COLLEGE OF REGISTERED NURSES OF ALBERTA (the "**College**")

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **LARA ARNOTT**, REGISTRATION **#96,498**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

DECEMBER 16, 2024

INTRODUCTION

A hearing was held on December 16, 2024, via Microsoft Teams videoconferencing by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**") to hear a complaint against Lara Arnott, registration #96,498 (the "**Registrant**").

Those present at the hearing were:

a. Hearing Tribunal Members:

Claire Mills, RN, Chairperson
Maggie Convey, RN
Vince Paniak, Public Member
Kevin Kelly, Public Member

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. College Counsel:

Stacey McPeek, Conduct Counsel

d. College Staff

Marina Skoreiko, Hearings Coordinator as Clerk supporting Chair of the Tribunal in procedural management of virtual proceeding technology.

PRELIMINARY MATTERS

Conduct Counsel confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing.

Conduct Counsel noted that the Registrant was not in attendance and advised that neither the Registrant nor anyone on her behalf had contacted the College with respect to the hearing.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was open to the public. No application was made to close the hearing.

The Chairperson noted that there were public observers, including one member of the Hearing Tribunal roster present as an observer for educational purposes.

<u>Application to Proceed in the Registrant's Absence</u>

Conduct Counsel brought an application to proceed in the absence of the Registrant, pursuant to section 79(6) of the HPA. The Affidavit of Amy Payne (Exhibit 2) was provided in support of this application.

The Affidavit of Amy Payne demonstrates that several attempts were made to serve the Notice to Attend Hearing on the Registrant at the address provided in the College's registration records by

registered mail and by courier and through email. The registered mail and courier were returned to the College as unclaimed. The College attempted to contact the Registrant by telephone at the telephone numbers provided by the Registrant at the time of registration. The College also took the steps of publishing the Notice to Attend Hearing in the newspaper, in accordance with the College's Bylaws.

Conduct Counsel noted that section 120 of the HPA provides requirements for service and the College Bylaws also address service on investigated persons.

Conduct Counsel noted that she has never been contacted by the Registrant. The College has been unable to contact the Registrant with respect to attending the hearing.

The Hearing Tribunal carefully reviewed the Affidavit of Amy Payne and considered the submissions of Conduct Counsel. The Hearing Tribunal found that the College has been thorough and diligent in its attempts to contact the Registrant and to serve the Notice to Attend a Hearing. Section 120(3) of the HPA provides that notice is sufficient if provided by registered mail at the person's address shown on the register. The College has met this requirement. The College Bylaws further provide for notice by way of publication in a local newspaper. This requirement was also met.

The Hearing Tribunal was satisfied that the College's attempts at service were reasonable and sufficient. The College has met its statutory requirement for service and has also taken several additional steps to try to serve the Registrant beyond simply meeting the minimum requirements. The Hearing Tribunal also considered that there was no evidence to suggest that an adjournment would result in the College being able to contact the Registrant or in securing the Registrant's attendance at the hearing.

For the reasons set out above, the Hearing Tribunal determined it would proceed with the hearing in the absence of the Registrant.

Application to Proceed by way of Affidavit Evidence

Conduct Counsel brought an application to proceed with the hearing by way of Affidavit evidence. Conduct Counsel noted that the case relied heavily on documentation, the Affidavit evidence was directly related to the allegations, and the Registrant was not present to cross-examine any witnesses.

The Hearing Tribunal considered the application. Given that the Registrant was not in attendance, there were no procedural fairness issues to consider regarding the right to cross-examine. Given the nature of the case, the Hearing Tribunal determined that it was reasonable to proceed by way of Affidavit evidence.

ALLEGATIONS

The allegations in the Notice to Attend a Hearing are as follows:

1. On or about February 24, 2021, the Registrant failed to demonstrate adequate skill and/or judgment in their care of [PATIENT 1] when they did one (1) or more of the following:

a. Failed to review the patient's chart, including the patient's Dynamic Appraisal of Situational Aggression ("**DASA**") score, prior to or upon the Registrant receiving the patient into care;

b. Failed to conduct an adequate DASA assessment, or any assessment, of the patient upon receiving the patient into care;

c. Failed to identify, and/or document a safety care plan for the patient;

d. Failed to enter the patient's sedative medication order in a timely manner;

e. Failed to administer the patient's ordered intramuscular ("**IM**") sedative medication without direct instruction from the Charge Nurse;

f. Risked the safety of other patients and co-workers, specifically when:

i. The Registrant allowed the patient to have a chair, cellphone and/or book while in seclusion; and/or

ii. The Registrant failed to ensure security was present when opening the door to the patient's seclusion room.

2. In or between July 2023 and February 2024, the Registrant failed to demonstrate accountability when they failed to respond to concerns identified in an investigation by the College.

It is further alleged that the Registrant's conduct constitutes "unprofessional conduct," as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the HPA, and in particular:

1. The conduct underlying **Allegation 1**:

a. Contravenes one (1) or more of the following: *Canadian Nurses Association Code of Ethics (2017)* ("***CNACE***"); *College's Practice Standards for Regulated Members (2013)* ("***CPSRM***"); *College's Documentation Standards for Regulated Members (2013)* ("***CDSRM***"); *College's Entry Level Competencies for the Practice of Registered Nurses (2019)* ("***CELCPRN***"); *College's Medication Management Standards (2021)* ("***CMMS***"); and/or

b. Contravenes one (1) or more employer policies, contrary to the *CPSRM*.

2. The conduct underlying **Allegation 2**:

a. Contravenes one (1) or more of the following: *CNACE*; *CPSRM.*

EVIDENCE

The following documents were entered as Exhibits:

Exhibit 1 – Notice to Attend a Hearing
Exhibit 2 – Affidavit of Amy Payne
Exhibit 3 – Affidavit of Dolores Leia
Exhibit 4 – Affidavit of Calvin Lee
Exhibit 5 – Affidavit of Sarah Quon
Exhibit 6 – Affidavit of Beverly Armstrong
Exhibit 7 – Affidavit of Christina Alexandropoulos
Exhibit 8 – Proposed Order

Book of Authorities (with attachments 1-11):
1. HPA excerpts sections 77 to 83
2. HPA excerpts, section 120
3. College Bylaw 5.2
4. College Decision, KH December 7, 2022
5. HPA excerpts, section 1(1)(pp)
6. Canadian Nurses Association Code of Ethics (2017)
7. College Practice Standards for Regulated Members (2013)
8. College Documentation Standards, 2013
9. College Entry-Level Competencies, 2019
10. College Medication Management Standards, 2021
11. *Jaswal v Medical Board (Nfld)*, 1996 CanLII 11630 (NL SC)

AFFIDAVIT EVIDENCE

Dolores Leia

Delores Leia is a registered nurse who worked on unit 45 (the "**Unit**") at the Rockview General Hospital ("**RGH**") for seven years. Ms. Leia was the Charge Nurse on February 24, 2021.

Ms. Leia's evidence indicates that on February 24, 2021, the Registrant was assigned a patient named [PATIENT 1], who was secluded due to behaviour issues and placed in a high observation room with a locked door. [PATIENT 1] was considered "high risk" for aggression based on a prior DASA assessment. Ms. Leia stated that DASA assessments are usually done at 1300h for existing patients and upon admission for new patients.

Ms. Leia believes that the Registrant failed to check if a prior DASA assessment had been done on [PATIENT 1] and also did not complete a new assessment upon receiving [PATIENT 1]. Given [PATIENT 1]'s high-risk status, a safety plan should have been implemented, but Ms. Leia does not believe the Registrant identified or charted a safety plan. When a patient is secluded, all potentially harmful equipment should be removed from the room. However, Ms. Leia found a chair in [PATIENT 1]'s room, which the Registrant stated she had placed there so [PATIENT 1] could look outside.

The Registrant repeatedly opened the door to [PATIENT 1]'s room without security. Ms. Leia spoke to the Registrant multiple times about giving [PATIENT 1] unsafe items and about the importance of calling for security, but the Registrant was argumentative in response.

[PATIENT 1]'s behavior escalated during the shift. The staff team decided [PATIENT 1] needed medication. When [PATIENT 1] refused long-acting oral Acuphase, Ms. Leia requested an order for intramuscular Acuphase. The Registrant refused to administer the intramuscular Acuphase,

claiming [PATIENT 1] did not need it, and Ms. Leia had to order the Registrant to administer the medication.

Ms. Leia also noted that the Registrant's charting was late, and the trainer had to discuss with her the importance of charting observations immediately after assessing a patient. Upon reviewing the Registrant's notes for the day, Ms. Leia found discrepancies, including differing times and notes that did not align with the events of the night.

Calvin Lee

Calvin Lee is a registered nurse who worked on the Unit at RGH from November 2016 to the present. Mr. Lee worked with the Registrant on the Unit from November 2016 until May 2021.

According to Mr. Lee, the Unit has three high observation rooms that can be magnetically locked and include little aside from a mattress and a pillow. For a patient to be in seclusion or high observation, there must be a daily order.

On February 24, 2021, Mr. Lee was informed upon arriving for the evening shift that a patient, [PATIENT 1], was being admitted into high observation. Mr. Lee reviewed [PATIENT 1]'s patient record, noting that [PATIENT 1] had been aggressive in the Emergency Room ("**ER**") and had a DASA score of 6, indicating a "high risk" for aggression. [PATIENT 1] was admitted directly to high observation with two protective services staff. The Registrant was assigned as [PATIENT 1]'s primary nurse.

Mr. Lee stated that the DASA assessment tool was relatively new, having been implemented one year prior. Staff received training on it, including in-person sessions with managers and educators. The tool uses a scoring system and criteria such as irritability, impulsivity, and verbal threats. The general rule was that the DASA should be completed daily before 1300h or on admission, it should be based on the previous 24 hours, and if a patient has a DASA score of 2 or higher, a safety plan must be put in place. Mr. Lee indicates that the Registrant should have completed a DASA on the Unit shortly after [PATIENT 1] arrived.

Mr. Lee noted that the Registrant placed a chair in [PATIENT 1]'s room before her first break without informing other staff. Mr. Lee believes that a chair in a seclusion room is a risk to both the patient and staff, and stated that while there is no specific policy about what can be in a seclusion room, safety protocols indicate that all team members must minimize the risk of aggression by not having objects like chairs, meal trays or plastic cutlery in the seclusion rooms. If a patient needs something or to use the bathroom, security is called, and security tend to position themselves between staff and the patient. Staff do not unlock the door until security arrives.

During the shift, staff had to call security several times for [PATIENT 1]. [PATIENT 1]'s aggression was primarily verbal, but at one point, he was also punching the air, and Mr. Lee heard a bang or thud from the room, likely from the chair. The staff discussed whether there were other medications that might help manage [PATIENT 1]'s aggression. The Charge Nurse obtained an order for a sedative, but the Registrant refused to administer it to [PATIENT 1] until the Charge Nurse ordered her to comply.

Sarah Quon

Sarah Quon is the Program Manager of Mental Health and Addictions at RGH and worked in that role on February 24, 2021. Ms. Quon was a registered nurse for four years in the Unit, then a

nurse clinician, then a Clinical Nurse Educator, and then the Unit Manager on unit 49 before being promoted to Program Manager in April 2019. In her role as Program Manager, she was responsible for 12 programs and approximately 300 staff. The Registrant was one of the staff she was responsible for.

Ms. Quon states there are three high observation lockable seclusion rooms in the Unit. Patients are moved in and out of high observation as their status changes. When stable, they are placed in a bed with an unlocked door, but when there is risk to the patient or staff, they are moved to seclusion with a locked door.

Ms. Quon was directly involved in the internal investigation into the Registrant's conduct on February 24, 2021 and was the original complainant in the complaint. Based on a review of internal information, Ms. Quon provides that the Registrant was an employee of RGH from March 25, 2013 to May 27, 2021 as a Registered Nurse, with her most recent position being part-time in the Unit. The Registrant went on a medical leave of absence around November 27, 2021 and has not returned to work. Ms. Quon was involved in the Registrant's human resources file from 2019 to 2022.

Prior to the incident

Prior to the incident, there had been concerns about the Registrant's conduct that required performance management. On June 25, 2020, the Registrant gave a patient a cell phone against a physician's order. The Charge Nurse had told the Registrant not to do so, as the Registrant had not read the order. The Unit manager had previously coached the Registrant about not making changes to care plans, and as a result, a learning plan was put in place. The Registrant was not compliant with the learning plan and did not complete the required courses by the deadline. The deadline was extended, but the Registrant still failed to complete the plan.

On November 12, 2020, Ms. Quon attended a meeting with the Registrant and the Unit manager, where they discussed the learning plan, her non-compliance, and some additional safety issues that had been reported. The Registrant indicated that she did not learn anything from the Learning Plan.

Between April 25, 2019, and May 7, 2021, the Unit manager met with the Registrant several times to provide coaching on conflict resolution, and notes from those meetings were relayed to Ms. Quon.

Incident on February 24, 2021

Ms. Quon was not present during the evening shift in the Unit on February 24, 2021, but received information about the incident from nurses who reported it to the Unit manager. On that evening, patient [PATIENT 1] was admitted to the Unit after exhibiting high levels of aggression in the ER, where he had overturned a stretcher.

Ms. Quon indicates that the DASA assessment is used to assess the likelihood of imminent aggression in mental health patients. A score is determined by assessing whether seven risk behaviors are present, including irritability, impulsivity, and verbal threats. A score of 0 or 1 is considered "low risk"; 2 or 3 is "moderate risk,"; and greater than 3 is "high risk." An aggression safety plan must be in place when there is a DASA score of 2 or greater. The ER had rated [PATIENT 1] a 6 out of 7 and ordered that he be placed on high observation.

[PATIENT 1] was placed into a high observation room with only a mattress and linens. The Registrant started her shift at 1515h and was assigned as [PATIENT 1]'s primary nurse. Around 1630h, the Registrant provided a chair to [PATIENT 1] in his room. The other staff expressed concern about the chair, but the Registrant ignored them. While the Registrant was on break, [PATIENT 1]'s behaviour escalated, and he threw a cup. When the Registrant returned, she removed the chair.

The Registrant's charting indicates that at 1528h she would not give [PATIENT 1] a chair until he demonstrated he was settled, and at 1820h, she removed the chair as a precautionary measure, but she did not chart that she gave [PATIENT 1] a chair in the first place. The Registrant also placed a telephone in [PATIENT 1]'s room at some point during the shift. The Registrant opened the door to [PATIENT 1]'s room several times without security present, and when the Charge Nurse told her to stop, the Registrant said [PATIENT 1] did not have a good experience with security and she felt it was best not to get them involved. The staff were concerned about safety and discussed their concerns with the Charge Nurse, who then paged the on-call physician for a sedative. The on-call nurse gave the Registrant a verbal order for a sedative, but the Registrant did not immediately enter the order or administer it.

Ms. Quon reviewed [PATIENT 1]'s chart which supports that the Registrant entered the order into the Medication Administration Record at 2035h and did not administer the sedative until 2030h, charting her administration of the order at 2112h.

Protocols and Policies

Ms. Quon states that Alberta Health Services ("**AHS**") has an Aggression and Violence Alert protocol which stipulates that minimal clinical judgement is anticipated, and if a deviation from the protocol is determined to be necessary, documentation must be included on the patient's health record. The patient's assigned nurse is to review the DASA using only data from the last 24 hours. Patients who have a moderate to high-risk score must have an aggression safety care plan in place. The specific care and safety plan to manage the aggression will be completed within the electronic health record and will reference the Violence Alert status, including triggers and approaches. The removal of a violence alert will be a team discussion.

The AHS Clinical Documentation Directive states that documentation must be accurate, complete, clear, concise, legible, and timely and entered at the time of the event or as soon as possible.

The AHS Clinical documentation process states that clinical documentation must include the care that was provided by the writer, be completed at the time of the event or as soon as possible afterwards.

Clinical assessment procedures state that clinical assessment include a review of appropriate documentation and the patient's current presentation.

AHS Investigation and suspension

There was an AHS investigation into the incident, and the Registrant was interviewed. Ms. Quon was one of the interviewers. During the interview, the Registrant confirmed that during her shift on February 24, 2021, she did not perform a complete clinical assessment, did not review all documentation, did not see the DASA score, did not document a safety plan, and that she placed the chair and telephone in [PATIENT 1]'s room. The Registrant was also aware that the patient's DASA score of 6 meant that security must be present during interactions, that she could change

the DASA score throughout her shift, and that a violence alert had to remain in place until the patient did not have a high DASA rating for three days. The Registrant was not aware that a staff member and a physician would be required to change or remove the DASA protocol.

Attached to Ms. Quon's affidavit were the Registrant's charting notes. Based on the chart review, Ms. Quon found that the Registrant did not complete or did not chart a clinical assessment of [PATIENT 1] and did not enter a safety plan per the DASA protocol.

The investigation concluded that the Registrant failed to adhere to safety protocols and clinical care expectations. The Registrant received a letter of suspension on March 25, 2021, imposing a one-day suspension. The Registrant grieved the suspension, but no grievance investigation meeting was held because the Registrant went on a medical leave of absence before one could be scheduled.

In addition to supporting documents for the above, Ms. Quon's affidavit also attached: the Registrant's Multidisciplinary Progress Report entries regarding Patient [PATIENT 1], the Registrant's Kardex entry on February 24, 2021, Patient [PATIENT 1]'s medication orders record, the AHS Aggression and Violence Alert protocol, AHS Clinical Documentation Directive, AHS Clinical Documentation Process, and AHS's Investigation into the February 24, 2021 incident which included notes from the complainant interview, witnesses interviews, an interview with the Registrant.

Beverly Armstrong

Beverly Armstrong is currently an Investigator in the Conduct Department for the College. She investigates complaints within the professional conduct process.

Ms. Armstrong was assigned the investigation for the complaint made against the Registrant on June 3, 2022. She investigated the matter between June 2022 and August 8, 2023, including interviewing potential witnesses and collecting relevant documents.

From September 8, 2022 to November 16, 2022, Ms. Armstrong attempted to contact the Registrant through email, phone, and registered mail to try and arrange an interview. The Registrant did not respond to any of Ms. Armstrong's correspondence.

On November 17, 2022, Ms. Armstrong emailed the Registrant indicating that this was her final opportunity to provide input into the investigation before she would submit the investigation report to the Complaints Director. Ms. Armstrong also telephoned the Registrant. The Registrant answered and indicated that it was not a good time. Ms. Armstrong informed the Registrant that the College had been trying to reach her to coordinate an interview and that if she did not meet with her, she would submit the report without her input. The Registrant indicated that she had been involved in an accident and it had impacted her physically and mentally, making it difficult for her to respond. She indicated she was happy to have an opportunity to respond to the allegations. Ms. Armstrong confirmed the Registrant's email address and address and told the Registrant that medical documentation of her health concerns was needed if these were preventing her from participating in the investigation process. Ms. Armstrong encouraged the Registrant to contact the United Nurses of Alberta for support.

From November 17, 2022 to November 30, 2022, Ms. Armstrong worked with the Registrant and the Registrant's Labour Relations Officer ("**LRO**") to obtain medical substantiation that she was unable to participate in the interview at that time.

On November 30, 2022, the College received a letter from the Registrant's physician indicating that the Registrant was not able to participate in an investigation at this time.

From December 8, 2022 to January 4, 2023, Ms. Armstrong worked with the Registrant and her LRO to obtain additional information from the Registrant's physician about how long the Registrant would not be able to participate in the investigation.

On January 6, 2023, the College received a letter from the Registrant's physician indicating that it was difficult to estimate, but she anticipated the Registrant would be able to participate in an interview in early April 2023.

On January 9, 2023, Ms. Armstrong emailed the Registrant and confirmed receipt of the physician's letter and indicated she would follow up with her in March 2023 regarding proceeding with the investigation interview in April 2023.

On April 3, 2023, Ms. Armstrong emailed the Registrant seeking an update on her ability to proceed with the investigation.

From April 4, 2023, to May 1, 2023, Ms. Armstrong worked with the Registrant to obtain further information from her physician regarding her capacity to participate in the interview process.

On May 4, 2023, Ms. Armstrong received a letter from the Registrant's physician indicating that the Registrant was unable to participate fully in an investigation. She suggested that the Registrant be reevaluated in early July 2023.

On July 10, 2023, Ms. Armstrong called the Registrant to follow up on whether she was able to participate in the interview. The call went to voicemail, and she left a message for the Registrant requesting a call back with an update. Ms. Armstrong followed up on the call with an email to the Registrant.

On July 13, 2023, Ms. Armstrong called the Registrant. It went to voicemail, and she left a message requesting a call back or response to her email of July 10, 2023. Ms. Armstrong followed up on the call with an email to the Registrant.

On July 19, 2023, Ms. Armstrong called the Registrant. It went to voicemail, and she left a message requesting a call back. Ms. Armstrong followed up on the call with an email to the Registrant.

On July 21, 2023, the Associate Complaints Director sent the Registrant an expectation to cooperate with the investigation by tracked mail. The Registrant received the letter on July 25, 2023.

On August 8, 2023, based on a lack of response from the Registrant, Ms. Armstrong proceeded to submit the investigation report to the Complaints Director in the absence of the Registrant's response to the concerns identified in the investigation.

Ms. Armstrong emailed the Registrant and her LRO to confirm that the Registrant had not responded with a physician update by the deadline indicated in the letter dated July 21, 2023, and confirmed that the investigation report had been submitted to the Complaints Director for review.

Ms. Armstrong did not receive any further responses to her attempts to contact the Registrant to schedule an interview other than the responses outlined above.

Additionally, in the context of the AHS investigation, Ms. Armstrong obtained a narrative from a Protective Services Guard that outlined their recollection of an interaction between the Registrant and the Patient [PATIENT 1]. The narrative included the Protective Services Officer being called to the Unit to assist with Patient [PATIENT 1] on February 24, 2021. The officer indicated the Patient [PATIENT 1] appeared visibly upset and was yelling. The officer called for more officers as [PATIENT 1] continued to yell. The officer recollects the Registrant's reluctance to administer the intravenous sedative medication.

Christina Alexandropoulos

Christina Alexandropoulos is a legal assistant in the Conduct Department of the College.

On December 4, 2023, Ms. Alexandropoulos emailed the Registrant and provided a copy of the redacted investigation report and appendices for her review and requested a response confirming receipt. The Registrant did not respond.

On December 7, 2023, Ms. Alexandropoulos called the Registrant. It went to voicemail, and Ms. Alexandropoulos left a message for the Registrant requesting a call back.

On February 21, 2024, Ms. Alexandropoulos called the Registrant, and she answered the phone. When Ms. Alexandropoulos identified herself, the Registrant asked whether Ms. Alexandropoulos could call her later. When Ms. Alexandropoulos requested a time that would be best to call, the Registrant requested an email to set up a time. The Registrant confirmed her email address and indicated she could not speak at that time, as she was waiting for her physician to call her.

Ms. Alexandropoulos emailed the Registrant to arrange a call with Conduct Counsel. The Registrant did not respond.

On February 23, 2024, Ms. Alexandropoulos emailed the Registrant, following up on the prior email.

From February 26, 2024, to February 28, 2024, Ms. Alexandropoulos called the Registrant once each day. The Registrant did not answer any of the calls. Ms. Alexandropoulos left messages requesting a call back on each call.

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel reviewed the evidence in each of the Affidavits. She submitted that all the allegations were proven and constituted unprofessional conduct. With respect to Allegation 1, the conduct demonstrates a lack of knowledge, skill or judgment under HPA s. 1(1)(pp)(i) and a contravention of the HPA, Code of Ethics or Standards of Practice under HPA s. 1(1)(pp)(ii). Allegation 2 is unprofessional conduct on the basis of failing to cooperate with an investigator under HPA s. 1(1)(pp)(vii)(B) and a breach of the Code of Ethics and Standards of Practice under HPA s. 1(1)(pp)(ii).

Conduct Counsel submitted that the Registrant contravened the following: **CNACE**: A5 and A12, **CPSRM**: 1.1, 1.2, 2.5, and 5.3, **CDSRM**: 1.4(e),(f),(i),(j), 1.7, 1.8, **CELCPRN**: 1.24, 2.1, 2.14, 4.1, 4.5, **CMMS**: 1.15, and the following **AHS employer policies**: AHS Aggression and Violence Alert Protocol: 1.3, 2.3, 2.3.1, 3.2, 6.1.6, AHS Clinical Documentation Directive: 2.1(e), AHS Clinical Documentation Process Directive: 4.1(a)(b) and (c).

HEARING TRIBUNAL FINDINGS AND REASONS

The Hearing Tribunal carefully reviewed and considered the evidence presented and the submissions of Conduct Counsel.

The Hearing Tribunal considered the uncontroverted evidence in the Affidavits. The Hearing Tribunal also noted the additional documentation attached to the Affidavits, which was reviewed by the Hearing Tribunal and which supported and corroborated the evidence of each witness. The evidence detailed above is not reproduced in detail in this section of the decision, but the Hearing Tribunal accepts the evidence of each witness as set out above as the Hearing Tribunal's findings of fact.

The Hearing Tribunal finds that based on the evidence presented, the following allegations are proven on a balance of probabilities and that the conduct constitutes unprofessional conduct for the reasons that follow.

Allegation 1

Allegation 1 states**:** On or about February 24, 2021, the Registrant failed to demonstrate adequate skill and/or judgment in their care of Patient [PATIENT 1] when they did one (1) or more of the following:

a. Failed to review the patient's chart, including the patient's DASA score, prior to or upon the Registrant receiving the patient into care;

b. Failed to conduct an adequate DASA assessment, or any assessment, of the patient upon receiving the patient into care;

c. Failed to identify, and/or document a safety care plan for the patient;

d. Failed to enter the patient's sedative medication order in a timely manner;

e. Failed to administer the patient's ordered IM sedative medication without direct instruction from the Charge Nurse;

f. Risked the safety of other patients and co-workers, specifically when:

    i. The Registrant allowed the patient to have a chair, cellphone and/or book while in seclusion;

    ii. The Registrant failed to ensure security was present when opening the door to the patient's seclusion room.

The Hearing Tribunal relied on the evidence summarized above, in particular that of Delores Leia, Calvin Lee, and Sarah Quon.

The Hearing Tribunal finds that each part of Allegation 1 is proven for the following reasons:

> *(a) Failure to review the patient's chart, including the patient's DASA score, prior to or upon the Registrant receiving the patient into care*

The Registrant's charting notes did not suggest any reference to previous assessments or DASA scores when Patient [PATIENT 1] was received into her care. Further, during the AHS interview, the Registrant admitted that on February 24, 2021, she did not review all of the documentation, did not see a DASA score, and only reviewed a physician's note later into the shift.

> (b) *Failure to conduct an adequate DASA assessment, or any assessment, of the patient upon receiving the patient into care*;

Despite the employer's Aggression and Violence Alert Protocol, which requires a patient's assigned nurse to conduct a DASA assessment upon receiving a patient into care, the Registrant's charting notes make no reference to performing a DASA assessment, and the Registrant admitted during the AHS interview that she did not perform a DASA assessment.

> *(c) Failure to identify, and/or document a safety care plan for the patient;*

Despite the Aggression and Violence Alert Protocol, which outlines the requirement to have a safety care plan when a patient's DASA score is higher than two, the Registrant admitted, during the AHS interview, to having not created a safety plan for Patient [PATIENT 1]. Further, none of the Registrant's charting notes make reference to a safety care plan.

This evidence, taken together with the general directives outlined in the AHS Clinical Documentation Directive which require that charting notes be accurate, complete, clear, concise, and timely, suggests that since there is no mention of a safety care plan, the Registrant, on balance of probabilities, did not identify or failed to document a safety plan.

> *(d) Failure to enter the patient's sedative medication order in a timely manner;*

The Registrant did not clearly record when she received the medication order nor when it was entered into the patient record. There are inconsistencies within the Registrant's charting notes, which suggest that a verbal order was obtained sometime prior to the Registrant administering Patient [PATIENT 1]'s sedative medication and charting it, along with conflicting time entries in the Registrant's Kardex entries.

While none of the witnesses could say with certainty when the verbal order was obtained, based on witness interviews during the AHS investigation, witness accounts suggest the verbal order was obtained around 1730h. The first mention of the medication in the Registrant's notes is at 2035h. Based on the evidence, it is more likely than not that the Registrant received the verbal order sometime before the time indicated in her notes, and she only then charted it after administering Patient [PATIENT 1] the sedative.

(e) Failure to administer the patient's ordered IM sedative medication without direct instruction from the Charge Nurse;

Affidavit evidence from Dolores Leia, Calvin Lee, and the narrative provided to Beverly Armstrong from the Protective Services Guard all corroborate that the Registrant refused to administer the intramuscular sedative prior to receiving direct instruction from the Charge Nurse.

Basic nursing knowledge provides that when an order is obtained, it should be followed through with. However, based on affidavit evidence and narrative accounts provided during the AHS investigation, the Registrant did not follow through with the order until explicitly directed to do so.

(f) Risking the safety of other patients and co-workers by

(i) allowing the patient to have a chair and cellphone while in seclusion;

During the AHS investigation, all three witnesses interviewed indicated that Patient [PATIENT 1] was presenting as a high risk for aggression. This was further corroborated by the Registrant's own charting notes describing several of Patient [PATIENT 1]'s behaviours, such as verbal outbursts, throwing a cup, yelling and anger directed toward staff, amongst others, that suggest that Patient [PATIENT 1] would have scored higher than a 2 on a DASA assessment. The Registrant's charting notes and witness accounts all indicate that there was a high-risk situation and required increased safety measures.

The Registrant charted her discussion with Patient [PATIENT 1] regarding putting a chair in the room, but that she would not do so until the patient demonstrated he had settled. The Registrant's charting notes also indicated that she removed the chair as a precautionary measure. Despite no documentation that a chair was placed in the room, witnesses observed a chair in the room, and the Registrant admitted during the AHS investigation interview to having put a chair in Patient [PATIENT 1]'s room.

Despite any mention of it in the Registrant's charting, she admitted during the AHS investigation interview, and affidavit evidence also corroborates, that the Registrant placed a phone in Patient [PATIENT 1]'s room.

The Registrant's notes also indicated that she obtained food and a book for Patient [PATIENT 1] but that after speaking with the Charge Nurse, she did not provide the book despite her intention to do so.

The Registrant risked the safety of other patients and co-workers by allowing Patient [PATIENT 1] to have a chair and cellphone while in seclusion. Objects are removed from the seclusion room for the purpose of safety.

(ii) by failing to ensure security was present when opening the door to the patient's seclusion room.

The Registrant acknowledged during the AHS investigation interview that a DASA score of 6 or greater required that security be present during any interaction with the patient. Affidavit evidence of Ms. Leia notes that she would have assessed [PATIENT 1] with a DASA score of 7. Despite

this, all three AHS investigation witnesses corroborate that the Registrant repeatedly entered Patient [PATIENT 1]'s room without security present. Based on the narrative provided to Beverly Armstrong from the Protective Services Guard and a review of the Registrant's chart notes, the Registrant had already entered Patient [PATIENT 1]'s room prior to them arriving to the room upon being called.

Allegation 2

Allegation 2 states: In or between July 2023 and February 2024, the Registrant failed to demonstrate accountability when they failed to respond to concerns identified in an investigation by the College.

The Hearing Tribunal relied on the evidence above, in particular that of Beverly Armstrong and Christina Alexandropoulos. The evidence demonstrates that between July 2023 and February 2024, the Registrant failed to respond to concerns identified in an investigation by the College.

Allegation 2 is proven on a balance of probabilities.

Unprofessional Conduct

Allegations 1 and 2 constitute unprofessional conduct as per the HPA, as follows:

> 1(1)(pp) "unprofessional conduct" means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice;
> …
>
> (vii) failure or refusal
>
> …
>
> (B) to comply with a request of or co-operate with an investigator,

Allegation 1

The Hearing Tribunal finds that the conduct in Allegation 1 demonstrates a serious lack of judgment on the part of the Registrant. Her conduct created risk to the Patient, her colleagues and herself. The conduct is serious and constitutes unprofessional conduct under HPA s. 1(1)(pp)(i).

The Hearing Tribunal further finds that the Registrant breached the 2017 Code of Ethics (**CNACE**) as follows:

> **A. Providing Safe, Compassionate, Competent and Ethical Care**
>
> Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

5. Nurses are honest and take all necessary actions to prevent or minimize **patient safety incidents**. They learn from **near misses** and work with others to reduce the potential for future risks and preventable harms (see Appendix B).

12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards for Regulated Members (2013) (**CPSRM**) as follows:

Standard 1: Responsibility and Accountability

The nurse is personally responsible and accountable for their nursing practice and conduct.

Indicators

1.1 The nurse is accountable at all times for their own actions.

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

Standard 2: Knowledge-Based Practice

The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

Standard 5: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

Indicators

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

The Hearing Tribunal also finds that the Registrant breached the Documentation Standards for Regulated Members (2013) (**CDSRM**) as follows:

Standard 1

Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

Criteria:

The nurse must:

1.4 Record:

…

e. contemporaneously

f. late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy

…

i. the date and time that nursing care was provided

j. communication with other care providers, including name and outcomes of discussion

1.7 Access client health information only for purposes that are consistent with professional responsibilities.

1.8 Comply with the applicable privacy legislation and follow employer policies regarding the collection, use (including access to), disclosure, retention and security of health information.

The Hearing Tribunal also finds that the Registrant breached the Entry-Level Competencies for the Practice of Registered Nurses, 2019 (**CELCPRN**) as follows:

Competency Category 1: Clinician

Registered nurses are clinicians who provide safe, competent, ethical, compassionate, and evidence-informed care across the lifespan in response to client needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.

Competencies

1.24 Uses effective strategies to prevent, de-escalate, and manage disruptive, aggressive, or violent behaviour.

Competency Category 2: Professional

Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession.

Competencies

2.1 Demonstrates accountability, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated scope of practice.

2.14 Recognizes, acts on, and reports actual and potential workplace and occupational safety risks.

Competency Category 4: Collaborator

Registered nurses are collaborators who play an integral role in the health-care team partnership.

Competencies

4.1 Demonstrates collaborative professional relationships.

4.5 Contributes to health-care team functioning by applying group communication theory, principles, and group process skills.

The Hearing Tribunal also finds that the Registrant breached the Medication Management Standards (**CMMS**) as follows:

Standard 1: Safety

Regulated members are responsible and accountable to provide safe medication management.

Criteria

The regulated member must:

1.15 accept verbal medication orders (including by telephone) only *in urgent or emergent circumstances* and according to employer requirements. Such orders must be read back to the *authorized prescriber* to confirm accurance and then accurately documented;

The Hearing Tribunal also finds that the Registrant breached the AHS Aggression and Violence Alert Protocol as follows:

Element 1: Unit Admissions

1.3 A care-plan is initiated for all patients who score 2 or greater (Moderate) on the DASA-IV.

Element 2: Daily Screening with the DASA-IV tool (every 24 hours at a consistent time)

2.3 ALL patients on the unit will be reviewed utilizing the DASA-IV tool each day.

2.3.1 The patient's assigned nurse will review the DASA-IV as it applies to the patient.

Element 3: Care-plans and Aggression mitigation

3.2 Patients who have a moderate to high risk score must have an Aggression safety care-plan identified to manage and mitigate the risks. This is a score 2 or greater on the DASA-IV.

Element 6: Documentation

6.1.6 The specific care & safety plan to manage the aggression will be completed within the electronic health record, and will reference the Violence Alert status including triggers and approaches.

The Hearing Tribunal also finds that the Registrant breached the AHS Clinical Documentation Directive as follows:

Element 2: Clinical Documentation Principles

2.1 Clinical documentation shall:

…

e) be accurate, complete, clear, concise, legible, timely, and ordered to enable the health care provider to:

(i) record the patient's perspective on their health care needs, goals, and preferences;
(ii) access the needed information to make informed clinical decisions;
(iii) communicate with the patient and other health care providers;
(iv) integrate information to evaluate the current health status of the patient;
(v) develop treatment goals and integrated plans of care in collaboration with the patient and other health care providers; and
(vi) provide continuity across care settings.

The Hearing Tribunal also finds that the Registrant breached the AHS Clinical Documentation Process Directive as follows:

Element 4: Timely Entry

4.1 Clinical documentation must:
a) be entered at the time of the event or as soon as possible thereafter;
b) document care that has been provided by the writer unless the health care provider is referring to patient interactions and/or interventions that are planned for the future but have not yet been started; and
c) be completed by signing, saving, and/or filing immediately.

The Registrant's conduct is in breach of the above provisions of the CNACE, CPSRM, CDSRM, CELCPRN, CMMS, and AHS policies. The Registrant failed to take accountability for her actions and acted in breach of legislation, standards and employer policies in failing to demonstrate skill

and judgment in her care of Patient [PATIENT 1], thereby also putting at risk the safety of other patients and co-workers. The public and hospital staff place a very high level of trust in Registered Nurses to foster and create a safe and quality practice environment, and the Registrant's conduct undermines this trust. The conduct in Allegation 1 contravened the Practice Standards and Code of Ethics. The breaches are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

Allegation 2

In failing to respond to the communications from the investigator, the Registrant impeded the College's ability to fully investigate the complaint made against the Registrant. This is very serious conduct.

If a College is unable to regulate its members, this places its ability to self-regulate in jeopardy; it also undermines the trust that the public has placed in the profession and could potentially create a safety risk to the public.

The conduct constitutes unprofessional conduct under section 1(1)(pp)(vii)(B) of the HPA.

The failure to cooperate with an investigator also demonstrates a failure to take responsibility and accountability for her actions and is a breach of section 1.1 and 1.2 of the CPSRM, constituting unprofessional conduct under section 1(1)(pp)(ii) of the HPA.

SUBMISSIONS ON SANCTION

The Hearing Tribunal advised Conduct Counsel of its decision on the allegations during the hearing and proceeded to hear submissions on sanction.

Submissions by Conduct Counsel

Conduct Counsel presented the proposed orders in Exhibit 8 for the Hearing Tribunal's consideration.

Conduct Counsel noted that the Registrant is not currently registered with the College. The Registrant went on medical leave following the incident and has not been practicing since then. The Registrant was given a one-day suspension by her employer that she never served because she went on medical leave, but that the one-day suspension would likely be an expectation upon her return.

Conduct Counsel reviewed the sentencing principles set out in *Jaswal v. Newfoundland Medical Board* (1996 CanLII 11630) as follows:

Nature and gravity of the conduct: The incident was a serious ethical and professional lapse, putting patients, colleagues, and the Registrant at risk. There was also evidence of similar behaviour previously addressed by the employer. The Registrant's failure to cooperate with the investigation was also considered serious, as the ability of the profession to self-regulate depends on cooperation with the regulator.

Number of times the conduct occurred: While it was a single incident, the number of times the conduct occurred was considered an aggravating factor because there was evidence that the Registrant had been warned about similar behaviour.

Previous character or complaints: There were no prior complaints or disciplinary actions against the Registrant, which was considered a mitigating factor with respect to previous character or complaints.

Whether the Registrant has suffered other serious financial or other penalties: The Registrant received a one-day suspension from her employer, but it was never served because she went on medical leave. The possibility that ongoing health issues may have hindered the Registrant's participation in the investigation was considered a mitigating factor.

Age and experience of the Registrant: The age and experience of the Registrant were not considered a significant factor in the conduct.

The role of the Registrant in acknowledging what has occurred: The Registrant acknowledged the conduct during the AHS investigation, which is slightly mitigating, but did not acknowledge it at the hearing.

Impact on the Patient: The impact on the patient was potential rather than proven.

Conduct Counsel made submissions regarding costs and noted the recent case law in *Jinnah v Alberta Dental Association and College* (2022 ABCA 336). The general principle is that costs should not be imposed unless there is a compelling reason. Conduct Counsel submitted that compelling reasons exist in this case because the Registrant failed to continue to cooperate with the College investigator, forcing the College to expend more resources and engaged in conduct that unnecessarily prolonged the hearing. It was estimated that the cost of the investigation increased by $1,000 due to these issues, and the total cost of the hearing was estimated to be around $7,000. The director is requesting that the Registrant pay 50% of the costs, up to a maximum of $4,000.

REASONS FOR ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal carefully considered the submissions of Conduct Counsel, the wording of the Proposed Order (Exhibit 8) and the case law presented.

The Hearing Tribunal agreed that the Registrant’s conduct in this case was a serious ethical and professional lapse, which included failure to follow safety measures which put patients, colleagues, and the Registrant at risk.

In failing to continue to cooperate with the College investigator, the Registrant further harmed the integrity of the profession and the public trust. If the College cannot govern its members, it cannot effectively protect the public interest.

The Hearing Tribunal agreed with the *Jaswal* sentencing principles as put forward by Conduct Counsel. The Hearing Tribunal found that the proposed orders were reasonable and presented as a balance between admonishing the behaviour and promoting rehabilitation. The proposed orders will serve to uphold the standards of the profession, ensure the safety of the public, and demonstrate the seriousness of the conduct while also supporting the Registrant's rehabilitation.

The proposed courses, learning activities and review of the Code of Ethics and Standards are appropriate and serve a remedial function. They will assist the Registrant to ensure she is competent. These serve to protect the public interest.

The proposed Practice Setting Letter and Employer Reference also serve to ensure the public is protected. These are proportionate to the conduct at issue and will ensure that similar conduct does not reoccur.
The proposed fine of $500 is appropriate. It reflects the seriousness of the conduct, in particular the failure to cooperate with the investigator.

In addition, the Hearing Tribunal acknowledges that the Registrant did receive a one-day suspension from her employer, though it was never served due to medical leave. If the Registrant returns to practice, this suspension will likely be an expectation. While there were some mitigating factors, such as no previous complaints and the possibility of health issues, the aggravating factors and seriousness of the conduct warrant the sanctions imposed.

The Hearing Tribunal also found the proposed costs of the Registrant paying 50% of the costs, up to a maximum of $4,000.00 to be appropriate in this case. In accordance with the decision in *Jinnah*, this is a case where there is a compelling reason to order costs. The Registrant failed to cooperate with the investigators and engaged in conduct that unnecessarily prolonged the investigation. That factor, along with the seriousness of the conduct in the Allegations, justifies ordering the Registrant to pay a portion of costs. The proposed costs are reasonable in the circumstances. In addition, the Hearing Tribunal notes the Registrant is provided a two year timeline for payment of costs.

ORDER OF THE HEARING TRIBUNAL

For the reasons outlined above, the Hearing Tribunal orders:

1. Prior to applying for reinstatement with the College, the Registrant shall provide proof of completion satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities:

    a. Critical Thinking in Nursing (John Collins Consulting);
    b. Professionalism and Ethics for Healthcare Professionals (IPHE201 - NAIT); and
    c. Introduction to Health Assessment (NURS0163 – MacEwan University);

2. Prior to applying for reinstatement with the College, the Registrant shall provide a written declaration to the Complaints Director, in the form approved by the Complaints Director, confirming that they have read and reviewed:

    a. the Canadian Nurses Association Code of Ethics for Registered Nurses (2017);
    b. the Documentation Standards (2022);
    c. the Practice Standards for Registrants (2023); and
    d. the Entry-Level Competencies for the Practice of Registered Nurses (2019);

3. Prior to next commencing employment, or otherwise performing any type of nursing practice hours, as a registrant of the College (RN, Nurse Practitioner ("**NP**"), Provisional Permit Holder ("**PPH**")), the Registrant shall provide a letter ("**Practice Setting Letter"**) to the Complaints Director from the Registrant's prospective RN or NP Supervisor (the "**Supervisor"**) at their place of employment ("**Practice Setting"**), confirming:

    a. The Supervisor's name and contact information;
    b. The Practice Setting;
    c. The Registrant's role of employment;
    d. That the Supervisor has reviewed the Complaint OR the Supervisor has reviewed the Agreement; and
    e. That the Supervisor agrees to provide to the College **two (2)** Employer References in the form approved by the Complaints Director.

4. The Registrant shall provide the first Employer Reference from their Supervisor **sixty (60) days** after their Practice Setting Letter is approved by the Complaints Director. The Employer Reference must be acceptable to the Complaints Director and confirm the following:
    a. whether the Registrant has completed at least **four hundred (400) hours** of nursing practice;
    b. confirmation that such nursing practice hours occur no earlier than the date of this Order; and
    c. whether concerns exist about the Registrant's practice and whether they met or exceeded the standards expected of a RN;

5. The Registrant shall provide the second Employer Reference from their Supervisor **sixty (60) days** after the first Employer Reference is approved by the Complaints Director. The Employer Reference must be acceptable to the Complaints Director and confirm the following:

    a. whether the Registrant has completed at least **four hundred (400) hours** of nursing practice;
    b. confirmation that such nursing practice hours occur no earlier than the date of this Order; and
    c. whether concerns exist about the Registrant's practice and whether they met or exceeded the standards expected of a RN/NP;

6. Until the Registrant has submitted the final Employer Reference to the Complaints Director, as required by paragraph 5, and it is deemed satisfactory to the Complaints Director, the Registrant shall not be employed in any other setting except the Practice Setting(s) approved by the Complaints Director, unless:

    a. The Registrant submits a letter to the Complaints Director from their prospective employer detailing the new Practice Setting, following the requirements in paragraph 3 and that acknowledges that the Supervisor is prepared to provide outstanding Employer Reference(s) as required in paragraphs 4 and 5, or as directed by the Complaints Director; and

b. The Complaints Director, acting reasonably, acknowledges receipt of the letter and deems it satisfactory.

7. By **December 16, 2026** or on terms agreeable to the Complaints Director, the Registrant shall pay a fine in the sum of $500.00, via payment to the College (the "**Fine**") and shall provide proof of payment satisfactory to the Complaints Director, noting the following terms apply:

    a. pursuant to Section 82(3)(c) of the HPA, the Registrant may be automatically suspended for any non-payment;
    b. if the Registrant fails to pay the Fine by the deadline indicated, the Complaints Director may publish an Administrative Notice of Non-Payment of the Fine on the College's website including the Registrant's name and registration number and that the Fine arose from a Decision of the Hearing Tribunal;
    c. the Registrant must pay the Fine owed to the College, whether or not the Registrant has an active practice permit with the College; and
    d. the Fine is a debt owed to the College and if not paid, may be recovered by the College by an action of debt.

8. By **December 16, 2026** or on terms agreeable to the Complaints Director, the Registrant shall pay 50 % of the costs of the investigation and hearing to a maximum of $4,000.00, via payment to the College (the "**Costs**"), and shall provide proof of payment satisfactory to the Complaints Director, noting the following terms may apply:

    a. pursuant to Section 82(3)(c) of the HPA, the Registrant may be automatically suspended for any non-payment;
    b. if the Registrant fails to pay the Costs by the deadline indicated, the Complaints Director may publish an Administrative Notice of Non-Payment of the Costs on the College's website including the Registrant's name and registration number and that the Costs arose from a Decision of the Hearing Tribunal;
    c. the Registrant must pay the Costs owed to the College, whether or not the Registrant has an active practice permit with the College; and
    d. the Costs are a debt owed to the College and if not paid, may be recovered by the College by an action of debt.

9. Should the Registrant be successful in being reinstated with the College and reissued a practice permit, the usual terms of the costs payment, as per 82(3)(c) of the HPA shall apply, whereby Registrant may be automatically suspended for any then, or thereafter, outstanding non-payment of the costs as set out above in paragraph 1.

10. For clarity and certainty, the Registrant is, in addition to what is set out in this Order, required to complete any and all requirements as have or may be imposed from the College's Registration Department. This Order does not supersede or, if complied with, serve to satisfy any such requirements from the College's Registration Department.

CONDITIONS

11. The Registrar of the College will be requested to put the following conditions against Registrant's registration or practice permit (current and/or future) and shall remain until the condition is satisfied:

    a. Course work required – Arising from Disciplinary Matter;
    b. Confirmation of Practice Setting(s) required - Arising from Disciplinary Matter;
    c. Employer Reference(s) (practice report) required – Arising from Disciplinary Matter;
    d. Shall pay fine – Arising from Disciplinary Matter
    e. Shall pay costs – Arising from Disciplinary Matter.

12. Effective December 16, 2024, or the date of this Order if different from the date of the Hearing, notifications of the above conditions shall be sent out to Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which Registrant is also registered (if any).

13. Once Registrant has complied with a conditions listed above, it shall be removed. Once a condition has been removed, the Registrar will be requested to notify the regulatory college of the other Canadian jurisdictions.

14. This Order takes effect December 16, 2024, or the date of this Order if different from the date of the Hearing, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

COMPLIANCE

15. The Complaints Director of the College shall determine Compliance with this Order. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

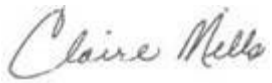
16. The Registrant will provide proof of completion of any conditions to the Complaints Director via e-mail to procond@nurses.ab.ca or via fax at 780-453-0546.

17. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of HPA.

18. The Registrant has the responsibility to comply with this Order and to initiate communication with the College for any anticipated non-compliance and any request for an extension.

This Decision is made in accordance with Sections 80, 82, and 83 of the HPA.

Respectfully submitted,



Claire Mills, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: December 16, 2024