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 BUKOLA ABIONA

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 BUKOLA ABIONA, LPN #38059, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via videoconference on June 13, 2022, with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Nicole Searle, LPN
Naz Mellick, Public Member
Doug Dawson, Public Member

Heidi Besuijen, Independent Legal Counsel for the Hearing Tribunal

Staff:
Caitlyn Field, Legal Counsel for the Complaints Officer, CLPNA
Susan Blatz, Complaints Officer, CLPNA

Investigated Member:
Bukola Abiona, LPN ("Ms. Abiona" or "Investigated Member")
Lucy Mewanu-Mensah, Legal Counsel 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. Abiona was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Abiona was initially licensed as an LPN in Alberta on March 25, 2014.

By letter dated February 9, 2022, the CLPNA received a complaint from Ms. Kristina Beyaert, Administrator, Southwood Care Centre and Hospice in Calgary, Alberta (the "Facility") pursuant to s. 57 of the Act. The Complaint stated Ms. Bukola Abiona, LPN, was suspended for 10 days following an instance of incompetent client care.

By way of letter dated February 11, 2022, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Ms. Abiona with notice of the Complaint. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Abiona that she had appointed Judith Palyga, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

The Complaints Director delegated her authority and powers under Part 4 of the Act regarding the Complaint to Susan Blatz, Complaints Officer for the CLPNA ("Complaints Officer"), pursuant to s. 20 of the Act.

On February 11, 2022, the Complaints Officer requested that Carrie Waggott, Executive Director of the CLPNA, impose an interim suspension of Ms. Abiona'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. Abiona. Ms. Abiona was provided an opportunity to reply to the Complaints Officer's request, and provided a written statement to Ms. Waggott in response.

By letter dated March 4, 2022, Ms. Waggott granted the request for an interim suspension effective the date of the letter.

On February 28, 2022, the Investigator concluded the investigation into the Complaint.

The Complaints Officer determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Abiona received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated April 6, 2022.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Abiona under cover of letter dated May 4, 2022.

(4) Allegations

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

"It is alleged that Bukola Abiona, LPN, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about December 30, 2021, failed to provide compassionate care to client HM by using her foot to move HM after a fall at approximately 1119 hours.

2. On or about December 30, 2021, acted in an unprofessional manner while interacting with client HM's wife, PK, particulars of which include one or more of the following:

    a) Yelled at PK;

    b) Aggressively grabbed PK's phone from her hands.

3. On or about December 30, 2021, failed to respond in an appropriate and/or safe manner after witnessing HM slide out of his wheelchair and fall, particulars of which include one or more of the following:

    a) Failed to reposition and/or attempt to reposition client HM when HM was sliding down in his wheelchair;

    b) Failed to communicate with client HM in a timely manner after his fall;

    c) Failed to provide assistance to client HM in a timely manner after his fall;

    d) Failed to assess client HM after the fall;

    e) Failed to complete neuro-vital signs and/or vital signs assessment of client HM;

    f) Left client HM alone and unattended on the floor;

    g) Ignored HM's complaints of pain when removing the sling from around client HM's legs;

    h) Failed to accurately and completely document in the Progress Notes client HM's fall that occurred at approximately 1920 hours;

    i) Failed to complete a Post Fall Review form as per policy;

    j) Failed to document on the Fall Log as per policy;

    k) Failed to contact client HM's family after the fall as per policy.

4. On or about December 30, 2021, acted in an unprofessional manner while providing care to client HM after witnessing HM slide out of his wheelchair and fall, particulars of which include one or more of the following:

    a) Moved a blanket under HM's head with her foot;

    b) Roughly pushed and pulled client HM while he was on the floor;

    c) Aggressively pulled client HM forward by his arms;

    d) Aggressively pulled client HM forward by his head and/or neck;

    e) Used force to push client HM in his wheelchair while HM's feet were on the floor;

    f) Spoke in a raised voice criticizing client HM's wife while providing care to client HM;

g) Failed to communicate to HM in a respectful and/or therapeutic manner by saying “I am smarter than you”, or words to that effect;

h) Failed to communicate to HM in a respectful and/or therapeutic manner by saying “Yes, you are going to bed. Enough is enough. We cannot be lifting you all the time”, or words to that effect;

i) Failed to treat client HM with respect and dignity;

j) Failed to provide safe and competent care.

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

1. Standards of Practice for Licensed Practical Nurses in Canada, Standard 1: Professional Accountability and Responsibility, Indicators 1.4, 1.6, 1.9, and 1.10;

2. Standards of Practice for Licensed Practical Nurses in Canada, Standard 2: Knowledge-Base Practice, Indicators 2.2, and 2.11;

3. Standards of Practice for Licensed Practical Nurses in Canada, Standard 3: Service to the Public and Self Regulation, Indicators 3.3, 3.4, and 3.6;

4. Standards of Practice for Licensed Practical Nurses in Canada, Standard 4: Ethical Practice, Indicators 4.1, 4.4, 4.5, 4.7, 4.9 and 4.10;

5. Code of Ethics for Licensed Practical Nurses in Canada, Principal 1: Responsibility to the Public, Ethical Responsibility, Indicators 1.1, 1.2, and 1.5;

6. Code of Ethics for Licensed Practical Nurses in Canada, Principal 2: Responsibility to Clients, Indicators 2.2, 2.4, 2.6, 2.8, 2.9;

7. Code of Ethics for Licensed Practical Nurses in Canada, Principal 3: Responsibility to the Profession, Indicators 3.1, 3.3, and 3.4;

8. Code of Ethics for Licensed Practical Nurses in Canada, Principal 5: Responsibility to Self, Indicators 5.1, 5.2, 5.3, 5.5, and 5.8;

9. CLPNA Policy: Client & Co-Worker abuse;

10. CLPNA Policy: Professional Responsibility and Accountability.”

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	Surveillance Footage from the Facility
Exhibit #4:	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 as well as the Surveillance Footage entered as Exhibit #3 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Abiona'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. Abiona.

Allegation 1

Ms. Abiona admitted that on or about December 30, 2021, she failed to provide compassionate care to client HM by using her foot to move HM after a fall at approximately 1119 hours.

On December 30, 2021, Ms. Abiona worked at the Facility and provided care to client HM.

Client HM had moderate to advanced dementia and although he could walk and was able to respond to verbal cues by staff, he often slipped out of his wheelchair and fell to the ground.

At approximately 1117 hours, HM began to slip from his wheelchair while sitting in the Facility's dining room. Ms. Abiona was present and assisted in lowering HM to the floor along with her colleague Joy Tamse, HCA. Ms. Tamse then left the Dining Room to obtain the mechanical lift to lift client HM from the floor.

While client HM was lying on the floor waiting to be lifted, Ms. Abiona used her foot to rotate HM rather than asking HM to reposition his body or assisting him to reposition in an appropriate manner.

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

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

Ms. Abiona displayed a lack of knowledge of or lack of skill or judgement by using her foot to move HM once he was on the floor. There was no need for Ms. Abiona to do this as she could have gotten down closer to HM and used her hands to help position HM for the sling to be placed under him.

This type of behavior is not what is expected of an LPN in this circumstance. It would be expected that an LPN or any health care professional would not place their foot on a patient. In addition to lacking knowledge, skill or judgment, this conduct diminishes the LPN profession by demonstrating behaviour which showed a lack of regard for the dignity of this client.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics" and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice") adopted by the CLPNA on June 3, 2013, which state as follows:

CLPNA Code of Ethics:

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

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

1.2 Provide only those functions for which they are qualified by education or experience.

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

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

2.2 Advocate for the client to receive fair and equitable access to needed and reasonably available health services and resources.

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

2.6 Provide care to each client recognizing their individuality and right to choice.

2.8 Use evidence and judgement to guide nursing decisions.

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 states 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.

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.

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

5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills, and judgement.

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

5.5 Inform the appropriate authority in the event of becoming unable to practice safely, competently and/or ethically.

5.8 Maintain the required mental and physical wellness to meet the responsibilities of their role.

CLPNA Standards of Practice:

Ms. Abiona 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 states that LPNs:

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.

1.9 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 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically states that LPNs:

2.2 Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision-making and LPN practice.

2.11 Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

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 states 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.

3.6 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 states that LPNs:

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

4.4 Develop ethical decision-making capacity and take responsible action toward resolution.

4.5 Advocate for the protection and promotion of clients' right to autonomy, respect, privacy, confidentiality, dignity, and access to information.

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

4.9 Support and contribute to healthy and positive practice environments.

4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

The Hearing Tribunal finds that Ms. Abiona did not act in a way another LPN would act in the same situation in accordance with the integrity LPNs are required to have in their practice. Ms. Abiona did nothing to stop HM when he was sliding out of his wheelchair and moving towards the floor. In doing this she failed to ensure his safety, minimize harm and apply her training and knowledge.

There were a couple of things that Ms. Abiona could have done to prevent HM from going on to the floor. Once it was noticed that HM was sliding Ms. Abiona could have got HM's attention and asked him to reposition himself in the wheelchair so that he wouldn't fall. Ms. Abiona also could

have asked Ms. Tamse, who assisted Ms. Abiona in lowering HM to the floor, to also help reposition HM in the wheelchair back to a sitting position once he did start sliding. HM did have an anti-slip mat for his wheelchair and another option that could have been used was to have a seat belt in the wheelchair to help prevent the slipping as well.

When HM was on the floor, Ms. Abiona used her foot to move the blanket that was next to HM's head and moved it under his head. This is not what is expected of an LPN. Ms. Abiona should have bent down next to HM and then supported his neck with one hand and then placed the blanket under his head and neck using her other hand. There was no reason as to why this could not be done as Ms. Tamse was also kneeling next to HM at this time.

This conduct is not in accordance with the obligation to protect and promote a client's dignity and contravenes the spirit and intention of both the Code of Ethics and Standards of Practice. A client, their family, and the public have a right to expect that the client would not be maneuvered in such a manner which is uncaring and suggestive of a disregard for HM.

Allegation 2

Ms. Abiona admitted that on or about December 30, 2021, she acted in an unprofessional manner while interacting with client HM's wife, PK, particulars of which include one or more of the following:

a) Yelled at PK;

b) Aggressively grabbed PK's phone from her hands.

On December 30, 2021, while client HM was waiting to be lifted, his wife, PK, entered the dining room. PK was a visitor to the Facility and often came to visit her husband.

At approximately 1120 hours, PK began to speak to Ms. Abiona about HM. PK asked why HM was still on the floor and whether she could help to lift him up. Ms. Abiona explained that they were required to use the mechanical lift to move HM back to his wheelchair.

PK attempted to assist client HM from the floor by herself. Ms. Abiona reminded PK that they were not permitted to manually lift HM from the floor. Ms. Tamse arrived with the mechanical lift and worked with Ms. Abiona and another colleague, Sally Tulliong, TRA, to place the lifts sling underneath client HM.

While HM was being maneuvered into the lift, PK took out her cellphone and began to record the three care providers, including Ms. Abiona.

Ms. Tamse noticed that PK was recording HM and gestured to Ms. Abiona indicating that they were being filmed. Ms. Abiona informed PK that she was not allowed to take pictures within the Facility. PK was resistant to putting her phone away and insisted that Ms. Abiona contact her manager to make her stop filming.

PK continued to use her cellphone and Ms. Abiona loudly yelled for PK to not take a picture of her while she grabbed PK's cellphone out of her hands. Ms. Abiona continued to yell at PK, yelling "what is the meaning of this" that PK should "call the police" to get her phone back. PK grabbed her phone back from Ms. Abiona, who continued to loudly argue with PK.

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

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

Ms. Abiona displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services in that she began to yell at PK who was the spouse of HM while PK was a visitor in the Facility. This is not an acceptable behavior of an LPN to be yelling at anyone in the Facility whether they are a family member or a patient. Ms. Abiona also displayed a lack of judgement when she aggressively grabbed PK's phone from her hands. It is never acceptable to take someone else property especially without permission.

Ms. Abiona failed to act in a manner which is expected that another LPN would do in a similar situation. This conduct harms the integrity of the profession as it is so discordant with the expectations of a skilled healthcare provider.

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

CLPNA Code of Ethics and CLPNA Standards of Practice are referenced in Allegation 1 above and the Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1 above.

Ms. Abiona yelled at PK which is not an acceptable behavior for an LPN. Even though PK was recording Ms. Abiona and Ms. Abiona knew that it was a policy for there not to be any type of recording Ms. Abiona should never of acted this way towards PK. Ms. Abiona should have spoken in a calm, non-raised voice to PK as this might have changed the outcome of the situation. Ms. Abiona also grabbed PK's phone when PK continued to record what was happening. Ms. Abiona should have, at that point in time, walked away from the situation and called a manger to come and deal with the fact that PK was recording. By Ms. Abiona grabbing PK's phone she could have exposed herself to a different type of liability and outcome.

In addition to the reasons previously given, this conduct does not show an understanding of the privilege of self-regulation and the obligation to practice in a manner consistent with it.

Allegation 3

Ms. Abiona admitted that on or about December 30, 2021, she failed to respond in an appropriate and/or safe manner after witnessing HM slide out of his wheelchair and fall, particulars of which include one or more of the following:

a) Failed to reposition and/or attempt to reposition client HM when HM was sliding down in his wheelchair;

b) Failed to communicate with client HM in a timely manner after his fall;

c) Failed to provide assistance to client HM in a timely manner after his fall;

d) Failed to assess client HM after the fall;

e) Failed to complete neuro-vital signs and/or vital signs assessment of client HM;

f) Left client HM alone and unattended on the floor;

g) Ignored HM's complaints of pain when removing the sling from around client HM's legs;

h) Failed to accurately and completely document in the Progress Notes client HM's fall that occurred at approximately 1920 hours;

i) Failed to complete a Post Fall Review form as per policy;

j) Failed to document on the Fall Log as per policy;

k) Failed to contact client HM's family after the fall as per policy.

On December 30, 2021, at approximately 1900 hours, client HM began to slide out of his wheelchair while in the Facility's dining room. Ms. Abiona was present in the dining room and observed HM sliding out of his chair. Ms. Abiona did not ask HM to reposition himself or made no attempt to reposition client HM when he was sliding.

At approximately 1910 hours, client HM slid out of his wheelchair and fell onto the floor. Ms. Abiona did not communicate with client HM after his fall and did not provide him assistance. After HM's fall, Ms. Abiona did not perform an assessment of HM and did not complete neurological vital signs or a vital signs assessment.

Ms. Abiona left the dining room while client HM was on the floor with no other care providers present to obtain the mechanical lift. After some time, Ms. Abiona returned to the dining room and contacted a colleague to assist her with the mechanical lift.

At approximately 1914 hours, Maricar Castillo, HCA, came into the dining room to assist Ms. Abiona in lifting HM off the floor. While Ms. Abiona placed HM in the mechanical lifts sling, HM repeatedly stated "ow" and expressed that he was in pain. Ms. Abiona ignored client HM and made no acknowledgement of his pain.

Ms. Abiona documented client HM's fall in his Progress Notes. However, this documentation does not accurately or completely document the nature of clients HM's fall, or the care provided. Ms. Abiona documented that she completed an assessment of client HM for ankle and leg pain and noted that pain was present in the right calf. However, Ms. Abiona did not complete an assessment of HM after his fall.

The Facility's Resident Care Manual established a policy for Mobility – Falls. This policy required that each fall must be recorded in the fall log to streamline data collection and facilitate quality. The recording nurse must include, among other information, the circumstances of the fall and any injury outcomes.

The Mobility – Falls Policy also establishes that nurses must document the date and time of the fall, as well as other relevant information such as an environmental scan, the resident's clothing/footwear at the time, what the resident was trying to do, the results of their physical assessment of the resident, the resident's vital and neurological vital signs. Nurses must subsequently continue to monitor neuro vital signs every four hours for 24 hours.

The Policy requires nurses to notify the treating physician about the fall, regardless of whether the client was injured or not, and the client's family and/or substitute decision maker.

Ms. Abiona did not complete a Post Fall Review after HM's fall, did not document the fall on the Fall Log, and did not contact client HM's family as required by the Policy.

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

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

Ms. Abiona displayed a lack of knowledge of or lack of skill or judgement by not assisting HM when he was sliding out of his wheelchair. Ms. Abiona did not do a proper assessment once HM was on the floor, she did not follow proper policy and procedure nor did Ms. Abiona document the fall in a proper manner. These are basic skills all LPNs must apply in their daily practice; failing to apply them diminishes the profession as a whole.

Ms. Abiona did not act in a manner which is expected of an LPN in a similar circumstance. LPNs are expected to adhere to policies and procedures that are set out by their employer.

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

CLPNA Code of Ethics and CLPNA Standards of Practice are referenced in Allegation 1 above and the Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1 above.

Ms. Abiona did not respond appropriately to HM sliding on the floor. It is expected that when a patient is sliding out of their wheelchair that an LPN would try to prevent the patient from falling. It would be expected of an LPN that they would reposition the patient in their wheelchair and then apply proper restraints such as a seat belt.

It is also expected that when an LPN has a patient who falls that they would do all the proper documentation as well as not leaving the patient alone on the floor and that the proper people would be notified of the fall such as other health care professionals and the patient's family. This is a key point since a failure to document can put the client at risk and deprives subsequent caregivers of the full information they need to make informed clinical decisions. This introduces risk to the client and could well have caused him harm.

Allegation 4

Ms. Abiona admitted that on or about December 30, 2021, she acted in an unprofessional manner while providing care to client HM after witnessing HM slide out of his wheelchair and fall, particulars of which include one or more of the following:

a) Moved a blanket under HM's head with her foot;

b) Roughly pushed and pulled client HM while he was on the floor;

c) Aggressively pulled client HM forward by his arms;

d) Aggressively pulled client HM forward by his head and/or neck;

e) Used force to push client HM in his wheelchair while HM's feet were on the floor;

f) Spoke in a raised voice criticizing client HM's wife while providing care to client HM;

g) Failed to communicate to HM in a respectful and/or therapeutic manner by saying "I am smarter than you", or words to that effect;

h) Failed to communicate to HM in a respectful and/or therapeutic manner by saying "Yes, you are going to bed. Enough is enough. We cannot be lifting you all the time", or words to that effect;

i) Failed to treat client HM with respect and dignity;

j) Failed to provide safe and competent care.

The Facility's Corporate Administration Manual on Protection for Persons in Care Policy requires all care providers to protect residents from abuse during the provision of care and services to them, maintain a reasonable level of safety for residents, and to take all reasonable steps to provide for the immediate safety, security, and well-being.

The Facility's Corporate Administration Manual - Philosophy of Care and Service Policy emphasizes enhancing well-being and quality of life for residents, considering each resident is a unique individual. The Philosophy of Care and Service Policy requires treating residents with kindness, compassion, courtesy, respect, dignity, and privacy at all times.

On December 30, 2021, while client HM was lying on the floor Ms. Abiona used her foot to move a blanket under HM's head.

While transferring client HM into the mechanical lifts sling, Ms. Abiona roughly pushed and pulled client HM into the sling. Once HM was in the sling, Ms. Abiona loudly spoke to her colleague Ms. Castillo about HM's wife. Ms. Abiona recounted the events from that morning, saying loudly that HM's wife had tried to lift him from the floor, that she brought out her phone and took a video of Ms. Abiona, and her verbal confrontation with HM's wife.

Ms. Abiona and Ms. Castillo positioned client HM in his wheelchair with the mechanical sling, and while removing the sling from underneath HM, Ms. Abiona aggressively pulled HM forward by his arms, head, and neck. Client HM repeatedly said "it hurts" while he was being pulled in his wheelchair.

Ms. Abiona asked HM whether he was ready to go to bed, and when he replied that he was not ready she told him, "Yes, you are going to bed. Enough is enough. We cannot be lifting you all the time." Client HM tried to resist being taken to his room by placing his feet on the floor. Ms. Abiona told him to lift his feet, and when he did not, she used force to put client HM in his wheelchair.

Ms. Abiona ultimately turned client HM's wheelchair around so he could not resist her pushing. After she turned his chair around, Ms. Abiona told HM that she was smarter than him.

Ms. Abiona failed to treat HM with respect or dignity and did not provide safe or competent care.

Following the fall, HM was restless due to right leg pain. After having reduced pulse, HM was transferred to the Rockyview General Hospital emergency room. After being found to not be a surgical candidate to address a blood clot in his leg, he was admitted for pain control and palliative care. HM passed away on January 17, 2021.

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

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

Ms. Abiona displayed a lack of knowledge of or lack of skill or judgement by using her foot to place a blanket under HM's head which it would be expected that the LPN or Health Care

Professional would bend down and provide support to the patient once they are on the floor. It is also expected that an LPN is not rough with a patient in any way and Ms. Abiona was rough by pushing and pulling HM. Ms. Abiona also was aggressive with HM by pulling him forward by his head and neck and then, when HM was in his wheelchair, Ms. Abiona was aggressive while moving HM in his wheelchair. It is never acceptable for an LPN to be aggressive with a patient. Ms. Abiona then proceeded to talk about the encounter that she had with HM's wife PK earlier in the day in front of HM as well as a co-worker. This is also not acceptable behavior of an LPN.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics" and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice") as set out above. The reasons for these breaches are also substantially the same as those already discussed. The overarching theme is that the conduct which is the subject of this matter did not preserve, protect and promote HM's dignity and was therefore patently unprofessional.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Abiona jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #4. 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. Bukola Abiona shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months subject to the following:

    a) Bukola Abiona will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter").

3. Bukola Abiona's practice permit will remain suspended until she has complied with the following:

    a) Bukola Abiona 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" and will be provided to Bukola Abiona. Bukola Abiona shall provide a signed written declaration to the Complaints Director, attesting she has reviewed the CLPNA's documents:

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

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

ii. CLPNA Policy: Client & Co-Worker Abuse;

iii. CLPNA Policy: Professional Responsibility & Accountability;

iv. CLPNA Policy: Documentation;

v. CLPNA Competency Profile A1: Critical Thinking;

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

vii. CLPNA Competency Profile B: Nursing Process;

viii. CLPNA Competency Profile C: Professionalism and Leadership;

ix. CLPNA Competency Profile D: Communication and Technology;

x. CLPNA Competency Profile F3: Patient Safety;

xi. CLPNA Competency Profile P: Gerontology.

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

b) Bukola Abiona shall complete the following remedial education, at her own cost. Bukola Abiona shall provide the Complaints Director with certificates confirming successful completion of the following remedial education.

i. Health Assessment Self-Study course available online at www.clpna.com:

ii. Document It Right: would your charting stand up to scrutiny? Available online at www.nurse.com;

iii. Professionalism in Nursing available online at www.jcollinsconsulting.com;

iv. Healthcare Ethics and the Workplace available online at www.pedagogeducation.com;

v. Elderly Care and Caring for the Disabled available online at www.alison.com.

4. Should any of the above course(s) become unavailable, Bukola Abiona shall request, in writing, to the Complaints Director to be assigned alternative education. Upon receiving Bukola Abiona's written request, the Complaints Director, in her sole discretion, may assign

alternative education in which case Bukola Abiona will be notified in writing of the new education requirements.

5. The orders set out above at paragraphs 2-3 will appear as conditions on Bukola Abiona's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings outlined at paragraphs 2-3 will appear as "CLPNA Monitoring Orders (Conduct)", on Bukola Abiona's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. Health Assessment Self-Study Course;

        iii. Document It Right: would your charting stand up to scrutiny?;

        iv. Professionalism in Nursing;

        v. Healthcare Ethics and the Workplace;

        vi. Elderly Care and Caring for the Disabled.

    b) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Bukola Abiona's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

6. The conditions on Bukola Abiona's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 5.

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

8. Should Bukola Abiona be unable to comply with any of the deadlines for completion of the penalty orders identified above, Bukola Abiona may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Director shall, in her sole discretion, determine whether a time extension is accepted. Bukola Abiona will be notified by the Complaints Director, in writing, if the extension has been granted.

9. Should Bukola Abiona 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 Director 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 Bukola Abiona'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 Bukola Abiona's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

10. The parties agree that the Joint Submission on Penalty may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

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

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should 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. Abiona 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. Abiona 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:** The allegations relate to basic core competencies of an LPN, dealing with assessment, documentation, and client care. The treatment HM experienced was difficult to observe and was not trivial. This was an aggravating factor.

- **The age and experience of the investigated member:** Ms. Abiona had approximately seven years' experience at the time of the allegations.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** To the Hearing Tribunals' knowledge there are no prior complaints or convictions with respect to Ms. Abiona.

- **The age and mental condition of the victim:** HM had moderate to advanced dementia and was able to walk and was able to respond to verbal cues by the staff.

- **The number of times the offending conduct was proven to have occurred:** These allegations took place on the same day and during the same shift even though there are two separate events leading up to the allegations. This was not an instance of chronic behavior.

- **The role of the investigated member in acknowledging what occurred:** Ms. Abiona acknowledged and admitted the conduct, and this is a significant factor. This showed that she 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. Abiona was suspended from her employment for a period of ten days in February 2022 and then on March 4, 2022, there was an interim suspension of her license which remains in effect until Ms. Abiona has complied with the terms of the Joint Submission on Sanction which are outlined below.

- **The impact of the incident(s) on the victim:** There is no evidence of a particular impact with respect to HM. There were instances when HM did express that he was in pain, and he was present when Ms. Abiona spoke negatively about his spouse, PK. This is an aggravating factor but not to an extreme degree.

- **The presence or absence of any mitigating circumstances:** Ms. Abiona acknowledged that she was very fatigued on this day and there were extenuating circumstances of PK potentially breaching other policies within the Facility. However, ultimately it is an LPN's obligation to ensure they are mentally and physically well to meet their responsibilities and the breach of a policy by a family member does not warrant an unprofessional response. This is a neutral factor.

- **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. Abiona from repeating this type of conduct in the future. General deterrence is a concurrent need so as to prevent other LPNs from engaging in similar behavior by sending a message that this type of behavior will not be tolerated.

- **The need to maintain the public's confidence in the integrity of the profession:** Deterrence is a really important factor in maintaining the public's confidence in the profession.

- **The range of sentence in other similar cases:** There are three CLPNA cases from within the past couple of years, Fitzner from 2019, Wolkowycki from 2020, and Taylor from 2020. These were similar in the allegations as well as the Joint Submission on Sanctions.

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

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

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

(11) Orders of the Hearing Tribunal

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

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

2. Bukola Abiona shall pay 25% of the costs of the investigation and hearing to be paid over a period of 24 months subject to the following:

    a) Bukola Abiona will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter").

3. Bukola Abiona's practice permit will remain suspended until she has complied with the following:

    a) Bukola Abiona 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" and will be provided to Bukola Abiona. Bukola Abiona shall provide a signed written declaration to the Complaints Director, attesting she has reviewed the CLPNA's documents:

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

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

        iii. CLPNA Policy: Client & Co-Worker Abuse;

        iv. CLPNA Policy: Professional Responsibility & Accountability;

        v. CLPNA Policy: Documentation;

        vi. CLPNA Competency Profile A1: Critical Thinking;

vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

viii. CLPNA Competency Profile B: Nursing Process;

ix. CLPNA Competency Profile C: Professionalism and Leadership;

x. CLPNA Competency Profile D: Communication and Technology;

xi. CLPNA Competency Profile F3: Patient Safety;

xii. CLPNA Competency Profile P: Gerontology.

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

b) Bukola Abiona shall complete the following remedial education, at her own cost. Bukola Abiona shall provide the Complaints Director with certificates confirming successful completion of the following remedial education.

i. Health Assessment Self-Study course available online at www.clpna.com:

ii. Document It Right: would your charting stand up to scrutiny? available online at www.nurse.com;

iii. Professionalism in Nursing available online at www.jcollinsconsulting.com;

iv. Healthcare Ethics and the Workplace available online at www.pedagogeducation.com;

v. Elderly Care and Caring for the Disabled available online at www.alison.com.

4. Should any of the above course(s) become unavailable, Bukola Abiona shall request, in writing, to the Complaints Director to be assigned alternative education. Upon receiving Bukola Abiona's written request, the Complaints Director, in her sole discretion, may assign alternative education in which case Bukola Abiona will be notified in writing of the new education requirements.

5. The orders set out above at paragraphs 2-3 will appear as conditions on Bukola Abiona's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial education and readings outlined at paragraphs 2-3 will appear as "CLPNA Monitoring Orders (Conduct)", on Bukola

Abiona's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

i. Readings;

ii. Health Assessment Self-Study Course;

iii. Document It Right: would your charting stand up to scrutiny?;

iv. Professionalism in Nursing;

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vi. Elderly Care and Caring for the Disabled.

b) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Bukola Abiona's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

6. The conditions on Bukola Abiona's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 5.

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

8. Should Bukola Abiona be unable to comply with any of the deadlines for completion of the penalty orders identified above, Bukola Abiona may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Director shall, in her sole discretion, determine whether a time extension is accepted. Bukola Abiona will be notified by the Complaints Director, in writing, if the extension has been granted.

9. Should Bukola Abiona 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 Director 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 Bukola Abiona'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 Bukola Abiona's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

10. The parties agree that the Joint Submission on Penalty may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

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 7th DAY OF JULY 2022 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal