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 BRANDI MALTBY

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 BRANDI MALTBY, LPN #21173, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA (THE "CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Teleconference on November 16, 2022, with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Jennifer Martin, LPN
James Lees, Public Member
Anita Warnick, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Officer, CLPNA
Kevin Oudith, Complaints Officer, CLPNA
Stephanie Karkutly, Complaints Officer, CLPNA

Investigated Member:
Brandi Maltby, LPN ("Ms. Maltby" or "Investigated Member")
Lee Watson, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Maltby was an LPN within the meaning of the *Health Profession Act* (the "Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Maltby was initially licensed as an LPN in Alberta on January 1, 1988.

The CLPNA received a complaint dated June 1, 2022 (the "Complaint") from Lynn Borris, VP Operations of Rosedale Assisted Living (the "Facility"), pursuant to s. 57 of the Act. The Complaint advised that Ms. Maltby, LPN, had been suspended from her employment at the Facility.

By way of letter dated June 9, 2022, the Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Ms. Maltby with notice of the Complaint and notified Ms. Maltby that she was delegating her powers under Part 4 of the Act to Kevin Oudith, Complaints Officer (the "Complaints Officer") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Maltby that she had appointed Neal York, Investigator for the CLPNA (the "Investigator") to conduct an investigation into the Complaint.

On June 9, 2022, the Complaints Officer recommended that Wanda Beaudoin, Designated Person appointed by the CLPNA Council, impose an interim suspension of or a condition of direct supervised practice on Ms. Maltby's practice permit pending the outcome of disciplinary proceedings pursuant to s. 65(1)(b) of the Act due to the serious nature of the allegations against Ms. Maltby.

By letter dated June 20, 2022, Ms. Maltby was notified that Ms. Beaudoin granted the request to impose a condition on Ms. Maltby's practice permit requiring her to practice in the direct presence of one or more regulated health providers, effective the date of the letter.

On July 11, 2022, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the Complaints Officer.

Following receipt of the Investigation Report, the Complaints Officer determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Maltby received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report with attachments under cover of letter dated August 9, 2022.

On August 9, 2022, the Complaints Officer wrote to Ms. Beaudoin to recommend that the condition on Ms. Maltby's practice permit be lessened to indirect supervision.

On August 15, 2022, the condition on Ms. Maltby's practice permit requiring her to practice in the direct presence of one or more regulated health providers was lessened to a condition requiring indirect supervision.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Maltby under cover of letter dated September 13, 2022.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are:

1. On or between May 16 and May 17, 2022, did one or more of the following with regards to client JR:
    a. Failed to perform and/or document a Point of Care Risk Assessment after being notified JR was coughing, a symptom of COVID-19;
    b. Failed to isolate JR after he displayed COVID-19 symptoms, contrary to CMOH Order 02-2022;
    c. Failed to obtain a COVID-19 PCR Test or two Rapid Tests from JR in a timely manner, or at all, after he displayed COVID-19 symptoms;
    d. Failed to follow the Contact and Droplet/COVID-19 Precautions PPE Checklist when providing care to JR after he displayed COVID-19 symptoms; and
    e. Failed to report/communicate and/or document JR's COVID-19 symptoms for oncoming HCAs, LPNs and site management.

2. On or about May 17, 2022, did one or more of the following with regards to client JR after he suffered two separate unwitnessed falls:
    a. Failed to obtain and/or document Vital Signs ("VS") and Neuro Vital Signs ("NVS") after JR's first fall;
    b. Failed to perform and/or document a proper assessment after JR's second fall;
    c. Failed to obtain and/or document VS or NVS after JR's second fall;
    d. Inaccurately documented in the Multidisciplinary Notes how JR was found after JR's second fall;
    e. Failed to remain, or delegate an HCA to remain, with JR after his second fall until EMS arrived to JR's room;
    f. Improperly completed a transfer of care handover report to EMS; and
    g. Failed to communicate to the appropriate stakeholders of JR's two falls.

3. On or about May 12, 2022, did one or more of the following with regards to client HY after she suffered an unwitnessed fall:
    a. Failed to obtain and/or document VS for HY;
    b. Failed to communicate to the appropriate stakeholders of HY's fall;
    c. Failed to complete the required post-fall documentation.

4. On or about May 6, 2022, did one or more of the following with regards to client JH after she suffered an unwitnessed fall:
    a. Failed to perform and/or document an assessment in a timely manner, including obtaining VS, after being notified of JH's fall;
    b. Failed to communicate to the appropriate stakeholders of JH's fall; and
    c. Failed to complete the required post-fall documentation."

(5) Admission of Unprofessional Conduct

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

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

Legal Counsel for the Complaints Officer submitted 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 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 Ms. Maltby's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions

before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Maltby.

Allegation 1

Ms. Maltby admitted on or between May 16 and May 17, 2022, she did one or more of the following with regards to client JR:

a. Failed to perform and/or document a Point of Care Risk Assessment after being notified JR was coughing, a symptom of COVID-19;
b. Failed to isolate JR after he displayed COVID-19 symptoms, contrary to CMOH Order 02-2022;
c. Failed to obtain a COVID-19 PCR Test or two Rapid Tests from JR in a timely manner, or at all, after he displayed COVID-19 symptoms;
d. Failed to follow the Contact and Droplet/COVID-19 Precautions PPE Checklist when providing care to JR after he displayed COVID-19 symptoms; and
e. Failed to report/communicate and/or document JR's COVID-19 symptoms for oncoming HCAs, LPNs and site management.

On May 16 and May 17, 2022, Ms. Maltby worked her regular shift at the Facility from 0800 to 1600 hours.

On the morning of May 16, 2022, Ms. Maltby was informed by an HCA that a resident, JR, was not feeling well and had developed a cough. Ms. Maltby understood that JR's symptoms could have been an indication that JR was COVID-19 positive.

Ms. Maltby attended JR's suite to speak with JR and noticed that he had a cough. Ms. Maltby did not complete or document an assessment of JR at that time. She did not place JR in isolation, nor did she administer either a COVID-19 PCR test or two Rapid Tests to JR. Shortly after, Ms. Maltby left JR and carried on with her duties.

Ms. Maltby did not document or report JR's COVID-19 symptoms on May 16, 2022 to oncoming HCAs, LPNs, or site management. None of the documents provided to the Hearing Tribunal related to JR's care for that day include any documentation regarding JR's COVID-19 symptoms.

At approximately 0845 hours on May 17, 2022, Ms. Maltby was informed that JR had suffered an unwitnessed fall. Prior to entering JR's suite to provide care after his fall, Ms. Maltby failed to complete a Point of Care Risk Assessment.

The Facility's Infection Prevention and Control Policy & Procedure requires that a Point of Care Risk Assessment be completed prior to providing care to identify any risks pertaining to the task, resident, or environment. Based on the symptoms identified through the Point of Care Risk

Assessment, additional precautions such as Contact and Droplet precautions will be implemented.

Ms. Maltby did not perform or document a Point of Care Risk Assessment as required.

On May 16 and May 17, 2022, CMOH Order 02-2022 was in effect. Article 3.1(a) of CMOH Order 02-2022 mandated isolation for individuals displaying COVID-19 symptoms such as coughing not related to a pre-existing illness or health condition. Article 3.4 of CMOH Order 02-2022 provided that a symptomatic person was not required to isolate if a PCR test indicated the person was negative for COVID-19, or two rapid tests taken within 24 hours of each other indicated the person was negative for COVID-19.

Ms. Maltby did not isolate JR or obtain any tests from JR in a timely manner after he displayed COVID-19 symptoms as required by the CMOH Order 02-2022.

The Facility's Contact and Droplet/COVID-19 Precautions PPE Checklist requires that when donning PPE, staff are required to clean their hands, gown, don a mask and eye protection, and don gloves, in that order. Identical steps are required by the Facility's Infection Prevention and Control PPE Audit.

Ms. Maltby failed to follow the Contact and Droplet/COVID-19 Precautions PPE Checklist when providing care to JR as required as she did not don a protective gown.

It was confirmed that JR was COVID-19 positive on May 17, 2022.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Maltby's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

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

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

Ms. Maltby displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to perform and document an assessment of a patient after that patient displayed signs and symptoms of COVID-19. Ms. Maltby also failed to follow the CMOH Order 02-2022 which was in effect at the Facility at the time of the allegation. Not following the proper protocol and not doing the required assessment and documentation shows a lack of skill or judgment on the part of Ms. Maltby.

Ms. Maltby was in contravention of the Code of Ethics for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") and the Standards of Practice for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"), as acknowledged by Ms. Maltby in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct. It is expected that an LPN be familiar with these documents and work in adherence to these documents.

The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice, as set out below, and that such breaches are sufficiently serious to constitute unprofessional conduct.

CLPNA Code of Ethics:

Ms. Maltby acknowledges that her 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:

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

- 1.1 Maintain standards of practice, professional competence and conduct.

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

- 2.9 Identify and minimize risks to clients.

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 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

CLPNA Standards of Practice:

Ms. Maltby acknowledges that her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

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.

- 1.6 Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

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:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective, and ethical practice.

- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury.

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

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

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.

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

Ms. Maltby displayed conduct that harms the integrity of the regulation profession in that LPNs are held to high standards and it is an expectation that an LPN will withhold these standards and follow proper documentation, assessments, and protocols that are set out by their employer as well as the Government of Alberta.

Allegation 2

Ms. Maltby admitted on or about May 17, 2022, she did one or more of the following with regards to client JR after he suffered two separate unwitnessed falls:

a. Failed to obtain and/or document Vital Signs ("VS") and Neuro Vital Signs ("NVS") after JR's first fall;
b. Failed to perform and/or document a proper assessment after JR's second fall;
c. Failed to obtain and/or document VS or NVS after JR's second fall;
d. Inaccurately documented in the Multidisciplinary Notes how JR was found after JR's second fall;
e. Failed to remain, or delegate an HCA to remain, with JR after his second fall until EMS arrived to JR's room;
f. Improperly completed a transfer of care handover report to EMS; and
g. Failed to communicate to the appropriate stakeholders of JR's two falls.

On May 17, 2022, Ms. Maltby was informed that JR had suffered an unwitnessed fall. At approximately 0845 hours, Ms. Maltby and two HCAs entered JR's suite and located JR lying on the floor of the bathroom.

After assessing JR's range of motion and examining JR for obvious injuries, JR was lifted off the ground and put into a seated position. Ms. Maltby observed that JR had a small cut above his left eyebrow. Ms. Maltby did not complete or document an assessment of JR's vital signs and neurological vital signs at this time.

Ms. Maltby left JR with two HCAs and told them she would return to complete a full assessment at a later time. She proceeded to provide care to other residents.

At approximately 0915 hours, Ms. Maltby returned to JR's suite to take JR's vital signs and neurological vital signs. Upon her return, Ms. Maltby was informed that JR had fallen again. She entered JR's suite to find JR sitting on a chair, having already been assisted up off the floor by two HCAs. Prior to completing any assessment on JR, Ms. Maltby had JR stand up and walk a short distance to observe JR's mobility.

As JR had fallen twice and was shaky and weak when standing, Ms. Maltby called EMS. Ms. Maltby did not complete or document an assessment of JR at this time, including vital signs and neurological vital signs. After contacting EMS, Ms. Maltby departed JR's suite, leaving JR alone until EMS arrived.

Ms. Maltby documented JR's first and second fall in the Multidisciplinary Notes for JR, incorrectly noting that when she returned to JR's suite after 0900 hours, JR was "on the floor again".

Ms. Maltby prepared a package of JR's records for EMS and left them at the front reception desk of the Facility for EMS to retrieve. This document contained a hand-written note, noting that "2 falls – 5 mins apart. Loose stool. Cough. Cut R eye – on Eliquis." The note does not replace a verbal report and is inaccurate, as JR's falls were not 5 minutes apart.

The Facility's Emergency Care and Response Policy & Procedures requires that after EMS is called, the responsible LPN remains with the resident until EMS arrives.

Ms. Maltby failed to remain, or delegate an HCA to remain, with JR after his second fall until EMS arrived as required.

The Facility's Falls Prevention and Management Policy & Procedure requires that a resident who has suffered a fall not be moved until an LPN completes a nursing assessment. The Facility Post Fall Clinical Pathway requires that the LPN conduct an assessment that includes vital signs and neurological vital signs. The Falls Prevention and Management Policy & Procedure also requires neurological monitoring for unwitnessed falls where there is head injury, or it is unknown if there is a head injury.

The Falls Prevention and Management Policy & Procedure also requires that all falls be reported through the Shift Report, and that the LPN complete thorough documentation of the fall in the resident's chart. It also requires that after a PSL resident fall, an Incident Report must be completed, the fall must be recorded in the chart and communication logs, and the Alberta Health Services Care Manager must be notified.

Ms. Maltby failed to communicate JR's two falls to the appropriate stakeholders as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Maltby's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

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

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

Ms. Maltby displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to obtain and/or document Vital signs and Neuro Vital Signs after a patient had a fall. Ms. Maltby also failed to document the patient's fall or report this to any other care provider in the Facility. Ms. Maltby also failed to remain with JR to await EPS. By failing

to abide by her employer's policies and failing to provide appropriate client care to JR, Ms. Maltby demonstrated a lack of knowledge, skill and/or judgment.

Ms. Maltby did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Maltby in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. These actions did not demonstrate that Ms. Maltby was committed to avoiding and/or minimizing harm in situations in which client safety and well-being are compromised.

Ms. Maltby displayed conduct that harms the integrity of the regulation profession in that LPNs are held to high standards and it is an expectation that an LPN will uphold these standards and follow proper documentation and assessments to ensure client safety, including after falls.

Allegation 3

Ms. Maltby admitted on or about May 12, 2022, she did one or more of the following with regards to client HY after she suffered an unwitnessed fall:

a. Failed to obtain and/or document VS for HY;
b. Failed to communicate to the appropriate stakeholders of HY's fall;
c. Failed to complete the required post-fall documentation.

On May 12, 2022, Ms. Maltby worked her regular shift at the Facility from 0800 to 1600 hours.

On May 12, 2022, Ms. Maltby was informed by HCA Jennifer Dipasupil that resident HY had a black eye and that Ms. Dipasupil believed HY had suffered an unwitnessed fall. Ms. Maltby attended HY's suite and noted that HY had a bruised eye.

Ms. Maltby did not complete a full assessment on HY and failed to document HY's vital signs. The Facility Post Fall Clinical Pathway requires that the LPN conducts an assessment that includes vital signs and neurological vital signs.

The Falls Prevention and Management Policy and Procedure requires that falls be reported through the Shift Report, and that the LPN complete thorough documentation of the fall in the resident's chart. It also requires that after a PSL resident fall, an Incident Report must be completed, the fall must be recorded in the chart and communication logs, and the Alberta Health Services Care Manager must be notified.

Ms. Maltby did not complete an Incident Report as required. Ms. Maltby did not document the fall on the Care Calendar, the Shift Report sheet, or the Shift Report LPN/HCA Daily Communication record.

Ms. Maltby did not complete the required post-fall documentation and did not communicate HY's fall to the appropriate stakeholders as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Maltby's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

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

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

Ms. Maltby displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to obtain and/or document Vital Signs and Neuro Vital Signs after a patient had a fall. Ms. Maltby also failed to document the patient's fall or report this to any other care provider in the Facility. She also did not communicate HY's fall to the appropriate stakeholders, as required. All of this conduct demonstrates a lack of knowledge, skill and/or judgment on the part of Ms. Maltby.

Ms. Maltby did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Maltby in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. These actions did not demonstrate that Ms. Maltby was committed to avoiding and/or minimizing harm in situations in which client safety and well-being are compromised.

Ms. Maltby displayed conduct that harms the integrity of the regulation profession in that LPNs are held to high standards and it is an expectation that an LPN will withhold these standards and follow proper documentation and assessments.

<u>Allegation 4</u>

Ms. Maltby admitted on or about May 6, 2022, she did one or more of the following with regards to client JH after she suffered an unwitnessed fall:

a. Failed to perform and/or document an assessment in a timely manner, including obtaining VS, after being notified of JH's fall;
b. Failed to communicate to the appropriate stakeholders of JH's fall; and
c. Failed to complete the required post-fall documentation.

On May 6, 2022, Ms. Maltby worked her regular shift at the Facility from 0800 to 1600 hours.

On May 6, 2022, Ms. Maltby was informed by HCA Mary Boyke that resident JH had fallen. Ms. Maltby attended JH's suite and spoke with JH and JH's spouse, HH, and confirmed that JH had suffered an unwitnessed fall. Ms. Maltby did not complete an Incident Report at this time as required.

Ms. Maltby did not immediately complete a full assessment on JH, including failing to take and document JH's vital signs in a timely manner. The Facility Post Fall Clinical Pathway requires that the LPN conduct an assessment that includes vital signs and neurological vital signs.

The Falls Prevention and Management Policy and Procedure requires that falls be reported through the Shift Report, and that the LPN complete thorough documentation of the fall in the resident's chart. It also requires that after a PSL resident fall, an Incident Report must be completed, the fall must be recorded in the chart and communication logs, and the Alberta Health Services Care Manager must be notified.

Ms. Maltby did not document the fall on JH's Multidisciplinary Notes on that day, nor on the Care Calendar or Shift Report LPN/HCA Daily Communications record.

On May 16, 2022, Ms. Maltby was instructed to properly document the incident by Trish Geusebroek, Director of Care, and did so.

Ms. Maltby did not complete the required post-fall documentation and did not communicate JH's fall to the appropriate stakeholders as required.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Maltby's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 did in fact occur.

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

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

Ms. Maltby displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services by failing to obtain and/or document Vital signs and Neuro Vital Signs after a patient had a fall. Ms. Maltby also failed to document the patient's fall or report this to any other care provider in the Facility, or to JH's appropriate stakeholders. These actions demonstrate a lack of knowledge, skill or judgment.

Ms. Maltby did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Maltby in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, as set out in more detail under Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. These actions did not demonstrate that Ms. Maltby was committed to avoiding and/or minimizing harm in situations in which client safety and well-being are compromised.

Ms. Maltby displayed conduct that harms the integrity of the regulation profession in that LPNs are held to high standards and it is an expectation that an LPN will withhold these standards and follow proper documentation and assessments. It is an expectation that an LPN be familiar with assessment, documentation and communication within the Facility.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Maltby jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Ms. Maltby shall pay a fine of $2,000.00 within **12 months** of service of the Decision.

3. Ms. Maltby shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Maltby shall provide a signed written declaration to the Complaints Officer, within **30 days** of service of the Decision, attesting she has reviewed the CLPNA's documents:

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

    b) Standards of Practice for Licensed Practical Nurses in Canada;

    c) The CLPNA Policy: Professional Responsibility and Accountability;

    d) The CLPNA Policy: Documentation;

    e) The CLPNA Practice Guideline: Infection Prevention and Control;

    f) The CLPNA Competency Profile A1: Critical Thinking;

    g) The CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

    h) The CLPNA Competency Profile B1: Assessment;

i) The CLPNA Competency Profile D1: Communication and Collaborative Practice; and

j) The CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting.

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

4. Ms. Maltby shall complete the following remedial education, at her own cost:

    a) **LPN Ethics Course** available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

    b) **Health Assessment Self-Study Course** available online at https://studywithclpna.com/healthassessment/

    c) **Nursing Documentation 101 Self-Study Course** available online at https://studywithclpna.com/nursingdocumentation101/

    d) **15.3 Infections Transmission Precautions Quiz** available online at https://learningnurse.com/quizzes/ipc-transmission/

    e) **18.5 Mobility and Falls Quiz** available online at https://learningnurse.com/quizzes/mobilityfalls/

    Ms. Maltby shall provide the Complaints Officer with certificates confirming successful completion of each of the above education within **six (6) months** from service of the Decision.

    If any of the required education becomes unavailable, Ms. Maltby shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. Maltby's written request, the Complaints Officer, in his sole discretion, may assign alternative education in which case Ms. Maltby will be notified in writing of the new education requirements.

5. The condition on Ms. Maltby's practice permit and on the Public Registry requiring her to practice with indirect supervision will be removed upon completion of the hearing.

6. The sanctions set out above at paragraphs 2-4 will appear as conditions on Ms. Maltby's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the educational readings, courses and quizzes outlined at paragraphs 3-4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Maltby's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

i. Educational Reading;

ii. Ethics Course;

iii. Health Assessment Course;

iv. Nursing Documentation Course;

v. Infections Transmission Precautions Quiz; and

vi. Mobility and Falls Quiz.

b) The requirement to pay a fine, will appear as "Conduct Cost/Fines" on Ms. Maltby practice permit and the Public Registry until the fine has been paid in full as set out above at paragraph 2.

7. The conditions on Ms. Maltby's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 6.

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

9. Should Ms. Maltby be unable to comply with any of the sanctions' deadlines identified above, Ms. Maltby may request an extension. The request for an extension must be submitted in writing to the Complaints Officer, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Officer shall, in their sole discretion, determine whether a time extension is accepted. Ms. Maltby will be notified by the Complaints Officer, in writing, if the extension has been granted

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

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

    b) Treat Ms. Maltby's non-compliance as information for a complaint under s. 56 of the Act; or

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

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

The Hearing Tribunal is aware that while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should 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 Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

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

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

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

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

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

- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

The nature and gravity of the proven allegations: These allegations were not as a result of intentional conduct, and as such, they are on the lower scale of the gravity of conduct.

The age and experience of the investigated member: Ms. Maltby was initially registered with the CLPNA on January 1, 1988. Ms. Maltby began working at the Facility in 2000. Ms. Maltby has been an LPN for a significant period and therefore she did not lack experience as an LPN.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not made aware of any prior complaints or convictions with respect to Ms. Maltby.

The number of times the offending conduct was proven to have occurred: The allegations took place over a period of one month and as such, did not appear to be a longstanding concern but more a repeated pattern of conduct over a short period of time.

The role of the investigated member in acknowledging what occurred: Ms. Maltby acknowledged and admitted to the conduct, and this is a significant factor. This shows that Ms. Maltby accepted accountability with respect to the allegations.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Maltby was suspended for two days without pay.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware 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: Specific deterrence is a need to impose a sanction to deter Ms. Maltby from repeating this type of conduct in the future. General deterrence is a concurrent need to prevent other LPNs from engaging in similar behavior by sending a message that this type of behavior will not be tolerated. Given Ms. Maltby's engagement in this process, the Hearing Tribunal believes that there will be specific deterrence in this case. The severity of the sanctions should also be a message to the profession.

The need to maintain the public's confidence in the integrity of the profession: Deterrence is an important factor in maintaining the public's confidence in the LPN profession. These sanctions are intended to demonstrate to the public that the CLPNA takes these allegations seriously, along with protecting the public and remediating the member, Ms. Maltby.

It is important to the profession of LPNs to abide by the provisions of the CLPNA Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and,

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

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

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Maltby shall pay a fine of $2,000.00 within **12 months** of service of the Decision.

3. Ms. Maltby shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance". Ms. Maltby shall provide a signed written declaration to the Complaints Officer, within **30 days** of service of the Decision, attesting she has reviewed the CLPNA's documents:

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

    b) Standards of Practice for Licensed Practical Nurses in Canada;

    c) The CLPNA Policy: Professional Responsibility and Accountability;

    d) The CLPNA Policy: Documentation;

    e) The CLPNA Practice Guideline: Infection Prevention and Control;

    f) The CLPNA Competency Profile A1: Critical Thinking;

    g) The CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

    h) The CLPNA Competency Profile B1: Assessment;

    i) The CLPNA Competency Profile D1: Communication and Collaborative Practice; and

j) The CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting.

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

4. Ms. Maltby shall complete the following remedial education, at her own cost:

   a) **LPN Ethics Course** available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

   b) **Health Assessment Self-Study Course** available online at https://studywithclpna.com/healthassessment/

   c) **Nursing Documentation 101 Self-Study Course** available online at https://studywithclpna.com/nursingdocumentation101/

   d) **15.3 Infections Transmission Precautions Quiz** available online at https://learningnurse.com/quizzes/ipc-transmission/

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   Ms. Maltby shall provide the Complaints Officer with certificates confirming successful completion of each of the above education within **six (6) months** from service of the Decision.

   If any of the required education becomes unavailable, Ms. Maltby shall make a written request to the Complaints Officer to be assigned alternative education. Upon receiving Ms. Maltby's written request, the Complaints Officer, in his sole discretion, may assign alternative education in which case Ms. Maltby will be notified in writing of the new education requirements.

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

    b) Treat Ms. Maltby's non-compliance as information for a complaint under s. 56 of the Act; or

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

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

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

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 16th DAY OF DECEMBER 2022 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal