IN THE MATTER OF *THE LICENSED PRACTICAL NURSES ACT, 2000* AND BYLAWS AND IN THE MATTER OF A COMPLAINT AGAINST LICENSED PRACTICAL NURSE, SAVANNAH HODGSON

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

INTRODUCTION:

The hearing by the Discipline Committee into the complaints against Licensed Practical Nurse, Savannah Hodgson, was convened at the Royal Executive Hotel in Regina, Saskatchewan, on March 21, 2016 at 1:30 PM, that being the date and time set out in the Notice of Hearing sent to Savannah Hodgson. At the hearing, Darcia Schirr appeared as legal counsel for the Counselling and Investigation Committee (referred to as "the Investigation Committee") of the Saskatchewan Association of Licensed Practical Nurses (referred to as "SALPN"). The Member, Ms. Hodgson, did not appear at the outset of the hearing nor did she do so at any time during the course of the hearing. Before the Discipline Committee commenced the hearing, a lawyer assisting Ms. Schirr went to the Hotel lobby and called out Ms. Hodgson's name, but no one responded.

The complaint against Ms. Hodgson that is the subject of this hearing involves allegations of professional misconduct and professional incompetence related to: (i) her practice as an LPN while employed at the Kipling Integrated Health Centre; and (ii) a breach of a 2013 Alternative Dispute Resolution Agreement between the Member and SALPN. Appendix A to the Notice of Hearing dated March 1, 2016, contains the formal complaint and sets out the allegations, as amended, as follows:

> *1. On or about July 1, July 4 and July 5, 2015 and while you were employed at the Kipling Integrated Health Centre, you administered a placebo, to wit: water, to resident E.B. instead of Statex **2 mg prn**[1] as ordered. In doing so:*
>
> *(a) The resident was unaware that a placebo was being administered.*

[1] The original Notice of Hearing indicated that the prescribed dosage of Statex was "1 mg/ml." At the conclusion of the hearing and in accordance with the evidence, the Investigation Committee sought and was granted an amendment to the charges to indicate that the prescribed dosage was Statex "2 mg prn."

(b) The resident did not consent to the administration of a placebo.

(c) You acted outside the scope of practice for a licensed practical nurse.

2. On July 5 and July 6, 2015 and while you were employed at the Kipling Integrated Health Centre:

(a) You knowingly administered Seroquel 50 mg to resident M.V. contrary to the physician's order which provided for 12.5 mg ***hs****.*[2] *In doing so:*

(i) You acted contrary to the physician's order.

(ii) You acted outside the scope of practice for a licensed practical nurse.

(b) On the Medication Administration Record for the dates July 5 and July 6, 2015, you initially charted that you administered "50 mg" to the resident M.V. After you were advised of the complaint, you altered the record by striking out 50 mg and writing "25 mg" for the dates July 5 and July 6, 2015.

(c) Alternately and if you did not alter the record, your charting is confusing and inconsistent.

3. On December 20, 2013, you entered into an Alternative Dispute Resolution Agreement (the "Agreement") with SALPN as a result of complaint received on June 5, 2013 from the Regina General Hospital regarding your conduct. The Agreement contained these terms:

Breach of agreement

3. The member agrees that a breach of any of the terms of this Agreement constitutes professional misconduct, which may be referred to the Committee for investigation as a new complaint.

Report of any suspension or termination

8. The member agrees to arrange for her current employer(s), and any future employer(s) by whom she is employed to immediately report to the Committee any suspension or termination of her employment.

As a result of the incidents described in paragraphs 1 and 2 herein, your employer Sun Country Health Region suspended you for a period of five days commencing July 9, 2015. Contrary to paragraph 8 of the Agreement, you did not report the suspension of your employment to SALPN.

---

[2] The original Notice of Hearing indicated that the prescribed dosage of Seroquel was 12.5 mg "bid." At the conclusion of the hearing and in accordance with the evidence, the Investigation Committee sought and was granted an amendment to the charge to indicate that the prescribed dosage was Seroquel 12.5 mg "hs."

Appendix A of the Notice of Hearing also cites a number of provisions of *The Licensed Practical Nurses Act, 2000* (including sections 23, 24 and 49); the *Regulatory Bylaws* (sections 19 and 20), the *Code of Ethics for Licensed Practical Nurses in Canada* (including Principles 1, 2 and 5) and *Standards of Practice for Licensed Practical Nurses* (Standards 1, 2, 3 and 4), as all having application to the formal complaint against the Member.

PRELIMINARY ISSUES:

(i) Discipline Committee's decision to proceed with the hearing in the absence of the Member:

Given that the Member failed to attend the hearing at the designated time, date and place, as set out in the Notice of Hearing, it became necessary for us to determine whether the Member was properly served with the Notice of Hearing.

In an affidavit sworn on March 10, 2016, by Don Bushell, process server (Exhibit P-1), Mr. Bushell states that he personally served Savannah Hodgson with the Notice of Discipline Hearing (which includes the formal complaint attached as Appendix A), by leaving the same with Ms. Hodgson, who identified herself as such, in Kennedy, Saskatchewan, on March 5, 2016.

Section 29(11) of *The Licensed Practical Nurses Act, 2000* (the "*Act*") allows the Discipline Committee to proceed with a hearing in the absence of the member charged. It states:

> *29 (11) Where the member whose conduct is the subject of the hearing fails to attend the hearing, the discipline committee, on proof of service of the notice mentioned in subsection (1), may proceed with the hearing in his or her absence.*

Section 29(11) refers to a notice mentioned in s. 29(1). This subsection reads as follows:

> *29(1) Where a report of the counselling and investigation committee recommends that the discipline committee hear and determine a formal complaint, the executive director shall, at least 14 days before the date the discipline committee is to sit:*
>
> > *(a) send a copy of the formal complaint to the member whose conduct is the subject of the hearing; and*
> >
> > *(b) serve notice on the member whose conduct is the subject of the hearing of the date, time and place of the hearing.*

Therefore, on the basis of s. 29(1) and (11) of the *Act*, the Discipline Committee may proceed with this hearing without Ms. Hodgson in attendance provided there is adequate proof that the Notice of Hearing dated March 1, 2016, setting out the date, time and place of the hearing, was served on Ms. Hodgson, and the formal complaint was sent to Ms. Hodgson, at least 14 days before the date of the hearing.

Section 50 of the *Act* sets out the rules governing the service of notices under the *Act*, including a Notice of Hearing provided for in s. 29(1). Section 50 states:

> *50(1) Unless otherwise provided for in this Act or the bylaws, any notice or other document that is required to be served pursuant to this Act may be served by:*
>
> *(a) personal service made:*
>
> *(i) in the case of an individual, on that individual;*

Based on the evidence presented to us, the Discipline Committee made a finding at the hearing that proper service of the Notice of Hearing on Ms. Hodgson had been made in accordance with the above noted provisions, such that it was proper to proceed with the discipline hearing in her absence. The Notice of Hearing (and formal complaint) was personally served on Ms. Hodgson on March 5, 2016, which is at least 14 days in advance of the hearing date of March 21, 2016.

However, additional evidence presented at the hearing also demonstrated that Ms. Hodgson was aware of the charges against her and of the hearing before the Discipline Committee. Ms. Schirr advised that on March 15, 2016 she sent a letter and copies of documents relevant to the allegations to Ms. Hodgson via email, and asked Ms. Hodgson to advise if she would be attending the Discipline Hearing. Ms. Hodgson first responded at 4:08 PM on March 15, 2016, via return email, indicating that she would not be attending the disciplinary meeting and that she would contact the Registrar to terminate her license. Then, at 5:11 PM on that same date, Ms. Hodgson further replied via email that she "should not say that in 100% [she] will not be attending the hearing," that she is trying to arrange child care for her 6-week old son, and that the two hour commute represents a challenge. She added that, "I am not fighting my wrong actions, I only wish to resolve these issues."

Legal counsel for the Investigation Committee, Ms. Schirr, advised that she has not received any further communication from Ms. Hodgson since her last email message on March 15, 2016 and that the Registrar had not been contacted by Ms. Hodgson about the termination of her license.

Although there was some suggestion in Ms. Hodgson's last communication that she may have changed her mind and might possibly attend the hearing, but for her personal circumstances and the challenges of attending a hearing outside her home community, at no time did she indicate either a definite interest in attending the hearing (but for these challenges), or an intention to dispute the allegations. While we do not accept her statement that she is "not fighting" her "wrong actions" as proof that the allegations occurred, her statement provides a reason as to why she may not have attended the hearing. In addition, there was no indication that she required an adjournment of the hearing date or a change in venue for the hearing. This supports our conclusion that Ms. Hodgson did not intend to participate in the hearing and it was appropriate to proceed with the hearing in her absence.

(ii) Discipline Committee's decision re: bifurcation of the hearing:

At the outset of the hearing, Ms. Schirr requested that the hearing be bifurcated, that is, that the hearing proceed in two stages: (i) that the hearing before the Discipline Committee on March 21, 2016, proceed only on the question of liability or guilt regarding the allegations of professional misconduct and/or professional incompetence against the Member; and (ii) that in the event that the Member is found guilty of any of the allegations, that a subsequent hearing be held on the issue of the appropriate penalties for those acts of misconduct or incompetence. Ms. Schirr indicated that while the Member chose not to participate in the first stage, she may wish to participate at a subsequent hearing dealing with the penalties in the event that she is found guilty of any of the charges.

The Discipline Committee granted the request of legal counsel for the Investigation Committee, determining that it was appropriate to first hear the evidence and submissions on the issue of whether Ms. Hodgson is guilty of any of the allegations of professional misconduct and/or professional incompetence and reserve on the issue of appropriate penalties should any such findings be made. The Discipline Committee agreed that, if necessary, a separate hearing would be convened for that purpose, if necessary, and that the Member may attend and participate at such a hearing.

(iii) The Member's licensing status:

At the outset of the hearing, counsel for the Investigation Committee introduced an affidavit sworn by Cara Brewster, Registrar of SALPN, setting out the details of Ms. Hodgson's licensing status with SALPN. Ms. Brewster stated that Ms. Hodgson was first registered with SALPN as a practicing member on May 4, 2010. Since then, Ms. Hodgson has held a practicing license with SALPN, except during the following periods, when she held a non-practicing license: January 31 to November 2, 2012; January 1 to February 5, 2013; and January 1, 2016 to the date of the hearing. Ms. Brewster also clarified that, at all times material to the dates set out in the Notice of Discipline Hearing, Ms. Hodgson was a practicing member of SALPN.

On the basis of this evidence, the Discipline Committee finds that even though Ms. Hodgson was a non-practicing member at the time of the hearing, she remains a "member in good standing" under section 2(g) of the *Act* and is therefore appropriately subject to these discipline proceedings.

DECISION:

The primary issue before the Discipline Committee is whether Ms. Hodgson's conduct, as set out in the allegations contained in the Notice of Hearing and formal complaint, amount to "professional incompetence" and/or "professional misconduct" as defined in sections 23 and 24 of the *Act*, which state as follows:

Professional incompetence

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.

Professional misconduct

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.

As previously noted, the Notice of Hearing and formal complaint alleged violations of certain provisions of the *Code of Ethics* and *Standards of Practice*, documents which are adopted by virtue of section 19 of SALPN's Regulatory Bylaws. Therefore, a breach of a provision of the *Code of Ethics* or *Standards of Practice* is considered a breach of the bylaws, and by virtue of section 24(c) of the *Act*, as noted above, it amounts to "professional misconduct."

There were three witnesses who testified in person at the hearing on behalf of the Investigation Committee, all of whom were employed with the Kipling Integrated Health Centre: Kellie Beattie, Manager; Tina Logan, LPN; and Kim Balog, RN. In addition, a fourth witness, Della Bartzen, employed as an Investigator with SALPN, testified via teleconferencing. Each witness was questioned by Ms. Schirr and was subject to questions by members of the Discipline Committee. Documentary evidence was also introduced through these witnesses and will be specifically referred to when necessary.

Given that there were three separate allegations made against the Member, we will deal with each allegation separately, outlining the relevant evidence, the submissions of the Investigation Committee, and our findings in relation to each allegation. Before doing so, we note that the onus of proof is on the Investigation Committee to prove each charge on a balance of probabilities. This means that the Discipline Committee must determine whether it is more likely than not that the facts alleged did occur, and that the proven facts amount to professional misconduct and/professional incompetence, as those terms are defined in the *Act*.

Charge 1 – Resident EB

> *1. On or about July 1, July 4 and July 5, 2015 and while you were employed at the Kipling Integrated Health Centre, you administered a placebo, to wit: water, to resident E.B. instead of Statex **2 mg prn** as ordered. In doing so:*
>
> *(a) The resident was unaware that a placebo was being administered.*
>
> *(b) The resident did not consent to the administration of a placebo.*
>
> *(c) You acted outside the scope of practice for a licensed practical nurse.*

Evidence:

The evidence establishes that EB is a 96 year old resident of the facility that is "cognitively intact" and was not suffering with dementia at the time of the incidents in question. Most notably, she is able to speak and make her intentions known and she is familiar with her medications and the reasons she takes them. EB has severe osteoarthritis (witnesses testified that her x-rays reveal a state of "bone on bone") and as a result, she suffers chronic pain in her hips and knees. For this condition, EB had been prescribed Statex 2 mg/po for breakthrough pain (meaning, as needed) up to 3 times daily, since September 2014. Ms. Logan and Ms. Balog testified that they had no doubt that EB suffers significant pain as a result of this medical condition. However, Ms. Logan testified that EB wanted to use as little Statex as possible and as such, she usually asked for it at night only because she was most in pain when lying in bed.

The evidence also showed that EB had eye surgery on June 19, 2015, shortly before the events in question, and that this surgery and period of recovery would have likely been painful.

The documentary evidence showed that on July 1, 4 and 5, 2015, Ms. Hodgson administered water to EB instead of a dose of Statex. Ms. Hodgson's charting on July 1, 4 and 5, 2015, states as follows:

> July 1, 2015 2100 hours:
>
> *Resident had no complaints of pain yesterday evening or current evening, no facial grimaces or behavioural signs of pain. [No] Statex given, 2 mls of water administered as a placebo.*

July 4, 2015 2100 hours:

Resident had no complaints of pain throughout the evening or during HS care. Water given instead of Statex, will assess with day nurse tomorrow.

July 5, 2015 2100 hours:

Spoke to returning night staff regarding resident, no change in pain level or quality of sleep without Statex. No verbal/non-verbal complaints/cues of pain. Water given instead of Statex.

Ms. Logan testified that in addition to Ms. Hodgson having charted the above notes on the Medication Administration Record (the "MAR"), she listened to Ms. Hodgson's verbal reports (which were recorded reports made by the LPN or RN at the end of their shift) following each of these events, stating that she had administered water instead of the Statex without EB's knowledge and that she did so because she thought EB's medication was not needed. Ms. Logan stated that Ms. Hodgson also indicated in her verbal report that she administered a "placebo" to put EB at ease (thinking it was more of a mental health or anxiety issue), adding that EB should be assessed by the doctor. Ms. Logan testified that when she heard Ms. Hodgson's report and read her charting, she was concerned and reported the matter to her supervisor, Ms. Balog. Ms. Logan stated that her concern was that Ms. Hodgson acted outside the scope of her practice by administering a placebo without a doctor's order, and that she did so without EB's knowledge. In her view, a doctor's order that a medication be administered on an "as needed" basis does not authorize the administration of a placebo.

Ms. Logan, LPN, and Ms. Balog, RN, testified that they have never given a placebo in all of their years of practice. They and Ms. Beattie all testified that they were of the view that a placebo should not be given under any circumstances. In Ms. Balog's view, placebos are used in drug trials only. Ms. Logan testified that she would not give a placebo even with a doctor's order, unless the order came from a psychiatrist after an assessment. Ms. Beattie testified that at no time did Ms. Hodgson come to her to discuss any concerns she may have had about EB's use of Statex, including during rounds, at report, or in the nurse's communication sheet in the facility.

On July 8, 2015, shortly following the incidents in question, EB was reassessed by the doctor during rounds. While Ms. Logan had testified that it was Ms. Hodgson who suggested in her verbal report that EB be assessed by the doctor, Ms. Balog testified that she discussed the issue of EB's pain control with the doctor on rounds because of Ms. Logan's report to her about Ms. Hodgson having withheld EB's pain medication and based on her review of the nursing notes over the past week. Specifically, the nursing notes for EB over the course of the prior week included Ms. Hodgson's reports that EB said she was not having any pain, but also included reports that in the early morning of hours of July 6, EB indicated that she was unable to sleep due

to pain, and that later in the morning of July 6, a nurse gave EB a half dose of Statex in response to EB's complaints of pain in her eye. In any event, following the doctor's assessment, the doctor ordered that Statex 2 mg be administered at bedtime. In the nursing notes for July 8, Ms. Balog charted that "*Statex to now be scheduled and prn"* which suggests that the doctor made a new order for Statex 2 mg, which must be given at bedtime (the "scheduled" medication), in addition to continuing the earlier order of Statex 2 mg, as needed (the "prn" medication). Ms. Balog testified that these medication orders reflect what had been the usual practice for administering medications to EB.

Ms. Beattie testified that on July 16, 2015, she held an investigative meeting with Ms. Hodgson, at which time Ms. Hodgson said that she gave EB water to "ease EB's mind" at night time. In an emailed response on July 17, 2015, Ms. Hodgson acknowledged that her actions in administering a placebo were not appropriate. She stated, in part, as follows:

> *… I truly understand that my nursing action were not appropriate within my scope of practice; and even though my intentions were meant in the best interest of my residents that doesn't make me right. I have learned from this whole situation and would not overstep my boundaries again. I have made myself more knowledgeable since our meeting I have corrected my misjudgment regarding placebos.*
>
> *…. my thinking is now black and white regarding dr's orders for EVERY resident/patient….*

Also, in response to SALPN's investigation of the complaint, Ms. Hodgson stated in an email message dated August 10, 2015, addressed to SALPN, that she had spoken to her manager regarding the issues that were the subject of the complaint (and that the issues had been recorded on her 2000-hour appraisal) and that she has "*done some proper education for [herself] regarding the administration of placebos and have corrected that thinking and actions.*"

Submissions of the Investigation Committee:

Counsel for the Investigation Committee submitted that the evidence proves that Ms. Hodgson gave EB a "placebo" instead of her prescribed medication, and that she did so without EB's informed consent and without a physician's order. Counsel submitted that in doing so, Ms. Hodgson is guilty of both professional incompetence and professional misconduct, including a violation of Principles 2.1 and 2.1.1 and Principle 5.2 of the *Code of Ethics*. Counsel asserted that as a basic principle, in order to provide informed consent, every patient, including EB, has the right to be informed about and make decisions with regard to their health care/treatment. Counsel referred to companion decisions of the College of Nurses of Ontario (involving nurses Guy Cadieux and Josette Lafontant) as support for its position.

Counsel also submitted that even though SALPN's practice guidelines concerning medication administration do not specially address the issue of placebos, members must still conduct themselves in accordance with the *Code of Ethics* and the *Standards of Practice* which Ms. Hodgson failed to do. Counsel noted that in her responses to the SALPN complaint and to Ms. Beattie, Ms. Hodgson recognized that her actions were not appropriate and were outside her scope of practice.

Decision and Analysis:

The Discipline Committee accepts the evidence of the witnesses who testified at the hearing. Together with the documentary evidence submitted, the Discipline Committee finds that on three separate occasions, Ms. Hodgson administered a placebo (in the form of water) to resident, EB, at bedtime, instead of administering a prescribed dose of Statex. There was no physician's order for a placebo and Ms. Hodgson administered the placebo without EB's knowledge or consent. There was a physician's order for Statex 2mg. While it was a "prn" order, the evidence demonstrated that EB rarely asked for the pain medication during the day but took a dose of Statex at bedtime on a very regular basis to treat the pain associated with her osteoarthritis and to allow her to sleep.

In order to make a finding that Ms. Hodgson is guilty of professional incompetence warranting the imposition of discipline under the *Act*, her conduct must fall within the definition of "professional incompetence" in s. 23 of the *Act*, as set out earlier in this decision. Essentially, the Investigation Committee must prove that Ms. Hodgson displayed a lack of knowledge, skill or judgment, or a disregard for the welfare of a patient/resident, that was of a nature or to an extent that it demonstrates she is either: (i) unfit to continue to practice as an LPN; or (ii) unfit to provide one of the services that is ordinarily provided as part of the practice of an LPN.

In this case, the Discipline Committee is of the view that Ms. Hodgson displayed a lack of knowledge and judgment by giving EB a placebo when it is common knowledge that placebos are not to be administered in the context of direct patient care, or at a minimum, they should not be administered without a physician's order to do so. Ms. Hodgson also displayed a lack of judgment by failing to consult with her supervisor or a doctor about any concerns she had regarding EB's treatment or about a possible change to EB's medications. Instead, she proceeded to make her own decision about administering a placebo.

However, not every display of a lack of knowledge or judgment by an LPN leads to a finding of professional incompetence. Ms. Hodgson's lack of knowledge or judgment must be found to be of a nature or to an extent that demonstrates that she is unfit to either practice as an LPN at all, or to provide one or more services ordinarily provided by an LPN. In this case, the evidence falls short of proving that Ms. Hodgson's lack of knowledge/judgment (that is, her administration of a placebo without a doctor's order on three occasions and her failure to consult with her supervisor

or a doctor before proceeding as she did), was sufficiently significant or wide-ranging to conclude that she is unfit to continue to practice as an LPN. We also find that the Investigation Committee has not proven that Ms. Hodgson's conduct demonstrates that she is unfit to provide a service ordinarily provided by LPNs. Unfortunately, we did not receive any submissions on the issues of which "service" ordinarily provided by an LPN is the service that Ms. Hodgson is now unfit to practice, or how her particular display of a lack of knowledge/judgment makes her unfit to provide that service. However, if we consider the service to be the administration of medications, in our view, the nature and extent of her lack of knowledge/judgment (in administering the placebo on these three occasions) is not sufficient to demonstrate that she is unfit (or incapable) of administering medications generally to the residents under her care. Her lack of knowledge/judgment was more discrete in nature and center around the idea that she could make this decision without a doctor's input. For these reasons, we find that Ms. Hodgson is not guilty of professional incompetence.

In order to make a finding that Ms. Hodgson is guilty of professional misconduct warranting the imposition of discipline under the *Act*, her conduct must fall within one or more of the definitions of "professional misconduct" in s. 24 of the *Act*, as set out earlier in this decision. In the context of this case, the most relevant definitions of professional misconduct include conduct that is: harmful to the best interests of the public or the members (s. 24(a)); tends to harm the standing of the profession (s. 24(b)); or is a breach of this Act or the bylaws; (s. 24(c)). For the reasons that follow, we find that Ms. Hodgson is guilty of professional misconduct within the meaning of all three of these provisions of *Act*.

Before outlining the reasons for our findings, we will comment briefly upon the decision of the College of Nurse of Ontario regarding *Guy Cadieux* which was cited by legal counsel for the Investigation Committee. We note that in that decision, the Discipline Committee of the College accepted Nurse Cadieux's plea of guilt for professional misconduct for his having administered a placebo to a patient (saline instead of morphine that had been prescribed for the patient on a prn basis), on a three separate occasions without a physician's order and without the client's informed consent, and that he failed to document both the administration of the placebo and the withdrawal/wastage of the narcotic. Unfortunately, the College provided no reasons for its conclusion to accept the guilty plea, providing reasons only for its decision to accept and impose the jointly submitted penalty of a six month suspension and oral reprimand for his professional misconduct.

Unlike the fact situation in the *Cadieux*, there is no evidence that Ms. Hodgson was attempting to hide her actions: she documented her actions in detail in the MAR and disclosed the information on verbal report, in relation to each occasion she gave the placebo. In addition, it appears that she conducted an assessment of the resident on each occasion and documented her findings. However, the giving of a placebo, without the patient's consent and without a physician's order was not appropriate; this was not her decision to make. We agree with the submissions of

counsel for the Investigation Committee that if Ms. Hodgson was concerned about EB's usage of Statex, she ought to have discussed this with her nursing supervisor or the physician instead of acting unilaterally and administering a placebo, which she had no authority to do. In our view, it was also open to Ms. Hodgson to have simply declined to give the resident a dosage of Statex, given that it was a prn order. In giving EB the placebo, again without her consent and without a physician's order, she engaged in an act of professional misconduct.

Moving to the specific definitions of professional misconduct under the *Act*, we find that Ms. Hodgson engaged in conduct that is harmful to the best interests of the public ("professional misconduct" defined in s. 24(a)) because the public must be confident that members will confine themselves to activities that are within their scope of practice. When a member acts outside her or his scope of practice, patient safety is put at risk. Ms. Hodgson clearly acted outside her scope of practice as an LPN by choosing to administer a placebo to EB instead of her prescribed pain medications. We accept the evidence and agree that a placebo should never be administered in the context of direct patient care and certainly not without a doctor's order. While Ms. Hodgson acted within her scope of practice by assessing EB's pain levels and documenting this information, if she had concerns about administering the Statex, her next step should have been to contact her supervisor or the doctor. In addition, because this medication was ordered on a "prn" basis, it may have been open to Ms. Hodgson to decide not to administer the Statex. While the witnesses testified that EB's medical conditions were of the type to cause her significant pain, and that EB regularly took Statex at bedtime, we are not in a position to assess whether it would have been appropriate for Ms. Hodgson to determine that the Statex was not "needed" that night, but that does not have a bearing on this decision. The fact is that Ms. Hodgson administered a placebo to EB and in so doing, she exceeded her scope of practice.

We also find that Ms. Hodgson acted in a manner harmful to the best interests of the public, including EB, by administering EB a placebo without her knowledge or consent. According to Ms. Beattie, Ms. Hodgson is reported as saying that she gave EB the placebo to "ease her mind" – not only was this not her decision to make, but by giving the placebo, she essentially fooled EB into thinking that she was receiving her pain medications, as prescribed. This is highly inappropriate. Patients have the right to receive accurate information about their treatment, including their medication, and the right to consent or withhold consent to treatment. By not telling EB that she was receiving water instead of Statex, EB was unable to make a decision about whether to consent to that treatment.

We also find that Ms. Hodgson engaged in conduct that tends to harm the standing of the profession ("professional misconduct" within the meaning of s. 24(b)) by reason of her decision to administer the placebo to EB without a doctor's order, conduct which we have determined is outside her scope of practice. When a member acts outside her scope of practice, it means that she is doing something that she is not trained to do. Such conduct reflects poorly on the

profession and leads to a risk of declining public confidence in members of the profession and SALPN's ability to properly regulate the profession.

Lastly, we find that Ms. Hodgson is guilty of professional misconduct within the meaning of s. 24(c) of the *Act*, in that her conduct amounts to a breach of the bylaws. The Regulatory Bylaws incorporate the *Code of Ethics* and the *Standards of Practice*. As such, a violation or breach of the *Code of Ethics* or the *Standards of Practice* amounts to a breach of the bylaws, which, I turn, forms a basis for a finding of professional misconduct under s.24(c). Specifically, we find that Ms. Hodgson violated Principles 2.1, 2.1.1 and 5.2 of the *Code of Ethics*, which state as follows:

> **PRINCIPLE 2: Responsibility to Clients**
>
> Ethical Responsibilities:
>
> LPNs:
>
> 2.1 Respect the right and responsibility of clients to be informed and make decisions about their health care.
>
> 2.1.1 Respect and support client choices.
>
> **PRINCIPLE 5: Responsibility to Self**
>
> Licensed Practical Nurses recognize and function within their personal and professional competence and value systems.
>
> Ethical Responsibilities:
>
> LPNs:
>
> 5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgement.

We make these findings for the same reasons that supported our findings of professional misconduct under sections 24(a) and 24(b) of the *Act*, as outlined above. In summary, Ms. Hodgson violated Principle 2.1 by failing to respect EB's right to be informed that Ms. Hodgson was not administering a dose of Statex but giving her a placebo in the form of water instead and that Ms. Hodgson was doing so without a doctor's order. Furthermore, by failing to inform EB of this treatment, Ms. Hodgson removed EB's ability to make a decision about her treatment. Ms. Hodgson also violated Principle 2.1.1 by exercising her own choice about how to treat EB and not disclosing that choice to EB, conduct which has the effect of failing to respect and support EB's choices. We also find that Ms. Hodgson violated Principle 5.2 by failing to recognize and

function within her scope of practice when she decided to administer a placebo to EB to ease her mind.

Therefore, on the basis of the evidence presented to it at the hearing and the submissions of legal counsel for the Investigation Committee, the Discipline Committee finds that in relation to Charge 1, Ms. Hodgson's conduct amounts to professional misconduct within the meaning of section 24 of *The Licensed Practical Nurses Act*.

Charge 2 – Resident MV

> *2. On July 5 and July 6, 2015 and while you were employed at the Kipling Integrated Health Centre:*
>
> *(a) You knowingly administered Seroquel 50 mg to resident M.V. contrary to the physician's order which provided for 12.5 mg hs. In doing so:*
>
> *(i) You acted contrary to the physician's order.*
>
> *(ii) You acted outside the scope of practice for a licensed practical nurse.*
>
> *(b) On the Medication Administration Record for the dates July 5 and July 6, 2015, you initially charted that you administered "50 mg" to the resident M.V. After you were advised of the complaint, you altered the record by striking out 50 mg and writing "25 mg" for the dates July 5 and July 6, 2015.*
>
> *(c) Alternately and if you did not alter the record, your charting is confusing and inconsistent.*

Evidence:

(i) Evidence re: administration of Seroquel to resident MV:

The evidence establishes that MV is a male resident in his late 40's, who experiences delayed cognitive functioning as a result of brain injury. MV has been prescribed Seroquel (or Quetiapine) for this condition. The doctor's order which was in effect on July 5 and 6, 2015 was dated May 27, 2015 and it provided for "Seroquel 12.5 hs." The MAR for this time period indicates that the prescribed medication was Quetiapine 25 mg, with the direction to "take ½ tablet at bedtime."

On each of July 5 and July 6, 2015, Ms. Hodgson appears to have administered Seroquel to resident MV. On the July 2015 MAR, Ms. Hodgson wrote "50 mg" above her initials in relation to the dates July 5 and July 6, 2015. Consistent with the information she recorded in the MAR, Ms. Hodgson charted "50 mg Seroquil (sic) given instead of 25 mg" in the nursing notes for July 5, 2015. Also consistent with the information recorded in the MAR, Ms. Hodgson stated in her

recorded verbal report for July 6, 2015, "I actually gave him 50 mg of seraquil (sic) instead of the 25 again …"

Ms. Balog testified that Seroquel is an anti-psychotic medication that needs to be used carefully in a long term care facility. Because long term care residents are considered a vulnerable sector, the usage of this medication is monitored by the Ministry of Health. The monitoring includes regular attempts to reduce these medication dosages. As such, efforts had been made over time to reduce MV's dosage of Seroquel. Ms. Balog's evidence of the attempts to reduce MV's dosages is generally accurate; the records establish that the doctor's orders for Seroquel had been changed over time as follows:

(i) December 14, 2014: "25 mg twice daily"

(ii) May 6, 2015: decreased to "12.5 mg bid" (meaning twice daily)

(iii) May 27, 2015: decrease to "12.5 mg hs only" (meaning one dose at bedtime only), with the notation "Continue to monitor behaviour"

However, the nursing notes for July 8, 2015 (which was shortly following the events in question), indicate that during physician's rounds, the doctor increased MV's dosage to "12.5 mg bid po" (meaning twice daily, taken orally) with a direction to "monitor agitation." This dosage change is also indicated in the Physician's Orders. It appears that Ms. Hodgson may have prompted the doctor to reassess MV with a view to increasing his dosages. In her verbal report of July 6, 2015 (in which she indicated she gave MV 50 mg of Seroquel instead of the 25mg), Ms. Hodgson also noted MV's increased restlessness, the facts that he had suffered a fall, and that she put MV "on the doctors rounds cause he just seems unsettled."

Ms. Beattie first raised concerns with Ms. Hodgson about her administration of medications to MV on July 9, 2015. Ms. Hodgson was then interviewed by Ms. Beattie on July 16, 2015 to discuss the dosage of Seroquel given to MV. Ms. Beattie testified that when confronted with the issue, Ms. Hodgson stated that she actually gave MV 25 mg of Seroquel, not 50 mg. Ms. Beattie's meeting notes indicate that Ms. Hodgson said that the 25 mg dose was given as two ½ tablets (information on the MAR indicates that one tablet is 25 mg and therefore, two ½ tablets would be 25 mg). Ms. Beattie also testified that when she showed Ms. Hodgson the MAR (with the notation "50 mg" recorded for July 5 and 6) and the nursing notes for July 5, 2015 (with the notation that "50 mg" was given instead of 25 mg), Ms. Hodgson stated that these notations were "charting errors" (as opposed to "medication errors") and she maintained that she administered only 25 mg on each day. It appears from the notes that Ms. Hodgson also explained that she gave the increased dosage because of MV's increased agitation and his having fallen.

On July 17, 2015, Ms. Hodgson sent an email message to Ms. Beattie in follow-up to their meeting the day before. In that message, Ms. Hodgson appeared to be concerned that she be

perceived as sincere regarding the issues discussed at the meeting and she stated, in part, as follows:

> *… I truly understand that my nursing action were not appropriate within my scope of practice; and even though my intentions were meant in the best interest of my residents that doesn't make me right. I have learned from this whole situation and would not overstep my boundaries again. …*
>
> *I also now will not assume that what the doctor intended before would be the same course of medical intervention later. I knew that evening I should have phoned the dr but I didn't want to be a bother. That won't happen again, my thinking is now black & white regarding dr's orders for EVERY resident/patient. I should not have made an exception regarding ---.*

Ms. Beattie testified that Kipling has three doctors and a nurse practitioner and she could not foresee any problem with a nurse contacting these professionals for advice.

In response to SALPN's investigation of the complaint, Ms. Hodgson sent an email message to SALPN on August 10, 2015 stating that she understood that the doubling of MV's dosage of Seroquel was beyond her scope of practice as an LPN, though she did this "based on the specific resident." Ms. Hodgson then appeared to suggest that this was a practice engaged in by all nurses (RNs and LPNs) in that facility. However, she added that she understands that that "does not make [her] actions right." During her testimony, Ms. Beattie agreed with Ms. Hodgson's latter comment but took issue with Ms. Hodgson's suggestion that other nurses in the facility were administering MV's Seroquel in a manner other than that prescribed by the physician, stating that the facility had no evidence that that was occurring.

(ii) Evidence re: alterations to MAR:

During the course of SALPN's investigation of the allegation involving the improper administration of the medication Seroquel to resident MV, the Investigation Committee came to receive a second copy of the relevant MAR that contained some different information from the initial copy the Committee had received. Specifically, the first copy indicated that Ms. Hodgson charted that she had administered 50 mg of Seroquel on each of July 5 and 6, 2015 (with the "50 mg" notation written above Ms. Hodgson's initials), while the second copy of the MAR contained this same information, but the "50 mg" notations were crossed out and below Ms. Hodgson's initials appeared the notation "25 mg," for each of July 5 and 6. Both copies of the MAR were entered into evidence at the hearing and witnesses testified about the chronology of the employer's and SALPN's investigations, as well as the circumstances surrounding SALPN's receipt of this second copy of the MAR.

Ms. Beattie testified that when she met with Ms. Hodgson on July 16, 2015, the July 2015 MAR contained only the notation that 50 mg of Seroquel was given to MV by Ms. Hodgson on July 5

and 6; there was no notation of 25 mg having been given. At that meeting, Ms. Hodgson stated that she had administered 25 mg, not 50 mg, on each of those dates, and that she had made a charting error on the MAR – instead of noting 50 mg, she should have noted a dose of 25 mg. On July 22, 2015, Ms. Beattie submitted the complaint regarding Ms. Hodgson's practice to SALPN, via email. This submission contained a package of supporting documents, including a copy of the July 2015 MAR that contained only a notation of the 50 mg dose. On July 24, 2016, SALPN notified Ms. Hodgson of the complaint, via email, and invited her response. On August 10, 2015, Ms. Hodgson responded to SALPN via email and she included a reference to her having *doubled* MV's dose of Seroquel.

Della Bartzen, the investigator for SALPN's Investigation Committee, testified that in November 2015, she had contacted Ms. Beattie with a request to provide additional documentation, including the MARs related to MV for the months of April, May and June 2015. Although she had not been asked to re-send the July 2015 MAR, Ms. Beattie sent Ms. Bartzen copies of the MARs from April 2015 to July 2015 inclusive. Upon the receipt of these documents, Ms. Bartzen compared the copy of the July 2015 MAR that she received in November 2015 to the copy she had received in July 2015 and noticed the changes that had been made to the July MAR. Ms. Bartzen said that she immediately notified Ms. Beattie about the differences between the two copies; Ms. Beattie was shocked to learn that changes had been made.

Ms. Beattie testified that on the original copy of the July 2015 MAR, the alteration was very obvious in that it was made with ink of a different colour. In her view, it was apparent that Ms. Hodgson had crossed out the notation "50 mg" and wrote in the notation "25 mg" under her initials, sometime after the investigation into her conduct began. Ms. Beattie explained that she first met with Ms. Hodgson about the medication issues involving residents EB ad MV on July 9, 2015 and at that point, placed Ms. Hodgson on a non-disciplinary suspension while she investigated the allegations. Ms. Beattie conducted her investigation and on July 22, 2015, met with Ms. Hodgson to present her with a letter of discipline. Given Ms. Beattie's decision to impose a 5-day suspension that would be considered as having already been served (on July 9, 2015 to July 13, 2015), Ms. Hodgson was able to return to work on the same day she was disciplined, that is, July 22, 2015. Ms. Hodgson continued to work shifts in her part time position until September 4, 2015, at which time the Investigation Committee of SALPN suspended her license to practice under the terms of an Alternate Dispute Resolution Agreement between the Committee and Ms. Hodgson.[3] Therefore, Ms. Beattie concluded, Ms. Hodgson was working in the facility and had access to the MARs between July 22, 2015 and September 4, 2015.

[3] On November 25, 2015, the Investigation Committee notified Ms. Hodgson that the Committee had lifted her suspension and that the complaint made by the Kipling Integrated Health Facility (the complaint that is the subject of this hearing) has been referred to the Discipline Committee.

Ms. Beattie testified that one cannot make changes to a MAR without proper consultation, and if it is determined that a change should be made, there has to be a notation regarding the change. Ms. Hodgson did not follow the proper procedure for making a change. In addition, Ms. Hodgson had not been instructed to make any such changes during any of the meetings they held to discuss Ms. Hodgson's conduct. Ms. Beattie finds the alteration to the MAR particularly problematic because the nursing notes indicate that a 50 mg dose was given and Ms. Hodgson's verbal report indicated a 50 mg dose had been given.

Submissions of the Investigation Committee:

Legal counsel for the Investigation Committee submitted that the evidence demonstrates that Ms. Hodgson improperly administered medication to resident MV on both July 5 and 6, 2015 (by either giving a double or quadruple dosage of Seroquel) and that she improperly altered the July 2015 Medication Administration Record in relation to her administration of these medications.

(i) Submissions re: administration of Seroquel to resident MV:

Counsel submitted that based on the documentary evidence and testimony of the witnesses, it is unclear what dosage of Seroquel Ms. Hodgson administered to MV on July 5 and 6, 2015, which is a "frightening proposition" given the nature of the medication. However, whether she administered 50 mg (as per her charting and verbal report) or 25 mg (as per her recollection, which she reported to Ms. Beattie at the July 16, 2015 meeting), she had no authority to administer either of these doses. She could administer only the dosage ordered by the doctor which, at this time, was 12.5 mg hs. If Ms. Hodgson had concerns about MV's treatment plan or the sufficiency of the Seroquel dosage, she should have discussed that with her supervisor or a physician. Counsel referred to a decision of the College of Nurses of Ontario (involving nurse Victoria Walton) as support for its position that Ms. Hodgson's concerns about the sufficiency of MV's medications or her desire to improve his treatment on her own, are not explanations of the type that would afford her a defense to charges of professional misconduct concerning the administration of medications.

(ii) Submissions re: alterations to MAR:

Legal counsel for the Investigation Committee also submitted that the evidence demonstrates that Ms. Hodgson improperly altered the July 2015 MAR, and described this conduct as very serious and troubling. Counsel submitted that it is reasonable for the Discipline Committee to draw an inference that Ms. Hodgson altered the July 2015 MAR for the purposes of making the July 2015 MAR "fit" with the explanation she gave to SALPN in her August 10, 2015 response; that is, her reference to "the *doubling* of the dosage" of Seroquel for MV. In fact, counsel argued, the only reasonable inference to draw is that after Ms. Hodgson was advised of the complaint by SALPN on July 24, 2015 (which complaint had been submitted by the employer on July 22, 2015), she had to alter the July 2015 MAR to match her explanation to SALPN. Counsel pointed out that

the MAR is a legal record of the drugs administered to a patient and it forms part of the patient's permanent record on their medical chart. Counsel submitted that altering such a record is a very serious matter, particularly in circumstances where one's conduct is under scrutiny by the professional regulatory body.

Legal counsel referred to a decision of the Discipline Committee of the College of Physicians and Surgeons of Saskatchewan involving Dr. Amjad Ali, who had been found guilty of professional misconduct for having falsified a patient's medical record after he had been advised of the patient's complaint to the College. In the course of addressing the penalties to be imposed for the misconduct, the Discipline Committee highlights the seriousness with which such conduct is viewed.

Lastly, and in the alternative, counsel submitted that it the Discipline Committee is unable to make a finding that Ms. Hodgson altered the July 2015 MAR upon being advised that a complaint had been made against her, legal counsel submitted that the evidence demonstrates that Ms. Hodgson's charting is confusing. Specifically, Ms. Hodgson charted in the nursing notes that "50 mg Seroquil (sic) given instead of 25 mg" which seems to imply that 25 mg is the operative physician's order when the only order in place is for 12.5 mg hs.

Decision and Analysis:

(i) Decision/analysis re: administration of Seroquel to resident MV:

Having accepted the evidence of the witnesses who testified and the documentary evidence submitted, the Discipline Committee finds that on two separate occasions, Ms. Hodgson intended to and did give MV a dosage of Seroquel higher than that prescribed by the doctor, which at the time of these incidents was 12.5 mg at bedtime. While there was an issue as to whether Ms. Hodgson gave 50 mg or 25 mg, the fact remains that she deliberately chose to give MV more than his prescribed dose based on her own assessment of his needs and what she thought was appropriate treatment for him.

As discussed earlier in relation to the first charge, in order to make a finding that Ms. Hodgson is guilty of professional incompetence warranting the imposition of discipline under the *Act*, her conduct must fall within the definition of "professional incompetence" in s. 23 of the *Act*. Essentially, the Investigation Committee must prove that Ms. Hodgson displayed a lack of knowledge, skill or judgment, or a disregard for the welfare of a patient/resident, that was of a nature or to an extent that it demonstrates she is either: (i) unfit to continue to practice as an LPN; or (ii) unfit to provide one of the services that is ordinarily provided as part of the practice of an LPN.

In this case, the Discipline Committee is of the view that Ms. Hodgson displayed a lack of knowledge and judgment by failing to administer MV the prescribed dosage of Seroquel as

ordered by the doctor. Ms. Hodgson also displayed a lack of judgment by failing to consult with the doctor about MV's behaviour and symptoms and a possible change to EB's medications, and instead, proceeded to make her own decision about the proper dosage to give MV.

However, utilizing the same analysis here as in relation to charge 1 involving EB, we find that the evidence falls short of proving that Ms. Hodgson's lack of knowledge/judgment was sufficiently significant or wide-ranging to conclude that she is either unfit to continue to practice as an LPN, or that she is unfit to provide a service ordinarily provided by LPNs. Again, we did not receive any submissions on the issues of which "service" ordinarily provided by an LPN is the service that Ms. Hodgson is now unfit to practice, or how her particular display of a lack of knowledge/judgment makes her unfit to provide that service. However, if we consider the service to be the administration of medications, in our view, the nature and extent of her lack of knowledge/judgment in relation to this charge is not sufficient to demonstrate that she is unfit (or incapable) of administering medications generally to the residents under her care. Her lack of knowledge and judgment appears to relate to her lack of a full understanding of her limited ability to make decisions about medication administration within her scope of practice in the particular circumstances of this case, but not to the extent that she is incapable of administering medication generally. For these reasons, we find that Ms. Hodgson is not guilty of professional incompetence.

However, for the reasons that follow, we do find that Ms. Hodgson is guilty of professional misconduct within the meaning of s. 24 of the *Act*, specifically, that her conduct is: harmful to the best interests of the public or the members (s. 24(a)); tends to harm the standing of the profession (s. 24(b)); or is a breach of this *Act* or the bylaws; (s. 24(c)).

We note that in the decision of the College of Nurse of Ontario regarding *Victoria Walton*, the Discipline Committee of the College accepted Nurse Walton's plea of guilt for professional misconduct for her having: (i) contravened a standard of practice of the profession and having failed to meet the standards of practice of the profession with respect to administration and documentation of medications for patients; and (ii) engaged in conduct that was disgraceful, dishonourable and unprofessional with respect to administration and documentation of medications for patients. Specifically, Nurse Walton admitted that there were numerous instances in which she deviated from the physician's orders for medication for residents (primarily by giving medications at the wrong times, including giving two doses at the same time) and incorrectly documenting on the MAR the times that the residents received their prescribed medications, or documenting that they did not receive their bedtime medications because they were sleeping. Notably, the Agreed Statement of Facts indicated that had Nurse Walton testified, she would have indicated that she believed that the medication regime for certain residents could be improved and she determined she would make those improvements on her own with the intent of later reporting the residents' responses to the physician. She also explained that she administered the medications in the way she did to save time so that she could

provide essential care to the residents, which she believed had been substandard in the facility. Legal counsel for the Investigation Committee referenced this decision as authority for the proposition that Ms. Hodgson's explanations for having given MV at least a double dose of Seroquel would not afford her a defence to charges of professional misconduct, just as Nurse Walton's did not in the case before the College of Nurse of Ontario.

Unfortunately, the College provided no actual reasons for its decision to accept the agreed statement of facts and the Nurse's guilty plea, or for its conclusion that the facts substantiated a finding of professional misconduct. However, on the face of the decision, it seems that we may draw two conclusions. Firstly, that by reason of her having entered a guilty plea, we can assume that Nurse Walton was not taking the position that her explanations justified her actions or provided her with a defence to the charge. Secondly, that by accepting the guilty plea, the College did not disagree with Nurse Walton's position. While this provides us with little direction, we do share the view that the explanations offered by Ms. Hodgson do not afford her a defence to the charges and do not justify her actions of deliberately administering medication that is not in accordance with a physician's order. Doing so clearly exceeds her scope of practice as an LPN. Although it was certainly appropriate for her to assess the resident and document her concerns, as well as put the resident on a list to be seen by the doctor on the next rounds, it was not open to her to decide upon and effect a change to his medications, regardless of her knowledge of the resident or the fact that she thought that other nurses were doing the same thing.

Furthermore, Ms. Hodgson's July 17th email message seems to suggest that in administering the double dose of Seroquel, she was presuming what the doctor's course of action would be by taking into account the recent reductions to the dosage levels and the doctor's direction to "continue to monitor behaviour" such that MV needed to go back to the higher dose of 25 mg of Seroquel (albeit 25 mg bid, not 25 mg hs). Even though the doctor increased MV's Seroquel dosage during rounds on July 8, 2015, to "12.5 mg bid po" with a direction to "monitor agitation," Ms. Hodgson's decision to increase MV's dosage on July 5 and 6, 2015 was not hers to make. Such a decision was clearly outside her scope of practice. In addition, her explanation (in that same email message) that she did not want to "bother" a doctor that evening about her concerns and seek advice or direction, also does not justify her acting beyond her scope of practice by administering a dosage of medication not prescribed.

Moving to the specific definitions of professional misconduct under the *Act*, we find that Ms. Hodgson engaged in conduct that is harmful to the best interests of the public ("professional misconduct" defined in s. 24(a)) because the public must be confident that members will confine themselves to activities that are within their scope of practice. When a member acts outside her or his scope of practice, patient safety is put at risk. Ms. Hodgson clearly acted outside her scope of practice by choosing to administer a dose of medication to MV that was at least double that prescribed by the doctor. While Ms. Hodgson acted within her scope of practice by assessing

MV's behaviour and documenting this information, if she had concerns about the effectiveness of his medication at the prescribed dosage, she should have contacted the doctor. Her suggestion that she did not want to bother the doctor is no excuse and she should not have presumed that the doctor would put MV back to the higher dosage he was on before the most recent change. In addition, we find that Ms. Hodgson acted in a manner harmful to the best interests of the public, and specifically the resident, MV, by administering a dose of medication higher than the prescribed dosage because a higher dose of any medications could result in unintended consequences or cause direct harm to patients. In the case of MV, we are aware that MV had been prescribed higher doses of this medication in the past; perhaps that lessens the safety risk, but that was not an assessment Ms. Hodgson could make, it being outside her scope of practice.

We also find that Ms. Hodgson engaged in conduct that tends to harm the standing of the profession ("professional misconduct" within the meaning of s. 24(b)). When a member acts outside her scope of practice (in this case, ignoring the doctor's order and making her own decisions about proper medical treatment), it means that she is doing something that she is not trained to do. Such conduct reflects poorly on the profession and leads to a risk of declining public confidence in members of the profession to provide proper care and SALPN's ability to properly regulate the profession.

Lastly, we find that Ms. Hodgson is guilty of professional misconduct within the meaning of s. 24(c) of the *Act*, in that her conduct amounts to a breach of the bylaws, specifically, Principle 5.2 of the *Code of Ethics*, as set out earlier in this decision. It is our view that Ms. Hodgson violated Principle 5.2 by failing to recognize and perform the nursing functions that fall within her scope of practice when she decided not to follow the doctor's medication order and instead gave MV at least double the dose of his prescribed medication.

Therefore, on the basis of the evidence presented to it at the hearing and the submissions of legal counsel for the Investigation Committee, the Discipline Committee finds that in relation to this aspect of Charge 2, Ms. Hodgson's conduct amounts to professional misconduct within the meaning of section 24 of *The Licensed Practical Nurses Act*.

(ii) Decision/analysis re: alterations to MAR:

We agree with the submissions of counsel for the Investigation Committee that altering the MAR is a very serious matter because it is a legal record of the drugs administered to a patient and it forms part of the patient's permanent record on their medical chart. However, we do not accept that Ms. Hodgson altered the July 2015 MAR for the purposes of making it "fit" with the explanation she gave to SALPN in her August 10, 2015 response; that is, her reference to "the *doubling* of the dosage" of Seroquel for MV. In our view, the evidence shows that it is more likely than not that Ms. Hodgson made the alteration to the MAR for the purposes of correcting the record to reflect her recollection that she gave MV a dose of 25 mg and not 50 mg on each of

July 5 and 6, 2015, and that she had made a charting error by noting a dose of 50 mg. We do not view her changes as an attempt to "falsify" the records. While we accept that Ms. Hodgson must have made this change on the MAR sometime between July 22 and September 4, 2015, and that she had notice that a complaint had been made on July 24, 2015 (when SALPN sent it to her), the fact is, she first took the position that she gave MV doses of 25 mg and not 50 mg when she met with Ms. Beattie on July 16, 2015. Her response to SALPN on August 10, 2015 that she *doubled* the dosage is simply consistent with the position she has taken from the time she was notified of the problem by Ms. Beattie; that she gave two half tablets but charted this incorrectly as 50 mg, when she should have charted 25 mg.

We also do not accept that Ms. Hodgson made these changes to the MAR for the purposes of misleading anyone, including SALPN. The manner in which Ms. Hodgson made changes to the MAR demonstrate that she was not trying to hide her error – she did not obliterate the notation "50 mg" but rather crossed it out so that it was still visible. In addition, she used a different colour of ink for her changes, which included crossing out the 50 mg and writing 25 mg in a different place. As Ms. Beattie noted when Ms. Bartzen notified her that changes had been made to the MAR, the changes Ms. Hodgson made were very obvious. Had Ms. Hodgson been trying to mislead anyone, one would expect to see the MAR changed in a way that would not make it obvious that the original notation was 50 mg. In addition, we note that there was no evidence that Ms. Hodgson made any similar changes to the nursing notes so those continue to indicate that she gave a 50 mg dose instead of 25 mg. While this may present some confusion in that the entry on the July 2015 MAR is now different than the entry in the nursing notes, it further demonstrates that Ms. Hodgson was not trying to mislead or cover up her actions.

For these reasons, Ms. Hodgson's conduct is quite unlike that of Dr. Ali's as outlined in the decision of the Discipline Committee of the College of Physicians and Surgeons of Saskatchewan. We find that she did not falsify a patient's medical record after being advised of a complaint having been made to SALPN.

However, this does not end the inquiry. The fact is, Ms. Hodgson did make changes to the July 2015 MAR and even though she intended it to be a "correction" to reflect what she says actually occurred, the evidence demonstrates that she did not make this correction in accordance with proper procedures and she did so without anyone's knowledge. As such, we find that Ms. Hodgson made an improper alteration to the MAR and that such conduct amounts to professional misconduct under the *Act*.

In particular, we find that Ms. Hodgson's conduct is harmful to the best interest of the public and the members. The MAR is an important legal record upon which the public and other members are entitled to rely. There is a specific procedure for making any changes to it, even if that change is in the nature of a correction of the information on the document. By failing to follow that procedure, Ms. Hodgson made an improper alteration and reliance on the document is

compromised. In addition, Ms. Hodgson's improper alteration has led to a situation where the information in the MAR is different than in other documentation (such as the nursing notes) which could lead to confusion for someone interpreting the resident's history, making it potentially harmful to the best interests of this resident, as a member of the public.

Ms. Hodgson's conduct also harms the standing of the profession. When an LPN does not act in accordance with proper procedures for a task as important as properly documenting the administration of medications, it can reflect poorly on the profession as a whole.

Therefore, on the basis of the evidence presented to it at the hearing and the submissions of legal counsel for the Investigation Committee, the Discipline Committee finds that in relation to this second aspect of Charge 2, Ms. Hodgson's conduct amounts to professional misconduct within the meaning of section 24 of *The Licensed Practical Nurses Act*.

Charge 3 – Alternate Dispute Resolution Agreement

> *3. On December 20, 2013, you entered into an Alternative Dispute Resolution Agreement (the "Agreement") with SALPN as a result of complaint received on June 5, 2013 from the Regina General Hospital regarding your conduct. The Agreement contained these terms:*
>
> > *Breach of agreement*
> >
> > *3. The member agrees that a breach of any of the terms of this Agreement constitutes professional misconduct, which may be referred to the Committee for investigation as a new complaint.*
> >
> > *Report of any suspension or termination*
> >
> > *8. The member agrees to arrange for her current employer(s), and any future employer(s) by whom she is employed to immediately report to the Committee any suspension or termination of her employment.*
>
> *As a result of the incidents described in paragraphs 1 and 2 herein, your employer Sun Country Health Region suspended you for a period of five days commencing July 9, 2015. Contrary to paragraph 8 of the Agreement, you did not report the suspension of your employment to SALPN.*

Evidence:

As a result of a complaint made to SALPN on May 31, 2013 by the Regina Qu'Appelle Health Region, Ms. Hodgson's prior employer, concerning her nursing practice in the Mother Baby Unit of the Regina General Hospital, the Investigation Committee conducted an investigation and determined that the complaint could be resolved through an ADR Agreement. The Agreement required Ms. Hodgson to complete a course through SIAST and submit periodic performance appraisals completed by her employer(s). The terms of the Agreement also required Ms.

Hodgson's agreement "*to arrange*" for her employer(s) "*to immediately report to the Committee any suspension or termination of her employment.*"

Ms. Bartzen testified that as an investigator with SALPN, she monitors compliance with ADR agreements. Mr. Bartzen stated that Ms. Hodgson completed the SIAST course, as required, and that Ms. Hodgson had requested that her employer submit performance appraisals, which her employer did, after she completed intervals measured by "actual worked hours of LPN practice," which included 500 hours, 1000 hours, and 1500 hours. All three of these performance appraisals appear to have been completed by Ms. Beattie and are all quite complimentary of Ms. Hodgson's performance. As of July 2015, only one term of the ADR agreement remained outstanding and that was to request that her employer submit a performance appraisal after she had completed 2000 hours.[4]

On July 21, 2015, Ms. Bartzen contacted Ms. Hodgson by email inquire about whether Ms. Hodgson had completed the "2000 hour performance appraisal," noting that the last performance appraisal for 1500 hours had been submitted on June 20, 2015[5] and therefore one would have anticipated that she had completed 2000 hours. Ms. Hodgson replied within minutes of receiving this message on July 21, 2015 to indicate that she would count her hours and get back to Ms. Bartzen.

Coincidentally, early the very next morning, July 22, 2015, Ms. Bartzen received a telephone call from Ms. Beattie who indicated that she wanted to file a complaint about an LPN but was having difficulties with the on-line submission process. Ms. Bartzen stated that she did not recognize Ms. Beattie's name at that time. Ms. Beattie advised Ms. Bartzen that she was filing a complaint as a result of a suspension of an LPN. When Ms. Beattie identified Ms. Hodgson by name, Ms. Bartzen was surprised because this was the first she heard about Ms. Hodgson's suspension despite Ms. Hodgson's requirement under the ADR agreement to notify SALPN of a suspension. Ms. Bartzen testified that following Ms. Beattie's on-line filing of the complaint, it is another SALPN staff member who sends the complaint to the member and requests a written response. The complaint was sent to Ms. Hodgson for a response on July 24, 2015. However, Ms. Bartzen stated that she was of the view that there now appeared to be two issues to deal with: the investigation of the new complaint as well as consideration about whether the ADR agreement had been breached.

---

[4] The evidence was not clear in terms of precisely when Ms. Hodgson had reached 2000 hours of practice. A performance appraisal dated January 20, 2015 indicates that she had reached 1500 hours, and a 2000-hour performance appraisal was completed on August 4, 2015.

[5] Based on other documentation, including the January 20, 2015 performance appraisal, it appears that the date referenced by Ms. Bartzen should have been "January 20" and not "June 20."

As previously noted, Ms. Beattie initially met with Ms. Hodgson on July 9, 2015 to discuss the medication issues involving EB and MV, and she advised Ms. Hodgson at that time that she would be off work on a non-disciplinary suspension while the employer investigated the issues. The investigation took a couple weeks and included Ms. Beattie meeting with Ms. Hodgson on July 16th. It appears that the employer finished its investigation and made a decision about the matters on or just before July 22, 2015, as that was the date upon which Ms. Beattie met with Ms. Hodgson, issued a letter of discipline (imposing a 5-day suspension, considered to have been served July 9-13, 2015) and Ms. Hodgson began working again.

Ms. Beattie completed a 2000-hour performance appraisal for Ms. Hodgson on August 4, 2015 and submitted it to the Investigation Committee. The results of this appraisal were less positive than prior appraisals that had been submitted: compared to the appraisal completed in January 2015 (using SALPN's standard format), Ms. Hodgson was rated as having "partially" met standards in three of four categories, rather than "fully" meeting standards of all categories, and the appraisal makes reference to the fact that Ms. Hodgson had recently been disciplined for inappropriate mediation administration.

As previously noted, once the Investigation Committee learned of the negative performance appraisal and the nature of the concerns raised, the Investigation Committee suspended Ms. Hodgson's license purportedly under a term of the ADR agreement that states that if a performance appraisal is "*unacceptable in the opinion of the Committee, her license will immediately be suspended until the circumstances are reviewed by the Committee*."

Submissions of the Investigation Committee:

Legal counsel for the Investigation Committee submitted that the evidence shows that Ms. Hodgson was suspended by Sun Country Health Region on July 9, 2015 pending the ongoing internal investigation by the facility, yet Ms. Hodgson failed to advise the Investigation Committee of that suspension; it was not until Ms. Beattie called Ms. Bartzen on July 22, 2015 seeking assistance in submitting a complaint on-line that Ms. Bartzen learned of Ms. Hodgson's suspension. Legal counsel further submitted that Ms. Hodgson failed to advise the Investigation Committee of the negative performance appraisal she received. In summary, legal counsel submitted that Ms. Hodgson breached the substance and intention of the ADR agreement and in particular, the requirement that the Investigation Committee be advised if her employment has been either suspended or terminated.

Decision and Analysis:

The issue to be determined, as outlined in the charge set out above, is whether Ms. Hodgson breached the ADR agreement when she did not report the suspension of her employment by the Sun Country Health Region to SALPN, specifically in contravention of paragraph 8 of that agreement. Before examining that issue, it is necessary to comment about the suggestion in the

evidence and submissions that Ms. Hodgson had also failed to advise the Investigation Committee about a negative performance appraisal she received.

The Investigation Committee led evidence concerning a negative performance appraisal Ms. Hodgson received on August 4, 2015. While the Investigation Committee made a submission at the hearing that Ms. Hodgson failed to advise the Investigation Committee about this negative performance appraisal, this allegation did not form part of the charges against Ms. Hodgson, as set out in the Notice of Discipline Hearing and formal complaint. Further, there was no application made at the hearing to amend the charges to include this allegation. For these reasons, this allegation is not properly before the Discipline Committee to consider and make any findings upon.

However, even if we had considered this allegation as part of the charges against Ms. Hodgson, we are of the view that Ms. Hodgson's conduct is not in violation of the terms of the ADR agreement. Although the negative performance appraisal may have provided proper grounds for the suspension of Ms. Hodgson's license under the terms of the ADR agreement (until such time as the circumstances were reviewed by the Investigation Committee), the agreement does not appear to obligate Ms. Hodgson to advise the Investigation Committee that she received a negative performance appraisal. The agreement states only that Ms. Hodgson "*agrees to request*" that her employer "*conduct performance appraisals*" regarding certain of her abilities with the appraisals to be provided at specified intervals. The evidence suggests that Ms. Hodgson would have been involved in having the employer complete the performance appraisals (which demonstrates that she has met the terms of the ADR agreement by "requesting" that her employer conduct the appraisals), but all of the appraisals appear to have been completed and delivered to SALPN by Ms. Beattie as representative of Ms. Hodgson's employer. In addition, the nature of SALPN's concern is unclear: the performance appraisal was completed and submitted on or after August 4, 2015 and it is therefore unclear whether the problem is that Ms. Hodgson should have submitted it herself or that it should have been submitted sooner. In any event, by the time the performance appraisal had been conducted and submitted, the Investigation Committee was already aware of the negative issues identified in the appraisal because they were the same issues that were the subject of the complaint made to SALPN by Ms. Beattie on July 22, 2015. Therefore, even if Ms. Hodgson was obligated to submit the performance appraisal and she failed to do so, or to do so sooner, there was really no impact given SALPN's prior knowledge of the identified issues.

Returning to the issue of whether Ms. Hodgson breached the ADR agreement when she did not report the suspension of her employment by the Sun Country Health Region to SALPN, paragraph 8 of that agreement requires careful examination to determine Ms. Hodgson's obligations. It states as follows:

> *8. The member agrees to arrange for her current employer(s), and any future employer(s) by whom she is employed to immediately report to the Committee any suspension or termination of her employment.*
>
> [emphasis added]

The evidence shows that effective July 9, 2015, Ms. Hodgson was off work on a "non-disciplinary" suspension to allow the employer time to investigate concerns that had been reported about Ms. Hodgson's administration of medications to EB and MV. On July 22, 2015, the employer notified Ms. Hodgson that the investigation was complete, that it had been determined that Ms. Hodgson's conduct warranted a disciplinary response, and that the discipline imposed was a 5-day suspension. However, the employer decided that the 5-day suspension will be considered as having been served from July 9, 2015 to July 13, 2015 inclusive (during which time Ms. Hodgson had been considered to have been on a non-disciplinary suspension for the purposes of an investigation) and allowed Ms. Hodgson to return to work that very day, July 22, 2015.

Clearly, it was not until July 22, 2015 that the employer decided and Ms. Hodgson learned that she was being disciplined for the medication administration incidents and given a 5-day suspension, which suspension was effectively back-dated to the period of time Ms. Hodgson was off work on a non-disciplinary suspension while the employer investigated the incidents in question. As such, the first question in this case is whether a "non-disciplinary" suspension (where an employee remains off work while the employer conducts an investigation) is a "suspension" as that term is used in paragraph 8 of the ADR agreement. In our view, it is not. Although paragraph 8 refers to the need to report "*any suspension or termination of … employment,*" it is our view that the parties to this agreement intended this requirement to refer to a disciplinary response by the employer, rather than an administrative action of the type here, where an employee is required to remain off work while an investigation is conducted in the workplace. It would appear that the purpose of including such a term in an ADR agreement is to provide the Investigation Committee with an additional method of "monitoring" the Member's conduct during the operative period of the ADR agreement. That is, in situations where the Member faces a significant disciplinary response (suspension or termination) from his or her employer, it is important that the suspension or termination be reported to the Investigation Committee so that the Committee can investigate the conduct underlying the imposition of that discipline. However, if an employer suspends an employee for the purposes of conducting an investigation where no determination has yet been made about whether there is conduct that warrants discipline, the professional regulatory body would likely find it premature to investigate the matter – in part because the workplace investigation may reveal that there is no conduct warranting any kind of response or disciplinary action. In this case, even though Ms. Hodgson's disciplinary suspension was "served" from July 9 to July 13, the employer's determination that Ms. Hodgson had engaged in conduct warranting discipline and the decision to impose a

disciplinary suspension was not made by the employer and communicated to Ms. Hodgson until July 22, 2015. Therefore, it is our view that any obligation under the ADR agreement to report a suspension or termination did not arise until July 22, 2015.

With respect to the obligation to report the suspension as of July 22, 2015, it is our view that Ms. Hodgson did not contravene the terms of paragraph 8 of the ADR agreement on the basis that paragraph 8 does not require Ms. Hodgson to personally report a suspension issued by her employer. Paragraph 8 indicates that Ms. Hodgson agrees "*to arrange for*" her employer "*to immediately report*" the suspension to the Investigation Committee. In this case, we do not have any evidence about whether Ms. Hodgson "arranged for" her employer to report the suspension to SALPN, but we do know that such a report was made. Most importantly, the employer made Ms. Hodgson aware that the matter would be reported to SALPN when they met on July 22, 2015 and as such, there would have been nothing more for Ms. Hodgson to "arrange" in terms of the employer's report. In addition, Ms. Beattie's disciplinary letter to Ms. Hodgson dated July 22, 2015 includes notice that the employer will be reporting the matter to SALPN and requesting that SALPN conduct its own investigation. In these circumstances, it would not have been unreasonable for Ms. Hodgson to assume that SALPN would be properly notified about her suspension, as indicated by the employer.

The Investigation Committee first learned of Ms. Hodgson's disciplinary suspension on July 22, 2015 when Ms. Beattie spoke to Ms. Bartzen about the filing of a complaint regarding Ms. Hodgson's suspension. Even if the ADR agreement imposed a requirement on Ms. Hodgson to "immediately" report the suspension to the Investigation Committee, it is our view that there needs to be an element of reasonableness applied. In this case the evidence shows that it could only have been a matter of minutes to a couple of hours between the time Ms. Hodgson was notified of the disciplinary suspension and the time Ms. Bartzen learned of the suspension from Ms. Beattie. That is not a reasonable time within which to have expected Ms. Hodgson to report the suspension, particularly because she was working on that date.

For all of these reasons, we find that Ms. Hodgson did not fail to notify SALPN of the suspension of her employment or to otherwise contravene paragraph 8 of the ADR agreement. This charge is dismissed.

DATED at Regina, Saskatchewan, this 11th day of July, 2016.

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES, DISCIPLINE COMMITTEE

Don Robinson, Public Representative, Chairperson
Brenda Lalonde LPN, Member
Arlene Patron, LPN, Member
Barb Lindsay, LPN, Member