CARNA College & Association of Registered Nurses of Alberta

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF SIOBHAN ORIAIFO, REGISTRATION #106,399

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

APRIL 7 & 8, 2020

INTRODUCTION

[1] A hearing was held on April 7 & 8, 2020 by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta ("CARNA") to hear a complaint against Siobhan Oriaifo, registration #106,399.

[2] Those present at the hearing were:

a. Hearing Tribunal Members:

Nancy Goddard, Chairperson
Lynn Headley
Claire Mills
Nancy Brook, public representative

b. Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. College Representative:

Kate Whittleton, Conduct Counsel

[3] Conduct Counsel was present at the CARNA offices and the other participants attended by Webex videoconference.

PRELIMINARY MATTERS

[4] The hearing was called to order at 9:40 a.m. on April 7, 2020. Due to COVID-19, the hearing was held by videoconference. Conduct Counsel advised that she was present at the CARNA offices and that Siobhan Oriaifo (sometimes hereinafter referred to as "the Regulated Member") was not present. Conduct Counsel advised that neither the Regulated Member nor anyone on her behalf had contacted CARNA with respect to the hearing nor attended at the CARNA offices that morning.

[5] 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.

[6] 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. Conduct Counsel confirmed that there were no members of the public present.

[7] Conduct Counsel made two preliminary applications. The first was an application under section 79(6) of the HPA to proceed with the hearing in the absence of the Regulated Member. Conduct Counsel asked for a short adjournment to check her voicemails as she advised she had just received a call. After a short adjournment, Conduct Counsel advised that the voicemail was not from the Regulated Member and proceeded with her submissions.

[8] Conduct Counsel reviewed section 79(6) of the HPA, which states:

> **79(6)** Despite section 72(1), if the investigated person does not appear at a hearing and there is proof that the investigated person has been given a notice to attend the hearing tribunal may
>
> (a) proceed with the hearing in the absence of the investigated person, and
>
> (b) act or decide on the matter being heard in the absence of the investigated person.

[9] Conduct Counsel reviewed section 120(3) of the HPA which provides that service of a notice is sufficient if served by personal service on the person or by certified or registered mail at that person's address as shown on the register or record of the registrar. Conduct Counsel also reviewed CARNA Bylaw 27 which provides that service shall be sufficient if a notice is published at least twice in a local newspaper circulating at or near the address last shown for that person in the CARNA Records.

[10] An Affidavit sworn by [staff member 1] was entered as an Exhibit. [Staff member 1] outlines the various attempts at service of the Notice of Hearing on the Regulated Member, as well as attempts to contact the Regulated Member with respect to the hearing. [Staff member 1] made attempts to serve the Regulated Member with the referral to hearing documentation on July 25, 2019 and on August 22, 2019 at the address provided by the Regulated Member when she applied for registration with CARNA. The letters were returned to CARNA by Canada Post. [Staff member 1] emailed the Regulated Member on August 28, 2019 at the email address provided by the Regulated Member when she applied for registration. [Staff member 1] did not receive a reply from the Regulated Member to her email.

[11] [Staff member 1]'s Affidavit indicates that Conduct Counsel also emailed the Regulated Member and Tricia Gibbs, a Labour Representative Officer, on September 10, 2019 and September 24, 2019 to advise that CARNA was trying to send correspondence to the Regulated Member. There is delivery notification of the two emails provided as Exhibits E-2 and F-2 to [staff member 1]'s Affidavit. Conduct Counsel received no response to her emails. Conduct Counsel attempted to reach the Regulated Member by telephone and left a voicemail at the number provided to CARNA by the Regulated Member. [Staff member 1] again attempted to serve the Regulated Member with the referral to hearing date documentation on October 21, 2019 at the address provided by the Regulated Member. The letter was returned to CARNA by Canada Post. [Staff member 1] emailed the Regulated Member on December 4, 2019 advising that CARNA had been trying to reach her by telephone and mail and provided her the dates of the hearing. [Staff member 1] then published a notice in the Calgary Herald daily newspaper on January 17, 2020 and January 24, 2020 in accordance with Bylaw 27.

[12] [Staff member 1]'s Affidavit states that Conduct Counsel reviewed the Texas Board of Nursing verification webpage and discovered that the Regulated Member appeared to be registered with the Texas Board of Nursing. However, while Conduct Counsel contacted the Texas Board of Nursing, the individual she spoke with refused to provide her any information other than the Regulated Member has a current license in Texas, USA. From a review of CARNA's records, it was confirmed that the Regulated Member has never provided alternate contact information.

[13] The Hearing Tribunal considered the application to proceed in the Regulated Member's absence. The Hearing Tribunal held that service of the Notice to Attend a Hearing was made in accordance with the requirements of the HPA and Bylaw 27. CARNA made several attempts, over and above the requirements of the HPA, to contact the Regulated Member. Regulated members are responsible for providing current contact information to CARNA so that CARNA can contact them. It is also the responsibility of regulated members to review mail and email communications from CARNA. The Hearing Tribunal found that it was appropriate in this case to proceed in the absence of the Regulated Member. There was no indication that an adjournment would permit CARNA to communicate with the Regulated Member or that the Regulated Member would participate in the hearing at a later date. In addition, CARNA's mandate to ensure the public is protected requires that hearings be held in a timely manner.

[14] Conduct Counsel brought a second application to have the evidence of its witnesses entered by way of Affidavit. Conduct Counsel took the position that the evidence was reliable and relevant. It was evidence sworn before a Commissioner for Oaths, and so was reliable. Conduct Counsel noted that section 79(5) of the HPA provides that evidence may be given before the Hearing Tribunal in any manner that it considers appropriate. She noted that due to COVID-19 issues, it was not possible to have the witnesses attend in person. Conduct Counsel advised that each witness was able to attend by Webex videoconference if the Hearing Tribunal wished to ask any questions after having reviewed the Affidavit evidence. The Hearing Tribunal determined that it would allow the evidence to be entered by way of Affidavit and that it would call the witnesses to give evidence by Webex videoconference if there were any further questions after having reviewed the Affidavit evidence.

ALLEGATIONS

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

> While employed as a Registered Nurse [working in a continuing care facility], [city redacted], Alberta, your practice fell below the standard expected of an RN when,
>
> 1. On or about September 29/30, 2018, when providing care for [Patient 1], you:
>   a. Failed to appropriately manage or de-escalate the patient's aggressive behavior and obvious distress when you:
>   i. Shook or rocked his wheelchair;
>   ii. Grabbed his jaw when trying to administer an oral medication, which he was refusing;
>   iii. Raised your fist to the patient and made remarks that could reasonably be perceived as threatening;
>   b. Failed to document your administration of Ativan to the patient;
>   c. Entered inaccurate documentation of care and observations at 0103 which then described care during shift 2300 to 0700;
>   d. Failed to document observations of change in the patient's demeanor after administration of Ativan.

EVIDENCE

[16] The following documents were entered as Exhibits:

Exhibit #1 – Affidavit of [staff member 1]
Exhibit #2 – Notice to Attend a Hearing
Exhibit #3 – Affidavit of [RN 1]
Exhibit #4 – Affidavit of [RN 2]
Exhibit #5 – Affidavit of [HCA 1]
Exhibit #6 – Affidavit of [HCA 2]
Exhibit #7 – Affidavit of [RN 3]
Exhibit #8 – Book of Authorities
Exhibit #9 – Affidavit of [staff member 2]
Exhibit #10 – Proposed Order
Exhibit #11– Course Outlines/Descriptions: NURS0162, NURS0260, NCDEM014, Learning Modules
Exhibit #12 – Estimated Statement of Costs, April 7, 2020
Exhibit #13 – CARNA Decision #1
Exhibit #14 – CARNA Decision #2
Exhibit #15 – Revised Estimate of Costs, April 8, 2020

[17] The following individuals provided evidence on the allegations by way of Affidavit evidence:

[RN 1]
[RN 2]
[HCA 1]
[HCA 2]
[RN 3]

[18] The following is a summary of the evidence given by each witness:

[RN 1]

[19] [RN 1] is a Registered Nurse, working as a Facility Administrator at [a continuing care facility]. At the time the Regulated Member applied to work at the Facility, she was working in Alberta on a Study Permit Visa from the Department of Immigration. The Facility is a long term care level five facility. The patient population includes a wide range of care requirements, including complex dementia management, physical disability and mobility issues, and chronic diseases such as diabetes, heart failure, respiratory disease and end of life care. There are one Registered Nurse and two Health Care Aides ("HCAs") on the night shift.

[20] The Regulated Member received the standard orientation for registered nurses when she commenced work at the Facility on July 31, 2018. During the first day of orientation, the Facility policies were reviewed, including the "Zero Tolerance of Resident Abuse and Neglect" and the Regulated Member was required to sign an acknowledgement form and an employee pledge.

[21] [RN 1] did not directly witness the incidents that are the subject of this hearing. When [RN 1] arrived at work on Monday, October 1, 2018, she was given two separate written

reports describing abusive behavior by the Regulated Member to a patient, which had occurred on the night shift of September 29/30, 2018. [RN 1] removed the Regulated Member from her schedule of shifts and an investigation was conducted. The Regulated Member was interviewed on two occasions. The two HCAs who reported the incidents were interviewed and the Regulated Member's actions were demonstrated to [RN 1] by the HCAs during the interviews. The Regulated Member was terminated from her employment and a complaint made to CARNA on October 19, 2018.

[22] [Patient 1] is an 82 year old male with complex medical issues including diabetes and advanced vascular dementia. He can be aggressive and yells inappropriately at times but can be redirected. Discomfort such as being wet or soiled often precipitates escalation in his behavior. His patient care profile plan includes strategies for managing his care including agitated or aggressive behavior.

[23] During the Facility's investigation, the Regulated Member stated in her interview that she administered, or attempted to administer, Seroquel (quetiapine) and Ativan (lorazepam) to [Patient 1]. [RN 1] reviewed [Patient 1]'s patient chart and noted an entry at 0103, 2018/Sept. 30, signed by the Regulated Member that "po Seroquel was offered, but resident spat it out." The Regulated Member also documented that the patient displayed aggressive behavior during shift 2300 to 0700, even though the entry was made at 0103, and not at the end of the shift.

[24] The Nurses Daily Record dated September 30, 2018 notes that [Patient 1] received Seroquel 25 mg po at 0030 for agitation.

[25] [Patient 1]'s Medication Administration Record shows an entry that Seqoquel 25 mg was given September 30 for agitation, but was spat out.

[26] There was no documentation for the administration of Ativan, nor was there any documentation regarding any changes to [Patient 1]'s behavior after the administration of Ativan.

[RN 2]

[27] [RN 2] is a Registered Nurse working as the Director of Care at the Facility. [RN 2] first received information about the incident through text messages on her cell phone from [HCA 2] and [HCA 1] that something had happened with the Regulated Member and that they would leave reports under her office door. [HCA 2] and [HCA 1] were experienced staff members and familiar with all the patients, responsibilities and routines.

[28] On Monday October 1, 2018, [RN 2] found a letter from [HCA 2] and a letter from [HCA 1] describing occurrences of what they described as abusive behavior that they had witnessed by the Regulated Member toward [Patient 1].

[29] Neither [HCA 2] nor [HCA 1] had complained about the Regulated Member or any other registered nurse in the past. [HCA 2] and [HCA 1] are not friends outside of work.

[30] [RN 2] spoke to the Regulated Member the morning of October 1, 2018. The Regulated Member had stayed overtime to complete her charting. She denied everything except putting her fist up and making the comment that hers was bigger. The Regulated Member's explanation was that she was joking with [Patient 1]. [RN 2] also spoke to [RN

3] that morning and was advised by [RN 3] that the Regulated Member had told [RN 3] that: "I rocked [Patient 1] like a baby in his wheelchair."

[HCA 1]

[31] [HCA 1] is a HCA who works at the Facility. On September 29/30, 2018, she was working the night shift at the Facility with the Regulated Member and [HCA 2] when the incident occurred.

[32] [HCA 1] states that she called [RN 2] and left a message on her cell phone. She wrote a detailed description of what she had witnessed prior to leaving the Facility at the end of her shift on September 30, 2018. [HCA 1] participated in two meetings as part of the Facility's investigation.

[33] [HCA 1] states at paragraph 7 of her Affidavit: "I confirm that I witnessed the following:

a. At around midnight on this shift, [HCA 2] and I had just finished in another resident's room, and went hopper room to drop off some garbage and clean our hands.

b. I heard [Patient 1] yelling, which I would characterize as not "normal" yelling.

c. I looked down the 200 wing hallway and saw [Patient 1] in his wheelchair being shaken and rocked aggressively, side to side, by the Member. The Member was literally tipping [Patient 1]'s wheelchair side to side and the wheels were off the ground. [Patient 1]'s body was going side to side, front to back, and was yelling.

d. [HCA 2] and I went to intervene, and saw the Member go to her medication cart and get [Patient 1] a pill. It was a little white round pill on a white plastic spoon. The member grabbed [Patient 1]'s face under the jaw, pressing his cheeks, and was trying to force him to take the pill.

e. I was trying to calm [Patient 1] down, which was working fine until the Member tried giving him the pill again. [Patient 1] started swinging and swearing at the Member.

f. [HCA 2] and I suggested that [Patient 1] was probably wet, and that we should take him and put him in bed. The Member refused for us to change [Patient 1] or put him in bed, and said [Patient 1] was too agitated.

g. The Member continued to try and talk [Patient 1] into taking the pill. Once again [Patient 1] was yelling and swinging at the Member. The Member raised her left fist and put it up close to [Patient 1]'s face and said, "I'll give you a bigger one" and "you want to go?" [HCA 2] then said, "That's not the answer!"

h. I did not witness [Patient 1] take the pill at any point.

i. Even after [Patient 1] started to calm down he continued to express agitation towards the Member. [Patient 1] asked me not to leave him with the Member. [Patient 1] also told the Member to get away from him.

j. The Member then started fanning [Patient 1] with a piece of paper.

k. [Patient 1] said he wanted the bathroom, so the Member and I took [Patient 1] back to his room. [Patient 1] was agitated that the Member was in the room. The Member stated that [Patient 1]'s internal insides were heated up and he had to cool off. The Member was fanning [Patient 1] with a piece of paper because she said his body temperature was increased.

l. [HCA 2] came in and, together, we got him to the bathroom and then into bed."

[HCA 2]

[34] [HCA 2] is a HCA who works at the Facility. On September 29/30, 2018, she was working the night shift at the Facility with the Regulated Member and [HCA 1] when the incident occurred.

[35] [HCA 2] wrote a detailed description of what she had witnessed prior to leaving the Facility at the end of her shift on September 30, 2018 and placed this under the door of [RN 2]'s office. [HCA 2] participated in one meeting as part of the Facility's investigation.

[36] [HCA 2] states at paragraph 6 of her Affidavit: "I confirm that I witnessed the following:

a. At around midnight on this night shift, I came out of another resident's room and intended to go to the soiled room. I then heard [Patient 1] hollering. It sounded like [Patient 1] was being rattled, it was a different sound.

b. I then witnessed the Member shaking [Patient 1]'s wheelchair side to side, very hard while [Patient 1] was in the wheelchair, which resulted in him calling out in distress. [Patient 1] was leaning forwards and leaning back, and hollering.

c. [HCA 1] and I tried to intervene and told the Member that [Patient 1] was probably incontinent and/or needed some space, and said that we could take him to his room to change him. The Member replied "no", and stated that [Patient 1] needed to cool down.

d. [Patient 1] started trying punch the Member as she remained close to him. The Member stated she had to give [Patient 1] a pill, and asked me to get him a cloth.

e. The Member then grabbed [Patient 1] by the jaw and tried to administer some medication to him.

f. As [Patient 1] continued to try to punch the Member, the Member made a fist and put it in [Patient 1]'s face and said, I'll give you a bigger one", to which I replied, "that's not the right answer".

g. The Member did not reply but stopped and began fanning [Patient 1] with paper."

[RN 3]

[37] [RN 3] is a Registered Nurse working at the Facility. [RN 3] did not witness any of the incidents in the allegations. She received the RN handover report from the Regulated Member after the night shift on September 30, around 0700 hours. [RN 3] recalls the

Regulated Member saying she had an “awful, awful night” when she gave the handover report.

[38] The Regulated Member told [RN 3] that she was upset and frustrated that [Patient 1] did not have any other medications ordered or alternate routes to administer mediations in response to escalating aggressive behaviors. The Regulated Member told her that she thought the physicians could be more proactive in ordering more appropriate medications and doing psycho-geriatric assessments for pharmacologic management. The Regulated Member told [RN 3] that she had tried to give Seroquel and Ativan that were ordered, but [Patient 1] spat them out.

[39] The Regulated Member told [RN 3] that she tried other non-pharmacologic interventions including: “fanning him manually and rocking him in his wheelchair – like you would rock a baby.” [RN 3] states in her Affidavit that she is absolutely certain about this comment. She reported it to [RN 2] the same day she heard it. [RN 3] states that [Patient 1] remained upset and agitated on the day shift while she was there, in spite of interventions to calm his behavior.

SUBMISSIONS

Submissions by Conduct Counsel:

[40] Conduct Counsel noted that the onus of proof is on the Complaints Director and that the standard of proof is the balance of probabilities. Conduct Counsel reviewed the relevant information from the Affidavits and detailed how the evidence related to each particular in the allegations.

[41] Conduct Counsel submitted that each particular in the allegations was proven on a balance of probabilities. Conduct Counsel noted that there were many similarities between the evidence provided by the witnesses and the Regulated Member, including that the Regulated Member showed [Patient 1] her fist and stated something to the effect that hers was bigger, that the Regulated Member attempted to give [Patient 1] medication and that the Regulated Member fanned [Patient 1].

[42] With respect to shaking the wheelchair, both [HCA 1] and [HCA 2] stated they witnessed this and [RN 3]’s evidence is that the Regulated Member told her she had rocked [Patient 1] in his wheelchair “like you would rock a baby”. Although the Regulated Member denied shaking [Patient 1]’s wheelchair in the interviews during the Facility’s investigation, Conduct Counsel noted that there is no contrary sworn evidence. There is no sworn evidence from the Regulated Member in this hearing although she could have attended the hearing and provided evidence.

[43] Conduct Counsel submitted that any conflict in the evidence could be resolved based on the sworn evidence available to the Hearing Tribunal.

[44] Conduct Counsel also made submissions on why the conduct was unprofessional conduct and noted that the conduct is unprofessional conduct on the basis that it displays a lack of knowledge of, or a lack of skill or judgment in the provision of professional services; it contravenes the CARNA Standards of Practice and Code of Ethics; and is conduct that harms the integrity of the profession of nursing.

[45] Conduct Counsel noted that the conduct was unskilled in that the Regulated Member did not de-escalate [Patient 1]'s behavior. She did not follow the care plan or listen to the pleas of the HCAs. She tried to force him to take medication, raised her fist to the patient and made comments that could reasonably be perceived as threatening. With respect to the allegations related to documentation, documentation is a fundamental aspect of nursing. The patient chart is a legal document and must accurately reflect the medications given and what has occurred.

[46] Conduct Counsel submitted that the following provisions of the Standards of Practice were applicable: Standards 1.1, 1.2, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 3.1, 3.2, 3.3, 3.4, 4.2, 4.3, 5.2, 5.3 and 5.5. Conduct Counsel submitted that the following provisions of the Code of Ethics were applicable: A1, 2, 3, 4, 6, 12, 13; B1, 4; C3, 4; D1, 2, 4, 6, 13; and G1, 4.

Hearing Tribunal Questions:

[47] The Hearing Tribunal carefully reviewed and considered the evidence in the Exhibits. After a careful review of the Affidavit evidence, the Hearing Tribunal determined that it did not have any additional questions of the individuals who provided evidence by way of Affidavit. The hearing reconvened and the Chairperson advised that the Hearing Tribunal had considered the evidence and allegations and found the allegations to be proven.

[48] The Chairperson advised Conduct Counsel that the Hearing Tribunal was considering removing Standard of Practice section 4.3, adding Standard of Practice sections 4.1 and 5.9, removing Code of Ethics provisions C3, D4 and adding Code of Ethics provisions A5, 14, 15; C9, D8; F3 and G5.

[49] Conduct Counsel was provided an opportunity to make submissions on these changes. Conduct Counsel indicated that it was within the Hearing Tribunal's jurisdiction to do so and that in her view, the proposed changes were reasonable.

HEARING TRIBUNAL FINDINGS AND REASONS

[50] The Hearing Tribunal finds that the allegations are proven on a balance of probabilities and that the conduct constitutes unprofessional conduct. The Hearing Tribunal's findings and reasons are set out below.

[51] The evidence is clear that the Regulated Member worked the night shift at the Facility on September 29/30, 2018 and was responsible for providing care to [Patient 1].

<u>Allegation 1 (a)</u>

[52] [HCA 1] and [HCA 2] were directly involved and were able to provide first hand evidence. They both gave evidence that they witnessed the Regulated Member shaking [Patient 1]'s wheelchair aggressively, side to side. They describe that [Patient 1]'s body was going side to side, front to back and that he was yelling. [HCA 1] describes that the wheels were off the ground.

[53] [RN 3] also gave evidence about the rocking of the wheelchair. While she did not witness the incident, [RN 3]'s evidence is that the Regulated Member told her during the transfer of care that she had rocked [Patient 1]'s wheelchair, "like you would rock a baby."

[54] Both [HCA 1] and [HCA 2] observed the Regulated Member grab [Patient 1] by the jaw in an attempt to administer medication.

[55] Finally, [HCA 1] and [HCA 2] both witnessed the Regulated Member raise her fist to [Patient 1] and state something to the effect that hers was bigger. The Hearing Tribunal accepts that this remark could be perceived as threatening given that she was raising her fist to the patient.

[56] The Regulated Member denied that that she rocked or shook the patient's wheelchair during interviews that took place as part of the Facility's investigation. She admitted to trying to administer medication but denied grabbing the patient's jaw. She admitted to saying "mine is bigger" with respect to her fist, but stated that this was done in a joking manner. The Regulated Member's information is not sworn evidence and by failing to participate in the hearing, the Hearing Tribunal did not have the benefit of hearing from the Regulated Member.

[57] On the other hand, the Affidavit evidence from the witnesses provides sworn evidence. The Hearing Tribunal found the Affidavit evidence to be relevant and reliable and accepts the evidence of the witnesses. [HCA 1] and [HCA 2], who observed the incidents directly, provide consistent accounts of the events. Their observations are consistent with each other and their Affidavit is consistent with their written statements prepared the morning after the incident. In addition, the comment made by the Regulated Member to [RN 3] that she rocked the patient's wheelchair corroborates the accounts of [HCA 1] and [HCA 2].

[58] The evidence shows that [Patient 1] was upset. He was screaming and trying to punch the Regulated Member. [Patient 1]'s patient profile care plan and patient task sheet were attached to the Affidavit of [RN 1]. These provided strategies for managing [Patient 1]'s care including agitated or aggressive behavior. These were not followed by the Regulated Member. The Regulated Member did not appropriately manage [Patient 1] or de-escalate his behavior.

[59] The Hearing Tribunal finds that this allegation is proven on a balance of probabilities.

Allegation 1(b)

[60] The Regulated Member indicated during the Facility's investigation on October 4, 2018 that she administered or attempted to administer Ativan to the patient. The notes from the interview with the Regulated Member during the Facility's investigation are attached to the Affidavit of [RN 1].

[61] There is no documentation of this in the patient record. The patient chart, Nurses Daily Record and Medication Administration Record for the shift of September 29/30, 2018 are attached to the Affidavit of [RN 1]. None of these documents make reference to the administration or attempted administration of Ativan.

[62] Allegation 1(b) is proven on a balance of probabilities.

Allegation 1(c)

[63] There is an entry in [Patient 1]'s patient chart at 0103, 2018/Sept. 30, signed by the Regulated Member that "po Seroquel was offered, but resident spat it out." The Regulated Member also documented that the patient displayed aggressive behavior during shift 2300 to 0700. The entry was made at 0103 and not at the end of the shift. This is an inaccurate documentation of care and observations as the entry was made prior to the time to which it applies.

[64] Allegation 1(c) is proven on a balance of probabilities.

Allegation 1(d)

[65] The Regulated Member indicated during the Facility's investigation on October 4, 2018 that [Patient 1] had Ativan and became a bit calmer. There is no documentation of this in the patient record. The patient chart, Nurses Daily Record and Medication Administration Record for the shift of September 29/30, 2018 are attached to the Affidavit of [RN 1]. None of these documents make reference to Ativan or to any changes in [Patient 1]'s demeanor.

[66] Allegation 1(d) is proven on a balance of probabilities.

Unprofessional Conduct

[67] The Hearing Tribunal finds that the conduct in Allegations 1(a) to (d) constitutes unprofessional conduct. The Hearing Tribunal considered the following definition of unprofessional conduct:

> 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;
>
> …
>
> (xii) conduct that harms the integrity of the regulated profession;

[68] The conduct demonstrates a lack of knowledge, skill or judgment in the provision of professional services. Registered nurses are trained to deal with patients who are aggressive and to manage and de-escalate aggressive behavior. There were strategies in place to deal with [Patient 1]'s aggressive behavior. These were not followed by the Regulated Member. Instead, the Regulated Member shook the patient's wheelchair, grabbed his jaw and raised her fist to him, making threatening remarks. This conduct shows a lack of knowledge and skill in dealing with a patient and a serious lack of judgment.

[69] The documentation issues in allegation 1(b) to (d) also demonstrate a lack of knowledge or skill. Accurate and appropriate documentation is a basic skill expected of all registered nurses. A failure to document appropriately impairs the ability of the health care team to care for a patient and can place the patient at risk.

[70] In addition, the Hearing Tribunal finds that the conduct breaches several provisions of the Standard of Practice and Code of Ethics, as follows:

Standards of Practice

Standard One: 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.

1.4 The nurse practices competently.

Standard Two: Knowledge-Based Practice

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

Indicators

2.1 The nurse supports decisions with evidence-based rationale.

2.2 The nurse uses appropriate information and resources that enhance client care and the achievement of desired client outcomes.

2.3 The nurse uses ***critical inquiry*** in collecting and interpreting data, planning, implementing and evaluating all aspects of their nursing practice.

2.4 The nurse exercises reasonable judgment and sets justifiable priorities in practice.

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

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Standard Three: Ethical Practice

The registered nurse complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of *Health Professions Act* and CARNA bylaws (CARNA, 2012).

Indicators

3.1 The nurse practices with honesty, integrity and respect.

3.2 The nurse protects and promotes a client's right to autonomy, respect, privacy, dignity and access to information.

3.3 The nurse ensures that their relationships with clients are therapeutic and professional.

3.4 The nurse communicates effectively and respectfully with clients, significant others and other members of the ***health care team*** to enhance client care and safety outcomes.

Standard Four: Service to the Public

The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Indicators

4.1 The nurse coordinates client care activities to promote continuity of ***health services***.

4.2 The nurse collaborates with the client, significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation.

Standard Five: Self-Regulation

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

Indicators

5.2 The nurse follows all current and relevant legislation and regulations.

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

5.5 The nurse practices within their own level of ***competence***.

5.9 The nurse ensures their ***fitness to practice***.

Code of Ethics

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

3. Nurses build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a **conscious** effort. Such relationships are critical to understanding people's needs and concerns.

4. Nurses question, intervene, report and address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care; and they support those who do the same (see Appendix B).

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).

6. Nurses practice "within their own level of competence and seek [appropriate] direction and guidance . . . when aspects of the care required are beyond their individual competence" (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island, & Prince Edward Island Health Sector Council, 2014, p. 3).

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

13. Nurses work toward preventing and minimizing all forms of **violence** by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventive measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves (CNA, 2016a; CNA & CFNU, 2015; Canadian Nursing Students' Association, 2014).

14. When differences among members of the health-care team affect care, nurses seek constructive and collaborative approaches to resolving them and commit to conflict resolution and a person-centred approach to care.

15. Nurses support each other in providing person-centred care.

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.

4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical responsibilities:

4. Nurses are sensitive to the inherent power differentials between care providers and persons receiving care. They do not misuse that power to influence decision-making.

9. For any person that is considered incapable of consenting to care, nurses promote that person's participation in discussions and decisions regarding their care in a manner that is adapted to the person's capabilities.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.

2. Nurses support persons receiving care in maintaining their dignity and integrity.

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

8. In all practice settings where nurses are present, they work to relieve pain and suffering, including appropriate and effective symptom management, to allow persons receiving care to live and die with dignity.

13. Nurses treat each other, colleagues, students and other health-care providers in a respectful manner, recognizing the power differentials among formal leaders, colleagues and students. They work with others to honour dignity and resolve differences in a constructive way.

F. Promoting Justice

Nurses uphold principles of justice by safeguarding **human rights**, equity and **fairness** and by promoting the **public good**.

Ethical responsibilities:

3. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

4. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

5. Nurses maintain their **fitness to practice**. If they are aware that they do not have the necessary physical, mental or emotional capacity to practice safely and competently, they withdraw from the provision of care after consulting with their employer. If they are self-employed, they arrange for someone else to attend to their clients' health-care needs. Nurses then

take the necessary steps to regain their fitness to practice, in consultation with appropriate professional resources.

[71] Nurses are accountable for practicing in accordance with the Standards of Practice and Code of Ethics. The Regulated Member's conduct is a serious breach of the both the Standards of Practice and Code of Ethics.

[72] Finally, the Hearing Tribunal finds that the Regulated Member's conduct harms the integrity of the profession of nursing. Regulated Members are trusted to provide care to vulnerable individuals. The conduct by the Regulated Member was abusive and undermines this trust.

[73] The conduct of the Regulated Member is serious and constitutes unprofessional conduct under section 1(1)(p)(i), (ii) and (xii) of the HPA.

EVIDENCE ON SANCTION

[74] The Affidavit of [staff member 2], was entered as an Exhibit. [Staff member 2]'s evidence was that the Regulated Member's initial registration with CARNA was May 29, 2017, at which time she was issued a Temporary Permit. The Regulated Member was continuously registered with a Temporary Permit until she was issued an initial RN Permit on October 1, 2018 and was continuously registered with an RN Permit until September 30, 2019.

[75] The Regulated Member did not renew her practice permit and has not had a practice permit since September 30, 2019. On October 1, 2019, the Regulated Member's practice permit was suspended for non-renewal and payment of fees, and later cancelled, effective October 1, 2019, pursuant to section 43 of the HPA.

SUBMISSIONS ON SANCTION

Submissions by Conduct Counsel:

[76] Conduct Counsel made submissions on sanction. Conduct Counsel reviewed the Orders proposed by the Complaints Director. Conduct Counsel reviewed some of the factors in *Jaswal* v. *Newfoundland Medical Board*, [1996] N.J. No. 50, as follows:

1. The nature and gravity of the proven allegations: The conduct is extremely serious. It involves patient care and documentation. The conduct is unacceptable and must be denounced.

2. The age and experience of the member: The Regulated Member had been registered with CARNA since May 2017. However, she had been registered in other jurisdictions since 2014. She should have been well aware that the conduct was not acceptable.

3. The previous character of the member: There is no history of complaints or findings in Alberta and no information available regarding other jurisdictions.

4. The age and mental condition of the offended patient: [Patient 1] was an 82 year old individual with vascular dementia. He was a very vulnerable patient who could not remove himself from abusive behavior.

5. The number of times the offence was proven to have occurred: The incident occurred on one shift. There is no indication of a pattern of behavior.

6. The role of the registered nurse in acknowledging what occurred: The Regulated Member has not attended the hearing and appears to have left the jurisdiction. This is an aggravating factor as she has not taken accountability for her conduct.

7. Whether the member has already suffered other serious financial or other penalties: The Regulated Member was terminated from the Facility.

8. The impact on the offended patient: There was no evidence of long-lasting impact on the patient. However, the evidence indicates that his behavior escalated and he was in distress.

9. The presence or absence of any mitigating factors: Conduct Counsel was not aware of any mitigating factors.

10. The need to promote specific and general deterrence: These are important factors to ensure the Regulated Member does not repeat the behavior and that a strong message is sent to other regulated members.

11. Range of sentences in similar cases: Conduct Counsel provided some cases with similar conduct for review and consideration of the Hearing Tribunal.

[77] Conduct Counsel noted that the proposed Order would put a number of conditions on the Regulated Member's permit, should she become re-registered in Alberta. The proposed Order also ensures that further issues with the Regulated Member's practice would be identified. The proposed Order provides for self-reflection so the Regulated Member can consider her actions and how to prevent them. The proposed Order also serves the purpose of deterrence, both specific and general.

[78] Conduct Counsel proposed that this was a case where the award of costs would be appropriate. Conduct Counsel indicated that the Complaints Director was seeking 50% of costs. Conduct Counsel reviewed the decisions in *K.C.* v. *the College of Physical Therapists of Alberta* and *Wright* v. *College and Association of Registered Nurses of Alberta*.

[79] Conduct Counsel noted the seriousness of the conduct in this case and that the hearing was necessary. The Regulated Member did not cooperate and significant time and expense were required. An award of 50% of costs is reasonable.

Questions from the Hearing Tribunal:

[80] The Hearing Tribunal asked Conduct Counsel for additional submissions regarding the proposed fine and amount of costs. Conduct Counsel noted that a fine was important to denounce the conduct and send a strong message to the Regulated Member and the profession that this type of conduct will not be tolerated. She also provided additional

information regarding costs and additional submissions on why a portion of costs should be awarded in this matter.

[81] The Hearing Tribunal also asked questions relating to one of the proposed Orders for a practice improvement plan for frustration/anger management. The Hearing Tribunal indicated that it believed that this was already covered in the proposed Order for a Communication Improvement Plan and proposed removing the additional requirement. Conduct Counsel indicated that she did not object to this being removed.

[82] The Hearing Tribunal also noted its preference to reference a "mentor" rather than a "counsellor" in the Order, as a mentor could be either a registered nurse, or other health professional. Conduct Counsel had no objection to this.

REASONS FOR ORDER OF THE HEARING TRIBUNAL

[83] The Hearing Tribunal carefully considered the proposed Orders and submissions from Conduct Counsel. The Hearing Tribunal finds that the proposed Orders are generally appropriate and reasonable, although some adjustments have been made to reflect the matters noted above.

[84] The Hearing Tribunal views the conduct as very serious. Abuse of a patient is abhorrent and cannot be tolerated by CARNA. A very strong message must be sent to the Regulated Member and to the members of the profession generally. The reprimand and fine are appropriate to denounce the Regulated Member's conduct and to impose a punishment. Registered Nurses are trusted with the care of the most vulnerable patients. The public and patients must trust that patients will be cared for with compassion, competence and skill.

[85] The Orders also address public protection should the Regulated Member return to Alberta and seek to re-register with CARNA. Many of the Orders are remedial in nature, which will ensure that the Regulated Member practices competently and that the public is protected. There will be conditions in place to ensure the Regulated Member is appropriately supervised and that performance evaluations are done at certain intervals. The Regulated Member will be required to take courses and to create a Communication Improvement Plan, which will allow her the opportunity for self-reflection. There will be a requirement for counselling with a mentor in order to ensure that the Regulated Member is dealing with any issues that led her to conduct and that she is demonstrating insight into her behaviour. These orders are appropriate in the circumstances of this case.

[86] The Hearing Tribunal agreed that it was appropriate to order costs in this case. The Hearing Tribunal considered that the Regulated Member had not made any efforts to attend the hearing and take responsibility for her conduct. CARNA had to incur expenses and time in bringing this matter to a hearing. However, the Hearing Tribunal was also mindful that the costs should not represent a crushing financial blow to the Regulated Member. The Hearing Tribunal thought that a specific amount of costs should be ordered, and the Regulated Member given a period of time to pay.

ORDER OF THE HEARING TRIBUNAL

[87] The Hearing Tribunal orders as follows:

1. Siobhan Oriaifo shall receive a reprimand.

2. Siobhan Oriaifo shall pay a fine to CARNA in the amount of **$2,000.00**, payable upon the following terms: four payments of $500.00 payable every three months from the date of service of this Decision, payable over a one year period or upon such further payment plan that is acceptable to the Complaints Director, not to exceed 24 months from the date of this Decision.

3. Siobhan Oriaifo shall pay costs of the investigation and of this Hearing to CARNA fixed at $6,000.00, to be paid upon a payment schedule acceptable to the Complaints Director, not to exceed 36 months from the date of this Decision.

4. Siobhan Oriaifo's registration was cancelled by CARNA's Registration Department effective October 1, 2019 pursuant to section 43 of the Health Professions Act, RSA 2000, c H-7 ("HPA").

5. Should Siobhan Oriaifo be successful in being reinstated with CARNA and reissued a practice permit, the usual terms of fine and costs payment, as per 82(3)(c) of the HPA shall apply, whereby Siobhan Oriaifo may be automatically suspended for any then, or thereafter, outstanding non-payment of the fine or costs as set out above in paragraphs 2 and 3, respectively.

6. The balance of this Hearing Tribunal Order shall apply, should Siobhan Oriaifo be successful in being reinstated with CARNA and is reissued a practice permit.

7. Siobhan Oriaifo shall provide proof satisfactory to the Complaints Director **within six (6) months of obtaining a CARNA practice permit** that she has successfully completed and passed the following courses of study and learning activity:

    a. *Documentation in Nursing* (NURS 0162 – MacEwan University);

    b. *Leading Dementia Care* (NURS 0260 – MacEwan University) or *Nursing Clients with Dementia* (NCDEM014 – John Collins Consulting); and

    c. *CNA Ethics Modules* (available online).

8. Siobhan Oriaifo is only permitted to practice as a registered nurse under supervision of another registered nurse ("**RN**") or nurse practitioner ("**NP**"), and it is the responsibility of Siobhan Oriaifo to advise any prospective employer(s) of this restriction prior to obtaining employment. The nature of this supervision may be direct or indirect, meaning that an RN supervisor must always be in the same facility and working the same shifts as Siobhan Oriaifo, but need not be always present on the same unit for the entire shift. The supervision shall include the following:

    a. Review of Siobhan Oriaifo's charting and other documentation in the practice setting, by an RN or NP who acts in a supervisory capacity to Siobhan Oriaifo;

b. Consultation with recipients of Siobhan Oriaifo's nursing care, their family members, co-workers and colleagues by an RN or NP who acts in a supervisory capacity to Siobhan Oriaifo.

9. Prior to commencing employment as a regulated member of CARNA, Siobhan Oriaifo shall provide to the Complaints Director a letter from her prospective employer, signed by her prospective RN supervisor at the prospective employment setting:

    a. Listing the names of the RNs and/or NPs under whose supervision Siobhan Oriaifo will be working pursuant to paragraph 8 and confirming that those RNs and/or NPs have agreed to be supervisors and understand their duties;

    b. Confirming the RN supervisor has read the Decision of this Hearing Tribunal (including the allegations, findings and Order);

    c. Confirming the RN supervisor shall provide **two (2) Performance Evaluations** required by this Order, on the terms set out in paragraph 16 below;

10. Siobhan Oriaifo is prohibited from working as a regulated member of CARNA until she provides the letter required under paragraph 9 to the Complaints Director, and the Complaints Director approves the prospective employment setting.

11. Siobhan Oriaifo shall undergo individual counseling with a mentor (registered nurse or other health care professional approved by the Complaints Director), who has knowledge of the therapeutic communications expected of a registered nurse. The mentor will assist Siobhan Oriaifo to:

    a. Improve her communication skills with cognitively impaired patients; and

    b. Address how to appropriately manage her level of frustration/anger at work without directing it at patients or others at work.

12. **Within three (3) months of obtaining a CARNA practice permit** Siobhan Oriaifo shall provide proof that she has commenced counseling, as described in paragraph 11, to the Complaints Director.

13. **Within eight (8) months of commencing counseling** required under paragraphs 11 and 12 above, Siobhan Oriaifo must provide to the Complaints Director a report from the mentor, which must be satisfactory to the Complaints Director, and which must include the following:

    a. The mentor must confirm he/she has seen the Decision of this Hearing Tribunal (including the allegations, findings and Order);

    b. The mentor must confirm that Siobhan Oriaifo has attended a minimum of **eight (8) sessions**;

c. The mentor must describe the work that has been done with Siobhan Oriaifo to mentor, coach and assist Siobhan Oriaifo to improve her communication skills;

d. The mentor must describe the work that has been done with Siobhan Oriaifo to mentor, coach and assist Siobhan Oriaifo to appropriately deal with her issues of frustration/anger management;

e. The mentor must confirm that Siobhan Oriaifo has demonstrated insight into the problems with her communications with patients and has demonstrated insight into how to improve her behavior patterns;

f. The mentor must confirm that Siobhan Oriaifo has demonstrated insight into the problems with her frustration/anger and has demonstrated insight into how to effectively manger her frustration/anger at work so that she is not directing it at patients or others at work.

14. Siobhan Oriaifo shall create and provide to the Complaints Director a Communication Improvement Plan **within <u>three (3) months</u> of obtaining a CARNA practice permit** or **prior to next commencing employment** as a regulated member of CARNA, whatever comes first. The Communication Improvement Plan shall consist of the following:

    a. Siobhan Oriaifo shall create a list of at least five (5) unhelpful communication habits (eg. how to manage anger or frustration) that she has had that may inhibit effective communication/behavior with geriatric and/or dementia patients who are cognitively impaired;

    b. For each of those five (5) unhelpful communication habits (eg. how to manage anger or frustration), Siobhan Oriaifo shall come up with a written plan of how she will practice changing that negative habit into a positive communication strategy;

    c. Siobhan Oriaifo will create a list of indicators that will tell her new communication strategies/behaviors are successful.

15. **Within <u>six (6) months</u> of commencing employment** as a regulated member of CARNA, Siobhan Oriaifo shall provide the Complaints Director with specific examples of how she implemented the changes outlined in the Plan in paragraph 14.

16. The terms of the Performance Evaluations are as follows:

    a. Siobhan Oriaifo shall provide **<u>two (2)</u> Performance Evaluations** from her prospective employer, to be completed by her RN supervisor;

    b. The first Performance Evaluation is due **within <u>6 months</u> of commencing employment** as a regulated member of CARNA, at the new employer, covering at least **<u>750 hours</u>** of nursing practice (the "**First Performance Evaluation**");

c. The second Performance Evaluation is due **within <u>6 months</u> of the First Performance Evaluation**, covering at least an additional **<u>750 hours</u>** of nursing practice (the "**Second Performance Evaluation**");

d. Both Performance Evaluations must include the following:

i. The RN Manager must confirm that he/she has obtained feedback from the RN supervisors who were supervising Siobhan Oriaifo pursuant to paragraphs 8 and 9 above;

ii. The Performance Evaluations must specifically comment on all of the following:

- Administration of medications and medication charting, including:
  - critical thinking skills in determining the patient's medication needs and all steps taken prior to actual administration of the medication;
  - knowledge of medications;
  - administration of medications using the rights;
  - assessment of patient pre and post administration; and
  - documentation;
- Medication reconciliation;
- Charting, all aspects, plus narcotic records, incident reports;
- Assessment skills: both initial assessment and ongoing assessment of patients' conditions;
- Reporting the results of assessments to the appropriate persons, including other staff, charge nurse and physician; effective communication of all appropriate information to other staff/physicians regarding patient's condition;
- Implementation of appropriate nursing interventions based on the assessment;
- Setting priorities for patient care;
- Taking responsibility to ask questions or find necessary information;
- Specific skills that are necessary on the unit;
- Professional responsibility;
- Communication style with patients/families of patients - whether the style demonstrates respect, kindness, gentleness and compassion;
- Manner of interactions with patients when required to touch the patient – whether the manner demonstrates respect, kindness, gentleness and compassion;
- Following the policies of the unit regarding all aspects of nursing practice;
- Processing of physician's orders; and
- Any other issues that the supervisor thinks are relevant.

iii. The Performance Evaluations must indicate Siobhan Oriaifo is performing to the standard expected of a RN and that there have

been no problems related to the issues identified in the findings in the Decision;

iv. The Performance Evaluations must incorporate the elements of Siobhan Oriaifo's Communication Plan and indicate whether she has successfully implemented the Plan. The Performance Evaluation may be in the form of a checklist with room for comments or in the form of a detailed letter signed by the RN supervisor;

v. The Performance Evaluations must indicate that Siobhan Oriaifo has appropriately managed her frustration/anger in the workplace; it has not interfered with the provision of care to patients or working collaboratively with colleagues; and is not an issue;

vi. The Performance Evaluations must confirm that Siobhan Oriaifo is providing safe, compassionate care to all patients. The Performance Evaluations must be satisfactory to the Complaints Director in that the Complaints Director shall be satisfied from information in the Performance Evaluations that Siobhan Oriaifo has consistently demonstrated a high level of respect, kindness and compassion toward all patients and their families and her colleagues, and is otherwise practicing at the level expected of a registered nurse. The Performance Evaluations shall specifically comment on her practice as it relates to her attitude toward patients as demonstrated through her interactions with patients; and as demonstrated through her discussions about patients with other members of the health care team.

vii. The Performance Evaluations must confirm that the RN supervisor(s) had sufficient opportunities to personally observe Siobhan Oriaifo in her practice to provide informed input into the performance evaluations. The Performance Evaluations must also confirm that the RN supervisors have received information from other staff and patients regarding the RN care provided by Siobhan Oriaifo.

17. Until Siobhan Oriaifo has complied with paragraph 16 above she is prohibited from practicing as an RN in any setting except for the employment setting approved by the Complaints Director under paragraphs 9 and 10 under the supervision of the RN(s) approved pursuant to paragraphs 9 and 10. In the event Siobhan Oriaifo wants to change employers or employment sites prior to fully complying with paragraph 16 above, she must request permission from the Complaints Director who will have to approve an appropriate RN supervisor at the new employer and/or employment site, and require Performance Evaluation(s) from the approved employer as per paragraph 16 above, and Performance Evaluation(s) from the new employer as per paragraph 16 above for the time period deemed appropriate by the Complaints Director.

18. Once Siobhan Oriaifo has successfully complied with paragraph 16 above, she is no longer required to work under supervision.

19. For the **next two (2) years**, starting from the date the Complaints Director confirms that Siobhan Oriaifo has fully complied with paragraph 16, Siobhan Oriaifo must comply with the following:

    a. Siobhan Oriaifo must notify the Complaints Director of all new employment sites (if any) immediately prior to commencement of employment;

    b. Siobhan Oriaifo must provide proof that her supervisor at the new site has read the Decision of the Hearing Tribunal in this matter (allegations, findings and Order) within **one (1) month** of Siobhan Oriaifo's commencement of employment;

    c. Siobhan Oriaifo must provide to the Complaints Director annual letters from all current employment sites she has or will have over the two (2) year period. If Siobhan Oriaifo leaves the employ of any of these sites, she is required to provide a letter from her nursing supervisor at that site indicating there were no performance issues;

    d. The annual letters from Siobhan Oriaifo's employer(s) are due

        i. **One (1) year** from the date the Complaints Director confirms that Siobhan Oriaifo has fully complied with paragraph 16; and

        ii. **Two (2) years** from the date the Complaints Director confirms that Siobhan Oriaifo has fully complied with paragraph 16;

    e. The annual letters must contain the following information:

        i. Whether Siobhan Oriaifo has consistently demonstrated a high level of respect, kindness and compassion toward all patients and their families, and her colleagues and is otherwise practicing at the level expected of a registered nurse;

        ii. The annual letters shall specifically comment on her practice as it relates to her attitude toward patients as demonstrated through her interactions with patients; and as demonstrated through her discussions about patients with other members of the health care team;

    f. The annual letters must be satisfactory to the Complaints Director in that the Complaints Director must be satisfied from information in the letters that Siobhan Oriaifo has consistently demonstrated a high level of respect, kindness and compassion toward all patients and their families, and her colleagues and is otherwise practicing at the level expected of a registered nurse.

COMPLIANCE

20. Compliance with this Order shall be determined by the Complaints Director of

CARNA. All decisions with respect to Siobhan Oriaifo's compliance with this Order will be in the sole discretion of the Complaints Director.

21. Proof of compliance with all requirements under this Order must be received by the Complaints Director of CARNA by the deadlines set out in the Order. If the Complaints Director deems it appropriate, and for the sole purpose of permitting Siobhan Oriaifo to proceed toward compliance with this Order, the Complaints Director may in her sole discretion grant extensions or make other minor adjustments to the Order that are in keeping with this Hearing Tribunal Order, without varying the substance of the Order.

22. Should Siobhan Oriaifo 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 the HPA, and, in so doing, may rely on any non-compliance with the this Order as grounds to make a recommendation under section 65 of the HPA which may include suspension of Siobhan Oriaifo's practice permit.

23. The responsibility lies with Siobhan Oriaifo to comply with this Order. It is the responsibility of Siobhan Oriaifo to initiate communication with CARNA for any anticipated non-compliance and any request for an extension.

CONDITIONS

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

    a. *Must pay fine (Call CARNA);*

    b. *Must pay costs (Call CARNA);*

    c. *Course work required (Call CARNA);*

    d. *Must practice under supervision (Call CARNA);*

    e. *Letter from employer required (Call CARNA);*

    f. *Mentoring required (Call CARNA);*

    g. *Must complete Practice Improvement Plan(s) (Call CARNA);*

    h. *Performance Evaluation(s) required (Call CARNA);*

    i. *Restricted re employment setting (Call CARNA);*

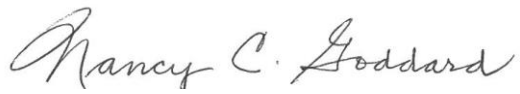
    j. *Annual letter(s) from employer required (Call CARNA).*

25. Effective the date of this Order if, notifications of the above conditions shall be sent out to Siobhan Oriaifo's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which Siobhan Oriaifo is also registered (if any).

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

27. This Order takes effect on the date of this Decision and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

Respectfully submitted,



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Nancy Goddard, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: May 19, 2020