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 CYNTHIA HOLT PERRAS

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 CYNTHIA HOLT PERRAS, LPN #25827, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES ("CLPNA") OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted at the offices of the College of Licensed Practical Nurses of Alberta in Edmonton, Alberta on July 31, 2019 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN"), Chairperson
Christine Buck, LPN
Johanne Chicoine, LPN
Hugh Campbell, Public Member

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

Investigated Member:
Cynthia Holt Perras, LPN ("Ms. Holt Perras" or "Investigated Member")
Lee Watson, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Cynthia Holt Perras 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. Cynthia Holt Perras was initially licensed as an LPN in Alberta on February 1, 2002.

On June 4, 2018, the College of Licensed Practical Nurses of Alberta received a letter dated June 4, 2018, from Kathleen Montague, Unit Manager for Unit 54, Royal Alexandra Hospital ("Royal Alexandra") in Edmonton, Alberta, pursuant to s. 57 of the Act. The letter was notification that Cynthia Holt Perras, LPN, received a three (three) day suspension for unprofessional conduct (the "Complaint"). The three (three) day suspension was subsequently reduced by the employer to a one (one) day suspension.

The CLPNA was provided with a copy of a letter dated June 1, 2018, from Tim Tsounis, Patient Care Manager, which was notification of Ms. Holt Perras' suspension.

By way of a letter dated June 8, 2018, Sandy Davis, Complaints Director for the CLPNA ("Complaints Director"), notified Ms. Holt Perras that the Complaint was received and that Judith Palyga, Investigator for the CLPNA (the "Investigator"), was appointed to conduct an investigation in accordance with s. 55(2)(d) of the Act. The Complaints Director also advised Ms. Holt Perras that she would be making a recommendation to Jeanne Weis, Executive Director for CLPNA, for an immediate suspension of Ms. Holt Perras' practice permit due to the serious allegations.

On June 15, 2018, Jeanne Weis, Executive Director, issued a decision to not proceed with an interim suspension of Ms. Holt Perras' practice permit.

The Investigator concluded the investigation into the Complaint on July 8, 2018 and submitted an Investigation Report to the CLPNA.

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

Following the receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Holt Perras received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated January 25, 2019.

Following the issuance of the Statement of Allegations on January 25, 2019, the same were revised (the "Revised Statement of Allegations").

A Notice of Hearing, Notice to Attend and Notice to Produce were served upon Ms. Holt Perras under cover of letter dated May 31, 2019.

(4) Allegations

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

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

1. On or about April 30 or May 1, 2018 did one or more of the following with respect to client BO who was suffering from opioid withdrawal:
   a) Failed to document the reason for administering Gravol 50 mg at 0700 on May 1, 2018;
   b) Failed to document adequately the care provided to BO and BO's behaviors;
   c) Failed to document adequately or at all an altercation with BO."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits a 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. Holt Perras 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/Consultant 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. Holt Perras' 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. Holt Perras.

Allegation 1

Ms. Holt Perras admitted on or about April 30 or May 1, 2018, she did one or more of the following with respect to client BO who was suffering from opioid withdrawal:

a) Failed to document the reason for administering Gravol 50 mg at 0700 on May 1, 2018;

b) Failed to document adequately the care provided to BO and BO's behaviors;

c) Failed to document adequately or at all an altercation with BO."

Ms. Holt Perras acknowledged on or about April 30 or May 1, 2018, Ms. Perras did one or more of the following with respect to patient BO who was a patient who was suffering from opioid withdrawal.

Ms. Holt Perras failed to document the reason for administering Gravol 50mg at 0700 hours on May 1, 2018 to patient BO. Ms. Holt Perras worked from 1900 hours on April 30, 2018 until 0715 hours on May 1, 2018. During this time, Ms. Perras provided care to patient BO. A copy of Patient Care Unit 54 employee schedule report for Cynthia Holt Perras for the period of April 28, 2018 until May 5, 2018 was provided in the Agreed Statement of Facts in Tab 8.

Ms. Holt Perras failed to document adequately the care that she provided to BO and BO's behaviors at that time. Patient BO was admitted to the Royal Alexandra Hospital for Acute Opioid Withdrawal. BO was ordered 25 - 50mg of Gravol q6h PRN to treat nausea. A copy of BO's Medicine Admission Order indicating this was included in the Agreed Statement of Facts in Tab 9.

Ms. Holt Perras checked patient BO's state at approximately 0302 hours on May 1, 2018. Ms. Holt Perras documented at this time that the call bell was in reach of patient BO, there were no

concerns, and that the IV fluid was infusing as ordered. A copy of the Nursing Assessment and Care Record indicating the same was provided in the Agreed Statement of Facts in Tab 10.

Patient BO was in and out of his room and the shower repeatedly throughout the night. Ms. Holt Perras had to restart BO's IV during the night because BO had gotten the IV site wet in the shower.

At approximately 0700 hours, Ms. Holt Perras provided care to patient BO after BO's roommate rang the call bell. Ms. Holt Perras entered BO's room and noticed urine and vomit on the floor. Ms. Holt Perras informed patient BO that she would administer Gravol as anti-nausea medication and left BO's room to get the Gravol.

On May 1, 2018 at 0700 hours, Ms. Holt Perras documented that she signed out 50mg of IV Gravol on patient BO's Medication Administration Record (MAR). A copy of the Medication Administration Record indicating the same was included in the Agreed Statement of Facts in Tab 11.

Ms. Holt Perras did not document the reason for signing out the Gravol for BO at 0700 hours and did not document BO's condition to indicate why the Gravol was required. A copy of the Nursing Assessment and Care Record indicating the same was included in the Agreed Statement of Facts in Tab 10.

When Ms. Holt Perras returned to patient BO's room with the Gravol, BO was in the shower. Ms. Holt Perras requested that BO exit the shower so she could administer the Gravol via IV, however, BO did not exit the shower and became angry.

There was an altercation that took place between patient BO and Ms. Holt Perras. BO pushed the IV pole towards Ms. Holt Perras, and the IV pole then hit her in the elbow.

Ms. Holt Perras continued to provide care to patient BO after the altercation. She instructed patient BO to sit in the shower so that she could unwind the IV line that was wrapped around the pole and administer the Gravol.

Ms. Holt Perras failed to document adequately or at all any altercation that she had with patient BO. Ms. Holt Perras did not document that patient BO was in and out of his room or the shower during the night shift and did not document the care that she provided to patient BO before and after the altercation. Ms. Holt Perras did not document the administration of Gravol in the Nursing Assessment and Care Record.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Holt Perras' 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. Specifically, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services**: Ms. Holt Perras displayed a lack of knowledge by not documenting any of her assessment of patient BO prior to administering Gravol to him. Ms. Holt Perras also did not document any of the altercation that took place between herself and patient BO in the Nursing Assessment and Care Records. This lack of documentation and clarity in BO's treatment records demonstrates a lack of skill or judgment in the provision of professional services being provided by Ms. Holt Perras;

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice**: Ms. Holt Perras did not adhere to the standard to which an LPN should uphold and did not do what is expected of an LPN. Documentation is a core competency being an LPN and is expected to be done and done to a certain standard. The sections of the CLPNA Code of Ethics and CLPNA Standards of Practice that are engaged are outlined below.

xii. **Conduct that harms the integrity of the regulated profession**: Ms. Holt Perras did not do what is reasonably expected of what an LPN with the same experience would have done in the same situation, and this harms the integrity of the nursing profession because patients expect that their LPNs will act with proper skill, judgment and experience at all times.

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:

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.

1.5 Provide care directed to 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:

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

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

2.8 Use evidence and judgement to guide nursing decisions; and

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:

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

CLPNA 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 states that LPNs:

1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.

1.2 Engage in ongoing self-assessment of their professional practice and competence, and seek opportunities for continuous learning.

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

1.7 Incorporate established client safety principles and quality assurance/improvement activities into LPN practice.

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

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:

2.1 Possess current knowledge to support critical thinking and professional judgement.

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 (CCPRN) 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.

The Hearing Tribunal accepted Ms. Holt Perras' admission of unprofessional conduct. The failure to document medication, behaviour and patient care properly is a failure in basic nursing skills expected of all LPNs, and shows a lack of skill, knowledge or judgment in the provision of

professional services. In addition, Ms. Holt Perras' failure to follow policies and procedures put patient safety at risk as those are developed to assist the care team in ensuring competent and consistent care.

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

Summary

In summary, the Hearing Tribunal considered the evidence put forth in Exhibit #2, and the documents included in Exhibit #2, and concluded that each of the Allegations against Ms. Holt Perras were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act and the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Ms. Holt Perras as an LPN, the Hearing Tribunal found that for each allegation, unprofessional conduct had occurred.

(9) Joint Submission on Penalty

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

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

2. Ms. Holt Perras shall pay 25% of the costs of the investigation and hearing to a maximum of $3,500.00, subject to the following:

    (a) Costs will be paid in equal monthly installments over a period of 18 months, or over such other period of time as agreed to by the Complaints Consultant; and
    (b) Ms. Holt Perras shall pay $500.00 to the CLPNA within three (3) months of service of the Decision.

3. Ms. Holt Perras shall read and reflect on how the following CLPNA document, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact her nursing practice. Ms. Holt Perras shall provide a written declaration confirming that the documents have been reviewed to the Complaints Consultant within thirty (30) days of service of the Decision:

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

d. CLPNA Practice Policy: Documentation;

e. CLPNA Competency Profile D1: Effective Communication;

f. CLPNA Competency Profile D3: Therapeutic Nurse-Client Relationship;

g. CLPNA Competency Profile D5: Legal, Protocols, Documenting and Reporting;

h. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

i. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

j. CLPNA Competency Profile E13: Client Centered Care;

k. CLPNA Competency Profile M: Mental Health and Addiction; and

l. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Ms. Holt Perras shall complete, at her own cost, the "Understanding Addiction" course available online at https://www.understandingaddiction.ca/ and provide documentation confirming its successful completion to the Complaints Consultant within four (4) months of service of the Decision.

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

5. Ms. Holt Perras shall complete the "Documentation 101" course available online at http://www.clpna.com/ and provide a certificate confirming its successful completion to the Complaints Consultant within ninety (90) days of service of the Decision.

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

6. Ms. Holt Perras shall complete the following nursing quizzes located on website http://www.learningnurse.org/ and provide documentation confirming successful completion of the quizzes (a mark of at least 80%) to the Complaints Consultant within thirty (30) days of service of the Decision:

   (a) 11.8 Safe Medication Principles 25Q; and

(b) 15.3 Professional Practice.

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

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

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

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

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

   (b) Treat Ms. Holt Perras's non-compliance as information under s. 56 of the *Health Professions Act*; or

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

Legal Counsel for the Complaints Director/Complaints Consultant 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 that 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.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Holt Perras and the Complaints Consultant.

(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. Holt Perras 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: Ms. Holt Perras did not intend to cause harm to patient BO. Her conduct was mainly in failing to document the medications, behaviour and an altercation that occurred with patient BO. With regards to the type of misconduct of an LPN, this is on the lower range of continuum in that it has to do with documentation.

The age and experience of the investigated member: Ms. Holt Perras was initially registered as an LPN in February 2002 and has been a regulated member of the CLPNA since that time. Ms. Holt Perras currently has an active registration with the CLPNA. Ms. Holt Perras began working with Alberta Health Services on March 23, 2002 and at all material times to the allegations, has been working as an LPN at the Royal Alexandra Hospital. Therefore, given her extensive work experience as an LPN, Ms. Holt Perras should have known the importance of accurate charting and documentation in ensuring competent and consistent care for patients.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The CLPNA is not aware of any previous complaints with regards to Ms. Holt Perras.

The number of times the offending conduct was proven to have occurred: This was an isolated incident with regard to that this happened with a single patient on a single shift. There is no evidence of any repeated behavior, which is a mitigating factor.

The role of the investigated member in acknowledging what occurred: Ms. Holt Perras did acknowledge her actions and cooperated with both the CLPNA and AUPE in both the investigation process as well as by providing an Agreed Statement of Facts to the Hearing Tribunal. This is a mitigating factor.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Holt Perras did receive a three (3) day suspension for unprofessional conduct which was subsequently reduced by the employer to a one (1) day suspension. The Hearing Tribunal notes that Ms. Holt Perras is also ordered in the Joint Submission on Sanctions that she must pay partial hearing costs of 25% of the investigation and hearing to a maximum of $3,500.00 which will be paid in monthly installments over a period of 18 months, or over another period of time as agreed to by the Complaints Consultant.

The presence or absence of any mitigating circumstances: Ms. Holt Perras was injured as a result of the altercation that took place between her and patient BO. The altercation that took place while BO was in the shower when he pushed the IV pole and hit Ms. Perras in the elbow. This does not excuse that Ms. Holt Perras did not document her care to patient BO. In addition to this, the Hearing Tribunal takes into account the other mitigating factors discussed above, including the nature of the conduct, the isolated incident, and Ms. Holt Perras' cooperation in the process.

The need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice: With regard to specific deterrence, there is a need to impose sanctions towards Ms. Holt Perras to make her aware that her behavior is not acceptable of an LPN. With regards to general deterrence, the public must have confidence that this type of behavior is not acceptable or tolerated by the CLPNA and that such behavior is dealt with in a serious manner. The sanctions that are imposed on Ms. Holt Perras will also act as a deterrent to other LPNs by CLPNA acknowledging the seriousness of these breaches and responding with appropriate orders.

The need to maintain the public's confidence in the integrity of the profession: CLPNA deals with the actions of the members when they conduct themselves in a way that is not becoming to the LPN profession. LPNs are trusted caregivers for populations that are often vulnerable and require attentive, careful care. The public's trust must be maintained by demonstrating

that the CLPNA will deal with any breaches in the Act, Code of Ethics and Standard of Practice in a manner that reflects the seriousness of this conduct.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA 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 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 decision (the "Decision") shall serve as a reprimand.

2. Ms. Holt Perras shall pay 25% of the costs of the investigation and hearing to a maximum of $3,500.00, subject to the following:

    (a) Costs will be paid in equal monthly installments over a period of 18 months, or over such other period of time as agreed to by the Complaints Consultant; and
    (b) Ms. Holt Perras shall pay $500.00 to the CLPNA within three (3) months of service of the Decision.

3. Ms. Holt Perras shall read and reflect on how the following CLPNA document, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact her nursing practice. Ms. Holt Perras shall provide a written declaration confirming that the documents have been reviewed to the Complaints Consultant within thirty (30) days of service of the Decision:

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

d. CLPNA Practice Policy: Documentation;

e. CLPNA Competency Profile D1: Effective Communication;

f. CLPNA Competency Profile D3: Therapeutic Nurse-Client Relationship;

g. CLPNA Competency Profile D5: Legal, Protocols, Documenting and Reporting;

h. CLPNA Competency Profile E1: Critical Thinking and Critical Inquiry;

i. CLPNA Competency Profile E2: Clinical Judgment and Decision Making;

j. CLPNA Competency Profile E13: Client Centered Care;

k. CLPNA Competency Profile M: Mental Health and Addiction; and

l. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Ms. Holt Perras shall complete, at her own cost, the "Understanding Addiction" course available online at https://www.understandingaddiction.ca/ and provide documentation confirming its successful completion to the Complaints Consultant within four (4) months of service of the Decision.

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

5. Ms. Holt Perras shall complete the "Documentation 101" course available online at http://www.clpna.com/ and provide a certificate confirming its successful completion to the Complaints Consultant within ninety (90) days of service of the Decision.

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

6. Ms. Holt Perras shall complete the following nursing quizzes located on website http://www.learningnurse.org/ and provide documentation confirming successful completion of the quizzes (a mark of at least 80%) to the Complaints Consultant within thirty (30) days of service of the Decision:

   (a) 11.8 Safe Medication Principles 25Q; and

(b) 15.3 Professional Practice.

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

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

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

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

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

(e) Treat Ms. Holt Perras's non-compliance as information under s. 56 of the *Health Professions Act*; or

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

The Hearing Tribunal believes these orders 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 8th DAY OF AUGUST 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal