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 HARJIT GURAYA

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 HARJIT GURAYA, LPN #29131, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

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 September 30, 2019 with the following individuals present:

Hearing Tribunal:
Patricia Standage, Licensed Practical Nurse ("LPN"), Chairperson
Doris Kuelken, LPN
Jan Schaller, LPN
Marg Hayne, Public Member

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

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

(2) Preliminary Matters

The hearing was open to the public.

Harjit Guraya was unable to attend in person and agreed to have the Hearing proceed in her absence indicating she would be available by phone should the Hearing Tribunal Panel have any questions.

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

Harjit Guraya 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. Harjit Guraya was initially licensed as an LPN in Alberta on June 18, 2013.

On November 5, 2018, the CLPNA received an undated complaint from Javier Martinez ("the Complainant"), RN/Clinical Leader for Supportive Living at St. Marguerite Manor/Covenant Health in Calgary, Alberta (the "Complaint"). The Complaint was sent pursuant to s. 57 of the Act, and alleged that Ms. Guraya had failed to provide appropriate care to residents on two different occasions.

Subsequently, the Complainant provided the CLPNA with a copy of a letter from Mr. Martinez to Ms. Guraya, dated November 13, 2018, informing Ms. Guraya that she was subject to a three day suspension due to the serious nature of the allegations. This suspension was later reduced to a period of one day.

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

Ms. Guraya received notice of the Complaint, investigation, and appointment of the Investigator by letter dated November 6, 2018.

During the course of the investigation, Mr. Martinez informed the investigator of several additional incidents involving Ms. Guraya, and those incidents were also investigated.

On March 14, 2019, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the Complaints Consultant.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the matters should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Guraya received notice that the Complaint was referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated June 18, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Guraya under cover of letter dated July 23, 2019.

(4) Allegations

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

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

1. On or about August 26, 2017, failed to take appropriate steps to ensure it was safe for resident JM to receive her morning medications at 0800 hours after JM received another resident's medications on August 25, 2017 at 2000 hours, particulars of which include one or more of the following:

    a) Failed to conduct an adequate assessment of JM before JM received her morning medications; and

    b) Failed to consult the RN or Nurse Practitioner for direction before JM received her morning medications.

2. On or about October 6, 2018, did one or more of the following with regards to resident EP:

    a) Failed to assess and/or document an assessment after EP's daughter reported EP had slurred speech; and

    b) Failed to report EP's daughter's concerns to the RN or Nurse Practitioner.

3. On or about October 19, 2018, did one or more of the following with regards to resident ME:

    a) Failed to adequately assess and/or document an adequate assessment after HCA's reported ME was confused, had slurred speech and facial drooping;

    b) Failed to take adequate steps to ensure ME was monitored; and

    c) Failed to report ME's status to the RN or Nurse Practitioner.

4. On or about February 4, 2019 did one or more of the following:

    a) Failed to assess and/or document an assessment of resident IR's swollen right leg prior to notifying the Nurse Practitioner to assess; and

    b) Failed to assess and/or document an assessment of resident NP's swollen lower lip prior to notifying the Nurse Practitioner to assess."

(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. Guraya acknowledged unprofessional conduct and pled guilty to all the Allegations as evidenced by her signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. This non-verbal admission of guilt was accepted by the Hearing Tribunal Panel.

Legal Counsel for the Complaints 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
Exhibit #4: Ms. Guraya's Essay

(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 Harjit Guraya'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 Harjit Guraya.

Allegation 1

Ms. Guraya, LPN, admitted on or about August 26, 2017, she failed to take appropriate steps to ensure it was safe for resident JM to receive her morning medications at 0800 hours after JM received another resident's medications on August 25, 2017 at 2000 hours, particulars of which include one or more of the following:

a) Failed to conduct an adequate assessment of JM before JM received her morning medications; and

b) Failed to consult the RN or Nurse Practitioner for direction before JM received her morning medications.

Ms. Guraya was working at St. Marguerite Manor on August 26, 2017, and during this time provided care to resident JM. Resident JM was a 94 year old woman living in a residential ward of St. Marguerite Manor.

On August 25, 2017, at approximately 2000 hours, resident JM had been given another resident, KC's, medications in error by a Resident Assistant ("RA"). The medications that were given in error included: Metoprolol, Atorvastatin, Clozapine, and Clonazepam. As a result, JM was being monitored.

Ms. Guraya began her shift on August 26 at 0700 hours, and was informed that resident JM had received incorrect medication in error. In spite of this, Ms. Guraya administered resident JM's scheduled 0800 hours medication to her without conducting an assessment of resident JM.

Ms. Guraya also failed to consult with a Registered Nurse ("RN") or Nurse Practitioner ("NP") for direction prior to administering JM's morning medications.

At 0930 hours, resident JM appeared to be very drowsy, had difficulty speaking, and was unable to swallow fluids. Resident EM was transferred via Emergency Medical Services to a hospital for treatment.

St. Marguerite Manor's "Communication Algorithm" requires LPNs to perform assessments of residents, and document those assessments, prior to contacting an NP or physician. When an issue is identified by an LPN, the LPN must conduct an assessment, determine if the matter is urgent, and if so, contact the appropriate member of the inter-professional team, be it an NP or physician.

Despite these requirements, Ms. Guraya did not complete or document an assessment of resident JM prior to administering her morning medication. Ms. Guraya further failed to consult an RN or NP for direction before administering JM's morning medications.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Guraya'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:** Ms. Guraya displayed a lack of knowledge by failing to adequately assess resident JM prior to giving morning medications;

ii. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Guraya 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. Standard 1 (Professional Accountability and Responsibility), as indicated by the fact that she failed to report according to established employer policies (Standard 1.10) to an RN or Nurse Practitioner prior to administering morning medications to JM;

b. Standard 1 (Professional Accountability and Responsibility) as indicated by the fact that she failed to take action to avoid and/or minimize harm (Standard 1.6) by not assessing JM prior to administering morning meds;

c. Standard 3 (Service to the Public and Self-Regulation) as indicated by the fact that she failed to provide relevant and timely information to an RN or Nurse Practitioner (Standard 3.5); and

d. Code of Ethics, Principle 4 (Responsibility to Colleagues) by failing to collaborate with colleagues to promote safe, competent practice (Principle 4.2), by not reporting to an RN or Nurse Practitioner, prior to administering morning medications to JM.

The Hearing Tribunal finds the conduct displayed a lack of knowledge, skill or judgment in the provision of professional services and contravened the CLPNA's Code of Ethics and CLPNA's Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct.

Allegation 2

Ms. Guraya, LPN, admitted on or about October 6, 2018, she did one or more of the following with regards to resident EP:

a) Failed to assess and/or document an assessment after EP's daughter reported EP had slurred speech; and

b) Failed to report EP's daughter's concerns to the RN or Nurse Practitioner.

Ms. Guraya was working at St. Marguerite Manor on October 6, 2018, and during this time provided care to resident EP. EP was an 85 year old woman with dementia and living in a residential ward of St. Marguerite Manor.

On or about October 6, 2018, resident EP's daughter reported to Ms. Guraya that EP's speech was slurred during a telephone conversation and requested that Ms. Guraya check on resident EP. EP's daughter was worried that her mother was exhibiting stroke-like symptoms.

Ms. Guraya observed EP throughout her shift, and noted that EP appeared to be "normal." However, she did not perform or document an assessment of EP after EP's daughter reported her concerns to Ms. Guraya. Further, although Ms. Guraya made note of EP's daughter's concern in EP's Nurses Progress Notes, she failed to report the concerns to an RN or NP.

In spite of the above, Ms. Guraya failed to assess and/or document an assessment of EP after EP's daughter reported she had slurred speech. Ms. Guraya further failed to report EP's daughter's concerns to an RN or NP.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Guraya'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 definition of unprofessional conduct have been met:

i. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Guraya breached the following principles and standards set out in CLPNA's Code of Ethics and CLPNA's Standards of Practice:

    a. Standard 2 (Knowledge-Based Practice) when she failed to adequately assess and/or document resident EP, by not applying knowledge from nursing theory and science (in particular, Standard 2.2);

    b. Standard 2 (Knowledge-Based Practice) by not communicating to an RN or Nurse Practitioner about EP's condition (Standard 2.13);

    c. Standard 3 (Service to the Public and Self-Regulation) by failing to provide relevant and timely information to clients and co-workers, and by not reporting EP's daughter's concerns to the RN or Nurse Practitioner (Standard 3.5); and

    d. Code of Ethics, Principle 2 (Responsibility to Clients), by failing to use evidence and judgment when she did not report EP's condition to an RN or Nurse Practitioner (Principle 2.8).

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

<u>Allegation 3</u>

Ms Guraya, LPN, admitted on or about October 19, 2018, she did one or more of the following with regards to resident ME:

a) Failed to adequately assess and/or document an adequate assessment after HCA's reported ME was confused, had slurred speech and facial drooping;

b) Failed to take adequate steps to ensure ME was monitored; and

c) Failed to report ME's status to the RN or Nurse Practitioner.

Ms. Guraya was working at St. Marguerite Manor on October 19, 2018, and during this time provided care to resident ME. ME was an 82 year old woman living in a residential ward of St. Marguerite Manor.

Juliet Etulle, a Resident Attendant ("RA") working at St. Marguerite Manor on October 19, 2018, noted that resident ME seemed sleepy after receiving her medications. RA Etulle called Ms. Guraya, who was on her break, to request an assessment. Ms. Guraya did not attend to assess resident ME.

At approximately 1210-1230 hours, Azenith Faelnar-Shestak, an RA working at St. Marguerite Manor on October 19, 2018, noticed that resident ME had a facial droop, ME's face was red, she was drooling and mumbling, and was unable to lift her cup. RA Faelnar-Shestak suspected that resident ME may have been having a stroke or stroke-like illness.

RA Faelnar-Shestak called Ms. Guraya, as she was responsible for resident ME's care, to relay her observations of ME and request an assessment. Ms. Guraya instructed RA Faelnar-Shestak to monitor resident ME, and to inform her if ME's condition worsened. At this time, Ms. Guraya did not attend to resident ME herself, nor did she perform an assessment of ME's condition.

Shortly after the above phone call, RA Faelnar-Shestak took resident ME's blood pressure, and immediately called Ms. Guraya to report her preliminary assessment of high blood pressure. At this time, Ms. Guraya attended to ME to take her blood pressure and asked her to raise her arms. However, Ms. Guraya failed to perform a full neurological assessment of resident ME.

Ms. Guraya determined that resident ME was fit to return to the dining room to finish her lunch, and instructed the RAs to keep resident ME in the television room for a period of one hour following lunch in order to observe her symptoms. Ms. Guraya then returned to her break and did not report her findings to a Registered Nurse or Nurse Practitioner.

Following lunch, ME was observed by RAs in the television room of St. Marguerite Manor for a period of one hour before being returned to her suite. Ms. Guraya did not monitor or assess ME during this time.

At 1430 hours, Ms. Judi Klein, RN and Case Manager at St. Marguerite Manor, attended at resident ME's room on an unrelated matter. At that time, Ms. Klein found that ME had slurred speech and unequal hand grip strength, both indicia of a stroke or stroke-like illness. Upon discussion with RAs, Ms. Klein became aware that ME had been slurring and drooling at lunch.

On these bases, Ms. Klein contacted an NP for an assessment of ME, and requested that staff begin procedures to transfer ME to a hospital. As assessment of resident ME by the NP revealed left side weakness and slow speech.

Upon resident ME's arrival at the Foothills Medical Centre in Calgary, Alberta, she was admitted based on her symptoms of stroke, and was found to have difficulty finding words, left arm and face weakness. Resident ME was referred to a Stroke Prevention Clinic.

Ms. Guraya did not document her incomplete assessment of ME until 1303 hours. This entry in resident ME's Progress Notes indicates that Ms. Guraya assessed resident ME's blood pressure, temperature, oxygen saturation, and respiration, but fails to indicate that she performed an assessment of ME's neurological vital signs as would be required in the circumstances based on ME's symptoms. No further monitoring or assessment of resident ME by Ms. Guraya is evident.

Ms. Guraya failed to adequately assess and/or document an adequate assessment after she became aware that ME was confused, had slurred speech and facial drooping; failed to take adequate steps to ensure that ME was monitored; and failed to report ME's status to an RN or NP in accordance with St. Marguerite Manor's Communication Algorithm.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Guraya'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. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Guraya breached the following principles and standards set out in CLPNA's Code of Ethics and CLPNA's Standards of Practice:

    a. Standard 2 (Knowledge-Based Practice) when she failed to apply knowledge from nursing theory and science by not assessing or documenting patient ME when it was reported to her by HCAs that resident ME was confused, had slurred speech and facial drooping (in particular, Standard 2.2);

    b. Standard 2 (Knowledge -Based Practice) by failing to communicate to an RN or Nurse Practitioner that ME's status had changed (Standard 2.13);

    c. Standard 1 (Professional Accountability and Responsibility) when she failed to report to an RN or Nurse Practitioner about ME's status according to employer policies (in particular, Standard 1.10); and

    d. Code of Ethics, Principle 1 (Responsibility to the Public) by failing to provide care directed to the health and well-being of the person, when she failed to report resident ME's status change to an RN or Nurse Practitioner (in particular, Principle 1.5).

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

Allegation 4

Ms. Guraya, LPN, admitted on or about February 4, 2019, she did one or more of the following:

a) Failed to assess and/or document an assessment of resident IR's swollen right leg prior to notifying the Nurse Practitioner to assess; and

b) Failed to assess and/or document an assessment of resident NP's swollen lower lip prior to notifying the Nurse Practitioner to assess.

Ms. Guraya was working at St. Marguerite Manor on February 4, 2019, and during this time provided care to residents IR and NP. IR was a 96 year old woman living in a residential ward of St. Marguerite Manor. NP was a 95 year old woman living in a residential ward of St. Marguerite Manor.

Ms. Guraya contacted NP Cooper to assess residents IR and NP in relation to a swollen right leg and swollen lower lip, respectively. NP Cooper attended at the suites of both residents IR and NP, and noted at that time that Ms. Guraya had contacted her for an assessment of the two residents without performing her own assessment first, as required by St. Marguerite Manor's "Communication Algorithm".

Ms. Guraya failed to adequately assess and/or document an adequate assessment of resident IR's swollen right leg prior to notifying the Nurse Practitioner for an assessment; and failed to assess and/or document an assessment of resident NP's swollen lower lip prior to notifying the Nurse Practitioner for an assessment.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Guraya's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that 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. **Contravention of this Act [the Act], a code of ethics or standards of practice:** Ms. Guraya breached the following principles and standards set out in CLPNA's Code of Ethics and CLPNA's Standards of Practice:

    a. Standard 1 (Professional Accountability and Responsibility) by not documenting an assessment prior to reporting resident IR's swollen right leg, or resident NP's swollen lower lip in accordance with her employer policy (in particular, Standard 1.10); and

b. Code of Ethics, Principle 4 (Responsibility to Colleagues) by failing to collaborate with her colleagues to provide safe and competent care, when she failed to document an assessment prior to reporting resident IR's swollen right leg, or resident NP's swollen lower lip (in particular, Principle 4.2).

The Hearing Tribunal finds the conduct contravened the CLPNA's Code of Ethics and CLPNA's 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. Guraya were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act, the CLPNA's Code of Ethics and CLPNA's Standards of Practice applicable to Ms. Guraya 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. Guraya 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 reasons for decision (the "Decision") shall serve as a reprimand.

2. Ms. Guraya shall pay 25% of the costs of the hearing to a maximum of $3,500 subject to the following:

   (a) Ms. Guraya will pay the full amount of costs to the CLPNA once her maternity/parental leave has ended, or by September 30, 2020, whichever is earlier; and

   (b) If Ms. Guraya cannot meet the deadline for payment of costs, she may request an extension by submitting her request to the Complaints Consultant.

3. Ms. Guraya shall, within 30 days of service of the Decision, read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide the Complaints Consultant a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice:

   (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: B: Nursing Process;

(f) CLPNA Competency Profile D2: Collaborative Team Practice;

(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.

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

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

5. Ms. Guraya shall, within 60 days of service of the Decision, complete, at her own cost, the **NURS0163 Introduction to Health Assessment** course available online at macewan.ca, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Ms. Guraya shall, within 30 days of service of the Decision, complete, at her own cost, the **Documentation and Reporting** course available at www.coursepark.com, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Ms. Guraya shall, within 60 days of service of the Decision, complete, at her own cost, the **4 Essential Communication Strategies that Promote Patient Safety** course available online at www.pedagogyeducation.com and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. A condition shall be placed on Ms. Guraya's practice permit requiring her to submit performance appraisals from her immediate supervisor(s) at all facilities where she is employed, subject to the following terms and conditions:

    (a) The supervisor(s) will provide written confirmation that they have reviewed a copy of the Decision;

    (b) The supervisor will provide the CLPNA will two performance evaluations, indicating whether they have any concerns with Ms. Guraya's performance;

    (c) The first performance evaluation will be due within three months of the date of that Ms. Guraya returns to work following her maternity/parental leave;

    (d) The second performance evaluation will be due six months after the first evaluation was provided;

    (e) If the performance evaluations are not satisfactory, the Complaints Consultant may, in her discretion, request a further performance evaluation from Ms. Guraya's employer(s) which will be due three months after the last performance evaluation was provided;

    (f) Once the Complaints Consultant has determined that the performance evaluations are satisfactory, the condition will be removed from Ms. Guraya's practice permit;

    (g) If at any time the supervisor(s) identify concerns regarding Ms. Guraya's performance, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

9. Ms. Guraya 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. Guraya will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Ms. Guraya 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.

11. Should Ms. Guraya 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, one or more of the following steps may occur:

(a) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

(b) the Complaints Consultant may treat Ms. Guraya's non-compliance as information under s. 56 of the *Health Professions Act*; and

(c) the Complaints Consultant may, in the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Guraya'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 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 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 Harjit Guraya 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. Guraya 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 Hearing tribunal carefully considered the above factors in coming to the decision on penalties and found that Ms. Guraya clearly demonstrated unprofessional conduct.

The nature and gravity of the proven allegations: Ms. Guraya was found guilty of four allegations. All of the allegations had a direct impact on clients under her care. In each allegation, the clients involved did not receive immediate care for potential life threatening conditions. The seriousness of the unprofessional conduct indicates the need for appropriate penalties.

The age and experience of the investigated member: Ms. Guraya was initially licensed as an LPN in Alberta on June 18, 2013. At the time of the allegations Ms. Guraya had been practicing for between 4 and 5 years. The Hearing Tribunal finds that 4 to 5 years is not considered a new graduate, and at this point in her career she should have had the appropriate assessment skills to ensure the safety of her clients.

The number of times the offending conduct was proven to have occurred: The Hearing Tribunal took into consideration that five separate clients were impacted, on four separate dates, by Ms. Guraya's actions. The offending conduct occurred over three years (2017, 2018 and 2019) therefore indicating that this was not an isolated incident. The Hearing Tribunal considered this factor of unprofessional conduct to be a serious indication of the need for appropriate penalties.

The role of the investigated member in acknowledging what occurred: The Hearing Tribunal would like to acknowledge the fact that Ms. Guraya took responsibility for her actions. The Hearing Tribunal also took into consideration that Ms. Guraya opted for an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, and also wrote an essay admitting to her errors and outlining her learning experience. This was viewed as a mitigating factor with respect to the seriousness of the penalties.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

In assessing the overall proportionality of the penalties it orders, the Hearing Tribunal took into consideration any other penalties suffered by the Investigated Member as a result of the unprofessional conduct in question. The Hearing Tribunal is aware that Ms. Guraya did receive a 3-day suspension and that she is currently unable to work due to her pregnancy/parental leave. The Hearing Tribunal has considered this when assessing orders for penalty.

The impact of the incident(s) on the victim: The Hearing Tribunal was not made aware of any impact on the residents that were in Ms. Guraya's care at the time of the allegations; however, there was a potential of harm to take place given that there was a lack of assessment of patients at critical times. The Hearing Tribunal did consider the potential impact of the unprofessional conduct on the victims, and found it to be a serious factor when assessing the orders for penalty.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: Regarding specific deterrence, Ms. Guraya must understand personally that this this type of behavior is not acceptable of an LPN, nor will it be tolerated by the CLPNA and that this type of behavior is dealt with in a serious manner. The sanctions that are imposed with regards to Ms. Guraya will also act as a deterrent to other LPNs.

The need to maintain the public's confidence in the integrity of the profession: The public needs to be assured that all LPNs must continue to meet or exceed the CLPNA Standards of Practice. The public should also be made aware that the CLPNA deals with the actions of members when they conduct themselves in a way that is not becoming to the LPN profession in a careful and considered way. The CLPNA will deal with any breaches of the HPA, the CLPNA Code of Ethics and the CLPNA Standards of Practice in a manner that the CLPNA deems acceptable. The Hearing Tribunal took this into consideration when imposing the penalties.

It is important to the profession of LPNs to maintain the CLPNA's Code of Ethics and the CLPNA's 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. Guraya shall pay 25% of the costs of the hearing to a maximum of $3,500 subject to the following:

   (a) Ms. Guraya will pay the full amount of costs to the CLPNA once her maternity/parental leave has ended, or by September 30, 2020, whichever is earlier; and

   (b) If Ms. Guraya cannot meet the deadline for payment of costs, she may request an extension by submitting her request to the Complaints Consultant.

3. Ms. Guraya shall, within 30 days of service of the Decision, read and reflect on the following CLPNA documents located on the CLPNA website at http://www.clpna.com under the "Governance" tab, and provide the Complaints Consultant a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice:

   (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: B: Nursing Process;

   (f) CLPNA Competency Profile D2: Collaborative Team Practice;

   (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.

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

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

5. Ms. Guraya shall, within 60 days of service of the Decision, complete, at her own cost, the **NURS0163 Introduction to Health Assessment** course available online at macewan.ca, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Ms. Guraya shall, within 30 days of service of the Decision, complete, at her own cost, the **Documentation and Reporting** course available at www.coursepark.com, and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Ms. Guraya shall, within 60 days of service of the Decision, complete, at her own cost, the **4 Essential Communication Strategies that Promote Patient Safety** course available online at www.pedagogyeducation.com and provide the Complaints Consultant with a certificate confirming successful completion of the course. If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. A condition shall be placed on Ms. Guraya's practice permit requiring her to submit performance appraisals from her immediate supervisor(s) at all facilities where she is employed, subject to the following terms and conditions:

    (a) The supervisor(s) will provide written confirmation that they have reviewed a copy of the Decision;

    (b) The supervisor will provide the CLPNA will two performance evaluations, indicating whether they have any concerns with Ms. Guraya's performance;

    (c) The first performance evaluation will be due within three months of the date of that Ms. Guraya returns to work following her maternity/parental leave;

(d) The second performance evaluation will be due six months after the first evaluation was provided;

(e) If the performance evaluations are not satisfactory, the Complaints Consultant may, in her discretion, request a further performance evaluation from Ms. Guraya's employer(s) which will be due three months after the last performance evaluation was provided;

(f) Once the Complaints Consultant has determined that the performance evaluations are satisfactory, the condition will be removed from Ms. Guraya's practice permit;

(g) If at any time the supervisor(s) identify concerns regarding Ms. Guraya's performance, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

9. Ms. Guraya 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. Guraya will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Ms. Guraya 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.

11. Should Ms. Guraya 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, one or more of the following steps may occur:

(d) the Complaints Consultant may refer the matter back to a Hearing Tribunal, which shall retain jurisdiction with respect to penalty;

(e) the Complaints Consultant may treat Ms. Guraya's non-compliance as information under s. 56 of the *Health Professions Act*; and

(f) the Complaints Consultant may, in the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Guraya'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 balance 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 18th DAY OF OCTOBER, 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

P. Standage LPN

Patricia Standage, LPN
Chair, Hearing Tribunal