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 HEATHER TAYLOR

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 HEATHER TAYLOR, LPN #29139, 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 December 10, 2019 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Marie Concepcion, LPN
James Lees, Public Member

Staff:
Tessa Gregson, Legal Counsel for the Complaints Consultant
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Heather Taylor, LPN ("Ms. Taylor or "Investigated Member")
Kathie Milne, 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. Taylor 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. Taylor was initially licensed as an LPN in Alberta on April 10, 2007.

First Complaint

On April 19, 2018, the CLPNA received a complaint from Tricia Coish, General Manager for Points West Living Cold Lake ("Points West") in Cold Lake, Alberta (the "First Complaint"). The First Complaint was sent pursuant to s. 57 of the *Health Professions Act* (the "Act"), notifying that Ms. Taylor, LPN had received a one-day suspension.

Ms. Taylor received notice of the First Complaint, notice of a preliminary investigation and request for a written statement by letter dated April 23, 2018 from Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director").

The Complaints Director finished her preliminary investigation into the First Complaint and notified Ms. Taylor that in accordance with s. 55(2)(d) of the Act, the Complaints Director appointed Kerry Palyga, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the First Complaint.

Second Complaint

Also, on August 15, 2018, the CLPNA received a further complaint from Ms. Coish pursuant to s. 57 of the Act, notifying that Ms. Taylor had received a three day suspension (the "Second Complaint").

The Complaints Director, in accordance with s. 55(2)(d) of the Act, appointed the Investigator to conduct an investigation into the Second Complaint. The Complaints Director also delegated her authority and powers under Part 4 of the Act to the Complaints Consultant for the CLPNA, Amanda Winterhalt (the "Former Complaints Consultant"), pursuant to s. 20 of the Act.

Ms. Taylor received notice of the Second Complaint, notice of delegation to the Former Complaints Consultant and notice of investigation into the Second Complaint by letter dated August 15, 2018.

Third Complaint

On August 21, 2018, the CLPNA received a further complaint from Ms. Coish pursuant to s. 57 of the Act, notifying that Ms. Taylor had been terminated from her position at Points West (the "Third Complaint").

The Complaints Director, in accordance with s. 55(2)(d) of the Act, appointed the Investigator to conduct an investigation into the Third Complaint. The Complaints Director also delegated her authority and powers under Part 4 of the Act to the Former Complaints Consultant pursuant to s. 20 of the Act.

On October 30, 2018, the Investigator concluded the investigation into the First, Second and Third Complaints and submitted the Investigation Report to the CLPNA.

In November 2018, Susan Blatz, Complaints Consultant with the CLPNA (the "Complaints Consultant"), took carriage of the First, Second and Third complaints against Ms. Taylor.

Following the Complaints Consultant's review of the Investigation Report into the Complaints, 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. Taylor received notice that the matters were referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated August 26, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Taylor under cover of letter dated October 31, 2019.

(4) Allegations

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

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

1. **Withdrawn.**
2. On or about February 17, 2018 did one or more of the following after client WW suffered a fall and was sent to the hospital:
    a. Failed to notify the public guardian of client WW's fall and client WW, being sent to the hospital or request the oncoming LPN to notify the public guardian;
    b. Failed to complete an incident management report, post-fall checklist and Neurological Flow Sheet as required;
    c. Failed to complete a post-fall assessment as required; and
    d. Failed to document anything relating to the fall and/or client WW being sent to the hospital in client WW's Log Book Report.
3. On or about April 18, 2018 failed to perform and/or document an assessment of client RM during her shift.
4. On or about April 19, 2018 did one or more of the following with regards to client RM's catheter failing to drain any urine on her shift:
    a. Failed to perform and/or document an adequate assessment of client RM; and
    b. Failed to provide and/or document any interventions to address the catheter not draining any urine.
5. On or about July 25, 2018 did one or more of the following with regards to client AP:
    a. Failed to perform and/or document an assessment of client AP;
    b. Withdrawn.

c. Withdrawn.

6. On or about July 26, 2018 did one or more of the following with regards to client AP:
    a. Failed to perform and/or document any assessment of client AP during her shift; and
    b. Failed to monitor and/or record urinary output during her shift as requested.
7. **Withdrawn.**
8. On or about August 18, 2018, did one or more of the following with regards to client AP's Log Book Report:
    a. Made entries into client AP's Log Book Report for July 25, 2018 and July 26, 2018 while suspended from the facility; and
    b. Failed to indicate the entries for July 25, 2018 and July 26, 2018 were late entries."

(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. Taylor acknowledged unprofessional conduct to all the allegations as evidenced by his/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 Consultant submitted, where there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3: Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #2.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #2, and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Heather Taylor'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 Heather Taylor.

Allegation 1

Allegation 1 was withdrawn by the Complaints Consultant at the hearing of this matter.

Allegation 2

Ms. Taylor admitted on or about February 17, 2018, she did one or more of the following after client WW suffered a fall and was sent to the hospital:

a. Failed to notify the public guardian of client WW's fall and client WW being sent to the hospital or request the oncoming LPN to notify the public guardian;

b. Failed to complete an incident management report, post-fall checklist and Neurological Flow Sheet as required;

c. Failed to complete a post-fall assessment as required; and

d. Failed to document anything relating to the fall and/or client WW being sent to the hospital in client WW's Log Book Report.

Ms. Taylor worked a day shift on February 17, 2018, which was a Saturday. A copy of Ms. Taylor's February Time Sheet was provided to the Hearing Tribunal. It was during this shift that Ms. Taylor provided care to client WW, who was under the care of the Office of the Public Guardian and Trustee ("OPGT").

During this shift, client WW, fell and hit the back of his head on a dresser. Ms. Taylor attended to client WW, called EMS and client WW was transported to the hospital for treatment of the laceration on his head.

The Post Fall Assessment Policy requires that after a fall, an LPN must: perform a head-to-toe assessment, including vital signs and neurovital signs prior to moving the resident to determine if there are any injuries; ask a series of questions outlined in the policy; complete a post-fall form and place it in the chart; and complete an incident management report.

Despite attending to client WW and calling EMS to transport client WW to the hospital, Ms. Taylor failed to complete a post-fall assessment of client WW, which is required by Points West's Post Fall Assessment Policy.

Points West also requires that a Post Fall Checklist and Neurological Flow Sheet be completed.

In addition to failing to complete a post-fall assessment, Ms. Taylor failed to complete an incident management report, post-fall checklist and Neurological Flow Sheet as required by the Post Fall Assessment Policy.

Ms. Taylor further failed to document any details on client WW's fall or transport to the hospital in client WW's Log Book Report.

The second-floor nursing office contains a notice specifying when and how to contact the OPGT after hours. It outlines the emergent situations where the OPGT's crisis line should be used versus non-urgent situations, where it is permitted to pass along the information on the next business day, leave a voicemail message or fax an incident report:

a. Examples of emergency situations include where: "a Represented Adult has an illness or injury that requires immediate consent for treatment" and where "the Represented Adult's health or safety is at immediate risk".

b. Examples of non-urgent situations include where: "a Represented Adult falls but no medical treatment is required".

A copy of the Agency Information/Guidelines for afterhours calls with the OPGT was provided to the Hearing Tribunal.

Given that client WW required treatment for the laceration on his head, the OPGT needed to be notified that client WW had fallen and was sent to the hospital for treatment. Upon client WW's return to Points West at 1650 hours, the LPN on duty, Nicanelle Orobia, noted that client WW had seven (7) staples at the back of his head closing the laceration.

Despite this, Ms. Taylor failed to notify the OPGT during her shift and failed to request that the oncoming LPN notify the OPGT.

Following Points West's Investigation into the conduct outlined, Ms. Taylor received a one (1) day suspension.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor'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**: Ms. Taylor failed to notify the OPGT, as well as, failed to complete required information after client WW sustained a fall. This displays a lack of knowledge, skill or judgment by not doing what is expected of a health care provider. Ms. Taylor was not an inexperienced member of the health care team and should know what the proper protocol is when a client has a fall within the facility. If Ms. Taylor was unaware of what should have been done regarding a Post Fall Assessment, she should have asked another health care team member;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and as set out specifically below and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**. Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Ms. Taylor should have known what to do when a client has a fall and who would be the reasonable resources to communicate this to.

<u>CLPNA Code of Ethics and CLPNA Standards of Practice:</u>

Ms. Taylor acknowledged that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada ("CLPNA Code of Ethics"), which states as follows:

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.

- 1.5 Provide care directed to the health and well-being of the person, family, and community.

Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.

- 2.8 Use evidence and judgement to guide nursing decisions.

- 2.9 Identify and minimize risks to clients.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:

- 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.

- 3.3 Practice in a manner that is consistent with the privilege and responsibility of self-regulation.

- 3.4 Promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations in which they are accountable.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

- 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.

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

Ms. Taylor acknowledged that her conduct breached one of more of the following Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice") which state as follows:

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 competencies within applicable legislation regulations, by-laws and employer policies.

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

- 1.4 Recognize their own practice limitations and consult as necessary.

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

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

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

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to the professional LPN practice. Standard 2 specifically provides that LPNs:

- 2.1 Possess current knowledge to support clinical thinking and professional judgement.

- 2.2 Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice.

- 2.7 Demonstrate understanding of their role and its interrelation with clients and other health care colleagues.

- 2.11 Use critical inquiry to assess, plan and evaluate the implications of interventions that impact client outcomes.

- 2.13 Modify and communicate to appropriate person changes to specific interventions based on the client's responses.

Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness or injury.

- 3.5 Provide relevant and timely information to clients and co-workers.

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

Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPRN) Code of Ethics. Standard 4 specifically provides that LPNs:

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

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

- 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

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

Allegation 3

Ms. Taylor admitted on or about April 18, 2018, she failed to perform and/or document an assessment of client RM during her shift.

Client RM returned from the hospital to Points West on April 17, 2018 at 1710 hours with a catheter in place.

Ms. Taylor worked the night shift at Points West from 0000 hours to 0800 hours on April 18, 2018. A copy of Ms. Taylor's April Time Sheet was provided to the Hearing Tribunal.

However, Ms. Taylor failed to perform and document any assessments of client RM during her shift from 0000 hours to 0800 hours on April 18, 2018. A copy of client RM's Log Book Report was provided to the Hearing Tribunal, demonstrating no entries by Ms. Taylor between 2141 hours on April 17, 2018 and 1641 hours on April 18, 2018.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor'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**: Ms. Taylor displayed a lack of knowledge, skill or judgment by not performing a proper assessment or documentation of client RM once client RM returned from the Hospital to Points West. This is a basic core competency for LPNs and Ms. Taylor should have known the proper protocol of what to do when a client returns from the Hospital to Points West;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out specifically above and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**: Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Documentation and assessments are core competencies of an LPN.

Allegation 4

Ms. Taylor admitted on or about April 19, 2018, she did one or more of the following with regards to client RM's catheter failing to drain any urine on her shift:

a. Failed to perform and/or document an adequate assessment of client RM; and

b. Failed to provide and/or document any interventions to address the catheter not draining any urine.

Ms. Taylor also worked the night shift on April 19, 2018 from 0000 hours to 0800 hours and provided care to client RM.

Client RM returned from the hospital on April 17, 2018 with a catheter in place. By 2240 hours on April 18, 2018, client RM's urinary output for the evening was only 85 mls. The LPN who worked the evening shift from 1600 hours to 0000 hours, Ms. Orobia, monitored client RM's output and reported to the oncoming LPN, Ms. Taylor, that client RM's output needed continued monitoring. This could be seen in client RM's Log Book Report.

At 0910 hours on April 19, 2018, Natalie Senez, RN and Home Care Case Manager with AHS, attended to client RM to irrigate client RM's catheter. At this time, Ms. Senez discovered that the catheter tubing was kinked in two (2) places. Ms. Senez unkinked the tubing at which time the catheter immediately started to drain. Ms. Senez clamped the tubing after 1000 mls of output and took client RM's vital signs then drained a further 400 mls of urine from client RM. Ms. Senez observed the output was dark red and murky but then started to clear. Ms. Senez reported concerns about Ms. Taylor's care of client RM to Ms. Coish.

Despite client RM's catheter and the instruction to continue monitoring, Ms. Taylor failed to perform and complete adequate assessments of client RM during her night shift. Ms. Taylor documented that she checked client RM's catheter three times during her shift and no output was noted.

However, merely checking client RM for catheter output during a night shift is an insufficient assessment of the client. A proper assessment of client RM would have entailed, among other things: checking the catheter and tubing to ensure it was not kinked; a physical assessment of the bladder using palpation; vital signs; chest assessment; assessment of extremities for

swelling; and asking health care providers and the patient about fluid intake to ensure the patient was not dehydrated.

Further, had proper assessments been completed, issues with the catheter tubing preventing drainage could have been detected.

As mentioned, Ms. Taylor noted no urinary output for client RM for her entire shift from 0000 hours until 0800 hours. Given that client RM had minimal output on April 18, 2018 (as reported by Ms. Orobia), Ms. Taylor had instructions to continue monitoring urinary output. As Ms. Taylor observed no urinary output during her shift, Ms. Taylor should have performed and documented interventions to address the catheter failing to drain any urine. This was not done.

Following Points West's investigation into the conduct outlined in allegations 3 and 4, Ms. Taylor received a three (3) day suspension.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor'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. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services**: Ms. Taylor displayed a lack of knowledge, skill or judgment in that Ms. Taylor failed to perform or document an assessment. Nor did Ms. Taylor document any interventions with regards to the Foley catheter not draining any urine. Basic assessments and documentation are basic core competencies of an LPN, and Ms. Taylor should have been aware of what to do in regards to this client. By Ms. Taylor not performing a proper assessment, this had the potential of great harm to client RM as the urine was not being drained from the client's bladder;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as specifically set out above and that such breaches are sufficiently serious to constitute unprofessional conduct;

iii. **Conduct that harms the integrity of the regulated profession**: Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Documentation and assessments are core competencies of an LPN. Ms. Taylor did not meet the expectations or the standards of what is expected of an LPN in this situation.

Allegation 5

Ms. Taylor admitted on or about July 25, 2018, she did one or more of the following with regards to client AP:

a. Failed to perform and/or document an assessment of client AP;

b. Withdrawn.

c. Withdrawn.

Ms. Taylor worked a night shift at Points West from 0000 hours to 0800 hours on July 25, 2018. During this shift, she provided care to client AP.

On July 23, 2018, following removal of client AP's Foley catheter, client AP's poor urine output prompted a new physician's order. The physician ordered an In & Out catheter be administered to client AP. The order specified that if there was significant output, the catheter would be left in situ and if client AP was unable to void in 8 hours after the In & Out catheter was administered, the In & Out Catheter should be repeated.

On July 24, 2018 at 1845 hours Ms. Orobia catheterized client AP; 350 cc's of output was noted at this time and the catheter was therefore left in. This information was passed onto Ms. Taylor who, as above, worked the night shift on July 25, 2018 from 0000 hours until 0800 hours. Ms. Orobia charted this at 2245 hours on July 24, 2018.

In the morning of July 25, 2018, Ms. Taylor reported to the oncoming LPN, Alison Anstruther, and RN, Ms. Senez, that client AP had not voided during her shift and a dayshift LPN would therefore need to perform an In & Out catheter. Ms. Anstruther assisted Ms. Senez with the In & Out catheter at 1100 hours on July 25, 2018, and drained 350 cc's of urine at that time.

Despite having client AP in her care and information regarding client AP's catheterization, Ms. Taylor failed to perform and document any assessments of client AP during her shift. This included the failure to assess and document client AP's urinary output during her shift, as required by the Physician's order. Client AP's Log Book Report was provided to the Hearing Tribunal.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor'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**: Ms. Taylor displayed a lack of knowledge, skill or judgment by

failing to perform and document a proper assessment of client AP, once client AP's Foley catheter was removed, nor did Ms. Taylor communicate the status of her client to other Health Care Providers. Communication is vital when dealing with clients as failure to do so can pose a potential risk to the client;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as specifically set out above and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**: Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Documentation and assessments are core competencies of an LPN. Ms. Taylor did not meet the expectations or the standards of what is expected of an LPN in this situation.

Allegation 6

Ms. Taylor admitted on or about July 26, 2018, she did one or more of the following with regards to client AP:

a. Failed to perform and/or document any assessment of client AP during her shift; and

b. Failed to monitor and/or record urinary output during her shift as requested.

Ms. Taylor worked the night shift at Points West from 0000 hours to 0800 hours on July 26, 2018 and during this shift she provided care to client AP. Ms. Taylor's July Time Sheet was provided to the Hearing Tribunal.

As noted above, client AP continued to have issues voiding into the day on July 25, 2018. Following orders from client AP's physician, at 1430 hours on July 26, 2018, Ms. Anstruther inserted a Foley catheter which would be left in for one week. Ms. Anstruther instructed the oncoming LPN, Ms. Taylor, to collect urine output each shift.

Despite this, Ms. Taylor failed to monitor and record any urinary output of client AP during her shift, as requested by Ms. Anstruther. The only urinary output monitoring performed was completed by the HCA, Brandi Burge. Ms. Burge did not discuss client AP's status with Ms. Taylor.

Ms. Taylor further failed to perform and document any assessments of client AP during her shift from 0000 hours to 0800 hours on July 26, 2018.

Following Points West's investigation into the conduct outlined in allegations 5 and 6, Ms. Taylor's employment with Points West was terminated as of August 21, 2018.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 6 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. Taylor displayed a lack of knowledge, skill or judgment by failing to perform and document a proper assessment of client AP, once client AP's Foley catheter was removed, nor did Ms. Taylor communicate the status of her client to other Health Care Providers. Communication is vital when dealing with clients as failure to do so can pose a potential risk to the client;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as specifically set out above and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**: Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Documentation and assessments are core competencies of an LPN. Ms. Taylor did not meet the expectations or the standards of what is expected of an LPN in this situation.

<u>Allegation 7</u>

Allegation 7 was withdrawn by the Complaints Consultant at the hearing of this matter.

<u>Allegation 8</u>

Ms. Taylor admitted on or about August 18, 2018, she did one or more of the following with regards to client AP's Log Book Report:

a. Made entries into client AP's Log Book Report for July 25, 2018 and July 26, 2018 while suspended from the facility; and

b. Failed to indicate the entries for July 25, 2018 and July 26, 2018 were late entries.

Ms. Taylor was placed on an administrative leave with pay from August 10 until August 21, 2018, pending the outcome of Points West's investigation into her care of client AP (as outlined in allegations 5 and 6). During this time, Ms. Taylor was not permitted to attend the facility or access client records.

As noted above, Ms. Taylor failed to perform and document any assessments of client AP during her July 25 and July 26, 2018 night shifts.

Despite being on an administrative leave from Points West pending the investigation into her care of client AP, on August 17, 2018, Ms. Taylor accessed the Senior Care System, which is the system through which clients' log book reports are accessed and modified. Ms. Taylor proceeded to add an entry for July 25, 2018 at 0906 hours into client AP's Log Book Report describing reports received by the HCA regarding client AP's output, the reason she failed to perform an In & Out catheter on client AP and that she would inform the oncoming LPN.

Subsequently, at 2321 hours on August 17, 2018, Ms. Taylor added an entry into client AP's Log Book Report for July 26, 2018 at 0917 hours describing client AP's output as low, that she instructed an HCA to check the catheter tubing for kinks and that she would inform the oncoming LPN and monitor client AP.

An audit of client AP's Log Book Report demonstrated that Ms. Taylor added the entries for July 25, 2018 at 2317 hours and July 26, 2018 at 2321 hours on August 17, 2018. This was presented in Exhibit 2 under Tab 20.

Furthermore, Ms. Taylor failed to indicate that either the July 25, 2018 or the July 26, 2018 entries in client AP's Log Book Report were late entries, as required by the CLPNA practice policy on Documentation.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Taylor's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 8 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. Taylor displayed a lack of knowledge, skill or judgment in that Ms. Taylor was off on an administrative leave at the time of this allegation, pending the outcome of an investigation by Points West. Ms. Taylor, despite being on leave, accessed the Senior Care System and then documented entries into a client's records. Ms. Taylor proceeded to make entries into the client's Log Book Reports in which she failed to document assessments in, as listed in prior allegations. This is not something that is expected of an LPN, to be accessing clients' records or documents without the proper authorization to do so, especially when they are placed on an administrative leave from their employer;

ii. **Contravention of the Act, a code of ethics or standards of practice**: Ms. Taylor did not abide by the CLPNA Code of Ethics or the CLPNA Standard of Practice, as acknowledged by her in the Agreed Statement of Facts and Acknowledgement of Unprofessional

Conduct as specifically set out above and that such breaches are sufficiently serious to constitute unprofessional conduct; and

iii. **Conduct that harms the integrity of the regulated profession**. Ms. Taylor harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Documentation and assessments are core competencies of an LPN. Ms. Taylor did not meet the expectations or the standards of what is expected of an LPN in this situation.

Conclusion

In sum, the Hearing Tribunal considered the evidence put forth in Exhibit #2 and concluded that each of the Allegations against Ms. Taylor were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act, the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Ms. Taylor 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. Taylor 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. Taylor shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the letter advising of the final costs once the same have been confirmed.

3. Ms. Taylor shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Taylor shall provide a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice 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 B: Nursing Process;

    f. CLPNA Competency Profile D1: Communication and Collaborative Practice;

g. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;

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

i. CLPNA Competency Profile C: Professionalism; and

j. CLPNA Competency Profile U: Medication Management.

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

4. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Taylor shall within two (2) weeks of being notified by the Complaints Consultant the reflective paper is 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. Taylor shall complete the course: **LPN Ethics** available online at http://www.learninglpn.ca/index.php/courses. Ms. Taylor shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

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

6. Ms. Taylor shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

7. Ms. Taylor shall complete, at her own cost, the following course: **NURS 0163: Introduction to Health Assessment** offered on-line at www.macewan.ca. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

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

8. Ms. Taylor shall complete, at her own cost, the following course: **Advanced Bladder Management** offered on-line at www.pedagogyeducation.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

9. Ms. Taylor shall complete, at her own cost, the following course: **Documentation and Reporting** offered on-line at www.coursepark.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

10. Ms. Taylor 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. Taylor will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms. Taylor 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.

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

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

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

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

The nature and gravity of the proven allegations: This is a significant factor as there are six (6) allegations over a period of seven (7) months. The allegations that were presented deal with monitoring, documentation, and assessments of clients which are basic core competencies of what is expected of an LPN. It was as a result of the lack of Ms. Taylor's skill that the clients that are referenced in the allegations were exposed to the potential of harm.

The age and experience of the investigated member: Ms. Taylor was initially registered with the CLPNA on April 10, 2017. At all material times to the allegations, Ms. Taylor was employed at Points West. Although a new LPN, the lack of skills and judgment shown here should have been clear to Ms. Taylor at all times as they are basic nursing skills.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: Ms. Taylor has been through the investigation and complaint process before. The Hearing Tribunal was presented with a written decision that was dated September 21, 2017, with respect to a Hearing that was held on July 31, 2017. At that time there were five (5) allegations made with respect to Ms. Taylor and those allegations were very similar to the ones that the Hearing Tribunal heard today. The allegations from 2017 also dealt with failure to document and failure to assess clients that were in Ms. Taylor's care.

The number of times the offending conduct was proven to have occurred: There were six (6) allegations presented to the Hearing Tribunal which took place over a seven (7) month time period.

The role of the investigated member in acknowledging what occurred: Ms. Taylor did acknowledge the allegations that were brought forward by Points West. Ms. Taylor also did cooperate with both the CLPNA and her AUPE representative by providing the Hearing Tribunal with an Agreed Statement of Facts as well as a Joint Submission on Penalty.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. Taylor did receive two (2) separate suspensions. First, a one (1) day suspension which she served on March 19, 2018. Ms. Taylor then received a second suspension which was for three (3) days and Ms. Taylor served this on May 24, 25, and 27, 2018. Both suspensions were without pay. Then, following these suspensions, on August 21, 2018, Ms. Taylor subsequently was terminated from Points West.

The impact of the incident(s) on the victim: The Hearing Tribunal was not made aware of any impacts on the clients that Ms. Taylor was responsible for providing care; however, the potential of an adverse reaction was a great risk and situation that Ms. Taylor put both herself and her clients in.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware 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: Regarding specific deterrence, there is a need to impose sanctions with regards to Ms. Taylor as she should be aware that her behavior is not acceptable or what is expected of an LPN. Regarding general deterrence, the public should also be made aware that this type of behavior will not be tolerated by the CLPNA and such behavior will be dealt with in a serious manner. The CLPNA does have a discipline process in place which helps

to ensure that LPNs are competent and self-regulated professionals and the public needs to be reassured that this standard is upheld.

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 Act, the CLPNA Code of Ethics and the CLPNA Standards of Practice which reflects the seriousness of the conduct which is expected of LPNs and for the purpose of protecting the public and they do this by imposing sanctions towards the member.

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. Taylor shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the letter advising of the final costs once the same have been confirmed.

3. Ms. Taylor shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Taylor shall provide a written reflection of 500 – 750 words, satisfactory to the Complaints Consultant, on how the CLPNA documents will impact her professional practice 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 B: Nursing Process;

f. CLPNA Competency Profile D1: Communication and Collaborative Practice;

g. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;

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

i. CLPNA Competency Profile C: Professionalism; and

j. CLPNA Competency Profile U: Medication Management.

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

4. In the event the reflective paper is not satisfactory to the Complaints Consultant, Ms. Taylor shall within two (2) weeks of being notified by the Complaints Consultant the reflective paper is 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. Taylor shall complete the course: **LPN Ethics** available online at http://www.learninglpn.ca/index.php/courses. Ms. Taylor shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

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

6. Ms. Taylor shall complete the following course: **Nursing Documentation 101** offered on-line at www.clpna.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

7. Ms. Taylor shall complete, at her own cost, the following course: **NURS 0163: Introduction to Health Assessment** offered on-line at www.macewan.ca. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **6 months** of service of the Decision.

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

8. Ms. Taylor shall complete, at her own cost, the following course: **Advanced Bladder Management** offered on-line at www.pedagogyeducation.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

9. Ms. Taylor shall complete, at her own cost, the following course: **Documentation and Reporting** offered on-line at www.coursepark.com. Ms. Taylor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

10. Ms. Taylor 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. Taylor will keep her contact information current with the CLPNA on an ongoing basis.

11. Should Ms. Taylor 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.

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

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

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

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

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

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

DATED THE 31st DAY OF DECEMBER, 2019 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal