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 ELIZABETH ALADEYELU

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 ELIZABETH ALADEYELU, LPN #45003, 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 29, 2020 with the following individuals present:

Hearing Tribunal:
Johanne Chicoine, Licensed Practical Nurse ("LPN") Chairperson
Sheila Pratchler, LPN
Nancy Brook, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Elizabeth Aladeyelu, LPN ("Ms. Aladeyelu or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Aladeyelu 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. Aladeyelu was initially licensed as an LPN in Alberta on September 11, 2017.

By letter received September 27, 2019, the College of Licensed Practical Nurses of Alberta ("CLPNA") received a complaint (the "Complaint") from Mr. Douglas Griffeth, the son of client D.G. a previous resident of St. Teresa Place, Covenant Care in Calgary, AB (the "Facility"), pursuant to s. 57 of the Act. The Complaint stated that Ms. Aladeyelu, LPN, failed to provide appropriate post-fall care to client D.G. and in doing so engaged in unprofessional conduct.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Katie Emter, Investigator for CLPNA, (the "Investigator") to conduct an investigation into the Complaint. Ms. Aladeyelu received notice of the Complaint and the investigation by letter dated September 27, 2019.

On January 31, 2020, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to 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. Aladeyelu received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report with attachments under cover of letter dated June 15, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Aladeyelu under cover of letter dated September 14, 2020.

(4) Allegations

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

"It is alleged that Elizabeth Aladeyelu, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct with respect to the care she provided to patient D.G. on August 10, 2018 as follows:

1. Failed to conduct an adequate assessment prior to assisting D.G. up from the floor after D.G. suffered an unwitnessed fall, particulars of which include one or more of the following:
    a. Failed to conduct a full head to toe assessment;
    b. Failed to take D.G.'s vitals or neurovitals;
    c. Failed to check oxygen saturation;
    d. Failed to assess or conduct an adequate assessment for alignment of extremities;
    e. Failed to adequately assess voluntary range of motion;
    f. Failed to palpate the lower and upper long bones, joints, and spinal column;

g. Failed to use the numeric rating scale and verbal rating scale to assess perception of pain.

2. Failed to comply with Covenant Care's Post Fall Protocol, particulars of which include one or more of the following:
    a. Failed to use a mechanical sling lift to move D.G. from the floor to the toilet;
    b. Failed to reassess patient D.G. immediately after assisting her up from the floor;
    c. Did not contact D.G.'s daughter to advise her of the fall with a reasonable period of time;
    d. Did not complete the Post Fall Alogorithm.

3. Failed to conduct an adequate assessment of patient D.G. after assisting her back to bed, particulars of which include one or more of the following:
    a. Failed to conduct a full head to toe assessment;
    b. Failed to assess or conduct an adequate assessment for alignment of extremities
    c. Failed to palpate the lower and upper long bones, joints and spinal column;
    d. Failed to use the numeric scale and verbal rating scale to assess perception of pain.

4. Failed to recognize that D.G. may have suffered one or more fractures, which resulted in a delay in transferring D.G. to the hospital for further assessment.

5. Failed to adequately chart the incident or the care provided, particulars of which include one or more of the following:
    a. Failed to include sufficient detail regarding the fall in D.G.'s progress notes;
    b. Failed to adequately chart assessments, interventions, clinical decisions or care provided;
    c. Failed to complete an Incident Report."

(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. Aladeyelu 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. Aladeyelu'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. Aladeyelu.

Allegation 1

Elizabeth Aladeyelu admitted on or about August 10, 2018 she failed to conduct an adequate assessment prior to assisting D.G. up from the floor after D.G. suffered an unwitnessed fall, particulars of which include one or more of the following:

a. Failed to conduct a full head to toe assessment;

b. Failed to take D.G.'s vitals or neurovitals;

c. Failed to check oxygen saturation;

d. Failed to assess or conduct an adequate assessment for alignment of extremities;

e. Failed to adequately assess voluntary range of motion;

f. Failed to palpate the lower and upper long bones, joints, and spinal column;

g. Failed to use the numeric rating scale and verbal rating scale to assess perception of pain.

On August 10, 2018 at approximately 0130 hours, client D.G. suffered an unwitnessed fall in her room. Vera Ogbomo, HCA, responded to a distress alarm triggered by client D.G. At the request of Ms. Ogbomo, Ms. Aladeyelu responded to assess client D.G.

In conducting her assessment, Ms. Aladeyelu had client D.G. lie on her back. Ms. Aladeyelu then asked client D.G. if she was in pain or if she had hit her head and conducted a visual assessment. As part of this visual assessment, Ms. Aladeyelu had client D.G. extend and raise her arms and legs. Without conducting any further assessments, Ms. Aladeyelu proceeded to lift client D.G., with the assistance of Ms. Ogbomo, into a standing position. Client D.G. was then placed on the toilet.

The Covenant Care Post Fall Algorithm calls for all or some of the following assessments and tasks to be completed by an RN or LPN as part of a post-fall assessment, with or without an apparent injury, depending on the nature of the fall: level of consciousness, vital signs including neuro-vital signs, blood glucose, oxygen saturation, cognitive changes, alignment of extremities, pain (the client's perception of pain is to be assessed using the Numeric Rating Scale and the Verbal Rating Scale), edema, loss of function and deformities, voluntary range of motion, an inspection of the skin for discoloration, swelling, lacerations or tears and a gentle palpation of the lower and upper long bones, joints and spinal column. The decision to move a client post-fall is to be based on the results of these assessments.

In conducting her assessment, Ms. Aladeyelu failed to do a full head to toe assessment, failed to take client D.G.'s vitals or neuro-vitals, failed to check D.G.'s oxygen saturation, failed to assess or conduct an adequate assessment for alignment of extremities, failed to adequately assess voluntary range of motion, failed to palpate the lower and upper long bones, joints and spinal column and failed to use the numeric rating scale and verbal rating scale to assess client D.G.'s perception of pain.

After client D.G. was placed on the toilet, Ms. Aladeyelu showered her and had her return to bed through the use of her walker.

Ms. Aladeyelu asked client D.G. is she was experiencing any pain. According to Ms. Aladeyelu, client D.G. stated that she was not. The numeric rating scale was not employed. Ms. Aladeyelu did not document a pain assessment in the Progress Notes of client D.G.

At approximately 0630 hours, Ms. Aladeyelu re-assessed client D.G. At this time, Ms. Aladeyelu noted swelling in the right arm and right leg of client D.G. and an inability for her to raise these extremities. Ms. Aladeyelu then notified the family of client D.G. and called for EMS.

At hospital, client D.G. was diagnosed and treated for a fractured humerus and hip.

As a result of the failure of Ms. Aladeyelu to conduct a proper post-fall assessment, client D.G.'s fractured humerus and hip went undetected and she was not transferred to hospital in a timely manner.

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

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

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

Ms. Aladeyelu displayed a lack of judgement and skills by failing to conduct a proper post-fall assessment with regards to client D.G. These skills are part of the LPN training, and therefore, Ms. Aladeyelu should have known that it was critical to assess and treat client D.G. post-fall in accordance with her training.

Ms. Aladeyelu did not abide by the CLPNA Code of Ethics and the CLPNA Standards of Practice, as acknowledged by Ms. Aladeyelu in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in details below. The Hearing Tribunal finds the conduct breaches the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct.

Ms. Aladeyelu's conduct harmed the integrity of the regulated profession as she behaved in a manner that is not expected of an LPN in similar situations. The public would expect an LPN to be well versed in post-fall assessments, and that an LPN would ensure client safety at all times and identify injuries/fractures as soon as possible to ensure proper treatments. By failing to act properly, Ms. Aladeyelu harmed the integrity of the regulated profession.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Code of

Ethics" and the CLPNA's Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice") which states 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 provides that LPNs:
>
> - 1.1 Maintain standards of practice, professional competence and conduct.
>
> Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
>
> - 2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.
>
> - 2.3.1 Safeguard health and personal information by collecting, storing, using and disclosing it in compliance with relevant legislation and employer policies.
>
> Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:
>
> - 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
>
> - 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.

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 provides that LPNs:
>
> - 1.1. Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.
>
> - 1.6. Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

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

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:

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

- 3.8. Practice within the relevant laws governing privacy and confidentiality of personal health information.

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.

Allegation 2

Elizabeth Aladeyelu admitted on or about August 10, 2018, she failed to comply with Covenant Care's Post Fall Protocol, particulars of which include one or more of the following:

a. Failed to use a mechanical sling lift to move D.G. from the floor to the toilet;
b. Failed to reassess patient D.G. immediately after assisting her up from the floor;
c. Did not contact D.G.'s daughter to advise her of the fall within a reasonable period of time;
d. Did not complete the Post Fall Alogorithm.

Ms. Aladeyelu, with the assistance of Ms. Ogbomo, manually lifted client D.G. from the floor to the toilet. On lifting client D.G., Ms. Aladeyelu failed to immediately re-assess her. Ms. Aladeyelu did ask client D.G. is she was experiencing any pain and, according to Ms. Aladeyelu, client D.G. again responded no. The numeric rating scale was not employed and Ms. Aladeyelu did not document a pain assessment in the Progress Notes of client D.G.

Client D.G.'s family was not notified of the fall until approximately 0630 hours. Ms. Aladeyelu called the family after she re-assessed client D.G. at 0630 hours to inform them of the decision to transport client D.G. to hospital.

Ms. Aladeyelu did not complete the Post-Fall Algorithm as per Facility policy.

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

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

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

Ms. Aladeyelu displayed a lack of judgement and skills by not following the employer's policy in regard to post-fall algorithm and not documenting or reporting of the incident appropriately in a timely manner.

The Hearing Tribunal finds the conduct breaches the CLPNA Code of Ethics and the CLPNA Standard of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 3

Elizabeth Aladeyelu admitted on or about August 10, 2018, she failed to conduct an adequate assessment of patient D.G. after assisting her back to bed, particulars of which include one or more of the following:

a. Failed to conduct a full head to toe assessment;
b. Failed to assess or conduct an adequate assessment for alignment of extremities
c. Failed to palpate the lower and upper long bones, joints and spinal column;
d. Failed to use the numeric scale and verbal rating scale to assess perception of pain.

On assisting client D.G. back to bed, after having used the toilet and shower, Ms. Aladeyelu failed to do a full head to toe assessment, failed to assess or conduct an adequate assessment for alignment of extremities, failed to palpate the lower and upper long bones, joints and spinal column and failed to use the numeric rating scale and verbal rating scale to assess client D.G.'s perception of pain.

On being placed back in bed, client D.G. was left to sleep. She was not re-assessed by Ms. Aladeyelu until approximately 0630 hours.

As a result of Ms. Aladeyelu's failure to conduct a proper post-fall assessment, client D.G.'s fractured humerus and hip went undetected and she was not transferred to hospital in a timely manner.

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

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

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

Again, Ms. Aladeyelu displayed lack of judgement and skills, as these are basic skills LPNs learned in training. Post-Fall assessments are critical to the care of clients, who trust LPNs to do proper assessment to ensure that there are no issues resulting from the fall. These are basic LPN skills learned during training. Ms. Aladeyelu acknowledged that she did fail to abide to the CLPNA Code of Ethics and the CLPNA Standard of Practice in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. This lack of judgment and skills harmed the Regulated Profession and the Public Trust.

The Hearing Tribunal finds the conduct breaches the CLPNA Code of Ethics and the CLPNA Standard of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 4</u>

Elizabeth Aladeyelu admitted on or about August 10, 2018, she failed to recognize that D.G. may have suffered one or more fractures, which resulted in a delay in transferring D.G. to the hospital for further assessment.

Client D.G. suffered an unwitnessed fall in her room at approximately 0130 hours. As a result of the fall, client D.G. incurred a fractured humerus and hip. Ms. Aladeyelu failed to conduct a proper post-fall assessment that met the requirements of the Covenant Care Post Fall Algorithm. As a result of this failure, Ms. Aladeyelu did not recognize that client D.G. may have suffered fractures as a result of her fall.

As a result of Ms. Aladeyelu's lack of a proper assessment, client D.G. was not transferred to hospital by EMS until approximately 0700 hours.

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

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

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

Ms. Aladeyelu's failure to properly assess client D.G., as per post-fall protocol, delayed the needed treatment. Ms. Aladeyelu acknowledged that she did fail to abide to the CLPNA Code of Ethics and the CLPNA Standard of Practice in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. This lack of judgment and skills harmed the Regulated Profession and the Public Trust.

The Hearing Tribunal finds the conduct breaches the CLPNA Code of Ethics and the CLPNA Standard of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct

<u>Allegation 5</u>

Elizabeth Aladeyelu admitted on or about August 10, 2018, she failed to adequately chart the incident, or the care provided, particulars of which include one or more of the following:

a. Failed to include sufficient detail regarding the fall in D.G.'s progress notes;
b. Failed to adequately chart assessments, interventions, clinical decisions or care provided;
c. Failed to complete an Incident Report."

In the course of her post-fall treatment of client D.G., Ms. Aladeyelu failed to include sufficient detail regarding the fall in client D.G.'s Progress Notes, failed to adequately chart the assessment, interventions, clinical decisions or care provided and failed to complete an Incident Report.

The Covenant Care Post-Fall Algorithm calls for assessments to be thoroughly documented in the client's progress notes. The entirety of Ms. Aladeyelu's charting and notes in regards to client D.G.'s fall, and subsequent assessments, is limited to one paragraph in the Progress Notes. In this paragraph, there is no mention of alignment of extremities or a pain assessment.

After the initial assessment at 0130 hours, Ms. Aladeyelu makes no mention of any injury to client D.G.'s right leg or hip in the Progress Notes. There is no evidence that the lower body was examined for any potential injury. The Progress Notes only mention bruising to the right arm.

Beyond the Progress Notes, there is no other documentation of the fall event incurred by client D.G. provided by Ms. Aladeyelu.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Aladeyelu's 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;
xii. Conduct that harms the integrity of the regulated profession.

Documentation and reporting are another basic skill that LPNs learn during their training. Ms. Adaleyelu's lack of judgement and skills in documentation harmed the Regulated Profession and the Public Trust as LPNs are to display accountability and professionalism in the care they provide as part of a multidisciplinary team including factual and accurate documentations.

The Hearing Tribunal finds the conduct breaches the CLPNA Code of Ethics and the CLPNA Standard of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Aladeyelu 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. Aladeyelu shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

    a) Ms. Aladeyelu will be provided with a letter advising of the final costs once the same have been confirmed.

3. Ms. Aladeyelu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Ms.

Aladeyelu will provide to the Complaints Director, a written reflection of 500 – 750 words, satisfactory to the Complaints Director, on how the CLPNA documents will impact her professional practice within **60 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: A1 Critical Thinking;

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

g. CLPNA Competency Profile B2: Nursing Diagnosis;

h. CLPNA Competency Profile C4: Professional Ethics; and

i. CLPNA Competency Profile C5: Accountability and Responsibility.

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

In the event the reflective paper is not satisfactory to the Complaints Director, Ms. Aladeyelu shall within two (2) weeks of being notified by the Complaints Director the reflective paper is not satisfactory, or such longer period as determined by the Complaints Director at her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

4. Ms. Aladeyelu shall complete the following remedial education, at her own cost. Ms. Aladeyelu shall provide the Complaints Director with a certificate confirming successful completion of the remedial education within **six (6) months** of service of the Decision.

    a) Documentation 101- offered on line by CLPNA
    b) Health Assessment Self-Study Course – offered on line by CLPNA
    c) 8.3 HA Abnormal Findings II - offered on line by Learning Nurse at https://www.learningnurse.org/index.php/assessment/quizzes
    d) 5.10 Musculoskeletal offered on line by Learning Nurse at https://www.learningnurse.org/index.php/assessment/quizzes

e) 15.3 Nursing Ethics Quiz offered on line by Learning Nurse at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

If the quiz becomes unavailable, then Ms. Aladeyelu shall request in writing to be assigned an alternative quiz prior to the deadline. The Complaints Director shall, in her sole discretion, reassign a quiz. Ms. Aladeyelu will be notified by the Complaints Director, in writing, advising of the new quiz required.

5. The sanctions set out above at paragraphs 2 to 4 will appear as a condition/conditions on Ms. Aladeyelu's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings/reflection paper outlined at paragraphs 2 to 4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Aladeyelu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings/Reflection Paper;

        ii. Documentation 101;

        iii. Health Assessment Self-Study Course;

        iv. 8.3 HA Abnormal Findings II Quiz;

        v. 5.10 Musculoskeletal Quiz; and

        vi. Nursing Ethics Quiz.

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

6. The conditions on Ms. Aladeyelu's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 to 4.

7. According to LPN Regulations and Bylaws, Ms. Aladeyelu's shall provide CLPNA with current contact information (including home mailing address, home and cellular phone numbers, current e-mail address, and current employment information) and is required to provide updated contact information to CLPNA should this information change.

8. Ms. Aladeyelu shall provide the CLPNA with her contact information, including home mailing address, home and cellular telephone numbers, current email address and current

employment information. Ms. Aladeyelu will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Aladeyelu 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 Director.

10. Should Ms. Aladeyelu 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 Ms. Aladeyelu's non-compliance as information for a complaint under s. 56 of the Act; or
    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Aladeyelu'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.

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

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

1. **The nature and gravity of the proven allegations:** As admitted, there was a significant lack of skills and judgement involving the safety and care of the client because these allegations relate to a failure of Ms. Aladeyelu's part to properly assess a client after a fall. Failing to do so and to comply with the Facility's post-fall protocol are serious allegations and place the client at risk. In this case, the client's proper care was compromised, including her timely transfer to the hospital after the fall to treat her fractures. Therefore, the Hearing Tribunal finds the nature of these allegations are serious and merit discipline. This impacts the integrity of the profession and responsibility to the public because it demonstrates a lack of professionalism, knowledge and skills.

2. **The age and experience of the investigated member:** Ms. Aladeyelu registered as an LPN with the CLPNA in September 2017 and worked at the facility involved since March 2018. At the time of the allegations, Ms. Aladeyelu had been practicing as an LPN for almost one year, and though a new LPN, she should have had the knowledge, experience and skill to properly treat client D.G. after her fall.

3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Ms. Aladeyelu has no previous complaints or reprimands to the Hearing Tribunal's knowledge.

4. **The number of times the offending conduct was proven to have occur:** The offending conduct was only committed once but did result in five (5) separate allegations of misconduct, all of which have been acknowledged by Ms. Aladeyelu.

5. **The role of the investigated member in acknowledging what occurred:** Ms. Aladeyelu acknowledged she failed to provide appropriate post-fall care to client D.G. and provided the Hearing Tribunal with an Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct, which demonstrates that she takes responsibility for her actions.

6. **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 not made aware of any serious financial or other penalties directly related to the allegations.

7. **The impact of the incident(s) on the victim:** The victim suffered multiple bone fractures and eventually passed away at the hospital on August 26, 2018. It was the responsibility of Ms. Aladeyelu to provide proper post-fall care in accordance with her training and her employer's post-fall protocol, and she did not do so, and this impacted the assessment and treatment received by client D.G.

8. **The presence or absence of any mitigation circumstances:** The Hearing Tribunal was not made aware of any mitigating circumstances in this incident other than what was outlined in the Agreed Statement of Facts.

9. **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** Specific deterrence is required to ensure that it is brought home to Ms. Aladeyelu that her conduct is unacceptable and cannot be repeated in the future. General deterrence is required to ensure that other members of the LPN profession do not engage in this type of conduct and to make it known that this type of conduct will not be tolerated by the CLPNA. It is imperative that LPNs provide safe and competent care to their clients and have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public.

10. **The need to maintain the public's confidence in the integrity of the profession:** The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

11. **The range of the sentence in other similar cases:** The Hearing Tribunal was not made aware of sentences in other similar cases.

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. Aladeyelu shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

    a) Ms. Aladeyelu will be provided with a letter advising of the final costs once the same have been confirmed.

3. Ms. Aladeyelu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Ms. Aladeyelu will provide to the Complaints Director, a written reflection of 500 – 750 words, satisfactory to the Complaints Director, on how the CLPNA documents will impact her professional practice within **60 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: A1 Critical Thinking;

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

g. CLPNA Competency Profile B2: Nursing Diagnosis;

h. CLPNA Competency Profile C4: Professional Ethics; and

i. CLPNA Competency Profile C5: Accountability and Responsibility.

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

In the event the reflective paper is not satisfactory to the Complaints Director, Ms. Aladeyelu shall within two (2) weeks of being notified by the Complaints Director the reflective paper is not satisfactory, or such longer period as determined by the Complaints Director at her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

4. Ms. Aladeyelu shall complete the following remedial education, at her own cost. Ms. Aladeyelu shall provide the Complaints Director with a certificate confirming successful completion of the remedial education within **six (6) months** of service of the Decision.

    a) Documentation 101- offered on line by CLPNA
    b) Health Assessment Self-Study Course – offered on line by CLPNA
    c) 8.3 HA Abnormal Findings II - offered on line by Learning Nurse at https://www.learningnurse.org/index.php/assessment/quizzes
    d) 5.10 Musculoskeletal offered on line by Learning Nurse at https://www.learningnurse.org/index.php/assessment/quizzes
    e) 15.3 Nursing Ethics Quiz offered on line by Learning Nurse at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

    If the quiz becomes unavailable, then Ms. Aladeyelu shall request in writing to be assigned an alternative quiz prior to the deadline. The Complaints Director shall, in her sole discretion, reassign a quiz. Ms. Aladeyelu will be notified by the Complaints Director, in writing, advising of the new quiz required.

5. The sanctions set out above at paragraphs 2 to 4 will appear as a condition/conditions on Ms. Aladeyelu's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial education and readings/reflection paper outlined at paragraphs 2 to 4 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Aladeyelu's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

   i. Readings/Reflection Paper;

   ii. Documentation 101;

   iii. Health Assessment Self-Study Course;

   iv. 8.3 HA Abnormal Findings II Quiz;

   v. 5.10 Musculoskeletal Quiz; and

   vi. Nursing Ethics Quiz.

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

6. The conditions on Ms. Aladeyelu's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 to 4.

7. According to LPN Regulations and Bylaws, Ms. Aladeyelu's shall provide CLPNA with current contact information (including home mailing address, home and cellular phone numbers, current e-mail address, and current employment information) and is required to provide updated contact information to CLPNA should this information change.

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

9. Should Ms. Aladeyelu 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 Director.

10. Should Ms. Aladeyelu 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 Ms. Aladeyelu's non-compliance as information for a complaint under s. 56 of the Act; or

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

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 IN THE EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

JRChicoine

Johanne Chicoine, LPN
Chair, Hearing Tribunal