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 MARGARET KAPUWA

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 MARGARET KAPUWA, LPN #35660, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via Teleconference on December 9, 2021 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Angelica de Vera, LPN
James Lees, Public Member
Pat Matusko, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Officer, CLPNA
Kimberly Precht, Legal Counsel for the Complaints Officer, CLPNA
Susan Blatz, Complaints Officer, CLPNA

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

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Ms. Kapuwa was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Ms. Kapuwa was initially licensed as an LPN in Alberta on September 24, 2012.

The CLPNA received a complaint dated October 7, 2019 (the "First Complaint"), from Trish Ramstead, RN, Director of Care at Wentworth Manor, pursuant to s. 57 of the Act. The First Complaint advised Ms. Kapuwa, LPN, had been suspended from her employment at Wentworth Manor for four days without pay as a result of unprofessional communication, conduct and interaction in the workplace.

By letter dated October 18, 2019, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Ms. Kapuwa with notice of the First Complaint and notified Ms. Kapuwa that she was delegating her powers under Part 4 of the Act to Susan Blatz, Complaints Consultant (the "Complaints Consultant") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Ms. Kapuwa she had appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the First Complaint.

On April 9, 2020, the Investigator concluded the investigation of the First Complaint.

The CLPNA received a further complaint dated July 10, 2020 (the "Second Complaint"), from Carol Henckel, Administrator at Wentworth Manor, also pursuant to s. 57 of the Act. The Second Complaint advised Ms. Kapuwa was suspended for seven days without pay in November 2019 in relation to care Ms. Kapuwa provided to a patient who suffered a fall on October 15, 2019. The Second Complaint also advised Ms. Kapuwa's employment was terminated in July 2020.

The Complaints Director notified Ms. Kapuwa of the Second Complaint by letter dated July 15, 2020. The Complaints Director further notified Ms. Kapuwa she was delegating her powers under Part 4 of the Act to the Complaints Consultant pursuant to s. 20 of the Act and appointing the Investigator to conduct an investigation into the Second Complaint pursuant to s. 55(2)(d) of the Act.

The Investigator concluded the investigation of the Second Complaint on October 28, 2020.

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

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Kapuwa under cover of letter dated October 22, 2021.

Subsequently, an Amended Statement of Allegations was provided to Ms. Kapuwa.

(4) Allegations

The Allegations in the Revised Statement of Allegations dated November 24, 2021 (the "Allegations") are:

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

1) On or about September 30, 2019 refused to provide care to her assigned clients in Royal Oak following several requests made by management.
2) On or about October 15, 2019 did one or more of the following with regards to client FD:
    a. Transferred client FD from the floor after a fall, contrary to facility policy;
    b. Failed to document clearly in the Multidisciplinary Progress Notes the Acetaminophen 500 mg given to or taken by client FD after the fall.
3) Documented information not directly relevant to the client's care in a client's Multidisciplinary Progress Record on one or more of the following occasions:
    a. August 22, 2019, client JP;
    b. September 18, 2019, client HL;
    c. April 20, 2020, client IJ;
    d. April 30, 2020, client IG;
    e. May 8, 2020 client GK;
    f. May 17, 2020, client EM.
4) [Withdrawn]
5) [Withdrawn]"

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #2: 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 #1.

(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 #1 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Kapuwa'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. Kapuwa.

Allegation 1

Ms. Kapuwa admitted on or about September 30, 2019, she refused to provide care to her assigned clients in Royal Oak following several requests made by management.

On or around September 24, 2019, Wentworth Manor in Calgary Alberta (the “Facility”) implemented precautionary measures in relation to potential cases of influenza.

In an email to Facility staff on September 24, 2019, Nina Solas, RN, Program Manager, clarified the Facility did not meet the criteria for an influenza outbreak and the measures were only precautionary.

In an email to Facility staff on September 27, 2019, Shalika Wijesundera, RN, Program Manager, directed staff to "please continue with precautionary measures in place such as high touch surface cleaning, good hand hygiene, wearing PPE, no single use items and room service and no sharing of staff."

On September 30, 2019, Ms. Kapuwa was scheduled to work 0700 hours to 1515 hours. Her assignment required her to cross over to the Royal Oak unit.

Before Ms. Kapuwa started her shift on September 30, 2019, Ms. Kapuwa informed Tamara Graham, RN, Nursing Supervisor, she believed there was an outbreak in the Royal Oak unit and did not want to cross over. Ms. Graham informed Ms. Kapuwa there was no outbreak and Ms. Kapuwa needed to work on her assigned unit. However, Ms. Kapuwa insisted there was an outbreak and refused to go to the Royal Oak unit to provide care to residents.

Near the start of Ms. Kapuwa's shift on September 30, 2019, Ms. Kapuwa also informed Ms. Solas she was not working on her assigned Royal Oak unit because she believed there was an outbreak.

Around 1000 hours on September 30, 2019, Trish Ramstead, RN, Director of Care spoke to Ms. Kapuwa in the hallway outside a resident's room. The resident was in isolation and was being monitored. Ms. Ramstead told Ms. Kapuwa the Facility was not in an outbreak. Ms. Kapuwa disagreed. Ms. Ramstead explained the Facility went through the required process to determine whether it met the criteria for an outbreak as based on a review of the criteria there was no outbreak. Ms. Kapuwa still disagreed. Ms. Ramstead instructed Ms. Kapuwa to go to the Royal Oak unit and work Ms. Kapuwa's assigned shift.

At 1133 hours on September 30, 2019, Ms. Wijesundera sent an email to Facility staff stating, "We can cross over to the other neighborhoods."

Around 1400 hours on September 30, 2019, Carol Henkel, Administrator, instructed Ms. Kapuwa to go to work on the Royal Oak unit.

Despite being directed by Ms. Graham, Ms. Ramstead, and Ms. Henkel to work on her assigned Royal Oak unit on September 30, 2019, Ms. Kapuwa did not do so. Other facility staff had to go to the Royal Oak unit to provide care to residents in Ms. Kapuwa's absence.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kapuwa's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 1 did in fact occur.

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

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

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

Ms. Kapuwa displayed a lack of knowledge of or lack of skill or judgement in that Ms. Kapuwa failed to follow direction by Tamara Graham, Nursing Supervisor; Trish Ramstead, Director of Care; and Carol Henkel, Administrator when Ms. Kapuwa refused to provide care to patients in the Royal Oak unit of the Facility. Ms. Kapuwa was clearly told that she was able to cross over to the other neighborhood and that there was no outbreak, and that Ms. Kapuwa was needed to work on her assigned unit. By failing to attend at the Royal Oak unit, it caused other staff to have to go to the Royal Oak unit and provide care to residents in Ms. Kapuwa's absence. The requirement for the Facility to expend time and additional staff was unnecessary and was due to Ms. Kapuwa's belief that there was an outbreak at the Royal Oak unit despite being informed by senior staff that there was in fact no outbreak.

Ms. Kapuwa did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Kapuwa in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Kapuwa failed to effectively collaborate with her health care colleagues in a meaningful way by choosing not to attend where she was required to provide care based on an incorrect assumption (which was corrected multiple times) that there was an influenza outbreak on a particular unit. This demonstrated a failing in her effective collaboration with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families and communities.

The conduct breached the following principles and standards set out in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") and the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"):

<u>CLPNA Code of Ethics:</u>

Ms. Kapuwa acknowledges that her conduct breached one or more of the following requirements in the CLPNA Code of Ethics:

Principle 1: Responsibility to the Public – LPNs, 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.
- 1.6 Collaborate with clients, their families (to the extent appropriate to the client's right to confidentiality), and health care colleagues to promote the health and well-being of individuals, families and the public.

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

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

- 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.

- 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.

Principle 4: Responsibility to Colleagues – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically states that LPNs:

- 4.2 Collaborate with colleagues in a cooperative, constructive and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families and communities.

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

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

<u>CLPNA Standards of Practice:</u>

Ms. Kapuwa acknowledges that her conduct breached one or more of the following CLPNA Standards of Practice:

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.

- 1.6 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 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically states that LPNs:

- 2.8 Collaborate in the development, review and revision of care plans to address client needs and preferences and to establish clear goals that are mutually agreed upon by the client and the health care team.

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.

- 3.5 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.

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

Ms. Kapuwa's conduct harms the integrity of the regulated profession in that Ms. Kapuwa did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to follow the direction of their management team in their employment, and should they not agree with what they are being asked to do then there is a proper protocol to follow, and they should not just refuse to provide care for their residents especially when given direction and guidance by management.

Allegation 2

Ms. Kapuwa admitted on or about October 15, 2019, she did one or more of the following with regards to client FD:

a. Transferred client FD from the floor after a fall, contrary to facility policy;

b. Failed to document clearly in the Multidisciplinary Progress Notes the Acetaminophen 500 mg given to or taken by client FD after the fall.

On October 15, 20219, Ms. Kapuwa worked from 0700 to 1515 hours.

Around 1050 hours, client FD had an unwitnessed fall on the bathroom floor. Ms. Kapuwa was notified and came to assist.

The Facility's Falls Prevention and Management Program (the "Policy") sets out post fall procedures requiring the attending nurse to:

- Ensure resident safety and assess for injury. Before moving the resident, complete an assessment, including neurovital signs and neurovascular assessment.
- If the resident is unable to stand, or if medical treatment is indicated (severe pain, suspected head injury, suspected fracture, limb deformity, spinal injury, other) immediately call 911 and do not move the resident until EMS arrives.
- If it is safe to do so and the resident is able, assist the resident to transfer to a chair or bed if unable to safely transfer use the body life with 2 staff (in Wentworth call RN from PLTC).

Although client FD complained of pain to her left knee, could not weight bear or walk, and was unstable and unable to move, Ms. Kapuwa lifted client FD off the floor with the mechanical lifting device and the assistance of two others, contrary to the Policy which required Ms. Kapuwa to call 911 and wait for EMS to arrive before moving client FD.

On the Patient Information Transfer, Ms. Kapuwa stated that client FD had taken "PRN Acetaminophen 500mg orally at 11:30am."

On the Multidisciplinary Progress Report ("MPR"), Ms. Kapuwa documented "encouraged to take PRN Tylenol 500mg orally as resident is self-medicated." However, Ms. Kapuwa did not document on the MPR whether client FD in fact took any Tylenol.

Ms. Kapuwa's documentation on the Patient Information Transfer was inconsistent with her charting on the MPR. As a result, it was not clear whether Acetaminophen 500mg had in fact been given to or taken by client FD after the fall.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kapuwa's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 2 did in fact occur.

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

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

Ms. Kapuwa displayed a lack of knowledge of or lack of skill or judgement in that Ms. Kapuwa failed to follow the Policy. Due to client FD's complaint of pain, instability, and inability to move, she should have called 911 and waited for EMS rather than moving client FD herself. There was also no indication that Ms. Kapuwa completed the assessments required, including neurovital signs and a neurovascular assessment. This was contrary to the Policy, which was established to ensure resident safety in the event of a fall and to assess for injury.

Ms. Kapuwa did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Kapuwa in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct as set out in Allegation 1. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct. Ms. Kapuwa was required to promote workplace practices and policies that facilitate professional practice in accordance with the principles, standards, laws and regulations under which she was accountable, and minimize risk to the clients under her care, like FD. By failing to follow the Policy and not providing proper documentation about FD's fall, she put the client's care at risk.

Ms. Kapuwa's conduct harms the integrity of the regulated profession in that Ms. Kapuwa did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to follow the policies and procedures that are set out by their employers. Given that Ms. Kapuwa was an employee of the Facility since 2012, it would be expected that she would adhere to the Policy. If Ms. Kapuwa was not aware of the Policy, it would be expected that she would know where the policies are located for the Facility and to ensure she is aware of and up-to-date on all policies which could be applicable to the clients in her care.

Allegation 3

Ms. Kapuwa admitted she documented information not directly relevant to the client's care in a client's Multidisciplinary Progress Record on one or more of the following occasions:

a. August 22, 2019, client JP;

b. September 18, 2019, client HL;

c. April 20, 2020, client IJ;

d. April 30, 2020, client IG;

e. May 8, 2020 client GK;

f. May 17, 2020, client EM.

On August 22, 2019, Ms. Graham worked the day shift and expected client JP would be discharged from the hospital and return to the Facility before Ms. Graham finished her shift. When client JP had not arrived by 1630 hours, Ms. Graham asked Ms. Kapuwa to receive client JP and client JP's daughter when they arrived, because Ms. Graham felt unwell and wanted to go home. Ms. Kapuwa was working the evening shift. Ms. Graham had not yet done client JP's medication reconciliation, but expected Ms. Kapuwa would receive client JP, do the medication reconciliation, and follow client JP's care plan in the chart.

When client JP returned to the Facility on the evening of August 22, 2019, accompanied by client JP's daughter, Ms. Kapuwa received them. When client JP's daughter asked Ms. Kapuwa if client JP's medications were there, Ms. Kapuwa replied they were not, and medication reconciliation needed to be done. Ms. Kapuwa then documented in client JP's MPR:

> "Medication reconciliation left undone, verbally told it was not completed by nursing supervisor and that she is leaving, no update in care plan for Health Care Aides to review."

Ms. Kapuwa's comment about her conversation with Ms. Graham was not directly relevant to client JP's care and should not have been included in client JP's MPR.

On the morning of September 18, 2019, Ms. Kapuwa asked Ms. Graham if Ms. Graham had done an assessment on client HL concerning a previous fall. Ms. Kapuwa then documented in client HL's MPR:

> "Supervisor Tamara Graham stated she was thinking resident need assessment. Unsure if resident was assessed by supervisor."

Ms. Kapuwa's comments about Ms. Graham was not directly relevant to client HL's care and should have not been included in client HL's MPR for September 18, 2019.

On April 20, 2020, after assisting client IJ following an unwitnessed fall, Ms. Kapuwa documented in client IJ's MPR the need to explain a policy to an RN:

> "Waited for RN's opinion, who stated I just needed the lift to transfer. Explained as per policy when resident is on the floor I have to page or call for the RN in the building to access and to accompany an HCA with mechanical lift if resident unable to follow direction in move."

This comment was not directly relevant to client IJ's care and should not have been included in client IJ's MPR.

On April 30, 2020, in client IG's MPR, Ms. Kapuwa documented a shortage of PPE:

> "Writer checked with unit clerk, referred to Bobby Ann, who instructed to collect hand sanitizer from previous resident on PLTC. Writer explained was referred same yesterday on put on the other residents entrance door. Brought a liquid watery hand sanitizer in container. Writer put by door. Writer got some gowns from 357's box."

> "Writer came from isolated unit asked the evening RN at 1640 for more PPE (gowns) as were completely out."

These comments were not directly relevant to client IG's care and should not have been included in client IG's MPR.

Ms. Kapuwa also documented in client IG's MPR on April 30, 2020, an "RN instructed and pushed her way into the room followed by writer to assist" after client IG had an unwitnessed fall. Ms. Kapuwa's description of the RN "push[ing] her way into the room" was not directly relevant to client IG's care and should not have been included in client IG's MPR.

Additionally, Ms. Kapuwa document in client IG's MPR on April 30, 2020, Ms. Kapuwa's request for overtime and discussion with Edward Giminez, Director of Care ("Mr. Giminiez"):

> "Director called on the phone questioning why requesting for overtime when my shift is not ended. Writer responded due to frequency with assessment on unwitnessed fall and handling the rest of the other residents will put me behind schedule. "Oh you should know how to manage your time" says Director of Care. Writer responded I do try to manage my time but not with unpredictable incident like unwitnessed fall and new admission. Considering the pandemic and precaution measures I do need to take precautions and implement care to residents safely and on timely manner to the best that I can. Director of Nursing Edward Giminez indicated from now on to complete overtime and leave in his office, he will be the one to authorize. Contrary to what we have been told by [???] the DNS that situation might lead to overtime and ask for then authorization. Discussed with Director of Nursing it was and has been a struggle to look out for Personal Protective Equipment as all items are been locked up and requires the approval of him/management to utilize at our disposals. This alone wears time off and put writer behind schedules as I literally had to go from units to units calls, before getting the PPE needed with limit to what we can use."

Ms. Kapuwa's discussion with Mr. Giminez about Ms. Kapuwa's overtime request was not directly relevant to client IG's care and should not have been included in IG's MPR.

On May 8, 2020, Ms. Kapuwa documented in client GK's MPR:

> "Disruptive behavior, residents complaining, not appropriate for this unit. [….] redirected to no success. Can management look into secured unit?"

Ms. Kapuwa should not have included her request to management in client GK's MPR.

On May 17, 2020, in client EM's MPR, Ms. Kapuwa documented her discussion with Ms. Solas about COVID-19 swab testing:

> "Discussed with program manager, Nina Solas again prior to shift end, asked why LPN was asking RN to do swab collection. Informed it was on calendar for RN to assist and that this was Doctor's order given for testing. Nina Solas asked Why? Writer explained due to update on resident's status."

This comment was not directly related to client EM's care and should not have been included in client EM's MPR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Kapuwa's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 3 did in fact occur.

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

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

Ms. Kapuwa displayed a lack of knowledge of or lack of skill or judgement in that Ms. Kapuwa's entries on various clients' MPRs were not appropriate to be documented on residents' MPRs as Ms. Kapuwa's documentation was not directly relevant to the residents' care. As an LPN with seven years' experience at the time of the allegations, Ms. Kapuwa should be competent in what does and does not go into a patient's MPR, as this a core competency for an LPN, regardless of their experience. Adding additional, irrelevant information on an MPR which does not assist the patient does not demonstrate knowledge in the area, or good judgment.

Ms. Kapuwa did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Ms. Kapuwa in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to

constitute unprofessional conduct. Ms. Kapuwa was required to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies, and in this case it was clear that her documentation, which included unnecessary and irrelevant entries in client's MPRs, fell below that requirement.

Ms. Kapuwa's conduct harms the integrity of the regulated profession in that Ms. Kapuwa did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to adhere to proper documentation practices, which is a core competency of an LPN.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Kapuwa jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. 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. Kapuwa shall pay a portion of the costs of the investigation and hearing, in the amount of **$4,000.00**, to be paid over a period of **24 months** from service of the Decision.
3. Ms. Kapuwa shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Kapuwa shall provide a signed written declaration to Susan Blatz, Complaints Consultant, within **30 days** of service of the Decision, attesting that she has reviewed the CLPNA documents:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. CLPNA Policy: Documentation;
    d. CLPNA Policy: Professional Responsibility and Accountability;
    e. CLPNA Competency Profile A1: Critical Thinking;
    f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
    g. CLPNA Competency Profile C4: Professional Ethics;
    h. CLPNA Competency Profile D1: Communication;
    i. CLPNA Competency Profile D4: Conflict Management; and
    j. CLPNA F2: Infection Prevention and Control.

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

4. Ms. Kapuwa shall complete the course: **LPN Ethics Course** available online at www.learninglpn.ca/index.php/courses. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision .

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

5. Ms. Kapuwa shall complete, at her own cost, the following course: **Professional Accountability and Legal Liability for Nurses** offered on-line at www.learningext.com. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision

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

6. Ms. Kapuwa shall complete, at her own cost, the following course: **4 Essential Communication Strategies that Promote Patient Safety** offered on-line at www.pedagogyeducation.com. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

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

   a. The requirement to complete the readings and courses outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Kapuwa's practice permit and the public register until the below orders have been satisfactorily completed;

      i. Reading CLPNA documents;

      ii. LPN Ethics Course;

      iii. Professional Accountability and Legal Liability for Nurses;

      iv. 4 Essential Communication Strategies that Promote Patient Safety.

   b. The requirement to pay the costs outlined at paragraph 2 will appear as "Conduct Cost/Fines" on Ms. Kapuwa'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. Kapuwa's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Kapuwa be unable to comply with any of the sanctions' deadlines identified above, Ms. Kapuwa may request an extension. The request for an extension must be submitted in writing to the Complaints Consultant, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Consultant shall, in their sole discretion, determine whether a time extension is accepted. Ms. Kapuwa will be notified by the Complaints Consultant, in writing, if the extension has been granted.

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

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

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

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

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

parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Kapuwa has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

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

The nature and gravity of the proven allegations: This is serious conduct, as Ms. Kapuwa refused to provide care for her assigned residents, failed to follow direction of her supervisors, failed to follow applicable policies of her employer, and she clearly committed errors in her documentation on multiple clients' charts. By doing this, other staff members had to go to the Royal Oak unit to provide care to residents in Ms. Kapuwa's absence. Ms. Kapuwa failed to follow protocol and policy when it came to a resident who fell on the floor and could have potentially had a serious injury, and she failed to properly document whether the patient had taken Acetaminophen 500mg or not prior to going to the hospital. Ms. Kapuwa then documented incorrectly in residents' charts by documenting information that was not directly relevant to patients' care. Many of the inappropriate entries dealt with concerns relevant to the Facility

and/or her employment and could have been addressed by Ms. Kapuwa in a more appropriate manner.

The age and experience of the investigated member: Ms. Kapuwa was initially registered with the CLPNA on September 24, 2012. At the time of these allegations Ms. Kapuwa had been an LPN for approximately seven years. Ms. Kapuwa had worked for the Facility for those seven years and should have known the policies, protocols and documentation expectations. At this point of her career, Ms. Kapuwa should have been able to demonstrate the core competencies of an LPN.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: There were no prior complaints or convictions with respect to Ms. Kapuwa and the CLPNA.

The age and mental condition of the victim, if any: No direct information on the impact on any patient was presented to the Hearing Tribunal.

The number of times the offending conduct was proven to have occurred: There were three allegations with respect to Ms. Kapuwa. These allegations took place from August 2019 until May 2020.

The role of the investigated member in acknowledging what occurred: Ms. Kapuwa did acknowledge the three allegations that were brought forward to the CLPNA by her employer. Ms. Kapuwa did provide the Hearing Tribunal with an Agreed Statement of Facts, which demonstrates that she did in fact take 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. Kapuwa initially had a four day unpaid suspension as a result of the first complaint and her unprofessional communication, conduct and interaction at the Facility in October 2019. Then a further complaint advised the CLPNA that Ms. Kapuwa was suspended for seven days without pay in November 2019 in relation to the care that Ms. Kapuwa provided to a patient who suffered a fall. Then Ms. Kapuwa was terminated from the Facility in July 2020.

The impact of the incident(s) on the victim, and/or: The Hearing Tribunal was not made aware of any direct impact because of the care that Ms. Kapuwa provided to the residents.

The presence or absence of any mitigating circumstances: The Hearing Tribunal was not made aware of any mitigating circumstances with respect to Ms. Kapuwa.

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. Kapuwa 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 health care 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 made aware of any other similar cases.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA 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. Kapuwa shall pay a portion of the costs of the investigation and hearing, in the amount of **$4,000.00**, to be paid over a period of **24 months** from service of the Decision.
3. Ms. Kapuwa shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Kapuwa shall provide a signed written declaration to Susan Blatz, Complaints Consultant, within **30 days** of service of the Decision, attesting that she has reviewed the CLPNA documents:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;

c. CLPNA Policy: Documentation;

d. CLPNA Policy: Professional Responsibility and Accountability;

e. CLPNA Competency Profile A1: Critical Thinking;

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

g. CLPNA Competency Profile C4: Professional Ethics;

h. CLPNA Competency Profile D1: Communication;

i. CLPNA Competency Profile D4: Conflict Management; and

j. CLPNA F2: Infection Prevention and Control.

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

4. Ms. Kapuwa shall complete the course: **LPN Ethics Course** available online at www.learninglpn.ca/index.php/courses. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision .

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

5. Ms. Kapuwa shall complete, at her own cost, the following course: **Professional Accountability and Legal Liability for Nurses** offered on-line at www.learningext.com. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision

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

6. Ms. Kapuwa shall complete, at her own cost, the following course: **4 Essential Communication Strategies that Promote Patient Safety** offered on-line at www.pedagogyeducation.com. Ms. Kapuwa shall provide Susan Blatz, Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

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

c. The requirement to complete the readings and courses outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Kapuwa's practice permit and the public register until the below orders have been satisfactorily completed;

   i. Reading CLPNA documents;

   ii. LPN Ethics Course;

   iii. Professional Accountability and Legal Liability for Nurses;

   iv. 4 Essential Communication Strategies that Promote Patient Safety.

d. The requirement to pay the costs outlined at paragraph 2 will appear as "Conduct Cost/Fines" on Ms. Kapuwa'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. Kapuwa's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 7.

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

10. Should Ms. Kapuwa be unable to comply with any of the sanctions' deadlines identified above, Ms. Kapuwa may request an extension. The request for an extension must be submitted in writing to the Complaints Consultant, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Consultant shall, in their sole discretion, determine whether a time extension is accepted. Ms. Kapuwa will be notified by the Complaints Consultant, in writing, if the extension has been granted.

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

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

    e. Treat Ms. Kapuwa's non-compliance as information for a complaint under s. 56 of the Act; or

    f. In the case of non-payment of the costs described in paragraph 2 above, suspend Ms. Kapuwa's practice permit until such costs are paid in full or the Complaints Consultant

is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

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

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

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

DATED THE 20th DAY OF DECEMBER 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal