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 UDAYAKUMARI ILLANGAMUDALIGE
LPN #37169

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 UDAYAKUMARI ILLANGAMUDALIGE, LPN #37169, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The virtual Hearing was conducted using the Zoom platform ("Zoom"), based in Edmonton, Alberta on May 13, 2020 with the following individuals participating online:

Hearing Tribunal:
James Lees, Public Member, Chairperson
Verna Ruskowsky, LPN
Marie Concepcion, LPN

Staff:
Tessa Gregson, Legal Counsel for the Complaints Director, CLPNA
Kevin Oudith, Complaints Consultant for CLPNA

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

(2) Preliminary Matters

The hearing was open to the public.

In order to observe health guidelines regarding social distancing, the Parties have agreed to proceed with this hearing using Zoom, an online platform allowing multiple participants to meet and communicate from remote sites.

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

(3) Background

Ms. Illangamudalige was an LPN within the meaning of the *Health Professions Act* ("the Act") at all material times, and more particularly, was registered with the College of Licensed Practical Nurses of Alberta ("CLPNA") as an LPN at the time of the complaint. Ms. Illangamudalige was initially licensed as an LPN in Alberta on August 12, 2013. At all material times to the complaint, Ms. Illangamudalige was working at The Edgemont, Revera (the "Facility") until her termination from the Facility on March 28, 2019.

By letter dated November 23, 2018, the CLPNA received a complaint (the "Complaint") from Ellie Bromley, Area Operations Manager, Scenic Acres Retirement Centre and Acting Executive Director, Edgemont Revera facility in Calgary, Alberta. The Complaint was sent pursuant to s. 55 and 57 of the Act notifying the CLPNA that Ms. Illangamudalige, LPN, had been suspended for three days due to errors in medication administration. Ms. Bromley submitted a second letter to CLPNA dated November 23, 2018 which provided specific concerns identified with respect to Ms. Illangamudalige's nursing practice. On February 1, 2019, Ms. Illangamudalige received a further suspension of 5 days for medication errors and was moved to the Facility's day shift.

In accordance with s. 55(2)(d) of the Act, Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director"), determined she would appoint Kathryn (Katie) Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint. Written notice of the Complaint, investigation, and appointment of the Investigator was provided to Ms. Illangamudalige by letter dated November 27, 2018.

The Complaints Director subsequently delegated her authority and powers under Part 4 of the Act to Kevin Oudith, Complaints Consultant for the CLPNA (the "Complaints Consultant") pursuant to s. 20 of the Act.

On April 14, 2019, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Illangamudalige received notice that the Complaint was referred to a hearing as well as a copy of the Investigation Report and Statement of Allegations under cover of letter dated October 15, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Illangamudalige under cover of letter dated April 24, 2020.

Ms. Illangamudalige waived the thirty (30) days' notice required under s. 77 of the Act.

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

(4) Allegations

The Allegations in the Statement of Allegations, Exhibit #1, are:

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

1. On or about June 6, 2018 did one or more of the following with regards to client EW:
   a. Failed to follow proper medication administration processes when administering Morphine 0.5 mg via Subcutaneous Line ("SC Line");
   b. Administered Morphine 5 mg via SC Line instead of the ordered dose of Morphine 0.5 mg; and
   c. Failed to document on the progress notes the insertion and location of the SC Line.
2. On or about June 7, 2018 did one or more of the following with regards to client EW:
   a. Failed to follow proper medication administration processes when administering Morphine 0.5 mg via SC Line; and
   b. Administered Morphine 5 mg via SC Line instead of the ordered dose of Morphine 0.5 mg.
3. On or about November 1, 2018 did one or more of the following with regards to client DC:
   a. Failed to adequately assess and/or document DC's blood pressure prior to administering Captopril 2.5 mg, as required; and
   b. Failed to adequately assess and/or document DC's blood pressure post administration of Captopril 2.5 mg to assess effectiveness of medication, as required.
4. On or about December 1, 2018 failed to follow proper medication administration processes with regards to client MR by doing one or more of the following:
   a. Left a medication cup containing medication unattended in client MR's room; and
   b. Failed to ensure client MR consumed the medications.

5. On or about September 21, 2018 did one or more of the following with regards to client CK:
    a. Incorrectly documented on the Progress Notes client CK's daily total scheduled dose of Tylenol as 3600 mg instead of 3900 mg;
    b. Administered Tylenol 325 mg at 01:30 hours thus exceeding the daily maximum dose of 4000 mg; and
    c. Administered Tylenol 650 mg at approximately 0610 hours thus exceeding the daily maximum dose of 4000 mg.
6. On or about September 25, 2018 failed to remove client CK's Nitropatch 0.4 mg at approximately 2000 hours, as ordered.
7. On or about February 15, 2019 did one or more of the following with regards to client RS:
    a. Failed to administer the scheduled dose of Morphine 2.5 mg at 0800 hours;
    b. Failed to document on the MAR and/or progress notes the reason for not administering the Morphine 2.5 mg at 0800 hours in a timely manner; and
    c. Failed to document on the MAR for the administration of Morphine 2.5 mg at 1400 hours."

(5) Admission of Unprofessional Conduct

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

Ms. Illangamudalige 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 to unprofessional conduct to all the Allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Consultant submitted that where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances, noting there was no evidence of exceptional circumstances in this matter.

(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 and Reasons of the Hearing Tribunal

The Hearing Tribunal is aware that 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, the Hearing Tribunal must then proceed to determine whether such conduct rises to the threshold of unprofessional conduct as defined under s. 1(1)(pp) of the Act.

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. Illangamudalige'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. Illangamudalige.

Allegation 1:

Ms. Illangamudalige admitted on or about June 6, 2018, she did one or more of the following with regards to client EW:

a. Failed to follow proper medication administration processes when administering Morphine 0.5 mg via Subcutaneous Line (“SC Line”);

b. Administered Morphine 5 mg via SC Line instead of the ordered dose of Morphine 0.5 mg; and

c. Failed to document on the progress notes the insertion and location of the SC Line.

Ms. Illangamudalige worked the night shift from June 6-7, 2018, and during this time, provided care to client EW including the administration of Morphine. Paragraphs 11-17 of the Agreed Statement of Facts confirms that while preparing and administering client EW's 2200 hours dose of Morphine, Ms. Illangamudalige failed to follow the 8 rights and 3 checks required of proper medication processes, specifically the right dose and right documentation. Client EW received 10 times the ordered dose of Morphine as a result. Further, Ms. Illangamudalige primed a new SC line for the administration of Morphine at 2200 hours on June 6, 2018 but failed to document the removal of the old SC line, as well as the insertion and location of the new SC line. This is confirmed by client EW's Narcotic Control Record and Progress Notes.

Based on the information provided, the Hearing Tribunal finds that Allegation 1 is factually proven. By failing to follow proper medication processes Ms. Illangamudalige failed to demonstrate her professional knowledge and skill. This resulted in the client receiving a significantly larger dose than was ordered. This is further underlined by the failure to document the insertion and location of a new SC line. Further, these actions amount to breaches of the codes of ethics and standards of practice as is set out below. As such the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 2:

Ms Illangamudalige admitted on or about June 7, 2018, she did one or more of the following with regards to client EW:

a. Failed to follow proper medication administration processes when administering Morphine 0.5 mg via SC Line; and

b. Administered Morphine 5 mg via SC Line instead of the ordered dose of Morphine 0.5 mg.

Client EW was to receive Morphine 0.5 mg via SC line at 0600 hours on June 7, 2018. Paragraphs 18-20 of the Agreed Statement of Facts confirms that Ms. Illangamudalige failed to follow proper medication administration processes when preparing and administering client EW's morning Morphine dose. As a result, client EW again administered 0.5 ml (or 5 mg)

Morphine to client EW at 0600 hours on June 7, 2018, which was 10 times the prescribed dose. This is confirmed by client EW's Narcotic Control Record.

Based on the information provided in the Investigation Report, the Hearing Tribunal finds that Allegation 2 is factually proven. Failing to follow proper medication administration processes demonstrates a lack of knowledge and skill on the part of Ms. Illangamudalige. The result of these failures was that the client received a far greater dose of Morphine than had been prescribed creating risk for the client. Further, these actions constitute breaches of the code of ethics and standards of practice for the reasons explained below. The Hearing Tribunal finds that the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 3:

Ms. Illangamudalige admitted on or about November 1, 2018, she did one or more of the following with regards to client DC:

a. Failed to adequately assess and/or document DC's blood pressure prior to administering Captopril 2.5 mg, as required; and
b. Failed to adequately assess and/ or document DC's blood pressure post administration of Captopril 2.5 mg to assess effectiveness of medication, as required.

Ms. Illangamudalige worked the night shift from November 1-2, 2018, and during this time, she provided care to client DC, including the administration of Captopril. Paragraphs 21-26 of the Agreed Statement of Facts confirms that while administering Captopril to client DC, Ms. Illangamudalige failed to adequately assess and document client DC's blood pressure before and after administering this medication. She failed to comply with the Facility's policy on Health Records and Interdisciplinary documentation. Ms. Illangamudalige also failed to document anything regarding client DC's blood pressure and the PRN administration of Captopril on November 2, 2018 in the client's Progress Notes or Vital Signs History, copies of which were included in the Investigation Report. As a result of her actions, Ms. Illangamudalige received a 3-day suspension on November 24, 2018.

Based on the information provided, the Hearing Tribunal finds that Allegation 3 is factually proven. In failing to assess and document the client's blood pressure and in failing to properly document essential information about the client, Ms. Illangamudalige failed to demonstrate her

skill, knowledge and judgment as an LPN, failing to assess and document could lead to harm a client and compromise their health. Further, her actions breached the code of ethics and standards of practice as explained below. The Hearing Tribunal finds that the following definitions of unprofessional practice in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 4:

Ms. Illangamudalige admitted on or about December 1, 2018, she failed to follow proper medication administration processes with regards to client MR by doing one or more of the following:

a. Left a medication cup containing medication unattended in client MR's room; and
b. Failed to ensure client MR consumed the medications.

Ms. Illangamudalige worked the night shift from November 30-December 1, 2018, and during this time she provided care to client MR. Paragraphs 27-30 of the Agreed Statement of Facts confirm that on December 1, 2018 she left a medication cup containing Tylenol 1 unattended at client MR's bedside, and failed to ensure that client MR consumed the medication by witnessing its ingestion. The medication was later found by a co-worker, still in the cup at the client's bedside. Ms. Illangamudalige's actions do not comply with the Facility's Medication Administration policies. As a result of her actions, Ms. Illangamudalige received a 5-day suspension on February 1, 2019 and was moved to day shifts to allow for closer supervision.

Based on the information provided, the Hearing Tribunal finds that Allegation 4 is factually proven. In failing to ensure that this client took her medication, Ms. Illangamudalige showed a lack of knowledge, skill and judgment in that she did not follow the established medication administration policies. Further, this conduct amounts to breaches of the code of ethics and standards of practice as outlined below. The Hearing Tribunal finds that the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 5:

Ms. Illangamudalige admitted on or about September 21, 2018, she did one or more of the following with regards to client CK:

a. Incorrectly documented on the Progress Notes client CK's daily total scheduled dose of Tylenol as 3600 mg instead of 3900 mg;
b. Administered Tylenol 325 mg at 0130 hours thus exceeding the daily maximum dose of 4000 mg; and
c. Administered Tylenol 650 mg at approximately 0610 hours thus exceeding the daily maximum dose of 4000 mg.

Ms. Illangamudalige worked the night shift from September 20-21, 2018, and during this time she provided care to client KW. Paragraphs 31-37 of the Agreed Statement of Facts confirm that client CK was to receive a total of 3900 mg of Tylenol per day, and had standing orders to be administered additional Tylenol every 4 hours up to the specified limit for any 24-hour period. Ms. Illangamudalige incorrectly documented the amount of Tylenol that client CK had received during the day. As a result client CK received 875 mg over the daily maximum allowed on September 21, 2018. This was confirmed by client CK's Standing Orders, Medication Administration Record and Progress Notes.

Based on the information provided, the Hearing Tribunal finds that Allegation 5 is factually proven. By incorrectly recording the medication which this client received, Ms. Illangamudalige exposed the client to unnecessary risk. In doing so, she failed to demonstrate her skill, knowledge and judgment as an LPN. This conduct is further a breach of both the code of conduct and standards of practice as outlined below. The Hearing Tribunal finds that the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 6:

Ms. Illangamudalige admitted on or about September 25, 2018, she failed to remove client MI's Nitropatch 0.4 mg at approximately 2000 hours, as ordered.

Ms. Illangamudalige worked the night shift from September 25-26, 2018 and during this time she provided care to client MI. Paragraphs 38-42 of the Agreed Statement of Facts confirm that client MI had orders for the placement and removal of a Nitropatch at specific times. These

physician's orders were revised following the client's return from the Peter Lougheed Emergency Room. Ms. Illangamudalige was aware of the new physician's order, but failed to remove client MI's Nitropatch at the time specified. As a result, the new treatment plan for client MI was delayed. This was confirmed by the original and revised physician orders, and client MI's Progress Notes.

Based on the information provided, the Hearing Tribunal finds that Allegation 6 is factually proven. The failure to remove the client's Nitropatch could have caused real harm to the client and interfered with the course of treatment as the client's physician had set out. This reflects an absence of the application of the knowledge and skill which is expected of an LPN. The Hearing Tribunal finds that the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Allegation 7:

Ms. Illangamudalige admitted on or about February 15, 2019, she did one or more of the following with regards to client RS:

a. Failed to administer the scheduled dose of Morphine 2.5 mg at 0800 hours;
b. Failed to document on the MAR and/or progress notes the reason for not administering the Morphine 2.5 mg at 0800 hours in a timely manner; and
c. Failed to document on the MAR for the administration of Morphine 2.5 mg at 1400 hours.

Ms. Illangamudalige worked the day shift at the Facility on February 15, 2019 and during this time, she provided care to client RS. Paragraphs 43-49 of the Agreed Statement of Facts confirms that Ms. Illangamudalige failed to follow the Facility's policies on Medication Administration in administering Morphine to client RS at the time(s) ordered, improperly withheld the medication from client RS, and failed to properly document her actions on client RS's Medication Administration Record. This is confirmed in client RS's Medication Administration Record and Progress Notes, as well as a Medication Incident Report filled out by Ms. Illangamudalige.

Based on the information provided, the Hearing Tribunal finds that Allegation 7 is factually proven. Ms. Illangamudalige's conduct in failing to administer this client's medication and in failing to properly document medication as administered shows a lack of skill and judgment

other than is expected of an LPN. Further, these actions constitute breaches of the code of conduct and standards of practice as outlined below. Accordingly, the Hearing Tribunal finds that the following definitions of unprofessional conduct in s. 1(1)(pp) of the Act have been met:

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

(ii) contravention of the Act, a code of ethics or standards of practice.

Code Of Ethics

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

> **Principle 1**: Responsibility to the Public – 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; and
>
> 1.5 Provide care directed to the health and well-being of the person, family, and community.
>
> **Principle 2:** Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
>
> 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities;
>
> 2.8 Use evidence and judgement to guide nursing decisions; and
>
> 2.9 Identify and minimize risks to clients.
>
> **Principle 3**: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:
>
> 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession; and

3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

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

5.1 Demonstrate honesty, integrity and trustworthiness in all interactions; and

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

Ms. Illangamudalige's conduct in failing to administer medication as prescribed or in accordance with policy on multiple occasions, to document the care she provided to clients, in failing to take and record vital measurements amount to a failure to provide care directed at the health and wellbeing of her clients. She failed in her responsibility to her clients to apply her judgment and minimize risk or hamrful situations. This conduct was not consistent with what is expected of LPNs or the privilege of membership in a self-regulating profession. Finally, Ms. Illangamudalige's conduct was not consistent with her responsibilities to herself. As such, her conduct amounts to breaches of the above noted Principles of the Code of Ethics and in doing so she engaged in unprofessional conduct.

Standards of Practice

In addition, Ms. Illangamudalige's 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 state as follows:

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

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

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

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

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

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

2.1 Possess current knowledge to support critical thinking and professional judgment;

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

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

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:

3.3 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;

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

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

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

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

Ms. Illangamudalige engaged in mutiple instances of improper record keeping, improper adminsitration of medication and also failed to take and record vital information from her clients. In doing this she did not meet the competencies required of her, she introduced rather than minimized harm and compromised client safety. She did not document and record the care provided to her clients as is so essential to the practice of an LPN. She failed to apply her knowledge and training in order to enhance client outcomes. She failed in her service to the public and as a self-regulated profession by not providing health care services as a member of a team acting in the best interests of the public. In sum, she breached the provisions of the Standards of Practice set out above and therefore engaged in unprofessional conduct.

In summary, the Hearing Tribunal finds that the seven allegations regarding the conduct of Ms. Illangamudalige are factually proven, and her actions do rise to the level of unprofessional conduct as defined in the Act. The Hearing Tribunal then considered the Joint Submission on Penalty provided by the parties.

(9) Joint Submission on Penalty

The Complaints Consultant and Ms. Illangamudalige 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. Illangamudalige shall pay 25% of the costs of the investigation and hearing to be paid for a period of **48 months** subject to the following:

    a. Ms. Illangamudalige will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter");

    b. Ms. Illangamudalige shall notify the Complaints Consultant when she has secured employment, whether as an LPN or otherwise;

c. Payments of costs will not commence until the first of the month after she has secured employment; and

d. Should Ms. Illangamudalige secure employment prior to service of the Costs Letter, payment of costs shall commence on the first of the month following service of the Costs Letter.

3. Ms. Illangamudalige 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. Illangamudalige shall provide to the Complaints Consultant, a signed declaration within thirty (30) days of service of the Decision, attesting she has reviewed the following CLPNA documents:

   a. Code of Ethics for Licensed Practical Nurses in Canada;
   b. Standards of Practice for Licensed Practical Nurses in Canada;
   c. CLPNA Practice Policy: Professional Responsibility & Accountability;
   d. CLPNA Practice Policy: Documentation;
   e. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;
   f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
   g. CLPNA Competency Profile B1: Assessment;
   h. CLPNA Competency Profile C: Professionalism and Leadership; and
   i. CLPNA Competency Profile U: Medication Management.

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

4. Ms. Illangamudalige shall complete the course: **LPN Ethics** available online at http://www.learninglpn.ca/index.php/courses. Ms. Illangamudalige shall provide the Complaints Consultant with a certificate confirming successful completion of the course within 30 days of service of the Decision.

   If the course becomes unavailable, Ms. Illangamudalige shall request in writing to be assigned an alternative course prior to the deadline. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Illangamudalige will be notified by the Complaints Consultant, in writing, advising of the new course required.

5. Ms. Illangamudalige shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Illangamudalige shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within 60 days of service of the Decision.

   If the course becomes unavailable, Ms. Illangamudalige shall request in writing to be assigned an alternative course prior to the deadline. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Illangamudalige will be notified by the Complaints Consultant, in writing, advising of the new course required.

6. Ms. Illangamudalige shall complete, at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Illangamudalige shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within 6 months of service of the Decision.

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

7. Ms. Illangamudalige must within thirty (30) days of obtaining new employment as an LPN:

   a. Provide the Complaints Consultant with the name of her supervisor(s);
   b. Provide her supervisor(s) with a copy of the Decision in this matter;
   c. Provide her supervisor(s) with a copy of CLPNA's Medication Administration Skills Evaluation Tool; and
   d. Provide the Complaints Consultant with a written acknowledgment signed by her supervisor(s) confirming the receipt of a copy of the Decision.

8. Upon completion of three (3) months and then six (6) months of employment, the supervisor(s) must provide an evaluation of Ms. Illangamudalige's medication administration to the Complaints Consultant.

9. In the event the supervisor(s)'s evaluations referred to in paragraph 8 identify concerns with Ms. Illangamudalige's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the Act.

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

11. Should Ms. Illangamudalige 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. Illangamudalige 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. Illangamudalige's 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. Illangamudalige's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

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

The Hearing Tribunal is aware that 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, or brings the administration of justice into disrepute. 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 Consultant to enter into such agreements. If the Hearing Tribunal has 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. Illangamudalige and the Complaints Consultant.

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

The Hearing Tribunal recognizes that its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case. To assess whether the sanctions recommended will bring the administration of justice into disrepute the Hearing Tribunal considered the five objectives of sanctioning, namely:

- **Protection of the Public** – The CLPNA is a self-governing body established under the Health Professions Act and is responsible for regulation of the profession in the public interest. Protection of the public and the public interest is the primary objective in determining sanctions for unprofessional conduct.

- **Deterrence**- to ensure that recurrence of unprofessional practice is prevented. The objective of specific deterrence is to reinforce the requirement that the regulated member not engage in further unprofessional conduct in the future. The sanctions imposed on Ms. Illangamudalige will serve to guide her in the future and reinforce that unprofessional conduct has consequences which she would bear in the event of any future instances of unprofessional conduct.

  General deterrence has a similar objective with a broader audience. This sanction will communicate to other members of the profession that unprofessional conduct is unacceptable and will be dealt with by the CLPNA in accordance with the Act. This objective is reinforced by publishing decisions on CLPNA's website of Hearing Tribunals involving findings of unprofessional conduct, which are available for all members to read.

- **Rehabilitation** - The nature of Ms. Illangamudalige's actions needs to be addressed to ensure that there are no future concerns of this nature, or of any other unprofessional conduct. Having the correct policies and procedures in place, followed up by education and periodic external reviews will support proper medication administration and care provided to clients.

- **Fairness**- as related to the consequences of unprofessional conduct. The Hearing Tribunal recognizes the need of fairness in determining sanctions that are appropriate for the unprofessional conduct of Ms. Illangamudalige. The course work required, on the job supervision, and the assignment of costs together serve to recognize that Ms. Illangamudalige's conduct has direct consequences for patients. In addition, Ms. Illangamudalige has acknowledged the appropriateness of the orders made.

- **Integrity -** in terms of ensuring that the integrity of the profession is upheld and protected. The CLPNA is self-regulated and as such, is responsible for ensuring that the Code of Ethics and Standards of Practice are followed by all registered members, and for taking disciplinary action in cases of unprofessional conduct by a regulated member. Failure to maintain high professional standards and ethics by the CLPNA would serve to undermine public confidence in the profession and all registered LPNs.

In the Hearing Tribunal's view, the proposed penalties would protect the public from the type of conduct that Ms. Illangamudalige 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:

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

The Hearing Tribunal considered factors outlined in the *Jaswal* decision.

1. **The nature and gravity of the proven Allegations -** The Hearing Tribunal finds that most of the Allegations were of moderate severity; however, there were many charting failures that could have been dangerous in some of the situations. There was one serious situation set out in Allegations 1 and 2, where a client was given an incorrect dosage of Morphine. Incorrect administration of drugs like Morphine has the potential to be very harmful to clients in a nursing home situation. The Hearing Tribunal considers this to be an aggravating factor.

2. **The age and experience of the investigated member –** Ms. Illangamudalige has been a practicing LPN for 5 years. Medication administration is a core competency, and there is no excuse for the errors in her charting and administration of medication. These activities are

foundational to the profession of nursing, and are considered to be basic knowledge for any LPN. The Hearing Tribunal considers this to be an aggravating factor

3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions -** There was no evidence presented regarding prior complaints about Ms. Illangamudalige's practice.

4. **The age and mental condition of the victim, if any -** Ms. Illangamudalige's clients were nursing home residents. This is a population that is highly vulnerable. They may be unable to communicate their needs or even express how much discomfort they are in. Ms. Illangamudalige was in a nursing environment where it was critical that she report, record, and administer medications correctly in order to have continuity of care, as well as safety and comfort for those in her care. This factor was considered to be neutral.

5. **The number of times the offending conduct was proven to have occurred –** There were multiple errors identified over an eight month period.

6. **The role of the investigated member in acknowledging what occurred -** The Hearing Tribunal appreciates and commends Ms. Illangamudalige's cooperation with the College in admitting to her actions and unprofessional conduct. The Hearing Tribunal considers this to be a mitigating factor.

7. **Whether the investigated member has already suffered other serious financial or other penalties as a result of the Allegations having been made -** In direct consequence of her conduct, Ms. Illangamudalige received two unpaid suspensions from her employer, one for three days and one for five days. Ms. Illangamudalige was terminated from her employment at the Facility on March 29, 2019. The Hearing Tribunal was advised that Ms. Illangamudalige is not currently working. In view of these circumstances, the Hearing tribunal finds there is a mitigating element to this factor.

8. **The impact of the incident(s) on the victim –** No evidence was presented regarding actual harm to any of the clients under Ms. Illangamudalige's care, although there is the risk of potential harm from medication errors. This factor is considered to be neutral.

9. **The presence or absence of any mitigating circumstances –** Ms. Illangamudalige was cooperative during the investigation, and took ownership of her errors. Ms. Drennan noted that Ms. Illangamudalige had over one hundred clients under her care when working the night shift and she was responsible for a very busy workload that required ongoing multi-tasking.

It is important to send a message to other LPNs, and thereby to the public, that issues such as those under consideration today are taken seriously. 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. The CLPNA's primary purpose is to protect the public and ensure that the public has trust and confidence in the profession.

The Hearing Tribunal has considered all of the factors in the deliberation of this matter, and the seriousness of the member's actions. The proposed penalties in this case are intended, in part, to demonstrate to the profession that actions and unprofessional conduct such as this is not tolerated and the intent is that these orders will, in part, act as a deterrent to others.

The Hearing Tribunal is of the view that the proposed penalties adequately balance the factors referred to in *Jaswal* and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected. The orders also ensure that Ms. Illangamudalige's conduct will be remediated. As a result, the Hearing Tribunal finds the Joint Submission on Penalty appropriate, reasonable and not against the public interest in the circumstances and therefore accepts the parties' proposed penalties as outlined in Exhibit #3, the Joint Submission on Penalty.

(11) <u>Orders of the Hearing Tribunal</u>

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. Illangamudalige shall pay 25% of the costs of the investigation and hearing to be paid over a period of 48 months, subject to the following:

    a. Ms. Illangamudalige will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter");

    b. Ms. Illangamudalige shall notify the Complaints Consultant when she has secured employment, whether as an LPN or otherwise; and

    c. Payment of costs will not commence until the first of the month after she has secured employment; and

d. Should Ms. Illangamudalige secure employment prior to service of the Costs Letter, payment of costs shall commence on the first of the month following service of the Costs Letter.

3. Ms. Illangamudalige 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. Illangamudalige shall provide to the Complaints Consultant, a signed declaration within **thirty (30) days** of service of the Decision, attesting she has reviewed the following CLPNA documents:

   a. Code of Ethics for Licensed Practical Nurses in Canada;
   b. Standards of Practice for Licensed Practical Nurses in Canada;
   c. CLPNA Practice Policy: Professional Responsibility & Accountability;
   d. CLPNA Practice Policy: Documentation;
   e. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;
   f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
   g. CLPNA Competency Profile B1: Assessment;
   h. CLPNA Competency Profile C: Professionalism and Leadership; and
   i. CLPNA Competency Profile U: Medication Management.

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

4. Ms. Illangamudalige shall complete the course: **LPN Ethics** available online at http://www.learninglpn.ca/index.php/courses. Ms. Illangamudalige shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of the Decision.

   If the course becomes unavailable, Ms. Illangamudalige shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Illangamudalige will be notified by the Complaints Consultant, in writing, advising of the new course required.

5. Ms. Illangamudalige shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Illangamudalige shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

If the course becomes unavailable, Ms. Illangamudalige shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Consultant shall, in his sole discretion, reassign a course. Ms. Illangamudalige will be notified by the Complaints Consultant, in writing, advising of the new course required.

6. Ms. Illangamudalige shall complete at her own cost, the following course: **NURS 0161: Medication Management** offered on-line at www.macewan.ca. Ms. Illangamudalige shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **6 months** of service of the decision.

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

7. Ms. Illangamudalige must within **thirty (30)** days of obtaining new employment as an LPN:

   a. Provide the Complaints Consultant with the name of her supervisor(s);

   b. Provide her supervisor(s) with a copy of the Decision in this matter;

   c. Provide her supervisor(s) with a copy of CLPNA's Medication Administration Skills Evaluation Tool; and

   d. Provide the Complaints Consultant with a written acknowledgement signed by her supervisor(s) confirming the receipt of a copy of the Decision.

8. Upon completion of **three (3) months** and then **six (6) months** of employment, the supervisor(s) must provide an evaluation of Ms. Illangamudalige's medication administration to the Complaints Consultant.

9. In the event the supervisor(s)'s evaluations referred to in paragraph 8 identify concerns with Ms. Illangamudalige's practice, the Complaints Consultant may treat the information as a complaint in accordance with s. 56 of the Act.

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

11. Should Ms. Illangamudalige 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. Illangamudalige 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. Illangamudalige's 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. Illangamudalige's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

The Hearing Tribunal retains jurisdiction to address any issues arising from non-compliance with its orders.

DATED THE 25th DAY OF JUNE 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

James Lees, Public Member
Chair, Hearing Tribunal