IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF JEANETTE HOWELL, LPN #35664, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The Hearing was conducted in Calgary, Alberta on October 18, 19, 20, 2022 with the following individuals present:

Hearing Tribunal
Jim Lees, Public Member, Chairperson
Jan Schaller, LPN, Panel Member
Patricia Riopel, LPN, Panel Member
David Rolfe, Public Member, Panel Member

Independent Legal Counsel for the Hearing Tribunal:
Heidi Besuijen

Staff:
Jason Kully, Legal Counsel for the Complaints Director
Evie Maldonado, Legal Counsel for the Complaints Director
Sandy Davis, Complaints Director, College of Licensed Practical Nurses of Alberta ("CLPNA")

Investigated Member:
Jeanette Howell, LPN ("Mrs. Howell", "Investigated Member")
Carol Drennan, Representative for Mrs. Howell

(2) Preliminary Matters

The hearing was open to the public pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 (the "HPA").

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

(3) Allegations

The Allegations in the Statement of Allegations are:

It is alleged that **JEANETTE HOWELL**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. Between June 2021 and October 2021 failed to maintain professional boundaries with Patient RP by doing one or more of the following:

    a) Entered into a friendship/relationship beyond providing nursing care with Patient RP;

    b) Visited and/or communicated with Patient RP while off-duty;

    c) Spent time with Patient RP while on-duty and assigned to other patients;

    d) Became inappropriately emotional when Patient RP's wife died;

    e) Inappropriately disclosed to Patient RP that a complaint had been made about their relationship.

2. Failed to foster a respectful working environment by doing one or more of the following:

    a) On or about July 2021, belittled AS, HCA when she brought AS, HCA into Patient RP's room to discuss an issue of Patient RP yelling at the HCA;

    b) On or about October 2, 2021, belittled CD, LPN, in front of Patient RP with regards to applying a wound dressing incorrectly;

    c) On or about October 2, 2021, informed Patient RP that colleagues were incorrectly performing his wound care;

    d) On or about October 2, 2021, spoke negatively about AD, RN, in front of co-workers;

    e) On or about October 2, 2021, provided Patient RP with X-ray results when it was not her role nor was she assigned to Patient RP's care;

    f) On or about October 9, 2021, completed Patient RP's vital signs while not assigned to Patient RP's care and/or despite LM, LPN stating they would assess Patient RP together.

At the beginning of the hearing the Complaints Director withdrew Allegations 2a) and 2d) and the Hearing Tribunal has made no consideration of the same.

(4) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Exhibit Book

(5) Witnesses

The following individuals were called as witnesses in the hearing:

Shannon Harvey
Lynn Huskins
Grace Tasie-Olru
Caralee Kurio
Amina Noorali
Brooklyn Hurman
Christina Dela Rosa
Lilia Metua
Carleen Campbell
Karen Danyluk
Janice Sharpe
RP (Patient)
Jeanette Howell

The Hearing Tribunal recognizes some of the evidence it may be asked to accept and consider in this matter may be hearsay evidence. The Hearing Tribunal concludes that hearsay evidence can be admissible when it is determined the central issues have been established or where there is additional evidence to support the Allegations. All issues of guilt or innocence are considered on a balance of probabilities. The onus is on the Complaints Director to establish on a balance of probabilities the facts as alleged in the Statement of Allegations occurred and that the conduct rises to the level of unprofessional conduct as defined in the HPA.

The following is a summary of the evidence given by each witness:

Shannon Harvey

Shannon Harvey has been a Registered Nurse (RN) since 2004 and prior to that was a Health Care Aide (HCA). She worked at Carewest Sarcee (the Facility) for approximately 24 or 25 years with a few years spent at the Foothills Hospital.

Ms. Harvey's role was to oversee Licensed Practical Nurses ("LPNs"), HCAs, and to provide care to patients. She worked in the alternate level of care unit ("ALC" or the "Unit") which

was a newer unit to the Facility. It provided a place for individuals who no longer needed full hospital services but did not have placement in the community.

During her employment at the Facility, Ms. Harvey worked with Mrs. Howell on the ALC unit and she stated that she worked with Mrs. Howell approximately 2 to 3 days a week but that it was not always on the same shift. Ms. Harvey described Mrs. Howell as a very good LPN with excellent communication skills who has a high degree of knowledge regarding wounds and medications.

Ms. Harvey gave evidence that she had made a complaint to the CLPNA regarding Mrs. Howell on August 25, 2021. She confirmed she made a second complaint on October 11, 2021 (Exhibit 2, Tab 1). She told the Hearing Tribunal that she made the complaints because of concerns about professional boundaries being crossed and thereby compromising a patient's care. She brought forward her concerns that the relationship between the patient (RP) and the nurse (Mrs. Howell) was no longer therapeutic. She noted that Mrs. Howell had been directed not to work with the patient in question but that she did so anyway and that the patient's care was being compromised.

Ms. Harvey described the result of the relationship as being emotional and psychological stress on the patient and the team. She also described how RP was refusing care from other nurses and that there was co-dependency that had developed. Her evidence was that Mrs. Howell was spending extended periods of time in RP's room even when she was told not to work on that side. RP also became very verbally aggressive towards other staff.

Ms. Harvey read from her complaint in which she wrote that RP was talking non-stop about how Mrs. Howell was a great nurse and the only one that truly cares and about how she was advocating for him. She also indicated that other staff were coming to her to say that Mrs. Howell was spending a lot of extra time in RP's room.

Ms. Harvey described RP as a very nice patient and very easy to talk to. She said he is a young man and enjoyed company; he would normally be chatty when you went into his room. That was at the beginning but then, as time went on, he changed. He would get angry, make demands and was directive. She stated she was aware of an occasion when RP threw a remote control at someone. He began to swear. There was a time when he was calling Ms. Harvey an "effing bitch". He would pick and choose who he wanted to work with.

Ms. Harvey recalled a few occasions when medication rounds were being done, Ms. Harvey would ask the HCA where Mrs. Howell was and they would reply she was in RP's room.

There was one weekend when Ms. Harvey was working the day shift. She saw Mrs. Howell come in on her day off in shorts and a t-shirt with Starbucks. Mrs. Howell said, "Hello" and walked down the hall and spent the day with RP. Ms. Harvey heard from the nurses that it had happened before. Ms. Harvey stated Mrs. Howell was with RP for about 2.5 hours which

she knew because Mrs. Howell came in during the morning and was still there when the lunch meal was served.

Ms. Harvey also gave evidence that an LPN, Grace, told Ms. Harvey that Mrs. Howell would go to RP's room on lunch breaks. Another LPN, Lilia, told Ms. Harvey that Mrs. Howell came in on days off and spent lunch breaks in RP's room. Cristina, an LPN, also related that Mrs. Howell spent a lot of time in RP's room. It seemed to Ms. Harvey that every time she was looking for Mrs. Howell, Mrs. Howell was in RP's room. The comments from other nurses came to Ms. Harvey in the context of being on shift and wanting to know where the floor nurse was because things were needing to be done.

Ms. Harvey viewed the time Mrs. Howell was spending with RP as very unprofessional. She stated it's ok to chat with clients but when you come in on days off to visit then it goes beyond the nurse-patient relationship. Further, the team was getting upset because of the impacts on them.

Ms. Harvey talked about observations she made when RP's wife died. She saw Mrs. Howell cry and how she knew Mrs. Howell was crying because she was red faced, had a lot of tears, and was very upset. Mrs. Howell was crying in RP's room. His mom and sister were in the room sitting in chairs and off to the side was Mrs. Howell who she described as being red-faced, teary and had a creaky voice. The family was also upset and all of them were crying together.

Ms. Harvey also found this unprofessional because she said the nurse is there to support the family and the patient and they were supporting the nurse. It's also a time to leave the family to have their time. It's ok to express condolences but it was important to leave the family to be the family.

Ms. Harvey indicated that it was after RP's wife's death that Mrs. Howell began to spend long periods of time in RP's room.

Ms. Harvey confirmed the portions of her complaint touching on when she saw Mrs. Howell when Mrs. Howell was not on duty were accurate. She indicated she had asked Mrs. Howell why she was there and Mrs. Howell had told her she was there to see RP. It was then when staff told her that Mrs. Howell had done that before. She believed she had seen Mrs. Howell come in around 10:00 am but could not provide the date it occurred but stated it would have been a Saturday or Sunday. Ms. Harvey knew Mrs. Howell was not working that day because she was the floor nurse and would have been working with Mrs. Howell if she was on shift. Ms. Harvey again indicated Mrs. Howell stayed for about 2.5 hours, until lunch when the HCAs told her she was still in there. Ms. Harvey considered the visit unprofessional and indicated it was definitely not normal on the Unit.

The complaint also advised that RP was refusing other nurses. Ms. Harvey explained this was a problem because everyone works together as a health care team. When RP refused to work

with other nurses then they would have to re-arrange the nursing staff and the work on that wing. RP would miss out on care because he didn't like the nurse working assigned. The HCAs would feel they were having a hard time with him and he would refuse to work with them. It was causing hard feelings amongst staff. She also described how there was a lot of anger being directed toward staff.

Ms. Harvey also reviewed an email she had sent to Lynn Huskins, the Client Service Manager, found at Tab 2 of Exhibit 2. Ms. Harvey explained she sent the email because she could see the professional boundaries being crossed and how Mrs. Howell was becoming overly involved. Mrs. Howell was getting upset RP was denied surgery and would talk to RP about that. Ms. Harvey's email also described how on the day RP's wife died, Mrs. Howell spent a long time with RP in his room. Ms. Harvey described it as developing a close personal friendship and forgetting about the nursing role.

Ms. Harvey felt Mrs. Howell was getting over-involved because she was spending so much time in RP's room and got so involved with the surgery, with what happened when his wife died, and the anxiety and excitement Mrs. Howell was showing about RP.

Her email also described how after Mrs. Howell saw an email Ms. Harvey had sent to Ms. Huskins, RP refused to have Ms. Harvey as his nurse and would repeatedly and harshly say, "You know what you did, get out". RP would glare angrily and point his finger at Ms. Harvey. RP told other staff Ms. Harvey was not to go in his room.

Ms. Harvey explained she assessed the relationship between RP and Mrs. Howell as co-dependant because she thought Mrs. Howell was relying on RP to give her attention so she was sharing her thoughts and feelings with him. Ms. Harvey stated she knew Mrs. Howell was telling RP she was being bullied by the other nurses to get attention from him.

Ms. Harvey explained she concluded Mrs. Howell had told RP about the email Ms. Harvey had sent to Ms. Huskins because Ms. Harvey did not tell anyone about the email. The only people that knew about it were Mrs. Howell, Ms. Harvey, and Ms. Huskins. Ms. Harvey knew Mrs. Howell was an open book and talked and talked. Ms. Harvey knew Mrs. Howell would tell RP about it.

Not long after Mrs. Howell saw the email in Ms. Huskins office during a meeting, Mrs. Howell called in sick. Ms. Harvey answered the phone, confirmed it was not COVID and advised Mrs. Howell to tell Ms. Huskins. About five minutes later an HCA came to tell Ms. Harvey that RP was yelling Ms. Harvey's name and calling her a "fucking bitch" and saying, "that fucking email" and screaming it down the hall. She said RP does not have a loud voice, sort of a raspy soft voice but she could hear him. He was saying other things like "it's not right that she makes you feel afraid" and "Shannon, that fucking bitch. She had no right to send that email". She stated this was on August 3 but later corrected herself that it was August 1 based on her email to Ms. Huskins at Tab 4, Exhibit 2 which was from that day.

On the same day RP told Ms. Harvey “You know what you did, get out”. She recalled it was within a day or two of the meeting when Mrs. Howell had seen the email in Ms. Huskins’ office. Ms. Harvey asked RP what happened and he kept repeating “you know what you did” and “you’re no friend of mine”. Ms. Harvey did not tell anyone about her email nor did Ms. Huskins so the only way RP could have found out about it was from Mrs. Howell. She concluded RP had been speaking on the phone with Mrs. Howell because it happened within minutes of her calling in sick.

Ms. Harvey related that Mrs. Howell had scorned a co-worker over the dressings she had done which signalled to RP that Mrs. Howell was the only nurse capable of his care.

In regard of the last point, Ms. Harvey described when Ms. Dela Rosa had been very upset because Mrs. Howell had called her into RP’s room at a time when Mrs. Howell was not supposed to be working with RP. Mrs. Howell told Ms. Dela Rosa she had done it wrong. It’s not appropriate to do this because it affirms one nurse is better than another. Ms. Harvey indicated Ms. Dela Rosa had told her this had occurred. Ms. Harvey said it’s not a professional way to communicate by criticizing another nurse in front of a patient.

As to why she believed RP to be a vulnerable patient, Ms. Harvey explained RP was a very large man stuck in a bed, he lost his job, he lost his wife, and he was not getting the surgery he wanted. He had been through a lot of losses and his health was suffering. He had emotional and psychological suffering too. He was in a vulnerable state, reliant on them for everything.

In terms of how Ms. Harvey regarded RP’s care being compromised, she indicated it was because they were unable to meet his physical needs as he was refusing care from the nurses and it was as though he was experiencing more health care problems due to the excess stress. He was carrying the burden of what was happening on the floor with nurses and felt that Mrs. Howell was being bullied. At one point, Ms. Harvey described, an HCA approached her to say that RP was emotionally upset. He was saying it was his fault what was happening to Mrs. Howell. Ms. Harvey stated it was a burden no patient should have to carry.

Ms. Harvey explained she had the opinion Mrs. Howell was building a personal relationship with RP because she was sharing personal emotions with him. Mrs. Howell was telling RP she was being bullied, had her feelings hurt, and similar things. Further, coming in on one’s days off with Starbucks for the patient was building a personal relationship not a professional relationship. Visiting a patient when off shift has nothing to do with nursing care.

The result was also that there was a toxic work environment. Everyone was on eggshells around Mrs. Howell because she would assume people were talking about her. There was also the aspect of people wondering what the point of rules were if there was no affect as when Mrs. Howell continued to go into RP’s room when she was not supposed to be. Ms. Harvey stated that Mrs. Howell came in on a shift to cover for another nurse and insisted on working in the hall where RP’s room was.

Ms. Harvey gave evidence she spoke with management about these concerns. She was aware, by her role as a team lead, that Mrs. Howell had been told not to work with RP anymore. It was handled professionally and it was not a big group discussion just information that Mrs. Howell would not be working with RP.

At Tab 3, Exhibit 2 was an email Ms. Harvey identified as being one she sent to Ms. Huskins which was dated July 31. In it, Ms. Harvey expressed that she was sure Mrs. Howell was discussing issues on the Unit with RP.

Ms. Harvey explained she wrote the August 1 email at Tab 4, Exhibit 2 because it was evident Mrs. Howell called RP and that he had knowledge of Ms. Harvey's earlier email. She detailed how on July 30 she was assigned to the area of the Unit where RP was. The HCA attended to his room and reported RP was not happy Ms. Harvey was his nurse. When she went to his room, he was very angry and told her she was never to enter his room again. He repeatedly told her to get out and that she knew what she had done. As a result, she switched patients with an LPN on shift.

Ms. Harvey explained this occurred right after Ms. Huskins pulled Ms. Harvey aside to let her know Mrs. Howell had seen her name on the email. The next day was the day Mrs. Howell called in sick and RP called her a "fucking bitch".

In describing the relationship between Mrs. Howell and RP, Ms. Harvey indicated it was co-dependant. Her assessment was that it was not a therapeutic relationship for RP since he was supporting Mrs. Howell and a patient should not be supporting the nurse. It was causing him emotional stress and was a burden on him.

Ms. Harvey was asked whether she had invited RP to Vancouver Island. She denied that she had, she said she told him if he was ever out there, she would be out there.

On cross examination Ms. Harvey indicated that she was aware Mrs. Howell had been admitted to the "psych unit" in the past, and that her medications had been adjusted but then Mrs. Howell came back to work. Ms. Harvey saw that Mrs. Howell still had issues which she observed in Mrs. Howell's attention seeking behaviours. She referred to a text message purportedly from Mrs. Howell's son advising she had attempted suicide which Ms. Harvey did not believe came from Mrs. Howell son. There was also a text message a number of staff members received about other personal matters. Ms. Harvey assessed those as being attention seeking.

Ms. Harvey stated she did not observe Mrs. Howell in RP's room at lunch but when she would ask where Mrs. Howell was, she was told Mrs. Howell goes to RP's room on lunch breaks. Ms. Harvey indicated she would have to send an HCA to get Mrs. Howell from RP's room to do meds or respond to call bells that were not being answered because Mrs. Howell was spending extra time in RP's room. All of this had a big impact on the team and caused

animosity. Ms. Harvey denied the time spent in RP's room was for the purpose of doing wound care.

Ms. Harvey's evidence was that she was not aware until after the fact that Mrs. Howell would be advocating for RP in a conference call. Ms. Harvey indicated she would not have known whether RP and Mrs. Howell went outside, she was busy on shift and did not follow them. She was firm that Mrs. Howell was in for 2.5 hours.

Ms. Harvey confirmed that occasionally a social worker would arrange for a nurse to get cigarettes for a patient who could not get out of the building, but they were not brought as gifts. She said she had never done it herself, usually it was someone who smokes who would do it.

Ms. Harvey reviewed Tab 8, Exhibit 2 which was an email from RP to David Sawatzky, the Director of Operations. She agreed she did not see RP indicate he only wanted Mrs. Howell to be his nurse. Ms. Harvey indicated she did see that a patient was writing a letter to a director of care. She also read out that although RP did not want Mrs. Howell to be his personal nurse, she was the only person on the staff who he completely trusted. Ms. Harvey expressed this was a huge red flag.

Ms. Harvey explained she found out Mrs. Howell was advocating for RP because he told Ms. Harvey that Mrs. Howell was the only one advocating for him. Ms. Harvey indicated usually the LPNs and RNs don't get involved in the surgeries and had to clarify who RP was talking about.

Ms. Harvey confirmed her evidence was that Mrs. Howell disclosed the contents of Ms. Harvey's email to RP. Ms. Harvey did not believe anyone else could have told RP about her email because the only people who knew about it were herself, Ms. Huskins, Mrs. Howell, and RP.

In regard to whether RP's voice was heard down the hall, Ms. Harvey was firm that he was heard by her and by others.

Ms. Harvey denied telling RP she had a property on Vancouver Island because she does not have a property there but rents. She denied knowing anything about RP and his wife having a special time there. She confirmed she had told RP that if he was on Vancouver Island, he could look her up. She said she stated that casually and it was not an invitation.

Ms. Harvey indicated that neither Ms. Huskins nor Ms. Kurio had brought to her attention any interaction in which she made RP uncomfortable. Ms. Harvey denied she had shown photos to RP or that this was the reason his demeanour towards her changed.

Lynn Huskins

Lynn Huskins gave evidence that has been an RN for 36 years and had worked at the Facility since 2015. She is a Client Service Manager ("CSM"); she manages the day-to-day operations of the ALC unit including budgeting, staffing, and anything else pertaining to the unit. Ms. Huskins worked with Mrs. Howell from June 2020 until September 2021. Ms. Huskins explained her hours of work are Monday to Friday while Mrs. Howell worked shift work which mean she would work days and evening shifts. There would be some days where their time at work would overlap but others when that was not the case.

Ms. Huskins described her relationship with Mrs. Howell as a friendly one in an employee/employer way. Her evidence was that Mrs. Howell was an excellent LPN who did not cause concern and had strong skills.

Ms. Huskins had knowledge of RP; she told the Hearing Tribunal he had come to the Unit from another unit and the plan was for him to stay on the unit until he received bariatric surgery. She described him as an overall pleasant man from what she had heard and what she had observed herself.

Ms. Huskins related that she had become aware that RP's wife has passed away. She explained that Ms. Harvey had told her Mrs. Howell was in RP's room when his family came to tell him about his wife's passing. She reported she had been told Mrs. Howell became quite upset and had cried a lot in the room, so Ms. Harvey had ushered Mrs. Howell out of the room. When asked what she had thought of it, Ms. Huskins explained she thought it was excessive. While it was ok for professionals to cry in front of families, they should not be overly emotional. Such a situation was very private so families should be left alone to support one another.

Ms. Huskins told the Hearing Tribunal about Mrs. Howell's involvement with RP's planned bariatric surgery and a consult with a surgeon for the same. She explained she had received an email from Mrs. Howell on 13 June 2021 advising that RP's surgical consult was upcoming, and RP had asked her to be present for it. Mrs. Howell explained to Ms. Huskins that the date of the consult was her day off and asked whether she could attend the meeting. Ms. Huskins explained that since, at that time, she had no concerns about Mrs. Howell's relationship with RP, she agreed Mrs. Howell could come in for four hours paid and would be assigned other duties until the consult. Ms. Huskins related it was not normal for an LPN to be present in such meetings or consults but that clients had requested that in the past. She did not have further information on that point.

Ms. Huskins gave evidence as to the complaint she received from Ms. Harvey and identified the email she received on July 4,2021. She explained that in response to that email she started to do an investigation because she had concerns about Mrs. Howell visiting RP on a day off. She was concerned about that report, as doing so could lead to the erosion of the therapeutic relationship.

The investigation included speaking to other staff that worked with Mrs. Howell more often than she did. Ms. Huskins spoke with approximately 5-6 people including RNs, LPNs, and potentially HCAs. She learned from the investigation that Mrs. Howell had been observed by staff attending to the Unit on her days off to visit RP. Also, that Mrs. Howell had been staying anywhere between 2-4 hours and that she was bringing coffee to RP. Ms. Huskins was not sure how many times this had occurred as some staff had observed visiting occurring on the same days, but she stated it was not common, perhaps once a week.

Ms. Huskins described having concerns and planning to meet with Mrs. Howell when Mrs. Howell emailed to inquire whether she could bring her dog in on the weekend to visit with RP. She noted no one had ever requested that before. As Mrs. Howell was working later that day, Ms. Huskins met with her then. During the meeting, Ms. Huskins told Mrs. Howell she did not think it was a good idea for Mrs. Howell to bring her dog in to the unit. She talked with Mrs. Howell about boundaries and the fact other staff had brought to her attention Mrs. Howell was coming in on days off and the concerns she had about it.

Ms. Huskins noted she was surprised by Mrs. Howell's response to their conversation. She had expected the meeting to be a gentle reminder of professional boundaries, but Mrs. Howell became quite defensive and reacted unexpectedly. She advised that Mrs. Howell said staff were out to get her and asked why what she was doing with RP was different than other staff doing laundry for clients. Ms. Huskins explained this was happening when clients came in that did not have any family members and it was being done on another unit and always during work hours. Ms. Huskins confirmed Mrs. Howell did not deny coming in on days off to see RP. Ms. Huskins characterized her conversation with Mrs. Howell as being very clear that Mrs. Howell could not come in to see RP.

When asked whether anything followed the meeting. Ms. Huskins referenced an email which RP sent to the Director of Operations later that evening found at Tab 8, Exhibit 2. Her interpretation was that it was another example of boundary crossing as Mrs. Howell had shared their private conversation with a client which was not appropriate. She had concluded this was the case because the email stated Mrs. Howell "was called in to Lynn's office today and told that staff members were complaining that they had seen her hugging me and holding my hand". Ms. Huskins explained that she and Mrs. Howell had also discussed the hugging but not the holding of hands.

Ms. Huskins confirmed she had not discussed the meeting with any other person and that it was not common knowledge. She indicated that if anyone knew about the meeting it would have been the team lead, Caralee Kurio.

On the Monday following, Ms. Huskins followed up with the Director to discuss next steps. They agreed to gather more information. Ms. Huskins reported that she also reviewed the CLPNA's website to review documentation relating to boundaries, ethics and standards.

After this, Ms. Huskins indicated Ms. Harvey sent an email discussing concerns about RP whenever she was assigned to provide him care. Ms. Huskins said the email also advised Mrs. Howell was still attending on days off to visit RP.

Following that email, Ms. Huskins again called Mrs. Howell into her office on July 20 or July 21 to discuss professional boundaries. Her concern was that Mrs. Howell was crossing those boundaries and to remind Mrs. Howell of those again. Ms. Huskins indicated she called the further meeting because she had again spoken with staff and found out that Mrs. Howell was still coming in on days off but also when on shift, she was spending more time with RP than other clients.

Ms. Huskins' evidence was that, as before, Mrs. Howell because quite defensive. Mrs. Howell said the staff were being malicious and that the reports were not from a place of concern but that they were watching her and RP and gossiping on the Unit. When asked, Ms. Huskins said she did not think that was the case as when she was speaking to staff about the reports she received, it was clear to her that everyone had concerns about the situation. Further, that Mrs. Howell has again asked to know what was different about what she was doing and what other staff members were doing. Ms. Huskins told Mrs. Howell she did not think Mrs. Howell should be coming in on her days off.

Ms. Huskins stated she had the CLPNA document about boundaries and the therapeutic relationship in front of her but that she did not give Mrs. Howell a copy. She explained she had not provided it to Mrs. Howell because it was readily available on the CLPNA's website.

Ms. Huskins described how she had other CLPNA papers in front of her and underneath those papers the original email from Ms. Harvey which she believed Mrs. Howell was able to see when she had moved some of the papers covering it. Ms. Huskins advised she had not raised the complaint with Mrs. Howell and only referenced an official complaint had been received.

Ms. Huskins gave evidence that after the meeting Ms. Harvey was assigned to look after RP and that he had become belligerent with her. RP yelled at Ms. Harvey saying "fucking Shannon", "fucking bitch" which was heard down the hall by other clients and staff. Ms. Huskins was not at work that day but Marlene Viside was covering her. Ms. Viside contacted Ms. Huskins and told her how she had been called into the Unit when this was going on so had spoken with staff and RP.

Based on RP's words and his reaction to Ms. Harvey, she concluded Mrs. Howell had told RP about the complaint. The only people who knew about the boundary concerns were herself, Ms. Harvey, the Director, Caralee Kurio – none of whom would have told RP – and Mrs. Howell. Ms. Huskins expressed that the incident was, for her, another example of how Mrs. Howell had crossed the professional boundary with RP in sharing information about her workplace with him.

Shortly after that occurred, Mrs. Howell sent a complaint to AUPE and a safe and respectful workplace complaint to Carewest human resources ("HR"). The complaint was part of Exhibit 2 at Tab 5. Ms. Huskins first saw the complaint when HR asked her to respond to it. Ms. Huskins understood the complaint to be about her and it indicated that Mrs. Howell had been subject to rumours and gossip about a client (who Ms. Huskins understood to be RP). The complaint indicated that "on a couple of occasions, I have held his hand" and that "in the context of helping this resident through his grief, I hugged him". Ms. Huskins indicated that it might ok for an LPN to do either of these things, it would depend on the circumstances in which it occurred.

The complaint also indicated "on a couple of occasions after the loss of his wife, I came to visit this resident on my own time bringing him coffee". Ms. Huskins indicated she did not think it was ok for an LPN to visit with a client on their days off. She explained she felt it would blur the boundary of the LPN-client relationship and that RP would have been vulnerable with his wife's recent passing.

Ms. Huskins noted RP had written emails, largely to Ms. Kurio, about care being provided by other staff members and that he did not trust them to provide competent care. From what Ms. Huskins understood Mrs. Howell had similar feelings and had reprimanded another staff member in front of RP.

Following the incident above, Ms. Huskins checked in with Ms. Harvey to see if she was ok and instructed Ms. Harvey to avoid RP while on shift and not to provide him with care. Ms. Huskins confirmed that it was July 30th when Ms. Harvey emailed that RP had told her to "get out, you know what you did" and that the email which was sent the next day, on August 1, indicated that RP was swearing at her.

Ms. Huskins also received an email from Amina Noorali, LPN, on August 1, 2021 (Exhibit 2, Tab 9). Ms. Noorali described how RP wanted to speak to her and when she went into his room, she found him crying and upset because, he said, Mrs. Howell might lose her nursing licence and wanted to quit because she is being bullied by staff all thanks to the "fucking bitch Shannon".

Ms. Huskins was very concerned upon receiving the email. Her initial meeting with Mrs. Howell had been to offer a gentle reminder around boundaries but the matter had only gotten bigger and worse since then.

Ms. Noorali's email went on to describe how RP had said Ms. Harvey had sent an email reporting Mrs. Howell to the manager and that he would see to it Ms. Harvey and anyone else involved would be reprimanded for what was happening to Mrs. Howell.

After receiving Ms. Noorali's email, Ms. Huskins spoke with Ms. Noorali and other staff members to make sure everyone was doing ok. Ms. Noorali told Ms. Huskins it was very concerning and that staff were talking about what was happening.

Ms. Huskins also attended to RP to speak with him, along with Ms. Kurio. They asked RP how he was doing, and he became upset and started crying. He was very stressed that Mrs. Howell was going to lose her job and her licence because of him. They offered him support but didn't bring anything up in particular given his state of mind at that time.

Ms. Huskins gave evidence she never told Mrs. Howell she would lose her job or her licence.

Ms. Huskins' response to HR was included at Tab 6, Exhibit 2. In it she offered replies to incidents around care provided by staff to RP. Ms. Huskins' email indicated that she had concluded Mrs. Howell had not followed the standards of practice set by the CLPNA regarding professional boundaries. Ms. Huskins explained to the Hearing Tribunal that in gathering information she had concluded that Mrs. Howell was acting outside her professional standards by coming in on days off and sharing information with RP that should not have been shared.

Ms. Huskins responded to Mrs. Howell's complaint where it indicated Ms. Huskins had given Mrs. Howell permission to come in on days off. Ms. Huskins explained she did not tell Mrs. Howell it was ok to come in but that if Mrs. Howell insisted on coming in then she should consider using a different door.

Ms. Huskins' response email also noted that it had been very evident Mrs. Howell spoke to RP about the conversation they had on July 9. Also, that RP perceived that he was not receiving competent care which reflected what Mrs. Howell seemed to be feeling based on her reprimand of other staff.

Ms. Huskins described the relationship between Mrs. Howell and RP as very friendly but that it was her belief it went above and beyond the therapeutic professional relationship of an LPN and client. Ms. Huskins explained RP would have been very vulnerable after his wife's death and any extra attention might be perceived differently than what it was meant to be.

Ms. Huskins explained to the Hearing Tribunal her perception of the impact of the relationship on RP was that he was very angry, stressed, emotional, would easily cry. Further, that there was a lot of resulting tension with other staff.

In cross examination, Ms. Huskins confirmed it was common knowledge RP had become angry with Ms. Harvey and refused to have her in his room. She confirmed she had followed up with Ms. Harvey about RP's concern about Ms. Harvey discussing family property on Vancouver Island. Ms. Huskins spoke with Ms. Harvey and it was within the ordinary course of conversation you might carry on while providing care. Ms. Harvey had been talking about a possible move to BC. Ms. Huskins advised she did not follow up with RP about that.

Ms. Huskins advised she did not believe she had spoken with Mrs. Howell about possibly discussing the concerns with RP. Ms. Huskins had gone to speak with RP after he was upset

with Ms. Harvey but she felt that he was so upset that she did not feel it was appropriate to bring it up at the time.

Ms. Huskins confirmed that Mrs. Howell had come in for a pre-conference call or consult meeting with RP about his bariatric surgery and that Ms. Huskins had given her four hours to come in to do that and complete other tasks outside of when the meeting was taking place. The timing of that was before Ms. Huskins was aware of any concerns. Ms. Huskins' evidence was that she was not aware of other occasions when Mrs. Howell came in to talk with RP about the conference call.

Ms. Huskins was asked whether she noticed, in her conversations with him, that RP had voice limitations. Ms. Huskins replied that she did not notice limitations.

Ms. Huskins confirmed it was not normal for other staff on the Unit to come in on days off to visit a client or to bring in laundry or cigarettes. She explained that if staff do laundry for a patient, its while they're on shift.

Grace Tasie-Olru

Grace Tasie-Olru's evidence was that she had been an LPN since 2020 and prior to that had been an HCA since 2016. She was an employee of Carewest from February 2016 until July 2020. Ms. Tasie-Olru worked in the Unit alongside Mrs. Howell quite a lot. Ms. Tasie-Olru described Mrs. Howell as an LPN with many technical skills and was someone you could call on. Ms. Tasie-Olru described her relationship with Mrs. Howell as a very good one and explained she had learned a lot from Mrs. Howell.

Ms. Tasie-Olru confirmed she provided care to RP when she was assigned to the wing where his room was. She described him as initially being very pleasant, smiling, and that he would remember your name and mention you by it. She explained he was easy to care for. As time went on, however, she explained he became more particular about his care.

In describing the relationship between RP and Mrs. Howell, Ms. Tasie-Olru advised that Mrs. Howell provided care to RP and had a client-patient relationship.

Ms. Tasie-Olru related how on one evening she was working and at about 10:00 p.m. she saw Mrs. Howell, who was not working that day. She asked someone about Mrs. Howell being there and they told Ms. Tasie-Olru that Mrs. Howell had come to see RP. Ms. Tasie-Olru did not see Mrs. Howell in RP's room, only near it but asked if Mrs. Howell was working and was told no she came to visit. Ms. Tasie-Olru recalled that Mrs. Howell was dressed in casual clothing wearing shorts and a t-shirt. Ms. Tasie-Olru did not see Mrs. Howell leave so she did not know what time that happened.

Ms. Tasie-Olru also described a second time when she observed Mrs. Howell in the Unit when she was not working. On that occasion Ms. Tasie-Olru had observed Mrs. Howell sitting by the nursing station near the computer.

Ms. Tasie-Olru also related that sometimes RP would refuse his dressing change and if Mrs. Howell was there she would ask to help. Ms. Tasie-Olru would gladly accept that help; she explained she only wanted RP to get care no matter who is providing it so if RP preferred to have it from Mrs. Howell that was fine.

Ms. Tasie-Olru described one occasion when she had been assigned to RP and Mrs. Howell came in to his room. RP asked Ms. Tasie-Olru whether blood work had come in, which she confirmed it had, and told him the result. Ms. Tasie-Olru went on break and when she returned, Mrs. Howell was holding the results and bringing them to RP even though he was assigned to Ms. Tasie-Olru.

Over time, Ms. Tasie-Olru explained, RP became more difficult to provide care for. She would start to bring another LPN with her if doing RP's dressing in order to have a second opinion. She related that RP had told her not to do his dressing change and that he would wait until Mrs. Howell was on duty. Ms. Tasie-Olru explained that happened perhaps twice.

Ms. Tasie-Olru was able to observe Mrs. Howell was never assigned to RP and at a point she inquired about it and was advised Mrs. Howell was not permitted to provide care to RP any longer. The occasion when Mrs. Howell brought the blood test results to RP was after this point.

In describing her experience in providing care to RP, Ms. Tasie-Olru explained that as she had noted before, initially he was okay and then he became unfriendly. She related that he was quick to anger so if providing RP with care she would brace herself for that. At that point she would provide care but if it related to dressings, she would be sure to have a second nurse accompany her. It was around this time that Ms. Tasie-Olru observed RP started to prefer Mrs. Howell. Further, some HCAs would prefer to report to Mrs. Howell even if RP was Ms. Tasie-Olru's client. She explained that she recognizes Mrs. Howell was more experienced than she was but if a resident is assigned to a nurse, then concerns should go to that nurse.

In cross examination, Ms. Tasie-Olru denied she had told RP she was not going to be able to do his wound care but instead gave evidence that RP would refuse other staff and would ask for Mrs. Howell to do it.

<u>Caralee Kurio</u>

Caralee Kurio has been an RN since 2013 and has worked at the Facility that entire time. Her position at the time of the hearing was nurse clinician, alternatively referred to as team lead. She indicated her role entails providing support and education resources to front line staff as well as assistance to the management team. She is currently assigned to the ALC unit and

while she had previously worked between that unit and another, she had been assigned to the ALC unit exclusively for about a year.

Ms. Kurio confirmed she worked with Mrs. Howell and while they had not always worked on the same unit together, they had worked in the same building since 2013. Their professional relationship was good and Mrs. Howell would report to her. Ms. Kurio explained her schedule was different than Mrs. Howell's but they would cross paths two to three times a week depending on the week.

In terms of the working relationship with Mrs. Howell, Ms. Kurio described it as really good and that they worked really well together. She assessed Mrs. Howell as being very skilled, experienced and a strong LPN with amazing clinical skills.

Ms. Kurio confirmed RP was a patient at the Facility and described him as a bariatric client with specialized needs. Ms. Kurio indicated she did interact with RP on an average of twice per week. She observed that he was very friendly and sociable but anxious about his care needs. She related that RP had a lot of pain and anxiety around his care. Ms. Kurio noted RP's wife passed away unexpectedly when he was in care at the Unit after which he became quite sad and seemed angrier.

In terms of Mrs. Howell providing care to RP, Ms. Kurio explained she was made aware there were issues around that. Staff brought forward concerns that Mrs. Howell was coming in on her time off and spending time with RP. She indicated she learned this around the beginning of July although she had been aware of an occasion in June when Mrs. Howell asked Ms. Kurio and the manager, Lynn, to be permitted to advocate for RP. Ms. Kurio explained there was a phone conference with RP's surgeon which was going to occur on one of Mrs. Howell's days off, so Mrs. Howell and RP were hoping to have that discussion with the surgeon together. Ms. Kurio related how she and Ms. Huskins had discussed it and agreed it was reasonable and could use the extra help so Ms. Kurio told Mrs. Howell that she could come in and be paid for four hours while taking care of other duties around the appointment.

Later, in July, Ms. Kurio said Mrs. Howell asked her if she could come in on her weekend off and bring her dog. Mrs. Howell said she was going to be in the area to drop her son off to work and wondered if she could come in with her dog to visit RP. Initially Ms. Kurio thought that was nice but gave it second thought as it was different from a medical appointment and was more personal. She was also unaware of whether a dog would even be permitted in the Facility. Ms. Kurio told Mrs. Howell to make the request to Ms. Huskins so Mrs. Howell sent an email to Ms. Huskins with the request.

Ms. Kurio's evidence was that the occasion of the phone appointment was the only time Mrs. Howell was approved to come to visit RP on what was scheduled as a day off. She explained that at the time Mrs. Howell had asked to bring her dog in, Ms. Kurio was not aware of any concerns. Then the same day when Mrs. Howell asked Ms. Huskins for permission to bring her dog in, Ms. Huskins had received concerns from staff who had observed Mrs. Howell

attending the unit when she was not working. Ms. Kurio explained that Ms. Huskins told Mrs. Howell she could not bring her dog in and that other staff members had raised concerns about Mrs. Howell coming in when off duty. The concerns related to two occasions other than when Mrs. Howell had been given permission to attend the teleconference with RP and his surgeon outside of her scheduled working hours.

Ms. Kurio's evidence was that it was not normal for staff to ask to come in on their time off and that she had never received such a request before.

Ms. Kurio was aware when Mrs. Howell was meeting with Ms. Huskins to discuss the request to bring her dog in. Later that day after the meeting, Ms. Kurio observed Mrs. Howell in the hallway. Mrs. Howell told Ms. Kurio she felt very hurt and attacked and that Ms. Huskins told Mrs. Howell she could not come in and that staff were gossiping about Mrs. Howell and RP. Ms. Kurio noted her reaction was shock because she did not know any of the background and wondered why staff would make up rumours about Mrs. Howell and RP. After that Ms. Kurio went to see Ms. Huskins. Ms. Huskins advised Ms. Kurio that other staff had noticed Mrs. Howell coming in on her days off and has reported it directly to Ms. Huskins.

After this, Ms. Kurio learned that RP emailed David Sawatzky telling him that he, RP, was very upset Mrs. Howell had been in Ms. Huskins' office that day. RP knew the meeting had occurred and felt it was ridiculous. RP was angry anyone would dare to say anything about Mrs. Howell, that nothing inappropriate had occurred, and that staff were being evil and malicious. Ms. Sawatzky forwarded the email to Ms. Huskins; Ms. Kurio learned about the email in July but did not see it for herself until September. On July 20, Ms. Huskins asked Ms. Kurio if she herself had received anything from RP or had conversations with him while Ms. Huskins had been away for vacation in July. Ms. Kurio confirmed she had not and didn't know anything about the email until that time. Ms. Kurio identified the email which she saw herself in September at Tab 8, Exhibit 2.

Ms. Kurio related that her thoughts on learning about the email were to wonder how RP knew about the meeting and why he was involving himself. The language he used was different than what Ms. Huskins had discussed with Mrs. Howell – the meeting had not been to punish Mrs. Howell but to bring something to her attention as all nurses need to be mindful of boundaries. Since Ms. Kurio, Ms. Huskins, and Mrs. Howell were the only ones that knew about the meeting, she concluded Mrs. Howell has told RP about it.

After July 20, Mr. Sawatzky advised Ms. Huskins that she should have another meeting with Mrs. Howell and he printed the CLPNA professional boundaries document, asking Ms. Huskins to review it with Mrs. Howell again. Ms. Huskins held that meeting. She had the professional boundaries document and an email from a nurse raising a concern about Mrs. Howell coming in on her time off. Ms. Kurio indicated that Mrs. Howell saw the name of the nurse on the email since the email was on her desk, and Ms. Huskins did not cover it up. Ms. Kurio was not in the meeting but knew that had occurred as both Mrs. Howell and Ms. Huskins advised her of that.

Subsequent to that meeting, Mrs. Howell made a complaint to AUPE citing that she was not being provided with a respectful work environment. Ms. Kurio did not see that complaint until September, which is when she began to cover for Ms. Huskins. Ms. Kurio confirmed a copy of the complaint to AUPE was at Tab 5, Exhibit 2.

Ms. Kurio described how the complaint tried to portray that Mrs. Howell was advocating for RP and to make it seem that she did not do the things it was being said she had done and that rumours were circulating about her. Ms. Kurio stated her understanding is that it was not rumours or gossip, but that Mrs. Howell had been observed coming in on her days off and that it was factual. Ms. Kurio confirmed her understanding that a reference to an older bariatric patient was a reference to RP.

Ms. Kurio noted that in the complaint, Mrs. Howell indicated she had visited that resident (i.e. RP) on her own time bringing him coffee. Ms. Kurio stated coming in on personal time to visit a client is not within a nurses' professional boundaries, that this conduct was more related to friendship.

Ms. Kurio explained she covered for Ms. Huskins for about a month and a half beginning in mid-September 2021 and ending in late October 2021. During that time, Kerry Stevens was in place as the Acting Director. The Acting Director told Ms. Kurio that the complaint Mrs. Howell had put into AUPE was inconclusive and that Mrs. Howell had received a letter from HR explaining that, and which highlighted certain recommendations. One of the recommendations was a care mitigation plan which could involve changing care assignments. The Acting Director stated that definitely should be done.

In mid-September Ms. Kurio asked Mrs. Howell whether she had seen the letter and been able to go through it. Once Ms. Kurio was satisfied Mrs. Howell had reviewed it carefully, they discussed the care mitigation plan to change the care assignments. They reviewed Mrs. Howell's schedule to see if she would be potentially working with RP. Since RP was to be discharged shortly there were only four shifts that needed to be swapped. Ms. Kurio and Mrs. Howell discussed it and agreed that the way it would be managed was for Ms. Kurio to discuss with the RNs that would be on shift for those days and tell them she would be adjusting assignments, which was done. Rather than re-assign all of the LPNs, Ms. Kurio and Mrs. Howell agreed that the RNs would take the area where RP was so that the LPNs would not notice there had been a change and question it. This was a way to cause the least disturbance and commotion and it was workable given the short period of time RP was expected to remain in the Facility. Ms. Kurio confirmed that she and Mrs. Howell had agreed that RP would not be part of Mrs. Howell's care assignment.

Ms. Kurio could not recall whether this involved a specific discussion that Mrs. Howell was not to provide care to RP but was sure that at least happened later on. In October she knew they had discussed that even if Mrs. Howell picked up shifts or RP demanded her to give him care, that Mrs. Howell was not to be going in to RP's room – even on RP's request.

Ms. Kurio related a meeting that occurred on September 24, a date when Ms. Kurio was not at work. The meeting was between Mrs. Howell and HR. Mrs. Howell was being advised her grievance was being declined. The RN who was supposed to work that day was not in, a different RN was working. Ms. Kurio had not spoken with that RN previously. Mrs. Howell emailed Ms. Kurio to tell her the day did not go well, and she was worried about telling a different RN that she could not work a particular assignment as that would be raising questions. She explained her feelings had been destroyed from her meeting with HR and that she felt she was being punished for advocating for someone. After that Mrs. Howell called in sick for two days so Ms. Kurio did not see her.

After that, RP began to email Ms. Kurio daily. He emailed that he was upset and angry about Mrs. Howell. He wanted to know how they could let that happen and that they had allowed Mrs. Howell to be demonized, that they were all evil and malicious and he didn't trust anybody. His emails became more and more angry. RP also expressed guilt and that he hated it in the Facility and just wanted to hide under a rock. RP said he would never forget it since Mrs. Howell provided him with the best care he had received in four years of being in the hospital setting. He expressed that it would be his mission in his remaining time at the Facility to destroy anyone that could have been involved with Mrs. Howell.

Ms. Kurio indicated that when she received that from RP she wondered where he was getting that information from. Ms. Kurio was surprised by the daily emails she was receiving. Based on the timing of things and how Mrs. Howell had been so upset after her last meeting, Ms. Kurio concluded Mrs. Howell had told RP about it. It was not only the timing but also the details and how it was expressed that both RP and Mrs. Howell were saying similar things and in the same manner. Ms. Kurio confirmed the September email she received from RP was located at Tab 10, Exhibit 2.

When asked whether there was anything in that email that she thought had come from Mrs. Howell, Ms. Kurio indicated it was that he was very aggravated and talked about the organization trying to destroy her good name when all she was doing was advocating for him.

Ms. Kurio referred to other emails she received from RP where he expressed concern that Mrs. Howell was the only person who knew how to do his wound care properly. In response to that concern, Ms. Kurio asked Brooklyn Hurman to attend to RP. Ms. Hurman had taken speciality education in wound care. Ms. Kurio told RP about Ms. Hurman and her specialty in wound care and that she would be following his wounds.

When RP met with Ms. Hurman, he told her he was upset about the situation with Mrs. Howell but Ms. Hurman had no idea what he was talking about. RP told Ms. Hurman he only wanted Mrs. Howell but then she had disappeared, and he felt guilty. This brought Ms. Hurman into things. After he first met with Ms. Hurman, RP emailed Ms. Kurio and asked to meet with Ms. Kurio, Ms. Hurman and the Acting Director to discuss the false accusations against Mrs. Howell.

The three did meet with RP the next day. Ms. Kurio indicated that meeting occurred on September 29. RP told them Mrs. Howell and RP had been accused of having an affair. This confused everyone else in the meeting but as RP was upset they allowed him to continue talking. He wanted to know where Mrs. Howell was and he was worried she lost her job. RP was incredibly upset, Ms. Kurio did not say anything but the Acting Director indicated that they could not disclose confidential information about staff but RP kept pushing, saying he believe something terrible happened to her. Finally, the Acting Director relented and told RP that Mrs. Howell still had a job. The remainder of that meeting was addressing care concerns which Ms. Kurio indicated had merit. After that meeting Ms. Kurio documented it and updated the staff about what had been discussed (aside from anything with Mrs. Howell) to be sure the care plan was being followed.

Later that day RP emailed to say he was bothered about being labelled a difficult client following the meeting. Ms. Kurio identified that email at Tab 10, Exhibit 2.

After that, Ms. Kurio would receive emails from staff advising that RP was mean or rude to them or that he would not permit them to provide care and would tell them Mrs. Howell was coming in and he only wanted her to give him medication or to do his dressings; he was refusing care from other staff.

Ms. Kurio also identified an email she received from Cristina Dela Rosa, LPN, at Tab 11, Exhibit 2 in which Ms. Dela Rosa stated Mrs. Howell "reprimanded me in front of [RP] over the weekend". Ms. Dela Rosa felt humiliated because she had worked hard to build trust with RP but since Mrs. Howell had told RP the other LPNs were doing his dressings wrong, he had lost the trust. The next day RP told Ms. Dela Rosa that she didn't know what she was doing and then emailed Ms. Kurio that night to tell her he was sick of having to educate the nurses because they are doing the care wrong.

In light of that email, Ms. Kurio asked Ms. Hurman to go and see RP. Ms. Hurman did and emailed Ms. Kurio to advise that RP told Ms. Hurman that Mrs. Howell had come in over the weekend and told him that his dressings were being done incorrectly. Ms. Hurman expressed concern as RP was very emotionally vulnerable and when Mrs. Howell would tell him things were done incorrectly that it was not good for RP and worked against the efforts to build the confidence and trust in other nurses. Ms. Kurio confirmed the email from Ms. Hurman was found at Tab 13, Exhibit 2.

Ms. Kurio explained upon learning this she was concerned since it was never appropriate to discuss a client's care in front of the client. If there was a concern, then the staff member involved should be pulled aside in private because to do otherwise was breaking the trust in that co-worker. Then next thing Ms. Kurio wondered was why Mrs. Howell was dealing with RP's wounds because this was after Mrs. Howell had been told not be involved with RP's care any longer.

In regard to the situation, Ms. Hurman assessed that the wound care had been done correctly. Ms. Hurman wondered whether Mrs. Howell had not done RP's dressings since the protocol had changed and therefore Mrs. Howell was under the mistaken impression the dressing was done incorrectly.

Ms. Kurio explained that she had ongoing complains from staff that RP only wanted Mrs. Howell, and the other nurses were feeling as though they were not capable or good enough. Ms. Kurio spoke with Mrs. Howell on October 6 to discuss that RP was being very demanding and that he was insisting Mrs. Howell only, so it was placing a spotlight on her. Ms. Kurio discussed with Mrs. Howell that even if RP was demanding her, she should not go in and simply explain she has her own caseload, which is true. Ms. Kurio indicated Mrs. Howell agreed with that and she also felt he was getting very dependant on her. Ms. Kurio confirmed clearly with Mrs. Howell that even if she is asked by someone else, that Mrs. Howell should not provide care to RP.

After that Ms. Kurio received a near miss report from Mrs. Howell regarding a medication error with RP on October 9. It was signed by Mrs. Howell and Mrs. Howell had done the vitals. Ms. Kurio wanted to be sure that it was not just that Mrs. Howell only documented it. On the Momentum system, a tracking system linked to each person's badge, she was able to determine that Mrs. Howell had been in RP's room. In reviewing those logs, Ms. Kurio was able to see that Mrs. Howell had been in the previous day on a number of times as well. Ms. Kurio confirmed she understood that system was accurate and identified the log she reviewed as being at Tab 15, Exhibit 2.

Lilia Metua, another LPN, was mentioned in the report so Ms. Kurio talked with her about it. Ms. Metua explained she had noticed the error with Mrs. Howell but that they realized RP had received the correct medication so they weren't overly concerned and rather than do a full assessment right at that time they agreed to do it at 6 a.m. When the time came, however, Ms. Metua found that Mrs. Howell had already done the vitals herself before Ms. Metua arrived.

After this happened, Ms. Kurio received a call from someone at the CLPNA advising that a report had been received about Mrs. Howell and that an investigation was being initiated. It was around this time that Ms. Kurio ended her time in that role.

In cross examination, Ms. Kurio confirmed that she was aware from Ms. Huskins that someone had reported two occasions when Mrs. Howell had visited RP on her days off for a few hours each time. She confirmed she was aware Mrs. Howell was approved to attend on one occasion for four hours to attend a conference call with RP. She did not know whether one of the two occasions reported was that occasion. The representative for Mrs. Howell asserted that it was but Ms. Kurio could not confirm that.

Ms. Kurio confirmed that she concluded Mrs. Howell had told RP about the meeting with Ms. Huskins but that she did not have confirmation from RP that Mrs. Howell had told him.

When an assertion from RP that Ms. Harvey had made RP feel uncomfortable was put to Ms. Kurio she noted that RP had not sent that concern to her. He referred to it in a later email, but Ms. Kurio did not receive the complaint in question. Ms. Kurio explained she told RP thank you for bringing that to her attention but that she would need to speak to Ms. Huskins regarding what had been raised in that email.

Ms. Kurio indicated that when she spoke to the RNs about re-doing care assignments, she simply explained she was doing it so RNs were to work Cart D until further notice (Cart D being the assignment including RP's care).

On redirect, Ms. Kurio confirmed the conference call with the doctor was held June 21 or 22 and that she first became aware of concerns about Mrs. Howell coming in on her days off on July 4.

Amina Noorali

Amina Noorali has been an LPN since 2013 and worked at the Facility for about 2 years at the time of the hearing. During that time, she worked with Mrs. Howell but indicated not frequently, maybe once or twice in a six-week rotation.

Ms. Noorali observed Mrs. Howell attend the unit to visit RP when she was not on shift. Ms. Noorali recalled it occurred on a weekend day at a time when Ms. Noorali was assigned to give RP care. Ms. Noorali described that Mrs. Howell stopped at the nursing desk and was holding a tray of Starbucks coffees while explaining that someone else in line had paid for them. When Ms. Noorali asked Mrs. Howell why she was there that day, Mrs. Howell stated she had come to visit RP. Mrs. Howell did not tell Ms. Noorali the purpose for the visit.

Ms. Noorali described Mrs. Howell's attire as including shorts, a tank top, and flip flops. Ms. Noorali stated that when Mrs. Howell was in RP's room the door was closed. Ms. Noorali had to knock on the door to go in and give RP his medications and Mrs. Howell was sitting on a chair beside his bed. When Ms. Noorali left, RP asked her to close the door. Ms. Noorali did not know how long Mrs. Howell was visiting RP and did not know when Mrs. Howell left.

Ms. Noorali explained that when she and three others were sitting at the nursing station and Mrs. Howell came in with coffees they thought it was not professional because there needs to be boundaries with patients. Ms. Noorali stated one of the others said it was something that needed to be reported to Ms. Huskins but did not report it herself since she knew another person was going to do that.

On August 1, 2021, Ms. Noorali wrote an email at 1803 hours to Ms. Huskins. In the email (at Tab 9, Exhibit 2) she described how she had been RP's nurse that morning. Around the beginning of her shift at 0800 hours she found him heavily crying. When she inquired with RP what was wrong, he asked her to leave him alone. Later in the shift he told her what was

wrong which she documented in the email she sent to Ms. Huskins. It described how RP had asked to speak to her later in the shift. When she went to his room she could see he was still crying and he told her he was upset because Mrs. Howell might lose her nursing licence and wants to quit because she is being bullied. RP told Ms. Noorali "the fucking bitch Shannon, who is walking around the unit like nothing happened yet Jeannette is suffering." Ms. Noorali wrote that RP had called Ms. Harvey a "fucking bitch" a number of times and stating he was mad because the staff were "kissing Shannon's ass".

Further, Ms. Noorali's email stated that RP told her Ms. Harvey had written an email to the manager and because of that he would see to it that Ms. Harvey and anyone else involved with what was happening to Mrs. Howell would be reprimanded. When Ms. Noorali asked RP how he knew the information he told her just knew. Further, RP told Ms. Noorali that Mrs. Howell did not want to see him anymore which hurt him because she was the best nurse and he only wanted her. He told Ms. Noorali that Mrs. Howell showed him "love and compassion and treated him like a human being with feelings and went above and beyond". RP told Ms. Noorali that an HCA had given him a hug and held his hand to comfort him so why didn't Ms. Noorali tell that to Ms. Harvey so she could report that too. RP said this is why he had been upset and crying over the past few days and asked to be alone. Ms. Noorali's email further described that as she left RP's room he cried more heavily. Later through the shift he could be heard yelling "Fucking bitch Shannon" down the hallways.

Ms. Noorali explained she sent the email because she had not known any of what RP had told her and, in her heart, she knew it was crossing an ethical boundary for RP to know it. Ms. Noorali stated she did not know the severity of what was happening but that Ms. Huskins needed to know and she reported it right away, considering it her ethical obligation to do so.

Ms. Noorali told the Hearing Tribunal this was the only time RP had mentioned anything of this nature to her. She described how after this it became harder and harder to give RP care because he stopped accepting care from many of the staff. She noted RP had complex wounds and would refuse nurses who attended to care for them. He would pick and choose who he wanted and it was becoming difficult for Ms. Noorali because he was ok with her. Ms. Noorali said it was also difficult because he was picking and choosing, which meant they could not provide him with the best care.

One day she recalled Mrs. Howell told her that she was not allowed to have RP as a patient anymore but also that she would tell the nurses assigned to RP that she would do RP's wound care, which the nurses would accept. Even though Mrs. Howell was not supposed to be RP's nurse, he would never refuse care from her and she would still go in and do that. Mrs. Howell would also look through RP's chart and read the charted notes for him.

Until his wife died, Ms. Noorali said RP was really happy but after that he took a bad turn emotionally. She thought he found it hard to cope and he was really fragile after his wife's death.

On cross-examination Ms. Noorali clarified that Mrs. Howell was the only person who had told her that Mrs. Howell was taken off RP's care. During that period of time Ms. Noorali recalled Mrs. Howell would have in-office meetings with Ms. Huskins and would be crying in the med room. Ms. Noorali explained it was during this time Mrs. Howell would tell everyone she could not be RP's nurses anymore and it became common knowledge but no one asked questions.

Ms. Noorali confirmed she observed Mrs. Howell going through RP's charts in the chart room and at the nursing station. She could not recall the exact dates but that it occurred a few times.

She confirmed she saw Mrs. Howell attend to visit RP when she was off-shift on a day shift which was usually from 9:00 to 3:15.

Ms. Noorali confirmed that the information RP had told her, and which she had documented in her email to Ms. Huskins, was information she did not have prior to that time. She re-iterated that RP did not say where he got the information from just that "he just knew".

On the occasion when Ms. Noorali observed Mrs. Howell with Starbucks coffee, she had no memory of Mrs. Howell saying anything about preparing for a conference call for bariatric surgery nor was Ms. Noorali aware of such a call.

Ms. Noorali explained that after the August 1 interaction with RP she did not bring it to Mrs. Howell's attention. She explained she did not because she considered it to be something for management to address and she didn't want to be involved.

When asked about RP yelling, Ms. Noorali explained he could be heard yelling down the hallway at the nursing station. She was firm that RP could be heard yelling.

On redirect, Ms. Noorali explained it was usual for a patient's door to be closed for family visits or if staff was providing care for privacy.

<u>Brooklyn Hurman</u>

Brooklyn Hurman has been an RN since 2010 and was an LPN for 6 years prior to that. She spent her entire career with Carewest at two of its locations. She explained she is currently a manager on the Unit. She never directly worked with Mrs. Howell but is aware who she is.

Ms. Hurman did provide care to RP and the frequency of the care depended on need, probably a few times a week. At the time RP was in the Facility, Ms. Hurman was a nurse-clinician and was involved in his care to support building capacity with communications and support wound care. Ms. Hurman stated she is "certified with wounds" and it is her area of speciality.

First, for the communication aspect of her work, Ms. Hurman explained it was about building rapport with staff. She coached and mentored on that. She noted wounds were a big concern for RP's discharge planning.

Ms. Hurman confirmed she worked with RP on October 4, 2021. She indicated she was discussing wound care with RP, and how things were going, in order to build rapport. RP was upset and believed the wound care was not being done correctly, that he had a spoken with Mrs. Howell over the weekend, and discussed how the wound care was not done correctly. Ms. Hurman described how she was gathering information from RP. Ms. Hurman noted Mrs. Howell should not have been providing RP with care at that time.

RP was very upset that his would care was not being done correctly. Ms. Hurman had made a new wound care protocol but RP was very upset. Ms. Hurman was concerned because RP was emotionally vulnerable which was part of the reason he continued to be a patient in the Unit.

Ms. Hurman clarified that RP told her Mrs. Howell had come in to tell RP his wound care was being done improperly, which upset him. This was a concern because Mrs. Howell was not supposed to be providing care to RP at that time, and Ms. Hurman was there to build rapport to have RP trust more than just Mrs. Howell. Ms. Kurio and Ms. Huskins had told Ms. Hurman that Mrs. Howell was not supposed to be providing care to RP. Ms. Hurman's involvement was to build RP's rapport with others.

Ms. Hurman recalled that RP had told her how Mrs. Howell had come and brought coffee to have with him while she was not on shift.

Ms. Hurman's assessment was that RP was vulnerable at that time. He was quick to react, angered easily, worried about his wound care and did not trust staff other than Mrs. Howell. Ms. Hurman was worried that since the care was 24 hours per day, if no trust could be built then it would not be possible to help RP to be emotionally, physically, and mentally stable in order to discharge him in a healthy state.

After discussing the above with RP, Ms. Hurman sent an email to give a synopsis of what had transpired with RP. The email was before the Hearing Tribunal at Tab 3, Exhibit 2. The email was sent to Ms. Kurio who was the team lead on October 5, 2021. The email set out what had happened. Ms. Hurman wrote she wondered whether, because the wound protocol has changed, that Mrs. Howell thought it had been done incorrectly. She also expressed her concern about building a rapport with RP while Mrs. Howell was discussing the approaches in care with RP.

Ms. Hurman expressed that on hearing that Mrs. Howell told RP the wound care of another nurse was incorrect, she thought that was inappropriate. She said if there was to be a discussion about something not being done properly then it should be outside the room and discussed among the professionals and not the patient. It raised concerns because of all the

planning that had gone into instilling confidence in RP that his care was being done properly. Further that he was already emotionally vulnerable, and this behaviour was rocking the boat and introducing doubt.

When asked about her references to RP being emotionally vulnerable or his emotional needs, Ms. Hurman explained he questioned the wound care protocol frequently, raised his voice often, and was frustrated. Staff began to be concerned that when they went in his room he would be elevated. Ms. Hurman was there to help calm things, establish trust, build confidence since his skin was a priority for him and for the caregivers.

Ms. Hurman's evidence was that she sent her email within a day of the events described in it. Her purpose for sending it was that it was important for a team of people to know what was happening with a client's care. Her concern was professionalism and that as a nurse if asked to do something for a specific reason or if asked to reflect on their practice then it was professional to follow through.

After the email was sent, Ms. Hurman and RP met with the Director to connect with RP and ensure he knew he was not responsible if Mrs. Howell was not permitted to come into his room. She had understood RP felt he was responsible when he didn't see her anymore.

The assessment of Ms. Hurman about what was happening was that Ms. Hurman was concerned if RP only trusted Mrs. Howell. Further, it appeared unhealthy since RP was fixated on his responsibility for Mrs. Howell's absence. She also thought the relationship or friendship or professional relationship (between Mrs. Howell and RP) was something to keep an eye on for RP's well-being.

RP had complex wound care which Ms. Hurman stated would worsen if he refused care, and that not following the recommendations for care was a risk for skin breakdown.

On cross examination, Ms. Hurman explained how a wound protocol is established and that it could be changed regularly. She confirmed she was one of the people RP would permit to provide him wound care.

Ms. Hurman recalled some discussion around a bariatric consult but that she was not very involved in it but thought Mrs. Howell's name might have come up in regard to advocating for that. She did not witness Mrs. Howell attending the Unit with coffee but was aware of it. She did not ask Mrs. Howell about it as they never worked together.

Following the meeting between RP, Ms. Hurman and the Director, Ms. Hurman described that RP was more confident with the team but he was still worried and concerned about not seeing Mrs. Howell.

In redirect, Ms. Hurman indicated that the first time she provided care to RP was around the beginning of October or end of September and she based that on the timing of her email.

Christina Dela Rosa

Christina Dela Rosa has been an LPN since 2019 and previously was an HCA; she started at the Facility in 2013 as an HCA.

Ms. Dela Rosa had worked shifts with Mrs. Howell, stating most of the time they worked together.

Ms. Dela Rosa provided care to RP and knew that Mrs. Howell had provided care to RP. She was asked to describe what occurred on October 2, 2021. She stated she worked the evening shift that day and was working with Mrs. Howell on that shift. Ms. Dela Rosa was the primary nurse for RP.

After shift report, Ms. Dela Rosa went to the nursing station, Mrs. Howell was there and asked Ms. Dela Rosa the difference between Biatin Ag and Aquacel Ag. Then Mrs. Howell asked Ms. Dela Rosa to come with her to RP's room saying that she had changed RP's dressing and did not find Aquacel Ag. When they got to the room, Mrs. Howell went in and pulled up a Ziploc bag with different kinds of dressings in it. She asked Ms. Dela Rosa whether it was the dressing she had used. Ms. Dela Rosa was looking at the Ziploc bag and could see a silver dressing. She said "yes" but did not really understand what she was being asked, but remembered that Aquacel Ag had silver on the other side. Mrs. Howell started telling Ms. Dela Rosa she had used the wrong dressing, and that Ms. Dela Rosa should follow the flow sheet. All of this happened in front of RP and an HCA.

Ms. Dela Rosa described how shocked she was that Mrs. Howell did this in front of RP. Ms. Dela Rosa wanted to inspect the Ziploc bag but Mrs. Howell gave it to RP. Mrs. Howell was talking in front of RP but Ms. Dela Rosa asked her to go into the hall. Mrs. Howell said to RP that, essentially, he needed to monitor that he was getting the right dressing.

As Mrs. Howell refused to go into the hall, Ms. Dela Rosa wanted to see whether she had been the one to last change RP's dressing, but during all of this Mrs. Howell continued to talk to RP. Ms. Dela Rosa also heard Mrs. Howell tell RP the result of his X-ray. Ms. Dela Rosa felt ashamed to hear that since RP had earlier asked Ms. Dela Rosa for the results. Ms. Dela Rosa had told him that the X-ray was there, the doctor was aware but there was no order. Further, that the doctor would come to explain the X-ray to RP. Ms. Dela Rosa felt like Mrs. Howell telling RP the results of the X-ray undermined Ms. Dela Rosa. That was showing Mrs. Howell was special.

After this, Ms. Dela Rosa left the room and went back to the nursing station to check if she really did make a mistake but found she was not the last person to change RP's dressing.

Ms. Dela Rosa questioned this treatment and wondered where the professionalism was. She expressed that she was a new nurse and was building her confidence. She wondered how she

would be able to build trust with the client and the HCA if this is the attitude. She noted she could accept if she made a mistake but if that occurred it should not be pointed out in front of the client because it breaks any trust in her. An LPN requires trust to do their job. In regard to what Mrs. Howell had said to her, she indicated that Mrs. Howell said you put on the wrong dressing, that she should follow the flow sheet, etc.

Ms. Dela Rosa explained she saw the result of the X-ray too but didn't tell RP because she knew the doctor looked at it, there was no order, and the doctor would come to explain it to RP. She recollected that Mrs. Howell told RP to google the term. Ms. Dela Rosa's evidence was that she could read exactly what was on the result to a client but did not have the right to explain it, that the doctor would have to explain it.

This incident impacted Ms. Dela Rosa making her lose confidence and to feel ashamed due to the pointing out of an error in front of the client and the HCA. It caused her stress and made her emotional. It caused her to question herself and how she could provide care to RP after that.

After she had confirmed she was not the last person to change RP's dressing, she went to explain this to RP but he rolled his eyes at her and said "whatever" then blamed her for his belly not healing.

The following day she was again assigned to work with RP but when he saw her he rolled his eyes. When she tried to apply a cream for his legs, he told her he did not need the cream any more but said it with a raised voice. When she asked him if there was anything else she could help him with he told her "no" so she returned to the nursing station. Soon after, an HCA came to tell her RP wanted to speak with her. RP told Ms. Dela Rosa she had to check his dressing because he had showered that morning but it was not changed. She left to get the flow sheet and returned and changed the first of two dressings without any comment from RP. When she began to cut dressings for the second change, RP began to comment on what she was doing and criticizing it. He told her to call Ms. Hurman to show her how to do the dressing. His voice was very angry and loud and he told her she should know how to do the dressing and that the reason he was not healing was because they were doing it wrong and nobody cares. He also said he was tired and sick of everything and that he was emailing but no one responded.

Ms. Dela Rosa knew RP did not trust her but she had the flowsheet and knew what to do. She told him this was the case and that the protocol had been updated. She eventually left the room and asked an HCA to finish the care, and she documented everything that happened.

Prior to that point, Ms. Dela Rosa explained she did not have a problem with RP and he was nice but that changed totally after October 2.

Ms. Dela Rosa identified her email to Ms. Kurio at Tab 12 of Exhibit 2. She had emailed Ms. Kurio after what happened on October 3 because she was unable to sleep, was questioning

herself and questioning what the policy was about a respectful environment. The email described that Mrs. Howell had reprimanded Ms. Dela Rosa in front of RP and saying that Ms. Dela Rosa did not know what she was doing and that the LPNs were putting the wrong dressing on his belly which was the reason he was not healing. Ms. Dela Rosa's email set out how after that, things changed suddenly. She described that she had been humiliated because the trust had been broken. Ms. Dela Rosa clarified that "trust had been broken" meant that the situation had made it such that the client and the HCA would not trust her.

Ms. Dela Rosa identified an unusual occurrence report she wrote and submitted right after the events above had occurred; this report was before the Hearing Tribunal at Tab 14, Exhibit 2. The report indicated that the impact of the incident on her was a loss of confidence, inability to concentrate and stress. She expressed the reason she had written the report is that she wanted the behaviour to stop and that it was not in accordance with Facility policy.

Ms. Dela Rosa also described that on RP's birthday she was assigned to his care and Mrs. Howell was assigned to another area. Ms. Dela Rosa was doing her initial round of the shift. When she got to RP's room, the door was closed so she knocked and came in. Inside she saw Mrs. Howell with RP. Mrs. Howell was putting new shoes on RP and Ms. Dela Rosa could see Amazon packaging nearby. Ms. Dela Rosa could not recall the exact date but it was in the same week as October 2/3 when the other event happened.

Ms. Dela Rosa related that on seeing Mrs. Howell in RP's room all she could think about was how RP would always tell her Mrs. Howell provided better care.

Returning to the topic of X-ray results, Ms. Dela Rosa affirmed that with the results of a lab or an X-ray all she could do is read it to the client because she did not have the education to explain what it meant or provide commentary.

Ms. Dela Rosa's evidence was that before the dressing incident RP had never refused care from her but after that he did refuse some care. She also explained there was an impact on the team because RP would refuse care from certain people, and others would then have to provide it.

In cross-examination Ms. Dela Rosa returned to the unusual incident report and clarified that it was RP who was swearing at her and not Mrs. Howell. She confirmed RP had been swearing a lot but she did not want to repeat those words. They had been recorded by her and the HCA in the chart.

Ms. Dela Rosa confirmed she tried to talk to RP and explain she had not been the last person to change his dressing, but he would not listen. She did not speak to Mrs. Howell about it as she was waiting for Mrs. Howell to come and apologize. She had been ready to forget what happened on October 2 but then when October 3 occurred, she saw that as being the impact of October 2 and decided to write the report.

Ms. Dela Rosa confirmed that when she saw that she was not the last person to change RP's dressing that it reassured her. She confirmed that when doing dressings, you always look at the flow sheet because you may not know when it had last been updated or changed. Her practice was that if she had a dressing change, she would always bring the flow sheet with her to do it. Even if a client was familiar, the proper procedure was to check the flow sheet.

During this interaction with Mrs. Howell, Ms. Dela Rosa explained that what Mrs. Howell was saying to her was not professional since it was in front of the client and an HCA. Ms. Dela Rosa said she would have accepted it if no one else was there, and they should have gone back and checked the flow sheet together; that would have resolved the problem.

Ms. Dela Rosa explained that when Mrs. Howell showed her the Ziploc bag with dressings in it she looked at it and saw the silver side of the dressing so she thought it was Aquacel AG but she made a mistake and should have paused before answering. Biatin Ag and Aquacel Ag both have a silver side.

Lilia Metua

Lilia Metua has been an LPN since 2019 and was an HCA from 2015 to 2019. She had worked at the Facility since April 2015. She worked with Mrs. Howell, stating that at first not regularly but after a few months when Ms. Metua had more shifts they worked together more frequently.

Ms. Metua confirmed she worked with RP and that she had admitted him to the Unit. She was aware Mrs. Howell provided care to RP and indicated she had seen Mrs. Howell visit with RP. She did not know the exact date but there was an occasion when she was working a shift from 3:00 p.m. to 11:15 p.m. and she saw Mrs. Howell. Ms. Metua had taken her break around 6:00 p.m. and was walking to the lunch room. In doing so she passed by the reception area where there was COVID screening at the time. As she was passing by, she saw Mrs. Howell being screened. Mrs. Howell was holding two iced coffees. Ms. Metua wondered whether someone had called in, or why Mrs. Howell was there. Then Ms. Metua realized Mrs. Howell was not wearing scrubs but a t-shirt and shorts. Ms. Metua waited there and when Mrs. Howell came in Ms. Metua asked Mrs. Howell why she was there. Mrs. Howell told her she had come to visit her friend RP. They then parted ways.

On her break Ms. Metua began to think about what was happening. She was a new nurse and could remember doing her CLPNA review and that there was a question about visiting a patient on days off. She recalled the answer she picked was to politely refuse because it is unethical to do that. Ms. Metua began to question whether it was right for Mrs. Howell to come in on her days off i.e., unpaid. She wondered if something had changed from the CLPNA. She recalled she was not comfortable on her break thinking about those things.

When she returned from her break she asked the RN, Ms. Harvey, whether they were allowed to visit patients on days off. The RN told her no. Then she realized she had picked the right answer to the question on whether they were allowed to visit patients on days off.

Ms. Metua indicated that it was almost Fall when this happened.

Ms. Metua also described what happened on her shift of October 9, 2021. She was working the night shift from 11:00 p.m. to 7:15 a.m. and Mrs. Howell was working the evening shift of 3:00 p.m. to 11:15 p.m. Mrs. Howell offered to stay overtime and stay overnight. Ms. Metua was appreciative and they worked together.

Ms. Metua did her initial round and during that time realized that RP's INR was not addressed to the doctor which is what is normally done when an INR result is received. They had to inform the physician of the order for the physician to give the correct dose of Warfarin. Ms. Metua noticed there was no order so it wasn't addressed. She wondered if there was an error and asked Mrs. Howell if it was an error, Mrs. Howell confirmed that was the case.

Ms. Metua asked whether she should make an incident report. Mrs. Howell asked her whether Ms. Metua wanted Mrs. Howell to check RP's vitals, but they decided to do them together at around 6:00 a.m. From there they continued on with their routines.

Around 6:00 a.m. Ms. Metua was attending to another patient where she had been called. When she got back to the nursing station she did not see Mrs. Howell. A few minutes later Mrs. Howell came back and told Ms. Metua that she had done RP's vitals.

Ms. Metua explained that the normal protocol is if you find an error it is your responsibility to do the vitals. She had asked Mrs. Howell's advice and they agreed to do it together. It made her feel useless and undermined that Mrs. Howell had done it without her. She didn't want to have a fight but felt like she was nothing.

On cross examination, Ms. Metua was asked why she did not fill out the occurrence report. Ms. Metua explained she had asked Mrs. Howell for her opinion about whether she thought it was an error and Mrs. Howell said it was. Mrs. Howell then pulled the forms. Ms. Metua did not ask her to fill out the incident report, however Mrs. Howell did complete it.

Ms. Metua confirmed it was evening when she saw Mrs. Howell come to the Facility with two iced coffees. Ms. Metua confirmed Mrs. Howell had told her she was coming to see her friend RP. Ms. Metua's evidence was that Mrs. Howell did not say anything to Ms. Metua regarding a consult call for bariatric surgery. Ms. Metua explained she did not see Mrs. Howell when she came back to the Unit as she was not assigned to RP that shift.

Carleen Campbell

Carleen Campbell has been an HCA for 10 years. She has worked at the Facility for that entire time and frequently worked with Mrs. Howell. Ms. Campbell initially began her work in long term care where Mrs. Howell was an LPN. Several years ago, Ms. Campbell was transferred to the ALC Unit where she continued working with Mrs. Howell.

Ms. Campbell never had concerns about Mrs. Howell.

Ms. Campbell described how around the end of 2019, the work began to change. This is when they were advised the unit would transition in to an ALC unit but then COVID started in 2020. This was a period of dramatic change at the Unit.

Ms. Campbell talked about when Mrs. Howell was communicating changes in protocol that it was team oriented rather than authoritative. Ms. Campbell said she had never seen Mrs. Howell be inappropriate with a client. She was sure there must have been shifts when she worked as an HCA with RP and Mrs. Howell was the LPN. She indicated she had never witnessed anything like overstepping of boundaries between Mrs. Howell and RP.

Ms. Campbell said that all the good LPNs and RNs and HCAs that she works with advocate for the clients that need to be advocated for. She could not think of a specific example but was sure Mrs. Howell and even herself had done that.

Ms. Campbell explained there was no duty to do laundry for a client but there had been situations where someone didn't have family and she had done their laundry when she had the time during her shift. It wasn't something she was asked to do but she just did it.

Ms. Campbell was aware of staff bringing in extra things they thought clients would need like maybe a t-shirt. Sometimes people would bring in old DVDs for clients to watch.

Ms. Campbell was not aware of anything specific with regard to allegations of unprofessional conduct between Mrs. Howell and RP. She had heard things at work but never thought any of it inappropriate. She knew Mrs. Howell supported RP but said others did as well.

Karen Danyluk

Karen Danyluk is an HCA; she has worked at the Facility since 1985. She said she had worked with Mrs. Howell for about 20 years. Ms. Danyluk had a very good working relationship with Mrs. Howell. She never had any problems with Mrs. Howell who was very warm, compassionate, and forthright.

Ms. Danyluk described the timeframe when the Unit transitioned to an ALC unit as very stressful for everyone. There was a lot of conflict on the Unit and people felt pressured.

Ms. Danyluk never saw co-workers being bullied or belittled by Mrs. Howell and never felt bullied by her either. Ms. Danyluk said Mrs. Howell was very much about advocating for clients. She also explained that when clients did not have family to do laundry for them the HCAs would do it for them. Ms. Danyluk never saw Mrs. Howell overstepping her professional boundaries with any clients.

Ms. Danyluk was familiar with RP and had worked with him. She had observed Mrs. Howell and RP together on occasion and did not witness anything unusual.

Ms. Danyluk did not know about any of the allegations Mrs. Howell was facing.

On cross examination Ms. Danyluk confirmed that she was also at work and on duty when she did laundry for clients.

Janice Sharpe

Janice Sharpe is an Occupational Therapist (OT) who works some of the time at the Facility. Her work involves providing equipment such as wheelchairs, compression stockings, and so on. Her job requires working with nurses because she gives recommendations but they are her “eyes and ears” and can give her information. It is part of a team approach. She advised she also does wound care because some pressure wounds are related to how someone is sitting or laying. She would assist in determining how to get rid of the cause of those wounds.

Ms. Sharpe indicated she also works with Ms. Hurman but is now the manager. She also referenced ISFL who have a wound specialist that can be called in.

Ms. Sharpe had worked for Carewest or over 20 years. She had worked with Mrs. Howell during that time. Her observations of Mrs. Howell were that she is very respectful of clients and interacts with them in a respectful way. She said Mrs. Howell explains things and advocates for clients, making sure they get the things they need. Her assessment was that Mrs. Howell had improved her skills in wound care because she is interested and pursued extra education and experience in it. Also, that she was proactive in seeking changes where wounds were not progressing.

Ms. Sharpe explained the flow chart for wound care and what that involves. She explained that this can differ from client to client and can change from time to time for the same client.

Ms. Sharpe was familiar with RP and indicated she was with Mrs. Howell doing wound-care rounds with respect to RP. Her observations of Mrs. Howell’s interactions with RP were that it was the same as with any other resident. She was professional and explained to him what they were doing. She never witnessed Mrs. Howell cross a professional boundary with RP, or with any other client.

Ms. Sharpe had witnessed Mrs. Howell giving instructions to colleagues and indicated Mrs. Howell is good at doing that. She indicated Mrs. Howell really worked as a team and would readily take care of something that maybe another LPN would call an HCA to come in and take care of.

Ms. Sharpe was not aware of any the allegations Mrs. Howell was facing other than what Mrs. Howell had told her briefly a long time before.

On cross-examination Ms. Sharpe confirmed Mrs. Howell had only told her something was going on in regard to the allegations and that there had been no discussions about that on the Unit. She could not recall when she had last seen Mrs. Howell provide care to RP but indicated that it was probably in August 2021.

RP

RP is a former client of the Facility; he was a client in the Facility until October 20, 2021. He described how when he was initially admitted in May 2021 that things went well at first. He gave evidence that he had a lot of complications with wound care and a lot of medication that had to be managed. He also related that he has osteoarthritis which made transferring and moving difficult.

Things began to change, according to RP, when his care started to become neglected which was around June 2021. He had specific wound care needs and most of the nurses weren't following the specific wound protocols. He indicated they were ignoring calls for assistance, for example he might wait 40 minutes to be able to use the commode. He understood that the HCAs were deciding not to assist him but he needed their assistance. He described that sometimes his gown or bedding would not be changed for a week.

RP explained he had a lot of pressure wounds that he needed to keep an eye on. Some were on his upper thigh towards his buttocks and he was unable to see them. He was depending on staff to make sure they were following the correct wound-care protocol and a lot of the time they weren't. He would find that out later and it was frustrating.

In regard to Ms. Harvey, RP recalled an interaction with her in late July. He related that he and his wife, who passed away in June 2021, had a memorable holiday in BC a few years prior on Vancouver Island. Ms. Harvey told RP she was from Vancouver Island and was showing him pictures of Vancouver Island and her renovations. He advised she had talked to him about coming to visit her and her family on Vancouver Island. He related that he was very uncomfortable about that but didn't know what to say or do because he was having so many issues with his care at that time. He was wary because he said he knew Ms. Harvey carried a lot of clout in the Facility. He had seen her take laundry from a client and give it to an HCA to do it.

He said things bothered him on an emotional level and he didn't want to have to deal with that anymore. He was very upset because his wife had just passed away and he was in an emotional state about it. He'd been going through a lot and didn't want to have to deal with inappropriate conversations. He did not want to see pictures of Ms. Harvey's family or guest house and did not want to visit her. He wanted his care to be done properly, he was upset and let his feelings be known about that. He thought that it seemed his care was secondary to staff's personal needs.

He said that he asked Ms. Harvey to leave the room and not to come back. He said he brought that to the manager's attention on September 25. He felt that if he brought up any issues they were ignored; if he let things pass by everyone thought he was great but if he had a concern, he was disgruntled. He said that he is not a cranky man but what was making him cranky was having his care neglected and it seemed like they were not concentrating on the job at hand. He said he had complex medical needs and they were not being addressed. At Tab 10, Exhibit 2 an email was brought to the Hearing Tribunal's attention in which RP indicated he was referencing the Vancouver Island issue and he said it was completely ignored.

RP recalled Mrs. Howell at the Facility. He denied having ever exchanged phone numbers with her or having any private calls with her. He stated he never exchanged numbers with anyone at that Facility. He said he received calls from family and friends.

When asked whether he recalled a call in which he said, "It's not right she makes you afraid to come to work. Shannon Harvey that effing bitch"; he denied it. He indicated that he did not know how anyone would hear him because his voice could not get very loud. He stated that at the Facility his bed was right beside the nursing station and he had to use his bell to call even when his door was open because they couldn't hear him. He said he was baffled how anyone could have heard him yelling. Further, he denied making any calls of the nature the one described.

RP stated he never had a call with Mrs. Howell. He denied that anyone questioned him about his relationship with Mrs. Howell.

He gave evidence that he called his room the water cooler hub and that HCAs were constantly talking to him. He described that they were constantly talking about who was getting in trouble and what was going on. They said in his room that Mrs. Howell had gotten into trouble for something with a manager. He stated they never went into details but he wanted to make sure with management and there were a lot of rumours. So, because of this he emailed Ms. Kurio to say that if anyone was concerned about nurses trying to take advantage of him then why wouldn't they ask him about that. He said no one came to ask him or to asked him how he was doing or if there were issues he was having trouble with. He said everything that was done was pure speculation on their part.

In terms of off-duty visits, RP advised Mrs. Howell had come to visit him twice and it was with regard to a conference call that had been set up to discuss his planned bariatric surgery. He said a team had been assembled consisting of Mrs. Howell, Ms. Kurio, Ms. Sharpe, and his doctor, Dr. Son. He stated David Sawatzky, the Facility Manager, was supposed to be in that as well. He advised the call was to discuss him having bariatric surgery and a hip replacement. He said that due to COVID and his inability to make it to appointments the surgery was on hold. The surgeon, Dr. Church, wanted RP to attend physiotherapy appointments and the call was to inform Dr. Church that being at the Facility was not a barrier and he could get to appointments. For this reason, Mrs. Howell came to visit him once on a Saturday to discuss what they were going to go over during the call. His wife passed away on Thursday June 17 and the call was June 22 so he needed the help. Of the "so-called" team that had been assembled, only Mrs. Howell attended it.

The Saturday visit, RP indicated, was just before or around noon. He remembered it was a nice sunny day outside and he had not been outside in a year and a half so she took him outside to discuss the call. He was very thankful for being able to go outside. He said that an HCA and a security guard had helped them out the side doors to go outside so it wasn't done in secret. He said they had the meeting outside in broad daylight.

He indicated the second time she came to visit was the Saturday after that regarding a post-conference call meeting to talk about steps going forward. They met outside again and she brought him a coffee. Again, he appreciated that because the coffee at the Facility was horrible. During the meeting they discussed all the issues and plans and steps going forward. RP stated those were the only two times Mrs. Howell had attended to visit him when she was on her own time and they occurred in the broad daylight.

RP's wife passed away suddenly on June 17. He said on the day he found out he was left alone. He was waiting for his mom and sister to see if they could get keys from the landlord because he had not heard from his wife. Usually his wife would call before noon and the longer the day went on the more concerned he grew.

Mrs. Howell came to his room and asked if she could stay with him because he was very worried. He was upset and nobody had come to sit with him. Mrs. Howell suggested he call the police to do a wellness check. He was concerned and he was wondering what was wrong. He did call the police and they were going to meet RP's sister-in-law at the apartment. He asked Mrs. Howell to stay with him. He said she held his hand a little while he was crying.

RP indicated Mrs. Howell had hugged him once when his mom and sister came in and that she had hugged them as well. Mrs. Howell got chairs for RP's mom and sister so they could sit and talk. RP stated Mrs. Howell never kissed him.

RP also denied Mrs. Howell ever talked to him about what was going on at the Facility regarding her. He said she never brought it up but the HCAs, they would come in and watch the hockey game, and they were like the gossip girls. They would talk about what was

happening. It was through them he found out that Mrs. Howell had been called into the manager's office.

RP denied he had ever told anyone that Mrs. Howell didn't want to see him or look after him. He confirmed he was worried that she was going to lose her job because there was so much rumour and speculation going on and for a while she was not involved in his care. He had no idea why. He thought maybe she had gotten in trouble for helping him with the conference call but could not figure out why that would be because she was just being a proactive nurse. He said he would ask what was happening, but no one would tell him.

He said that a lot of the time other nurses would ask Mrs. Howell to do his wound care and asked him if he would have problems with that. He would tell them its up to you but only if Mrs. Howell doesn't have a problem. He said Mrs. Howell was a wound care nurse and he knew she was competent with his wound care. So, if they offered to have her help with wound care, he had no problem with that. RP described it that nurses passed off his wound care to Mrs. Howell.

RP said there were a few nurses he had no problem with. He knew Mrs. Howell was capable because he knew she had been on the wound care team prior to the Unit being created. He said she always followed the wound care instructions and made recommendations about what was being used.

He indicated that this was understood or assumed to be him asking for or demanding something about his care which was not true. Instead, every time she came to do his wound care it was because someone asked her to. It was never him demanding to have Mrs. Howell. The only nurse he asked not to be assigned to him was Ms. Harvey and a few of the HCAs that he thought were not paying attention during transfers.

RP recalled a discussion with Ms. Dela Rosa and Mrs. Howell. He indicated Ms. Dela Rosa and another nurse had done the wound dressing incorrectly. He indicated he had two major wounds at that time – one on his belly button and one on his upper thigh. The wrong materials were consistently being used. He said Ms. Dela Rosa had brought Mrs. Howell into his room and Mrs. Howell went over the products that were supposed to be used and the product that should not be used. He described the interaction as a talk between one colleague helping another one. He said Ms. Dela Rosa had used a material without checking the wound care flow sheet. He was not certain why but she used the wrong one.

RP described the issues he had with his wounds and the progression with that. He denied ever yelling or throwing things. He stated he had a disagreement with Alex, an RN, at one point that he was having a panic attack and there was an issue about getting Ativan from Alex. It culminated in him throwing toilet paper at Alex to get him to leave. He explained that Alex would be giving him a lecture but he didn't want to hear it and Alex would refuse to leave so he tried to find something that wouldn't hurt anybody and threw his toilet paper or Kleenex box at Alex.

RP stated all of the employees at the Facility would visit him in his room during shifts. He indicated they would come and watch the hockey game and then go off to their assigned duties. It was the HCAs that were doing that. No other staff came in to chat but his room was like a water cooler for some of the HCAs. He mentioned some of them by name. He denied any private visits by staff.

On cross examination RP confirmed he was concerned with Ms. Harvey showing him photos of Vancouver and her property there. Also, that he brought the concerns to the attention of management within a few days of it happening. He recalled that it was sometime in August that had happened.

RP confirmed that while at the Facility he needed care from HCAs, LPNs and RNs. He described how he was able to move from bed to a wheelchair with the aid of a walker and fentanyl as well as some other transfers he could do with these aids. RP confirmed he had complex wounds and that he depended on all the nurses to provide him with care including Mrs. Howell, who was part of the team.

RP confirmed Mrs. Howell was in the room when he learned his wife passed away. He indicated she did cry but not until his mom and sister arrived and then she gave him a hug. He stated Mrs. Howell's crying was just tears. He stated he didn't ask for hugs from her but he needed someone there to hold his hand because he was worried something was going on but everyone else had abandoned him. He denied Mrs. Howell was crying excessively. He said she was only in the room briefly after he found out his wife had passed. She got chairs for his mom and sister and gave them hugs after they asked for them.

RP stated Mrs. Howell came to his room with regard to the conference call with Dr. Church. His wife passed June 17, the conference call was June 20. Mrs. Howell came in on a Saturday to go over that and then again after the call on a Saturday, for a post-call meeting. On both occasions they discussed medical matters and those were the only two occasions when she came to visit him on her own time. He confirmed Mrs. Howell brought coffee on both occasions. He said their conversations were all care related. He denied that Mrs. Howell ever comforted him or came to see him other than to provide care.

When asked whether Mrs. Howell provided him with the best care of all the nurses, RP replied that she was the most consistent. Other staff members did a really good job, and there were some that he knew did their care correctly. There were others that had no concern about whether his care was done correctly. It's not that he wouldn't trust other nurses, but he would have to challenge them on whether they were doing things correctly. He trusted Mrs. Howell the most and would not have doubts with her, but with others he did.

RP denied stating that Mrs. Howell was the only one that could provide competent care with compassion. RP was confronted with his email of July 9, 2021 to David Sawatzky which stated

> So I asked Caralee if Jeannette could be in charge of my care plan. I don't want her to be my personal nurse, but she is the only person on your staff who I completely trust. She is the only one that can provide competent care combined with compassion.

RP acknowledged he had written those statements, but at the time he was quite upset. He said that he asked that Mrs. Howell continue to provide him care. Further, he had concerns the other person supposedly in charge of his care plan was the RN that he had an issue with. He knew that if Mrs. Howell was working on his care plan it would always get done correctly.

RP denied asking other nurses if Mrs. Howell could provide him care. Instead, it was other nurses that asked him if Mrs. Howell could take over his wound care. He stated there were other nurses that were not doing his wound care properly. He said the wrong materials were being used and he would find out after one way or another. He confirmed Mrs. Howell was one of the nurses who would point that out to him. He confirmed Mrs. Howell told him that nurses were not using the proper materials but he said he also knew it himself. He confirmed this specifically occurred with Ms. Dela Rosa. He stated he had the wound flow chart in his room and knew that the incorrect materials were being used.

RP denied Mrs. Howell gave him test results, and that usually it was done by the attending nurse. He said the only X-ray he had was on his knee and that the attending nurse was Cristina. Further, he stated that Ms. Dela Rosa explained the results to him. He said he had a bone spur on his knee and it locked his patella onto his knee and it was causing pain. He denied googling the results of the X-ray, re-affirming he only knew what Ms. Dela Rosa had told him.

When asked whether he knew if Mrs. Howell wanted to bring her dog in to see him on days off; he said it was discussed as a possibility. He knew he had asked her if she was able to bring her dog because he loves dogs, so he asked her if it was possible. RP indicated Mrs. Howell told him she would have to check, and then told him she couldn't do it. He denied Mrs. Howell had told him she had been called into anyone's office. He said the HCAs told him, but the HCAs never told him why Mrs. Howell was in the office.

RP denied that Mrs. Howell had ever told him she had been brought into the office due to staff complaints that they had been hugging and holding hands. He said the HCAs had given him that information. He said the HCAs did not give him a specific reason but that they had been questioned about whether they were holding hands or in a relationship. He had an idea that was what Mrs. Howell was brought in to address but he was going by what the HCAs told him.

RP was shown the July 9 email to David Sawatzky which stated:

> Jeannette was called into Lynn's office today and told that there had been staff members complaining that they seen her hugging me and holding my hand and that this was inappropriate behaviour on her part.

RP's reply was that the nurses told him a lot in confidence. He indicated the HCAs must have told him more details than he recalled.

He confirmed he was concerned about Mrs. Howell being called into the office because of the serious accusation being made, especially since it was false. He stated he wanted to set the record straight which is what the emails were for. He wanted to make sure they knew she had not done anything unprofessional with regard to him and that it seemed like he was being used as a convenient scapegoat for accusations that weren't true.

RP referred to the July 9 email when asked whether he knew the meeting discussed had occurred that evening and confirmed that was his understanding. He confirmed that his evidence is that he was told by HCAs at some point between his email and the meeting as to what had happened. He denied Mrs. Howell had been the one to tell him.

When asked how RP knew Mrs. Howell had another meeting with Ms. Huskins on July 20, he stated he knew because whenever anyone was brought into the office the HCAs would tell him. He said they knew who was showing up but he didn't know if they knew what was going on inside. However, he was at the point where he thought something was going wrong and that somebody was taking everything out of context. He was concerned because she was a good nurse, but he denied they were friends.

RP agreed Mrs. Howell had come in to see him and taken him outside but he thought she was being a compassionate caregiver.

When it was suggested RP knew Ms. Harvey had written an email making allegations about RP and Mrs. Howell, RP denied knowing at the time of his complaint that Ms. Harvey had been the one that had put in the complaint against Mrs. Howell. He stated he did not know that Ms. Harvey had written any emails until after he left the Facility. His evidence was that he did not think Ms. Harvey had done that and he had no idea. He stated he had been concerned that Ms. Harvey had shown him pictures and invited him to Vancouver Island and had expressed that in August.

When asked why he told Ms. Harvey "you know what you did" and "get out", he stated that was because Ms. Harvey knew he was stressed and that Vancouver Island meant a lot to him and he was really upset. RP denied making those comments because Mrs. Howell told him about an email that Ms. Harvey had sent. He denied having any knowledge of whether Ms. Harvey was bullying Mrs. Howell. He said he knew something was going on but not that it was Ms. Harvey until much later. He said his problem was that issue with Vancouver Island and Ms. Harvey. He stated he told Ms. Harvey she knew what he was upset about and that he had sent an email to Ms. Huskins about it.

RP stated he did not know Mrs. Howell was not supposed to see him anymore and that he only learned this when Ms. Hurman and the acting Director came to speak with him. He agreed he thought Mrs. Howell was not coming to see him because of the accusations. He confirmed he sent an email to Ms. Kurio telling her it was not Mrs. Howell's fault. He explained the rumour mill was crazy and he wanted somebody to know that obviously someone was making accusations and he had no issues with Mrs. Howell. He confirmed he was worried she might lose her job but denied that Mrs. Howell discussed it with him. He denied being stressed about whether Mrs. Howell would lose her job. He agreed he sent emails to management about Mrs. Howell because he was concerned.

The Hearing Tribunal asked RP to confirm the pre- and post-conference visits were on Saturdays and that the bariatric conference was on a Tuesday, and that Mrs. Howell attended that teleconference.

Jeanette Howell

Jeanette Howell has been an LPN since 2012 and was previously an HCA since 2002. She had been at the Facility nearly the entire time other than working at the Rockyview Hospital for a year to build her knowledge and help bridge the transition from HCA to LPN.

Mrs. Howell described the transition on the Unit as chaotic because of various factors including elections staff had to make. Staff had been moved around and there was a lack of management to lead the transition.

She described how at the time of transition she had difficulty coping, in part because there was an issue over her likely exposure to COVID and she needed to rent an apartment away from her family to live in quarantine for two weeks. She explained that with all the arrangements, it was chaotic. At work it was also chaotic in trying to prevent clients in the Unit from getting COVID. There was also a lot of transition with staffing during that period. She gave evidence that she took time off to deal with anxiety at that time.

Mrs. Howell confirmed she worked with RP, a client at the Facility while she worked there. She denied having any contact with him since leaving the Facility and denied having his phone number or contact information. She stated she considered him a client rather than a friend.

Mrs. Howell described a bullying and harassment complaint she filed because she thought that when Ms. Huskins or others spoke to her it was about gossip from the unit. Ms. Huskins did not stop it even though she could have directed staff to stop.

Mrs. Howell said she did not know who was emailing Ms. Huskins but that someone told her Ms. Harvey did not care for her, which she found difficult.

The complaint was before the Hearing Tribunal at Tab 6, Exhibit 2. Mrs. Howell confirmed it was dated July 22, 2021 which was the time she felt others were gossiping about her. She said the conference call was something Ms. Harvey was not aware of but there were questions about why Mrs. Howell was involved in that process. She stated that at the Facility LPNs and RNs do the exact same thing, so her role was no different.

Mrs. Howell confirmed she had written that on a couple of occasions she had held RP's hand when he was going through a difficult time. She said she hugged RP once when his wife passed away in order to console him. The complaint indicated Mrs. Howell had visited RP on her own time which she explained was because RP wanted to give up on life after his wife died. She said she had mentioned it to others such as Mr. Sawatzky and Ms. Huskins who knew they were going to talk about the conference call and that it wasn't unusual. She stated she came through the front doors of the facility and the video of that could have been pulled because it wasn't hidden. Further, that her visit information would have been logged in the COVID screening logs.

She advised Ms. Huskins had given her four hours to come in to do the conference call so that it looked like Mrs. Howell did some other duties for the unit and then did the call in RP's room. Ms. Huskins and Ms. Kurio wanted to pay her so staff wouldn't question why she was doing it. For the Saturday meetings she said those were during the day, she would drop one of her children off at work near the Facility then go see RP. She said, again, it was never a secret and she had asked Mr. Sawatzky and Ms. Huskins to come in. She said she took RP outside because it was during COVID protocols and she didn't want to have to sit in RP's room with a mask on the whole time. She indicated an HCA and a security guard assisted with the door.

Mrs. Howell said the HCAs knew the conference was coming and it sparked questions about why Mrs. Howell was doing it, and those were the rumours going around. She said any nurse could have done that.

She denied having told RP about her feelings about working at the Facility. She said he had his own issues and was grieving and did not need to know what was happening on a dysfunctional unit.

Mrs. Howell confirmed she had seen Ms. Harvey's name on an email in Ms. Huskins' office because it was on the desk. She denied discussing that email or the context of it with the Unit after but said the HCAs saw her because Ms. Huskins' office was right at the front and sometimes they would stand and could look and see who was in the office. There were staff standing in the hallway when she came out so they knew she had been in the office.

Mrs. Howell denied hearing anything about an interaction between Ms. Harvey and RP on July 30 where he was yelling at Ms. Harvey to get out. She stated she never talked to RP about her concerns and feeling bullied at work. She said on one occasion she had sat in RP's room to have lunch with him but it was during COVID so there was no way to eat lunch without removing her mask. She concluded saying she did not eat in RP's room.

After being moved off Cart D (which was where RP's care would be done) she indicated she did not say anything to anyone that Ms. Huskins had suggested the change because it was feeding the fire of gossip that she had kissed RP or was in a relationship or had exchanged phone numbers with him. Mrs. Howell said she asked Ms. Kurio if they could keep it discrete so it did not add to the fire.

Mrs. Howell recalled working a double shift and the person who had been assigned to RP had never worked with him. She noticed there was a different inner dressing on his belly button. There needed to be a specific dressing on top. She asked Ms. Dela Rosa if she did RP's wound care because she had signed her name to it and Ms. Dela Rosa agreed she had. Then she told Ms. Dela Rosa she had used the wrong dressing because she used Biatin Ag when what was needed was Aquacel Ag. Mrs. Howell's evidence was that she had told Ms. Dela Rosa this in the report room, but Ms. Dela Rosa was worried and wanted to go and look at it in the room. There they pulled the bag out to look at the supplies being held for his care and there were materials brought in that weren't part of the protocol. Mrs. Howell denied a conversation took place in RP's room, only that they had verified the dressing in his room.

Mrs. Howell denied that Ms. Dela Rosa had ever told Mrs. Howell she was upset about it. Mrs. Howell said she walked on eggshells around Ms. Dela Rosa because she had experienced a loss in her life and would come to work crying. Mrs. Howell explained Ms. Dela Rosa would ask her questions and she would answer those for her. She denied ever having belittled Ms. Dela Rosa or use a tone other than what she was using to give evidence. Her evidence was that Ms. Dela Rosa cried a lot because she had lost her husband.

Mrs. Howell confirmed she had given X-ray results to RP. She said it was normal that clients on Warfarin would ask about whether their INR was in range, or they would notice their medications looked different and would ask about it.

Mrs. Howell confirmed working with Ms. Metua and that she had agreed to stay and work a double; normally she did not work nights. Mrs. Howell explained Ms. Metua would attend her shift early to review the MARs to prepare and, on that night, noticed the evening nurse had not called in RP's INR and therefore the evening nurse had made a medication error. Ms. Metua noticed the error and she asked Mrs. Howell about it. Mrs. Howell's evidence was that Ms. Metua asked her to complete the unusual occurrence report because her writing was nicer. Mrs. Howell said she wanted to do the vitals because she was signing her name so she wanted to do the assessment.

Mrs. Howell stated management had never come to speak to her about RP. She said the first talk she had with Ms. Huskins was about staff that were concerned that it looked like RP preferred Mrs. Howell to them. She advised Mrs. Howell that there were issues with gossip on the Unit so to be careful not to cross boundaries. Mrs. Howell stated she asked what boundaries was she crossing because Ms. Huskins and Mr. Sawatzky were aware when she was visiting RP on days off.

She denied having shared with RP the information about the complaint or what was going on. She stated Ms. Huskins could have brought Mrs. Howell into her office again and brought it to her attention. She advised there was no official investigation and also there was nothing to hide.

On cross examination Mrs. Howell confirmed she was an experienced LPN who prided herself on having good skills. She also agreed she had a long history of working with patients and a number of different types of patients including difficult ones. She agreed she had awareness of the expectations of health professionals, the limits of the therapeutic relationship and the boundaries between LPN and patient. She affirmed the importance of maintaining the boundaries. She denied ever having come in on her own time to see a patient other than RP. She said other staff had done that. She agreed she had never brought any other patient coffee, explaining no one else had ever said the coffee at the Facility was awful.

Mrs. Howell explained she asked if she could bring her dog in because a lot of staff brought in their dogs and it was during COVID so there were few visitors. She said she would never have asked to bring in her dog before that since she had just gotten the dog. She confirmed that she asked to bring her dog in on one of the occasions of the post-conference call.

Mrs. Howell denied telling Ms. Huskins she wanted to be in the room when RP found out his wife had passed. She said the way it worked out was that RP had called the police to do a wellness check and he asked her if she would stay. Mrs. Howell explained she notified the team that RP wanted her to stay with him until the police or his family came to tell him the news. She denied telling Ms. Harvey she wanted to be in RP's room when he found out his wife had passed. She denied crying in his room. She said his mom and sister came in the room; his mom started to cry almost like having a panic attack. She agreed some tears rolled out but she did not ugly cry and did not know what ugly cry means. She denied sobbing in RP's room or having to be asked to leave by Ms. Harvey. She said when she went to get chairs for RP's mom and sister, RP's assigned nurse took over so that was when she went back to her own duties.

When asked whether Mrs. Howell believed she was one of the only people that could help RP, she denied that. She stated that toward the end when she asked to be taken off his care she did so because RP had become dependant on her and she didn't want to be told RP didn't want others to be his nurse. She said she did not know whether he trusted her. She thought he was dependant on her because of the comments staff were making. She stated she did not know why he became dependant on her.

Mrs. Howell confirmed she held RP's hand when his wife passed, and then when he did not want to continue with his surgery conference because he thought he should die. Her evidence was that she had only held his hand on those two occasions. When asked whether she had hugged RP she stated she hugged RP when his wife passed away. She denied hugging him another time. She denied it was accurate if RP had said she hugged him on several occasions.

Mrs. Howell stated that twice she had come in to see RP when she was off duty - once for a pre-conference call, and once for a post-conference call. She also came in for the conference call but was paid for four hours for that occasion.

Mrs. Howell was unable to give dates as to when the pre-conference call, the conference call or the post-care plan discussion occurred. When confronted with her statement to the CLPNA investigator that she had arranged to meet with RP on Sunday June 20th about the teleconference, Mrs. Howell stated that did not refresh her memory of the date that took place. Further dates from her prior statement were not adopted.

Mrs. Howell confirmed that when she came in for a pre-consult meeting with RP, she had not been told to come in off duty to do that or that Ms. Huskins had cleared it as ok. She confirmed she came in to talk to RP post-conference and that she had not asked for permission to come in to do it.

Mrs. Howell referred to an email at Tab 5, Exhibit 2 which stated she had come in a couple of times to visit RP on her own time. Her evidence was that it was twice. Mrs. Howell stated she did not type the email and had no recollection of writing that way. Mrs. Howell stated that an AUPE representative had typed it, as he was helping her with talking to Mr. Sawatzky.

Mrs. Howell denied coming in more than twice on her time off. She denied coming in on an evening when Ms. Tasie-Orlu observed her. She confirmed Ms. Harvey had seen her because that was on the occasion of the pre-conference. She denied an occasion when Ms. Metua saw her. She denied Ms. Noorali had seen her in RP's room.

Returning to Tab 5, Exhibit 2, the email of July 22 stated Mrs. Howell only came in for tele-conferences. She confirmed the email did not reference surgery at all. She agreed she stated that she had come in to sit with RP but stated she did not go into the details of why she was sitting with him. She agreed she had stated she was supporting him in his grief. When asked whether she also wrote that she felt he was not being given enough social interaction she denied writing that. She said she did not mention the fact of the pre- and post-conferences because Mr. Sawatzky was aware of that. She confirmed management did not know she was coming in on her days off to address the conference.

Mrs. Howell stated Ms. Huskins wanted the fact of her attending to the conference call to be hidden so that staff would not ask questions. She denied coming in to do other tasks because, she said, then she just would have been scheduled. She agreed she had not done work on the two other occasions she came for a pre and post conference call.

Mrs. Howell was confronted with a signed statement she had previously provided which indicated Mrs. Howell had attended the second visit with RP on June 26, 2021, and asked Ms. Huskins to be able to bring her dog to the Facility on July 9. Mrs. Howell confirmed stating

she wanted to bring the dog in for her the post-conference call but denied stating she wanted to bring the dog in on her day off.

Mrs. Howell could not recall the date of her first meeting with Ms. Huskins but agreed it had taken place at the start of her shift. Mrs. Howell stated Ms. Huskins' office was outside the doors to the Unit and that she could see the staff, but they could not see her office. She stated she had no recollection about asking Ms. Huskins about bringing her dog in during that meeting. She indicated that exchange took place in the hallway.

She confirmed she had met with Ms. Huskins in her office and that Ms. Huskins had told her about possibly crossing boundaries and to be careful. Mrs. Howell's evidence was that Ms. Huskins told her bringing the dog in was not a good idea, so she respected that.

Mrs. Howell denied confiding with RP about the meeting with Ms. Huskins. She said staff observed her and Ms. Huskins talking in the hallway.

Mrs. Howell agreed a second meeting occurred but did not know the date. She confirmed Ms. Huskins had some documents but said they were not shown to her. Ms. Huskins had told her she looked them up on the CLPNA website, but that she did not read them out and just told Mrs. Howell to be careful. Mrs. Howell denied Ms. Huskins expressed concerns about boundaries but agreed Ms. Huskins wanted to talk to her about the CLPNA documents on boundaries so that Mrs. Howell wouldn't cross boundaries.

Mrs. Howell could not recall which meeting she had seen the email from Ms. Harvey in Ms. Huskins' office. She confirmed she thought she was getting in trouble because of that email and that it was unfair as nothing had been brought to her attention. Mrs. Howell denied telling RP about any accusations. She did not recall whether she had discussed the details with Ms. Kurio but said she was the team lead and would have known the meeting was going to happen. She denied talking to staff about false accusations. She denied telling RP her job was at risk. She stated Ms. Huskins never said that, so Mrs. Howell questioned why she would tell RP.

Mrs. Howell's evidence was that she discussed with Ms. Kurio not working with RP anymore but did not recall the date. She denied telling RP she could not provide him care anymore. She denied Ms. Kurio stated she could not provide care to RP anymore.

Mrs. Howell denied telling Ms. Dela Rosa she had used the wrong dressing in RP's room. She said Ms. Dela Rosa exposed herself to the client by grabbing the dressing she had used. She agreed she had told Ms. Dela Rosa that she had used the wrong dressing but stated that occurred in the med room. When pressed, she stated she did not remember whether she told Ms. Dela Rosa that she had put on the wrong dressing in RP's room. She denied Ms. Dela Rosa asked Mrs. Howell to go outside RP's room, and denied telling RP he had to monitor the nurses or ensure that they were using the proper dressings. She said this was because he

could only see one of the wounds. She confirmed she was sure she had never told RP he had to ensure nurses were putting on the correct dressings.

Mrs. Howell denied that Ms. Dela Rosa had used the correct dressing.

Mrs. Howell stated she had no memory of when she told RP about the X-ray results. She agreed she told him but said that was part of their job if someone asks about their test results. She denied there was ever a time when she was not to be providing care to RP. She said the discussion with Ms. Kurio was that she would be switched, and not that Mrs. Howell could not be RP's nurse.

Mrs. Howell confirmed she did RP's vitals after a medication error. She agreed she had gone in by herself. She explained Ms. Metua said they could do it together but not that they had to be together to do it. She stated she assessed RP's vitals because she had filled out the unusual occurrence form and her name was attached to it. Again Mrs. Howell denied being told she could not provide care to RP.

Mrs. Howell confirmed her evidence that she never thought she could provide better care. When referred to the email at Tab 5, Exhibit 2, Mrs. Howell again stated she did not write the email. She stated that she and the AUPE representative had spoken over the phone, he took her information and typed it up. She denied sending it despite it having been sent from her email address. She denied having read it before it was sent.

The email stated there were a number of circumstances in which Mrs. Howell felt care was done incorrectly in areas where she felt things should have been better. She stated again she did not write the email. She agreed the statement said she felt things should have been better. The email also stated that recognizing concerns and consistent with her professional practice, she sought to correct the errors and encourage the resident to advocate for himself. Mrs. Howell agreed she would point out errors of her colleagues. When asked about the conversation in RP's room she indicated that they spoke in RP's room because Ms. Dela Rosa was grabbing the dressing but she did not yell or teach her or tell her it was an error in front of RP.

Witness Credibility

The Hearing Tribunal has been mindful of the factors which impact credibility. Overall, the witnesses who gave evidence were credible.

The Hearing Tribunal did have issues with Mrs. Howell's evidence to some extent. For example, Mrs. Howell refused to accept that an email sent from her email account was written by her or that she had reviewed the contents of it. The email in question is material as it included details consistent with the events others had described. It was also a contemporaneous record which conflicted with some of Mrs. Howell's evidence during the hearing. This led the Hearing Tribunal to conclude Mrs. Howell was giving evidence which was

more favourable to her than it was faithful to what had actually happened. This was also evident in her overly pedantic explanation of the events that had occurred on the occasion of her taking RP's vitals without Ms. Metua, as discussed earlier. Further, Mrs. Howell had a markedly different demeanour on cross examination than she did in her examination in chief. The Hearing Tribunal did observe that she was combative and unwilling to accept non-controversial matters put to her by counsel.

Similarly, RP presented with some issues in his evidence. The Hearing Tribunal disagrees with Mrs. Howell's submission that RP did not have an interest in the outcome of this matter. It was apparent RP preferred Mrs. Howell to other caregivers both at the time of the events in question as well as at the time of the hearing. In particular, his tone in regard of Mrs. Howell in his email to Mr. Sawatzky showed his esteem for Mrs. Howell over others. RP also tried to downplay any aspects of his story which might reflect poorly on Mrs. Howell. For example, in regard what occurred between Mrs. Howell and Ms. Dela Rosa in his room regarding wound care he took pains to describe it as being professional and akin to "teaching". RP was not wholly unreliable, but portions of his evidence warrant further scrutiny and did not accord with the balance of the evidence the Hearing Tribunal received.

(6) Decision of the Hearing Tribunal

The onus is on the College Complaints Consultant to establish that the facts as alleged in the Statement of Allegations did occur. The standard of proof in civil cases is the balance of probabilities.

The Hearing Tribunal has 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 is found to have occurred, the Hearing Tribunal must then determine whether the proven conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has carefully considered the testimony of the witnesses and the exhibits. The Hearing Tribunal finds the particulars of Allegation 1, other than 1(d), and Allegation 2 are proven and that the conduct constitutes unprofessional conduct.

(7) <u>Hearing Tribunal Findings and Reasons</u>

1. **Between June 2021 and October 2021 failed to maintain professional boundaries with Patient RP by doing one or more of the following:**

    a) **Entered into a friendship/relationship beyond providing nursing care with Patient RP;**

The Complaints Director argues Mrs. Howell entered into a relationship in the nature of a friendship which was beyond the boundaries of providing nursing care. The Complaints

Director refers to the observations of witnesses of Mrs. Howell with RP and in regard to RP, and the concerns arising from what they saw. Further, to comments from Ms. Harvey as to the co-dependency between Mrs. Howell and RP. In particular, the manner in which RP began to prefer Mrs. Howell to other caregivers and the eroding trust in other caregivers as well as his personal feelings of guilt and responsibility about Mrs. Howell's well-being. All of these the Complaints Director suggests point to a friendship and not a therapeutic relationship.

Mrs. Howell argues that she testified that there was no friendship with RP. Further, that there was no evidence she was sharing thoughts with RP and that she had not exchanged phone numbers with RP or had seen him since he left the Facility. Mrs. Howell denies writing the complaint email of July 22, 2021, and indicates that failing to reference the bariatric surgery pre- and post- consults was an error. She also argues she did not view herself as a friend to RP and did not call him a friend.

The Hearing Tribunal accepts Mrs. Howell brought coffees in to RP. While this might seem like a small matter, it is not acceptable to single out one patient over others and to engage in this kind of direct gift giving. This is especially the case where the patient is as dependant and compromised as RP was at that point in time.

The Hearing Tribunal accepts that on at least two occasions Mrs. Howell attended the unit to visit RP when she was not on duty and that she was wearing street clothes rather than her work scrubs to do so, which suggests a non-professional encounter.

Ms. Metua's evidence that Mrs. Howell had told her she was coming to visit "her friend RP" was convincing. Ms. Metua's explanation of how she puzzled over this and followed up on it was compelling information to explain why it stood out to her that Mrs. Howell had attended to visit a patient while off-duty.

Mrs. Howell's email dated July 22, 2021, referred to visiting RP on her own time and that the purpose of the visits was to support him through grief. She wrote that she felt he was not being given enough social interaction which suggests this was also an aspect of those visits. The Hearing Tribunal finds that Mrs. Howell was responsible for the contents of the email in question.

Mrs. Howell also requested to bring her pet in to visit RP. The request shows something qualitatively different in how Mrs. Howell perceived RP as to other patients or as to how other nurses in the same setting perceived patients. This is underlined by Ms. Huskins' observation that she had never received such a request before.

The Hearing Tribunal also notes RP's email to Mr. Sawatzky referenced RP's reliance on Mrs. Howell and his singular trust in her as well as his refusal to receive care from certain others of the caregiving team.

Each of the above were indicative to the Hearing Tribunal that a relationship outside of the therapeutic relationship had developed as alleged. Rather than give consideration to the

question of unprofessional conduct in regard of each sub-allegation to Allegation 1, the Hearing Tribunal has provided its decision on that issue for all of Allegation 1 below.

b) Visited and/or communicated with Patient RP while off-duty;

The Complaints Director argues that Mrs. Howell attended to visit RP off duty on two occasions, which formed part of her testimony. Further, that Mrs. Howell did not have permission to see RP for those meetings which were distinct from the consult call which she did receive permission to attend. The Complaints Director points to Mrs. Howell requesting to bring her dog to visit RP as showing that Mrs. Howell's belief was that visiting RP when off duty was ok.

While RP's evidence was that visits occurred to discuss the consult, Mrs. Howell's email of July 22 did not mention it but did reference supporting RP through his grief. The Complaints Director also notes the evidence of other witnesses that they saw Mrs. Howell visiting RP and at times other than when the consult visits were said to have occurred. Further, that the topic of the bariatric surgery consult was not raised during interactions with Mrs. Howell around those occasions. Further, the Complaints Director highlights Ms. Huskins' evidence as to the results of her discussion with multiple staff members and the conclusions she drew about visits from that.

Mrs. Howell denies she shared the contents of any emails with RP and argues there is no concrete evidence of that occurring. Mrs. Howell admits there were two occasions when she came to see RP while off duty but that she had done that for the purpose of discussing the bariatric consult (both pre- and post- call). She states the failure to reference that in her email of July 22 was an error.

Mrs. Howell denies that she ever exchanged phone numbers with RP.

Ms. Huskins gave evidence that on two occasions she met with Mrs. Howell in order to discuss, amongst other things, that Mrs. Howell was visiting with RP when she was not on shift. While Ms. Huskins did not observe this herself, she gathered information about concerns from other staff members in her role as a manager. It is notable that in her discussions with Mrs. Howell, Mrs. Howell did not deny that occurring, but instead asked what was different between what she was doing and what other staff were doing. This stuck out to Ms. Huskins because she was surprised at how defensive Mrs. Howell became (at least on the first occasion) and how Mrs. Howell accused her co-workers of watching her and RP and gossiping.

Mrs. Howell was given permission to come in on a single occasion to attend to the bariatric conference call with RP and was scheduled for four hours on duty for that purpose. Mrs. Howell did not seek nor receive permission on the two other occasions that she had visited RP.

Mrs. Howell's own email indicated that she had come to visit RP after the loss of his wife. She described this as having been for the purpose of supporting him through his grief and not in reference to the bariatric consult. She wrote that she had felt he was not being given enough social interaction which implies that her purpose of visiting on those occasions was purely social. The Hearing Tribunal does not accept that Mrs. Howell was not the author of the email sent from her email address on July 22, 2021 or that she did not review that email before it was sent. The Hearing Tribunal determined Mrs. Howell did send that email and had no reason to do anything but faithfully report what had been occurring.

The Hearing Tribunal has concluded that Mrs. Howell did visit and communicate with RP while off duty and therefore this allegation is proven.

c) Spent time with Patient RP while on-duty and assigned to other patients;

The Complaints Director's arguments are prefaced by an acknowledgement that a nurse may make small talk or check in on a client during their shift, but points to evidence that Mrs. Howell spent an inordinate amount of time with RP while on shift, and so breached the professional boundary. She argues there was evidence Mrs. Howell would seek to provide care to RP, discussed RP's care with him after being directed not to, had told staff she was not allowed to care for RP anymore, and had met with Ms. Kurio to address that very issue. Further that Mrs. Howell would spend time with RP at the expense of her other duties and would frequently need to be brought from RP's room to attend to other clients.

Mrs. Howell argues RP's evidence was that no staff ever ate lunch in his room and only the HCAs visited his room. Mrs. Howell states she did provide care to RP during a night shift which she picked up when one of the RNs was not staying and coverage was needed.

The Hearing Tribunal concludes that at the very least Mrs. Howell was providing care to RP even after she had been directed not to do so. Mrs. Howell had positioned herself with RP in a manner that undermined the care other staff were giving to RP and so others were deferring to her in providing him with care.

The Hearing Tribunal also accepts the evidence of Ms. Harvey that it was frequently necessary to locate Mrs. Howell in RP's room when her other duties were being neglected. This is based both on her oral evidence as well as the contemporaneous emails she had sent reporting the same.

In providing care to RP or spending time with RP, duties owed to other patients were thereby being delayed or neglected. Nursing staff are assigned to specific patients for the purpose of ensuring every patient receives appropriate care. There should never be a need for other members of the health care team to find a nurse to ensure patient care is being delivered to all clients. This also speaks to the unprofessional nature of the relationship between the two, which was Mrs. Howell's obligation to preserve and protect.

Allegation 1(c) is proven.

d) Became inappropriately emotional when Patient RP's wife died;

The Complaints Director argues that while nurses may become emotional with or about clients, the evidence in this case demonstrates Mrs. Howell was inappropriately emotional and engaged with RP on the occasion when RP learned his wife had died. The Complaints Director submits the evidence shows Mrs. Howell was visibly emotional and was receiving support from RP's family when she should have been supporting the family. It is argued that Mrs. Howell's reaction was beyond what would be expected of an LPN in the typical relationship with a client and was indicative of the friendship with RP.

In regard to this allegation, Mrs. Howell points to the contradiction in her and RP's evidence as compared to Ms. Harvey's evidence. She denied crying excessively and was only in the room for a short time, got chairs for RP's family and gave them a hug because they asked for one. She notes Ms. Harvey was not in the room to observe what happened there.

The Hearing Tribunal received evidence from Shannon Harvey, Lynn Huskins, Mrs. Howell and RP in regard of what had occurred when RP's wife died. Ms. Harvey gave evidence that Mrs. Howell was red faced and "ugly crying" in RP's room and getting in the way of allowing his family to be together.

Ms. Huskins spoke to this matter but her information regarding this event was wholly from Ms. Harvey. As such, it is hearsay and more importantly, is a recounting of Ms. Harvey's evidence. In this way, while the Hearing Tribunal has no reason to doubt Ms. Huskins' evidence, it finds that it had little weight in terms of Hearing Tribunal's ability to decide this issue.

Mrs. Howell admitted she had tears at this time but denied "ugly crying".

The Hearing Tribunal has no doubt Mrs. Howell was emotional on this occasion but is not sufficiently convinced that her emotional outbreak was inappropriate given the difficult circumstances.

The Hearing Tribunal has not found this allegation to be factually proven. Therefore, there will be no consideration of unprofessional conduct with regard to this allegation.

e) Inappropriately disclosed to Patient RP that a complaint had been made about their relationship.

The Complaints Director's position is that a careful review of the timeline of events is necessary. There was Mrs. Howell's July 9 request to bring in her dog, and meeting with Ms. Huskins the same day, followed by RP's email to Mr. Sawatzky on the same date. Also, the meeting of July 20 between Ms. Huskins and Mrs. Howell when Mrs. Howell was able to observe Ms. Harvey's email, followed by RP being very upset with Ms. Harvey, and highly emotional, which coincided with Mrs. Howell calling in sick. The Complaints Director argues that when considered together with the limited group who were aware of what was

happening, and the short time frame, that the only inference which can reasonably be drawn is that Mrs. Howell disclosed to RP that a complaint had been made.

Mrs. Howell argues she did not have the email contents in order to disclose the email to anyone. She also argues her evidence was that she did not tell anyone she had discussed professional boundaries with Ms. Huskins. She argues RP's evidence was that any information he had came from what Mrs. Howell describes as another reliable source which the Hearing Tribunals takes to be a reference to the HCAs. Further, that RP explained the reason he was upset with Ms. Harvey was due to her having shown him photos and talking about visiting on Vancouver Island.

She also points to the unfortunate fact that no one asked Mrs. Howell if she shared information about her meeting with Ms. Huskins with RP. Others elected to stay out of it and were unaware of the details but had worked with her over a long period and were aware of her patient care and interactions with patients. She argues it does not make sense to admit she met with RP on two occasions to discuss his bariatric surgery consult but not to admit to other allegations.

As noted above, the Hearing Tribunal has determined that Mrs. Howell did disclose the contents of Ms. Harvey's email to RP. The timing of RP's outburst in proximity to Mrs. Howell's meeting with Ms. Huskins, and the duplication of language as well as the numerous reports of individuals who overheard RP swearing about Ms. Harvey leads the Hearing Tribunal to believe that, based on the balance of probabilities, this is what had occurred.

The Hearing Tribunal did not find RP's description of the HCAs spending time in his room to watch hockey or treat his room as a water cooler to use for gossiping to be convincing. HCAs are very busy and have many demands on their time in a care setting such as the Unit. The Hearing Tribunal heard testimony that RP's room door was closed most of the time, which makes it unlikely that HCAs were meeting in RP's room behind a closed door for social purposes. The Hearing Tribunal also notes that this scenario was never presented to any of the other witnesses for comment.

More importantly, there was also no plausible explanation for how RP would have become aware of the level of detail he had when the HCAs themselves would have, at most, been aware only that a meeting of some kind occurred between Mrs. Howell and Ms. Huskins. RP's evidence simply does not align with the extrinsic evidence surrounding this matter and is not credible.

Accordingly, the Hearing Tribunal has concluded that Allegation 1(e) has been proven.

Consideration of Unprofessional Conduct

The Hearing Tribunal finds that Allegations 1(a), (b), (c), and (e) have been factually proven, and therefore that Mrs. Howell failed to maintain professional boundaries with RP. The Hearing Tribunal has concluded that the proven conduct rises to the level of unprofessional

conduct. Mrs. Howell's actions in relation to RP demonstrate a serious lack of professional judgment. This was not a matter of a single instance, but a pattern of behaviour which persisted despite having concerns brought to her attention on more than one occasion by her superiors at the Facility. The Hearing Tribunal notes that it was appropriate for boundary concerns to be brought to Mrs. Howell's attention. It is ultimately Mrs. Howell's responsibility to ensure the relationship she has with a client is professional rather than personal, and to take action to address a situation where the boundary line is approached. Mrs. Howell was referred to CLPNA printed information regarding professional boundaries with clients by her manager on two occasions, and raised no questions, so she had to be aware of what her responsibilities were in regard to boundaries.

Of note was the defensive position Mrs. Howell took when Ms. Huskins met with her to discuss the boundary concerns. Rather than assess her own actions and consider the impact of those on RP, she became combative and defensive. This exemplifies her lack of understanding as to how her relationship with RP had become problematic. This lack of understanding is also observable in her email of July 22 which describes a concerning relationship wherein an LPN is visiting a client to support him in grief and to offer social interaction.

At all times while in the Unit, RP was a vulnerable person; this was the very reason he was there. RP had long term and complex care needs and was wholly dependant on the health care team around him to meet these. Instead of providing RP with care to meet his needs, Mrs. Howell confided in him details about conversations she had with management about her conduct. This had the effect of leading RP to conclude he was at fault or was to blame. He was highly emotional over this, which underlines the bond that he had developed with Mrs. Howell.

Again, this demonstrates an obvious lack of judgment. As the health professional in this situation Mrs. Howell should have refrained from sharing these details with a patient in her care. There are other more appropriate outlets than one's patient for expressing concern or frustration about one's workplace. By placing these concerns on RP's shoulders Mrs. Howell subverted the role she was charged with, which was to provide care to RP and not the other way around.

In addition to causing harm to RP, Mrs. Howell's conduct had the impact of compromising the care of other clients she was also assigned to whose needs were being neglected when she was spending excess time on shift visiting in RP's room. As is discussed more fulsomely below, it also undermined the ability of the entire care team to meet RP's health care needs and move him towards his goal of discharge.

Mrs. Howell's conduct has also violated the CLPNA's Standards of Practice of Licensed Practical Nurses on Boundary Violations: Protecting Patients from Sexual Abuse and Sexual Misconduct. The Hearing Tribunal agrees with the Complaints Director that the friendship/personal relationship which Mrs. Howell had with RP was not a professional relationship and therefore constituted a boundary violation. When a nurse cares for a client,

the client is to receive care from the nurse and there should be little or no reciprocation back to the nurse. It is obvious this was not what was happening between Mrs. Howell and RP. While Mrs. Howell may not control how RP expresses himself or to whom, the Hearing Tribunal accepts that it is her responsibility to ensure the relationship remains appropriate and that by her own actions she failed to discharge that duty. It's not that an LPN cannot be caring for a client, but they cannot have a relationship where the care sits outside of the professional or where the client is encouraged in words and actions to care for the nurse.

As such, this conduct also breaches numerous aspects of the Code of Ethics for Licensed Practical Nurses in Canada and the Standards of Practice for Licensed Practical Nurses in Canada. Mrs. Howell failed in her responsibility to maintain a therapeutic relationship with RP and her conduct did not reflect well on her profession. Her lack of introspection and personal responsibility for her actions was inconsistent with the privilege and responsibilities of self-regulation. Mrs. Howell's conduct also showed that, at least with regard to RP, she did not objectively see her role in what was happening and its impacts on RP and others on her team.

2. **Failed to foster a respectful working environment by doing one or more of the following:**

    b) On or about October 2, 2021, belittled CD, LPN, in front of Patient RP with regards to applying a wound dressing incorrectly;

The Complaints Director argues the evidence shows that Mrs. Howell belittled Ms. Dela Rosa in front of RP by stating Ms. Dela Rosa incorrectly applied RP's wound dressing. Ms. Dela Rosa's evidence was that Mrs. Howell told her, in front of RP, that Ms. Dela Rosa had used the wrong dressing. The fallout of that was how RP responded to Ms. Dela Rosa and from that point on, RP treated her differently. Ms. Dela Rosa made a contemporaneous record of the occurrence and the Carewest momentum log was consistent with her version of events. RP's evidence was there had been discussion about what should and should not be used. Further he confirmed Mrs. Howell told him incorrect materials had been used. Mrs. Howell admitted to telling Ms. Dela Rosa the wrong dressing was used in front of RP.

Therefore, the Complaints Director submits, RP's wound care was discussed in front of him and the impact was to undermine his confidence in his care, and this had a detrimental impact on Ms. Dela Rosa.

Mrs. Howell's position is that Ms. Dela Rosa asked about dressings, that it had been discussed at the desk or med room and then both nurses went to RP's room to look at the dressings. Mrs. Howell argues she did not say Ms. Dela Rosa used the wrong bandages but instead indicated it was the wrong material and told her the correct one. The purpose of the exchange was not to cause upset or belittle but RP's response upset Ms. Dela Rosa who was very sensitive due to having just lost a family member.

The Hearing Tribunal concluded that Mrs. Howell did address Ms. Dela Rosa in front of RP and that the manner in which she had done that was belittling. Ms. Dela Rosa's version of events was preferred to the description provided by RP and Mrs. Howell. While Ms. Dela Rosa's reaction may have been stronger than another nurse might experience, the focus of the issue is that Mrs. Howell spoke down to Ms. Dela Rosa in front of her client.

Mrs. Howell refused to bring the discussion into the hallway and prevented Ms. Dela Rosa from effectively addressing the matter. Further, it was not Ms. Dela Rosa who was the nurse that had last changed RP's dressing. This gives the Hearing Tribunal the impression that Mrs. Howell was more interested in demonstrating her value in front of RP than in addressing the care concern.

In talking to Ms. Dela Rosa as she did, for example in demanding that Ms. Dela Rosa identify a dressing in a Ziploc bag, Mrs. Howell did belittle Ms. Dela Rosa and treated her as something other than a competent caregiver and an equal colleague.

The Hearing Tribunal finds that Allegation 2(a) has been proven.

c) On or about October 2, 2021, informed Patient RP that colleagues were incorrectly performing his wound care;

The Complaints Director argues this allegation is proven, pointing largely to Ms. Hurman's evidence on this point. Ms. Hurman had been engaged in RP's care in order to built rapport with staff and address concerns RP had raised regarding his wound care. Her evidence was than in a discussion with RP he had told her Mrs. Howell informed him over the weekend that his wound care was not being done correctly. Ms. Hurman reported this conversation to Ms. Kurio in person and followed it up with an email the day after it occurred. Further, RP confirmed Mrs. Howell would advise him if incorrect materials were used in his wound care.

Mrs. Howell argues that RP's evidence was he had only refused care from one nurse and three HCAs. Further that specific efforts were being taken to ensure RP's wound care was not being compromised. She denies ever having viewed herself as better than her colleagues, but that RP's actions may have created the issues between Mrs. Howell and her colleagues.

The Hearing Tribunal considered the evidence given by Ms. Dela Rosa, Ms. Hurman, Mrs. Howell, and RP in regard to this matter.

Ms. Dela Rosa stated she had observed Mrs. Howell tell RP he needed to monitor the dressings to ensure he was getting the right ones. Ms. Hurman's evidence was that when she had attended to RP's room on October 4, he told Ms. Hurman that Mrs. Howell had told him the wound care was being done incorrectly. She also emailed Ms. Kurio that information on October 5 to report the concern.

Mrs. Howell's evidence was that she had never told RP he had to ensure nurses were providing the correct dressings. RP's evidence was that the wrong materials were consistently

being used on his wounds. He stated Ms. Dela Rosa had used the wrong materials but did not know why.

Given the contemporaneous records documenting RP's words that Mrs. Howell had advised him her colleagues were doing his wound care incorrectly and the evidence surrounding that, the Hearing Tribunal has concluded Mrs. Howell did advise RP that his wound care was being performed incorrectly. It is notable that RP consistently stated that his wound care was being done incorrectly, and that Ms. Dela Rosa had applied the wrong materials, when he would otherwise have no knowledge of whether this was the case.

The Hearing Tribunal concludes Mrs. Howell did inform RP that colleagues were incorrectly performing wound care.

e) On or about October 3, 2021, provided Patient RP with X-ray results when it was not her role nor was she assigned to Patient RP's care;

The Complaints Director submits Ms. Dela Rosa's evidence, as well as Mrs. Howell's own evidence on cross examination, was that Mrs. Howell told RP about the X-ray results.

Mrs. Howell did not provide specific argument on this point.

RP's evidence was that Mrs. Howell had not given him the results. He stated that was usually done but also that he only had one X-ray at the Facility when Ms. Dela Rosa was attending and she had explained X-ray results to him. Mrs. Howell's evidence was that she had given X-ray results to RP, and she described that as being normal for patients on Warfarin. Ms. Dela Rosa was firm that Mrs. Howell had given RP the results and has described how that made her feel. Her evidence was that Ms. Dela Rosa had not told RP the results because there was no doctor to explain it to him.

On the evidence overall, the Hearing Tribunal has concluded that Allegation 2(e) has been proven.

f) On or about October 9, 2021, completed Patient RP's vital signs while not assigned to Patient RP's care and/or despite LM, LPN stating they would assess Patient RP together.

The Complaints Director submits the evidence shows Ms. Metua identified a medication error which she asked Mrs. Howell to review and confirm. The two had agreed to check RP's vital signs at 6:00 a.m. Mrs. Howell did this alone. Mrs. Howell confirmed she did the vitals alone because Ms. Metua was not around at the appointed time even though Ms. Metua had told her they would do it together. However, the Momentum Log shows that Mrs. Howell went to RP's room before 6:00 a.m. Ms. Metua's evidence was that when this occurred, she felt like nothing and that she was useless.

Mrs. Howell submitted that she was not trying to undermine Ms. Metua and it was unfortunate she felt that way. She argues she was doing her job by doing the vitals to submit with the report she had written, which was for the purpose of getting the job done.

Mrs. Howell admitted that she had completed RP's vital signs explaining she wanted to do the vitals because she was signing her name to the report.

The Hearing Tribunal preferred Ms. Metua's evidence that she and Mrs. Howell had agreed to do RP's vitals together and that she was dismayed when she realized Mrs. Howell had done them without her since RP was one of Ms. Metua's clients that day. Mrs. Howell stated that Ms. Metua said they could do the vitals together, not that they had to be together to do it. The Hearing Tribunal does not accept that and instead finds that the intent of the conversations was to clarify that the two would do the vitals together.

Accordingly, Allegation 2(f) has been proven.

Consideration of Unprofessional Conduct

The Hearing Tribunal has found the individual particulars of Allegation 2 were factually proven and that Mrs. Howell failed to foster a respectful working environment. Again, the Hearing Tribunal concludes Mrs. Howell demonstrated a real lack of judgment which resulted in significantly undermining her colleagues. This was manifested in how her actions eroded RP's confidence in other caregivers, as well as in how her coworkers were diminished in their own estimation.

RP's communications with Facility management demonstrate his distrust. His evidence was also that he felt the need to challenge caregivers about their work. More than one witness spoke to the stress this caused for the health care team broadly as well as the individuals on the team. More than one staff member spoke to the changes in RP's demeanour towards staff over his time at the Unit. The issues were to such an extent that is was necessary for Ms. Hurman to work specifically to rebuild the rapport with RP, and she told Ms. Kurio in October that she was concerned about Mrs. Howell's continuing to interact with RP.

By belittling and demeaning Ms. Dela Rosa in front of a patient, Mrs. Howell undermined her colleague in RP's estimation as well as Ms. Dela Rosa's own feeling of self-worth. Following that incident, RP clearly distrusted Ms. Dela Rosa and treated her dismissively. His demeanour towards Ms. Dela Rosa was seemingly sanctioned by Mrs. Howell's earlier interactions with her in front of him when the discussion over his dressing happened.

It is not appropriate to tell a patient anything that would undermine their trust and confidence in the team or an individual team member. The effect of doing so is to aggrandize Mrs. Howell's care to RP at the expense of others. Where RP was refusing care from certain team members efforts would need to be undertaken to arrange client assignments to ensure he received care.

As with her conduct discussed above, the effect of Mrs. Howell giving x-ray results to RP in the manner that she did and when Mrs. Howell was not assigned to RP was to undermine the skills, work and trust in her team member, in this case Ms. Dela Rosa. The impression left with RP was that Mrs. Howell was singular in her ability to care for him and in her skills and knowledge. As noted previously, this has the impact of making RP more vulnerable, compromising his care and placing undue stress on the team. This conduct is another example of how Mrs. Howell acted in a manner that prioritized herself over the care RP needed or the wellbeing of the team.

Both Ms. Dela Rosa and Ms. Metua spoke to how Mrs. Howell's conduct had negative impacts on them. Both were left questioning their value.

The Hearing Tribunal finds that Mrs. Howell's conduct breached the CLPNA Code of Conduct and Standards of Practice.

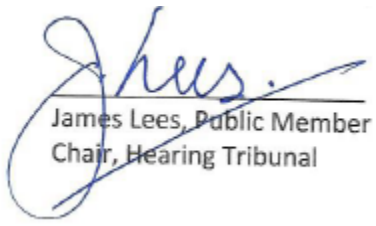
The Code of Conduct requires LPNs to work to ensure appropriate relationships which would include not only with a particular LPN but with others offering care to a client. Mrs. Howell failed in this. She also acted in a manner that did not uphold the integrity of the profession, which is one based on collaboration and teamwork for the benefit of those who rely on LPNs. The Standards of Practice also demand that LPNs work with their clients and their colleagues as a team. LPNs have duties to colleagues which Mrs. Howell failed to meet when she worked in a manner which undermined her co-workers. This also had the impact of diminishing the workplace and her colleagues' ability to work in it. Therefore Mrs. Howell's conduct did not promote a positive and health practice environment, in contradiction to the requirements of the Standards of Practice.

<u>Conclusion</u>

Accordingly, although not all particulars were proven, the Hearing Tribunal has determined Mrs. Howell engaged in unprofessional conduct and it will be necessary for the Hearing Tribunal to receive submissions from the parties as to sanction.

DATED THE 2ND DAY OF MARCH, 2023 IN THE CITY OF EDMONTON

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA



IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF JEANETTE HOWELL, LPN #35664, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION ON SANCTION OF THE HEARING TRIBUNAL

(1) Submissions

The submissions on sanction were provided to the Hearing Tribunal in writing. The submissions on sanction flow from findings of the Hearing Tribunal arising out of a hearing conducted in Calgary, Alberta on October 18-20, 2022 with the following individuals present:

Hearing Tribunal
Jim Lees, Public Member, Chairperson
Jan Schaller, LPN, Panel Member
Patricia Riopel, LPN, Panel Member
David Rolfe, Public Member, Panel Member

Independent Legal Counsel for the Hearing Tribunal:
Heidi Besuijen

Staff:
Jason Kully, Legal Counsel for the Complaints Director
Evie Maldonado, Legal Counsel for the Complaints Director
Sandy Davis, Complaints Director, College of Licensed Practical Nurses of Alberta ("CLPNA")

Investigated Member:
Jeanette Howell, LPN ("Mrs. Howell", "Investigated Member")
Carol Drennan, Representative for Mrs. Howell

(2) Preliminary Matters

Ms. Schaller did not participate in the sanction phase of the decision. The Hearing Tribunal continued with the remaining members in accordance with section 16(3) of the *Health Professions Act*, RSA 2000, c. H-7 (the "HPA").

Through agreement of the Parties, the sanction phase of the Hearing proceeded by way of written submissions. The Hearing Tribunal considered the following:

1. Written submissions from Counsel for the Complaints Director dated 21 March 2023;

2. Written submissions from the Representative for Mrs. Howell dated 4 April 2023;

3. Reply Submissions from Counsel for the Complaints Director dated 10 April 2023.

(3) Findings of Unprofessional Conduct

Upon consideration of the evidence presented before it at the Hearing as well as the submissions of the Parties, the Hearing Tribunal determined Mrs. Howell had engaged in the following conduct that was also determined to rise to the level of unprofessional conduct:

- Entered into a friendship/relationship beyond providing nursing care with Patient RP;
- Visited and/or communicated with Patient RP while off-duty;
- Spent time with Patient RP while on-duty and assigned to other patients;
- Inappropriately disclosed to Patient RP that a complaint had been made about their relationship;
- On or about October 2, 2021, belittled CD, LPN, in front of Patient RP with regards to applying a wound dressing incorrectly;
- On or about October 2, 2021, informed Patient RP that colleagues were incorrectly performing his wound care;
- On or about October 3, 2021, provided Patient RP with X-ray results when it was not her role nor was she assigned to Patient RP's care; and
- On or about October 9, 2021, completed Patient RP's vital signs while not assigned to Patient RP's care and/or despite LM, LPN stating they would assess Patient RP together.

(4) Submissions of the Parties on the Factors to be Considered in Sanction

Both parties referred to the leading case of *Jaswal v Newfoundland (Medical Board)*, 1996 CANLII 11630 at para 35 (NL SCTD)("*Jaswal*") in which the Court identified a list of factors to take into account when deciding the appropriate sanction in cases such as this. The list of factors offered in *Jaswal* includes:

- 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;
- 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 degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct; and
- The range of sentence in other similar cases.

The Nature and Gravity of the proven Allegations:

The Complaints Director submits the nature and gravity of Allegation 1 is significant and serious due to the failure to adhere to core competencies of an LPN. The Complaints Director suggests harm was caused to patients under Mrs. Howell's case as a result of her failure in this regard.

The Complaints Director submits the pattern of behaviour that carried on notwithstanding concerns about professional boundaries being brought to Mrs. Howell's attention on more than on occasion is serious and demonstrates a real lack of judgment.

With regard to Allegation #2 which related to failing to foster a respectful work environment, the Complaints Director again submits the conduct was serious and had a great impact on Mrs. Howell's coworkers. The Complaints Director points to the finding that Mrs. Howell's conduct caused RP to lose confidence in Mrs. Howell's coworkers and for those coworkers to doubt themselves as well.

In sum, the Complaints Director submits the conduct in question demonstrates a need for significant penalties.

Mrs. Howell argues that as permission had been given for her to advocate on behalf of RP, she was acting in a manner consistent with that permission when she attended to meetings with RP outside of work hours. She also points out that her supervisor did not address professional boundaries with her until after the 4 July 2021 email of Ms. Harvey.

She argues she did not intend to contravene the Act and the Code of Ethics. She states she did not know it would be deemed unprofessional conduct to visit with RP for the purpose of the advocacy she had been given permission to do.

Mrs. Howell makes no other specific submission in regard of Allegation #1 and or about Allegation #2.

Mrs. Howell states the seriousness of the conduct is on the low end of the scale.

The age and experience of the investigated member:

The Complaints Director notes Mrs. Howell has been an LPN since 24 September 2012 and previously worked as an HCA. Accordingly, Mrs. Howell is an experienced member of the profession and was aware of the expectations of her. The Complaints Director submits Mrs. Howell should have realized her conduct was unacceptable and that this is an aggravating factor tending to significant sanctions with a focus on remediation.

Mrs. Howell states she has been an LPN for nine years and that she is a strong and skilled nurse as evident in the testimony of a number of the witnesses. She again notes she was not aware it was unprofessional to attend advocacy meetings with RP.

She states the conduct which was found to belittle or undermine her coworkers should have been identified to her so that she could understand how her conduct was impacting others.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:

Both parties agree Mrs. Howell has had no prior findings of unprofessional conduct and or any prior discipline.

Mrs. Howell also states she was not disciplined by her employer, showing the conduct was not deemed serious.

The age and mental condition of the victim, if any:

The Complaints Director points to the comments of the Hearing Tribunal in finding RP was vulnerable as this was the reason he was in the Unit: RP had complex care needs and was fully dependent on the health care workers in the Unit. The Complaints Director submits RP was vulnerable and relied on Mrs. Howell for direct care but also to build trust in the care of others. The Complaints Director submits this is an aggravating factor.

Mrs. Howell submits RP was particular about his care and he thought Mrs. Howell provided competent and compassionate care. Mrs. Howell states it is RP's right to choose and expect proper care and he preferred the care of Mrs. Howell (amongst others).

Mrs. Howell continues to deny she confided in RP with any workplace issues she was experiencing.

The number of times the offending conduct was proven to have occurred:

The Complaints Director notes the conduct in question was a pattern of behaviour which continued even after concerns were brought to Mrs. Howell's attention. The repeated unprofessional conduct impacted RP as well as her coworkers. The Complaints Director

argues the number of times of the conduct occurred and the number of people impacted by it means this is an aggravating factor.

Mrs. Howell states there were two occasions to which she admitted, that she had visited RP off duty in regard of his bariatric surgery. She argues no witness gave evidence of the frequent visits to RP's room and that she did not visit except on one occasion when he was alone and worried (the day his wife passed away). Mrs. Howell states there was only one occurrence she was found to have belittled another LPN and one occasion when she was found to have undermined another LPN by completing vitals without the LPN.

Mrs. Howell submits the off-duty visits did not recur after her manager addressed professional boundaries with her and there were no other reports of her undermining her colleagues.

The role of the investigated member in acknowledging what occurred:

The parties agree this is a neutral factor.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

The Complaints Director notes only that she is not aware of any financial impact to Mrs. Howell.

Mrs. Howell submits she was not disciplined and did not lose her job nor was suspended without pay for any time. She advises the discipline process has had a significant impact on her psychological and physical health. She advises she is on long term disability which causes serious financial strain for her and her family.

The impact of the incident on the victim(s):

The Complaints Director submits Mrs. Howell's conduct was detrimental to RP and made him more vulnerable and compromised his care. Further that in attending to RP while assigned to care for others, Mrs. Howell neglected the needs of the clients to whom she was assigned.

The Complaints Director points to the finding of detrimental impact to Ms. Dela Rosa in the incident involving her. Further, the Complaints Director points to the involvement of Ms. Hurman who was brought in to rebuild the rapport with RP which was connected to Mrs. Howell's conduct.

Overall the Complaints Director argues there is ample evidence that Mrs. Howell's conduct impacted those around her to varying degrees which means this is an aggravating factor.

Mrs. Howell argues her manager did not raise concerns in her testimony that Mrs. Howell had compromised RP's care. She notes the evidence of Ms. Noorali who indicated that after RP's wife died he took a bad turn emotionally. Mrs. Howell states this stands to reason in the circumstances.

In relation to Ms. Dela Rosa, Mrs. Howell argues she did not act maliciously and instead was providing guidance. Ms. Dela Rosa's hurt feelings were never brought to Mrs. Howell's attention and the incident was a one-off.

Regarding Ms. Metua, Mrs. Howell states she did the vitals for RP when Ms. Metua was busy. Again, this was not a malicious attempt to undermine a colleague and she was ensuring the vitals were done as the person that completed the report. Again, the conduct was not repeated nor were Ms. Metua's feelings brought to Mrs. Howell's attention.

Mrs. Howell argues the statement that she neglected and compromised the care of other clients is not founded and there was no evidence at the Hearing of this being the case.

Mrs. Howell argues Ms. Tasie Orlu gave evidence that Mrs. Howell was always willing to assist with RP's wound care. Others also gave evidence of Mrs. Howell's willingness to assist, showing that she is a team player.

Mrs. Howell states that as others were unable to perform wound care to RP's expectations, she has been found to have undermined her colleagues. She argues what she was guilty of was ensuring he received wound care and for recognizing him as an individual with a right to choose. She states this is not her fault but RP's right to choose.

The presence or absence of any mitigating circumstances:

Neither party submitted any mitigating circumstances for the Hearing Tribunal's consideration.

The need to promote specific and general deterrence and, thereby protect the public and ensure the safe and proper practice:

In light of the need for specific deterrence of Mrs. Howell, the Complaints Director states that Mrs. Howell's conduct demonstrates patient wellbeing and care was not a priority for her but that she acted in her self-interest first. The Complaints Director submits the orders sought will prevent Mrs. Howell from engaging in such conduct again by imposing remedial and punitive sanctions.

The Complaints Director also submits the orders sought will demonstrate to all members of the profession that this conduct is not acceptable and will be addressed where it does arise.

Mrs. Howell submits remedial sanctions will help to refresh her knowledge. She states the order made should reflect general deterrence for all members. She submits the remediation sanctions the Complaints Director seeks will freshen up her knowledge and do reflect the goal of general deterrence.

The need to maintain the public's confidence in the integrity of the profession:

The Complaints Director argues the importance in this case is to hold LPNs to the standards and obligations expected of them including in fundamental issues such as maintaining professional boundaries and fostering a respectful workplace. The Complaints Director submits the public will want to see that the Hearing Tribunal has sanctioned Mrs. Howell appropriately and that her regulator has taken her conduct seriously. As such, the orders sought will maintain public confidence in the profession.

Mrs. Howell submits the remedial sanctions the Complaints Director is seeking will help maintain the public's confidence in the profession and in the CLPNA to hold its members to account. She does differ on the point of one course proposed as discussed below.

The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct:

The Complaints Director states Mrs. Howell's conduct is clearly a departure from the conduct expected of an LPN.

Mrs. Howell argues that meeting with a client for advocacy and bringing RP coffee for those meetings is not a serious breach. She submits that two coffees are minor when compared to giving clients gift cards, books, magazines or cigarettes.

Mrs. Howell submits she did not share anything personal with RP. She also submits she did not share work issues with colleagues. She states she was not prohibited from dealing with RP but discreetly removed from any assigned to him.

Mrs. Howell denies deliberately undermining her colleagues. She states the conduct in regard of the incident involving her colleagues are not significant departures from the range of expected conduct. She states she did not yell or make derogatory comments to her colleagues. She argues the proven conduct falls on the lower end of the spectrum and that the absence of intention or malice are relevant.

The range of sentences in other similar cases

The Hearing Tribunal has reviewed the Complaints Director's comments with regard to College of Licensed Practical Nurses of Alberta and Mr. La France. The Complaints Director suggests the focus of remedial education for Mr. La France as well as an order for costs were

appropriate responses to the scenario where Mr. La France had failed to maintain professional boundaries and failed to foster a positive work environment. The Complaints Director submits that the fact of Mr. La France's admission to the conduct and the resolution of his matter by agreement was a significant mitigating factor in the sanction on those facts.

Mrs. Howell states Mr. La France engaged in conduct that was a significant departure from the conduct expected of an LPN and that the remedial courses, sanction, and relatively low costs were appropriate.

Mrs. Howell also makes submissions in regard of another decision where a member's license was suspended, and they were ordered to undertake courses and readings as well as pay costs in the amount of $17,400. She states in that case the member did not admit to the conduct and was sanctioned harshly for serious conduct.

In regard of another decision involving an excessive use of force causing injury to a patient, a member's license was suspended for two years by reason of the extended interim suspension and the member was sanctioned to readings and courses with $38,000 in hearing costs. In that case the conduct was serious in that the LPN admitted to biting a patient.

Mrs. Howell states that in contrast to these other decisions her conduct was not as serious, she did not breach professional boundaries to the degree of Mr. LaFrance. She submits she admitted to meeting with RP off work hours on two occasions but that she did not confide in coworkers about her worksite situation until she filed a complaint.

(5) Submissions of the Complaints Director on Sanction

The Complaints Director proposed the following Orders:

a) Mrs. Howell shall pay 50% of the costs of the investigation and hearing to be paid over a period of 70 months from service of the Hearing Tribunal's written decision addressing sanction (the "Sanction Decision")

b) Mrs. Howell shall receive a reprimand with the Hearing Tribunals' Decision serving as the reprimand.

c) Mrs. Howell shall, within 30 days of receipt of the Sanction Decision, read and reflect on the following CLPNA documents. Mrs. Howell shall provide a signed written declaration to the Complaints Director attesting she has reviewed CLPNA's documents:

    i. Standards of Practice for Licensed Practical Nurses in Canada;

    ii. Code of Ethics for Licensed Practical Nurses in Canada;

    iii. CLPNA Policy: Professional Responsibility and Accountability;

iv. CLPNA Practice Guideline: Professional Boundaries;

v. CLPNA Competency Profile A1: Critical Thinking;

vi. CLPNA Competency Profile A2: Clinical Judgement and Decision Making;

vii. CLPNA Competency Profile C6: Professional Boundaries;

viii. CLPNA Competency Profile D1: Communication and Collaborative Practice;

ix. CLPNA Competency Profile Therapeutic Nurse-Patient Relationship.

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

d) Mrs. Howell shall, at her own cost, complete the following remedial education and provide the Complaints Director with a certificate confirming successful completion of each of the following courses, within the timelines set out below:

i. LPN Ethics Course, available online at

https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics within 2 months of receipt of the Sanction Decision;

ii. Professional Boundaries in Nursing (BOUND007) offered by John Collins Consulting at

https://www.jcollinsconsulting.com/images/Outlines/lpn/MODULE_OUTLINE_-_PROFESSIONAL_BOUNDARIES_IN_NURSING.pdf within 6 months of receipt of the Sanction Decision;

iii. Relational Practice Self Study offered by CLPNA at

https://studywithclpna.com/relationalpractice/ within 2 months of receipt of the Sanction Decision.

If a course becomes unavailable, Mrs. Howell shall request in writing to be assigned an alternative course. The Complaints Director shall, in her sole discretion, reassign a course. Mrs. Howell will be notified by the Complaints Director, in writing, advising of the new course required.

e) The orders set out above at paragraph 8 a) and d) will appear as conditions on Mrs. Howell's practice permit and the Public Registry subject to the following:

i. The requirement to complete the remedial education and readings/reflection paper will appear as "CLPNA Monitoring Orders (Conduct)" on Mrs. Howell's practice permit

and the Public Registry until the following sanctions have been satisfactorily completed:

i. CLPNA Reading

ii. LPN Ethics Course

iii. Professional Boundaries in Nursing

iv. Relational Practice Self Study

ii. The requirement to pay costs will appear as "Conduct Costs/Fines" on Mrs. Howell's practice permit and the Public Registry until all costs have been paid as set out above at paragraph a).

iii. The conditions on Mrs. Howell's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

The Complaints Director seeks an order requiring Mrs. Howell to pay 50% of the costs of the investigation and hearing which totaled $107,867.77.

The Complaints Director submits costs are not intended to be a penalty but an indemnity to the CLPNA for costs incurred as a result of the discipline process. The Complaints Director notes the Hearing Tribunal has the authority to award costs but also that the Alberta Court of Appeal has stated costs should not be awarded in every case. There is a two-stage consideration to be made. First is the question of whether a costs award is appropriate and, if they are, then the degree of costs to be awarded.

The Complaints Director suggests there was serious conduct in this matter which warrants a costs award as sought.

(6) Submissions of Mrs. Howell on Sanction

Mrs. Howell submits the remediation sought in the circumstances is appropriate except for the John Collins Professional Boundaries course as this process has reminded her of her professional boundaries and that Ms. Huskins had done the same.

Further she indicates the course entitled "Righting a Wrong – Ethics and Professionalism" would be a better course. She advises it assists LPNs coming out of a disciplinary process to rethink how they handle professional mistakes and shortcomings to demonstrate a commitment to ethical and safe practice. She suggests this course along with the others the Complaints Director is seeking will assist her to regain confidence and restore her commitment to ethical and safe nursing practices.

On the issue of costs, Mrs. Howell asks the Hearing Tribunal to consider the *Jinnah* decision in which the Alberta Court of Appeal discourages costs from becoming the main sanction. Further, that costs are discretionary and subject to reasonableness. She states the three cases she discussed above related to egregious professional misconduct and that her conduct was less serious. She states she has not been sanctioned previously, is not a serial offender and participated in the process without misconduct. Accordingly, she states costs should not be awarded in this case. She argues her conduct is not serious enough to warrant costs. She states there was no harm to anyone arising from her conduct and that $54,000 is an unreasonable amount to ask her to pay and that this amount would become the primary sanction if awarded. She states $54,000 would be crushing blow to her and to her family.

(7) Reply Submissions of Complaints Director on Sanction

The Complaints Director's reply submissions address the course Mrs. Howell proposes, "Righting a Wrong – Ethics and Professionalism in Nursing". The Complaints Director submits this course does not offer the same goals as the Professional Boundaries in Nursing (BOUND007) course from John Collins Consulting.

In particular, the Complaints Director states the John Collins Consulting course is comprehensive and will be tailored to address concerns raised by Mrs. Howell's specific conduct. As such, the course will be directly responsive to the unprofessional conduct proven and assist Mrs. Howell in rehabilitation. In comparison, the course Mrs. Howell suggests, the Complaints Director submits, is limited and does not specifically address the type of conduct the Hearing Tribunal has found Mrs. Howell engaged in.

(8) Decision of the Hearing Tribunal on Sanction

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 Mrs. Howell has engaged in. In making its decision on penalty, the Hearing Tribunal considered the number of factors identified in *Jaswal* as follows:

The Nature and Gravity of the proven Allegations:
The Hearing Tribunal finds that in all the circumstances, the conduct while certainly unprofessional was towards the lower end of conduct in the spectrum of seriousness.

While Mrs. Howell did cause disruptions and there was certainly impact to RP, the conduct was not on the high end of serious.

The Hearing Tribunal notes that while it referred to Mrs. Howell attending to RP when she had other patients assigned to her care, it did not mean by using the word "neglect" to import that those patients were neglected but that Mrs. Howell could not have been performing

those duties while attending to RP. Otherwise, the Hearing Tribunal confirms that in its consideration the conduct is found to have occurred.

The age and experience of the investigated member:

The Hearing Tribunal notes Mrs. Howell is a long time LPN and so this factor is aggravating.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:

Mrs. Howell, as noted, is a long time LPN who by all accounts is a strong practitioner. She has never had a prior complaint or finding of unprofessional conduct which the Hearing Tribunal finds mitigating.

The age and mental condition of the victim, if any:

RP was a demanding patient who preferred the care of Mrs. Howell, which she accommodated – to a point too far. His status as a patient in this unit and his needs made him dependent on the caregivers around him. This factor is aggravating.

The number of times the offending conduct was proven to have occurred:

There were multiple findings of unprofessional conduct, but this was not a matter of repeated unprofessional conduct of the exact same nature in a short period of time. The Hearing Tribunal finds this is aggravating.

The role of the investigated member in acknowledging what occurred:

This factor is neutral in this case.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

The Hearing Tribunal was not aware of any financial impact directly linked to this matter.

The impact of the incident on the victim(s):

The impact of Mrs. Howell's conduct on RP was to undermine his confidence in others on the care team. This was unfair to RP.

The impacts to Mrs. Howell's co-workers in direct and indirect ways are also unfortunate.

This factor is aggravating.

The presence or absence of any mitigating circumstances:

The Hearing Tribunal is not aware of any particular mitigating circumstances.

The need to promote specific and general deterrence and, thereby protect the public and ensure the safe and proper practice:

The Hearing Tribunal acknowledges the necessity of any sanction to address Mrs. Howell's specific conduct and to prevent her from engaging in the same in future. Further, of the need to deter other LPNs from engaging in conduct of this nature. In this way the public is protected in a proactive manner.

The need to maintain the public's confidence in the integrity of the profession:

Self-regulation is done in the public interest and so the public's confidence that it is being done effectively is important. It is also important for members of the public to understand that the CLPNA takes conduct of this nature seriously and that it addresses concerns where they arise in a proportionate manner.

The degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct:

The Hearing Tribunal agrees the conduct in question is a departure from permitted conduct.

The range of sentences in other similar cases:

The Hearing Tribunal agrees that cases presented to it which involve physical contact between an LPN and a patient are not helpful in coming to a determination as there is no such allegation in this matter.

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.

(9) 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 notes that aside from costs the parties are significantly aligned as to the proposed sanction. The biggest difference between the two is the question of which course is appropriate: the John Collins Consulting course or the "Righting a Wrong Course". The Hearing Tribunal has reflected on this matter and determined that the John Collins Consulting course will specifically address the concerns arising from Mrs. Howell's unprofessional conduct, offers a more rigorous educational opportunity and is therefore the more appropriate course.

On the question of costs, the Hearing Tribunal has considered *Jinnah v Alberta Dental Association and College*, 2022 ABCA 336 ("*Jinnah*"). On the first issue of whether or not costs should be awarded in this case, the Hearing Tribunal has considered the following factors:

1. Whether Mrs. Howell engaged in serious unprofessional conduct;

2. Whether Mrs. Howell was found to have engaged in unprofessional conduct on two or more occasions;

3. Whether Mrs. Howell failed to cooperate in the investigation or forced the College to expend more resources than otherwise necessary; or

4. Whether Mrs. Howell engaged in hearing misconduct.

The Hearing Tribunal does not find that there are compelling reasons to award costs in this case. While Mrs. Howell's conduct was unprofessional, it was not of the nature of serious unprofessional conduct as that described in *Jinnah* (i.e. sexual assault on a patient). Mrs. Howell did not cause the College to expend more resources through its investigation nor did she engage in misconduct during the hearing. Accordingly, the Hearing Tribunal has determined that no costs are ordered to be paid by Ms. Howell.

The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

1. The Hearing Tribunal's written reasons for decision ("the Decision") shall serve as a reprimand.

2. Mrs. Howell shall, within 30 days of receipt of the Sanction Decision, read and reflect on the following CLPNA documents. Mrs. Howell shall provide a signed written declaration to the Complaints Director attesting she has reviewed CLPNA's documents:

    i. Standards of Practice for Licensed Practical Nurses in Canada;

    ii. Code of Ethics for Licensed Practical Nurses in Canada;

    iii. CLPNA Policy: Professional Responsibility and Accountability;

iv. CLPNA Practice Guideline: Professional Boundaries;

v. CLPNA Competency Profile A1: Critical Thinking;

vi. CLPNA Competency Profile A2: Clinical Judgement and Decision Making;

vii. CLPNA Competency Profile C6: Professional Boundaries;

viii. CLPNA Competency Profile D1: Communication and Collaborative Practice;

ix. CLPNA Competency Profile Therapeutic Nurse-Patient Relationship.

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

3. Mrs. Howell shall, at her own cost, complete the following remedial education and provide the Complaints Director with a certificate confirming successful completion of each of the following courses, within the timelines set out below:

    i. LPN Ethics Course, available online at

    https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics within 2 months of receipt of the Sanction Decision;

    ii. Professional Boundaries in Nursing (BOUND007) offered by John Collins Consulting at

    https://www.jcollinsconsulting.com/images/Outlines/lpn/MODULE_OUTLINE_-_PROFESSIONAL_BOUNDARIES_IN_NURSING.pdf within 6 months of receipt of the Sanction Decision;

    iii. Relational Practice Self Study offered by CLPNA at

    https://studywithclpna.com/relationalpractice/ within 2 months of receipt of the Sanction Decision.

    If a course becomes unavailable, Mrs. Howell shall request in writing to be assigned an alternative course. The Complaints Director shall, in her sole discretion, reassign a course. Mrs. Howell will be notified by the Complaints Director, in writing, advising of the new course required.

4. The orders set out above at paragraphs 2 and 3 will appear as conditions on Mrs. Howell's practice permit and the Public Registry subject to the following:

    i. The requirement to complete the remedial education and readings/reflection paper will appear as "CLPNA Monitoring Orders (Conduct)" on Mrs. Howell's

practice permit and the Public Registry until the following sanctions have been satisfactorily completed:

i. CLPNA Reading

ii. LPN Ethics Course

iii. Professional Boundaries in Nursing

iv. Relational Practice Self Study

iii. The conditions on Mrs. Howell's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

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 12th of July 2023 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

James Lees, Public Member
Chair, Hearing Tribunal