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 MALAAK EL-TOUGHLOB

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 MALAAK EL-TOUGHLOB, LPN #46615, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was held via Videoconference using Zoom on January 27, 2021 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Patricia Riopel, LPN
Alan Naranin, LPN
Nancy Brook, Public Member

Staff:
Ayla Akgungor, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Malaak El-toughlob, LPN ("Ms. El-toughlob 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. El-toughlob was an LPN within the meaning of the *Health Professions Act* ("Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. El-toughlob was initially licensed as an LPN in Alberta on September 4, 2018.

The CLPNA received a complaint dated May 27, 2020 (the "Complaint") from Courtney Johnson, Registered Nurse and Clinical Nurse Educator (the "Complainant"). The Complaint raised concerns relating to Ms. El-toughlob's nursing practice while employed as an LPN at the Peter Lougheed Centre (the "Facility") in Calgary Alberta.

The Complaints Director, in accordance with s. 55(2)d of the Act, appointed Judy Palyga, Investigator for CLPNA (the "Investigator") to conduct an investigation into the Complaint. By way of letter dated May 28, 2020, the Complaints Director provided Ms. El-toughlob with notice of the Complaint and notice of the investigation into the Complaint. The Complaints Director also informed Ms. El-toughlob that due to the nature of the alleged conduct, she was recommending to Jeanne Weis, Chief Executive Officer for the CLPNA, that Ms. El-toughlob's practice permit be immediately suspended under s. 65(1)(b) of the Act.

The Complaints Director recommended Ms. Weis impose an immediate suspension of Ms. El-toughlob's practice permit under s. 65(1)(b) of the Act by letter dated May 28, 2020. Ms. El-toughlob received a copy of this letter and its corresponding attachments.

By letter dated May 29, 2020, Ms. Weis imposed an interim suspension of Ms. El-toughlob's practice permit and notified Ms. El-toughlob accordingly.

On October 1, 2020, the Investigator concluded the investigation into the Complaint.

The Complaints Director determined there was sufficient evidence that the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. El-toughlob received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Report on December 2, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. El-toughlob under cover of letter dated December 16, 2020.

(4) Allegations

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

"It is alleged that MALAAK EL-TOUGHLOB, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about February 4, 2020, while providing care to clients, failed to review and/or follow a physician's order by doing one or more of the following:
    a. Attempting to administer a 60 ml syringe via push feed when it was ordered to be administered via gravity;
    b. Failed to follow Physician's order by attempting to feed every four hours rather than flush every four hours; and/or
    c. Preparing the incorrect dosage of insulin for a client.

2. Withdrawn.

3. On or about February 2020, performed duties outside her scope as an LPN by initiating an epidural infusion.

4. On or about March 2020, failed to comply with Alberta Health Services and facility policy by transferring a client with high flow portable oxygen off unit despite not being authorized to do so.

5. On or about March 17, 2020, while providing care to client RD, failed to report client RD's increased and irregular heart rate to client RD's physician and/or the Care Hub Lead.

6. On or about March 17, 2020, while providing care to client PC, did one or more of the following:
    a. Incorrectly charted that she had not flushed client PC's intravenous line as the required medication was not available, when, instead, client PC's intravenous line had been discontinued; and/or
    b. Failed to provide ordered PRN pain management to client PC in spite of performing a pain assessment that indicated PC was experiencing significant pain.

7. On or about March 17, 2020, while providing care to client JM, failed to do one or more of the following:
    a. Start an intravenous line on client JM, as ordered, at or about 0821 hours, prior to the intravenous line's subsequent ordered discontinuance at or about 1014 hours; and/or
    b. Follow a physician's order, by failing to offer client JM an ordered 10mg nicotine inhaler.

8. On or about March 25, 2020, while providing care to client RM, despite not being certified by the facility to administer medication or flush central venous catheters, did one or more of the following:
    a. Provided the intravenous antibiotic cefazolin (Ancef) to client RM via his central venous catheter;
    b. Flushed client RM's central venous catheter with Heparin.

9. On or about May 4, 2020, while providing care to client GM, failed to obtain a co-signature for the administration of Tinzaparin, as required.

10. On or about May 20, 2020, while providing care to client JS, improperly administered Apixaban (Eliquis) tab 2.5 mg despite a physician's order suspending the dose.

11. On or about May 21st and 22nd, 2020, while providing care to client RK, did one or more of the following while completing a vacuum-assisted closure dressing change:

    a. Failed to review and/or follow a physician's order by attempting to use Tegaderm as a dressing when the physician's order indicated to use Jelonet;
    b. Failed to understand the proper use for Tegaderm;
    c. Failed to maintain a sterile field; and/or
    d. Caused client RK additional and unnecessary discomfort.

12. On or about May 23rd and 24th, 2020, worked at the Peter Lougheed Centre in Calgary, Alberta on a Saturday and Sunday, despite a restriction in place by her employer that she only work shifts scheduled on Monday to Friday.

13. On or about May 24, 2020, while providing care to client RM, administered hydromorphone, dimenhydrinate (Gravol), and cefazolin (Ancef) via client RM's central venous catheter, despite not being certified by her workplace to administer medication via central venous catheter."

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

The Hearing Tribunal also accepts Ms. El-toughlob'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. El-toughlob.

The Complaints Consultant requested that the Hearing Tribunal remove the interim suspension that was placed on Ms. El-toughlob's practice permit effective the date of the hearing. The Complaints Director is of the view that an additional suspension is not required and that the proposed condition of supervised practice to be placed on Ms. El-toughlob's practice permit, will ensure that her practice is safe. The Hearing Tribunal felt that this was a reasonable request and granted that the interim suspension on Ms. El-toughlob's practice permit be lifted effective January 27, 2021.

Allegation 1

Ms. El-toughlob admitted that on or about February 4, 2020, while providing care to clients, she failed to review and/or follow a physician's order by doing one or more of the following:

a. Attempting to administer a 60 ml syringe via push feed when it was ordered to be administered via gravity;
b. Failed to follow Physician's order by attempting to feed every four hours rather than flush every four hours; and/or
c. Preparing the incorrect dosage of insulin for a client.

Ms. El-toughlob worked at the Peter Lougheed Centre on or about February 4, 2020 and provided care to patients. It was during this shift that Ms. El-toughlob worked a "buddy shift" along with Isabel Dionisio, LPN.

While administering a feed to a patient, Ms. El-toughlob attempted to administer the feed through a 60ml syringe to push the feed, when it was ordered to be administered via gravity. Ms. El-toughlob failed to review and/or follow the physician's orders regarding feed administration. Ms. Dionisio stopped Ms. El-toughlob before she administered the feed.

Later in the same shift, Ms. El-toughlob provided care to the patient and attempted to administer the feed again. However, the physician's order indicated that the patient's feed line needed to be flushed every four hours, not that the patient required the feed to be administered every four hours.

Ms. El-toughlob was preparing a dose of Insulin for a patient and withdrew an Insulin pen from the medication administration room. Ms. El-toughlob failed to review and/or follow the physician's orders with regards to the ordered dose of Insulin and had prepared the incorrect dosage. The Insulin was not administered to the patient.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to follow physician's orders with respect to administering a feed to a patient via gravity. Ms. El-toughlob also failed to follow the physician's orders in that the feed line was to be flushed every four hours and not that the patient required the feed to be administered every four hours. Ms. El-toughlob also failed to follow the physician's orders when it came to preparing a dose of Insulin and had prepared the incorrect dosage for the patient. By not following the physician's order, Ms. El-toughlob was not following the "Rights of Medication Administration" which is a core competency which an LPN is expected to follow.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out in detail below. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. El-toughlob breached both the CLPNA Code of Ethics and the CLPNA Standards of Practice by failing to adhere to the physician's order, as well as, failing to follow the "Rights of Medication Administration".

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to confirm all medication interactions with a patient along with the physician's order; Medication administration is a core competency of an LPN's skill.

The 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 Code of Ethics:

Ms. El-toughlob acknowledged her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, 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 states 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.
- 1.5 Provide care directed to the health and well-being of 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 states that LPNs:

- 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 states 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.

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

- 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.

CLPNA Standards of Practice:

Ms. El-toughlob acknowledges her conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states 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 states that LPNs:

- 1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.
- 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.

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 states 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.

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 states that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.
- 4.7 Communicate in a respectful, timely, open and honest manner.
- 4.8 Collaborate with colleagues to promote safe, competent and ethical practice.

Allegation 2

Withdrawn

Allegation 3

Ms. El-toughlob admitted that on or about February 2020, she performed duties outside her scope as an LPN by initiating an epidural infusion.

In February 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided patient care. While providing patient care, Ms. El-toughlob initiated an epidural infusion.

Alberta Health Services Policy on Acute Pain Management – Epidural Analgesia, indicates that care of patients with an epidural infusion shall be provided by health care professionals who demonstrate competency in the specialized clinical competency of epidural analgesia management after receiving the appropriate didactic and clinical education and training. LPNs are not trained in this competency area, and Epidural Analgesia care is restricted to Registered Nurses who meet the competency requirements.

Ms. El-toughlob performed duties outside her scope as an LPN by initiating an epidural infusion.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to adhere to the Alberta Health Services Policy on Acute Pain Management – Epidural Analgesia. This Policy states that only those health care professionals who have demonstrated the competency with epidural analgesia management and who have received the proper education and training are able to do this task. Ms. El-toughlob performed this task which was out of her scope of practice as an LPN. According to the Alberta Health Services Acute Pain Management – Epidural Analgesia – Adult Policy, LPNs who have not received the proper training in epidural analgesia management cannot administer epidural analgesia. It is expected that LPNs are aware of what is within their scope of practice by adhering to hospital policies and ensuring that if additional training is required to do a task that they receive that training. Epidural management or initiation is not a core competency of an LPN and requires specialized training. Ms. El-toughlob demonstrated a lack of skill and judgement by not having the proper education to initiate the epidural infusion and demonstrated a lack of judgement by performing the epidural initiation even though she was not qualified to do so.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner of which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks in which they are asked to do. It is expected that if an LPN performs a procedure or task that they are not competent to perform that they would let their colleagues or supervisor know so that someone who is qualified may complete the task.

The conduct breached the same principles and standards set out in the CLPNA Code of Ethics and CLPNA Standards of Practice for Licensed Practical Nurses in Canada referenced in Allegation 1 above and the Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1 above.

Allegation 4

Ms. El-toughlob admitted that on or about March 2020, she failed to comply with Alberta Health Services and facility policy by transferring a client with high flow portable oxygen off unit despite not being authorized to do so.

In March 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided patient care. Ms. El-toughlob transported a patient with high flow portable oxygen off the unit.

Alberta Health Services Policy on Use of Portable Oxygen During Patient Transfers indicates that health care professionals, practicing within their scope or role, must follow a particular procedure when transporting clients receiving oxygen therapy. This practice is restricted to personnel who demonstrate competency, education, and training in portable oxygen management. LPNs are not trained in this competency area, and the transfer of clients with portable oxygen is restricted to Registered Nurses who meet the competency requirements.

Further, the Alberta Health Services orientation workbook for Units 42 and 43 at the Peter Lougheed Centre, which was provided to Ms. El-toughlob, indicates that the transport of high flow oxygen therapy patients is not within the scope of practice for LPNs at that Facility.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to adhere to the Alberta Health Services Policy on Use of Portable Oxygen During Patient Transfers. This Policy indicates that health care professionals, practicing within their scope or role, must follow particular procedures when transporting patients who are

receiving oxygen therapy. This practice is restricted to personnel who demonstrate competency, education, and training in portable oxygen management. LPNs are not trained in this competency and the transfer of patients with portable oxygen is restricted to Registered Nurses. This competency is also listed in the Alberta Health Services Orientation workbook for Units 42 and 43 at the Peter Lougheed Centre which was provided to Ms. El-toughlob. Ms. El-toughlob failed to work within her scope of practice as an LPN. Ms. El-toughlob demonstrated a lack of judgement by not ensuring that she was adhering to the Alberta Health Services Policy on Use of Portable Oxygen During Patient Transfers as well as the Alberta Health Services orientation workbook for Units 42 and 43 and by doing this Ms. El-toughlob was in violation of the policy.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons previously articulated.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks in which they are asked to do. It is expected that if an LPN is asked to perform a procedure or task that they are not competent to perform that they would let their colleagues or supervisor know so that someone else may complete the task.

Allegation 5

Ms. El-toughlob admitted on or about March 17, 2020, while providing care to client RD, she failed to report client RD's increased and irregular heart rate to client RD's physician and/or the Care Hub Lead.

On March 17, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to patient RD.

At about 0924 hours, Ms. El-toughlob performed an assessment of patient RD's vital signs and documented that RD had a heart rate of 120 bpm. This was a significant increase from the prior chart entry at 0220 hours which showed a pulse of 56 bpm. Further, at 0940 hours Ms. El-toughlob performed a second assessment of RD and documented that he had a heart rate of 100 bpm and that his heart rate was irregular.

Despite RD's increased and irregular heart rate, Ms. El-toughlob did not notify RD's physician or the Care Hub Lead as required.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to report an irregular heart rate of patient RD to RD's physician and/or the Care Hub Lead which is required. Ms. El-toughlob failed to follow protocol of reporting the irregular heart rate. By failing to report the irregular heart rate to RD's physician and/or the Care Hub Lead this could have posed serious harm to RD. Ms. El-toughlob did not do what would be expected of another LPN in a similar circumstance and she displayed a lack of skill and judgment in her practice.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons given above.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks in which they are expected to perform. It would be an expected practice of an LPN that if a patient had an increased heart rate that they would notify the Charge Nurse or the Physician. By not reporting the irregular heart rate to the proper Health Care Team members this causes lack of trust in the LPN profession as Ms. El-toughlob did not do what is expected of an LPN.

Allegation 6

Ms. El-toughlob admitted that on March 17, 2020, while providing care to client PC, she did one or more of the following:

a. Incorrectly charted that she had not flushed client PC's intravenous line as the required medication was not available, when, instead, client PC's intravenous line had been discontinued; and/or
b. Failed to provide ordered PRN pain management to client PC despite performing a pain assessment that indicated PC was experiencing significant pain.

On March 17, 2020, Ms. El-toughlob worked at the Peter Lougheed Facility and provided care to patient PC.

At 0800 hours, Ms. El-toughlob provided care to PC, and documented that she was unable to complete a flush of PC's intravenous line as the required medication was not available. In fact, PC's intravenous line had been discontinued. Ms. El-toughlob's documentation did not indicate that PC no longer had an intravenous line, and incorrectly indicated that the required medication was not available.

PC had an order to provide PRN, or as needed pain management. Ms. El-toughlob performed a Patient Assessment, which indicated that PC was experiencing significant pain at a level of approximately 7/10 on a pain scale. Despite the assessment, Ms. El-toughlob failed to provide ordered PRN pain management to PC.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by documenting that she was unable to flush a patient's intravenous line as she did not have the required medication. The patient, in fact, did not have an intravenous in place. Ms. El-toughlob also failed to follow a physician's order to provide pain management for her patient. Ms. El-toughlob failed to properly do an assessment of PC, as well as she failed to follow a physician's order. Both Physical Assessments and Medication administration are core competencies of an LPN. Ms. El-toughlob failed to follow the Medication Rights for Medication Administration as well, which is also a core competency for an LPN. By not demonstrating these competencies, Ms. El-toughlob showed a lack of skill in her practice.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons set out above.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified; medication administration is a core competency for an LPN. Ms. El-toughlob failed to do what would be expected of another LPN in a similar circumstance by not adhering to the physician's order. The public expects that LPNs act as part of a team of regulated professionals and where their conduct does not reflect this, it undermines the integrity of the profession.

<u>Allegation 7</u>

Ms. El-toughlob admitted that on March 17, 2020, while providing care to client JM, she failed to do one or more of the following:

a. Start an intravenous line on client JM, as ordered, at or about 0821 hours, prior to the intravenous line's subsequent ordered discontinuance at or about 1014 hours; and/or

b. Follow a physician's order, by failing to offer client JM an ordered 10mg nicotine inhaler.

On March 17, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to patient JM.

At 0821 hours, a physician ordered JM to receive an intravenous line to administer a 1000ml NaCl infusion. Despite this order, Ms. El-toughlob failed to start an intravenous line on JM.

Subsequently, at 1014 hours, the order for the NaCl infusion was discontinued. JM did not receive the 1000ml NaCl infusion.

JM had received an order for a 10mg nicotine inhaler. Despite this order, Ms. El-toughlob failed to offer JM the inhaler.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by not adhering to a physician's order of initiation of an intravenous line on JM and failing to administer the NaCl infusion. Ms. El-toughlob also failed to offer JM the nicotine inhaler for which there was a physician's order. Ms. El-toughlob failed to do a physical assessment of the patient as well as failed to follow the physician's orders on two accounts. By not doing the physical assessment, Ms. El-toughlob did not notice that JM did not have an intravenous line nor did she initiate an intravenous line so that JM could receive the 1000ml NaCL infusion that was ordered. Thus, she demonstrated a lack of skill in her work.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons articulated above.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified; medication administration is a core competency for an LPN. IV therapy is also a competency which LPNs are expected to be able to perform. It is expected that an LPN will perform proper assessments as well as following physician's orders. As noted above, where an LPN does not work as part of the greater team of regulated professionals, it undermines the integrity of LPNs as regulated professionals.

Allegation 8

Ms. El-toughlob admitted that on or about March 25, 2020, while providing care to client RM, despite not being certified by the facility to administer medication or flush central venous catheters, she did one or more of the following:

a. Provided the intravenous antibiotic cefazolin (Ancef) to client RM via his central venous catheter;
b. Flushed client RM's central venous catheter with Heparin.

On March 25, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to RM.

RM had a central venous catheter ("CVC") in situ. To provide medication or to flush CVCs, LPNs are required to complete education and training requirements to become CVC certified. Ms. El-toughlob had begun her training to become CVC certified, but on March 25, 2020 had not yet received the certification.

Despite not being certified to flush or administer medication via CVC, Ms. El-toughlob administered the intravenous antibiotic cefazolin (Ancef) and flushed RM's CVC.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by performing a procedure on RM which was providing Ancef, an antibiotic, via his central venous catheter which she was not qualified to perform. Ms. El-toughlob had begun her training to receive her certification; however, at the time of the allegation she had not received her certification. Ms. El-toughlob was not competent in the skill of medication administration when a patient had a central venous catheter. Ms. El-toughlob was in the process of obtaining this competency. This displays a lack of knowledge in that Ms. El-toughlob was aware that she required the competency but still performed the procedure with regards to RM.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for substantially the same reasons previously provided.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks in which they are asked to do. It is expected that, if an LPN is asked to perform a procedure or task that they are not competent to perform, they would let their colleagues or supervisor know so that someone else may complete the task. Ms. El-toughlob's failure to do this was serious and constituted unprofessional conduct.

Allegation 9

Ms. El-toughlob admitted on or about May 4, 2020, while providing care to client GM, she failed to obtain a co-signature for the administration of Tinzaparin, as required.

On May 4, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to patient GM.

The Alberta Health Services Policy on Management of High-Alert Medications indicates that medication protocols and procedures established by the province must be followed when administering high-alert medications.

In accordance with this policy, the Alberta Health Services Procedure on Management of High-Alert Medications indicates that an independent double-check is required to ensure appropriate administration.

Finally, Alberta Health Services Policy on Medication Administration indicates that an independent double check for designated high-alert medications must be performed prior to the administration of those medications.

Tinzaparin, is an anti-coagulant and is a "high-alert" medication. Therefore, it is required that the administering health care professional obtain a co-signature for the administration.

At 0835 hours, Ms. El-toughlob administered Tinzaparin injection 4,500 units and failed to obtain a co-signature prior to its administration, as required.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to adhere to the Alberta Health Services Policy on Management of High-Alert Medications which indicates that medication protocols and procedures established by the province must be followed when administering high-alert medications. The Policy

indicates that an independent double-check is required to ensure appropriate administration of the High-Alert Medication. Ms. El-toughlob failed to obtain a co-signature for the administration of Tinzaparin which is a High-Alert Medication. Ms. El-toughlob is expected to be aware of the Management of High-Alert Medications Policy and, when it comes to High Alert Medications, it is expected that a co-signature is required prior to the administration of the medication. By not adhering to these expectations, she demonstrated a lack of judgment.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the same provisions in the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons previously indicated.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks in which they are asked to do. In accordance with the Alberta Health Services Policy on Management of High-Alert Medications, Ms. El-toughlob should have had a co-worker perform a double check of the medication as well obtaining that co-worker's signature to fulfil the obligation of the co-signature. This harms the LPN's profession by not doing what is expected of another LPN in a similar circumstance in that it is expected that LPNs are competent in the tasks that they are performing and medication administration is a core competency of an LPN. Where an LPN does not carry out tasks in accordance with their core competencies it leads to an erosion of the confidence others place in LPNs as professionals.

<u>Allegation 10</u>

Ms. El-toughlob admitted that on or about May 20, 2020, while providing care to client JS, she improperly administered Apixaban (Eliquis) tab 2.5 mg despite a physician's order suspending the dose.

On May 20, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to JS.

JS had a physician's order for Apixaban (Eliquis) tab 2.5mg. At 0905 hours, the physician ordered to suspend JS's dose of Apixaban in anticipation of a surgical procedure.

Despite this order that was suspending the administration of Apixaban, Ms. El-toughlob administered JS's typical dose of Apixaban at 0920 hours.

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;

xii. Conduct that harms the integrity of the regulated profession.

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by improperly administering a medication prior to a surgical procedure. Ms. El-toughlob demonstrated a failure to follow a physician's order by improperly administering the medication to the patient. Ms. El-toughlob failed to follow a physician's medication order with respect to the anticipation of the patient having a surgical procedure. Medication Administration is a core competency for LPNs, and it is expected that LPNs will follow the "Rights" of medication administration and, where they do not, it demonstrates a lack of knowledge or of skill or of judgment – or of all three.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as Ms. El-toughlob acknowledged. The Hearing Tribunal finds the conduct breached provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the reasons previously discussed.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. It is expected that LPNs will follow physicians' orders.

Allegation 11

Ms. El-toughlob admitted that on or about May 21st and 22nd, 2020, while providing care to client RK, she did one or more of the following while completing a vacuum-assisted closure dressing change:

a. Failed to review and/or follow a physician's order by attempting to use Tegaderm as a dressing when the physician's order indicated to use Jelonet;
b. Failed to understand the proper use for Tegaderm;
c. Failed to maintain a sterile field; and/or
d. Caused client RK additional and unnecessary discomfort.

On May 21 to May 22, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to RK.

RK had an exposed wound on her coccyx which required dressing changes several times per week. RK's physician ordered that Jelonet be used as a protective barrier, with black branufoam in contact with the wound.

While providing care to RK, Ms. El-toughlob performed a dressing change. Ms. El-toughlob requested that her co-worker, Amanda Warne, LPN, assist her with the change.

During the dressing change, Ms. El-toughlob began to prepare Tegaderm to put inside the wound to cover the boney protuberances. Tegaderm is a medical dressing used to protect wounds and catheter sites and is not intended for internal use. Ms. Warne stopped Ms. El-toughlob from using

the Tegaderm and reviewed the physician's orders along with Ms. El-toughlob, which indicated to use the Jelonet on the wound.

Throughout the remaining dressing change, Ms. El-toughlob failed to maintain a sterile field as she did not replace the necessary sterile products needed prior to continuing to complete the dressing.

As a result of Ms. El-toughlob's failure to review and/or follow the physician's order, use the inappropriate dressings, and maintain a sterile field, the dressing change took longer than normal, at almost a full hour to completed, and caused RK discomfort.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to follow the physician's order of the proper dressing change for the patient. Ms. El-toughlob was not qualified to do this task at the time that she performed the task. Ms. El-toughlob did request the assistance of her co-worker; however, Ms. El-toughlob used the incorrect type of dressing which then caused the dressing change to take a fair amount longer than it should have. By using the incorrect dressing type there was a potential of harm to the patient as Ms. El-toughlob was using a dressing in a way that it is not intended to be used. Ms. El-toughlob failed to follow the physician's order with respect to the dressing change in that Ms. El-toughlob did not adhere to both the physician's order nor the manufacturer of the Tegaderm in which a Tegaderm is not intended for internal use. Ms. El-toughlob also did not maintain a sterile field during the dressing change. Performing dressing changes is a core competency for LPNs in which Ms. El-toughlob failed by using the incorrect supplies and failure to maintain sterile technique which showed Ms. El-toughlob's lack of knowledge.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, which she acknowledged. The Hearing Tribunal finds the conduct breached the sections of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct in accordance with the reasons previously stated.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. It is expected that an LPN will follow the physician's order and, if they are asked to do a task that they are not familiar with, they ask for assistance, as well as do research on what is expected of them. Ms. El-toughlob did not perform the dressing change in the manner which it should have been

performed nor did she review how to perform the dressing change. Dressing changes are a core competency for LPNs and Ms. El-toughlob did not do what another LPN would have done in a similar circumstance and thereby harmed the integrity of her profession.

Allegation 12

Ms. El-toughlob admitted that on or about May 23rd and 24th, 2020, she worked at the Peter Lougheed Centre in Calgary, Alberta on a Saturday and Sunday, despite a restriction in place by her employer that she only work shifts scheduled Monday to Friday.

On April 13, 2020, Ms. El-toughlob worked with her employer to develop a learning plan to ensure that she could practice safely.

In conjunction with this plan, it was determined that Ms. El-toughlob was only permitted to work Monday to Friday day shifts and could not pick up any additional shifts.

Ms. El-toughlob was informed of this restriction to Monday to Friday day shifts on April 15, 2020 via email from Alanna Cunningham, Unit Manager for Unit 43 at the Peter Lougheed Centre.

On May 23 and May 24, 2020, which were a Saturday and Sunday, Ms. El-toughlob worked at the Peter Lougheed Centre on Unit 43.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by failing to adhere to the restriction that was in place by her employer. Ms. El-toughlob failed to follow the restrictions that were placed on her by working on a Saturday and Sunday after being instructed by her manager that she was to work Monday to Friday only.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, which she acknowledged. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct in accordance with the reasons discussed above.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to adhere to any restrictions that are placed on their employment. It is expected that if

a manager placed restrictions on an LPN as part of a learning plan that they would adhere to these restrictions.

Allegation 13

Ms. El-toughlob admitted that on or about May 24, 2020, while providing care to client RM, she administered hydromorphone, dimenhydrinate (Gravol), and cefazolin (Ancef) via client RM's central venous catheter, despite not being certified by her workplace to administer medication via central venous catheter.

On May 24, 2020, Ms. El-toughlob worked at the Peter Lougheed Centre and provided care to RM.

RM had a CVC placed. To provide medication via a CVC, LPNs are required to complete educational and training requirements to become CVC certified. Ms. El-toughlob had begun her training to become CVC certified but on May 24, 2020 Ms. El-toughlob had not yet received her certification.

Despite not being certified to flush or administer medication via CVC, Ms. El-toughlob administered hydromorphone, dimenhydrinate (Gravol), and cefazolin (Ancef) to RM via his CVC.

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

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

Ms. El-toughlob displayed a lack of knowledge of or lack of skill or judgement in the provision of professional services by performing a procedure on RM which was providing medications which included hydromorphone, dimenhydrinate, and cefazolin via his central venous catheter in which she was not qualified to perform. Ms. El-toughlob had begun her training to receive her certification; however, at the time of the allegation, she had not received her certification. Ms. El-toughlob was not competent in the skill of medication administration when a patient had a central venous catheter. Ms. El-toughlob was in the process of obtaining this competency. This displays a lack of knowledge in that Ms. El-toughlob was aware that she required the competency but still performed the procedure with regard to RM.

Ms. El-toughlob did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. El-toughlob. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the reasons discussed previously.

Ms. El-toughlob's conduct harms the integrity of the regulated profession in that Ms. El-toughlob did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to be competent and qualified for the tasks which they are asked to do. It is expected that, if an LPN is asked to perform a procedure or task that they are not competent to perform, they would let their colleagues or supervisor know so that someone else may complete the task. Ms. El-toughlob's failure to do this was serious and constituted unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Director and Ms. El-toughlob 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. El-toughlob shall pay 25% of the costs of the investigation and hearing to be paid over a period of 36 months from service of letter advising of final costs. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. El-toughlob 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. El-toughlob shall provide the Complaints Director with a signed written declaration within **60 days** of service of the Decision, attesting that she has reviewed the following CLPNA documents:

    (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 Practice Guideline: Medication Management;

    (f) CLPNA Competency Profile A1: Critical Thinking;

    (g) CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

    (h) CLPNA Competency Profile B: Nursing Process;

    (i) CLPNA Competency Profile C2: Licensed Practical Nurse Scope of Practice;

    (j) CLPNA Competency Profile C3: Professional Standards of Practice;

(k) CLPNA Competency Profile C4: Professional Ethics;

(l) CLPNA Competency Profile C5: Accountability and Responsibility;

(m) CLPNA Competency Profile D3: Legal Protocols, Documentation and Reporting;

(n) CLPNA Competency Profile U: Medication Management; and

(o) CLPNA Competency Profile V: Infusion Therapy.

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

4. Ms. El-toughlob will provide the Complaints Director with a written (typed) reflection paper, no less than 500 words, on how the CLPNA's documents set out in paragraph 3 above will impact her nursing practice and clinical judgement when providing a professional service in Alberta within **sixty (60) days** of service of the Decision. In the event the reflection paper is not satisfactory to the Complaints Director, Ms. El-toughlob shall within two (2) weeks of being notified by the Complaints Director the reflection paper is not satisfactory, or such longer period as determined by the Complaints Director in her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

5. Ms. El-toughlob shall complete, at her own cost, the following remedial education within **six (6) months** of service of the Decision. If the any of the courses becomes unavailable, then Ms. El-toughlob shall request in writing to be assigned alternative course(s) **prior to the deadline**. The Complaints Director shall, in her sole discretion, reassign the course(s). Ms. El-toughlob will be notified by the Complaints Director, in writing, advising of the course(s) required. Ms. El-toughlob shall provide the Complaints Director with a declaration and/or copy of certification confirming successful completion for all courses:

a) LPN Code of Ethics Learning Module available online at http://www.learninglpn.ca/index.php/courses.

b) NURS 0167 - Nursing Process, offered on-line by MacEwan University: https://www.macewan.ca/wcm/SchoolsFaculties/SchoolofContinuingEducation/Courses/NURS0167

c) CLPNA Nursing Documentation 101 offered on line at https://studywithclpna.com/nursingdocumentation101/

d) CLPNA's Health Assessment Self-Study Course offered on line at https://studywithclpna.com/healthassessment/

e) CLPNA's Medication Admininstration Self-Study Course offered on-line at https://studywithclpna.com/medicationadministration/

6. Ms. El-toughlob's practice permit will be subject to a condition of supervised practice at **all** facilities where Ms. El-toughlob is employed in the capacity of an LPN for a period totalling 75 hours, subject to the following terms and conditions:

a) The supervisor(s) must be an RN or LPN;

b) Ms. El-toughlob must provide her supervisor(s) with a copy of the Decision;

c) Prior to the commencement of supervised practice, Ms. El-toughlob will provide the Complaints Director with the name of the supervisor(s) and a written acknowledgement signed by her supervisor(s) confirming receipt of a copy of the Decision and willingness to provide supervision in accordance with the terms of the Decision;

d) The supervisor(s) must be available and onsite for the duration of all shifts worked by Ms. El-toughlob during the period of supervised practice;

e) The supervisor(s) will agree to submit a performance evaluation to the Complaints Director immediately following the completion of the 75 hours of supervised practice confirming whether the supervisor(s) has identified any concerns with respect to the issues raised in the Decision. The performance evaluation must make an overall assessment of whether Ms. El-toughlob's performance is satisfactory or not.

f) If the supervisor(s) identify concerns with respect to Ms. El-toughlob's practice, the period of supervised practice may be extended in the sole discretion of the Complaints Director for a further period of 75 hours, subject to the same terms set out above in paragraph 6(e).

g) If, at the conclusion of the period of supervised practice or any extended period of supervised practice, the supervisor(s) have any concerns regarding Ms. El-toughlob's practice, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

7. The sanctions set out above at paragraphs 3 to 6 will appear as a condition/conditions on Ms. El-toughlob's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial education, reading/reflection paper outlined at paragraphs 3 - 5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. El-toughlob's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

   i. Readings/Reflection Paper;

   ii. LPN Code of Ethics Learning Module;

   iii. NURS 0167 - Nursing Process;

   iv. CLPNA's Nursing Documentation 101;

   v. CLPNA's Health Assessment Self-Study Course; and

   vi. CLPNA's Medication Admininstration Self-Study Course.

b) The requirement to practice under supervision will continue to appear on Ms. El-toughlob's practice permit and the Public Registry until she provides proof to the Complaints Director that she has successfully completed the requirements set out above at paragraph 6; and

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

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

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

10. Should Ms. El-toughlob be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Director.

11. Should Ms. El-toughlob 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. El-toughlob'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. El-toughlob'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. El-toughlob and the Complaints Director.

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. El-toughlob 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: The conduct is significant as it deals with core competencies of an LPN and Ms. El-toughlob failed to meet those core competencies which also created a safety risk for the patients in Ms. El-toughlob's care.

The age and experience of the investigated member: Ms. El-toughlob has been registered with the CLPNA since September 4, 2018. At the time of the allegations Ms. El-toughlob had been an LPN for approximately two (2) years and was still relatively new to the career.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: There are no prior findings of unprofessional conduct.

The number of times the offending conduct was proven to have occurred: There was a pattern in which the allegations took place from February 4, 2020 until May 24, 2020 and contained a series of errors and near misses. There were twelve (12) allegations presented to the Hearing Tribunal which dealt with patient safety concerns.

The role of the investigated member in acknowledging what occurred: Ms. El-toughlob did acknowledge the allegations that were brought forward to the CLPNA by her employer. Ms. El-toughlob did provide the Hearing Tribunal with an Agreed Statement of Facts, which demonstrates that she took responsibility for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Ms. El-toughlob had an interim suspension placed on her practice permit on May 29, 2020, which prevented Ms. El-toughlob from being employed as an LPN.

The impact of the incident(s) on the victim, and/or: The Hearing Tribunal was not made aware of any impact.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was made aware at the time of the allegations, Ms. El-toughlob was taking care of her mother along with her brother. Also, during this time her brother was in a car accident and unfortunately was killed in the car accident which then made Ms. El-toughlob the sole caretaker of her mother.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: Specific deterrence is required to keep Ms. El-toughlob from repeating the same conduct in the future. General deterrence is required to ensure that other members of the LPN profession do not engage in similar conduct as well as to make sure that it is known that this type of conduct will not be tolerated by the CLPNA. LPNs are recognized as independent and capable members of the healthcare team and follow self-regulation, 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 CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

The range of sentence in other similar cases: The Hearing Tribunal was not provided with a range of sentences in other similar cases.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the Act to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the Act:

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

2. Ms. El-toughlob shall pay 25% of the costs of the investigation and hearing to be paid over a period of 36 months from service of letter advising of final costs. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. El-toughlob 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. El-toughlob shall provide the Complaints Director with a signed written declaration within **60 days** of service of the Decision, attesting that she has reviewed the following CLPNA documents:

   (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 Practice Guideline: Medication Management;

   (f) CLPNA Competency Profile A1: Critical Thinking;

   (g) CLPNA Competency Profile A2: Clinical Judgment and Decision Making;

   (h) CLPNA Competency Profile B: Nursing Process;

   (i) CLPNA Competency Profile C2: Licensed Practical Nurse Scope of Practice;

   (j) CLPNA Competency Profile C3: Professional Standards of Practice;

   (k) CLPNA Competency Profile C4: Professional Ethics;

   (l) CLPNA Competency Profile C5: Accountability and Responsibility;

   (m) CLPNA Competency Profile D3: Legal Protocols, Documentation and Reporting;

   (n) CLPNA Competency Profile U: Medication Management; and

   (o) CLPNA Competency Profile V: Infusion Therapy.

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

4. Ms. El-toughlob will provide the Complaints Director with a written (typed) reflection paper, no less than 500 words, on how the CLPNA's documents set out in paragraph 3 above will impact her nursing practice and clinical judgement when providing a professional service in Alberta within **sixty (60) days** of service of the Decision. In the event the reflection paper is not satisfactory to the Complaints Director, Ms. El-toughlob shall within two (2) weeks of being notified by the Complaints Director the reflection paper is not satisfactory, or such longer period as determined by the Complaints Director in her sole discretion, submit a revised paper that is acceptable to the Complaints Director.

5. Ms. El-toughlob shall complete, at her own cost, the following remedial education within **six (6) months** of service of the Decision. If the any of the courses becomes unavailable, then Ms. El-toughlob shall request in writing to be assigned alternative course(s) **prior to the deadline**. The Complaints Director shall, in her sole discretion, reassign the course(s). Ms. El-toughlob will be notified by the Complaints Director, in writing, advising of the course(s) required. Ms. El-toughlob shall provide the Complaints Director with a declaration and/or copy of certification confirming successful completion for all courses:

   a) LPN Code of Ethics Learning Module available online at http://www.learninglpn.ca/index.php/courses.
   b) NURS 0167 - Nursing Process, offered on-line by MacEwan University: https://www.macewan.ca/wcm/SchoolsFaculties/SchoolofContinuingEducation/Courses/NURS0167
   c) CLPNA Nursing Documentation 101 offered on line at https://studywithclpna.com/nursingdocumentation101/
   d) CLPNA's Health Assessment Self-Study Course offered on line at https://studywithclpna.com/healthassessment/
   e) CLPNA's Medication Admininstration Self-Study Course offered on-line at https://studywithclpna.com/medicationadministration/

6. Ms. El-toughlob's practice permit will be subject to a condition of supervised practice at **all** facilities where Ms. El-toughlob is employed in the capacity of an LPN for a period totalling 75 hours, subject to the following terms and conditions:

   a) The supervisor(s) must be an RN or LPN;

   b) Ms. El-toughlob must provide her supervisor(s) with a copy of the Decision;

c) Prior to the commencement of supervised practice, Ms. El-toughlob will provide the Complaints Director with the name of the supervisor(s) and a written acknowledgement signed by her supervisor(s) confirming receipt of a copy of the Decision and willingness to provide supervision in accordance with the terms of the Decision;

d) The supervisor(s) must be available and onsite for the duration of all shifts worked by Ms. El-toughlob during the period of supervised practice;

e) The supervisor(s) will agree to submit a performance evaluation to the Complaints Director immediately following the completion of the 75 hours of supervised practice confirming whether the supervisor(s) has identified any concerns with respect to the issues raised in the Decision. The performance evaluation must make an overall assessment of whether Ms. El-toughlob's performance is satisfactory or not.

f) If the supervisor(s) identify concerns with respect to Ms. El-toughlob's practice, the period of supervised practice may be extended in the sole discretion of the Complaints Director for a further period of 75 hours, subject to the same terms set out above in paragraph 6(e).

g) If, at the conclusion of the period of supervised practice or any extended period of supervised practice, the supervisor(s) have any concerns regarding Ms. El-toughlob's practice, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

7. The sanctions set out above at paragraphs 3 to 6 will appear as a condition/conditions on Ms. El-toughlob's practice permit and the Public Registry subject to the following:

a) The requirement to complete the remedial education, reading/reflection paper outlined at paragraphs 3 - 5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. El-toughlob's practice permit and the Public Registry until the below sanctions have been satisfactorily completed:

i. Readings/Reflection Paper;

ii. LPN Code of Ethics Learning Module;

iii. NURS 0167 - Nursing Process;

iv. CLPNA's Nursing Documentation 101;

v. CLPNA's Health Assessment Self-Study Course; and

vi. CLPNA's Medication Admininstration Self-Study Course.

b) The requirement to practice under supervision will continue to appear on Ms. El-toughlob's practice permit and the Public Registry until she provides proof to the Complaints Director that she has successfully completed the requirements set out above at paragraph 6; and

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

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

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

10. Should Ms. El-toughlob be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Director.

11. Should Ms. El-toughlob 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. El-toughlob'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. El-toughlob'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 1st DAY OF MARCH 2021 IN CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal