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 SHERRI HAKKARAINEN

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 SHERRI HAKKARAINEN, LPN #29290, 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 on October 28, 2020 with the following individuals present:

Hearing Tribunal:
Marg Hayne, Public Member, Chairperson
Noreen Mills, ("Licensed Practical Nurse") LPN
Verna Ruskowsky, LPN

Staff:
Jason Kully, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Sherri Hakkarainen, LPN ("Ms. Hakkarainen or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. Hakkarainen was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Hakkarainen was initially licensed as an LPN in Alberta on March 4, 2007.

The College of Licensed Practical Nurses of Alberta ("CLPNA") received a complaint dated September 18, 2019 (the "First Complaint") from Angela Henke, Site Manager, at the Good

Samaritan Society facility ("GSS") in Cardston, Alberta, pursuant to s. 57 of the Act. The First Complaint stated Ms. Hakkarainen, LPN, had received a three-day suspension of her employment at GSS as a result of several practice issues.

In accordance with s. 55(2)(d) of the Act, Ms. Sandy Davis, the Complaints Director of the CLPNA (the "Complaints Director") appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to investigate the First Complaint.

By way of letter dated October 7, 2019, the Complaints Director provided Ms. Hakkarainen with notice of the First Complaint and of the appointment of the Investigator.

The CLPNA received a further complaint dated November 6, 2019 (the "Second Complaint") from Ms. Henke pursuant to s. 57 of the Act. The Second Complaint stated that Ms. Hakkarainen had received a ten-day suspension of her employment at GSS as a result of a breach of confidentiality.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed the Investigator to investigate the Second Complaint.

By way of letter dated November 13, 2019, the Complaints Director provided Ms. Hakkarainen with notice of the Second Complaint and of the appointment of the Investigator.

The CLPNA received a third complaint dated December 31, 2019 (the "Third Complaint") from Ms. Henke pursuant to s.57 of the Act. The Third Complaint stated that Ms. Hakkarainen's employment with GSS had been terminated with just cause due to considerable concerns about her competency, trustworthiness and inability to work within facility policy.

In accordance with s. 55(2)(d) of the Act, the Complaints Director appointed the Investigator to investigate the Third complaint.

By way of letter dated January 9, 2020, the Complaints Director provided Ms. Hakkarainen with notice of the Third Complaint and of the appointment of the Investigator.

On March 31, 2020, the Investigator concluded the investigation into the First Complaint, the Second Complaint, and the Third Complaint and submitted an Investigation Report to the Complaints Director.

Following receipt of the Investigation Report, the Complaints Director determined there was sufficient evidence that the issues raised in the First Complaint, the Second Complaint, and the Third Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. Hakkarainen 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 25, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Hakkarainen under cover of letter dated September 14, 2020.

(4) Allegations

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

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

1. On or about January 18, 2019, did one or more of the following in regard to resident RM:
    a. Failed to process a Physician's Order, dated January 15, 2019, as instructed by failing to record the discontinuance of Irbesartan and the change from Xarelto to Eliquis on RM's Medication Administration Record;
    b. Failed to process a Physician's Order, dated January 15, 2019, as instructed by failing to record the administration of Lantus if blood glucose was higher than 10.0 mmol/L and to hold Lantus if blood glucose was lower than 10.0 mmol/L on RM's Medication Administration Record;
    c. Failed to complete a medication reconciliation form.

2. On or about January 19, 2019 did one or more of the following in regard to resident AS after a fall:
    a. Failed to complete an initial assessment;
    b. Failed to document an initial assessment;
    c. Failed to complete neuro vitals as required by the post-fall protocol monitoring.

3. On or about January 20, 2019 did one or more of the following in regard to resident AS after a fall:
    a. Failed to complete an initial assessment;
    b. Failed to document an initial assessment;
    c. Failed to complete neuro vitals as required by the post-fall protocol monitoring.

4. On or about January 28-29, 2019, instructed an HCA to administer high alert medications and antibiotics which HCA was not authorized to administer to residents, including residents RW or KS.

5. On or about September 2019, did one or more of the following in regard to resident LT:

a. Failed to complete an assessment when an HCA reported LT was screaming in pain;

b. Failed to administer a PRN medication for pain to LT.

6. On or between January 2019 and September 25, 2019, breached the duty to maintain confidentiality by doing one or more of the following:

   a. Removed the Progress Notes for five residents, which contained residents' personal and medical information, from the Lee Crest Facility without justification or authorization;

   b. Stored the Progress Notes for five residents, which contained patients' personal and medical information, in her home without justification or authorization.

7. On or about October 8, 2019 did one or more of the following with regard to resident DP:

   a. Failed to perform an assessment after receiving a report that resident DP was agitated;

   b. Instructed an HCA to administer Risperidone, at 2055 hours scheduled medication, as a PRN medication at 1835 hours;

   c. Instructed an HCA to administer medication which the HCA was not authorized to administer;

   d. Failed to document an assessment of the therapeutic effectiveness of the Risperidone administered at 1835 hours."

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

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

(6) Exhibits

The following exhibits were entered at the hearing:

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

(7) Evidence

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

(8) Decision of the Hearing Tribunal and Reasons

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

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

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

Allegation 1

Ms. Hakkarainen admitted that on or about January 18, 2019, she did one or more of the following in regard to resident RM:

a. Failed to process a Physician's Order, dated January 15, 2019, as instructed by failing to record the discontinuance of Irbesartan and the change from Xarelto to Eliquis on RM's Medication Administration Record;

b. Failed to process a Physician's Order, dated January 15, 2019, as instructed by failing to record the administration of Lantus if blood glucose was higher than 10.0 mmol/L

and to hold Lantus if blood glucose was lower than 10.0 mmol/L on RM's Medication Administration Record;

c. Failed to complete a medication reconciliation form.

Ms. Hakkarainen worked a 12-hour day shift on Friday, January 18, 2019.

On January 18, 2019, Ms. Hakkarainen found paperwork which had not been processed. The paperwork included Physician's Order for resident, RM, dated January 15, 2019, for the discontinuance of Irbesartan and a change from Xarelto to Eliquis. Included with Exhibit #2 at TAB 12 is a copy of a physician's response note on a letter from a pharmacist, dated January 15, 2019, which constituted the Physician's Order regarding Irbesartan and Eliquis. The paperwork also included a Physician's Order for resident RM, dated January 15, 2019, requiring the administration of Lantus if RM's blood glucose was higher than 10.0 mmol/L and the holding of Lantus if RM's blood glucose was lower than 10.0 mmol/L. Included with Exhibit #2 TAB 13 is a copy of the documentation taken by Yolaine Bottle, LPN, dated January 15, 2019, of the physician's verbal order for RM regarding Lantus.

Karen Olshaski, the Site Manager of GSS at the time, directed Ms. Hakkarainen to process the paperwork during Ms. Hakkarainen's January 18, 2019 shift.

On Monday, January 21, 2019, when she returned to work, Ms. Olshaski observed the same stack of unprocessed documents in an office.

Ms. Hakkarainen failed to process the Physician's Order, dated January 15, 2019, and failed to record the discontinuance of Irbesartan and the change from Xarelto to Eliquis on RM's Medication Administration Record.

Ms. Hakkarainen also failed to process the Physician's Order, dated January 15, 2019, and failed to record the administration of Lantus if blood glucose was higher than 10.0 mmol/L and to hold Lantus if blood glucose was lower than 10.0 mmol/L on RM's Medication Administration Record.

Ms. Hakkarainen did not complete a medication reconciliation form as required due to the medication changes ordered for resident RM. Policy at the GSS was to complete a medication reconciliation form when there was a change in medication to ensure a medication error did not occur.

As a result of Ms. Hakkarainen's actions, patients did not receive the correct medications or failed to receive any medication at all. This placed patients at risk.

Including with Exhibit #2 at TAB 14 is a copy of an email Ms. Hakkarainen sent on January 19, 2019, in which she indicated she was aware of RM's medication changes and that she did not process the paperwork as directed.

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

Ms. Hakkarainen failed to follow the direction of Ms. Olshaski which had the effect of some medications being continued when they were to stop and others to be delayed in being implemented. This resulted in resident RM receiving incorrect medication which risked adverse health impacts. These failures demonstrate a lack of skill on the part of Mr. Hakkarainen who did not follow established practices for LPNs in relation to medication.

The risk which resident RM was subjected to was unnecessary and could have serious effects. Errors of this nature erode the public's trust that LPNs will provide appropriate care either to themselves or their loved ones when under the care of an LPN. The result is harm to the integrity of the profession.

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

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

The Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, state as follows:

a. Principle 1: Responsibility to the Public - LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 specifically provides that LPNs:
    - 1.1 Maintain standards of practice, professional competence and conduct.
    - 1.5 Provide care directed to 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 well-being of individuals, families and the public.

b. Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:
    - 2.6 Provide care to each client recognizing their individuality and their right to choice.

- 2.7 Develop trusting, therapeutic relationships, while maintaining professional boundaries.

- 2.8 Use evidence and judgement to guide nursing decisions; and

- 2.9 Identify and minimize risks to clients.

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

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

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

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

d. Principle 4: Responsibility to the Profession – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically provides 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.

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

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

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

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

The Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, state as follows:

a. Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct

meet both the standards of the profession and legislative requirements. Standard 1 specifically provides that LPNs:

- 1.1. 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.

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

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

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

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice
- 3.5 Provide relevant and timely information to clients and co-workers.
- 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

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

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

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

Ms. Hakkarainen breached her obligations under the Code by failing to maintain the standards required of her as an LPN, did not provide care for the well being of RM, a person under her care, and did not work with her colleagues to ensure the well-being of RM. Her failures with regard to these medications also mean she failed in her responsibility to provide safe care to RM as her actions placed RM at risk and undermined her ability to carry on a therapeutic relationship with RM. In doing so she did not follow practices and policies which bind her nor acted in accordance with the privilege of self-regulation.

She also failed in maintain the standards of practice of an LPN by not practicing as she is trained and required to practice, by failing in her obligations to maintain proper documentation and did not demonstrate a knowledge-based practice in making these medication errors. The result is that others in the care team who rely on her to maintain documentation did not have all of the information needed to provide care to RM which also amounts to communications which were not timely and in doing so failed her team.

Allegation 2

Ms. Hakkarainen admitted on or about January 19, 2019, she did one or more of the following in regard to resident AS after a fall:

a. Failed to complete an initial assessment;

b. Failed to document an initial assessment;

c. Failed to complete neuro vitals as required by the post-fall protocol monitoring.

Resident AS suffered a fall on January 19, 2019 during Ms. Hakkarainen's shift at approximately 1145 hours. Resident AS suffered an injury to her head and was bleeding from her head.

Ms. Hakkarainen failed to complete and document an initial assessment of AS after the fall as required.

Ms. Hakkarainen failed to complete and chart neuro vitals as required by the post-fall protocol and no monitoring took place. A copy of the Post-Fall Protocol at GSS is included with Exhibit #2 at Tab 15.

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; and
xiii. Conduct that harms the integrity of the regulated profession.

Falls can have serious complications, especially for older persons such as AS. Post-fall assessment procedures are implemented in order to ensure adverse impacts from a fall can be identified and monitored and offer a point in time assessment against which a client's health at a later time can be compared. The knowledge of the importance of completing such assessments is basic to an LPN's practice and failing to complete one demonstrates a lack of judgment. She also failed in her duty to her employer to follow policies and procedures that are established to protect clients. The failure to complete a post-fall assessment could lead to very serious consequences and as a result a member of the public may well question the value of LPNs as a profession where such adverse consequences arise.

This conduct also breached the provisions of the Code of Ethics and Standards of Practice cited in relation to Allegation #1. As noted above, post-fall tracking is an important process for identifying a client's status following an event which could have significant consequences, it contributes to collaboration amongst a client's health care team by providing important information about a client's health. Where this assessment is not done, the important goals that it serves are not met. Not only does this not meet the expectations of an LPN but it also undermines the well-being of that client. It also undermines the ability for caregivers in the future to be able to adequately assess care and make decisions based on evidence.

By failing to complete the post-fall assessment Ms. Hakkarainen failed to engage in skilled practice which reflects the reality that each health care giver and the work they do is one piece of the overall picture of care. When a piece is missing, the care will be incomplete. In this case, Ms. Hakkarainen did not practice her duty to her client, her profession, her colleagues or herself.

Allegation 3

Ms. Hakkarainen admitted that on or about January 20, 2019, she did one or more of the following in regard to resident AS after a fall:

a. Failed to complete an initial assessment;

b. Failed to document an initial assessment;

c. Failed to complete neuro vitals as required by the post-fall protocol monitoring.

AS suffered another fall on January 20, 2019 during Ms. Hakkarainen's shift at approximately 1745 hours. The fall was not witnessed and AS was found lying on the ground.

Ms. Hakkarainen failed to complete and document an initial assessment of AS after the fall as required.

Ms. Hakkarainen failed to complete and chart neuro vitals as required by the post-fall protocol and no monitoring took place. A copy of the Post-Fall Protocol at GSS is attached to Exhibit #2 at Tab 15.

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

For the same reasons that failing to complete a post-fall assessment amounted to unprofessional conduct with regard to Allegation #2, this same conduct amounts to unprofessional conduct with regard to Allegation #3. Furthermore, for the same reasons this conduct constitutes a breach of the Code and Standards for Allegation #2, this conduct is a breach of the Code and Standards. All of these reasons are amplified in Allegation #3 because they demonstrate the failures of Ms. Hakkarainen were repeated with the same client only one day later.

Allegation 4

Ms. Hakkarainen admitted that on or about January 28-29, 2019, she instructed an HCA to administer high alert medications and antibiotics which HCA was not authorized to administer to residents, including residents RW or KS.

On January 28-29, 2019, Ms. Hakkarainen instructed Chynna Johnson, HCA, to administer Coumadin, an anticoagulant medication used to treat and prevent blood clots and which is a high alert medication, to residents RW and KH at 1600 hours. Ms. Hakkarainen instructed Ms. Johnson to notify her when this was complete. Ms. Hakkarainen did not supervise the administration of the medication and did not return to check on the residents.

On January 28-29, Ms. Hakkarainen also instructed Ms. Johnson to administer antibiotics in eye drops to a resident. Ms. Hakkarainen instructed Ms. Johnson to notify her when this was complete. Ms. Hakkarainen did not supervise the administration of the medication and did not return to check on the residents.

HCAs are not authorized to administer high alert medications and antibiotics to residents without direct supervision.

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.

An LPN must be fully aware of when it is appropriate to delegate medication administration to an HCA and when it is not. Further, when delegation is appropriate, proper supervision must be provided. Ms. Hakkarainen demonstrated a lack of judgment in this impermissible and unsupervised delegation to an HCA. These failures harm the integrity of the profession of LPNs as an informed observer might conclude that LPNs do not demonstrate rigour in ensuring they work with team members as appropriate – either because they are not skilled or because they are indifferent to whether they engage in skilled and competent practice.

The provisions of the Code of Ethics and Standards of Practice previously identified were also breached by this Conduct. Ms. Hakkarainen did not ensure her practice met with the standards of her profession and failed to take steps to avoid risk to this resident in inappropriately delegating these medications. In doing so she also showed a lack of understanding of her role in relation to the roles of her colleagues. Self-regulation requires professionals who identify the requirements on them and the boundaries on the abilities of those working under them. Furthermore, regulated professionals must adhere to their professional standards and the policies of their workplaces --- Mr. Hakkarainen did not do this. Inappropriate delegation also undermines the collaborative environment of care because it could lead to risk for a client that would negatively impact the client but also the whole time responsible for their care.

Allegation 5

Ms. Hakkarainen admitted that on or about September 2019, she did one or more of the following in regard to resident LT:

a. Failed to complete an assessment when an HCA reported LT was screaming in pain;

b. Failed to administer a PRN medication for pain to LT.

Sometime in September 2019, at approximately 1830 hours, resident LT was screaming in pain.

Chyna Johnson, HCA, called Ms. Hakkarainen and advised her that LT was screaming in pain and that he required a PRN medication for the pain.

Ms. Hakkarainen did not assess LT to determine if pain medication should be administered. Ms. Hakkarainen did not administer any medication to LT for pain.

LT continued to scream in pain during Ms. Hakkarainen's shift. Ms. Johnson advised the evening shift LPN of this and Ms. Hakkarainen's refusal to assess LT or administer medication. The evening shift LPN administered pain medication to LT.

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. Hakkarainen was alerted to the likelihood LT was in pain and elected not to assess him to determine whether medication should be administered to provide relief. In doing so she demonstrated poor judgment and did not act in a manner which one would expect of an LPN. Her profession is one which exists to apply its specialized knowledge to reduce harm to those under their care, this conduct has the opposite effect. Any member of the public who might have witnessed this conduct would have a diminished view of the care LT was receiving and of the institution as a whole. This conduct therefore harms the integrity of the regulated profession.

The conduct breached the principles and standards set out in relation at Allegation #1.

Ms. Hakkarainen's failure to assess LT in the face of his clear discomfort and expressions of pain was not in keeping with her obligations to the public and to the well-being of LT nor was it indicative of collaboration for the benefit of LT. By not assessing LT for pain, Ms. Hakkarainen chose not to exercise her judgment to provide competent care. This behaviour was not in keeping with the obligations of a regulated professional and was not in keeping with the obligations bearing on her as an LPN. It betrayed a lack of cooperation with the health care team and demonstrated a lack of responsibility. In these ways she has breached the Code.

This conduct similarly breached the Standards by not acting within the full range of her practice or in a manner to minimize harm to LT. The HCA which reported LT's condition to Ms. Hakkarainen was unable to provide LT with pain medication and by failing to act, Ms. Hakkarainen failed to fulfill her role as part of LT's health care team and therefore undermined the effectiveness of that team. Leaving LT without any assessment for pain also showed a lack of respect for LT as a person and was not in keeping with the values and beliefs of her profession.

<u>Allegation 6</u>

Ms. Hakkarainen admitted on or between January 2019 and September 25, 2019, she breached the duty to maintain confidentiality by doing one or more of the following:

a. Removed the Progress Notes for five residents, which contained residents' personal and medical information, from the Lee Crest Facility without justification or authorization;

b. Stored the Progress Notes for five residents, which contained patients' personal and medical information, in her home without justification or authorization.

On September 25, 2019, Ms. Hakkarainen attended a grievance meeting with managers from GSS.

Ms. Hakkarainen brought copies of Progress Notes relating to five residents from GSS to the grievance meeting to reference in support of her position. The Progress Notes contained patients' personal and medical information, including their names and Alberta Health Care numbers. Attached to Exhibit #2 at TAB 16 are copies of the Progress Notes brought by Ms. Hakkarainen to the meeting.

Ms. Hakkarainen had printed and copied the Progress Notes while at work at the GSS facility in approximately January 2019 prior to going on a leave. She did not advise anyone that she was removing the Progress Notes. She placed the Progress Notes in her work bag and removed them from the GSS facility without authorization or justification.

Ms. Hakkarainen kept the Progress Notes in her home between January 2019 and September 2019 until she brought them to the grievance meeting.

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;
iii. Contravention of another enactment that applies to the profession, and
xii. Conduct that harms the integrity of the regulated profession.

Maintaining the privacy inherent to health care records, which Progress Notes are, and of health care information of clients generally is a keystone aspect of the obligations of an LPN. Removing records for personal benefit shows a lack of judgment and is a contravention of the *Health Information Act*, RSA 2000, c H-5. It harms the integrity of the profession by breaching the trust people place in LPNs when they seek care.

The conduct breached the principles and standards set out in relation to Allegation #1. It also breached the following provision of Principle 2 of the Code of Ethics:

- 2.3 Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.

Further, this conduct breached Principle 3 of the Standards of Practice as follows and which was not previously cited:

- 3.8 Practice within the relevant laws governing privacy and confidentiality of personal health information.

Removing a client's personal health information for her own benefit contradicted all aspects of the Code and Standards which require an LPN to maintain the confidentiality of their clients. Further, it undermined the trust which is reposed in an LPN, the duty of an LPN to work for the well-being of others and in concert with other members of her team. Ms. Hakkarainen did not

respect client rights, demonstrate good judgment nor an understanding of the purpose and responsibility of a regulated professional. The removal of records did not demonstrate an understanding of the purpose of those records and the role of an LPN in the care provided to a client.

Allegation 7

Ms. Hakkarainen admitted on or about October 8, 2019, she did one or more of the following with regard to resident DP:

a. Failed to perform an assessment after receiving a report that resident DP was agitated;

b. Instructed an HCA to administer Risperidone, at 2055 hours scheduled medication, as a PRN medication at 1835 hours;

c. Instructed an HCA to administer medication which the HCA was not authorized to administer;

d. Failed to document an assessment of the therapeutic effectiveness of the Risperidone administered at 1835 hours."

On October 8, 2019, Marsha Acosta, HCA, reported to Ms. Hakkarainen that resident DP was agitated prior to DP's evening bath. Ms. Acosta requested that Ms. Hakkarainen administer a PRN medication to resident DP for agitation.

Resident DP had a PRN medication order for 0.5 mg Lorazepam for agitation. Attached at Exhibit #2 at TAB 17 is a copy of DP's PRN Medication Administration Record indicating same.

Resident DP had a scheduled medication order for Risperidone to be given at 2055 hours. Attached at Exhibit #2 at TAB 18 is a copy of DP's Medication Administration Record indicating same.

Ms. Hakkarainen did not assess resident DP after receiving the report from Ms. Acosta that DP was agitated.

After receiving the report from Ms. Acosta that DP was agitated, Ms. Hakkarainen instructed Ms. Acosta to administer the 2055 hours scheduled Risperidone to resident DP for the agitation. Ms. Hakkarainen did not direct Ms. Acosta to administer Lorazepam as a PRN medication.

Ms. Hakkarainen did not assess resident DP prior to directing Ms. Acosta to administer Risperidone.

Ms. Acosta administered the Risperidone to resident DP at approximately 1835 hours as directed. Attached to Exhibit #2 at TAB 19 is a copy of DP's Progress Notes for October 8, 2019 which include Ms. Acosta's documentation of the incident. Attached to Exhibit #2 at TAB 20 is a copy of the Incident Report completed by Ms. Acosta on October 8, 2019.

As an HCA, Ms. Acosta was not authorized to administer the Risperidone.

Ms. Hakkarainen did not document an assessment of the therapeutic effectiveness of the Risperidone administered to resident DP at approximately 1835 hours. Attached at Exhibit #2 at TAB 19 is a copy of DP's Progress Notes for October 8, 2019 indicating same.

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

Failing to assess DP prior to ordering medication was a failure by Ms. Hakkarainen to employ her knowledge and skill to her profession and it was also a lapse in judgment to proceed in this manner. Furthermore, directing an HCA who could not administer this medication to do so was a further failure to exercise judgment. Finally, by not assessing DP after the medication was administered placed DP at risk. She demonstrated a lack of judgment in choosing to administer the medication as PRN rather than a scheduled medication as ordered. This conduct undermines the integrity of the LPN profession because it shows an LPN operating with disregard of their obligations which calls into question the purpose of the LPN in the health care team.

This conduct also breached those provisions of the Code of Ethics and Standards of Practice cited in relation to Allegation #1. Making a clinical decision without assessing the need for the response placed DP at risk of harm; this risk was magnified by the improper delegation of the administration of the medication and the failure to assess DP following administration. When an LPN acts in this manner they fail in their obligations to the public to provide knowledgeable and competent care, to the particular client by introducing them to risk, to their colleagues by asking them to undertake tasks which are not within their scope and they betray the ethical underpinnings of their profession. Failing to assess and document also leaves a hole in the information available to team members providing care to DP in the next shift and beyond. In this way, Ms. Hakkarainen's conduct had the ability to ripple through and causing further risk and harm to DP in the future. All of this indicates a lack of understanding of what a regulated professional is called to do and the public's agreement to allow for self regulation. If LPNs operate in a manner so as to neglect to apply the skills and knowledge of their profession they undermine the reason for its existence and the public's confidence in the profession as a whole. Ms. Hakkarainen failed this client, her team, the public, her profession and herself.

(9) Joint Submission on Penalty

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

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

2. Ms. Hakkarainen shall pay 25% of the costs of the investigation and hearing to be paid over a period of **thirty-six (36) months** from service of letter advising of the Decision.

    (a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Hakkarainen shall pay a fine of $1,500.00 within **thirty-six (36) months** of service of the Decision.

4. Ms. Hakkarainen shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Hakkarainen shall provide the Complaints Director with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the documents:

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

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

    iii. CLPNA's Interpretive Document: Privacy Legislation in Alberta;

    iv. CLPNA's Practice Guideline: Confidentiality;

    v. CLPNA Practice Policy: Professional Responsibility & Accountability;

    vi. CLPNA Competency Profile A1: Critical Thinking;

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

    viii. CLPNA Competency Profile B: Nursing Process;

    ix. CLPNA Competency Profile C3: Professional Standards;

    x. CLPNA Competency Profile C4: Professional Ethics;

    xi. CLPNA Competency Profile C5: Accountability and Professional Standards;

xii. CLPNA Competency Profile C9: Informal Leadership;

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

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

xv. CLPNA Competency Profile U: Medication Management.

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

5. Ms. Hakkarainen shall, at her own cost, complete the following remedial education. Ms. Hakkarainen shall provide the Complaints Director with documentation confirming successful completion of the remedial education within **nine (9) months** of service of the Decision:

   a) LPN Ethics Course offered online by Learning Nurse available at http://www.learninglpn.ca/index.php/courses;

   b) Health Assessment Self-Study Course offered online by CLPNA at https://studywithclpna.com/healthassessment/;

   c) Medication Administration Self-Study Course offered online by CLPNA at https://studywithclpna.com/medicationadministration/;

   d) Nursing Documentation 101 offered online by CLPNA at https://studywithclpna.com/nursingdocumentation101/;

   e) AHS Affiliates Information & Privacy Online Learning Module available online at https://www.albertahealthservices.ca/info/Page3962.aspx. This education includes viewing the Information & Privacy and IT Security & Awareness Video available online at https://www.albertahealthservices.ca/info/Page3962.aspx. Ms. Hakkarainen shall, in addition to documentation confirming successful completing of the Online learning Module, also provide the Complaints Director with a signed declaration attesting she watched the video prior to completing the Online Learning Module.

   If any of the required remedial education becomes unavailable, Ms. Hakkarainen shall request, **in writing prior to the deadline**, to be assigned alternative education. The Complaints Director shall, in her sole discretion, reassign the education. Ms. Hakkarainen will be notified by the Complaints Director in writing, advising of the new required remedial education.

6. The orders set out above at paragraphs 2-5 will appear as conditions on Ms. Hakkarainen's practice permit and the Public Registry subject to the following:

    (a) The requirement to complete the remedial education and reading outlined at paragraphs 4-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Hakkarainen's practice permit and the Public Registry until the below orders have been satisfactorily completed;

        i. CLPNA Reading;

        ii. LPN Ethics Course;

        iii. Health Assessment

        iv. Medication Administration

        v. Documentation 101

        vi. Information & Privacy Learning

    (b) The requirement to pay costs and fines will appear as "Conduct Cost/Fines" on Ms. Hakkarainen's practice permit and the Public Registry until all costs and fines have been paid as set out above at paragraphs 2-3.

7. The conditions on Ms. Hakkarainen's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

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

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

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

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

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

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

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

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

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

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

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Hakkarainen 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

1. **The nature and gravity of the proven allegations**: There are several serious allegations in this matter which involve a variety of breaches relating to a number of areas of an LPN's practice. The Hearing Tribunal has noted this fact.

2. **The age and experience of the investigated member**: At the time of these issues, Ms. Hakkarainen was a 12 year member of the CLPNA. While this does not make her a senior practitioner, it certainly makes her an experienced practitioner. Moreover, these breaches go to the heart of basic skills and obligations of an LPN. There is no mitigating aspect of this factor.

3. **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:** Ms. Hakkarainen has had no prior complaints.

4. **The age and mental condition of the victim, if any:** No specific information was provided in regard of the clients impacted by Ms. Hakkarainen's conduct; however, the Hearing Tribunal notes she was working in a facility which houses older adults.

5. **The number of times the offending conduct was proven to have occurred**: Some of this conduct occurred more than once which the Hearing Tribunal considers to be a serious concern.

6. **The role of the investigated member in acknowledging what occurred:** Ms. Hakkarainen worked with the Complaints Director to proceed in this matter on an agreed basis which the Hearing Tribunal has noted.

7. **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Ms. Hakkarainen lost her position and prior to that was suspended for a number of days. The Hearing Tribunal is not aware of other impacts.

8. **The impact of the incident(s) on the victim, and/or:** The Hearing Tribunal was not made aware of the impact of these incidents other than the obvious such as where a client was left to suffer without consideration given to any relief by medication.

9. **The presence or absence of any mitigating circumstances:** The Hearing Tribunal was not made aware of any mitigating circumstances.

10. **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** These are serious allegations which involve not only passive contraventions of the obligations of an LPN but active ones such as the removal of documents or decision not to assess a client in pain. The Hearing Tribunal is aware of the great need for making it clear to Ms. Hakkarainen that she cannot practice in this manner, to other LPNs that issues of this nature will be taken seriously, and to the public to demonstrate that the CLPNA addresses these issues.

11. **The need to maintain the public's confidence in the integrity of the profession:** Again, the public must be assured that the CLPNA is capable of regulating its members and willing to do so where issues arise.

12. **The range of sentence in other similar cases:** The Hearing Tribunal was made aware that a fine of $1500 is consistent with findings of breaches of confidentiality.

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

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

(11) Orders of the Hearing Tribunal

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

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

2. Ms. Hakkarainen shall pay 25% of the costs of the investigation and hearing to be paid over a period of **thirty-six (36) months** from service of letter advising of the Decision.

(a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

3. Ms. Hakkarainen shall pay a fine of $1,500.00 within **thirty-six (36) months** of service of the Decision.

4. Ms. Hakkarainen shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance" and will be provided. Ms. Hakkarainen shall provide the Complaints Director with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the documents:

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

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

    iii. CLPNA's Interpretive Document: Privacy Legislation in Alberta;

    iv. CLPNA's Practice Guideline: Confidentiality;

    v. CLPNA Practice Policy: Professional Responsibility & Accountability;

    vi. CLPNA Competency Profile A1: Critical Thinking;

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

    viii. CLPNA Competency Profile B: Nursing Process;

    ix. CLPNA Competency Profile C3: Professional Standards;

    x. CLPNA Competency Profile C4: Professional Ethics;

    xi. CLPNA Competency Profile C5: Accountability and Professional Standards;

    xii. CLPNA Competency Profile C9: Informal Leadership;

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

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

    xv. CLPNA Competency Profile U: Medication Management.

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

5. Ms. Hakkarainen shall, at her own cost, complete the following remedial education. Ms. Hakkarainen shall provide the Complaints Director with documentation confirming successful completion of the remedial education within **nine (9) months** of service of the Decision:

   a) LPN Ethics Course offered online by Learning Nurse available at http://www.learninglpn.ca/index.php/courses;

   b) Health Assessment Self-Study Course offered online by CLPNA at https://studywithclpna.com/healthassessment/;

   c) Medication Administration Self-Study Course offered online by CLPNA at https://studywithclpna.com/medicationadministration/;

   d) Nursing Documentation 101 offered online by CLPNA at https://studywithclpna.com/nursingdocumentation101/;

   e) AHS Affiliates Information & Privacy Online Learning Module available online at https://www.albertahealthservices.ca/info/Page3962.aspx. This education includes viewing the Information & Privacy and IT Security & Awareness Video available online at https://www.albertahealthservices.ca/info/Page3962.aspx. Ms. Hakkarainen shall, in addition to documentation confirming successful completing of the Online learning Module, also provide the Complaints Director with a signed declaration attesting she watched the video prior to completing the Online Learning Module.

   If any of the required remedial education becomes unavailable, Ms. Hakkarainen shall request, **in writing prior to the deadline**, to be assigned alternative education. The Complaints Director shall, in her sole discretion, reassign the education. Ms. Hakkarainen will be notified by the Complaints Director in writing, advising of the new required remedial education.

6. The orders set out above at paragraphs 2-5 will appear as conditions on Ms. Hakkarainen's practice permit and the Public Registry subject to the following:

   (a) The requirement to complete the remedial education and reading outlined at paragraphs 4-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Ms. Hakkarainen's practice permit and the Public Registry until the below orders have been satisfactorily completed;

      i. CLPNA Reading;

      ii. LPN Ethics Course;

iii. Health Assessment

iv. Medication Administration

v. Documentation 101

vi. Information & Privacy Learning

(b) The requirement to pay costs and fines will appear as "Conduct Cost/Fines" on Ms. Hakkarainen's practice permit and the Public Registry until all costs and fines have been paid as set out above at paragraphs 2-3.

7. The conditions on Ms. Hakkarainen's practice permit and on the Public Registry will be removed upon completion of each of the requirements.

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

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

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

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

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

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

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

"87(1) An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that

(a) identifies the appealed decision, and

(b) states the reasons for the appeal.

(2) A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 1st DAY OF MARCH 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Marg Hayne, Public Member
Chair, Hearing Tribunal