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 IWONA SLOMKOWSKI

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 IWONA SLOMKOWSKI, LPN #32698, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA (THE "CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Zoom on February 28, 2022 with the following individuals present:

Hearing Tribunal:
Sheri Epp, Public Member, Chairperson
Jen Martin, LPN
Koreen Balaban, LPN
Naz Mellick, Public Member

Heidi Besuijen, Independent Legal Counsel for the Hearing Tribunal

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

Investigated Member:
Iwona Slomkowski, LPN ("Ms. Slomkowski" or "Investigated Member")
Angela Gill, 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. Slomkowski was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Slomkowski was initially licensed as an LPN in Alberta in 2010.

The CLPNA received a complaint on November 20, 2021 (the "Complaint") from KO, a member of the public, pursuant to s. 54 of the Act. The Complaint raised concerns regarding the practice of Ms. Iwona Slomkowski, LPN, employed at Green Acres Foundation – Sunny South Lodge (the "Facility").

By way of letter dated November 24, 2021, the Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), recommended that Carrie Waggot, Executive Officer of the CLPNA, impose an interim suspension of Ms. Slomkowski's practice permit pending the outcome of disciplinary proceedings pursuant to s. 65(1)(b) of the Act due to the serious nature of the allegations against Ms. Slomkowski.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed David Burke, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

Ms. Slomkowski received notice of the Complaint, investigation, appointment of the Investigator and the Complaints Director's recommendation of an interim suspension by letter dated November 24, 2021.

By letter dated December 16, 2021, Ms. Waggot granted the request for an interim suspension effective the date of the letter.

On December 20, 2021, the Investigator concluded the investigation into the Complaint and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Director determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Slomkowski received notice that the Complaint was referred to a hearing with a copy of the Statement of Allegations and the investigation report with attachments under a cover letter dated January 18, 2022.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Slomkowski under cover of letter dated January 21, 2022.

(4) <u>Allegations</u>

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

"It is alleged that Iwona Slomkowski, LPN, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about November 1, 2021, behaved in an unprofessional manner when attending with resident JO to take his blood pressure, particulars of which include one or more of the following:
    a. Pushed and/or slapped resident JO on his shoulder to stop him from moving around while taking his vital signs several times;

   b. Spoke to resident JO in an unprofessional manner by saying loudly “Stop”;
   c. Failed to treat resident JO with respect and dignity;
   d. Failed to provide safe and competent care.

2. On or about November 1, 2021, failed to prepare adequate documentation following her attempts to take JO’s blood pressure on resident JO’s progress notes.

3. On or about November 6, 2021, acted in an unprofessional manner while providing care to resident JO, particulars of which include one or more of the following:
   a. Yelled at resident JO to “get up” after finding him on the floor on his knees;
   b. Did not initially attempt to assist resident JO but continued to direct him to “get up”;
   c. Nudged and/ or pushed resident JO’s knee into the bed several times;
   d. Kicked and/ or nudged resident JO’s foot;
   e. Grabbed resident JO’s wrist;
   f. Used an unsafe transfer technique to assist resident JO off of the floor by roughly pulling him by his arm;
   g. Used unprofessional language by saying “Oh my Christ” or words to that effect.

4. On or about November 6, 2021, failed to respond in an appropriate and safe manner after entering resident JO’s room and finding him on the floor on his knees after an unwitnessed fall, particulars of which include one or more of the following:
   a. Failed to call for assistance from facility staff;
   b. Did not use a safe technique in assisting resident JO off the floor;
   c. Did not follow the facility’s Falls and Injury Prevention Procedure, including:
      i. Did not assess JO’s vital signs or look for visible injuries;
      ii. Did not assess whether it was safe to attempt to lift JO;
      iii. Document the incident on the Progress Notes or an Incident Report;
      iv. Did not complete the *Post Fall Clinical Pathway Form*.

It is further alleged that your conduct constitutes “unprofessional conduct” as defined in s. 1(1)(pp)(ii) and (xii) of the *Health Professions Act*, RSA 2000, c H-7, and in particular your conduct breaches one or more of the following:

1. *Standards of Practice for Licensed Practical Nurses in Canada*, Standard 1: Professional Accountability and Responsibility, Indicators 1.4, 1.6, 1.9, and 1.10;

2. *Standards of Practice for Licensed Practical Nurses in Canada*, Standard 2: Knowledge-Base Practice, Indicators 2.1, 2.2, and 2.11;

3. *Standards of Practice for Licensed Practical Nurses in Canada*, Standard 3: Service to the Public and Self Regulation, Indicators 3.3, 3.4, and 3.6;

4. *Standards of Practice for Licensed Practical Nurses in Canada*, Standard 4: Ethical Practice, Indicators 4.1, 4.4, 4.5, 4.7, 4.9 and 4.10;

5. *Code of Ethics for Licensed Practical Nurses in Canada*, Principal 1: Responsibility to the Public, Ethical Responsibility, Indicators 1.1 and, 1.2;
6. *Code of Ethics for Licensed Practical Nurses in Canada*, Principal 2: Responsibility to Clients, Indicators 2.2, 2.8, 2.9;
7. *Code of Ethics for Licensed Practical Nurses in Canada*, Principal 3: Responsibility to the Profession, Indicators 3.1, 3.3, and 3.4;
8. *Code of Ethics for Licensed Practical Nurses in Canada*, Principal 5: Responsibility to Self, Indicators 5.1, 5.2, 5.3, 5.5, and 5.8;
9. CLPNA Policy: Client & Co-Worker abuse;
10. CLPNA Policy: Professional Responsibility and Accountability."

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Ms. Slomkowski's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Slomkowski.

Allegation 1

Ms. Slomkowski admitted that on or about November 1, 2021, she behaved in an unprofessional manner when attending with resident JO to take his blood pressure, particulars of which include one or more of the following:

a. Pushed and/or slapped resident JO on his shoulder to stop him from moving around while taking his vital signs several times;
b. Spoke to resident JO in an unprofessional manner by saying loudly "Stop";
c. Failed to treat resident JO with respect and dignity;
d. Failed to provide safe and competent care.

JO suffers from dementia and is non-verbal. The most compelling evidence before the Hearing Tribunal as set out in the Agreed Statement of Facts is the video taken from JO's room and that KO provided to the CLPNA in which Ms. Slomkowski is observed attending to JO on November 1, 2021 to take his vital signs.

At or around 1221 hours, Ms. Slomkowski was taking JO's vital signs. JO was rocking back and forth and generally moving and Ms. Slomkowski was having difficulty obtaining his blood pressure. Ms. Slomkowski roughly pushed JO on his shoulder and held him still in order to stop him from moving. Shortly after, Ms. Slomkowski again pushed and/or slapped JO on his shoulder in order to stop him from moving.

The intensity of JO's rocking momentarily decreased but resumed and increased in intensity. Ms. Slomkowski then loudly said, "Stop" to JO, or words to that effect. This occurred twice more in quick succession.

The intensity of JO's rocking again increased, and Ms. Slomkowski again roughly pushed JO on his shoulder and held him still in order to stop him from moving while she was taking his vital signs. Ms. Slomkowski then again loudly said "Stop" to JO, or words to that effect. Ms. Slomkowski then pulled roughly on JO's shoulder in order to stop him from moving.

Throughout this interaction, Ms. Slomkowski failed to treat JO with respect and dignity, as she roughly pushed and/or slapped his shoulder four times and was visibly frustrated with JO throughout the interaction. As such, this was also a failure to provide safe and competent care to JO.

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 apply in this case:

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

The Hearing Tribunal finds Ms. Slomkowski displayed a lack of knowledge in that she failed to seek assistance when she was having difficulty in her interaction with JO in attempting to obtain JO's blood pressure and in her apparent lack of understanding in how JO's medical condition would impact his behavior. Further, she demonstrated a lack of skill or judgment in that she did not show compassion to JO, failed to appreciate his vulnerability, and caused harm to both JO and his family.

This conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics") and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice"):

CLPNA Standards of Practice

a. 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:

    - 1.4 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.
    - 1.9 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.

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

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

> The term "critical thinking" is defined as an active and purposeful problem-solving process. It requires the practical nurse to advance beyond the performance of skills and interventions to provide the best possible care, based on evidence-informed practice. It involves identifying and prioritizing risks and problems, clarifying and challenging assumptions, using an organized approach to assessment, checking for accuracy and reliability of information, weighing evidence, recognizing inconsistencies, evaluating conclusions and adapting thinking.

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

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

> The term "critical inquiry" is defined as expanding on the meaning of critical thinking to encompass critical reflection on actions. Critical inquiry refers to a process of purposive thinking and reflective reasoning whereby practitioners examine ideas, assumptions, principles, conclusions, beliefs and actions in the context of nursing practice. The critical inquiry process is associated with a spirit of inquiry, discernment, logical reasoning and application of standards.

c. 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 and 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.

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

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

- 4.4 Develop ethical decision-making capacity and take responsible action toward resolution.

- 4.5 Advocate for the protection and promotion of clients' right to autonomy, respect, privacy, confidentiality, dignity and access to information.

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

- 4.9 Support and contribute to healthy and positive practice environments.

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

CLPNA Code of Ethics

a. 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.

- 1.2 Provide only those functions for which they are qualified by education or experience.

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

- 2.8 Use evidence and judgement to guide nursing decisions.

- 2.9 Identify and minimize risks to clients.

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

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

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

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

d. 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.

    - 5.2 Recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgement.

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

    - 5.5 Inform the appropriate authority in the event of becoming unable to practise safely, competently and/or ethically.

    - 5.8 Maintain the required mental and physical wellness to meet the responsibilities of their role.

The conduct also breached two CLPNA policies which are not reproduced here:

- CLPNA Policy: Client & Co-Worker Abuse.

- CLPNA Policy: Professional Responsibility and Accountability.

Ms. Slomkowski failed to provide JO with compassionate care which reflected his inherent dignity. Her conduct did not reflect a knowledge-based approach which considered JO's circumstances and condition in determining how to proceed or resolve a difficult situation.

Her conduct introduced harm to JO rather than minimizing or avoiding it. It did not reflect the conduct of a professional working in the service of others and in recognition of the obligations and privileges of self-regulation.

Ms. Slomkowski's conduct showed a lack of integrity and undermines the trust the public reposes in LPNs to care for vulnerable people such as JO. In this way, the Hearing Tribunal also finds Ms. Slomkowski's treatment of JO on November 1, 2021 was demeaning, degrading, indignant and caused actual harm to JO. That JO is non-verbal makes this encounter even more concerning and egregious as JO had no way to communicate to anyone how he was being treated. It was only through happenstance this conduct was discovered after family placed a camera in the room to investigate JO's frequent falls. The Hearing Tribunal finds that the Complainant family member and members of the public would be shocked, saddened, concerned, and outraged upon viewing the video of this encounter. Accordingly, there can be no doubt this conduct harms the integrity of the profession.

Allegation 2

Ms. Slomkowski admitted that on or about November 1, 2021, she failed to prepare adequate documentation following her attempts to take JO's blood pressure on resident JO's progress notes.

Ms. Slomkowski completed a neurological flow sheet for JO at 1227 hours; however, she did not make an entry in JO's progress notes pertaining to care she provided to him on November 1, 2021. As such, Ms. Slomkowski made no record of her interaction or rough treatment of JO while she was attempting to take his vital signs, and made no record of any interventions, clinical decisions or care provided.

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

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

Documentation of care provided is a cornerstone to an LPN's practice. It permits anyone providing care to know the history of treatment, the reasons for treatment decisions, and to gain an understanding of a patient's status. Where records are incomplete, decision making will also be incomplete. Accordingly, a failure to record in this manner displays a lack of skill in the

provision of the professional services of an LPN. Similarly, this conduct diminishes the integrity of the profession in that it would tend to cast a poor light on all LPNs and their training.

Furthermore, the failure to record also contravenes the Standards of Practice and Code of Ethics provisions previously noted in regard of Allegation #1. Of note, Standard 1.10 specifically requires the maintenance of documentation which did not occur. The failure to maintain appropriate records is also a lack of effective communication and is a failure to contribute to a safe and effective care environment.

Allegation 3

Ms. Slomkowski admitted that on or about November 6, 2021, she acted in an unprofessional manner while providing care to resident JO, particulars of which include one or more of the following:

a. Yelled at resident JO to "get up" after finding him on the floor on his knees;
b. Did not initially attempt to assist resident JO but continued to direct him to "get up";
c. Nudged and/ or pushed resident JO's knee into the bed several times;
d. Kicked and/ or nudged resident JO's foot;
e. Grabbed resident JO's wrist;
f. Used an unsafe transfer technique to assist resident JO off of the floor by roughly pulling him by his arm;
g. Used unprofessional language by saying "Oh my Christ" or words to that effect.

Again, the Hearing Tribunal had evidence in the form of a video taken from JO's room which captured the encounter at issue. The video establishes that on November 6, 2021, Ms. Slomkowski was working at the Facility and provided care to JO. At or around 1236 hours, Ms. Slomkowski entered JO's room and found him on his knees slumped over the side of his bed, appearing to have suffered a fall.

As JO struggled to get up, Ms. Slomkowski stood in front of him and failed to assist him. Ms. Slomkowski yelled at JO to "get up" three times while JO continued to struggle. Ms. Slomkowski watched JO struggle to get up without assisting for approximately two minutes.

When Ms. Slomkowski did attempt to assist JO, she nudged and/or pushed his foot several times. Additionally, Ms. Slomkowski picked up his left knee and pushed it into the bed frame several times. This was not effective in assisting JO up.

JO reached out with his left hand and grabbed Ms. Slomkowski's left hand in an effort to help himself get up. Ms. Slomkowski quickly removed her left hand and grabbed his left wrist with her right hand. Ms. Slomkowski then yanked on JO's left arm several times. This was not effective in assisting JO up.

Ms. Slomkowski let go of JO's wrist and proceeded behind him to grab his left arm to assist him in standing up. Ms. Slomkowski pulled roughly on JO's left arm in an effort to assist him up. This

was an unsafe transfer technique to assist a resident who has suffered a fall and could have caused injury to JO. When this was not effective in assisting JO up, Ms. Slomkowski said, "Oh my Christ" or words to that effect. She was visibly frustrated throughout the entire interaction.

At or around 1241 hours, Jessica Dawson, HCA entered JO's room to investigate shouting she had heard. At this point, Ms. Slomkowski kicked JO's foot twice. Ms. Slomkowski then lifted JO's right leg and assisted him into a lying position on the bed, where JO was lying on his left side. HCA Dawson then lifted JO's left side to put him in a seated position. HCA Dawson then assisted JO to a standing position.

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

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

The Hearing Tribunal finds that Ms. Slomkowski displayed a lack of knowledge of or a lack of skill or judgment in the provision of professional services for substantially the same reasons as articulated in relation to Allegation #1. Additionally, she did not immediately assist JO when he was clearly in need and, when she did help did, she did so in a manner which could have caused injury to JO and spoke harshly to JO when he needed care and compassion.

The conduct also breached the Standards of Practice and Code of Ethics provisions identified above. Nursing is a caring profession, but Ms. Slomkowski did not demonstrate this and her conduct was not consistent with the values and obligations in the Code of Ethics. Self-regulated professionals are entrusted to provide competent and skilled care for the benefit of those receiving the care and for the public good. Ms. Slomkowksi carried forward with disregard of her training, her obligations, and of the privileges of self-regulation.

The Hearing Tribunal finds Ms. Slomkowski's treatment of JO on November 6, 2021 harmed the integrity of the profession. It was again demeaning, degrading, without dignity and caused actual harm to JO. Even more egregious is the fact this is the second such instance of Ms. Slomkowski's unprofessional conduct involving JO in the span of six days. The Hearing Tribunal again finds that the Complainant family member and members of the public would be shocked, saddened, concerned, and outraged upon viewing the video of this encounter.

Allegation 4

Ms. Slomkowski admitted that on or about November 6, 2021, she failed to respond in an appropriate and safe manner after entering resident JO's room and finding him on the floor on his knees after an unwitnessed fall, particulars of which include one or more of the following:

a. Failed to call for assistance from facility staff;
b. Did not use a safe technique in assisting resident JO off the floor;
c. Did not follow the facility's Falls and Injury Prevention Procedure, including:
   i. Did not assess JO's vital signs or look for visible injuries;
   ii. Did not assess whether it was safe to attempt to lift JO;
   iii. Document the incident on the Progress Notes or an Incident Report;
   iv. Did not complete the *Post Fall Clinical Pathway Form*.

The Agreed Statement of Facts establishes that on November 6, 2021, at or around 1236 hours, Ms. Slomkowski found JO in his room on his knees with his upper body slumped over the bed, appearing to have suffered a fall. Ms. Slomkowski did not call for assistance from facility staff in order to properly respond to JO's unwitnessed fall. As described above, Ms. Slomkowski did not use a safe technique to assist JO off of the floor.

Ms. Slomkowski did not assess JO's vital signs or look for visible injuries. Ms. Slomkowski did not assess whether it was safe to attempt to lift JO.

The Facility's Falls and Injury Prevention Procedure requires that, after a resident falls, an LPN or an RN assess the resident's vital signs and look for visible injuries. Further, if the resident is not able to get up on their own, an LPN or an RN must assess and determine if care staff are able to safely assist or lift the resident.

In JO's progress notes for November 6, 2021, there is no entry from Ms. Slomkowski. As such, Ms. Slomkowski made no record of her interaction or rough treatment of JO, or of JO's unwitnessed fall, and made no record of any interventions, clinical decisions or care provided. Ms. Slomkowski did not complete an Incident Report regarding the fall. Ms. Slomkowski did not complete the *Post Fall Clinical Pathway* for JO after the fall, nor were Neurological Flow Sheets completed.

The Facility's Falls and Injury Prevention Procedure requires that, after a resident falls, an Incident Report be completed. It also requires that the *Post Fall Clinical Pathway* form be completed, and if an unwitnessed fall occurs, a Neurological Flow Sheet be completed.

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

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

According to the video evidence and other records contained in the Agreed Statement of Facts, Ms. Slomkowski entered JO's room and left him in a fallen, helpless position for several minutes before attempting to assist him. She encountered difficulties in trying to raise JO and in doing so

used techniques that could have caused injury to JO. This establishes a clear lack of skill and judgment in the provision of professional services.

The conduct also breached multiple provisions of the Standards of Practice and Code of Ethics in part for reasons previously articulated. By ignoring a prescribed procedure intended to ensure no persisting ill effects to a resident, Ms. Slomkowski exposed JO to risk of harm. Her attempts to deal with JO's fall and failure to check vitals or for any sign of injury put JO's health at risk.

Ms. Slomkowski's conduct with JO on November 6, 2021 shows a distinct lack of professionalism and caring for a patient who is unable to communicate. Her behaviour displayed frustration and annoyance rather than concern, care, safety and empathy. Her treatment of JO caused his family great emotional distress and worry. Any person viewing the video or learning about Ms. Slomkowski's conduct on November 6, 2021 would be rightly concerned and outraged. This certainly amounts to a diminishment of the integrity of the profession.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Slomkowski jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Ms. Slomskowski shall pay 25% of the costs of the investigation and hearing to be paid within **24 months** of the date when she receives a letter advising her of the final hearing costs.

3. Ms. Slomskowski will not be eligible to apply for registration or reinstatement until she has complied with the following:

    a) Ms. Slomkowski 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. Slomkowski will provide the Complaints Director with a signed declaration attesting that she has read the documents and has reflected on how they impact her practice:

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

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

        iii. CLPNA Practice Policy: Professional Responsibility & Accountability;

iv. CLPNA Practice Policy: Documentation;

v. CLPNA Practice Policy: Client & Co-Worker Abuse;

vi. CLPNA Competency Profile A1: Critical Thinking;

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

viii. CLPNA Competency Profile B: Nursing Process;

ix. CLPNA Competency Profile C4: Professional Ethics;

x. CLPNA Competency Profile C5: Accountability and Responsibility;

xi. CLPNA Competency Profile C8: Professional Development;

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

xiii. CLPNA Competency Profile D2: Therapeutic Nurse-Patient Relationship;

xiv. CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting;

xv. CLPNA Competency Profile F3: Patient Safety;

xvi. CLPNA Competency Profile P2: Cognitive Care;

xvii. CLPNA Competency Profile P3: Dementia Care.

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

b) Ms. Slomskowski will complete the following remedial education, at her own cost:

i. LPN Code of Ethics Leanring Module available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

ii. Staying Cool Under Fire available online at https://www.nurse.com/ce/staying-cool-under-fire-how-well-do-you-communicate

iii. Nursing Clients with Dementia (NCDEM014) offered online by John Collins Consulting

4. Should any of the above course(s) referred to above at paragraph 3 become unavailable, then Ms. Slomkowski shall request in writing to be assigned an alternative course. The

Complaints Director shall, in her sole discretion, reassign a course. Ms. Slomkowski will be notified by the Complaints Director, in writing, advising of the new course required.

5. Once Ms. Slomkowski has completed the requirements set out in paragraph 3, and provided that she is not in default of the requirement to pay costs as set out in paragraph 2, she will be eligible to apply for reinstatement.

6. If, upon receiving her application for registration, the Registrar determines that Ms. Slomkowski meets the CLPNA's requirements for reinstatement, Ms. Slomkowski's practice permit shall be reinstated.

7. The sanctions set out at paragraph 2 will appear as condition on Ms. Slomkowski's practice permit and the Public Registry subject to the following:

    a) The requirement to pay costs will appear as "Conduct Costs" on Ms. Slomkowski's practice permit and the Public Registry until all costs have been paid as set out at paragraph 2.

8. The conditions on Ms. Slomkowski's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out in paragraph 2 and paragraph 4 above.

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

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

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

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

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

The Hearing Tribunal is aware, while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should defer to a joint submission unless the proposed sanction is unfit, unreasonable or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Slomkowski and the Complaints Director.

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Iwona Slomkowski 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 considered the fairness and reasonableness in accordance with the factors laid out in *Jaswal*, and has determined the following findings:

1) **The nature and gravity of the proven allegations:** the proven conduct is very serious and the Hearing Tribunal was particularly swayed by this factor. The conduct proven constitutes an egregious breach of the professional obligations of an LPN.

2) **The age and experience of the investigated member:** Ms. Slomkowski has been an LPN for approximately 12 years and, as such, she is not a new member.

3) **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Ms. Slomkowski had an unblemished record as an LPN prior to these allegations.

4) **The age and mental condition of the victim, if any:** JO is an elderly man with dementia and is therefore particularly vulnerable.

5) **The number of times the offending conduct was proven to have occurred:** There were two distinct incidents which were proven, each with multiple consequences.

6) **The role of the investigated member in acknowledging what occurred:** Ms. Slomkowski acknowledged her conduct and accepted responsibility for it which is a significant mitigating factor. The Hearing Tribunal also notes she has already taken steps to complete some of the educational components in the proposed sanction which demonstrates she had learned from this process and is actively engaged in improving her education and training.

7) **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** following the suspension of her license as a result of these matters, Ms. Slomkowski has lost her vehicle and been forced to give up her residence due to financial hardship.

8) **The impact of the incident(s) on the victim:** it is clear Ms. Slomkowski's treatment of JO without care, empathy, dignity, or compassion caused actual harm to JO. The Hearing Tribunal also notes the harm and severe distress which JO's family experienced in knowing the treatment to which he was subjected.

9) **The presence or absence of any mitigating circumstances:** Ms. Gill noted that while not an excuse, it was a factor that Ms. Slomkowski was placed in a care environment dealing with persons who have dementia but received no specialized training or supports for the same.

10) **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** It is important to the LPN profession 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.

11) **The need to maintain the public's confidence in the integrity of the profession:** a member of the public who became aware of this conduct would be shocked and appalled and, accordingly, the response to it must assure the public that the CLPNA takes this matter seriously and works to address that it happened but also prevent it from recurring.

12) **The range of sentence in other similar cases:** counsel for the Complaints Director reviewed the sentences in other cases which the Hearing Tribunal considered for reference but does not replicate here given that these cases did not deal with conduct that was substantially similar. However, the Hearing Tribunal is satisfied the proposed penalty fits within the spectrum of sanctions previously ordered in relation to conduct of a similar nature.

It is important to note Ms. Slomkowski's license was suspended in mid-December 2021 and under the proposed sanction she would not be eligible to be reinstated until after she has successfully completed all the remedial education, which includes a 10-week course. As such, the minimum time in which she would not be able to practice would be 5 months in total which the Hearing Tribunal considers significant.

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. Slomskowski shall pay 25% of the costs of the investigation and hearing to be paid within **24 months** of the date when she receives a letter advising her of the final hearing costs.

3. Ms. Slomskowski will not be eligible to apply for registration or reinstatement until she has complied with the following:

a) Ms. Slomkowski 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. Slomkowski will provide the Complaints Director with a signed declaration attesting that she has read the documents and has reflected on how they impact her practice:

   i. Code of Ethics for Licensed Practical Nurses in Canada;
   ii. Standards of Practice for Licensed Practical Nurses in Canada;
   iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
   iv. CLPNA Practice Policy: Documentation;
   v. CLPNA Practice Policy: Client & Co-Worker Abuse;
   vi. CLPNA Competency Profile A1: Critical Thinking;
   vii. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
   viii. CLPNA Competency Profile B: Nursing Process;
   ix. CLPNA Competency Profile C4: Professional Ethics;
   x. CLPNA Competency Profile C5: Accountability and Responsibility;
   xi. CLPNA Competency Profile C8: Professional Development;
   xii. CLPNA Competency Profile D1: Communication and Collaborative Practice;
   xiii. CLPNA Competency Profile D2: Therapeutic Nurse-Patient Relationship;
   xiv. CLPNA Competency Profile D3: Legal Protocols, Documenting, and Reporting;
   xv. CLPNA Competency Profile F3: Patient Safety;
   xvi. CLPNA Competency Profile P2: Cognitive Care;
   xvii. CLPNA Competency Profile P3: Dementia Care.

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

b) Ms. Slomskowski will complete the following remedial education, at her own cost:

   i. LPN Code of Ethics Leanring Module available online at https://www.learningnurse.org/index.php/e-learning/lpn-code-of-ethics

   ii. Staying Cool Under Fire available online at https://www.nurse.com/ce/staying-cool-under-fire-how-well-do-you-communicate

   iii. Nursing Clients with Dementia (NCDEM014) offered online by John Collins Consulting

4. Should any of the above course(s) referred to above at paragraph 3 become unavailable, then Ms. Slomkowski shall request in writing to be assigned an alternative course. The Complaints Director shall, in her sole discretion, reassign a course. Ms. Slomkowski will be notified by the Complaints Director, in writing, advising of the new course required.

5. Once Ms. Slomkowski has completed the requirements set out in paragraph 3, and provided that she is not in default of the requirement to pay costs as set out in paragraph 2, she will be eligible to apply for reinstatement.

6. If, upon receiving her application for registration, the Registrar determines that Ms. Slomkowski meets the CLPNA's requirements for reinstatement, Ms. Slomkowski's practice permit shall be reinstated.

7. The sanctions set out at paragraphs 2 and 3 will appear as conditions on Ms. Slomkowski's practice permit and the Public Registry subject to the following:

   a) The requirement to pay costs will appear as "Conduct Costs" on Ms. Slomkowski's practice permit and the Public Registry until all costs have been paid as set out at paragraph 2.

8. The conditions on Ms. Slomkowski's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out in paragraph 2 and paragraph 4 above.

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

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

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

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

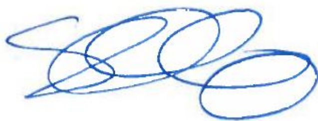
The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

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

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

DATED THE 21st DAY OF MARCH, 2022 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA



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Sheri Epp, Public Member
Chair, Hearing Tribunal