IN THE MATTER OF *THE LICENSED PRACTICAL NURSES ACT, 2000* AND BYLAWS AND A FORMAL COMPLAINT DATED APRIL 11, 2011 AGAINST MARIA LARSON, LPN, OF GRENFELL, SASKATCHEWAN, SALPN File No. 38-10

DECISION OF:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

INTRODUCTION:

The hearing by the Discipline Committee into the complaints against Maria Larson was convened in the Cedar Room of the Best Western Seven Oaks Hotel in Regina, Saskatchewan, on May 10, 2011 at 9:00 a.m., being the date and time set out in the Notice of Hearing sent to Maria Larson. Ms. Larson participated in the hearing by way of teleconferencing. Present at the hearing were Merrilee Rasmussen, Q.C., legal counsel for the Counselling and Investigation Committee of the Saskatchewan Association of Licensed Practical Nurses (referred to as the "Investigation Committee") and Della Bartzen, SALPN Investigator.

The complaint against Ms. Larson that is the subject of this hearing involves an allegation of professional misconduct and/or professional incompetence on the basis that Ms. Larson altered the Medication Administration Record, a medical document, by voiding two entries made by her colleagues.

EVIDENCE:

At the outset of the hearing, the following Agreed Statement of Facts and Documents was filed with the Discipline Committee [the information referenced in the "Tabs" is not included]:

Both the Counselling & Investigation Committee of the Saskatchewan Association of Licensed Practical Nurses and Maria Larson hereby agree to the following facts and documents to be received in evidence by the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses in relation to the hearing of the formal complaint described above:

1. *Maria Larson is a member of the Saskatchewan Association of Licensed Practical Nurses ("SALPN"), registration number 10132. She has been a member of SALPN since May 15, 2000. She graduated as an LPN in Ontario in 1986 and was a practising LPN in that province before coming to Saskatchewan. A copy of her resume is attached at Tab A.*

2. *Membership in SALPN, and the conduct of members, is governed by* The Licensed Practical Nurses Act, 2000 *(the "Act"), the SALPN bylaws, and the Code of Ethics.*

3. *As a self-regulating profession, SALPN is authorized by the Act to discipline its members for failure to adhere to the requirements of the Act, the bylaws, or the Code of Ethics.*

4. *Pursuant to s. 26 the Act, the Counselling and Investigation Committee (the "Investigation Committee") is required to investigate allegations of professional misconduct, and on completion of its investigation, to make a written report to the Discipline Committee recommending that either that the subject matter of the complaint be referred for a discipline hearing or that no further action be taken.*

5. *A written complaint dated July 20, 2010 regarding the nursing practice of Ms Larson was received by SALPN from [redacted] LPN, then-manager of Grenfell Pioneer Home, being the facility where Ms Larson was working. In that complaint Ms [redacted] alleged that Ms Larson had falsified a medical record, failed to follow a physician's orders in the administration of prescribed medications, and had breached a patient's confidentiality by discussing with the resident a complaint made by the resident to Ms [redacted] as manager of the facility. The written complaint was referred to the Investigation Committee for review and investigation pursuant to ss. 26(1) of the Act. A copy of the complaint is provided at Tab B.*

6. *In the course of its investigation, the Investigation Committee caused its Investigator to interview the complainant, the member and other persons employed in the facility where the member worked. After completing its review and investigation of the complaint, and being unable to obtain the consent of the complainant to a resolution of the complaint by agreement, the Investigation Committee recommended that the Discipline Committee should hear and determine the formal complaint against Ms Larson. The Investigation Committee's report containing the formal complaint was submitted to the Discipline Committee on April 11, 2011. A copy of the report and formal complaint is attached at Tab C.*

7. *Ms Larson has not been working or practising as an LPN since July 19, 2010, when she was called to a meeting with Ms [redacted] a representative of the RQHR human resources department, and a union representative about these three incidents, at which time she was administered a three-day suspension by her employer. Her licensing status at this time is non-practising.*

Charge #1

8. *Ms Larson says that on May 25, 2010, she was working nights, from 6:30 pm to 6:30 am. While comparing the Medical Administration Records (MARs) to the doctor's orders, she noted that a new order for Celexa had been made for patient A. Previous doctor's orders dated August 18, 2009 and August 21, 2009 also referred to the drug to be administered by its brand name, Celexa, as did the doctor's order dated May 25, 2010. The drug was already listed under its generic name (citalopram) on the MAR for the month of May,*

apparently pursuant to the doctor's order from August 2009. On May 25, 2010 during the day shift, an RN added the new order on the MAR by hand, referring to the drug by its brand name. The RN also made note of the new order in the communication book. A copy of the doctor's orders, the MAR, and the communication book entry for patient A is attached at Tab D.

9. *During the night shift on May 25-26, 2010, Ms Larson discovered the two entries on the MAR that referred to the same drug, and believed this represented an error. The RN who administered the drugs to patient A on May 25 initialled the MAR for the generic drug and the brand name drug, indicating that a double dose of the drug had been administered. It is not clear whether the double dose had in fact been administered. Ms Larson checked patient A's bubble pack for May 26 and saw that it had been prepared with two doses of the drug, one for the brand name entry and one for the generic name entry. She removed one of the doses from the package so that it could not be administered.*

10. *Patient A received her medications during the day shift on May 26, 2010. The LPN who administered the drugs initialled the MAR for the generic drug and the brand name drug, indicating that a double dose of the drug had been administered. However, there had only been one dose present in the pack, thus the MAR was not accurate.*

11. *The error in the charting was discovered during the night shift on May 26, 2010. Ms Larson believed that the double entries for both May 25 and May 26 were erroneous. Ms Larson advised her colleagues who had charted the administration of the drugs that the error should be corrected by writing "VOID" beside one of the two entries for each day and initialling. Ms Larson therefore wrote the word "VOID" on the chart, but did not initial that entry, nor did the RN and the LPN who had charted that the medication had been administered. Nothing further was said to Ms Larson about this until her meeting in July with management and human resources.*

Charge #2

12. *On June 6-7, 2010, Ms Larson was again working nights. Patient B was up at 3:00 am and was very agitated. Ms Larson noticed that her bath things were set out and ready for the next morning. Patient B regularly becomes agitated when she has to take a bath. Ms Larson believed that patient B was upset because she thought it was bath time. The doctor's order for patient B prescribed "Ativan 1 mg p.o. (ac bath) prn". Patient B asked for the pill that she got before her bath because she was feeling very anxious. Ms Larson checked her pulse and it was 97, while it was normally 68, although her blood pressure was normal. Ms Larson removed the bath things from patient B's room and gave her the Ativan as well as tea with milk and honey and sat with her til she settled down. She administered the Ativan and charted it in the MAR, then went off shift at 6:30 am. On June 10, 2010, an entry was recorded in the communication book attempting to*

clarify the prescription. A copy of the doctor's order, the MAR, and the communication book entry for patient B is attached at Tab E.

Charge #3

13. *During May 23-24, 2010 (Sunday/Monday) night shift, patient C climbed over her bedrail to get to the bathroom because her call button was not working and no one came when she called for help. May 24, 2010 was Victoria Day. Ms Larson was not working on May 23-24, but was working on May 24-25 (Monday/Tuesday). During her shift on May 24-25, Ms Larson had a conversation with patient C, who was concerned about her call button not working. Ms Larson told patient C that she would come by to check on her more frequently and help her get to the bathroom if she needed to and that she could speak to Ms [redacted] the manger of the facility, about it in the morning. Maintenance did not check the call button until Tuesday because of the long weekend.*

14. *When Ms Larson came on shift on May 25-26 (Tuesday/Wednesday), there was a memo from Ms [redacted] waiting for her. A copy of the letter is attached at Tab F. Ms Larson replied to that letter and a copy of her reply letter is attached at Tab G. Ms Larson did not talk to patient C about Ms [redacted] letter; she talked to the patient about the patient's concerns that her bed rails were now down. Ms Larson explained that they were down because the patient had crawled over them, and if that was going to happen again it was safer to have them down. The patient told Ms Larson that she hadn't climbed over the rails on Monday/Tuesday, but on the previous night (when Ms Larson had not been working). Ms Larson said she was only trying to clarify this point for Ms [redacted] who seemed to think that the incident had occurred while Ms Larson was on shift. In addition to writing the letter to Ms [redacted] in response, Ms Larson waited after her shift on Wednesday morning to speak to Ms [redacted] about it. Ms Larson did not in fact talk to the patient about Ms [redacted] letter.*

15. *On May 26, 2010 when Ms Larson arrived at work for the Wednesday/Thursday shift, she went directly to the Resident Care Coordinator's office and worked there all night at other work, an didn't interact with any of the patients.*

16. *With respect to charge #1, Ms Larson acknowledges that she wrote VOID on the chart relating to medications that she had not administered.*

17. *The Investigation Committee withdraws the formal complaint in relation to charges #2 and #3 for the reason that:*

    (a) *In the case of charge #2, there was a genuine ambiguity in the doctor's orders that was also questioned by at least one other member of the nursing staff, and Ms Larson accurately charted her administration of the medication in question;*

(b) In the case of charge #3, there was a misunderstanding on the part of management as to the timing of Ms Larson's conversation with the resident.

SUBMISSIONS OF PARTIES:

Legal Counsel for the Counselling and Investigation Committee submitted that the Discipline Committee should accept the facts set out in the Agreed Statement of Facts and Documents. Legal counsel confirmed that the Counselling and Investigation Committee withdraws charges #2 and #3 in the formal complaint for the reasons stated and therefore, the only charge before the Discipline Committee for a determination is charge #1.

Legal counsel for the Counselling and Investigation Committee noted that while the Member's employer ("the complainant") reported the Member's conduct as the "falsification of a medical document," the Counselling and Investigation Committee viewed it not as "falsification," but rather as an "alteration" of a medical record. Accordingly, the charge reads: "On May 26, 2010, she altered the Medication Administration Record, a medical document, by voiding two entries without the knowledge or consent of the person who had recorded the entries." The Counselling and Investigation Committee takes the position that the Member improperly altered the medical records by writing the word "Void" on the Medication Administration Record in relation to an entry made by the co-worker who administered the medication. It is not the use of the word "void" that is objectionable, but rather the fact that she altered an entry that was not hers. Compounding the problem was that in making such an alteration, the Member failed to initial the change she made. The Counselling and Investigation Committee took the position that the Member's conduct amounts to professional incompetence and/or professional misconduct, having noted in the formal complaint that this conduct is also in contravention of s. 19 of *The Health Information Protection Act*. In terms of appropriate penalties for a finding of professional incompetence and/or misconduct, the Counselling and Investigation Committee suggested that the Discipline Committee issue a formal reprimand and order the Member to review the charting procedures and comply with those procedures in the future.

Counsel pointed out that the primary objective of this process is not to punish LPNs but to ensure they act appropriately and meet the standards of the profession. Counsel submitted that a formal reprimand is one of the less serious penalties available but it is an appropriate way in which to convey the message to the Member and other LPNs that medical records cannot be altered in any way.

In response to the submissions of the Counselling and Investigation Committee, the Member provided further information about how she came to write the word "void" on two entries on the Medication Administration Record. She said she met with the RN and LPN who had each administered this patient's medications during their respective day shifts on May 25 and 26, 2010, and asked them if they noticed the fact that the medication orders included two of the same type of medication – one by its brand name and the other its generic name. She showed them that they had both initialled the Medication Administration Record as having given both medications to the patient.

The Member said she had asked the RN and LPN if they had each given the patient both medications and

the RN and LPN denied having done so. The Member said she then told them they should correct the Medication Administration Record by marking one medication entry as "void". The LPN responded that she was in a hurry, that the Member could write it in, and that she'd deal with it the next day. The RN responded to the Member that he didn't know what "void" meant and that they should use "white-out" [meaning correction fluid] over the initials instead. Both the Member and the LPN told the RN that white-out cannot be used; that that issue had been discussed many times and the manager was clear that white-out should not be used on a medical record. The Member also showed the RN a "document standards" document used by the health region. The Member proceeded to write the word "void" on the Medication Administration Record. The Member said that because the RN was still confused about the issue, he took the Medication Administration Record and the "document standards" document to their manager.

The Member maintains the position that her writing of the word "void" on the entries in question is appropriate and not an "alteration of a medical record." Writing the word "void" on a Medication Administration Record acts as a "flag" to show that there's been an error or improper entry so that someone else will notice it when they look at the Medication Administration Record to see if the patient needs anything. The Member stated that there was still a medication error that needed to be dealt with - all she had done was draw attention to the error by having written the word "void" on the Medication Administration Record. She submitted that simply writing the word "void" on the Medication Administration Record does not "change" the record – she did not draw a line through or cross out the original entry, nor did she initial her writing as a change or correction. In a further response, the Member insisted that her use of the word "void" was an effective means to "flag" or draw attention to the issue.

In reply to the Member's submissions, legal counsel for the Counselling and Investigation Committee pointed out that the information given by the Member during this hearing is different than what they previously discussed while preparing the Agreed Statement of Facts. Specifically, counsel says that the Member made no mention of the conversation she had with the LPN and RN who had administered the patient's medications. However, counsel submitted that the new information provided by the Member is of no consequence. The facts remain that the Member acknowledged writing the word "void" on the Medication Administration Record in relation to an entry made by someone else and also, that the Member failed to initial her own entries (of the word "void") on the Medication Administration Record. Counsel stated that the appropriate course of action would have been to have the RN and LPN each correct their own entries. If that was not possible, the Member should have made a notation elsewhere (i.e. not in a medical record) in order to draw attention to the errors. Under no circumstances should the Member have altered or changed someone else's entry on a medical record. The fact that the Member did not cross out or specifically change any of the entries made by others is irrelevant – writing anything on the chart amounts to an alteration.

The Member indicated that she looks forward to having this medication/charting issue clarified. She indicated that, if she is to receive a penalty for her conduct, she is open to receiving education about the matter at issue because she is unclear about why her conduct was improper. The Member opposed the penalty of a formal reprimand.

DECISION:

The primary issues before the Discipline Committee are:

i. Whether the conduct of Ms. Larson is "professional incompetence" within the meaning of s.23 of the *Act* and/or "professional misconduct" within the meaning of s.24 of the *Act*; and

ii. If so, what penalties under s. 30 of the *Act* are appropriate in the circumstances.

The relevant sections of the *Act* are sections 23, 24 and 30, which read as follows:

> *23. Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:*
>
> *(a) continue in the practice of the profession; or*
>
> *(b) provide one or more services ordinarily provided as a part of the practice of the profession;*
>
> *is professional incompetence within the meaning of this Act.*
>
> 24. *Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this* Act *if:*
>
> *(a) it is harmful to the best interests of the public or the members;*
>
> *(b) it tends to harm the standing of the profession;*
>
> *(c) it is a breach of this Act or the bylaws; or*
>
> *(d) it is a failure to comply with an order of the counselling and investigation committee, the discipline committee or the council.*
>
> *30(1) Where the discipline committee finds a member guilty of professional misconduct or professional incompetence, it may make one or more of the following orders:*
>
> *(a) an order that the member be expelled from the association and that the member's name be struck from the register;*
>
> *(b) an order that the member's licence be suspended for a specified period;*
>
> *(c) an order that the member's licence be suspended pending the satisfaction and completion of any conditions specified in the order;*

(d) an order that the member may continue to practise, but only under conditions specified in the order, which may include, but are not restricted to, an order that the member:

(i) not do specified types of work;

(ii) successfully complete specified classes or courses of instruction;

(iii) obtain medical or other treatment or counseling or both;

(e) an order reprimanding the member;

(f) any other order that the discipline committee considers just.

(2) In addition to any order made pursuant to subsection (1), the discipline committee may order;

(a) that the member pay to the association, within a fixed period:

(i) a fine in a specified amount not exceeding $5,000; and

(ii) the costs of the investigation and hearing into the member's conduct and related costs, including the expenses of the counseling and investigation committee and the discipline committee and costs of legal services and witnesses; and

(b) where a member fails to make payment in accordance with an order pursuant to clause (a), that the member's licence be suspended.

(3) The executive director shall send a copy of an order made pursuant to this section to the member whose conduct is the subject of the order and to the person, if any, who made the complaint.

(4) Where a member is expelled from the association or a member's licence is suspended, the registrar shall strike the name of the member from the register or indicate the suspension on the register, as the case may be.

(5) The discipline committee may inform a member's employer of the order made against that member where that member has been found guilty of professional misconduct or professional incompetence.

As stated previously, the first issue for our determination is whether Ms. Larson's conduct is "professional incompetence" within the meaning of s. 23 of the *Act* and/or "professional misconduct" within the meaning of s. 24 of the *Act*. "Professional incompetence" is defined in s. 23 of the *Act* in terms of a "lack of knowledge, skill or judgment" of the type that shows that the member is not fit to either

continue practicing as an LPN or providing one or more of the usual services of an LPN. "Professional misconduct" covers a broader range of conduct by a member, including conduct both within and outside the workplace. Whether an LPN is guilty of professional incompetence and/or professional misconduct is a question of fact and certain conduct may give rise to a finding of one or the other, or both.

For the most part, the facts of this case are not in dispute. During the parties' submissions, legal counsel for the Counselling and Investigation Committee suggested that in her submissions, Ms. Larson added factual information that was different than what she mentioned during the preparation of the Agreed Statement of Facts. Although the Discipline Committee does not usually consider unsworn evidence without the consent of both parties, in this case, we find it appropriate to take into account the additional information Ms. Larson provided at the hearing, information that is summarized in this decision under the section "Submissions of Parties." In our view this new information does not conflict with the facts that had been agreed upon. The new information simply expands on the statements in paragraph 11 of the Agreed Statement of Facts that "Ms. Larson advised her colleagues who had charted the administration of the drugs that the error should be corrected by writing "void" beside one of the two entries for each day and initialling". Furthermore, we believe it likely that Ms. Larson, who was not represented by legal counsel, would not have understood what information was relevant and important for her to mention during the preparation of the Statement of Agreed Facts. Lastly, while we find that the new information is helpful to our understanding of the entire circumstances, the new information is more relevant to the issue of penalty and does not affect our findings on the question of whether Ms. Larson's conduct amounts to professional incompetence and/or misconduct. We also note that even though the formal complaint alleged that Ms. Larson altered the medical records "without the knowledge or consent of the person who had recorded the entries," that was not the primary focus of the complaint at the hearing – counsel for the Investigation Committee focused on the inappropriateness of the alternations to the medical record and the failure to initial the alterations.[1]

The Discipline Committee finds, on the basis of the evidence and after considering the parties' submissions, that Ms. Larson did alter the medical records by writing the word "void" on two entries on the Medication Administration Record. Even though Ms. Larson did not cross out any information on the Medication Administration Record when she wrote the word "void", she made an "alteration" to the record because in doing so, she intended to alter or change the effect or meaning of the RN's and LPN's entries. In our view, she wrote the word "void" not only to flag the issue of an apparent problem with the medications ordered, but to "correct" the Medication Administration Record to show that the double doses had not been administered. Also of concern, although less so in our view, was Ms. Larson's failure to initial her changes to the record. We do not accept Ms. Larson's explanations that she didn't initial her entries either because the LPN and RN were to do so, or because it was only her intention to send the message that there was a problem with the orders rather than an intention to actually change the entries. We note that this is at odds with her statement that she advised the others to write the word "void" and initial it. In our view, her decision not to initial does not negate the fact that she did indeed change the record.

[1] In fact, the above noted statements in paragraph 11 of the Agreed Statement of Facts clearly reference a discussion Ms. Larson had with her colleagues about the charting error. As such, there is some agreed upon evidence that the RN and LPN had knowledge of the Member's changes to the record.

While Ms. Larson demonstrated conscientiousness by identifying the potential problem in the first place, she responded to it in an inappropriate manner – even if the RN and LPN said that they didn't give the double dose, these were not Ms. Larson's entries to change (regardless of the fact that the RN and LPN had knowledge of Ms. Larson's change or that the LPN may have consented to that change). In this regard, we also note that while she had personal knowledge that the double dose had not been given by the LPN on May 26th (because Ms. Larson, having discovered the error during the preceding nightshift, removed a second dose from the patient's bubble pack for May 26th), she had no such personal knowledge about the medications the RN gave the patient on May 25th. At the hearing Ms. Larson stated that in her conversation with the LPN and RN, the RN said he did not give the double dose. Even if it was not improper for Ms. Larson to have written the word "void" in relation to that entry, this was an unreliable basis on which to do so. Aside from the issue of the reliability of the RN's memory, it would seem illogical for the RN to have not given the double dose (both of which were presumably in the bubble pack) and then not make note of this fact.

We suggest that once Ms. Larson had this conversation with the RN, she should have identified the possibility that a medication error had been made, whether that occurred because of the possible administration of medications made according to orders that were incorrect, or that medications were not administered in accordance with the medication orders. In such circumstances, the usual response would be to complete an incident report. This too would have "flagged" the issue of whether there was an error in the medication orders and what dosage of the medications the patient should be receiving.

We appreciate that Ms. Larson's intentions were good – she primarily wanted to flag the issue of the orders for duplicate medications for clarification/correction and ensure the patient received the proper dose of medication. In our view, however, there were other ways to do so without altering entries made by others. For example, making a note in the communications book would have been appropriate and would have allowed her to provide additional important information, including specific mention of the fact that the medication orders required clarification and that there were questions about the medications signed for by the RN and LPN.

Although not an issue indentified by the Investigation Committee, we also question Ms. Larson's conduct in removing one of the doses of the medication in question from the patient's bubble pack for May 26th. Again, Ms. Larson's conscientiousness led her to notice what appeared to her to be an error in the medication orders – there had been a long standing order for Citalopram 20 mg (the generic drug) when, on May 25th, an order was made for Celexa 20 mg. We question the appropriateness of her decision to unilaterally remove one of the medications from the May 26th bubble pack. In doing so, she was making the assumption that the most recent medication order the doctor made was an error because there was already a medication order for the same dosage of the medication by its generic name.[2] This should have prompted Ms. Larson to take steps to clarify the order instead of (or at least before) removing the duplicate medication from the bubble pack. In our view, Ms. Larson acted outside the scope of her authority as an LPN.

[2] Incidentally, we note that there was a new medication order made on May 28, 2010 for Celexa (Cita10 pram) 40 mg.. This replaced the medication orders in place at the time of the conduct in issue here, that is, the long-standing order for Citalopram 20 mg (the generic brand) and the May 25, 2010 order for Celexa 20 mg. This suggests that Ms. Larson's presumption that the May 25th medication order was an error was likely not correct.

In our view, Ms. Larson's conduct is more in the nature of professional misconduct that professional incompetence. A finding of professional incompetence is often made where there are a series of errors that demonstrate that an LPN has a lack of knowledge or skill, or displays poor judgment, in relation to either specific services or duties that are typically performed by LPNs or the practice of an LPN as a whole. Although less common, even without a series of errors or a pattern of mistakes, professional incompetence might still be established if the conduct in question displays a lack of knowledge/skill/judgment so significant that it clearly demonstrates that the LPN is unable to perform a specific service or to practice at all as an LPN.

In the present case, Ms. Larson's conduct might be characterized as demonstrating a lack of judgment. However, it is very clear that Ms. Larson has not made a series of errors. While the importance of accurate and appropriate charting in relation to patient medications (a core duty of an LPN) cannot be understated, in this case, Ms. Larson's lack of judgment was not so serious as to demonstrate that she is unfit to continue to practice as an LPN or to provide any specific service as an LPN.

The Discipline Committee finds that Ms. Larson's conduct in: (i) altering medication record entries made by others; (ii) failing to initial her entries on the medical record; (iii) failing to appropriately make known her concerns about the possible error in the medication orders; and (iv) having removed from the patient's bubble pack one dose of what appeared to her to be a double dose ordered in error, amounts to "professional misconduct" within the meaning of sections 24(a) and (b) of the *Act*. The failure to properly administer medications in accordance with doctor's orders and to chart medications in accordance with accepted practices and the rules of the facility is harmful to the best interests of the public, including the patient. It is reasonable for the public to expect that an LPN will follow the doctor's medication orders and, if necessary, seek to clarify those orders in an appropriate way. It is also reasonable expectation of the public that the charting of their medical records will be accurate, clear and without error. Adding to or altering a medical record entry made by someone else is also conduct that is harmful to the best interests of the members, each of whom have a responsibility to properly administer and chart medications, because it raises possible questions about the accuracy of the entries they have charted.

Furthermore, Ms. Larson's conduct tends to harm the standing of the profession. In recent years, LPNs have become responsible for the task of administering medications. Along with that responsibility comes the duty to perform that function properly and in accordance with the standards of the profession and the rules of the facility. Altering medication record entries made by someone else, and doing so in a way not generally accepted, amounts to a failure to properly chart the administration of medications. In addition, the removal of medications from a patient's bubble pack amounts to having made a decision about the type of medications a patient receives and it is a decision outside the scope of the Member's authority. In our view, the Member's conduct reflects poorly on the profession.

PENALTY:

Having concluded that Ms. Larson's conduct amounts to professional misconduct under s. 24 of the *Act*, it is necessary for us to determine an appropriate penalty pursuant to s. 30 of the *Act*. While the alteration of a medical record can be a very serious matter warranting serious consequences, there are a number of mitigating factors in this case that we have taken into account in determining the appropriate penalties.

They include:

- that Ms. Larson demonstrated conscientiousness by promptly identifying a possible error in the patient's medication orders - the second order was made only that day and it had not been Ms. Larson's responsibility to administer that patient's medications that day;
- that upon discovering this potential problem, Ms. Larson took immediate steps to determine if the medication orders were being filled as per the doctors' orders;
- that she immediately raised the potential problem with the employees who had been responsible for administering the medications;
- that even though she improperly altered the record by writing the word "void" next to the entries, she did not delete information (or cross-out information) - this, along with the fact that she discussed the issue with her colleagues, demonstrates that these alterations were not of the type that attempted to conceal or mislead; and
- that Ms. Larson cooperated with the investigation into her conduct and participated in the hearing process - although Ms. Larson defended her conduct vigorously, she had a genuine interest in understanding any problems with her conduct and in learning appropriate professional standards.

Although several mitigating factors are present, we are of the view that the conduct in question was clearly improper and of sufficient seriousness that a formal reprimand should be given. A formal reprimand is one of the least serious orders the Discipline Committee may make in response to a finding of professional incompetence or professional misconduct. In addition, we also find it appropriate to make an order that is remedial in nature as it is not our aim to punish the Member. In this regard, we find it appropriate to make an order requiring Ms. Larson to review the policies and procedures in her workplace that relate to the administration of medication and proper charting. We believe that this can be accomplished through a review within her workplace rather than through a formal course of instruction.

Therefore, pursuant to s. 30 of the Act, the Discipline Committee makes the following orders:

1. That Maria Larson be formally reprimanded in respect of her professional misconduct;
2. That Ms. Larson review the policies and procedures in her workplace that relate to the administration of medication and proper charting with her manager or someone designated by her manager. If Ms. Larson's manager will not assist Ms. Larson with such a review, Ms. Larson may review these policies and procedures on her own. In either case, Ms. Larson must provide her written confirmation that she has completed this review to the Investigation Committee of the Saskatchewan Association of Licensed Practical Nurses no later than two (2) months from the date of this Order, failing which her license to practice shall be suspended until she complies with this requirement. However, in the event that Ms. Larson is not practising as a Licensed Practice Nurse as of the date of this Order, this condition must be met within two (2) months of the date of her return to the practise of an LPN, failing which her license to practice shall be suspended until she complies with this requirement; and

3. That Maria Larson comply with the policies and procedures in her workplace that relate to the administration of medication and proper charting.

DATED at Regina, Saskatchewan, this 24th day of November 2011.

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES, DISCIPLINE COMMITTEE

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Angela Zborosky, Chairperson

Kathy Ogle, LPN, Member
Marjorie Molsbery, LPN, Member
Andrea Zavislak, LPN, Member
Tony Linner, Public Representative, Member