COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

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

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF ANAYO AKABOGU

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

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF ANAYO AKABOGU, LPN #40637, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the College of Licensed Practical Nurses of Alberta ("CLPNA") in Edmonton, Alberta on June 25, 2019 with the following individuals present:

Hearing Tribunal:
Nancy Brook, Public Member, Chairperson
Kimberley Chin, LPN
Mohamed Belfair, LPN
Nicole James, LPN

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Anayo Akabogu, LPN ("Mr. Akabogu" or "Investigated Member")

(2) Preliminary Matters

The hearing was open to the public.

When the hearing began, the Chairperson of the Hearing Tribunal advised the Investigated Member he had the right to legal counsel under section 72(1) of the *Health Professions Act* (the "Act"). The Investigated Member confirmed he wished to proceed with the hearing without legal counsel.

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

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

(3) Background

Mr. Akabogu was an LPN within the meaning of the Act at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Mr. Akabogu was initially licensed as an LPN in Alberta on June 22, 2015.

On July 11, 2018, the CLPNA received a complaint from Tanya DeGrace, Executive Director (the "Complainant"), Lewis Estates Retirement Residence ("Lewis Estates") in Edmonton, Alberta (the "Complaint"). The Complaint was sent pursuant to s. 57 of the Act. Further, the Complainant notified the CLPNA that Mr. Akabogu, LPN, had been terminated from his position with Lewis Estates due to a lack of clinical competency.

Sandy Davis, Complaints Director for the CLPNA, delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act.

In accordance with s. 55(2)(d) of the Act, Judith Palyga, Investigator for the CLPNA (the "Investigator") was appointed to conduct an investigation into the Complaint. Mr. Akabogu received notice of the Complaint and notice of investigation by letter dated July 12, 2018.

On November 17, 2018, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Akabogu received notice that the Complaint was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated March 12, 2019.

A Notice of Hearing, Notice to Attend, and Notice to Produce were served upon Mr. Akabogu under cover of letter dated April 25, 2019.

(4) Allegations

The Allegations in the Statement of Allegations are:

"It is alleged that Anayo Akabogu, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about March 21/22, 2018, failed to contact EMS to request adequate pain control medication for resident MM.
2. On or about March 22/23, 2018 failed to follow proper medication administration practices by doing one or more of the following with regards to client MM:

a) Failed to document the administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls at 2400, 0100, 0200, 0300, 0400, and 0500 hours in the Nurse's PRN Notes and/or Multidisciplinary Notes;

b) Failed to assess and/or document an assessment of client MM prior to and/or after the administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls at 2400, 0100, 0200, 0300, 0400 and 0500 hours;

c) Contrary to an order for administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls every one hour as needed, administered and/or documented the administration of Hydromorphone 0.25 mls and Haliperidol at 0500 hours twice; and

d) Failed to document the dose of Haliperidol documented as administered at 0500 hours.

3. On or about June 20/21, 2018 did one or more of the following with regards to client MJ after AB [sic] was found on the floor:

    a) Failed to provide and/or document any nursing intervention for low oxygen saturation levels after a fall;

    b) Documented at 0600 hours that client MJ was orientated to person and place, had no change in behavior, and was not drowsy when client MJ was found unresponsive at 0600 hours;

    c) Documented client MJ's vitals on the Post-Fall Clinical Pathway Monitoring at 0700 hours after client MJ had been transferred to the hospital; and

    d) Failed to document MJ's status and transfer to the hospital in the Multidisciplinary Notes in a timely manner."

(5) <u>Admission of Unprofessional Conduct</u>

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

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of an Agreed Statement of Facts and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

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

The Hearing Tribunal has reviewed the documents included in Exhibit #2, and finds as facts the events as set out in the Agreed Statement of Facts.

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

Allegation 1

Mr. Akabogu admitted on or about March 21/22, 2018, he failed to contact EMS to request adequate pain control medication for resident MM.

Mr. Akabogu worked a night shift at Lewis Estates, starting at 2300 hours on March 21, 2018 and ending at 0700 hours on March 22, 2018.

On March 22, 2018 at 0515 hours, MM was complaining of back pain and MM’s daughter requested that Mr. Akabogu call Emergency Medical Services (“EMS”) because MM was in pain. A copy of MM’s Multidisciplinary Notes indicating the same is attached to Exhibit # 2 at TAB 5.

Mr. Akabogu did not contact EMS to request adequate pain medication for MM.

MM's daughter contacted EMS for MM. EMS attended Lewis Estates and provided pain medication to MM.

On March 21/22, 2018 there was no PRN order for pain control for MM. However, there was a Physician's Order Sheet that directed the LPN to contact EMS if MM required further medical support. A copy of the Physician's Order Sheet is in Exhibit # 2 at TAB 6.

It is clearly stated in the orders, Exhibit # 2 at TAB 6, that if patient MM required further medical assistance, that EMS should be called to provide such medical assistance. Mr. Akabogu failed to comply with the doctor's orders.

Mr. Akabogu explained that on a previous occasion he had called EMS for a different resident because he believed the resident required the assistance of EMS. According to Mr. Akabogu, he was verbally reprimanded for doing so. Therefore, he was very hesitant to repeat this action again.

The Hearing Tribunal understands Mr. Akabogu's dilemma in this situation as it seems that he was not sure what should be done. However, the doctor's directions on the chart are explicit. The Hearing Tribunal finds that the directions and orders for MM's care were clear and they did not present any conflict. On the March 21, 2018 doctor's orders in Exhibit # 2 at TAB 6, clearly state as item number 4, "LPN to contact EMS care & treat..."

Resident MM required additional treatment for pain, so much so, that even MM's daughter asked Mr. Akabogu to call EMS.

Not calling for EMS assistance in this situation indicates a lack of judgement on Mr. Akabogu's part.

In addition, Mr. Akabogu's failure to contact EMS, was a contravention of the Standards of Practice for an LPN. It is foundational to an LPN's practice to implement a doctor's orders when required. Mr. Akabogu failed to do this.

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

(i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and

(ii) Contravention of the Act, a code of ethics or standards of practice.

Allegation 2

Mr. Akabogu admitted on or about March 22/23, 2018, he failed to follow proper medication administration practices by doing one or more of the following with regard to client MM:

a) Failed to document the administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls at 2400, 0100, 0200, 0300, 0400, and 0500 hours in the Nurse's PRN Notes and/or Multidisciplinary Notes;

b) Failed to assess and/or document an assessment of client MM prior to and/or after the administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls at 2400, 0100, 0200, 0300, 0400 and 0500 hours;

c) Contrary to an order for administration of Hydromorphone 0.25 mls and Haliperidol 0.2 mls every one hour as needed, administered and/or documented the administration of Hydromorphone 0.25 mls and Haliperidol at 0500 hours twice; and

d) Failed to document the dose of Haliperidol documented as administered at 0500 hours.

Mr. Akabogu worked a night shift at Lewis Estates, starting at 2300 hours on March 22, 2018 and ending at 0700 hours on March 23, 2018.

Mr. Akabogu administered MM's scheduled Hydromorphone 0.25 ml. Mr. Akabogu also administered the ordered PRN Hydromorphone 0.25 ml and Haliperidol 0.2 mls which were ordered every 1 hour as needed.

Mr. Akabogu administered both PRN Hydromorphone 0.25 ml and PRN Haliperidol 0.2 mls every hour from 2400 hours on March 22, 2018 to 0500 hours on March 23, 2018. However, Mr. Akabogu did not document the administration of each PRN medication after each administration in the Nurse's PRN Notes or the Multidisciplinary Notes as required.

Mr. Akabogu also failed to assess or document an assessment prior to or after the administration of PRN Hydromorphone 0.25 ml and PRN Haliperidol 0.2 mls at 2400 hours, 0100 hours, 0200 hours, 0300 hours, 0400 hours and 0500 hours as required.

On March 23, 2018, MM was found to be heavily sedated and not responsive to stimuli. Tanya DeGrace reviewed the documentation completed by Mr. Akabogu for MM and found that Mr. Akabogu had not completed any documentation as to why the PRN medications were administered and had not completed any documentation about the administration of medication to MM.

Ms. DeGrace directed Mr. Akabogu to attend Lewis Estates to complete the documentation as the physician could not properly assess the effectiveness of the medications and MM was inappropriately medicated and heavily sedated.

On March 23, 2018, Mr. Akabogu returned to Lewis Estates and completed a late entry for MM on the Nurse's PRN Notes and the Multidisciplinary Notes. A copy of the Nurse's PRN Notes is

attached to Exhibit #2 at TAB 7 and a copy of the Multidisciplinary Notes are attached to Exhibit #2 at TAB 8.

On the Nurse's PRN Notes (in Exhibit # 2 at TAB 7) Mr. Akabogu documented the administration of each Hydromorphone 0.25 ml and Haloperidol 0.2 ml twice at 0500 hours, even though the order was only for a single dose every hour as needed.

Mr. Akabogu failed to document the dose of Haloperidol on the second documented 0500 hours administration. A copy of the Nurse's PRN Notes indicating same is in Exhibit #2 at TAB 7**.**

MM was so sedated after the night shift that he did not require any further PRN medications until he passed away on March 24, 2018.

Proper medication administration is a foundational and critical skill for an LPN. Incorrect medication administration has the potential to harm a patient or can cause the patient to suffer unnecessarily or could interfere with the proper treatment of a patient.

The accurate and timely charting of medications, along with follow-up assessments of the patient's condition is vitally important to make sure that the patient is or is not responding to medications as would be expected.

In failing to exercise proper medication administration, Mr. Akabogu has demonstrated a lack of skill, and has also violated the standards of practice for an LPN.

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

> (i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
>
> (ii) Contravention of the Act, a code of ethics or standards of practice.

<u>Allegation 3</u>

Mr. Akabogu admitted on or about June 20/21, 2018, he did one or more of the following with regards to client MJ after AB was found on the floor:

a) Failed to provide and/or document any nursing intervention for low oxygen saturation levels after a fall;
b) Documented at 0600 hours that client MJ was orientated to person and place, had no change in behavior, and was not drowsy when client MJ was found unresponsive at 0600 hours;
c) Documented client MJ's vitals on the Post-Fall Clinical Pathway Monitoring at 0700 hours after client MJ had been transferred to the hospital; and

d) Failed to document MJ’s status and transfer to the hospital in the Multidisciplinary Notes in a timely manner.

Mr. Akabogu worked a night shift at Lewis Estates, starting at 2300 hours on June 20, 2018 and ending at 0700 hours on June 21, 2018.

At approximately 0245 hours on June 21, 2018, resident MJ had an unwitnessed fall in his room and was found on the floor by Raphael Olaogun, HCA. As Mr. Akabogu was the LPN on duty, he went to MJ’s room and completed an assessment of MJ, including vital signs.

Mr. Akabogu documented on the Incident Report (Exhibit #2 at TAB 9) and the Multidisciplinary Notes (Exhibit #2 at TAB 10) that MJ’s initial oxygen saturation level after the fall was 79%.

Normal range for someone of MJ’s age is above 88%. Someone with a level of 79% would require to be placed on oxygen immediately.

Nonetheless, Mr. Akabogu documented the oxygen saturation level and then documented on the Multidisciplinary Notes, “no concerns noted at this time” (see Exhibit #2 at TAB 10). Mr. Akabogu did not provide or document any nursing intervention for the low oxygen saturation level at this time.

Mr. Akabogu continued to monitor MJ’s vital signs as per post-fall clinical monitoring.

Mr. Akabogu documented that MJ’s oxygen saturation level was 79% at 0300 hours, 77% at 0330 hours, 78% at 0400 hours, 75% at 0500 hours, 76% at 0600 hours and recorded 78% at 0700 hours. A copy of MJ’s Post-Fall Clinical Monitoring form indicating same is found at Exhibit #2 at TAB 11.

Despite the low oxygen saturation level, Mr. Akabogu did not provide or document any nursing intervention to address the low level through his shift.

On June 21, 2018, at 0600 hours, Prisca Kuissu, HCA went to check on MJ in MJ’s room. Ms. Kuissu found MJ lying in his bed and MJ had fast breath, was weak, and unresponsive. A copy of the Incident Report completed by Ms. Kuissu indicating same is found at Exhibit #2 at TAB 12.

Ms. Kuissu called Mr. Akabogu for assistance. Mr. Akabogu attended MJ’s room. Despite the fact that MJ was found unresponsive at 0600 hours, Mr. Akabogu documented that, at 0600 hours, MJ was orientated to person and place, that there was no change in behavior, and that MJ was not drowsy. A copy of MJ’s Post-Fall Clinical Monitoring form indicating same is found at Exhibit #2 at TAB 11.

Mr. Akabogu contacted EMS due to MJ’s unresponsiveness. Mr. Akabogu did not provide or document any nursing intervention to address the low oxygen saturation level at this time.

MJ was transported to the hospital at approximately 0644 hours. A copy of the Emergency Medical Services Report of June 21, 2018 for MJ indicating same is found at Exhibit #2 at TAB 13.

Mr. Akabogu documented MJ's vitals on MJ's Post-Fall Clinical Monitoring form for 0700 hours, even though MJ was not at Lewis Estates at the time and had already been transported to the hospital. A copy of MJ's Post-Fall Clinical Monitoring form indicating same is found at Exhibit #2 at TAB 11.

Mr. Akabogu did not document the episode with MJ that occurred at 0600 hours, or MJ's status, or the transfer of MJ to the hospital in the Multidisciplinary Notes prior to the end of his shift on June 21, 2018. Mr. Akabogu completed a late entry during his shift the next night on June 21, at 2315. A copy of MJ's Multidisciplinary Notes indicating same is found at Exhibit #2 at TAB 10.

The Hearing Tribunal finds that it is not acceptable to delay information as important as this until the next evening. Mr. Akabogu should have documented MJ's condition and transfer to the hospital prior to leaving on the morning of June 21, 2018.

Timely and accurate documentation of patient assessments and treatment is paramount to good and proper patient care. It is critical to ongoing continuity of treatment. Therefore, this skill and practice is vital and foundational to a nurse's practice.

In failing to properly chart oxygen levels or nursing intervention in client MJ's chart after MJ had fallen, Mr. Akabogu demonstrated a lack of basic nursing skills and judgment. Inaccurate and significantly late entry of vital signs after MJ's fall, as well as failing to document MJ's status and transfer to the hospital in the Multidisciplinary Notes in a timely manner, is basic to nursing practice as this is critical to any patient's continuity of care with other health professionals.

In failing to document properly and in a timely manner, Mr. Akabogu has failed in applying a basic nursing skill. Not documenting properly or accurately or timely is clearly a violation of Standards of Practice.

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

> (i) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services; and
>
> (ii) Contravention of the Act, a code of ethics or standards of practice.

Code of Ethics

Mr. Akabogu acknowledges his conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

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

   1.1 Maintain standards of practice, professional competence and conduct; and

   1.5 Provide care directed to the health and well-being of the person, family, and community.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

   2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities;

   2.8 Use evidence and judgement to guide nursing decisions; and

   2.9 Identify and minimize risks to clients.

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

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

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

   3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which they are accountable.

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

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

Standards of Practice

Mr. Akabogu admitted that his conduct breached the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which state as follows:

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

    - 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies;
    - 1.4. Recognize their own practice limitations and consult as necessary.
    - 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised;
    - 1.7. Incorporate established client safety principles and quality assurance/improvement activities into LPN practice;
    - 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses; and
    - 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

b. Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

    - 2.1. Possess current knowledge to support critical thinking and professional judgement; and
    - 2.2. Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice.

c. Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

   - 3.5. Provide relevant and timely information to clients and co-workers; and

   - 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

d. Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

   - 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs;

   - 4.7. Communicate in a respectful, timely, open and honest manner; and

   - 4.8. Collaborate with colleagues to promote safe, competent and ethical practice.

Mr. Akabogu's conduct breached the Code of Ethics and Standards or Practice outlined above. His actions could have negatively impacted those under his care and had the potential for real harm. As an LPN, Mr. Akabogu must provide care in accordance with his training, he must be competent and he must follow protocols that are in place – all of these things are reflected in the provisions noted above. The breaches of the above noted sections of the Code of Ethics and Standards of Practice by Mr. Akabogu are serious and constitute unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Akabogu made a joint submission with respect to penalty, entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

2. Mr. Akabogu shall pay 25% of the costs of the investigation and hearing to a maximum of $3,000.00, subject to the following:

   (a) Costs will be paid in equal monthly installments over a period of 36 months from service of the Decision.

3. Mr. Akabogu shall read and reflect on the following CLPNA documents, located on the CLPNA website at www.clpna.com under "Governance". Mr. Akabogu shall provide to the Complaints Consultant a written reflection of 500 – 700 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact his professional practice within thirty (30) days of service of the Decision:

   a. Code of Ethics for Licensed Practical Nurses in Canada;
   b. Standards of Practice for Licensed Practical Nurses in Canada;
   c. CLPNA Practice Policy: Professional Responsibility & Accountability;
   d. CLPNA Practice Policy: Documentation;
   e. CLPNA Practice Policy: Expectations and Obligations During Emergencies;
   f. CLPNA Practice Guideline: Medication Management;
   g. CLPNA Competency Profile B: Nursing Process;
   h. CLPNA Competency Profile D5: Legal Protocols, Documenting and Reporting;
   i. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;
   j. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;
   k. CLPNA Competency Profile F2: Oxygen Therapy;
   l. CLPNA Competency Profile U1: Principles of Pharmacology; and
   m. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Akabogu shall complete the LPN Ethics course available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its successful completion to the Complaints Consultant within thirty (30) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Mr. Akabogu shall complete the "Documentation 101" course available online at http://www.clpna.com/ and provide a certificate confirming its successful completion to the Complaints Consultant within sixty (60) days of service of the Decision.

If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Akabogu shall complete, at his own cost, the following courses located online at http://www.pedagogyeducation.com and provide a certificate confirming their successful completion to the Complaints Consultant within sixty (60) days of service of the Decision:

    (a) Using Critical Thinking to Manage Oxygen Therapies; and
    (b) Current Concepts in Pain Management

    If such courses become unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Akabogu shall complete the Health Assessment quiz located online at http://www.learningnurse.org/ and provide documentation confirming successful completion of the quiz (a mark of at least 80%) to the Complaints Consultant within thirty (30) days of service of the Decision.

    If such quiz becomes unavailable, an equivalent quiz may be substituted where approved in advance in writing by the Complaints Consultant.

8. Mr. Akabogu shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Akabogu will keep his contact information current with the CLPNA on an ongoing basis.

9. Should Mr. Akabogu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

10. Should Mr. Akabogu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

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

    (b) Treat Mr. Akabogu's non-compliance as information under s. 56 of the Act; or

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

Legal Counsel for the Complaints Consultant submitted the primary purpose of orders from the Hearing Tribunal is to protect the public.

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

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

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

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

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

1: The nature and gravity of the proven Allegations

Although Mr. Akabogu's actions were not intentional, they were careless, reckless, and for the most part demonstrated poor judgment. Although there was no evidence given that indicated Mr. Akabogu's failure to document, assess, or practice proper medication administration could have directly harmed a client under his care, all of his actions or lack thereof, are serious and potentially dangerous failures.

2: The age and experience of the investigated member

At the time of these occurrences, Mr. Akabogu was a junior nurse; however, all of the failures in Mr. Akabogu's practice are failures in foundational knowledge and skill, and are basic even for a junior nurse. However, Mr. Akabogu did tell the Hearing Tribunal that during his shifts there could be as many as 200 clients under his care and he only had three PA's helping on those shifts. The Hearing Tribunal recognizes that a nurse's shift can be very busy; however, it is the nurse's responsibility to make sure that clients in the nurse's care receive proper treatment, assessment, and medication administration.

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

The Hearing Tribunal understands that Mr. Akabogu has no prior complaints against him.

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

The people that were under Mr. Akabogu's care were elderly and vulnerable, and therefore highly dependent and relying upon their nurse's competent and skillful care.

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

In the conduct of Mr. Akabogu, there is a repetition of the same errors on two different individuals over a two night period. Although this does not represent a pattern of behavior as it was a short time and only with two patients, it is still a strong demonstration of reckless practice.

6: The role of the investigated member in acknowledging what occurred

The Hearing Tribunal commends Mr. Akabogu for recognizing his unprofessional conduct, and for his cooperation with the CLPNA in coming to an Agreed Statement of Fact and a Joint Submission on Penalty. Acknowledgement of conduct can help a nurse to improve their practice in the future.

7: 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 informed that Mr. Akabogu lost his job as a result of his unprofessional conduct.

8: The impact of the incident(s) on the victim, and/or

The Hearing Tribunal was not given any evidence that the victims suffered any impact as a result of Mr. Akabogu's conduct.

9: The presence or absence of any mitigating circumstances
Mr. Akabogu told the Hearing Tribunal that with regard to the EMS issue with client MM, he was hesitant to call EMS because he had recently been verbally reprimanded for calling EMS for another client in Lewis Estates, and therefore, he was somewhat reluctant to make, what he thought would be, "the same mistake" again. This does shed light on why he didn't call EMS, but the Hearing Tribunal finds that this is not a strong explanation for this situation, as it was clearly marked on the client's chart that EMS should be called if further treatment is required. Therefore, this is not a mitigating factor, it is poor judgment.

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 deterrents and, thereby, to protect the public. The Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, The Hearing Tribunal finds the joint submission on penalty is appropriate, reasonable and not against the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

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

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

2. Mr. Akabogu shall pay 25% of the costs of the investigation and hearing to a maximum of $3,000.00, subject to the following:

    (a) Costs will be paid in equal monthly installments over a period of 36 months from service of the Decision.

3. Mr. Akabogu shall read and reflect on the following CLPNA documents, located on the CLPNA website at www.clpna.com under "Governance". Mr. Akabogu shall provide to the Complaints Consultant a written reflection of 500 – 700 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact his professional practice within thirty (30) days of service of the Decision:

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

b. Standards of Practice for Licensed Practical Nurses in Canada;
c. CLPNA Practice Policy: Professional Responsibility & Accountability;
d. CLPNA Practice Policy: Documentation;
e. CLPNA Practice Policy: Expectations and Obligations During Emergencies;
f. CLPNA Practice Guideline: Medication Management;
g. CLPNA Competency Profile B: Nursing Process;
h. CLPNA Competency Profile D5: Legal Protocols, Documenting and Reporting;
i. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;
j. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;
k. CLPNA Competency Profile F2: Oxygen Therapy;
l. CLPNA Competency Profile U1: Principles of Pharmacology; and
m. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Akabogu shall complete the LPN Ethics course available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its successful completion to the Complaints Consultant within thirty (30) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Consultant.

5. Mr. Akabogu shall complete the “Documentation 101” course available online at http://www.clpna.com/ and provide a certificate confirming its successful completion to the Complaints Consultant within sixty (60) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Akabogu shall complete, at his own cost, the following courses located online at http://www.pedagogyeducation.com and provide a certificate confirming their successful completion to the Complaints Consultant within sixty (60) days of service of the Decision:

(a) Using Critical Thinking to Manage Oxygen Therapies; and
(b) Current Concepts in Pain Management

If such courses become unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Akabogu shall complete the Health Assessment quiz located online at http://www.learningnurse.org/ and provide documentation confirming successful completion of the quiz (a mark of at least 80%) to the Complaints Consultant within thirty (30) days of service of the Decision.

   If such quiz becomes unavailable, an equivalent quiz may be substituted where approved in advance in writing by the Complaints Consultant.

8. Mr. Akabogu shall provide the CLPNA with his contact information, including his home mailing address, home and cellular telephone numbers, current e-mail address and his current employment information. Mr. Akabogu will keep his contact information current with the CLPNA on an ongoing basis.

9. Should Mr. Akabogu be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

10. Should Mr. Akabogu fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Consultant may do any or all of the following:

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

    (e) Treat Mr. Akabogu's non-compliance as information under s. 56 of the Act; or

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

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

Under Part 4, sections 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 6TH DAY OF AUGUST 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Nancy Brook, Public Member
Chair, Hearing Tribunal