HW** and told **HW** that she was to call Ms. Robles when the doctor did rounds with her clients.

At this point, HW got upset and left the break room for approximately 5 minutes.

On HW's return to the break room, Ms. Robles asked HW if there was something wrong. HW informed Ms. Robles she felt that Ms. Robles was being mean and disrespectful toward her. HW advised that Ms. Robles had hurt her feelings and made her uncomfortable.

Ms. Robles apologized and indicated that she had been joking.

HW indicated to Ms. Robles that, according to how she was raised and in her book, pointing a finger and yelling at someone is rude and mean.

Ms. Robles then approached HW and stood approximately one inch away from her. Ms. Robles stated forcefully to HW words to the effect of "where is your book? Show me your book."

HW was upset and uncomfortable and asked Ms. Robles to get away from her.

GN, LPN, witnessed this exchange between Ms. Robles and HW. At this point in the exchange, GN advised Ms. Robles that she needed to leave the break room.

After the incident, HW was shaken and upset to the point that she called security to escort her to the parking lot after her shift.

On July 11, 2018, HW sent an email to LB reporting the incident which is included in **Exhibit #2.**

After reviewing the evidence in Exhibit #2, the Hearing Tribunal finds that Ms. Robles' communication with HW was not professional, respectful, and was threatening. Good communications with colleagues and other staff is a key skill in the nursing profession. It is the responsibility of every nurse to foster a team attitude. Clearly this was not apparent in Ms. Robles' communications with .

By having an aggressive and threatening conversation with HW, Ms. Robles demonstrated a lack of skill and judgment in her professional setting. Ms. Robles also violated the Standards of Practice and Code of Ethics for her regulated profession for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice;

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

CLPNA Code of Ethics

Ms. Robles acknowledges 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 members of the public. Principle 1 specifically provides that LPNs:

    - 1.1 Maintain standards of practice, professional competence and conduct.
    - 1.5 Provide care directed toward the health and well-being of the person, family, and community.
    - 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.

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 judgment 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 2 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 4: Responsibility to Colleagues – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals.

    - 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.

e. Principle 5: Responsibility to Self – LPNS 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.

A copy of the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is attached in **Exhibit #2**.

LPNs, as self-regulating professionals, commit to providing safe, effective, compassionate and ethical care to members of the public. Ms. Robles' conduct fell well below this level of ethical practice when she falsified the medication record, failed to give prescribed medications, and failed to chart medication administration. This conduct demonstrates that she failed to use evidence in guiding her nursing decisions and to minimize risk to clients. Her actions undermined the profession and were not consistent with the requirements and privileges of self-regulation. An LPN holds a position of trust and power with their clients and it is vital that they practise with this in mind at all times. When Ms. Robles failed to maintain the ethics of her profession she brought the profession into disrepute and undermined it. It is a serious issue when an LPN brings the profession into disrespect in the public's eyes. Of particular concern is that Ms. Robles repeatedly committed the same errors relating to medication. Overall, she did not act consistently with the requirements of her as an LPN.

Finally Ms. Robles' conduct did not accord with her ethical obligations to her colleagues. In engaging in confrontational behaviour with a colleague she failed to work cooperatively, collaboratively and in a manner that contributes to a positive environment.

<u>CLPNA Standards of Practice:</u>

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

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:

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

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

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

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

b. Standard 2: Knowledge-Based Practice:

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

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

c. Standard 3: Service to the Public and Self-Regulation:

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

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

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

d. Standard 4: Ethical Practice:

- 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.

A copy of the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 is attached in **Exhibit #2.**

The Standards of Practice are intended to provide regulations and oversight to the care LPNs provide. They are designed to ensure that care is given with compassion, honesty, and respect as the above standards convey. Ms. Robles, in failing to administer medications, charting those medications improperly or falsifying the medication records, has put her clients in potential danger and has compromised their care, and in so doing has not been compassionate, honest, and respectful of her client's needs. In breaching the above standards Ms. Robles has not only breached intentions of the Standards but she has shown a definite lack of skill and judgement in her practice.

She placed her clients in harm's way and introduced, not reduced, risk in the course of care. She did not apply the knowledge of her profession and failed to document and record as is necessary in accordance with regulations and employer policies. In general, she did not practice in accordance with the values espoused in the Code of Ethics and failed to demonstrate an

understanding of the privileges and responsibilities of being a self-regulated professional. Her conduct with her co-worker did not accord with the expectation of respectful communication in her practice.

As such, there were numerous breaches of the Standards of Practice that have arisen from Ms. Robles' conduct.

(9) Joint Submission on Penalty

The Complaints Consultant and Ms. Robles 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. Robles shall read and reflect on the following CLPNA documents located on the CLPNA website at www.clpna.com under "Governance". After completing the reading and reflection, Ms. Robles will provide the Complaints Consultant with a written reflection of 500-750 words, satisfactory to the Complaints Consultant, describing how the content contained in these documents will impact her professional practice. The written reflection must be provided within **thirty (30) days** of receipt of the Decision:

    a) Code of Ethics for Licensed Practical Nurses in Canada;

    b) Standards of Practice for Licensed Practical Nurses in Canada;

    c) CLPNA Practice Policy: Professional Responsibility & Accountability;

    d) CLPNA Practice Policy: Documentation;

    e) CLPNA Competency Profile B1: Assessment;

    f) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    g) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

    h) CLPNA Competency Profile U: Medication Administration; and

    i) CLPNA Competency Profile W: Professionalism.

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

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

4. Ms. Robles shall, complete, at her own cost, the following nursing quizzes located on website http://www.learningnurse.org/. Ms. Robles shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **<u>thirty (30) days</u>** of service of the Decision:

   a. Health Assessment; and

   b. Legal Risks

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

5. Ms. Robles shall complete, at her own cost, the following course: **NURS 0161 Medication Management** offered on-line by MacEwan University. Ms. Robles shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **<u>six (6) months</u>** of service of the Decision.

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

6. Ms. Robles shall complete, at her own cost, the following course: **4 Essential Communication Strategies that Promote Patient Safety** offered on-line by www.pedagogyeducation.com. Ms. Robles shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **<u>sixty (60) days</u>** of service of the Decision.

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

7. Ms. Robles shall, within **<u>thirty-six (36) months</u>** of service of the letter advising of the final costs, pay, in full, $4,000.00 of the investigation and hearing costs to the CLPNA. A letter advising of the final costs will be forwarded when final costs have been confirmed.

8. Ms. Robles 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. Robles will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Robles be unable to comply with any of the deadlines for completion of the penalty orders identified above, Ms. Robles may request an extension by submitting to the Complaints Consultant, prior to the deadline, a request in writing stating a reason for requesting the extension and a reasonable time frame for completion. The Complaints Consultant, shall, in her sole discretion, determine whether a time extension will be granted and will notify Ms. Robles in writing if the extension has been granted.

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

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

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

    c. In the case of non-payment of the costs described in paragraph 7 above, suspend Ms. Robles practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payments agreed to by the Complaints Consultant.

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

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

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

(10) <u>Decision on Penalty and Conclusions of the Hearing Tribunal</u>

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. Robles 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**

Although there was no evidence that any of the clients were harmed by Ms. Robles' conduct, it is possible that this conduct could have caused suffering or danger to her clients. Failing to administer medications, failing to document the administration of these medications, and having threatening communications with fellow staff members, is a serious breach of expected and required professional behavior.

2. The age and experience of the investigated member

Ms. Robles has 13 years of experience and should have known better on all accounts of her conduct.

3. The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions

The Hearing Tribunal did not receive any evidence of past complaints or decisions against this member.

3. The age and mental condition of the victim, if any

Ms. Robles' clients were a vulnerable community of aging seniors.

4. The number of times the offending conduct was proven to have occurred

All, except one of the eight allegations against Ms. Robles, involved medication errors and the proper recording of medication administration. All of these errors constitute serious failure in her practice. Her aggressive communication style with one of her colleagues is well over the line of expected professional behavior.

5. The role of the investigated member in acknowledging what occurred

The Hearing Tribunal was impressed with Ms. Robles' admission of her behavior and that she recognizes what she did in all the situations. She also worked with the College in drafting an Agreed Statement of Facts. In recognizing her errors Ms. Robles can now work on improving her practice.

6. Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made

Ms. Robles was fired from her job. She is a one wage earner household with children, and losing her job was a difficult situation for her.

7. The impact of the incident(s) on the victim, and/or

No evidence was provided that any of the victims were harmed. Although Ms. Robles' misconduct was serious enough, there was a possibility that a client could have been harmed.

8. The presence or absence of any mitigating circumstances

Ms. Robles' counsel advised the Hearing Tribunal, that Ms. Robles found that with the rigors of her job and personal life, she found herself in a situation where she was trying to juggle too many things.

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. Robles shall read and reflect on the following CLPNA documents located on the CLPNA website at www.clpna.com under "Governance". After completing the reading and reflection, Ms. Robles will provide the Complaints Consultant with a written reflection of 500-750 words, satisfactory to the Complaints Consultant, describing how the content contained in these documents will impact her professional practice. The written reflection must be provided within **thirty (30) days** of receipt of the Decision:

    a) Code of Ethics for Licensed Practical Nurses in Canada;

    b) Standards of Practice for Licensed Practical Nurses in Canada;

    c) CLPNA Practice Policy: Professional Responsibility & Accountability;

    d) CLPNA Practice Policy: Documentation;

    e) CLPNA Competency Profile B1: Assessment;

    f) CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

    g) CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

    h) CLPNA Competency Profile U: Medication Administration; and

    i) CLPNA Competency Profile W: Professionalism.

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

3. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Robles shall within two (2) weeks of being notified by the Complaints Consulant the reflective paper is not satisfactory, or such longer period as determined by the Complaints

Consultant at her sole discretion, submit a revised paper that is acceptable to the Complaints Consultant.

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    c. In the case of non-payment of the costs described in paragraph 7 above, suspend Ms. Robles practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payments agreed to by the Complaints Consultant.

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

(12) <u>Conditions on Investigated Member's Practice Permit</u>

The conditions on Ms. Robles' practice permit and on the public register will be removed upon completion as follows:

"CLPNA Monitoring Orders (Conduct)"

- Orders 1-6

"Conduct Costs/Fines"

- Order 7

DATED THE 24TH DAY OF AUGUST 2020 IN THE VILLAGE OF RYLEY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Nancy Brook, Public Member

Chair, Hearing Tribunal