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 TAIYE (DAVID) SYLVESTER-DAUDU

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 TAIYE (DAVID) SYLVESTER-DAUDU , LPN #45503, 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 October 14, 2020 with the following individuals present:

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

Staff:
Evie Thorne, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Taiye (David) Sylvester-Daudu, LPN ("Ms. David" or "Investigated Member")
Carol Drennan, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Ms. David 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. David was initially licensed as an LPN in Alberta on January 16, 2018.

By letter dated October 29, 2018, the CLPNA received a complaint (the "Complaint") from Ms. Dawnna-Lee Nielsen, Site Manager, at The Good Samaritan Society - Clearwater Centre in Rocky

Mountain House, AB pursuant to s. 57 of the Act. The Complaint stated that Ms. David, LPN, had her employment terminated, effective October 29, 2018.

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 Kathryn Emter, Investigator for the CLPNA, (the "Investigator") to conduct an investigation into the Complaint.

Ms. David received notice of the Complaint and the investigation by letter dated October 31, 2018.

On February 4, 2019, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Ms. David received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated May 21, 2020.

A Revised Statement of Allegations, Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. David under cover of letter dated July 27, 2020.

(4) Allegations

The Allegations in the "Revised" Statement of Allegations dated June 30, 2020 (the "Allegations") are:

"It is alleged that TAIYE (DAVID) SYLVESTER-DAUDU, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about September 10, 2018 failed to document on the Wound Assessment and Care Record any wound care provided for Client MB.

2. On or about September 26, 2018, did one or more of the following with regard to Client MM's catheter:
    a) Failed to use sterile gloves;
    b) Failed to adequately document by omitting the size of catheter inserted and any urinary output.

3. On or about October 5, 2018 did one or more of the following with regard to Client IB:
    a) Failed to provide intervention to address IB's complaint of pain;
    b) Failed to document intervention to address IB's complaint of pain.

4. On or about October 12, 2018, with regards to Client LS, failed to administer or document the administration of Ativan 1mg as requested by LS; or both.

5. On or about October 12, 2018 did one or more of the following with regards to client JN:
    a) Failed to respond to an HCA's request to assess JN;
    b) Failed to assess or document an assessment after a request was made by HCAs, or both;
    c) Failed to document JN's refusal of medication at 1200hrs, instead documenting it as administered.

6. On or about October 12, 2018 documented one or more of the following on the Medication Administration Record ("MAR") the administration of the following medications at 1700 when she was not at the facility:
    a) Client GN Neoral 100 mg capsule;
    b) Client MM Xarelto 15 mg;
    c) Client JN Apo-Levocarb CR 100/25 mg;
    d) Client GM Jamp-K8 600 mg;
    e) Client VK Arthritis Pain 650 mg and Vitamin B12 1200 mcg."

(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. David 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 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: Revised Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct

Exhibit #3: Partial 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 accepted 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. David'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. David.

Allegation 1

Ms. David admitted on or about September 10, 2018 she failed to document on the Wound Assessment and Care Record any wound care provided for Client MB.

On September 10, 2018, Ms. David worked from 0700 to 1900 hours and provided care for Client MB.

Client MB had wounds that required regular assessment and dressing. On September 10, 2018, Ms. David provided wound care to client MB but failed to document the same on the Wound Assessment and Care Record.

The evidence shows that Ms. David was responsible for assessing and caring for client MB on September 10, 2018. A copy of the wound care assessment record for that date was provided in Exhibit #2 and showed that there was no documentation in regard to MB's wound.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David'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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, failing to care for a wound by assessing and providing care as ordered is negligence of basic nursing care of an LPN. The public and the CLPNA and Ms. David's place of employment have trust and expectations that a self-regulated LPN will work and perform duties within the scope of their learning and to the best of their ability to perform at all times to keep the patient safe and avoid harmful situations.

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

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

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

Ms. David acknowledged that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

> **Principle 1**: Responsibility to the Public - Licensed Practical Nurses, as self-regulating professionals, commit to provide safe, effective, compassionate and ethical care to members of the public. Principle 1 states 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.
>
> **Principle 2**: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for clients. Principle 2 states that LPNs:
>
> - 2.8 Use evidence and judgement to guide nursing decisions.

- 2.9 Identify and minimize risks to clients.

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

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

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

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

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

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

CLPNA Standards of Practice:

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

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

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

- 1.4 Recognize their own practice limitations and consult as necessary.

- 1.6 Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

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

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

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

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.

<u>Allegation 2:</u>

Ms. David admitted on or about September 26, 2018, she did one or more of the following with regard to Client MM's catheter:

a) Failed to use sterile gloves;
b) Failed to adequately document by omitting the size of catheter inserted and any urinary output.

On September 26, 2018, Ms. David worked from 0700 to 1900 hours and provided care to client MM.

It was reported that client MM's catheter came out during morning care and the insertion of a new catheter was required. Kaitlyn Tanschyk, HCA, reported the same to Ms. David.

At approximately 1430 hours, Ms. David performed a catheter change on client MM. While doing so, Ms. David failed to use sterile gloves.

Ms. David also failed to properly document the catheter size inserted and any urinary output as required. As noted in the progress notes provided in Exhibit #2, the size of the catheter used, nor the volume of urinary output was documented, and it was noted that Ms. David neglected to wear sterile gloves.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David'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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, these procedures are basic expectations of LPNs in their nursing practice. Sterile procedure, when performing a catheter change, is an expected and learned process in basic training. It is expected by the public, the facility and the patient that LPNs will abide by learned procedures and not put the patient in danger by submitting them to unsterile and unsafe practices. In addition, by omitting to properly document the size of the catheter and the urinary output, the patient's care was put at risk by Ms. David which demonstrates a lack of knowledge and skill in the provision of her professional services.

Ms. David did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. David in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

<u>Allegation 3:</u>

Ms. David admitted on or about October 5, 2018, she did one of the following with regard to Client IB:

a) Failed to provide intervention to address IB's complaints of pain;

b) Failed to document intervention to address IB's complaint of pain.

On October 5, 2018, Ms. David worked from 0700-1900 hours and provided care to client IB.

On that date, client IB complained of pain. Ms. David was notified and attended to client IB, documenting on client IB's Progress Note at 1553 hours that IB was having "pain ++" and "declined going to hospital".

Despite Ms. David documenting on IB's Progress Note at 1553 hours that she would continue to monitor client IB and "give care as needed", Ms. David did not provide intervention to assist with client IB's pain and failed to document the same.

Client IB's MAR and PRN Documentation does not show the administration of Naproxen 250mg until 2130 hours by LPN Vender (the nurse on the next shift).

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 3 did in fact occur.

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

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

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, Ms. David failed to give basic care to IB on October 5, 2018 by recognizing this client's pain but not treating it responsibly. LPNs have the responsibility to respect complaints of pain and to treat them properly. In this case, there were PRN pain medications ordered by the physician which should have been given much earlier than 2130 hours to assist client IB with the complaints of pain made to Ms. David. Ms. David failed to complete her duty of care, a basic responsibility of an LPN.

Ms. David did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. David in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Allegation 4:

Ms. David admitted on or about October 12, 2018, with regards to client LS, she failed to administer or document the administration of Ativan 1mg, as requested by client LS; or both.

On October 4, 2018, Ms. David provided care for Client LS.

Client LS, a mentally competent client, was a new admission from the hospital on October 11, 2018.

Client LS was admitted with enough medication for October 12, 2018 including Ativan 1mg PRN.

On October 12, 2018 at approximately 0930 hours, Wanda Pelletier, Health Care Aide ("HCA"), checked on client LS and found her to be anxious. Client LS requested Ativan. Ms. Pelletier called Ms. David, who said client LS had already been given Ativan with breakfast and could have another at 1500 hours.

Client LS's MAR had no documentation of the administration of Ativan on October 12, 2018 by Ms. David. Ms. David failed to administer or document the administration of Ativan 1mg when requested by Client LS.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, Ms. David did not administer Ativan as requested at 0930 hours nor did she document on the MAR whether it was actually give at breakfast time, as she told her colleagues it was. No further documentation or administration of Ativan was apparent on Ms. David's shift as proven by the above documents. It is a basic nursing skill to ensure that medications required are given correctly, and that the client's documentation reflects exactly what medications were in fact required, and when they were administered.

Ms. David did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. David in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct

breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Allegation 5:

Ms. David admitted on or about October 12, 2018, she did one or more of the following with regards to client JN:

a) Failed to respond to an HCA's request to assess JN;
b) Failed to assess or document an assessment after a request was made by HCAs, or both;
c) Failed to document JN's refusal of medication at 1200 hours, instead documenting it as administered.

On October 12, 2018, Ms. David provided care for client JN. On October 10, 2018, Client JN fell at approximately 1433 hours.

On October 12, 2018, at approximately 1120 hours, client JN was found by Wanda Pelletier, HCA, to be unresponsive. Ms. Pelletier called Ms. David at 1136 hours to report that client JN was unresponsive to verbal and physical cues. As Ms. Pelletier was not as familiar with client JN, Ms. Pelletier called another HCA, Colleen Stewart, for assistance. After continuing to receive no response, Ms. Stewart called for Ms. David again at 1139 hours.

Due to their growing concern and Ms. David's failure to attend to client JN, Ms. Pelletier and Ms. Stewart took client JN to the LPN office where Ms. David checked client JN's vital signs.

Shortly after, in the dining room, Ms. David made several attempts to administer client JN's medication on a spoon with apple sauce. Client JN refused the medication.

Instead of documenting Client JN's refusal of the 1200 hours medication, Ms. David incorrectly documented that Apro-Levocarb CR 100/25mg and Jamp-K8 600mg were administered on client JN's MAR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, Ms. David has let her colleagues down by not responding to them and giving them support when JN fell. As the nurse responsible for JN, a complete assessment should have been done according to the Facility's post-fall protocol. Correct documentation regarding whether a patient took their medications or not is a vital skill for LPNs, as it is the only way that colleagues can check to see if a patient is medicated properly and effectively or not. These actions demonstrate a lack of knowledge, skill and judgment on the part of Ms. David.

Ms. David did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. David in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

Allegation 6:

Ms. David admitted on or about October 12, 2018 she documented one or more of the following on the Medication Administration Record ("MAR") the administration of the following medications at 1700 when she was not at the facility:

a) Client GN Neoral 100 mg capsule;
b) Client MM Xarelto 15 mg;
c) Client JN Apo-Levocarb CR 100/25 mg;
d) Client GM Jamp-K8 600 mg;
e) Client VK Arthritis Pain 650 mg and Vitamin B12 1200 mcg.

On October 12, 2018, Ms. David was scheduled to work 0700-1900 hours in the Clearwater Centre in Rocky Mountain House (the "Facility"). She was asked to finish work at approximately 1415 hours as a result of performance concerns. She left the Facility shortly thereafter.

Despite not being at the Facility, Ms. David documented the below medications were administered at 1700 hours:

1. Neoral 100mg capsule on Client GN's MAR;
2. Xarelto 15 mg on Client MM's MAR;
3. Apo-Levocarb CR 100/25mg on Client JN's MAR;
4. Jamp-K8 600 mg on Client GM's MAR;
5. Arthritis Pain 650 mg and Vitamin B12 1200 mcg on Client VK's MAR.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. David's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 4 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; and
ii. Contravention of the Act, a code of ethics or standards of practice.

Regarding the display of a lack of knowledge, or lack of skill or judgment in the provision of professional services, the Hearing Tribunal finds that for this allegation, this conduct demonstrated that Ms. David was not abiding by the 7 rights of medication administration – and in particular, that she was not actually providing medication to patients as she had written in their MARs and was possibly incorrectly or pre-charting entries of medication that was not administered. This falls far below the skills, knowledge and judgment expected of an LPN.

Ms. David did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Ms. David in the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and set out in detail above. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breaches these provisions for the reasons outlined in Allegation 1, above.

(9) Partial Joint Submission on Penalty

The Complaints Consultant and Ms. David jointly proposed to the Hearing Tribunal a Partial Joint Submission on Penalty, which was entered as Exhibit #3. The Partial 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. Taiye (David) Sylvester-Daudu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Taiye (David) Sylvester-Daudu shall provide the Complaints Consultant with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the CLPNA documents:

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

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

c. CLPNA Practice Policy: Professional Responsibility & Accountability;

d. CLPNA Practice Policy: Documentation;

e. CLPNA Competency Profile A1: Critical Thinking;

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

g. CLPNA Competency Profile B: Nursing Process;

h. CLPNA Competency Profile D: Communication and Technology;

i. CLPNA Competency Profile E3: Elimination;

j. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

3. Taiye (David) Sylvester-Daudu shall complete, at her own cost, the following course: **Aseptic Techniques (Guidelines)** offered on-line at https://www.coursepark.com/learningnetwork/courses/index/id/1089. Taiye (David) Sylvester-Daudu 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.

4. Taiye (David) Sylvester-Daudu shall complete the following nursing quizzes located on website http://www.learningnurse.org/. Taiye (David) Sylvester-Daudu 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) 11.7 Wound Care; and

   b) 12.8 Safe Medication Principles.

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

5. Taiye (David) Sylvester-Daudu shall complete the following courses offered on-line at www.clpna.com. Taiye (David) Sylvester-Daudu shall provide the Complaints Consultant,

with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

a) Health Assessment Self-Study Course; and
b) Nursing Documentation 101.

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

6. The orders set out above at paragraphs 2-5 will appear as conditions on Taiye (David) Sylvester-Daudu's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial activities outlined at paragraphs 2-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Taiye (David) Sylvester-Daudu's practice permit and the Public Registry until the below orders have been satisfactorily completed;

        i. Read and review CLPNA documents;

        ii. Aseptic Techniques (Guideline);

        iii. 11.7 Wound Care;

        iv. 12.8 Safe Medication Principles;

        v. Health Assessment Self Study Course;

        vi. Nursing Documentation 101.

7. The conditions on Taiye (David) Sylvester-Daudu's practice permit and on the public register will be removed upon completion of each of the requirements set out above at paragraph 6.

8. Taiye (David) Sylvester-Daudu 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. Taiye (David) Sylvester-Daudu will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Taiye (David) Sylvester-Daudu 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.

10. Should Taiye (David) Sylvester-Daudu 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 Taiye (David) Sylvester-Daudu's non-compliance as information for a complaint under s. 56 of the Act.

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 Partial Joint Submission on Penalty proposed by Ms. David and the Complaints Consultant.

Ms. David and Legal Counsel for the Complaints Consultant did not make joint submissions on the costs payable by Ms. David as a result of the hearing, and the Hearing Tribunal considered those submissions as well.

(10) Submissions by Complaints Consultant as to costs

Submissions were made by Legal Counsel for the Complaints Consultant. The submission made was that Ms. David should pay 25% of the costs of the investigation and hearing to be paid over a period of 36 months from service of letter advising final costs. In the case of non-payment of the costs, the Complaints Consultant may suspend Ms. David'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.

(11) Submissions on behalf of Ms. David as to Costs

Submissions were made by Ms. David's AUPE Representative, Ms. Drennan. Ms. Drennan spoke to the fact that Ms. David and her family moved to Calgary during the time of the Allegations, and that Ms. David also had a baby recently, so she is on maternity leave and unable to work at the present. Her husband has not found employment yet and so finances are limited. They sought to have a lesser amount of costs than that proposed by the Complaints Consultant.

(12) 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. David 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 Hearing Tribunal found the incidents to be significant and serious in nature and involved a failure of Ms. David to comply with core competencies of LPNs although it appears that no harm was intended.

- *The age and experience of the investigated member:* Ms. David has been an LPN since January of 2018. She is a relatively new member, but the misconduct underlying these allegations is so fundamental to the role of LPNs that it should have been known and followed by all LPNs, regardless of the amount of time they have practiced.

- *The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions*: The member has no previous complaints of unprofessional conduct that were brought to the attention of the Hearing Tribunal.

- *The age and mental condition of the victim, if any:* All of the clients involved are "seniors in care", so they are very dependent on the caregiver to ensure safe and proper practice. They are vulnerable.

- *The number of times the offending conduct was proven to have occurred:* These allegations occurred on multiple occasions over a number of months, which leads the Hearing Tribunal to believe that Ms. David needs further education, as risk was present for at least three clients.

- *The role of the investigated member in acknowledging what occurred:* The Member cooperated with the investigation as reflected in The Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct and the Joint Submission on Penalty for the

hearing. She has no previous findings of unprofessional conduct and The Hearing Tribunal feels these are all mitigating factors.

- *Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made*: The member was dismissed from her job on October 12, 2018 as a result of performance concerns. She has since moved to another location and has been unable to work as an LPN at this time. She has a young family to care for.

- *The impact of the incident(s) on the victim, and/or the presence or absence of any mitigating circumstances:* There has been no evidence of harm to the clients reported but the Hearing Tribunal observes that the risk of harm could certainly exist if these types of errors continued and were not recognized and dealt with properly.

- *The presence or absence of any mitigating circumstances:* The Hearing Tribunal noted that Ms. David is not working at the present time and took into account her cooperation during this process.

- *The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:* The Hearing Tribunal agrees that the public must believe that their health care staff will carry out their work competently. Therefore, the sanctions in place will address the education needs of Ms. David and deter her from further errors and poor judgement. Also, other members of the LPN profession need to know that such breaches will not be tolerated and there will be penalties for such actions.

- *The need to maintain the public's confidence in the integrity of the profession*: Errors such as these gravely affect the public's confidence in LPNs as a self-regulated profession. The sanctions need to address areas where core competencies are found lacking, such as documentation, medication administration and sterile procedures.

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.

On the matter of costs, the Hearing Tribunal orders that Ms. David shall be required to pay the hearing costs requested by the Complaints Consultant; however, in recognition of Ms. David's

financial situation, the payments should commence no later than six (6) months after the completion of her maternity leave.

(13) 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. Taiye (David) Sylvester-Daudu shall read and reflect on the following CLPNA documents. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Taiye (David) Sylvester-Daudu shall provide the Complaints Consultant with a signed written declaration within **30 days** of service of the Decision, attesting she has reviewed the CLPNA documents:

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

    d. CLPNA Practice Policy: Documentation;

    e. CLPNA Competency Profile A1: Critical Thinking;

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

    g. CLPNA Competency Profile B: Nursing Process;

    h. CLPNA Competency Profile D: Communication and Technology;

    i. CLPNA Competency Profile E3: Elimination;

    j. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

3. Taiye (David) Sylvester-Daudu shall complete, at her own cost, the following course: **Aseptic Techniques (Guidelines)** offered on-line at https://www.coursepark.com/learningnetwork/courses/index/id/1089. Taiye (David)

Sylvester-Daudu 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.

4. Taiye (David) Sylvester-Daudu shall, complete the following nursing quizzes located on website http://www.learningnurse.org/. Taiye (David) Sylvester-Daudu 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) 11.7 Wound Care; and

    b) 12.8 Safe Medication Principles.

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

5. Taiye (David) Sylvester-Daudu shall complete the following courses offered on-line at www.clpna.com. Taiye (David) Sylvester-Daudu shall provide the Complaints Consultant, with a certificate confirming successful completion of the course within **60 days** of service of the Decision.

    a) Health Assessment Self-Study Course; and
    b) Nursing Documentation 101.

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

6. Taiye (David) Sylvester-Daudu shall pay twenty-five (25%) percent of the hearing costs of the CLPNA, in full, with payments being made over a time period of 36 months to the CLPNA. The payments are required to commence no later than six (6) months after the completion of Ms. David's current maternity leave. Ms. David shall advise the Complaints Consultant, upon request, about when her maternity leave will be over.

    In the case of non-payment of the costs in accordance with the above, the Complaints Consultant may suspend Ms. David'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.

7. The orders set out above at paragraphs 2-6 will appear as conditions on Taiye (David) Sylvester-Daudu's practice permit and the Public Registry subject to the following:

    a. The requirement to complete the remedial activities outlined at paragraphs 2-5 will appear as "CLPNA Monitoring Orders (Conduct)", on Taiye (David)

Sylvester-Daudu's practice permit and the Public Registry until the below orders have been satisfactorily completed;

i. Read and review CLPNA documents;

ii. Aseptic Techniques (Guideline);

iii. 11.7 Wound Care;

iv. 12.8 Safe Medication Principles;

v. Health Assessment Self Study Course;

vi. Nursing Documentation 101.

8. The conditions on Taiye (David) Sylvester-Daudu'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. Taiye (David) Sylvester-Daudu 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. Taiye (David) Sylvester-Daudu will keep her contact information current with the CLPNA on an ongoing basis.

10. Should Taiye (David) Sylvester-Daudu 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.

11. Should Taiye (David) Sylvester-Daudu 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:

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

    d) Treat Taiye (David) Sylvester-Daudu's non-compliance as information for a complaint under s. 56 of the Act.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 12 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 4th DAY OF DECEMBER 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

V. Ruskowsky

Verna Ruskowsky, LPN
Chair, Hearing Tribunal