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 PRINCE ANNOR

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 PRINCE ANNOR, LPN #46409, 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 Videoconference using Zoom on September 4, 2020 with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Verna Ruskowsky, LPN
Nancy Brook, Public Member

Staff:
Katrina Haymond, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Prince Annor, LPN ("Mr. Annor 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

Mr. Annor was an LPN within the meaning of the *Health Profession Act* ("the Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Mr. Annor was initially licensed as an LPN in Alberta on August 1, 2018.

On February 20, 2020, the CLPNA received a complaint from Angela Fackrell, Wellness Manager at Saint Elizabeth Health Care Points West Living Facility ("the Facility") in Wetaskiwin, Alberta

(the "Complaint"). The Complaint was sent pursuant to s. 57(1) of the Act, stating that Mr. Annor, LPN had been suspended pending the outcome of two separate workplace investigations into his practice, conduct and performance.

In accordance with s. 55(2)(d) and s. 20(1) of the Act, Ms. Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director") appointed Susan Blatz, Complaints Consultant for the CLPNA, (the "Complaints Consultant") to handle the Complaint and Kerry Palyga, Investigator for the CLPNA, (the "Investigator") to conduct an investigation into the Complaint.

On February 20, 2020 the Complaints Director sent a letter to Jeanne Weis, Executive Director of the CLPNA (the "Executive Director"), requesting the immediate suspension of Mr. Annor's Practice Permit.

On February 20, 2020, the Complaints Director sent a letter to Mr. Annor advising him of the Complaint, the investigation and the request to the Executive Director for the immediate suspension of his Practice Permit.

On February 27, 2020, the Executive Director sent a letter to Mr. Annor advising him of the immediate suspension of his Practice Permit.

On April 6, 2020, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following the Investigation Report, the Complaints Consultant determined there was sufficient evidence that these matters should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Annor received notice that the matters were referred to a hearing as well as a copy of the Statement of Allegations and Investigation Report under cover of letter dated June 10, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Annor under cover of letter dated July 17, 2020.

(4) Allegations

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

> "It is alleged that **PRINCE ANNOR, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:
>
> (1) On or about January 13, 2020 did one or more of the following after becoming aware that KC and FC had been in a physical altercation resulting in both clients falling to the floor:
>
> (a) Failed to conduct any assessments or in the alternative failed to conduct adequate assessments;
>
> Failed to document the assessments of KC and FC in their Progress Notes;

(b) Failed to follow post-fall protocols, including:
   (i) Failed to complete incident reports;
   (ii) Failed to notify families and/or emergency contacts;
   (iii) Failed to document the incident in the PWL & HC Daily 24-Hour Communication Tool.

(2) On or about February 10, 2020, in his capacity as Lead LPN, failed to provide proper direction to another LPN regarding client GP, after becoming aware that GP suffered a fall and was exhibiting signs of a fractured femur."

(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.

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual

findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

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

The Hearing Tribunal also accepts Mr. Annor'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 Mr. Annor.

Allegation 1

Prince Annor admitted on or about January 13, 2020, he did one or more of the following after becoming aware that KC and FC had been in a physical altercation resulting in both clients falling to the floor:

a) Failed to conduct any assessments or in the alternative failed to conduct adequate assessments;
b) Failed to document the assessments of KC and FC in their Progress Notes;
c) Failed to follow post-fall protocols, including:
    i) Failed to complete incident reports;
    ii) Failed to notify families and/or emergency contacts;
    iii) Failed to document the incident in the PWL & HC Daily 24-Hour Communication Tool.

On January 13, 2020, Mr. Annor worked an evening shift at the Facility. At approximately 1730 hours, clients KC and FC engaged in a physical altercation which resulted in KC and FC wrestling each other to the ground. Tracey Brazeau, a Health Care Aide, was present and witnessed the altercation. Ms. Brazeau notified Mr. Annor of the occurrence. Mr. Annor promptly attended the location.

Mr. Annor conducted cursory assessments of clients KC and FC. The assessments were limited to a visual inspection and asking the residents if they were in any pain. Mr. Annor observed and treated a small abrasion on client KC's cheek.

Mr. Annor failed to document any assessment of clients KC or FC in their Progress Notes.

Mr. Annor failed to follow the Facility's post-fall protocols. Specifically, he failed to complete an incident report, failed to notify the families or emergency contacts that clients KC and FC had fallen to the ground as a result of an altercation, and failed to document the incident in the PWL & HC Daily 24-Hour Communication Tool.

On January 17, 2020, client FC complained of chest pain. Client FC was transferred to the Wetaskiwin Hospital by EMS. There he was diagnosed and treated for rib fractures attributed to the January 13, 2020 fall incident.

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

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

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.** Mr. Annor's conduct, which was demonstrated in the evidence reviewed by the Hearing Tribunal and acknowledged by him in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, demonstrated a severe lack of judgment in the provision of his professional services in that he failed to properly assess/treat the clients, as well as, failed to properly document the incident. Mr. Annor failed to conduct a proper assessment and only performed a visual assessment and only asked if the clients were in pain. Mr. Annor did not document any assessment in the progress notes. Mr. Annor also failed to follow the facility's post-fall protocols. Physical assessment and proper documentation are both skills that LPNs are expected to perform effectively, safely, and efficiently.

ii. **Contravention of the Act, a code of ethics or standards of practice.** Mr. Annor did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct. 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 demonstrate unprofessional conduct; and

xii. **Conduct that harms the integrity of the regulated profession.** The public has the right to expect respectful, safe, and competent care when receiving care from an LPN. The Hearing Tribunal recognized that this was not the case in this matter and that conduct such as this damages the profession in the eyes of the public and constitutes Unprofessional Conduct as defined in the Act.

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"):

CLPNA Code of Ethics:

Mr. Annor acknowledges that his conduct breached one or more of the following requirements in the CLPNA Code of Ethics, which states as follows:

- **Principle 1: Responsibility to the Public** – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:
    - 1.1 Maintain standards of practice, professional competence and conduct.
    - 1.5 Provide care directed toward the health and well-being of the person, family and community.
    - 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 wellbeing 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 provides that LPNs:
    - 2.8 Use evidence and judgment to guide nursing decisions.
    - 2.9 Identify and minimize risks to clients.
- **Principle 3**: **Responsibility to the Profession** – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically provides that LPNs:
    - 3.1 Maintain the standards of the profession and conduct themselves in a manner that upholds the integrity of the profession.
    - 3.3 Practise in a manner that is consistent with the privilege and responsibility of self-regulation.
- **Principle 4: Responsibility to Collegaues**: Licensed Practical Nurses develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals.
    - 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 have a commitment to recognize and function within their personal and professional competence and value systems. Principle 5 specifically provides that LPNs:

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

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

CLPNA Standards of Practice:

Mr. Annor acknowledges that his conduct breached one or more of the following CLPNA Standards of Practice, which state as follows:

- **Standard 1: Professional Accountability and Responsibility** – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

    - 1.1 Practice to their full range of 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.

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

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

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

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

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

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

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

- **Standard 3: Service to the Public and Self-Regulation** – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and

improve health care services in the best interests of the public. Standard 3 specifically provides that LPNs:

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

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

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

  Mr. Annor demonstrated a lack of judgement or skill by failing to properly assess the clients involved in the altercation, as well as, failing to properly document the altercation and any assessment he did perform.

Mr. Annor did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above under Allegation 1. The Hearing Tribunal finds the conduct breached the same provisions of the above CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 2</u>

Prince Annor admitted on or about February 10, 2020, in his capacity as Lead LPN, he failed to provide proper direction to another LPN regarding client GP, after becoming aware that GP suffered a fall and was exhibiting signs of a fractured femur.

On February 10-11, 2020, Mr. Annor worked a shift from 1900 hours to 0715 hours at the Facility. Mr. Annor was the Lead LPN for the duration of his shift.

At approximately 2000 hours, client GP suffered a fall. A Health Care Aide ("HCA") reported the fall to LPN Sang. LPN Sang assessed the client GP and suspected a leg fracture and requested Mr. Annor attend to provide an assessment and direction on next steps. Mr. Annor assessed the client GP and concluded GP had likely suffered a fractured femur.

Client GP had a goal of care of C2. This required the family to be notified and grant permission prior to her being transferred to the hospital. Mr. Annor did not direct LPN Sang to transfer client GP to the hospital, and instead directed LPN Sang to contact the family of client GP and inform them that GP had fallen and possibly suffered a fracture. Mr. Annor further directed LPN Sang to provide the family the options of having GP transferred to hospital or remain in the Facility overnight and potentially be transferred to hospital in the morning. The family elected to have GP remain in the Facility overnight.

Client GP complained of pain in her left leg. LPN Sang observed the leg to be sensitive to touch. LPN Sang administered PRN Tylenol #3 with codeine to client GP at 2030 hours and again at 0300 hours. Although client GP had a goal of care of C2, which required her family to be notified and to grant permission prior to being transferred to the hospital, given the injuries that GP had suffered, Mr. Annor ought to have instructed LPN Sang to advise GP's family that a transfer to the hospital was necessary, in order to provide for adequate care and comfort measures.

On February 11, 2020 at approximately 0700 hours, client GP was assessed by LPN Habel. LPN Habel concluded client GP had likely suffered a fractured femur. LPN Habel forthwith notified the family of client GP and called for EMS to transfer GP to hospital.

On February 11, 2020 client GP was diagnosed and treated at the hospital for a fractured femur.

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

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

i. **Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.** Mr. Annor's conduct, which was demonstrated in the evidence reviewed by the Hearing Tribunal and acknowledged by him in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct, demonstrated a severe lack of judgment in the provision of his professional services in that he failed to properly direct a colleague while he was in the role of lead LPN. Mr. Annor failed to direct the LPN to tell the family of GP that she had sustained an injury that required her to be sent to the hospital to ensure proper treatment and comfort were provided to GP.

ii. **Contravention of the Act, a code of ethics or standards of practice.** Mr. Annor did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct. 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 demonstrate unprofessional conduct; and

xii. **Conduct that harms the integrity of the regulated profession.** The public has the right to expect respectful, safe, and competent care when receiving care from an LPN. The Hearing Tribunal recognized that this was not the case in this matter and that conduct such as this damages the profession in the eyes of the public and constitutes Unprofessional Conduct as defined in the Act.

In addition, Mr. Annor did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by him in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and set out in detail above under Allegation 1. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out in Allegation 1 and that such breaches are sufficiently serious to constitute unprofessional conduct.

Summary

In summary, the Hearing Tribunal considered the evidence put forth in Exhibit #2, and the documents included in Exhibit #2, and concluded that each of the Allegations against Mr. Annor were factually found. In addition, after considering the definition of unprofessional conduct found in section 1(1)(pp) of the Act, the CLPNA Code of Ethics and CLPNA Standards of Practice applicable to Mr. Annor as an LPN, the Hearing Tribunal found that for each allegation, unprofessional conduct had occurred.

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Annor 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. Mr. Annor 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. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Mr. Annor 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. Mr. Annor shall provide the Complaints Consultant with a signed written declaration within **30 days** of the Decision, attesting he has reviewed CLPNA's documents:

    i. Code of Ethics for Licensed Practical Nurses in Canada;
    ii. Standards of Practice for Licensed Practical Nurses in Canada;
    iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
    iv. CLPNA Practice Policy: Documentation;
    v. CLPNA Competency Profile A1: Critical Thinking;
    vi. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
    vii. CLPNA Competency Profile B: Nursing Process;
    viii. CLPNA Competency Profile C9: Informal Leadership;
    ix. CLPNA Competency Profile C10: Formal Leadership;
    x. CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting.

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

4. Mr. Annor shall complete the following nursing quizzes located on the website http://www.learningnurse.org/. Mr. Annor shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **30 days** of service of the Decision:

    a. **8.1 Health Assessment;** and
    b. **16.3 Professional Practice.**

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

5. Mr. Annor shall complete, at his own cost, the following courses offered on-line at www.nurse.com. Mr. Annor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

    a. **Improving Critical Thinking and Clinical Reasoning;** and
    b. **Learning to Lead.**

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

6. Mr. Annor shall complete, at his own cost, the following course: **Documentation and Reporting** offered on-line at https://www.coursepark.com/learningnetwork/courses/index/id/1089. Mr. Annor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

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

   a. The requirement to complete the remedial activities outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr. Annor's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. Read and review CLPNA documents;

      ii. 8.1 Health Assessment;

      iii. 16.3 Professional Practice;

      iv. Improving Critical Thinking and Clinical Reasoning;

      v. Learning to Lead;

      vi. Documentation and Reporting.

   b. The requirement to pay costs, will appear as "Conduct Cost/Fines" on Mr. Annor's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Mr. Annor'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. The suspension of Mr. Annor's practice permit will be removed once he provides proof to the Complaints Consultant of completion of the orders referred to in paragraphs 3, 4, 5 and 6.

10. Mr. Annor shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Mr. Annor will keep his contact information current with the CLPNA on an ongoing basis.

11. Should Mr. Annor be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

12. Should Mr. Annor 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 Mr. Annor'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 Mr. Annor's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

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

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

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Mr. Annor and the Complaints Consultant.

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Mr. Annor 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:** Two (2) separate clients suffered injuries due to the falls they sustained and care was delayed in a hospital as a result of Mr. Annor's failure to assess, document and to notify families and emergency contacts. This demonstrates a pattern, in two (2) instances, of Mr. Annor not taking the falls seriously and potentially endangering clients as a result.

- **The age and experience of the investigated member:** Mr. Annor had been an LPN for less than 1.5 years at the time of the allegation. He started working at Points West in December 2018 and became Team Lead in July 2019. Although a relatively new LPN, the skills required here were fundamental to any LPN's training and despite his inexperience, it would have been expected of Mr. Annor to know that his conduct was improper.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** To the knowledge of the Hearing Tribunal there are no prior complaints or convictions.

- **The age and mental condition of the victim**: The age and mental conditions of the clients affected was not provided in the evidence.

- **The number of times the offending conduct was proven to have occurred:** There are two (2) incidents in this investigation that took place within a month of each other.

- **The role of the investigated member in acknowledging what occurred:** Mr. Annor acknowledged the allegations reported to CLPNA. He cooperated with the investigation. He also cooperated in providing the Hearing Tribunal with an Agreed Statement of Facts as well a Joint Submission on Penalty. The Hearing Tribunal acknowledges and appreciates Mr. Annor's participation in this process and his taking of responsibility.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Mr. Annor has had his practice permit suspended since February 27, 2020 and therefore has been unable to practice since that time.

- **The impact of the incident(s) on the victim:** In the first allegation, Mr. Annor failed to properly assess both clients involved in the altercation. He also failed to document any assessment he did perform. Four days after the incident client FC was transported to hospital due to chest pain. At this point FC was diagnosed with rib fractures attributed to the January 13, 2020. In the second incident, Mr. Annor was in a Team Lead position and failed to direct another LPN to inform the family of client GP that transport to the hospital was necessary to provide adequate care. It was later determined the client suffered a fractured femur. In both instances the clients involved were not appropriately assessed and thereby treatment at a hospital was delayed. However, the Hearing Tribunal was not made aware of any further impact on the victims.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice**: It is imperative that the penalty promotes specific deterrence to Mr. Annor. He needs to understand his conduct is not only unprofessional and not what is expected of LPN's. In regard to general deterrence, the Hearing Tribunal feels the Joint Submission on Penalty will help ensure that other members of CLPNA understand that the actions demonstrated by Mr. Annor will be dealt with in a serious manner. The CLPNA does have a discipline process in place which helps to ensure that LPNs are competent and self-regulated professionals and the public needs to be reassured that this standard is upheld.

- **The need to maintain the public's confidence in the integrity of the profession:** The public needs to be assured that LPNs are held accountable for their actions. It is the expectation that LPNs continue to meet the CLPNA Standards of Practice, the CLPNA Code of Ethics as well as the Act. Any instances of unprofessional conduct will be dealt with in a careful and considered manner.

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. Mr. Annor 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. A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Mr. Annor 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. Mr. Annor shall provide the Complaints Consultant with a signed written declaration within **30 days** of the Decision, attesting he has reviewed CLPNA's documents:

i. Code of Ethics for Licensed Practical Nurses in Canada;
ii. Standards of Practice for Licensed Practical Nurses in Canada;
iii. CLPNA Practice Policy: Professional Responsibility & Accountability;
iv. CLPNA Practice Policy: Documentation;
v. CLPNA Competency Profile A1: Critical Thinking;
vi. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
vii. CLPNA Competency Profile B: Nursing Process;
viii. CLPNA Competency Profile C9: Informal Leadership;
ix. CLPNA Competency Profile C10: Formal Leadership;
x. CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting.

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

4. Mr. Annor shall complete the following nursing quizzes located on the website http://www.learningnurse.org/. Mr. Annor shall provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within **30 days** of service of the Decision:

   a. **8.1 Health Assessment;** and
   b. **16.3 Professional Practice.**

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

5. Mr. Annor shall complete, at his own cost, the following courses: offered on-line at www.nurse.com. Mr. Annor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

   a. **Improving Critical Thinking and Clinical Reasoning;** and
   b. **Learning to Lead.**

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

6. Mr. Annor shall complete, at his own cost, the following course: **Documentation and Reporting** offered on-line at https://www.coursepark.com/learningnetwork/courses/index/id/1089. Mr. Annor shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

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

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

   a. The requirement to complete the remedial activities outlined at paragraphs 3-6 will appear as "CLPNA Monitoring Orders (Conduct)", on Mr. Annor's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. Read and review CLPNA documents;

      ii. 8.1 Health Assessment;

      iii. 16.3 Professional Practice;

      iv. Improving Critical Thinking and Clinical Reasoning;

      v. Learning to Lead;

      vi. Documentation and Reporting.

   b. The requirement to pay costs, will appear as "Conduct Cost/Fines" on Mr. Annor's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

8. The conditions on Mr. Annor'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. The suspension of Mr. Annor's practice permit will be removed once he provides proof to the Complaints Consultant of completion of the orders referred to in paragraphs 3, 4, 5 and 6.

10. Mr. Annor shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Mr. Annor will keep his contact information current with the CLPNA on an ongoing basis.

11. Should Mr. Annor be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

12. Should Mr. Annor 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 Mr. Annor'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 Mr. Annor'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 09TH OF NOVEMBER 2020 IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M. Stolz LPN

Michelle Stolz, LPN
Chair, Hearing Tribunal