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 EVALYNE KALINGA

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 EVALYNE KALINGA, LPN #45462, 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 Teleconference using Zoom on August 12, 2021 with the following individuals present:

Hearing Tribunal:
Patricia Standage, Licensed Practical Nurse ("LPN") Chairperson
Thea Dahl, LPN
David Rolfe, Public Member
Naz Mellick, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Officer, CLPNA
Susan Blatz, Complaints Officer, CLPNA

Investigated Member:
Evalyne Kalinga, LPN ("Ms. Kalinga 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. Kalinga 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. Kalinga was initially licensed as an LPN in Alberta on January 1, 2018.

The College of Licensed Practical Nurses of Alberta (the "CLPNA") received a complaint dated July 31, 2020 (the "Complaint") from Alaina Bosinski, Unit Manager, Unit 46, at Foothills Medical Centre in Calgary, Alberta, pursuant to s. 57 of the *Health Professions Act* (the "Act"). The Complaint advised Ms. Evalyne Kalinga, LPN, had been terminated from her employment at the Foothills Medical Center for numerous practice issues in relation to airway monitoring, narcotic administration and monitoring, and necessary clinical documentation.

By way of letter dated August 19, 2020, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Ms. Kalinga with notice of the Complaint and notified Ms. Kalinga that she was delegating her powers under Part 4 of the Act to Susan Blatz, Complaints Officer (the "Complaints Officer") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Kalinga that she had appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

On December 18, 2020, the Investigator concluded the investigation into the Complaint.

The Complaints Officer determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Kalinga received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report, on June 9, 2021.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Kalinga under cover of letter dated July 9, 2021.

(4) Allegations

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

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

1. On or about February 18,2020 did one or more of the following with regards to client BL:

a. Failed to perform vital signs every 15 – 30 minutes after the start of an iron sucrose infusion and for 30 minutes after the end of the infusion as required; and
b. Failed to document in the Multidisciplinary Progress Record how BL tolerated the iron sucrose infusion.

2. On or about February 21, 2020, did one or more of the following with regards to client RH:
    a. Documented the administration of Repaglinide and Ferrous Gluconate at 1635 hours instead of the ordered time of "with meals"; and
    b. Documented the administration of Repaglinide at 1635 hours prior to obtaining RH's blood glucose level as ordered.

3. On or about April 5, 2020, did one or more of the following:
    a. Failed to perform and/or document any assessment of client WR; and
    b. Failed to perform and/or document any assessment of client AZ.

4. On or about July 14 or July 15, 2020, failed to document the intravenous infusion of 0.9% NaCL @ 125 ml/hr for client WK on the EMAR.

5. On or about July 15, 2020, did one or more of the following with regards to client TL:
    a. Administered Hydromorphone 4 mg tablets at 0104 hours instead of the ordered Hydromorphone liquid.
    b. Failed to document the effectiveness of the Hydromorphone 4 mg administered at 0104 hours in the Multidisciplinary Progress Notes.

6. On or about July 15, 2020, did one or more of the following with regards to client GI:
    a. Failed to perform and/or document an assessment on the flowsheet.
    b. Failed to perform and/or document vital signs on the flowsheet between 0211 hours and 0609 hours.
    c. Copied and pasted information from previous charting into SCM documentation at 0005 hours.
    d. Failed to document suctioning performed between 2300 hours and 0340 hours.
    e. Failed to document oropharyngeal airway (OPA) status in the MPR after it was inserted at 0338 hours and remained in situ; and
    f. Failed to report OPA and oxygen status in the SCM.

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1:	Statement of Allegations
Exhibit #2:	Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3:	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. Kalinga'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. Kalinga.

Allegation 1

Ms. Kalinga admitted on or about February 18, 2020, she did one or more of the following with regards to client BL:

a. Failed to perform vital signs every 15 – 30 minutes after the start of an iron sucrose infusion and for 30 minutes after the end of the infusion as required; and
b. Failed to document in the Multidisciplinary Progress Record how BL tolerated the iron sucrose infusion.

The Hearing Tribunal considered the evidence that Ms. Kalinga did not take vital signs every 15-30 minutes, as required, when administering iron sucralose, according to the Sucrose Parental Monograph which is found at Tab 6.

Ms. Kalinga did not document patient BL's condition, while monitoring patient BL's iron sucrose infusion. This allegation can be proven by the flowsheet attached at Tab 7.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga'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. These allegations can be proven in Exhibit #2 (Tab 7) patient BL's flowsheet, and (Tab 8) BL's task sheet.

The Hearing Tribunal finds that the conduct admitted to, amounts to unprofessional conduct as defined in section 1 (pp) (i) of the Health Professions 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 judgement in the provision of professional services.
ii. Contravention of the Act, a code of ethics or standards of practice.

Ms. Kalinga displayed a lack of knowledge by failing to take vital signs every 15-30 minutes as required when administering iron sucralose, to patient BL according to the Sucrose Parental Monograph. Ms. Kalinga also failed to document patient BL's condition while monitoring patient BL, when giving the iron sucralose infusion.

Ms. Kalinga 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"):

a. Code of Ethics Principle 2: Responsibility to clients: In particular, Ms. Kalinga breached 2.6 as indicated by the fact that she failed to take vital signs every 15-30 minutes when administering iron sucralose. She failed to provide care to patient BL, as vital signs are considered nursing care.
b. Standard 1 (Professional Accountability and Responsibility): In particular, Ms. Kalinga breached Standard 1.10 when she failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies. In addition, she failed to document patient BL's vital signs and his condition while administering sucrose infusion.
c. Standard 2 (Knowledge -Based Practice): Ms. Kalinga breached 2.2 by not applying knowledge from nursing theory and science. She breached Standard 2.13 by failing to communicate, through documentation, changes to specific interventions based on client's responses

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgement in the provision of professional services and contravened 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.

Allegation 2

Ms. Kalinga admitted on or about February 21, 2020, she did one or more of the following with regards to client RH:

a. Documented the administration of Repaglinide and Ferrous Gluconate at 1635 hours instead of the ordered time of "with meals"; and
b. Documented the administration of Repaglinide at 1635 hours prior to obtaining RH's blood glucose level as ordered.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove Allegation 2 did in fact occur. These allegations can be proven by Ms. Kalinga's own admission and from evidence given in Exhibit 2, patient RH's Medication Administration record Tab 9 and a copy of RH's flowsheet indicating Ms. Kalinga took RH's blood glucose level at 1743 hours after the administration of Repaglinide at 1615.

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:

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

Ms. Kalinga breached the following standards set out in the CLPNA Standards of Practice:

a. Standard 1 (Professional Accountability and Responsibility): Ms. Kalinga documented the administration of Repaglinide and Ferrous Gluconate as 1635 hours. The order was to be administered "with meals". No meal was served to patient RH at that time. In particular (1.7) Ms. Kalinga failed to incorporate established client safety principles.
b. Standard 2 (Knowledge Based Practice): Ms. Kalinga documented the administration of Repaglinide at 1635 hours, prior to obtaining RH's blood glucose level as ordered. Repaglinide is to be given after taking a blood glucose level and was to be held if patient RH's blood glucose level was less than 7. Ms. Kalinga breached Standard 2.2 by not applying knowledge from nursing theory and science to make an informed decision.

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

Allegation 3

Ms. Kalinga admitted on or about April 5, 2020, she did one or more of the following:

a. Failed to perform and/or document any assessment of client WR; and
b. Failed to perform and/or document any assessment of client AZ.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove Allegation 3 did in fact occur. These allegations can be proven by Ms. Kalinga's own admission and from evidence given in Exhibit #2 Tab 11, a copy of

WR's blank multidisciplinary progress record, and Tab 12 a copy of AZ's multidisciplinary progress record indicating Ms. Kalinga only charted on AZ's transfer ability.

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:

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

Ms. Kalinga breached the following principles and standards set out in the CLPNA Code of Ethics and CLPNA Standard of Practice:

a. Code of Ethics: Principle 2 (Responsibility to Clients): Ms. Kalinga failed to perform an assessment on client WR and client AZ therefore breaching Principle 2 (2.6) by not providing care to each client, as assessment is considered a part of care.
b. Standard 1(Professional Accountability and Responsibility): By not documenting or performing any assessment of client WR and client AZ, Ms. Kalinga breached Standard (1.10). She failed to maintain documentation and reporting according to established regulations, laws, and employer policies.

The Hearing Tribunal finds the conduct contravened 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.

Allegation 4

Ms. Kalinga admitted on or about July 14 or July 15, 2020, she failed to document the intravenous infusion of 0.9% NaCL @ 125 ml/hr for client WK on the EMAR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove allegation 4 did in fact occur. These allegations can be proven by Ms. Kalinga's own admission, and from evidence given in Exhibit #2 Tab 13 a copy of the Medication Administration Record of patient WK's IV infusion.

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

Ms. Kalinga breached the following standards set out in the CLPNA's Standards of Practice:

a. Standard 1. (Professional Accountability and Responsibility) by not documenting the intravenous infusion of 0.9% NaCl @ 125ml/hr. for client WK on the EMAR. Ms. Kalinga breached Standard (1.10) when she failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

The Hearing Tribunal finds the conduct contravened 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.

Allegation 5

Ms. Kalinga admitted on or about July 15, 2020, she did one or more of the following with regards to client TL:

a. Administered Hydromorphone 4 mg tablets at 0104 hours instead of the ordered Hydromorphone liquid.
b. Failed to document the effectiveness of the Hydromorphone 4 mg administered at 0104 hours in the Multidisciplinary Progress Notes.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga's admission of unprofessional conduct. These allegations can be proven by Ms. Kalinga's own admission and by the evidence given in Exhibit #2 Tab 14 a copy of TL's Multidisciplinary progress record and Tab 15 a copy of TL's flowsheet.

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:

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

Ms. Kalinga breached the following principles and standards set out in the CLPNA's Standards of Practice

a. Standard 1. Professional Accountability and Responsibility: In particular, Ms. Kalinga breached Standard (1.6) when she administered Hydromorphone 4mg tablets at 0104 hours instead of the ordered hydromorphone liquid. She failed to take action to avoid harm and she put a client TL at risk by administering the wrong form of medication.

b. Ms. Kalinga also breached standard 1.10 when she failed to maintain documentation and reporting according to established regulations, laws, and employer policies by not documenting the effectiveness of the Hydromorphone 4mg she administered to client TL.

The Hearing Tribunal finds the conduct contravened 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.

Allegation 6

Ms. Kalinga admitted on or about July 15, 2020, she did one or more of the following with regards to client GI:

a. Failed to perform and/or document an assessment on the flowsheet.
b. Failed to perform and/or document vital signs on the flowsheet between 0211 hours and 0609 hours.
c. Copied and pasted information from previous charting into SCM documentation at 0005 hours.
d. Failed to document suctioning performed between 2300 hours and 0340 hours.
e. Failed to document oropharyngeal airway (OPA) status in the MPR after it was inserted at 0338 hours and remained in situ; and
f. Failed to report OPA and oxygen status in the SCM.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kalinga's admission of unprofessional conduct. These allegations can be proven by Ms. Kalinga's own admission and by the evidence given in Exhibit #2 Tab 16, 17, and 18.

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:

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

Ms. Kalinga breached the following principles and standards set out in the CLPNA Code of Ethics and CLPNA Standards of Practice:

a. Principle 5 (Responsibility to self): In particular, when Ms. Kalinga copied and pasted information from previous charting into SCM documentation on client GI, she breached 5.1 and failed to demonstrate honesty, integrity, and trustworthiness.

b. Principle 2 (Responsibility to Clients): In particular, when Ms. Kalinga failed to perform an assessment or vital signs on client GI, she breached 2.6 and failed to provide care to her client.
c. Standard 1 (Professional Accountability and Responsibility): Ms. Kalinga failed to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies (standard 1:10), when she failed to document an assessment on client GI's flowsheet. She also did not document that she performed suctioning on client GI, or the status of the Client GI's airway.
d. Standard 2 (Knowledge -Based Practice): In particular, Ms. Kalinga breached Standard 2.13 when she failed to notify and communicate to an appropriate person, changes to specific interventions based on the client's response, and when she failed to document and report OPA and oxygen status after the OPA was inserted on client GI.

The Hearing Tribunal finds the conduct contravened 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.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Kalinga 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. Kalinga shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Kalinga shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Kalinga shall provide a signed written declaration to the Complaints Officer attesting that she has reviewed the CLPNA documents within **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 A1: Critical Thinking;

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

g. CLPNA Competency Profile B1: Assessment; and

h. 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 Officer.

4. Ms. Kalinga shall complete the **NURS 0162: Documentation in Nursing** course offered online at www.macewan.ca. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

5. Ms. Kalinga shall complete the **Health Assessment** course offered on line at www.clpna.com. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

6. Ms. Kalinga shall complete the **Medication Errors: Causes and Prevention** offered online at www.ncsbn.com. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

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

    (a) The requirement to complete the remedial education and readings outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Ms. Kalinga's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. Documentation in Nursing;

        iii. Health Assessment; and

        iv. Medication Errors: Causes and Preventions.

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

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

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

10. Should Ms. Kalinga 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 Officer.

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

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

    (b) Treat Ms. Kalinga'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. Kalinga's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

The Hearing Tribunal is aware, 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. Kalinga and the Complaints Officer.

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Evalyne Kalinga 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 Hearing Tribunal places a great deal of weight on this factor and finds the nature and gravity of the proven allegations in this case to be serious. The clients in Ms. Kalinga's care were acutely ill and required high quality care that was not provided by Ms. Kalinga.
- *The age and experience of the investigated member*
  The Hearing Tribunal is not aware of the age of the member but does recognize that she had obtained her license in 2018, making her a relatively inexperienced nurse. Therefore, the hearing tribunal finds that this factor is not significant.
- *The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions*
  Legal Counsel advised that there were no previous findings in relation to the member, and this weighs in favor of the investigated person.
- *The age and mental condition of the victim, if any*
  The Hearing Tribunal was not made aware of the age or mental condition of any of the clients in Ms. Kalinga's care, and therefore this was not a factor.
- *The number of times the offending conduct was proven to have occurred*
  There are six different findings against Ms. Kalinga in this case, and therefore the Hearing Tribunal considers this to be a significant factor.

- *The role of the investigated member in acknowledging what occurred*
  The Hearing Tribunal recognizes that Ms. Kalinga did agree to all the allegations and has started to work towards finishing some of her penalties, which 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*
  The Hearing Tribunal is not aware of other serious financial penalties but is aware that Ms. Kalinga was terminated from her job as a result of the allegations.
- *The impact of the incident(s) on the victim*
  The clients in Ms. Kalinga's care were acutely ill and required high quality care which Ms. Kalinga did not provide. The Hearing Tribunal is not aware of any impact the allegations had on any of the clients in Ms. Kalinga's care.
- *The need to promote specific and general deterrence and thereby to protect the public and ensure the safe and proper practice*
  The Hearing Tribunal considered this factor to be significant, as it is part of the CLPNA's mandate to protect the public and ensure safe and proper practice. Therefore, the penalties imposed need to be enough of a deterrent to show the public that the profession takes these findings seriously.
- *The Presence or absence of any mitigating circumstances*
  The Hearing Tribunal was not made aware of any mitigating circumstances.
- *The need to maintain the public's confidence in the integrity of the profession*
  The Hearing Tribunal considered this factor to be significant. It is important that the public recognizes LPNs as professionals with integrity when interacting with them.
- *The range of sentence in other similar cases*
  The Hearing Tribunal reviewed other cases with similar allegations and finds the orders in this case are equivalent to those of 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. Kalinga shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Kalinga shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Kalinga shall provide a signed written declaration to the Complaints Officer attesting that she has reviewed the CLPNA documents within **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 A1: Critical Thinking;

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

    g. CLPNA Competency Profile B1: Assessment; and

    h. 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 Officer.

4. Ms. Kalinga shall complete the **NURS 0162: Documentation in Nursing** course offered online at www.macewan.ca. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

5. Ms. Kalinga shall complete the **Health Assessment** course offered on line at www.clpna.com. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

6. Ms. Kalinga shall complete the **Medication Errors: Causes and Prevention** offered online at www.ncsbn.com. Ms. Kalinga shall provide the Complaints Officer with a certificate confirming successful completion of the course within **90 days** of service of the Decision.

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

    (a) The requirement to complete the remedial education and readings outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Ms. Kalinga's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. Documentation in Nursing;

        iii. Health Assessment; and

        iv. Medication Errors: Causes and Preventions.

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

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

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

10. Should Ms. Kalinga 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 Officer.

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

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

(b) Treat Ms. Kalinga'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. Kalinga's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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

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

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

DATED THE 21ST DAY OF DECEMBER 2021 IN THE CITY OF EDMONTON , ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

P. Standage LPN

Patricia Standage, LPN
Chair, Hearing Tribunal