

COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

**IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT*,**

**AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF DANIELLE NOBERT**

**DECISION OF THE HEARING TRIBUNAL
OF THE
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

**IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE
CONDUCT OF DANIELLE NOBERT, LPN #32932, WHILE A MEMBER OF THE COLLEGE OF
LICENSED PRACTICAL NURSES OF ALBERTA (“CLPNA”)**

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference March 27, 2025 with the following individuals present:

Hearing Tribunal:

Sarah Kawaleski, Licensed Practical Nurse (“LPN”) Chairperson
Treena Currie, LPN
Don Wilson, Public Member
Brett Huculak, Public Member

Staff:

Evie Maldonado, Legal Counsel for the Complaints Director, CLPNA
Sanah Sidhu, Director of Professional Conduct, CLPNA

Investigated Member:

Danielle Nobert, LPN (“Ms. Nobert” or “Investigated Member” or “Registered Member”)
Jamie Oyarzun, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Nobert was an LPN within the meaning of the Health Professions Act, RSA 2000, c H-7 (“Act”) at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Nobert was initially licensed as an LPN in Alberta on September 23, 2010.

On November 7, 2023, the CLPNA received a complaint pursuant to s. 57 of the HPA, notifying that Ms. Nobert was terminated from South Health Campus, Alberta in Calgary, Alberta (the “Facility”) on November 3, 2023. The complaint alleged concerns regarding Ms. Nobert’s practice as an LPN, specifically with respect to removal of medication without authorization, and breaching employer policies and procedures.

On November 14, 2023, the Complaints Director for the CLPNA delegated their powers and duties under the HPA to Stephanie Karkutly, Complaints Officer (the “Complaints Officer”) and appointed Neal York, Investigator, to investigate the complaint.

Following the receipt and review of the Investigation Report, on November 12, 2024, the Complaints Officer determined this matter should be referred to a hearing and provided Ms. Nobert with a Statement of Allegations, which was amended on February 13, 2025.

Ms. Nobert was provided with all the required hearing notices, under the Act, on January 15, 2025.

Arising from the complaint, the Complaints Officer determined it was necessary to impose a condition on Ms. Nobert’s practice permit to ensure safe and ethical practice. On November 15, 2023, Ms. Nobert voluntarily entered into an Interim Agreement to impose a Narcotic Restriction on her practice permit. This condition remains in place and prohibits Ms. Nobert from accessing, dispensing, or administering any narcotics or controlled substances.

(4) Allegations

The Allegations in the Statement of Allegations (the “Allegations”) are:

“It is alleged that **DANIELLE NOBERT, LPN**, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or between June 28 to August 2, 2023, while working in the Rapid Access Unit (RAU) of the South Health Campus, displayed a lack of judgement, skill, or knowledge in safe medication management by doing one or more of the following:
 - a. on or about June 28, 2023, regarding patient RB, failed to document the administration, waste or return of four (4) tablets of Zopiclone 5 mg removed from the medication Automatic Dispensing Cabinet at 1144 hours and 1408 hours resulting in unaccounted medications;
 - b. on or about June 29, 2023, regarding patient RB, failed to document the administration, waste or return of two (2) tablets of Zopiclone 5 mg removed from

- the medication Automatic Dispensing Cabinet at 1351 hours; resulting in unaccounted medications;
- c. on or about July 6, 2023, regarding patient MJQ, failed to document the administration, waste or return of 0.5mg of Hydromorphone 2mg/ml withdrawn from the medication Automatic Dispensing Cabinet at 1243 hours; resulting in unaccounted medications;
 - d. on or about July 11, 2023, regarding patient BL, failed to document the administration, waste or return of one (1) tablet of Hydromorphone 1 mg removed from the medication Automatic Dispensing Cabinet at 1237 hours; resulting in unaccounted medications;
 - e. on or about July 20, 2023, regarding patient KC, failed to document the administration, waste or return of two (2) tablets of Hydromorphone 2 mg removed from the medication Automatic Dispensing Cabinet at 1215 hours; resulting in unaccounted medications; and
 - f. on or about August 2, 2023, regarding patient YC, failed to document the administration, waste or return of 0.5 mg of Hydromorphone 2 mg/ml removed from the medication Automatic Dispensing Cabinet at 0906 hours. resulting in unaccounted medications.
2. On or between August 22 to October 3, 2023, while working in the Emergency Department of the South Health Campus, displayed a lack of judgement, skill, or knowledge in safe medication management by doing one or more of the following:
- a. on or about August 22, 2023, regarding patient AC / AL, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg, two (2) tablets of Acetaminophen 500 mg, and one (1) tablet of Cyclobenzaprine 10 mg removed from the medication Automatic Dispensing Cabinet using the override function at 2059 hours without justification or an authorized prescriber's order, resulting in unaccounted medications;
 - b. on or about August 29, 2023, regarding patient CL, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet using the override function at 1607 hours without justification to do so or an authorized prescriber's order, resulting in unaccounted medications;

- c. on or about August 29, 2023, regarding patient MS, failed to document the administration, waste, or return of one (1) tablet of Ativan 1 mg removed from the medication Automatic Dispensing Cabinet at 1827 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- d. on or about September 17, 2023, regarding patient SM, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 1231 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- e. on or about September 17, 2023, regarding patient MB, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1738 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- f. on or about September 19, 2023, regarding patient LS, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 2014 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- g. on or about September 22, 2023, regarding patient AB, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 0955 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- h. on or about September 25, 2023, regarding patient GC, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 1507 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- i. on or about October 3, 2023, regarding patient OR, failed to document the administration, waste, or return of six (6) 30 mg tablets of Tylenol #3 and six (6) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1553 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- j. on or about October 3, 2023, regarding patient MM, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1755 hours and without an authorized prescriber's order, resulting in unaccounted medications; and

- k. on or about October 3, 2023, regarding patient CD, failed to document the administration, waste, or return of six (6) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 1755 hours and without an authorized prescriber's order, resulting in unaccounted medications.
3. On or between June – October 2023, misappropriated one or more of the unaccounted medications in allegations 1 or 2 without authorization, or for an improper purpose.

It is further alleged that this conduct constitutes “unprofessional conduct” as defined in s.1(1)(pp)(i), (ii) and (xii) of the *Health Professions Act*, RSA 2000 c H-7 (the “HPA”) and in particular, this conduct breaches one or more of the following:

1. Standards of Practice for Licensed Practical Nurses in Canada (2020), Standard 1: Professional Accountability and Responsibility, Indicators 1.1, 1.2, 1.4, 1.5, 1.8, and 1.9;
2. Standards of Practice for Licensed Practical Nurses in Canada (2020), Standard 3: Protection of the public through self regulation, Indicators 3.4, 3.5, 3.7;
3. Standards of Practice for Licensed Practical Nurses in Canada (2020), Standard 4: Professional and Ethical Practice, Indicator 4.6;
4. Standards of Practice for Licensed Practical Nurses on Restricted Activities, Advanced Practice and Supervision, 8.2, 8.3, 8.4, 8.5, 8.5.1, and 8.8;
5. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principle 1: Responsibility to the Public, Indicators 1.1;
6. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principle 3: Responsibility to the Profession, Indicators 3.1 and 3.3; and
7. Code of Ethics for Licensed Practical Nurses in Canada (2013), Principle 5: Responsibility to Self, Indicators 5.1, 5.2, 5.3, 5.5, and 5.8.”

(5) Admission of Unprofessional Conduct

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

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #1.

(8) Decision of the Hearing Tribunal and Reasons

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

The Hearing Tribunal has reviewed the documents included in Exhibit #1 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Nobert's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Nobert.

Background Facts

Before addressing the facts in relation to each allegation specifically, there are certain background facts which give context to the allegations.

Ms. Nobert has worked in the Emergency Department (ED) of the Facility since 2012. Ms. Nobert was subject of previous Narcotic Restriction condition on her practice permit from February 27, 2023 to June 6, 2023. Accordingly, on or about February 2023, Ms. Nobert was assigned to work on the Rapid Access Unit (RAU) at the Facility. On or about August 2023, Ms. Nobert returned to work in the Emergency Department.

On September 28, 2023, Ms. Danks was notified by the Pharmacy Department at the Facility that on August 29, 2023, there were two (2) narcotic withdrawals from the Automatic Dispensing Cabinet (ADC) by Ms. Nobert that did not have an authorized prescriber's order. This prompted Ms. Danks to order an audit for all the days Ms. Nobert had been working in the Emergency Department. The audit revealed multiple instances of ADC transactions by Ms. Nobert that lacked an authorized prescriber's order and unaccounted for medications.

A similar audit was conducted for the RAU, which also identified ADC transactions by Ms. Nobert that lacked an authorized prescriber's order and unaccounted for medications.

Automated Dispensing Cabinets

The Facility uses an ADC as an electronic medication management system. The Facility ADCs are maintained by the Pharmacy Department. The purpose of the ADC is to ensure that required medications are readily accessible without the need for the Pharmacy Department to first process prescriber orders and deliver the medications to the patient care area. This allows for timely medication administration and a reduction in delays in patient care.

The ADC permits staff or authorized users to withdraw medications as ordered and then tracks and records the withdrawals. The information the ADC records is available in audit reports. The following information is recorded on the ADC audit reports relevant to this matter:

- a. date and time medication is withdrawn;
- b. name of the staff member or authorized user who made the withdrawal;
- c. name, form, and dose of the medication being withdrawn, including the total amount of medication withdrawn; and
- d. whether the medication was wasted or returned and in what amount, and where applicable, a reason for the waste or return.

In the RAU, an authorized prescriber's order is required to remove medication from the ADC. The medication is then expected to be administered to the client, wasted, or returned to the ADC.

In the ED, a cabinet override function can be used to remove medications from the ADC. The cabinet override function is only available to staff and authorized users who work in the ED of the Facility. The purpose of the cabinet override function in the ED is to allow staff to easily access required medication in a timely manner such as an emergency or when requiring manual entry of an authorized prescriber's order prior to withdrawal could lead to delay in urgent patient care. Accessing medications through the ADC override function bypasses safeguards associated with a pharmacist review: the ADC override function in the ED is intended to address emergent and urgent situations in which a medication must be removed. Considering the lack of pharmacy safeguards, staff and authorized users are required to take extra care to ensure the medication removed from the ADC using the cabinet override function is safe and appropriate for the intended use.

The cabinet override function does not require a written prescriber's order first to access and remove medications from the ADC; however, does require users to obtain a verbal order from an authorized prescriber, and enter the order into the system as soon as possible. Staff are also required to document the administration of the medication in the patient's Connect Care Record (Chart) and Medication Administration Record (MAR) to ensure timely communication and an accurate record of care provided. Alternatively, staff must record waste or return of the dispensed medication in the ADC if it is not administered.

Restricted Activity

The Controlled Drugs and Substances Act, SC 1996, c 19 (the "CDSA") regulates the possession, production, distribution, and sale of controlled substances federally. Drugs and substances are classified into eight schedules based on their potential harm and abuse.

In the HPA, it is a restricted activity "to dispense, compound, provide for selling or sell a Schedule 1 drug or Schedule 2 drug within the meaning the Pharmacy and Drug Act (section 1.3(1)(h). Note Schedule 1 and Schedule 2 drugs in the Pharmacy and Drug Act refer to Schedule I and Schedule II drugs in the CDSA.

In accordance with the Health Professions Restricted Activity Regulation and the Standards of Practice on Restricted Activities, Advanced Practice, and Supervision, LPNs are authorized to dispense drugs in Schedule I and Schedule II of the CDSA where the dispensing of the drug is incidental to the practice of practical nursing.

The following medications relating to the allegations are contained within Schedule I of the CDSA:

- a. Zopiclone [Allegation 1(a)(b) and 2(a)(b)(e)(i)(j)];
- b. Hydromorphone [Allegation 1(c)(d)(e)(f)];
- c. Cyclobenzaprine [Allegation 2(a)];
- d. Acetaminophen [Allegation 2(a)]; and
- e. Ativan, also known as, Lorazepam– [Allegation 2(c)].

The following medications relating to the allegations are contained within Schedule II of the CDSA:

- a. Tylenol #3, also known as, acetaminophen/caffeine/codeine [Allegation 2(d)(f)(g)(i)(k)].

Allegation 1

Ms. Nobert admitted that on or between June 28 to August 2, 2023, while working in the Rapid Access Unit (RAU) of the South Health Campus, she displayed a lack of judgement, skill, or knowledge in safe medication management by doing one or more of the following:

- a. on or about June 28, 2023, regarding patient RB, failed to document the administration, waste or return of four (4) tablets of Zopiclone 5 mg removed from the medication Automatic Dispensing Cabinet at 1144 hours and 1408 hours resulting in unaccounted medications;
- b. on or about June 29, 2023, regarding patient RB, failed to document the administration, waste or return of two (2) tablets of Zopiclone 5 mg removed from the medication Automatic Dispensing Cabinet at 1351 hours; resulting in unaccounted medications;
- c. on or about July 6, 2023, regarding patient MJQ, failed to document the administration, waste or return of 0.5mg of Hydromorphone 2mg/ml withdrawn from the medication Automatic Dispensing Cabinet at 1243 hours; resulting in unaccounted medications;
- d. on or about July 11, 2023, regarding patient BL, failed to document the administration, waste or return of one (1) tablet of Hydromorphone 1 mg removed from the medication Automatic Dispensing Cabinet at 1237 hours; resulting in unaccounted medications;
- e. on or about July 20, 2023, regarding patient KC, failed to document the administration, waste or return of two (2) tablets of Hydromorphone 2 mg removed from the medication Automatic Dispensing Cabinet at 1215 hours; resulting in unaccounted medications; and
- f. on or about August 2, 2023, regarding patient YC, failed to document the administration, waste or return of 0.5 mg of Hydromorphone 2 mg/ml removed from the medication Automatic Dispensing Cabinet at 0906 hours. resulting in unaccounted medications.

Ms. Nobert worked on the RAU on June 28, 2023 and was the primary nurse for Client RB. Client RB had an authorized prescriber's order for one (1) tablet of Zopiclone 5 mg daily, at bedtime as needed. A copy of the Client RB's MAR for the prescribed Zopiclone 5 mg was included in Exhibit #1 at TAB 4.

Ms. Nobert removed two (2) tablets of Zopiclone 5 mg for Client RB at 1144 hours and 1408 hours resulting in four (4) tablets total withdrawn. Ms. Nobert did also initiate a different withdrawal of Zopiclone 5 mg at 1143 hours; however, cancelled that transaction. A copy of the ADC Report for Client RB was included in Exhibit #1 at TAB 5.

Ms. Nobert documented on Client RB's MAR that Zopiclone 5 mg was "Not Given" and "Entered in Error" for both the 1144 hours and 1408 hours withdrawals (Exhibit #1, TAB 4).

There was no documentation by Ms. Nobert on Client RB's MAR regarding administration or on the ADC report for the waste or return of the total of four (4) tablets of Zopiclone 5 mg withdrawn at 1144 hours and 1408 hours.

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

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

Medication administration and medication management are integral to the work of an LPN. Ms. Nobert failed to document the administration, waste, or return of both Zopiclone and Hydromorphone from the Automatic Dispensing Cabinet. By doing this, Ms. Nobert displayed a lack of skill or judgement and knowledge by failing to adhere to proper documentation in accordance with skills which are expected of an LPN as a core competency regardless of experience.

Medication administration and the documentation of medication administration is vital, as this allows for a clear record of what medication a client has received. This allows any member of the healthcare team who is reviewing the charting to make a health decision with accurate information about the client so they can make an evidence-based decision. This also allows for double-checking with medications to prevent the client receiving a double dose of medication, dosages can be properly tracked and to ensure that the client is receiving the proper dosage. This is especially important when it comes to narcotics.

This lack of documentation harms the integrity of the regulated profession as it is an expectation that an LPN will fill out all the proper documentation that is expected with medication administration when it comes to patient care. Members of the public need to be able to trust that the care they are receiving from an LPN is done in a way that ensures that they will receive the best possible outcomes and certainly not be performed in a manner that could cause harm.

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

CLPNA Code of Ethics:

Principle 1: Responsibility to the Public - LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:

1.1 Maintain standards of practice, professional competence and conduct.

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

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
- 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

Principle 5: Responsibility to Self - LPNs recognize and function within their personal and professional competence and value systems.

- 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.
- 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 judgment.
- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.
- 5.5 Inform the appropriate authority in the event of becoming unable to practice safely, competently and/or ethically.
- 5.8 Maintain the required mental and physical wellness to met the responsibilities of the role.

CLPNA Standards of Practice:

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

- 1.1 Practice within applicable legislation, regulations, by-laws, and employer policies.
- 1.2 Self-assess their professional practice and competence and participate in continuous learning.
- 1.4 Practice within LPN scope of practice and individual level of competence and consult and collaborate when necessary.
- 1.5 Have a duty to report any circumstances that potentially and/or actually impede professional, ethical, or legal practice.

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

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

Standard 3: Protection of the Public through self-regulation – LPNs collaborate with clients and other members of the healthcare team to provide safe care and improve health outcomes. Standard 3 specifically provides that LPNs:

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

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

3.7 Maintain their physical, mental, and emotional fitness to practice in order to provide safe, competent, and ethical nursing care.

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

4.6 Demonstrate practice that upholds the integrity of the profession.

Standard 8: Dispensing Medications – When an LPN dispenses a medication, the LPN must:

8.2 only dispense controlled drugs or substances listed in Appendix A;

8.3 have determined that pharmacy is not available to dispense the medication;

8.4 be knowledgeable about the CLPNA policy documents related to medication management;

8.5 ensure there is complete patient-specific medication order or protocol from an authorized prescriber;

8.5.1 if the order is incomplete, medications must not be dispensed until the medication order is clarified;

8.8 adhere to best practices and employer requirements in dispensing medication (i.e. rights and checks) to reduce the risk of medication error and ensure client safety.

The Hearing Tribunal finds that Ms. Nobert's conduct constituted a breach of the CLPNA Code of Ethics and CLPNA Standards of Practice.

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

By failing to adhere to proper documentation, Ms. Nobert did not identify and minimize risk to clients as these medication documentation errors deal with Hydromorphone which is a narcotic and controlled substance within the workplace. Hydromorphone belongs to the opioid drug class which includes morphine. It has an analgesic potency approximately two to eight times greater than that of morphine and has a rapid onset of action. Again, proper documentation is essential and allows the whole healthcare team the best information on which to make informed decisions about care.

Ms. Nobert failed to maintain the standards of the profession and to conduct herself in a manner that is expected of another LPN in a similar situation. Medication administration and documentation is a core competency that is expected of an LPN. If Ms. Nobert was having some doubt with her practice then she should have asked for assistance from another member of the health care team. This would allow Ms. Nobert to take responsibility for her own actions and to adhere to the self-regulation in which LPNs practice.

Allegation 2

Ms. Nobert admitted that on or between August 22 to October 3, 2023, while working in the Emergency Department of the South Health Campus, she displayed a lack of judgement, skill, or knowledge in safe medication management by doing one or more of the following:

- a. on or about August 22, 2023, regarding patient AC / AL, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg, two (2) tablets of Acetaminophen 500 mg, and one (1) tablet of Cyclobenzaprine 10 mg removed from the medication Automatic Dispensing Cabinet using the override function at 2059 hours without justification or an authorized prescriber's order, resulting in unaccounted medications;
- b. on or about August 29, 2023, regarding patient CL, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet using the override function at 1607 hours without justification to do so or an authorized prescriber's order, resulting in unaccounted medications;
- c. on or about August 29, 2023, regarding patient MS, failed to document the administration, waste, or return of one (1) tablet of Ativan 1 mg removed from the

medication Automatic Dispensing Cabinet at 1827 hours and without an authorized prescriber's order, resulting in unaccounted medications;

- d. on or about September 17, 2023, regarding patient SM, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 1231 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- e. on or about September 17, 2023, regarding patient MB, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1738 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- f. on or about September 19, 2023, regarding patient LS, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 2014 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- g. on or about September 22, 2023, regarding patient AB, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 0955 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- h. on or about September 25, 2023, regarding patient GC, failed to document the administration, waste, or return of four (4) 30 mg tablets of Tylenol #3 removed from the medication Automatic Dispensing Cabinet at 1507 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- i. on or about October 3, 2023, regarding patient OR, failed to document the administration, waste, or return of six (6) 30 mg tablets of Tylenol #3 and six (6) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1553 hours and without an authorized prescriber's order, resulting in unaccounted medications;
- j. on or about October 3, 2023, regarding patient MM, failed to document the administration, waste, or return of four (4) tablets of Zopiclone 7.5 mg removed from the medication Automatic Dispensing Cabinet at 1755 hours and without an authorized prescriber's order, resulting in unaccounted medications; and
- k. on or about October 3, 2023, regarding patient CD, failed to document the administration, waste, or return of six (6) 30 mg tablets of Tylenol #3 removed from the medication

Automatic Dispensing Cabinet at 1755 hours and without an authorized prescriber's order, resulting in unaccounted medications.

Ms. Nobert worked a shift in the ED on August 22, 2023.

Client AC / AL attended the ED on August 22, 2023, at 1726 hours and was discharged the same day at 2100 hours. A copy of Client AC / AL's Chart was included in Exhibit #1 at TAB 14.

Ms. Nobert removed the following medications under Client AC/AL's name on August 22, 2023, using the cabinet override function on the ADC without justification, at 2059 hours:

- a. one (1) tablet of Cyclobenzaprine 10 mg;
- b. two (2) tablets of Acetaminophen 500 mg; and
- c. four (4) tablets of Zopiclone 7.5 mg.

A copy of Client AC / AL's ADC Report for August 22, 2023 was included in Exhibit #1 at TAB 15.

Ms. Nobert removed the medication from the ADC on August 22, 2023 at 2059 hours, despite Client AC / AL being discharged at 2100 hours. Client AC / AL had no authorized prescriber's orders for Zopiclone 10 mg, Acetaminophen 500 mg, or Cyclobenzaprine 10 mg. The Attending Physician, Dr. C. Krook, did not reference any of these three medications in his Clinical Note dated August 22, 2023 at 2052 hours [Exhibit #1 at TAB 14].

There was no documentation by Ms. Nobert on Client AC/AL's MAR regarding administration of the medication, or on the ADC report for the waste or return of the for Zopiclone 10 mg, Acetaminophen 500 mg, or Cyclobenzaprine 10 mg.

Ms. Nobert worked a shift in the ED on August 29, 2023.

Client CL attended the ED on August 29, 2023, at 1214 hours and was discharged the same day at 1634 hours. A copy of Client CL's Chart was included in Exhibit #1 at TAB 16.

Client CL had authorized prescriber order's for Acetaminophen 1000 mg, Ibuprofen 400 mg, and Lorazepam 1mg during their ED visit [Exhibit #1 at TAB 16].

At 1607 hours, Ms. Nobert removed four (4) tablets of Zopiclone 7.5 mg, using the cabinet override function on the ADC, under Client CL's name. There was no justification for the removal. A copy of the ADC Report from August 28-29, 2023, was included in Exhibit #1 at TAB 17.

There was no documentation by Ms. Nobert on Client CL's MAR regarding administration of the four (4) tablets of Zopiclone 7.5 mg, or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on August 29, 2023.

Client MS attended the ED on August 29, 2023, at 1304 hours and was discharged the same day at 2012 hours. A copy of Client MS's Chart was included in Exhibit #1 at TAB 18.

Client MS had authorized prescriber order's Acetaminophen 975 mg and Ibuprofen 400 mg during their ED visit [Exhibit #1 at TAB 18].

At 1827 hours, Ms. Nobert removed one (1) tablet of Lorazepam 1 mg, also known as Ativan 1 mg, using the cabinet override function on the ADC, under Client MS's name [August 28-29, 2023 ADC Report Exhibit #1 at TAB 17].

There was no documentation by Ms. Nobert on Client MS's MAR regarding administration of the Lorazepam 1mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on September 17, 2023.

Client SM attended the ED on September 17, 2023 at 1114 hours and was discharged the same day at 1458 hours. A copy of Client SM's Chart was included in Exhibit #1 at TAB 19.

Client SM had authorized prescriber order's Acetaminophen 975 mg and Ibuprofen 400 mg during their ED visit [Exhibit #1 at TAB 19].

At 1231 hours, Ms. Nobert removed four (4) tablets of Acetaminophen/caffeine/codeine 30 mg, also known as Tylenol #3, using the cabinet override function on the ADC, under Client SM's name. A copy of the ADC Report from September 17 - 27, 2023 was included in Exhibit #1 at TAB 20.

There was no documentation by Ms. Nobert on Client SM's MAR regarding administration of the four (4) 30 mg Tylenol 3 or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on September 17, 2023.

Client MB attended the ED on September 17, 2023 at 1410 hours and was discharged the same day at 1825 hours. A copy of Client MB's Chart was included in Exhibit #1 at TAB 21.

Client MB had authorized prescriber order's Cephalexin 500 mg, Ibuprofen 400 mg, oxycodone-acetaminophen 5mg-325mg, and propofol 10 mg/ml during their ED visit [Exhibit #1 at TAB 21].

At 1738 hours, Ms. Nobert removed four (4) tablets of Zopiclone 7.5 mg, using the cabinet override function on the ADC, under Client MB's name [ADC Report from September 17 - 27, 2023 Exhibit #1 at TAB 20].

There was no documentation by Ms. Nobert on Client MB's MAR regarding administration of the four (4) tablets of Zopiclone 7.5 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on September 19, 2023.

Client LS attended the ED on September 19, 2023 at 1444 hours and was discharged the same day at 1939 hours. A copy of Client LS's Chart was included in Exhibit #1 at TAB 22.

At 2014 hours, Ms. Nobert removed four (4) tablets of Acetaminophen/caffeine/codeine 30 mg, also known as Tylenol #3, using the cabinet override function on the ADC, under Client LS's name [the ADC Report from September 17 - 27, 2023 Exhibit #1 at TAB 20].

Ms. Nobert removed the Tylenol #3 from the ADC at 2014 hours, without justification, after Client LS had been discharged from the ED at 1939 hours.

Additionally, there was no authorized prescriber's order documented for four (4) tablets of Tylenol #3 for Client LS [Exhibit #1 at TAB 22].

There was no documentation by Ms. Nobert on Client LS's MAR regarding administration of the four (4) Tylenol #3 30 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on September 22, 2023.

Client AB attended the ED on September 22, 2023 at 0229 hours and was discharged the same day at 0940 hours. A copy of Client AB's Chart was included in Exhibit #1 at TAB 23.

At 0955 hours, Ms. Nobert removed four (4) tablets of Acetaminophen/caffeine/codeine 30 mg, also known as Tylenol #3, using the cabinet override function on the ADC, under Client SM's name [the ADC Report from September 17-27, 2023, Exhibit #1 at TAB 20].

Ms. Nobert removed the Tylenol #3 from the ADC at 0955 hours, after Client AB had been discharged from the ED at 0940 hours.

Additionally, there was no authorized prescriber's order documented for four (4) tablets of Tylenol #3 for Client AB [Exhibit #1 at TAB 23].

There was no documentation by Ms. Nobert on Client AB's MAR regarding administration of the four (4) Tylenol #3 30 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on September 25, 2023.

Client GC attended the ED on September 25, 2023 at 0941 hours and was discharged the same day at 1524 hours. A copy of Client GC's Chart was included in Exhibit #1 at TAB 24.

Client GC had no authorized prescriber orders for Acetaminophen/caffeine/ codeine 30 mg, also known as Tylenol #3, during their ED visit.

At 1507 hours, Ms. Nobert removed four (4) tablets of Tylenol #3, using the cabinet override function on the ADC, under Client GC's name [the ADC Report from September 17 - 27, 2023 Exhibit #1 at TAB 20].

There was no documentation by Ms. Nobert on Client GC's MAR regarding administration of the four (4) Tylenol #3 30 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on October 3, 2023.

Client OR attended the ED on October 3, 2023 at 1141 hours and was discharged the same day at 1543 hours. A copy of Client OR's Chart was included in Exhibit #1 at TAB 25.

Ms. Nobert removed, using the cabinet override function on the ADC, under Client OR's name:

- a. six (6) tablets of Zopiclone 7.5 mg at 1553 hours; and
- b. six (6) tablets of Acetaminophen/caffeine/codeine 30 mg, also known as Tylenol #3, on at 1554 hours, for Client SM, with no documentation on waste or return.

A copy of the ADC Report from October 1-7 2023 was included in Exhibit #1 at TAB 26.

Ms. Nobert remove the above-noted medications from the ADC, after Client OR had been discharged from the ED.

There was no authorized prescriber's order documented for six (6) tablets of Zopiclone 7.5 mg or size (6) tablets of Tylenol #3 for Client OR [Exhibit #1 at TAB 25].

There was no documentation by Ms. Nobert on Client OR's MAR regarding administration of the six (6) Tylenol #3 30 mg or six (6) Zopiclone 7.5 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on October 3, 2023.

Client MM attended the ED on October 3, 2023 at 1323 hours and was discharged the same day at 1751 hours. A copy of Client MM's Chart was included in Exhibit #1 at TAB 27.

At 1755 hours, Ms. Nobert removed four (4) tablets of Zopiclone 7.5 mg, using the cabinet override function on the ADC, under Client OR's name [the ADC Report from October 1-7, 2023, Exhibit #1 at TAB 26].

Ms. Nobert removed the above-noted medications from the ADC, after Client MM had been discharged from the ED.

Additionally, there was no authorized prescriber's order documented for four (4) tablets of Zopiclone 7.5 mg for Client MM [Exhibit #1 at TAB 27].

There was no documentation by Ms. Nobert on client MM's MAR regarding administration of the four (4) Zopiclone 7.5 mg or on the ADC report for the waste or return of the same.

Ms. Nobert worked a shift in the ED on October 3, 2023.

Client CD attended the ED on October 2, 2023 at 1930 hours and was admitted to inpatient unit 78 from the ED on October 3, 2023, at 1320 hours. A copy of Client CD's Chart was included in Exhibit #1 at TAB 28.

At 1846 hours, Ms. Nobert removed six (6) tablets of Tylenol #3 (acetaminophen/caffeine/codeine 30 mg) using the cabinet override function on the ADC, under Client Cd's name [the ADC Report from October 1 – 7, 2023, Exhibit #1 at TAB 26].

Ms. Nobert removed the above-noted medications from the ADC, after Client CD had been discharged from the ED.

Additionally, Client CD did not have an authorized prescriber order for Tylenol #3 (acetaminophen/caffeine/codeine 30 mg) during their visit to the ED [Exhibit #1 at TAB 28].

There was no documentation by Ms. Nobert on client CD's MAR regarding administration of the six (6) 30 mg tablets of Tylenol #3 or on the ADC report for the waste or return of the same.

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

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

The Hearing Tribunal's reasons with respect to why the conduct found in Allegation #2 rises to the level of unprofessional conduct are substantially the same as those stated in Allegation #1.

Allegation 3

Ms. Nobert admitted that on or between June – October 2023, she misappropriated one or more of the unaccounted medications in Allegations 1 or 2 without authorization, or for an improper purpose.

Throughout June to October 2023, Ms. Nobert removed the following medications from the Facility's RAU and ED, not for a client-care or employment related purpose but instead for an unauthorized and improper purpose:

- a. On June 28, 2023, she removed four (4) tablets of Zopiclone 5 mg for Client RB and documented no administration, waste, or return (see Allegation 1(a));
- b. On June 29, 2023, she removed two (2) tablets of Zopiclone 5 mg for Client RB and documented no administration, waste, or return (see Allegation 1(b));

- c. On July 6, 2023, she removed 2 mg/ml of Hydromorphone for Client MJQ and documented wastage of 1.5 mg/ml, with no documented administration, waste or return of the remaining 0.5 mg/ml (see Allegation 1(c));
- d. On July 11, 2023, she removed two (2) tablets of Hydromorphone 1 mg for Client CL and documented administration of one (1) tablet, with no documented administration, waste, or return of the remaining one (1) tablet (see Allegation 1(d));
- e. On July 20, 2023, she removed three (3) tablets of Hydromorphone 2 mg and one (1) tablet of Hydromorphone 1 mg for Client KC and documented administration of one (1) tablet of each of the Hydromorphone 2 mg and Hydromorphone 1 mg, with no documented administration, waste, or return of the remaining two (2) tablets of Hydromorphone 2 mg (see Allegation 1(e));
- f. On August 2, 2023, she removed 2 mg/ml of Hydromorphone for Client YC and documented administration of 0.5 mg/ml, waste of 1 mg/ml, with no documented administration, waste, or return of the remaining 0.5 mg/ml (see Allegation 1(f));
- g. On August 22, 2023, she removed four (4) tablets of Zopiclone 7.5 mg, two (2) tablets of Acetaminophen 500 mg, and one (1) tablet of Cyclobenzaprine 10 mg for Client AC / AL, after they were discharged, with no documented administration, waste or return (see Allegation 2(a));
- h. On August 29, 2023, she removed four (4) tablets of Zopiclone 7.5 mg for Client CL and documented no administration, waste, or return of the same (see Allegation 2(b));
- i. On August 29, 2023, she removed one (1) tablet of Ativan 1 mg for Client MS and documented no administration, waste, or return of the same (see Allegation 2(c));
- j. On September 17, she removed four (4) tables of Tylenol #3 for Client SM and documented no administration, waste, or return of the same (see Allegation 2(d));
- k. On September 17, 2024, she removed four (4) tablets of Zopiclone 7.5 mg for Client MB and documented no administration, waste, or return of the same (see Allegation 2(3));
- l. On September 19, 2024, she removed four (4) tablets of Tylenol #3 for Client LS and documented no administration, waste, or return of the same (see Allegation 2(f));
- m. On September 22, 2023, she removed four (4) tablets of Tylenol #3 for Client AB and documented no administration, waste, or return of the same (see Allegation 2(g));
- n. On September 25, 2023, she removed four (4) tables of Tylenol #3 for Client GC and documented no administration, waste, or return of the same (see Allegation 2(h));

- o. On October 3, 2023, she removed six (6) tablets of Tylenol #3 and six (6) tablets of Zopiclone 7.5 mg and documented no administration, waste, or return of the same (see Allegation 2(i));
- p. On October 3, 2023, she removed four (4) tablets of Zopiclone 7.5 mg and documented no administration, waste, or return of the same (see Allegation 2(j)); and
- q. On October 3, 2023, she removed six (6) tablets of Tylenol #3 and documented no administration, waste, or return of the same (see Allegation 2(k)).

Ms. Nobert took advantage of her role and position in the RAU and ED of the Facility to gain access to medications, including ones classified as narcotics such as Hydromorphone and Tylenol #3, to misappropriate them.

There was also a pattern of how medication was misappropriated by Ms. Nobert, as she would:

- a. not administer prescribed medication to a client [Allegation 1(a)(b)(c)];
- b. remove greater quantities of medication and only administer or waste a portion, with no documented administration, waste or return of the remainder [Allegation 1(c)(d)(f)];
- c. remove medications from the ADC after the discharge of a patient [Allegations 2(a)(f)(g)(i)(j)];
- d. remove medications from the ADC without an authorized prescriber's order and have no documentation of administration, waste or return [Allegations 2(b)(c)(d)(e)(h)(k)].

The CLPNA's Medication Management Policy, at Exhibit #1 at TAB 29, in force during the relevant period of time requires nursing staff to follow the eight rights of medication administration, namely: right reason, right patient, right medication, right dose, right route, right time and frequency, right to refuse, and right documentation. By misappropriating medications for an improper purpose and documenting client care inaccurately for the purpose of misappropriating, she took advantage and failed to follow these eight rights of medication administration for multiple clients.

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

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

Misappropriation of medication is serious especially where the medications in question are narcotics. This demonstrates a lack of judgement and betrays the trust reposed in LPNs. Similarly, this conduct undermines the integrity of the profession as it signals that an LPN is not trustworthy.

Ms. Nobert did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

It demonstrates a failure to provide ethical and responsible care aimed at promoting the best possible health outcomes in those receiving it.

This conduct is not consistent with the privilege of self-regulation which requires integrity from every LPN in order to be maintained. It imparts a high degree of responsibility on each LPN, where one LPN fails to meet the CLPNA Code of Ethics and CLPNA Standards of Practice in such a manner, it impacts the clients receiving care, the healthcare team providing that care, the profession as a whole, and the particular LPN.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Nobert jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.
2. Ms. Nobert's practice permit shall be subject to a Narcotics Restriction condition which restricts her from being able to access, co-sign, administer narcotics and controlled substances.
3. Ms. Nobert shall, within 6 months of service of the Decision, undergo a Substance Use Assessment, at her own cost, through either Homewood Health or an independent Registered Psychologist or Psychiatrist qualified in substance use disorders (the "Assessor") acceptable to the Complaints Officer, subject to the following terms and conditions:
 - a) The Assessor will be provided with a copy of the ASF, the JSP, and a copy of Decision, if available by the date of the Substance Use Assessment;
 - b) The Assessor will provide a full copy of their completed assessment (the "Assessment") to Ms. Nobert and the Complaints Officer.

- c) The Assessment will:
- i. Include, where applicable, recommendations for ongoing counselling or treatment;
 - ii. Address the utility of an ongoing Narcotic Restriction on Ms. Nobert's CLPNA practice permit; and
 - iii. Address the need for any other conditions.
- d) Ms. Nobert shall comply with all recommendations made by the Assessor and provide proof of completion to the Complaints Officer.
4. The Narcotics Restriction may be removed by the Complaints Officer when the Complaints Officer, upon review and consideration of the Assessment and any recommendations made within, is satisfied that the Narcotics Restriction is no longer needed to ensure patient safety.
5. Ms. Nobert shall read and reflect on how the following Educational Readings will impact their nursing practice. These documents are available on CLPNA's website and will be provided. Ms. Nobert shall provide a signed written declaration to the Complaints Officer, within **30 days** of the service of the Decision, attesting that they have reviewed the documents:
- (a) Code of Ethics for Licensed Practical Nurses in Canada;
 - (b) Standards of Practice for Licensed Practical Nurses in Canada;
 - (c) Standards of Practice for Licensed Practical Nurses on Boundary Violations;
 - (d) CLPNA Policy: Documentation;
 - (e) CLPNA Policy: Medication Management; and
 - (f) CLPNA Policy: Professional Responsibility and Accountability.

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

6. Ms. Nobert shall complete the following remedial education, at her own cost, and shall provide the Complaints Director with documentation confirming successful completion within **6 months** of the service of the Decision:
- (a) CLPNA Learning Module - [Documentation - CLPNA](#)
 - (b) CLPNA Learning Module - [Medication Management - CLPNA](#)
 - (c) PBI Course - [Maintaining Ethics, Boundaries and Professionalism in Nursing \(NE-3\)](#)

(d) ICRS Course - [ICRS Righting a Wrong' - Ethics & Professionalism in Nursing](#)

If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Officer.

7. Ms. Nobert shall pay 15% of the costs of the investigation and hearing to a maximum of \$3,000, to be paid over **24 months** of service of the Decision.
 - a) A letter advising of the final costs will be provided to Ms. Nobert when final costs have been confirmed.
 - b) The costs must be paid to the CLPNA, whether or not Ms. Nobert holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered as an action in debt.
8. The sanctions set out above at paragraphs 2 to 7 will appear as conditions on Ms. Nobert's practice permit and the Public Registry subject to the following:
 - a) The condition at paragraph 2 will appear as "Restr. Narcotics Access & Admin." with the reason cited as "Conduct" until removed in accordance with paragraph 4;
 - b) The requirements at paragraphs 3, 5, and 6 will appear as "CLPNA Monitoring Orders (Conduct)" until they have all each been successfully completed; and
 - c) The requirement at paragraph 7, will appear as "Conduct Cost/Fines" until all costs have been paid.
9. Ms. Nobert shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information, and keep her contact information current with the CLPNA on an ongoing basis.
10. Should Ms. Nobert be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.
11. Should Ms. Nobert fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

- (a) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
- (b) Treat Ms. Nobert's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or
- (c) In the case of nonpayment of costs described at paragraph 7, suspend Ms. Nobert's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Nobert has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member

- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

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

The age and experience of the investigated member: Ms. Nobert has been an LPN since 2012, and this type of conduct cannot be excused. Ms. Nobert has the knowledge and experience from her years of experience that Ms. Nobert would be expected to demonstrate the minimum competencies of an LPN. Ms. Nobert has been employed by this employer since 2012.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: Ms. Nobert was previously put on a 20-day suspension on February 6, 2023 following another drug diversion investigation. The conduct from the current allegations occurred shortly after Ms. Nobert's return to work from her previous suspension.

The age and mental conditions of the victim: No specific information was provided in respect of the clients impacted by the conduct detailed above.

The number of times the offending conduct was proven to have occurred: The Hearing Tribunal was presented with three allegations, each with numerous sub-allegations, that took place over a period of August 19, 2023 until October 3, 2023. There are multiple instances over a two-month period. This was not a one-off situation as there was repeated conduct.

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

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Nobert does currently have a restriction on her practice permit with regard to accessing and administering narcotics. Ms. Nobert is unable to be hired again with AHS.

The impact of the incident(s) on the victim: The Hearing Tribunal does not have any evidence of direct impact to patients; however, errors with documentation or lack thereof could potentially impact patients.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: It is important that the Hearing Tribunal's decision on sanction has the dual effect of deterring Ms. Nobert from engaging in similar conduct in the future, but also that members of the LPN profession are deterred from similar conduct.

The need to maintain the public's confidence in the integrity of the profession: The public must have confidence that LPNs uphold the standards and requirements expected of them. Where that does not occur, the response to unprofessional conduct should signal to the public that such conduct is not accepted by the CLPNA and that LPNs who engage in unprofessional conduct are appropriately sanctioned. In this way, the public can feel confident that LPNs providing care to them will meet the requirements to ensure safe and effective health care.

The range of sentences in other similar cases: The Hearing Tribunal has considered the sentencing in similar cases. The Hearing Tribunal carefully considered the seriousness of the misconduct and whether or not cancellation of registration was required for the purposes of the protection of the public and deterrence, but ultimately concluded that the existing narcotic access restrictions, coupled with the reprimand, the substance use assessment and the remedial education requirements accomplish the objectives of sanction. The reprimand denounces the misconduct, and the Substance Use Assessment ensures the protection of the public. Further, the requirement that the Investigated Member pay 15% of the costs of the investigation and hearing ensures that she is required to accept a significant financial responsibility for her misconduct while not creating an insurmountable burden; the time period within which she must pay the amount provides some assurance that payment will not be crippling for the Investigated Member.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again, considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and

unprofessional conduct such as this is not tolerated, and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.
2. Ms. Nobert's practice permit shall be subject to a Narcotics Restriction condition which restricts her from being able to access, co-sign, administer narcotics and controlled substances.
3. Ms. Nobert shall, within 6 months of service of the Decision, undergo a Substance Use Assessment, at her own cost, through either Homewood Health or an independent Registered Psychologist or Psychiatrist qualified in substance use disorders (the "Assessor") acceptable to the Complaints Officer, subject to the following terms and conditions:
 - a) The Assessor will be provided with a copy of the ASF, the JSP, and a copy of Decision, if available by the date of the Substance Use Assessment;
 - b) The Assessor will provide a full copy of their completed assessment (the "Assessment") to Ms. Nobert and the Complaints Officer.
 - c) The Assessment will:
 - iv. Include, where applicable, recommendations for ongoing counselling or treatment;
 - v. Address the utility of an ongoing Narcotic Restriction on Ms. Nobert's CLPNA practice permit; and
 - vi. Address the need for any other conditions.

- d) Ms. Nobert shall comply with all recommendations made by the Assessor and provide proof of completion to the Complaints Officer.
4. The Narcotics Restriction may be removed by the Complaints Officer when the Complaints Officer, upon review and consideration of the Assessment and any recommendations made within, is satisfied that the Narcotics Restriction is no longer needed to ensure patient safety.
5. Ms. Nobert shall read and reflect on how the following Educational Readings will impact their nursing practice. These documents are available on CLPNA's website and will be provided. Ms. Nobert shall provide a signed written declaration to the Complaints Officer, within **30 days** of the service of the Decision, attesting that they have reviewed the documents:
- (a) Code of Ethics for Licensed Practical Nurses in Canada;
 - (b) Standards of Practice for Licensed Practical Nurses in Canada;
 - (c) Standards of Practice for Licensed Practical Nurses on Boundary Violations;
 - (d) CLPNA Policy: Documentation;
 - (e) CLPNA Policy: Medication Management; and
 - (f) CLPNA Policy: Professional Responsibility and Accountability.

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

6. Ms. Nobert shall complete the following remedial education, at her own cost, and shall provide the Complaints Director with documentation confirming successful completion within **6 months** of the service of the Decision:
- (a) CLPNA Learning Module - [Documentation - CLPNA](#)
 - (b) CLPNA Learning Module - [Medication Management - CLPNA](#)
 - (c) PBI Course - [Maintaining Ethics, Boundaries and Professionalism in Nursing \(NE-3\)](#)
 - (d) ICRS Course - [ICRS Righting a Wrong' - Ethics & Professionalism in Nursing](#)

If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Officer.

7. Ms. Nobert shall pay 15% of the costs of the investigation and hearing to a maximum of \$3,000, to be paid over **24 months** of service of the Decision.
- a) A letter advising of the final costs will be provided to Ms. Nobert when final costs have been confirmed.

- b) The costs must be paid to the CLPNA, whether or not Ms. Nobert holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered as an action in debt.
8. The sanctions set out above at paragraphs 2 to 7 will appear as conditions on Ms. Nobert's practice permit and the Public Registry subject to the following:
 - a) The condition at paragraph 2 will appear as "Restr. Narcotics Access & Admin." with the reason cited as "Conduct" until removed in accordance with paragraph 4;
 - b) The requirements at paragraphs 3, 5, and 6 will appear as "CLPNA Monitoring Orders (Conduct)" until they have all each been successfully completed; and
 - c) The requirement at paragraph 7, will appear as "Conduct Cost/Fines" until all costs have been paid.
9. Ms. Nobert shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information, and keep her contact information current with the CLPNA on an ongoing basis.
10. Should Ms. Nobert be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.
11. Should Ms. Nobert fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:
 - (d) Refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;
 - (e) Treat Ms. Nobert's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or
 - (f) In the case of nonpayment of costs described at paragraph 7, suspend Ms. Nobert's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

“87(1) An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

- (a) identifies the appealed decision, and
- (b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person.”

DATED THE 19th DAY OF JUNE 2025 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA



Sarah Kawaleski, LPN
Chair, Hearing Tribunal