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 CONNIE TOEWS

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 CONNIE TOEWS, LPN #28585, 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 using Zoom on October 21, 2020, with the following individuals present:

Hearing Tribunal:
Patricia Standage, Licensed Practical Nurse ("LPN") Chairperson
Jan Schaller, LPN
Sheri Epp, Public Member

Staff:
Gregory Sim, Legal Counsel for the Complaints Director, CLPNA
Caitlyn Field, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Connie Toews, LPN ("Ms. Toews or "Investigated Member")

(2) Preliminary Matters

The hearing was open to the public.

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

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

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

(3) Background

Ms. Toews was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Toews was initially licensed as an LPN in Alberta on March 24, 2006.

By letter dated March 6, 2019, the CLPNA received a complaint (the "Complaint") from Ms. Kike Kola-Ojo Loowell, Director of Care, AgeCare in Valleyview, Alberta ("AgeCare"), pursuant to s. 57 of the *Health Professions Act* (the "Act"). Ms. Kola-Ojo Loowell stated that Ms. Connie Toews, LPN, was terminated following a workplace investigation into allegations that Ms. Toews had performance issues and a lack of clinical knowledge/judgment. On March 5, 2019, Ms. Toews received a letter of termination from Ms. Kolo-Ojo Loowell.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Katie Emter, Investigator for the CLPNA (the "Investigator") to conduct an investigation into the Complaint.

By way of letter dated March 8, 2019, the Complaints Director provided Ms. Toews with notice of the Complaint.

On August 28, 2020, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Director 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. Toews received notice that the matters were referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report.

(4) Allegations

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

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

1. On or about February 21, 2019, failed to identify one or more of the following:
    a. The correct process for determining whether a client is able to competently self-administer medications.
    b. The eight rights of medication administration.
2. On or about February 21, 2019, failed to safely store two (2) insulin pens by leaving the medication administration cart unsupervised with two (2) insulin pens on top of the cart.

3. Failed to assess and/or failed to document an assessment of client "WM" following an unobserved fall.

4. On or about February 21, 2018 to February 28, 2019, failed to identify one or more of the following:
    a. The definition of a reportable incident and the proper procedure should one occur.
    b. The proper cleaning protocol for medical equipment.
    c. The proper protocol for reporting broken equipment.
    d. The proper reporting protocol to AHS Case Management.

5. On or about June 12, 2018, failed to use appropriate strategies to facilitate collaboration with a co-worker by failing to respond to the requests of co-worker CP for assistance with medication administration."

(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. Toews 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 Director 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: 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. Toews' 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.Toews.

Allegation 1

Ms. Toews admitted on or about February 21, 2019, she failed to identify one or more of the following:

a. The correct process for determining whether a client is able to competently self-administer medications.

b. The eight rights of medication administration.

When Ms. Toews began her employment at AgeCare, she underwent orientation training. As part of this training, AgeCare provides LPNs with a General Orientation Checklist that outlines training requirements and topics covered. This checklist includes training on resident rights and confidentiality, including AgeCare resident rights. A copy of the General Orientation Checklist was attached at TAB 7 of Exhibit #2.

In addition to monthly education, AgeCare posted a Professional Practice notice on eight patient rights, checks to be completed every time a medication is administered, and pre-pouring medications. The eight rights included the right: resident, medication, dose, time, route, right to refuse, documentation, and reason. This notice was posted for all staff to see. A copy of the Professional Practice notice was attached at TAB 8 of Exhibit #2.

On February 12, 2019, Ms. Rogers interviewed Ms. Toews as part of the AHS clinical audit. When interviewed, Ms. Toews failed to identify the process for assessing whether a client is able to competently self-administer medication and was unable to name the eight rights of medication administration.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Toews' 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 or of lack of skill or judgment in the provision of professional services; and

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

iii. conduct that harms the integrity of the regulated profession.

Ms. Toews displayed a lack of knowledge, skill, and judgment when she was unable to name the eight rights of medication administration and when she failed to assess as to whether client WM could safely self administer medication.

Further, Ms. Toews' conduct harmed the integrity of the profession by refusing to assist co-worker CP to administer medication when asked.

Ms. Toews did not abide by the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") or the Standards of Practice for Licensed Practical Nurses ("CLPNA Standards of Practice") as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail below.

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 were sufficiently serious to constitute unprofessional conduct.

CLPNA Code of Ethics

Principle 1: Responsibility to the Public – LPNs, as self-regulating professions, 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.

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 provides that LPNs:

> 2.7: Develop trusting, therapeutic relationships, while maintaining professional boundaries.

Principle 3: Responsibility for 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.

Ms. Toews' conduct, in failing to determine the correct process for whether a client is able to competently self-administer medications, is a failure to use judgment to guide nursing decisions as required by the Code.

Standards of Practice

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:

> 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.
>
> 3.6 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.

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

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

Allegation 2

Ms. Toews admitted on or about February 21, 2019, she failed to safely store two (2) insulin pens by leaving the medication administration cart unsupervised with two (2) insulin pens on top of the cart.

On February 21, 2019, Ms. Toews was responsible for completing the 1200 hours medication pass on the Long Term Care ("LTC") unit.

Ms. Rogers was completing the AHS audit of AgeCare and noticed that there was an unattended medication cart on the LTC unit. Ms. Rogers noticed two insulin pens were left unsupervised on the top of the cart.

Ms. Rogers instructed Ms. Toews that the insulin pens would have to be properly stored in order to ensure resident safety while Ms. Toews was away from the medication cart. In spite of this instruction, Ms. Toews failed to safely store the insulin pens.

Prior to February 21, 2019, AgeCare posted a Professional Practice notice which addressed advance preparation of medications. This notice indicated that any process of preparing medication in advance and then storing it until administering to the patient is unacceptable as it represents a safety risk for clients. This notice was posted for all staff to see. A copy of the Professional Practice notice was included at TAB 8 of Exhibit #2.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Toews' own 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
iii. Conduct that harms the integrity of the regulated profession.

Ms. Toews displayed a lack of knowledge, skill, and judgment when she failed to safely secure two insulin pens.

Further, Ms. Toews harmed the integrity of the profession when she did not adhere to a posted professional practice notice which addressed the advanced preparation of medication .

Ms. Toews did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledge by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 3

Ms. Toews admitted she failed to assess and/or failed to document an assessment of client "WM" following an unobserved fall.

In the course of completing the AHS audit, Ms. Rogers reviewed progress notes and medical charts of clients at AgeCare. While performing this review, Ms. Rogers noticed an unwitnessed fall had occurred and an HCA notified Ms. Toews. Ms. Toews documented that client WM felt "woozy", was placed in a chair and given water.

However, Ms. Toews failed to assess or failed to document the assessment of client WM's neurological vitals. Ms. Toews further failed to document any ongoing monitoring of client WM's neurological status.

In the course of Ms. Emter's investigation, Ms. Toews confirmed that client WM suffered a fall on the Retirement Living Unit and that she responded to find client WM on the floor complaining of pain in her left hip. Ms. Toews indicated that she called EMS as she believed client WM may have fractured her hip. Ms. Toews said that she did an assessment but failed to document it and did not create an incident report.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Toews admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct of 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
iii. Conduct that harms the integrity of the regulated profession.

Ms. Toews displayed a lack of knowledge, skill, and judgment when she failed to assess and document a fall by client WM.

Further, Ms. Toews' conduct harmed the integrity of the profession by failing to document client WM's fall, and not creating an incident report.

Ms. Toews did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 4

Ms. Toews admitted on or about February 21, 2018 to February 28, 2019, she failed to identify one or more of the following:

a. The definition of a reportable incident and the proper procedure should one occur.
b. The proper cleaning protocol for medical equipment.
c. The proper protocol for reporting broken equipment.
d. The proper reporting protocol to AHS Case Management.

In the course of completing the AHS audit, Ms. Rogers interviewed Ms. Toews. During this interview Ms. Rogers asked Ms. Toews to provide an answer to:

a. What a reportable incident was, and what to do should one occur;
b. The proper protocol for cleaning medical equipment;
c. The proper protocol for reporting broken equipment;
d. When to report to the AHS case manager.

Prior to February 21, 2019, AgeCare posted a notice on Incident Reporting and Documentation in the staff room which detailed the expectation for AgeCare staff to process a clinically adverse event, close call, or a resident safety concern. This process outlined that such events be documented and reported in the appropriate form, and that the immediate needs of the client be met. A copy of the Incident Reporting and Documentation noticed was attached at TAB 9 of Exhibit #2.

Further to the notice, AgeCare had a policy titled "Reporting and Management of Clinical Adverse Events, Close Calls, and Resident Safety Concerns Procedure." This policy outlines the definition

of a reportable incident and the proper procedure should one occur. A copy of this procedure was attached at TAB 10 of Exhibit #2.

AgeCare also has a policy titled “Medical Devices and Equipment” that outlines, along with the policy “Preventative Maintenance Program”, the required cleaning protocol for medical equipment, and the protocol for reporting broken equipment.

A copy of the “Medical Devices and Equipment” policy was attached at TAB 11 of Exhibit #2. A copy of the “Preventative Maintenance Program” policy was attached at TAB 12 of Exhibit #2.

In spite of the above, on February 12, 2018 Ms. Toews was unable to provide the correct answer to the definition of a reportable incident and the appropriate procedure should one occur, the proper cleaning protocol for medical equipment, the proper protocol for reporting broken equipment, or the proper reporting protocol to AHS Case Management. Ms. Toews was expected to know the appropriate response to these questions as they formed a part of her LPN duties at AgeCare as established by the above policies.

Subsequent to the AHS audit of February 21, 2018, Ms. Kola-Ojo Loowell completed an internal interview of Ms. Toews on February 29, 2019.

In the course of this interview, Ms. Toews was still unable to provide the correct policy based responses, and Ms. Kola-Ojo Loowell found that Ms. Toews did not know the definition of reportable incidents and the required procedures following a reportable incident, facility policies on cleaning equipment, dealing with broken equipment, and reporting to AHS case management.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Toews admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct of 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 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
iii. Conduct that harms the integrity of the regulated profession.

Ms. Toews displayed a lack of knowledge or lack of skill or judgment by failing to know several protocols needed to safely perform her duties as an LPN.

Further, Ms. Toews engaged in conduct that harmed the integrity of the profession by failing to know several protocols required as an LPN.

Ms. Toews did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledge by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

Allegation 5

Ms. Toews admitted on or about June 12, 2018, she failed to use appropriate strategies to facilitate collaboration with a co-worker by failing to respond to the requests of co-worker CP for assistance with medication administration.

On June 12, 2018, CP, a Registered Nurse ("RN"), worked with Ms. Toews.

At approximately 1030 hours, CP asked Ms. Toews to assist her in administering the 1230 hours medication pass to clients. CP was required to attend an occupational health and safety meeting and required LPN support.

Ms. Toews became flustered, and did not acknowledge CP's request, and ignored CP when she asked a second time for Ms. Toews to complete the 1230 hours medication pass. CP reported Ms. Toews' insubordination to Ms. Kim Swanson, the General Manager of AgeCare at the time.

Ms. Swanson, along with Dr. Peggy Riches, met with Ms. Toews on the morning of June 12, 2018. At this time Ms. Toews admitted that she had ignored CP's request.

After speaking with Ms. Swanson, Ms. Toews ultimately agreed to perform the 1230 medication pass.

AgeCare's position description for LPNs states that LPNs are expected to collaborate with AgeCare's interdisciplinary team, including with Registered Nurses, and are required to use proper channels of communication, demonstrate flexibility and reliability, and treat other team members with dignity and respect. A copy of AgeCare's description of the LPN position and its associated duties was attached at TAB 13 of the Exhibit #2.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Toews' admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 5 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
iii. Conduct that harms the integrity of the regulated profession.

Ms. Toews displayed a lack of judgment by ignoring a request from co-worker CP.

Further, Ms. Toews engaged in conduct that harmed the integrity of the profession by not collaborating with her co-worker to provide adequate care to clients.

Ms. Toews did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Toews 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. Toews shall pay 25% of the costs of the investigation and hearing to be paid over a period of 36 months from the date of service of the written decision. This was agreed by both sides during the hearing. (This is an amendment from the original Joint Submission on Penalty.) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Toews' practice permit shall be suspended until she has completed all of the following conditions:

    a) Ms. Toews shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Toews shall provide the Complaints Director with a signed declaration attesting that she has completed the required readings within **30 days** of the written Decision:

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

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

        iii. CLPNA Practice Policy: Professional Responsibility & Accountability.

        iv. CLPNA Practice Policy: Documentation.

        v. CLPNA Interpretive Document: Incapacity under the HPA.

        vi. CLPNA Competency Profile A1: Critical Thinking.

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

viii. CLPNA Competency Profile U: Medication Administration.

ix. CLPNA Competency Profile A3: Time Management.

x. CLPNA Competency Profile B: Nursing Process.

xi. CLPNA Competency Profile C3: Professional Standards of Practice.

xii. CLPNA Competency Profile C4: Professional Ethics.

xiii. CLPNA Competency Profile C5: Accountability and Responsibility.

xiv. CLPNA Competency Profile C7: Fitness to Practice.

xv. CLPNA Competency Profile U: Medication Management.

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

b) Ms. Toews shall complete the following courses at her cost and provide the Complaints Director with acceptable documentation confirming successful completion:

i. Documentation 101 - available on CLPNA's website http://www.clpna.com/ at no cost;

ii. Health Assessment Self-Study course - available on CLPNA's website http://www.clpna.com/ at no cost;

iii. Code of Ethics Learning Module – offered online at no cost by Learning Nurse at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics;

iv. Professionalism in Nursing – offered on line by John Collins Consulting at https://www.jcollinsconsulting.com/images/Outlines/lpn/MODULE_OUTLINE_-_PROFESSIONALISM_IN_NURSING.pdf

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

c) Ms. Toews shall undergo a fitness to practice and capacity assessment by her attending physician at her cost and provide the Complaints Director with an acceptable a report

validating her mental and physical fitness to provide professional nursing services in any healthcare setting, as an LPN in a safe and competent manner according to the CLPNA's Interpretive Document: Incapacity under the HPA. Any restrictions or limitations must be specified in the report.

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

    a) The order to pay costs of the investigation and hearing will appear on Ms. Toews' practice permit and the Public Registry as "Conduct Orders Cost/Fines" until paid in full.

    b) The requirements to read and reflect on CLPNA documents and to complete courses will appear on Ms. Toews' practice permit and the Public Registry as "CLPNA Monitoring Orders (Conduct)" until completed.

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

6. Should Ms. Toews be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time, with the written consent of the Complaints Director.

7. Should Ms. Toews fail or be unable to comply with any of the above orders, 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 sanctions.

    (b) Treat Ms. Toews' 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. Toews' 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.

Legal Counsel for the Complaints Director 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. Toews and the Complaints Director.

(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 Connie Toews has engaged in. In making its decision on penalty, the Hearing Tribunal considered several factors identified in *Jaswal* v *Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

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

- **The nature and gravity of the proven allegations:** The Hearing Tribunal finds that the proven allegations are of a moderate nature and gravity. While there was no known harm to the persons in care of Ms. Toews, there was certainly potential harm. The Hearing Tribunal did place some weight on this factor when making their decision.

- **The age and experience of the investigated member**: Ms. Toews has been practicing as a Licensed Practical Nurse since 2005. The Hearing Tribunal felt that a 15-year member should have the knowledge required to care for the persons in their care. The Hearing Tribunal placed a great deal of weight on this factor when making their decision.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions**: The Hearing Tribunal was provided no evidence which indicated any prior complaints or convictions of the member. Therefore, the Hearing Tribunal placed no weight on this factor when making their decision.

- **The age and mental condition of the victim, if any**: The Hearing Tribunal did not receive any specific evidence of the age or mental condition of any of the persons in Ms. Toews' care. Nor was the Hearing Tribunal made aware of any persons in Ms. Toews' care having suffered any adverse effects due to Ms. Toews' conduct. No weight was placed on this factor.

- **The role of the investigated member in acknowledging what occurred**: Ms. Toews agreed to the allegations. The Hearing Tribunal placed significant weight on this factor.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made**: The Hearing Tribunal was made aware that Ms. Toews has lost her job as a result of these incidents. This is a factor considered by the Hearing Tribunal in assessing the appropriateness of the sanction.

- **The impact of the incident(s) on the victim, and/or other members of the public**: The Hearing Tribunal is aware that Ms. Toews failed to properly assess and document a fall by client WM. However, the Hearing Tribunal is not aware of any negative results of this action. The Hearing Tribunal placed little weight on the factor.

- **The presence or absence of any mitigating circumstances**: The Hearing Tribunal is not aware of any mitigating factors, as none were brought up during the hearing.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice**: The Hearing Tribunal placed a significant amount of weight on this factor. The penalties given are required to deter Ms. Toews from repeating her actions. The penalties must also act as a general deterrent to others in the profession. A clear message must be sent to the profession.

- **The need to maintain the public's confidence in the integrity of the profession**: The Hearing Tribunal placed significant weight on this factor, as the profession must maintain the public's confidence in the integrity of the profession.

The Hearing Tribunal believes these orders adequately balance the *Jaswal* factors and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

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. Ms. Toews shall pay 25% of the costs of the investigation and hearing to be paid over a period of 36 months from the date of service of the written decision. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Toews' practice permit shall be suspended until she has completed all of the following conditions:

   a) Ms. Toews shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Toews shall provide the Complaints Director with a signed declaration attesting that she has completed the required readings within **30 days** of the written Decision:

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

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

iii. CLPNA Practice Policy: Professional Responsibility & Accountability.

iv. CLPNA Practice Policy: Documentation.

v. CLPNA Interpretive Document: Incapacity under the HPA.

vi. CLPNA Competency Profile A1: Critical Thinking.

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

viii. CLPNA Competency Profile U: Medication Administration.

ix. CLPNA Competency Profile A3: Time Management.

x. CLPNA Competency Profile B: Nursing Process.

xi. CLPNA Competency Profile C3: Professional Standards of Practice.

xii. CLPNA Competency Profile C4: Professional Ethics.

xiii. CLPNA Competency Profile C5: Accountability and Responsibility.

xiv. CLPNA Competency Profile C7: Fitness to Practice.

xv. CLPNA Competency Profile U: Medication Management.

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

b) Ms. Toews shall complete the following courses at her cost and provide the Complaints Director with acceptable documentation confirming successful completion:

i. Documentation 101 - available on CLPNA's website http://www.clpna.com/ at no cost;

ii. Health Assessment Self-Study course - available on CLPNA's website http://www.clpna.com/ at no cost;

iii. Code of Ethics Learning Module – offered online at no cost by Learning Nurse at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics;

iv. Professionalism in Nursing – offered on line by John Collins Consulting at https://www.jcollinsconsulting.com/images/Outlines/lpn/MODULE_OUTLINE_-_PROFESSIONALISM_IN_NURSING.pdf

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

c) Ms. Toews shall undergo a fitness to practice and capacity assessment by her attending physician at her cost and provide the Complaints Director with an acceptable a report validating her mental and physical fitness to provide professional nursing services in any healthcare setting, as an LPN in a safe and competent manner according to the CLPNA's Interpretive Document: Incapacity under the HPA. Any restrictions or limitations must be specified in the report.

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

a) The order to pay costs of the investigation and hearing will appear on Ms. Toews' practice permit and the Public Registry as "Conduct Orders Cost/Fines" until paid in full;

b) The requirements to read and reflect on CLPNA documents and to complete courses will appear on Ms. Toews' practice permit and the Public Registry as "CLPNA Monitoring Orders (Conduct)" until completed;

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

6. Should Ms. Toews be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Director.

7. Should Ms. Toews fail or be unable to comply with any of the above orders, or if any dispute arises regarding the implementation of these orders, the Complaints Director may do any or all of the following:

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

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

(f) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Toews' 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.

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 25th DAY OF NOVEMBER 2020

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

P. Standage LPN

Patricia Standage, LPN
Chair, Hearing Tribunal