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 KARLI CLIFTON

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 KARLI CLIFTON, LPN #27271, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference on December 4, 2023 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Sarah Kawaleski, LPN
Don Wilson, Public Member
Darwin Durnie, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Officer, CLPNA
Susan Blatz, Complaints Officer, CLPNA
Sanah Sidhu, Complaints Director, CLPNA

Investigated Member:
Karli Clifton, LPN ("Ms. Clifton" or "Investigated Member")
R. Frank Llewellyn, Legal Counsel 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. Clifton 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. Clifton was initially licensed as an LPN in Alberta in 2004.

The College of Licensed Practical Nurses of Alberta ("CLPNA") received a complaint dated January 27, 2023, (the "Complaint") from Dyan Lokhorst, Manager Unit 3C General Surgery at Chinook Regional Health Center in Lethbridge, Alberta, pursuant to s. 57 of the Health Professions Act (the "Act"), The Complaint advised Ms. Karli Clifton, LPN, had been suspended from her employment at the Chinook Regional Health Center ("CRHC") for concerns relating to failure to follow proper medication administration guidelines, possible narcotic diversion, and possible impairment.

By way of letter dated February 8, 2023, the Director of Professional Conduct/Complaints Director of the CLPNA, Sanah Sidhu ("Complaints Director"), provided Ms. Clifton with notice of the Complaint and notified Ms. Clifton that she was delegating her powers under Part 4 of the Act to Susan Blatz, Complaints Officer (the "Complaints Officer") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Clifton that she had appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint. Additionally, the Complaints Director informed Ms. Clifton that due to the nature of the alleged conduct, she was recommending to Carrie Waggott, Chief Executive Officer for the CLPNA, that Ms. Clifton's practice permit be subject to an immediate interim condition of "Narcotic Restriction" under s. 65(1)(b) of the Act.

The Complaints Director requested that Ms. Waggott impose an immediate interim condition of "Narcotic Restriction" on Ms. Clifton's practice permit under s. 65(1)(b) of the Act by letter on February 8, 2023. Ms. Clifton received a copy of this letter and its corresponding attachments.

By letter dated February 21, 2023, Ms. Waggott imposed an immediate interim condition of "Narcotic Restriction" on Ms. Clifton's practice permit pending the completion of any investigation and/or pending the outcome of disciplinary proceedings.

On May 4, 2023, the Investigator concluded the investigation into the Complaint.

The Complaints Officer determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Clifton received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report, on June 13, 2023.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Clifton under cover of letter dated November 2, 2023.

(4) Allegations

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

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

1) On or about October 20, 2022, documented on client MH's Medication Administration Record for the administration of Hydromorphone 1 mg at 2248 hours but failed to document the removal of Hydromorphone 1 mg from the Controlled Substances Record.

2) On or about October 21, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 1812 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

3) On or about October 21, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 2221 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

4) On or about October 22, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 1727 hours and 2235 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg at 1727 hours and 2235 hours.

5) On or about October 23, 2022, documented on client MH's System Assessments a PRN was given but failed to document any withdrawal for MH on the Controlled Substances Record and/or document the administration of any PRN on MH's Medication Administration Record and/or Nurses Notes.

6) On or about December 15, 2022, withdrew Morphine 5 mg from the Controlled Substances Record for client SR at 1535 hours but failed to document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Morphine 5 mg.

7) On or about December 16, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 1635 hours but failed to document on the Medication Administration Record and/or the Nurses Notes the reason for the removal of the Hydromorphone 1 mg.

8) On or about December 16, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 1921 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

9) On or about December 16, 2022, withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 2250 hours but failed to do one or more of the following:

a. document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg;

b. obtain a witness/co-signer for the wastage of 1 mg of Hydromorphone as required.

10) On or about December 18, 2022, withdrew Hydromorphone 2 mg from the Controlled Substances Record for client DM at 1530 hours but failed to document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Hydromorphone 2 mg.

11) On or about December 18, 2022, withdrew Hydromorphone 2 mg from the Controlled Substances Record for client DM at 1915 hours but failed to do one or more of the following:

a. document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Hydromorphone 2 mg;

b. document her signature on the Controlled Substances Record for the removal of the Hydromorphone 2mg.

12) [withdrawn]

13) [withdrawn]

(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. Clifton 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 Officer 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. Clifton'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. Clifton.

Allegation 1

Ms. Clifton admitted that on or about October 20, 2022, she documented on client MH's Medication Administration Record for the administration of Hydromorphone 1 mg at 2248 hours but failed to document the removal of Hydromorphone 1 mg from the Controlled Substances Record.

Client MH was ordered to receive 0.5-1.0 mg of Hydromorphone as needed (PRN) in the form of a subcutaneous injection.

On October 20, 2022, Ms. Clifton documented in MH's MAR that MH received a dose of Hydromorphone 1 mg at 2248 hours.

Ms. Clifton did not document the removal of Hydromorphone 1 mg for MH on the Controlled Substances Record.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

The conduct admitted to in this matter are very similar and overlapping. For this reason, the Hearing Tribunal will first review each of the allegations and confirm whether it accepts that the conduct in question constitutes unprofessional conduct but provide its reasons after all of the allegations are reviewed. Those reasons can be found below under the review of Allegation 11.

The Hearing Tribunal accepts the conduct in Allegation #1 is unprofessional conduct and provides its reasons for this finding below.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the removal of Hydromorphone from the Controlled Substances Record. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care. Medication administration and the documentation of medication administration is vital as this allows for a clear record of what medication a client has received. This allows any member of the healthcare team who is reviewing the charting to make a health decision with accurate information about the client so they can make an evidence-based decision. This also allows for double checking with medications to prevent the client receiving a double dose of medication, dosages can be properly tracked and to ensure that the client is receiving the proper dosage. This is especially important when it comes to narcotics.

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

CLPNA Code of Ethics:

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.

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:

    - 2.9 Identify and minimize risks to clients.

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

    - 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

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

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

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

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

CLPNA Standards of Practice:

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

    - 1.1 Practice within applicable legislation, regulations, by-laws, and employer policies.

    - 1.6 Adhere to established client safety principles and quality assurance measures to anticipate, identify, evaluate, and promote continuous improvement of safety culture.

    - 1.8 Are accountable and responsible for their own practice, conduct, ethical decision making.

    - 1.9 Document and report according to established legislation, regulations, laws, and employer policies.

b. Standard 3: Protection of the public through self-regulation – Licensed Practical Nurses collaborate with clients and other members of the healthcare team to provide safe care and improve health outcomes.

    - 3.3 Lead and contribute to a practice culture that promotes safe, inclusive, and ethical care.

    - 3.4 Provide relevant, timely, and accurate information to clients and healthcare team.

    - 3.5 Understand and accept the responsibility of self-regulation by following the standards of practice, the code of ethics, and other regulatory requirements.

c. Standard 4: Professional and Ethical Practice – Licensed Practical Nurses adhere to the ethical values and responsibilities described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics.

    - 4.5 Demonstrate effective, respectful, and collaborative interpersonal communication to promote and contribute to a positive practice culture.

    - 4.6 Demonstrate practice that upholds the integrity of the profession.

The Hearing Tribunal finds that Ms. Clifton's conduct constituted a breach of the CLPNA Code of Ethics and CLPNA Standards of Practice. The reasons provided here service all the findings relating to breaches of the Code of Ethics and the Standards of Practice.

Ms. Clifton failed to maintain standards of practice, professional competence, and conduct in that Ms. Clifton failed to document on Medication Administration Records, Controlled Substances Records, failed to do a pain assessment after the administration of a narcotic to a client, and failed to document in the Nursing Notes in regard to narcotic administration as well. These are core competencies that are expected of an LPN regardless of their experience.

By failing to adhere to proper documentation, Ms. Clifton did not identify and minimize risk to clients as these medication documentation errors deal with Hydromorphone which is a narcotic and controlled substance within the workplace. Hydromorphone belongs to the opioid drug class which includes morphine. It has an analgesic potency approximately two to eight times greater than that of morphine and has a rapid onset of action.

Ms. Clifton failed to maintain the standards of the profession and to conduct herself in a manner that is expected of another LPN in a similar situation. Medication administration and documentation is a core competency that is expected of an LPN. If Ms. Clifton was having some doubt with her practice then she should have asked for assistance from another member of the

health care team. This would allow Ms. Clifton to take responsibility for her own actions and to adhere to the self-regulation in which LPNs practice.

Allegation 2

Ms. Clifton admitted that on or about October 21, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 1812 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

On October 21, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for MH on the Controlled Substances Record at 1812 hours.

The administration of the Hydromorphone 1 mg at 1812 hours was documented on MH's MAR.

When a PRN medication is administered, health professionals are required to include and document a pain assessment describing the reason for administering the medication. Another pain assessment should be completed in the next 30 to 60 minutes to assess the effectiveness of the PRN medication.

Ms. Clifton did not document the reason for the administration of the Hydromorphone 1 mg at 1812 hours in the Nurses Notes.

According to the System Assessment notes MH denied any pain between 1630 hours and 2300 hours.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xiii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone in the Nurses Notes and/or the reason for the Administration. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care. Ms. Clifton failed to document a pain assessment which is important to document as other members of the health care team would need to follow up on the effectiveness of the medication with respect to the patient.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 3

Ms. Clifton admitted that on or about October 21, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 2221 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

On October 21, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for MH on the Controlled Substances Record at 2221 hours.

The administration of the Hydromorphone 1 mg at 2221 hours was documented on MH's MAR.

Ms. Clifton did not document the reason for the administration of the Hydromorphone 1 mg at 2221 hours in the Nurses Notes.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xiv. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone in the Nurses Notes and/or the reason for the Administration. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 4

Ms. Clifton admitted that on or about October 22, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client MH at 1727 hours and 2235 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg at 1727 hours and 2235 hours.

On October 22, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for MH on the Controlled Substances Record at 1727 hours and 2235 hours.

The administration of the Hydromorphone 1 mg was documented on MH's MAR for both the doses at 1727 hours and 2235 hours.

Ms. Clifton did not document any reason for the administration of the Hydromorphone 1 mg at 1727 hours or 2235 hours in the Nurses Notes.

According to the System Assessment notes MH denied any pain between 1630 hours and 2300 hours on October 22, 2022.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone in the Nurses Notes and/or the reason for the Administration. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 5

Ms. Clifton admitted on or about October 23, 2022, she documented on client MH's System Assessments a PRN was given but failed to document any withdrawal for MH on the Controlled Substances Record and/or document the administration of any PRN on MH's Medication Administration Record and/or Nurses Notes.

On October 23, 2022, Ms. Clifton documented the administration of a PRN to MH on the System Assessment.

Ms. Clifton did not document any withdrawal of Hydromorphone 1 mg for MH on the Controlled Substances Record, nor did she document the administration of any PRN on MH's MAR.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the removal of Hydromorphone from the Controlled Substances Record. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 6

Ms. Clifton admitted on or about December 15, 2022, she withdrew Morphine 5 mg from the Controlled Substances Record for client SR at 1535 hours but failed to document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Morphine 5 mg.

SR was ordered to receive 2.5-5 mg of Morphine intravenously or subcutaneously as needed (PRN).

On December 15, 2022, Ms. Clifton documented the removal of Morphine 5 mg from the Controlled Substances Record at 1535 Hours.

Ms. Clifton did not document the administration of the Morphine 5 mg on SR's MAR.

Ms. Clifton did not document any reason for the administration of the Morphine 5 mg at 1535 hours in the Nurses Notes.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone on the Medication Administration Record and/or Nurses Notes the reason for removal. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 7</u>

Ms. Clifton admitted on or about December 16, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 1635 hours but failed to document on the Medication Administration Record and/or the Nurses Notes the reason for the removal of the Hydromorphone 1 mg.

GO was ordered to receive 0.5-1 mg of Hydromorphone intravenously or subcutaneously as needed (PRN).

On December 16, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for GO on the Controlled Substances Record at 1635 hours.

Ms. Clifton did not document the administration of the Hydromorphone 1 mg on GO's MAR, nor did she document any reason for the administration of the Hydromorphone 1 mg at 1635 hours in the Nurses Notes.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone on the Medication Administration Record and/or Nurses Notes the reason for removal. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 8

Ms. Clifton admitted on or about December 16, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 1921 hours but failed to document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg.

On December 16, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for GO on the Controlled Substances Record at 1921 hours.

The administration of the Hydromorphone 1 mg was documented on GO's MAR at 1921 hours.

Ms. Clifton did not document any reason for the administration of the Hydromorphone 1 mg at 1921 hours in the Nurses Notes.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone in the Nurses Notes and/or the reason for the Administration. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 9

Ms. Clifton admitted on or about December 16, 2022, she withdrew Hydromorphone 1 mg from the Controlled Substances Record for client GO at 2250 hours but failed to do one or more of the following:

a) document in the Nurses Notes the administration and/or the reason for the administration of Hydromorphone 1 mg;

b) obtain a witness/co-signer for the wastage of 1 mg of Hydromorphone as required.

On December 16, 2022, Ms. Clifton documented the removal of Hydromorphone 1 mg for GO on the Controlled Substances Record at 2250 hours.

Ms. Clifton did not document any reason for the administration of the Hydromorphone 1 mg at 2250 hours in the Nurses Notes. An entry in the Nurses Notes at 2220 hours states GO denied any discomfort or pressure.

Ms. Clifton did not obtain another health care provider to witness and co-sign for wastage of 1 mg of Hydromorphone as required after she documented the removal of GO's dose at 2250 hours.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone in the Nurses Notes and/or the reason for the Administration. Ms. Clifton also did not obtain a witness/co-signer for the wastage of 1 mg of Hydromorphone as required. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 10

Ms. Clifton admitted on or about December 18, 2022, she withdrew Hydromorphone 2 mg from the Controlled Substances Record for client DM at 1530 hours but failed to document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Hydromorphone 2 mg.

DM was ordered to receive 1-2 mg of Hydromorphone intravenously as needed (PRN).

On December 18, 2022, Ms. Clifton documented the removal of Hydromorphone 2 mg for DM on the Controlled Substances Record at 1530 hours.

Ms. Clifton did not document the administration of the Hydromorphone 2 mg on DM's MAR, nor did she document the reason for the removal of the Hydromorphone 2 mg in the System Assessment and Nurses Notes.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone on the Medication Administration Record and/or Nurses Notes the reason for removal. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 11

Ms. Clifton admitted on or about December 18, 2022, she withdrew Hydromorphone 2 mg from the Controlled Substances Record for client DM at 1915 hours but failed to do one or more of the following:

a) document on the Medication Administration Record and/or Nurses Notes the reason for the removal of the Hydromorphone 2 mg;

b) document her signature on the Controlled Substances Record for the removal of the Hydromorphone 2mg.

On December 18, 2022, Ms. Clifton documented the removal of Hydromorphone 2 mg for DM on the Controlled Substances Record at 1915 hours.

Ms. Clifton did not document the administration of the Hydromorphone 2 mg on DM's MAR, nor did she document the reason for removal of the Hydromorphone 2 mg in the Nurses Notes.

Ms. Clifton did not document her signature as the person who removed the Hydromorphone 2 mg for DM at 1915 hours on December 18, 2022.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, in particular, the Hearing Tribunal found the following definitions of unprofessional conduct have been met:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

Medication administration and medication management are integral to the work of an LPN. Ms. Clifton failed to document the administration of Hydromorphone on the Medication Administration Record and/or Nurses Notes the reason for removal. Ms. Clifton also did not sign the Controlled Substance Record for the removal of the Hydromorphone 2 mg which is standard practice at her facility. By doing this Ms. Clifton displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience. This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care.

Ms. Clifton did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Clifton in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Clifton 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 decision (the "Decision") shall serve as a reprimand.

2. Ms. Clifton shall pay a fine of $2,000.00 within **24 months** of service of the Decision.

3. Ms. Clifton shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Karli Clifton shall provide a signed written declaration to the Complaints Officer, within thirty (30) days of service of the Decision, attesting she has reviewed the CLPNA's 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) The CLPNA Policy: Documentation;

    e) The CLPNA Policy: Medication Management.

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

4. Ms. Clifton shall complete, at her own cost, the course, **NURS 0161 Medication Management**, available online at www.macewan.ca. If the course becomes unavailable, Ms. Clifton shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. Clifton's written request, the Complaints Officer, in her sole discretion, may assign alternative education in which case Ms. Clifton will be notified in writing of the new education requirements. Ms. Clifton shall provide the Complaints Officer with a certificate confirming successful completion of the course.

5. The Narcotic Restriction on Karli Clifton's Practice Permit will remain in effect until confirmation of successful completion of the NURS 0161 Medication Management course.

6. Ms. Clifton shall provide the Complaints Officer with confirmation from a licensed Psychiatrist or Psychologist in Alberta, confirming she is fit to practice in the capacity of an LPN according to the "CLPNA's Interpretive Document: Fitness to Practice and HPA Definition of "Incapacitated"" located on the CLPNA's website at www.clpna.com.

7. The sanctions set out above at paragraphs 2 - 6 will appear as conditions on Ms. Clifton's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the educational readings and LPN Ethics Course outlined at paragraphs 4 - 7 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Clifton's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:
        i. Educational Readings;
        ii. NURS 0161 Medication Management; and
        iii. Fitness to Practice.

    b) The Narcotic Restriction will continue to appear on Karli Clifton's practice permit and the Public Registry until she/he provides proof to the Complaints Officer that she has successfully completed the requirement set out above at paragraph 5; and

    c) The requirement to pay the fine will appear as "Conduct Cost/Fines" on Karli Clifton's practice permit and the Public Registry until all fines have been paid as set out above at paragraph 2.

8. The conditions on Ms. Clifton's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Clifton be unable to comply with any of the sanctions' deadlines identified above, Ms. Clifton may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms. Clifton will be notified by the Complaints Officer in writing, if the extension has been granted.

11. Should Ms. Clifton fail or be unable to reasonably comply with any of the above orders for penalty, or if any dispute arises regarding the reasonable implementation of these orders, the Complaints Officer 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. Clifton's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or

    (c) In the case of non-payment of the costs described in paragraphs 2-3 above, suspend Ms. Clifton's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

Legal Counsel for the Complaints Officer 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. Clifton and the Complaints Officer.

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

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

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

The nature and gravity of the proven allegations: LPNs are expected to follow proper documentation requirements and medication administration requirements. When considered on a scale of seriousness of impact this is not the most serious type of conduct as compared to gross or willful neglect, but nonetheless it is still serious conduct as this is a basic core competency of what should be expected of an LPN. This is a failure to meet the minimum obligations of the profession and documentation of what has been done in nursing care and is the primary communication tool that is used to share information in a healthcare setting.

The age and experience of the investigated member: Ms. Clifton has been an LPN since 2004 and this type of conduct cannot be excused. Ms. Clifton has the knowledge and experience from her years of experience that Ms. Clifton would be expected to demonstrate the minimum competencies of an LPN. Ms. Clifton has been employed by this employer since 2004.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not made aware of any prior complaints or convictions with respect to Ms. Clifton.

The age and mental condition of the victim, if any: The Hearing Tribunal was made aware of the toll that this has taken on Ms. Clifton herself, in that Ms. Clifton is because of these allegations having extreme issues with anxiety and often has stress related to leaving her home.

The number of times the offending conduct was proven to have occurred: The Hearing Tribunal was presented with 11 allegations that took place over a period of October 20, 2022, until December 18, 2022. There are multiple instances over a two-month period. This was not a one-off situation as there was some repeated conduct.

The role of the investigated member in acknowledging what occurred: Ms. Clifton has acknowledged the lack of professional conduct and cooperated with the CLPNA Complaints Officer, which is a mitigating circumstance that the Hearing Tribunal did consider.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Clifton originally received a three day suspension from work without pay on February 2, 3, and 4, 2023. Ms. Clifton has also agreed to pay a fine of $2,000. The Hearing Tribunal notes that CLPNA did not pursue any of the hearing costs in the matter.

The impact of the incident(s) on the victim, and/or: There was a risk for patient concern given the lack of administration documentation even though there was no patient harm; this was not a mitigating factor.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware 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: There is a need to impose a sanction that deters Ms. Clifton from repeating this conduct as well as a sanction that would deter other LPNs from engaging in similar conduct. The sanctions that are ordered should send a message to both Ms. Clifton as well as other LPNs to state that this type of conduct will not be tolerated by the CLPNA. The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the CLPNA Code of Ethics and CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

The need to maintain the public's confidence in the integrity of the profession: The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches of the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

The range of sentence in other similar cases: The Hearing Tribunal was not made aware of any similar cases.

It is important for 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 decision (the "Decision") shall serve as a reprimand.

2. Ms. Clifton shall pay a fine of $2,000.00 within **24 months** of service of the Decision.

3. Ms. Clifton shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Karli Clifton shall provide a signed written declaration to the Complaints Officer, within thirty (30) days of service of the Decision, attesting she has reviewed the CLPNA's 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) The CLPNA Policy: Documentation;

    e) The CLPNA Policy: Medication Management.

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

4. Ms. Clifton shall complete, at her own cost, the course, **NURS 0161 Medication Management**, available online at www.macewan.ca. If the course becomes unavailable, Ms. Clifton shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. Clifton's written request, the Complaints Officer, in her sole discretion, may assign alternative education in which case Ms. Clifton will be notified in writing of the new education requirements. Ms. Clifton shall provide the Complaints Officer with a certificate confirming successful completion of the course.

5. The Narcotic Restriction on Karli Clifton's Practice Permit will remain in effect until confirmation of successful completion of the NURS 0161 Medication Management course.

6. Ms. Clifton shall provide the Complaints Officer with confirmation from a licensed Psychiatrist or Psychologist in Alberta, confirming she is fit to practice in the capacity of an LPN according to the "CLPNA's Interpretive Document: Fitness to Practice and HPA Definition of "Incapacitated"" located on the CLPNA's website at www.clpna.com.

7. The sanctions set out above at paragraphs 2 - 6 will appear as conditions on Ms. Clifton's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the educational readings and LPN Ethics Course outlined at paragraphs 4 - 7 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Clifton's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:
        i. Educational Readings;
        ii. NURS 0161 Medication Management; and
        iii. Fitness to Practice.

    b) The Narcotic Restriction will continue to appear on Karli Clifton's practice permit and the Public Registry until she/he provides proof to the Complaints Officer that she has successfully completed the requirement set out above at paragraph 5; and

    c) The requirement to pay the fine will appear as "Conduct Cost/Fines" on Karli Clifton's practice permit and the Public Registry until all fines have been paid as set out above at paragraph 2.

8. The conditions on Ms. Clifton's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

9. Ms. Clifton 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. Clifton will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Ms. Clifton be unable to comply with any of the sanctions' deadlines identified above, Ms. Clifton may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms. Clifton will be notified by the Complaints Officer in writing, if the extension has been granted.

11. Should Ms. Clifton fail or be unable to reasonably comply with any of the above orders for penalty, or if any dispute arises regarding the reasonable implementation of these orders, the Complaints Officer may do any or all of the following:

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

(e) Treat Ms. Clifton's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or

(f) In the case of non-payment of the costs described in paragraphs 2-3 above, suspend Ms. Clifton's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

DATED THE 27th DAY OF DECEMBER 2023 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal