COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

RE: CONDUCT OF **EDEM EKPE** AND R.N, REGISTRATION **#112,587**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

NOVEMBER 15, 16, 17, 18, 2022

INTRODUCTION

A hearing was held on November 15, 16, 17, and 18, 2022 at the College of Registered Nurses of Alberta (the "**College**" or "**CRNA**") by the Hearing Tribunal of the College to hear a complaint against Edem Ekpe, R.N., Registration #112,587. The parties provided written closing submissions on the allegations to the Hearing Tribunal on January 19, 2023 and the Hearing Tribunal met for deliberations on January 25 and 26, 2023.

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, RN Chairperson
Jofrey Wong, RN
Kevin Kelly, Public Representative
Sarita Dighe-Bramwell, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. CRNA Representative:

Kate Whittleton, Conduct Counsel
James Hart, Conduct Counsel (attending by videoconference)

d. Registrant Under Investigation:

Edem Ekpe (sometimes hereinafter referred to as the "**Registrant**")

e. Registrant's Counsel:

Tanya Kuehn, KC

f. Registrant's Labour Relations Officer:

Michelle Bogdan (attending by videoconference)

g. CRNA Staff:

Diana Halabi, Complaints Clerk (attending by videoconference)

PRELIMINARY MATTERS

Conduct Counsel and Registrant's 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. No preliminary applications were made.

The hearing proceeded at the offices of the College with some participants, including witnesses, attending by video conference.

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 unless an application was made to hold the hearing or a part of the hearing in private.

An application was made by Conduct Counsel to close the hearing for the portion of the hearing where the patient identified herself for the record and to identify her as [Patient 1] in the proceedings. Conduct Counsel noted that allegations 4(a),(b),(h) were being withdrawn by the Complaints Director. Conduct Counsel also requested an order under section 78(4) of the HPA excluding witnesses from attending as observers until they had given their evidence. Conduct Counsel noted that certain facts were agreed to in an Agreed Statement of Facts and that an Agreed Book of Exhibits had been prepared.

Registrant's Counsel also requested that the hearing be held in private for the purpose of the Registrant introducing himself. The application was made under section 78(1)(a)(i) of the HPA, which addresses possible or probable prejudice to the prosecution of an offence. Registrant's Counsel noted that the application was made to ensure that the Registrant's Charter rights were not infringed. Registrant's Counsel stated that although the Registrant was already identified in the Notice of Hearing, published on the College's website, the application was made to not continue to add information to what is in the public forum. Registrant's Counsel also requested that the Registrant not be identified by name in the transcript.

Conduct Counsel indicated that she took no position on the request for the hearing to be closed for the purposes of the Registrant identifying himself for the record.

The Hearing Tribunal asked Registrant's Counsel whether section 76(2) of the HPA which provides that evidence in the hearing cannot be used in another proceeding would address the Charter issue raised. Registrant's Counsel noted that the concern was broader than only the Registrant's evidence, and that evidence of other witnesses would be available to be used to a prosecutor in a criminal matter if the Registrant was identified in the transcript. Registrant's Counsel had no case law to provide to support the application.

The Hearing Tribunal considered the various preliminary matters. The Hearing Tribunal considered that the default is that hearings are open to the public. The reason for this is to have accountability and transparency in disciplinary proceedings. In addition, the request appeared to be to shield the Registrant from possible criminal prosecution. However, under section 80(2) of the HPA, if the Hearing Tribunal has reasonable and probable grounds to believe that the Registrant has committed a criminal offence, it must refer the matter to the Minister of Justice. Further, no case law was provided to support closing the hearing to protect Charter rights and so Registrant's Counsel had not met the burden of showing that the open hearing principle should be varied in this case. As such, the Hearing Tribunal determined that it would not close the hearing for the purpose of the Registrant introducing himself nor would his name be anonymized from the transcript.

However, with respect to the patient, identified as [Patient 1], the Hearing Tribunal noted that the HPA, section 78(1)(a)(iii), contemplates that a hearing, or a portion of a hearing, can be held in private to protect a person's personal and health information if "not disclosing a person's confidential personal, health, property or financial information outweighs the desirability of having the hearing open to the public". Given the nature of the allegations, the Hearing Tribunal viewed that it was appropriate in this case to hold the portion of the hearing for [Patient 1] in private in

order to not identify the patient. The Hearing Tribunal directed that the patient's testimony would be given in a closed portion of the hearing and that the patient would be identified in the hearing and transcript using the initials AB. The Hearing Tribunal was mindful in preparing its written decision that there be no personal identifying details for [Patient 1].

ALLEGATIONS

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

[redacted]

5. Further or in the alternative to Allegation 4, the Registrant, while attempting to place an intermittent catheter on [Patient 1], displayed a lack of skill or judgment and/or violated a code of ethics or practice standard when he did one or more of the following:

    a) failed to follow his employer's intermittent catheter insertion technique and policy;
    b) failed to ensure adequate lighting in [Patient 1]'s room;
    c) failed to gather and bring all necessary supplies, including a second catheter;
    d) failed to follow appropriate steps when unable to locate [Patient 1]'s urethra, including asking the patient bear down or cough;

    [redacted]

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 *Health Professions Act*, including:

1. The conduct underlying Allegations 1, 2, 3, and 5 contravenes one or more of the following: the CNACE; the CPSRM; and the CDSRM; and/or
2. The conduct underlying [redacted] as defined by [redacted] and contravenes one or more of the following: the CNACE; the CPSRM; and the [redacted]

EXHIBITS

The following documents were entered as Exhibits:

EXHIBIT	**DESCRIPTION**
Exhibit #1:	Agreed Book of Exhibits with Index

TAB A:	Complaint received January 19, 2022
TAB B:	Notice to Attend a Hearing, dated August 25, 2022
TAB C:	Amended Notice to Attend a Hearing, dated November 7, 2022
TAB D:	Registrant's Resume
TAB E:	Standardized Provincial Job Description – Clinical (RN), dated January 2, 2020
TAB F:	Job Summary – Spine RN (undated)
TAB G:	Health Care Record of [Patient 1] - Orders - Flowsheets - Spinal Assessment Sheets - Intake and Output Flowsheets - Additional Multidisciplinary Progress Records
TAB H:	Unit 101 Floor Plan (AHS)
TAB I:	AHS Policy – [redacted]
TAB J:	AHS Clinical Care Topic – Intermittent Urinary Catheters dated May 1, 2021
TAB K:	AHS Clinical Care Topic – Intermittent Catheterization Aseptic Technique Checklist dated September 15, 2019 **(the "Intermittent Catheterization Checklist")**
TAB L:	Clinical Neurosciences – Foothills Medical Centre – Nursing Orientation: Skill Stations Workbook
TAB M:	CNA Code of Ethics
TAB N:	CRNA Standards - Documentation Standards for Regulated Members (2013) - Practice Standards for Regulated Members (2013) [redacted]

TAB O: Health Care Record of [Patient 2]

Exhibit #2: Agreed Statement of Facts;

Exhibit #3: AHS Delirium Pamphlet

Exhibit #4: CRNA Certificate of Completion The Essentials of Nursing Documentation

Exhibit #5: [HCA Co-worker], CRNA Interview Redacted

Exhibit #6: [Patient 1], CRNA Interview Redacted

The following individuals were called as witnesses for the Complaints Director:

[Witness1],RN
[Witness 2], RN
[Patient 1]
[Patient 2]
[Witness 3], LPN
[Witness 4], RN
[Witness 5], RN
[Witness 6], RN

The following individuals were called as witnesses for the Registrant:

[Witness 7], RN
Edem Ekpe, RN

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

[Witness 1], RN

[Witness 1] is a Registered Nurse. In December 2021, Ms. [Witness 1] was the Unit Manager for Unit 101, acute spines and Unit 112, acute neurosciences at the Foothill Medical Centre ("**FMC**"). Ms. [Witness 1] reviewed the orientation for new nurses on Unit 101. She described FMC as a large, very specialized and highly acute and fast-paced hospital. Unit 101 is a specialized unit for spine surgeries. It is a 19-bed unit with an overcapacity space. Most patients are postoperative patients who have undergone spinal surgery. Unit 101 is generally full or overcapacity.

Unit 101 has shift rotations on a 12-hour basis. During the day shift there would be five nurses, one nurse clinician and two health care aide ("**HCA**") supports. For the night shift, there were four nurses, one nurse clinician and one HCA. The nursing station is at the center of the Unit.

Ms. [Witness 1] testified about the patient complaint she received regarding the Registrant and the internal FMC investigation of the complaint. She confirmed that she issued a letter of complaint to CRNA. In her investigation of the matter, she did not speak to [Patient 1]. As part of the investigation there was a question of talking to [Patient 1]'s roommate, but the roommate had exited the recovery room shortly after the Registrant had started his shift and was asleep for most of the shift, so it was felt that the roommate would not be a good witness.

Ms. [Witness 1] described the procedure of a female intermittent catheterization. Ms. [Witness 1] noted that it is common to have trouble landmarking for female catheterizations. Alberta Health Services ("**AHS**") has clinical care topics, which provide information, including on catheterizations. The Intermittent Catheterization Checklist includes an aseptic checklist, an outline of the steps to be followed for male and female catheterizations and neonates and troubleshooting information (Exhibit 1, Tab K).

[Witness 2], RN

[Witness 2] is a Registered Nurse. In December 2021, she was the Manager of the Calgary Spine Program, Units 101 and 112, at FMC.

Ms. [Witness 2] gave evidence about the patient population on Unit 101, which includes elective spine patients, emergency spine surgeries and spinal cord injury patients. She testified about the orientation received by new nurses on Unit 101. She identified the Nursing Orientation: Skills Stations Workbook (Exhibit 1, Tab L) which is used in the orientation of new nurses on the Unit.

Ms. [Witness 2] received an email from Ms. [Witness 4], the charge nurse who was working the overnight shift on December 23, 2021, who alerted her to the incident involving the Registrant. Ms. [Witness 2] went into work early the morning of December 24, 2021 to give herself extra time to address the matter. Ms. [Witness 2] gave evidence about the process she undertook the morning of December 24, 2021 to investigate the allegations.

Ms. [Witness 2] described the process for intermittent catheterization. Ms. [Witness 2] testified about the location and layout of room 23, which was [Patient 1]'s room. [Patient 1] was in the bed closest to the door. Ms. [Witness 2] testified that [Patient 1] described trying to find and press the call bell, but [Patient 1] was not sure if she did press the call bell. Ms. [Witness 2]'s interpretation was that [Patient 1] could not necessarily find the call bell or could not press it, rather than there being an actual problem with the call bell. [Patient 1] told Ms. [Witness 2] she asked her roommate to press her call bell to call for help.

[Patient 1]

[Patient 1] is [age] years old. [Patient 1] was admitted to the FMC on December 23, 2021 for spinal surgery. [Patient 1] testified that the first thing she recalled after surgery was waking up in the room and a female nurse was checking her different senses and different parts of her body. She believed this was around 1600 hours. She had a roommate in the room. There were sheets and blankets on the bed and a pillow. [Patient 1] testified that she was not wearing a gown. Her pain was very bad.

[Patient 1] testified that the first time she looked at the clock it was 1600. She first met the Registrant around 1930. He came to introduce himself to her and they had a short conversation. He did not provide any other care at that time.

[Patient 1] stated that within about a half hour or hour, her bladder was getting full. Someone brought her a bedpan and put it under her and left so she could have some privacy. She was not able to go. They checked her bladder and discovered her bladder was full. She was told they would contact the resident doctor to get an order for a catheter. They came in and said it was approved and would be calling her nurse to do the procedure. The Registrant was not there at this time. She was familiar with the procedure, as she had previous catheters done.

[Patient 1] testified that the Registrant came in to do the catheterization between 2030 and 2100. [Patient 1] stated that he had not provided her nursing care prior to the attempted catheterization. She stated she was wide awake. The only source of light was the light over the sink. The Registrant came in and organized his supplies on a table and chair that were in the room. She told him that the bedpan was underneath her and he removed it from underneath her buttock. He had already put his gloves on. He did not talk to her about the procedure or seek consent for the procedure. In terms of her positioning, she described that her legs were somewhat open so that he could apply the iodine.

[Patient 1] testified that after he applied the iodine, she mentioned to the Registrant that he might want to turn on the light behind her so he could see what he was doing a little better, that she could not reach it and that it was over her shoulder. He went over behind her and looked like he was going to put it on and then he hesitated and said, "no, I think I can see well enough." He did not turn on the light.

[Patient 1] stated that the Registrant used a lot of iodine. She could feel it on her thighs, her buttocks, her whole genitalia area. She had a hard time moving her head. She could see the Registrant's proximity, but not what he was do [redacted] That part of her body was exposed, but she was holding a sheet over her chest area.

[redacted] She told him they needed to get someone in to help. She wanted to call someone and he said that he would go and get help. He put down the tube and container and then went and walked outside the curtains. He held onto each side of the curtain and stood there for a few seconds. He still had his gloves on. Then he went down the hallway within the room and then turned around and came back in. She told him he could remove his gloves and he removed them. She went to use the call bell but the Registrant said that he would go and get someone to help finish the procedure. He reached for the call bell, but did not end up using it.

[redacted] [Patient 1] testified that she then asked her roommate to please call her nurse. [Patient 1] testified the nurse's name was [Witness 3] (being [Witness 3]). The roommate called her nurse and told her that [Patient 1] needed to see her. [Patient 1] told Ms. [Witness 3] what had happened. She asked to speak to the head nurse and Ms. [Witness 3] went to get her. [Patient 1] told the charge nurse, who she said was named [Charge Nurse], what occurred. [redacted]

[Patient 1] stated that she asked if she could contact her family. They were not able to be in the hospital because the snowstorm was so bad and some family was out of the country.

The next morning, the Unit Manager, named [Witness 2], came to speak to her about what had happened.

In cross-examination, [Patient 1] confirmed that there was a male nursing aide with Ms. [Witness 3]. They were both there when [Patient 1] first stated what had happened. She confirmed that she spoke to her parents, her children (they were together on speaker phone) and her fiancé. [Patient 1] confirmed that [Charge Nurse], the charge nurse, was named [Charge Nurse 2].

[redacted]

[redacted]

[Patient 1] confirmed that at one point during her hospital stay she was feeling light-headed and not quite right. It did not last but she did talk to a nurse about it.

In response to questions from the Hearing Tribunal, [Patient 1] described the iodine application. She stated that it felt very wet, there was lots of it and it was applied over a large area. She saw the Registrant holding a sponge-like object or a swab.

[Patient 2]

Prior to [Patient 2] giving evidence, Conduct Counsel requested that the hearing be closed for the portion of the hearing where [Patient 2] would be affirmed and identified on the record. Registrant's Counsel took no position on the application. The Hearing Tribunal directed that the hearing would be closed while the affirmation was administered and [Patient 2] identified but that the remainder of her evidence would be in an open hearing.

[Patient 2] is [Age] years old. She had a stroke in 2018. [Patient 2] was sharing a room with [Patient 1] at the FMC on December 23, 2021. She recalled that a male nurse came in for her

[redacted]

[Patient 2] said that she felt good at the time, she had clarity and could go to the bathroom on her own. She felt strong. She was not drowsy. She was wide awake.

[Patient 2] indicated that when the male nurse left the last time, [Patient 1] asked her in a stern voice to call the front desk. [Patient 2] used the call bell and her nurse came in within a minute. [Patient 2] told her nurse that her roommate was asking for support or help. [redacted]

[redacted] The nurse said there was no one from management in the hospital that evening, and asked if she could wait until the morning.

[redacted] [Patient 1] made a few phone calls, first to her husband and then to her mother. [Patient 2] stated that the husband and mother were not in no shape for driving and that [Patient 1] told her that her mother was in no shape to drive. [Patient 2] did not recall hearing [Patient 1] speaking to her children on the phone.

[Patient 2] testified that the events occurred over a period of one and a half to two hours. [Patient 2] heard [Patient 1] recall the events to only one nurse. [Patient 2] gave her opinion on what she believed had or had not occurred.

[Witness 3], LPN

[Witness 3] is a Licensed Practical Nurse. She described Unit 101 as a very busy unit. On December 23, 2021, Ms. [Witness 3] was responsible for [Patient 2], who was her patient. [Patient 1] was [Patient 2]'s roommate. Ms. [Witness 3] testified that [Patient 1] was unable to void, was in pain crisis and Ms. [Witness 3] had to perform an intermittent catheterization on her.

Ms. [Witness 3] provided care to [Patient 1] because the charge nurse asked her to do a catheterization. She grabbed her tools and asked the nursing attendant, [HCA Co-worker], to help her because if the patient is big, you may need another person to help you hold their legs. When Ms. [Witness 3] entered the room, the dim light over the patient's bed was turned on. Ms. [Witness 3] turned the bright light on because she was going to be doing an intermittent catheterization. [Patient 1] was wearing a gown.

Ms. [Witness 3] described that there are two lights above the patient's bed. They are rectangular. One is the bright light, which is white and is located on the ceiling. The other is the dim light. The switch for the bright light is behind the patient's bed.

[redacted]

Ms. [Witness 3] told [HCA Co-Worker] that she could do the catheterization by herself. [Patient 1] told Ms. [Witness 3] that the Registrant was really nice, really caring, but then he did the catheterization.

Ms. [Witness 3] confirmed that she went to the room because the charge nurse asked her to and not in response to a call bell. She did not speak to [Patient 2] first. She went to [Patient 1] because the charge nurse asked her to help [Patient 1].

Ms. [Witness 3] did not recall [Patient 1] being covered in iodine, and would have noticed if there was more iodine colouring than normal. [redacted]

[Witness 4], RN

[Witness 4] is a Registered Nurse. She has been a Registered Nurse for three years. In December 2021, she worked in Unit 101 at FMC. At the time, she generally worked as a floor nurse, but if they were short a charge nurse, then sometimes she worked as charge nurse as well.

On December 23, 2021, Ms. [Witness 4] was charge nurse on Unit 101. That shift was the first time she met the Registrant and the last time she had any interactions with him.

Ms. [Witness 4] described her interactions with [Patient 1]. [Patient 1] wanted to go to the bathroom. Ms. [Witness 4] stated she believed she helped her onto a bedpan. She was not able to void. Ms. [Witness 4] did a bladder scan and Ms. [Witness 4] offered for [Patient 1] to get an intermittent catheter done. Ms. [Witness 4] explained the procedure to her and [Patient 1] wanted the catheter done. Ms. [Witness 4] went to tell the primary nurse, the Registrant, to do an intermittent catheter. Ms. [Witness 4] stated that she believed [Patient 1] said she was in too much pain to try to void again.

Ms. [Witness 4] testified that the Registrant came out of [Patient 1]'s room and told her he could not get the catheter. Ms. [Witness 4] stated that this was in the hallway by [Patient 1]'s room. She was coming from another patient's room and he was leaving [Patient 1]'s room and they crossed paths. Ms. [Witness 4] told him that she would get another co-worker to attempt it. Ms. [Witness 4] spoke to Ms. [Witness 3] who went to attempt it with a nurse attendant.

After a few minutes, Ms. [Witness 3] and the nurse attendant called for her to come to the room. [redacted] Ms. [Witness 4] told her that since it was the night shift and close to the holidays, she was not sure who she would be able to get in touch with, but that the manager would be there in the morning.

Ms. [Witness 4] went and got the number for patient relations, provided [Patient 1] with the portable phone in case she wanted to call her family members and then she paged the resident. She also emailed her manager, Ms. [Witness 2], to let her know about the incident.

[redacted]

Ms. [Witness 4] got phone calls from [Patient 1]'s daughter, husband and mother. At around 230 or so, [redacted] Ms. [Witness 4] tried to reassure her and told her the Registrant had left the hospital. Ms. [Witness 4] stated that she believed one of her co-workers had gone into the room to see the roommate and [Patient 1] asked the co-worker if she could get Ms. [Witness 4].

Ms. [Witness 4] indicated that once a catheter is inserted, there would like be about 200 or 300 mils of urine output in a minute and within a couple of minutes the bladder would be completely empty.

[redacted]

Ms. [Witness 4] confirmed that she never saw or spoke to [Patient 2].

[Witness 5], RN

[Witness 5] is a Registered Nurse. She graduated with a Bachelor of Nursing in 2018. She works on Unit 101 and worked there in December 2021. She first met the Registrant during his training. She last saw him on December 23, 2021.

On December 23, 2021, Ms. [Witness 5] worked the day shift. She first encountered [Patient 1] when she admitted her around 1700 to 1730. [Patient 1] came in on a stretcher. Ms. [Witness 5] met her in the hallway. She transferred her to her bed and then did the assessment. She performed an initial assessment of [Patient 1]. She described [Patient 1] as alert, awake and in a little bit of pain, but did not remember her being overly confused.

Ms. [Witness 5] described the process for admitting someone. They do a head-to-toe assessment, including a spinal assessment and vital signs, then they do all documentation required. The spinal assessment is done using a pin to assess for sharp sensation. The patient tells if they feel sharp, dull or nothing. A cotton swab is used to assess for soft sensation.

[Patient 1]'s chart for sensation was reviewed. For certain areas on the left side, [Patient 1] did not have as much sensation as she did on the right.

At the end of her shift, Ms. [Witness 5] did hand over for [Patient 1] to the Registrant. The next time she saw [Patient 1] was when she returned for her shift the next day. [Patient 1] told her what had happened.

[Witness 6], RN

[Witness 6] is a Registered Nurse and became registered in May 2015. In December 2021, she worked on Unit 101 at the FMC.

On December 23, 2021, she worked a shift from 2300 to 730 the next morning. She recalls receiving a phone call from the family of [Patient 1]. She asked the Registrant if he wanted to take it and he said no, he was not [Patient 1]'s nurse anymore and so was not able to take the phone call. Ms. [Witness 6] took the call and then went to find the charge nurse.

Ms. [Witness 6] took over care of [Patient 1] and performed intermittent catheterizations for her. Ms. [Witness 6] described [Patient 1] as pleasant and cooperative.

[Witness 7], RN

[Witness 7] is a Registered Nurse. She was a classmate of the Registrant at the University of Calgary. They first met in January 2019. The program was a two-year program for previous degree holders or for licensed practical nurses.

Ms. [Witness 7] described her program, her friendship with the Registrant that developed during the course of the program. She testified about the Registrant's good character and work ethic.

Edem Ekpe, RN

Edem Ekpe gave evidence about his background. He described his educational and work history prior to coming to Canada and once in Canada. He gave evidence about his family and his community work.

The Registrant came to Canada with his family in 2013. He became a licensed practical nurse in 2018. He completed his Bachelor of Nursing program in February 2021.

The Registrant had two days of orientation training at FMC. He does not believe there was specific training for a female intermittent catheterization during orientation. Part of the orientation process was to work with training buddy nurses. He did a male catheterization with one of his training buddy nurses. When doing the catheterization, they did not refer to a policy. He testified that he did not recall having a conversation about the AHS intermittent catheterization policy until the AHS internal investigation.

The Registrant described Unit 101 at the FMC as a very fast unit. It was his first acute care experience since graduating as an LPN in 2018.

The Registrant stated that [Patient 1] was the first female intermittent catheterization he had performed himself. He felt confident that he could do it. He had done a female intermittent catheterization twice, once as an LPN student and once as a bachelor nursing student. He had also observed at least one.

The Registrant testified that December 23, 2021 was his second solo shift on the Unit. He was scheduled for a four-hour shift from 1915 to 2315. He worked the full shift. He had three patients when he started his shift. He took his patient assignments on the board, printed up the patients' histories to read for himself the status of his patients. He then took report from Ms.[Witness 5]. He described that his practice would be to prioritize where to go first and to do his initial rounds with each patient, which included doing a general head-to-toe assessment and vital signs.

The Registrant stated that, in his first round with [Patient 1] he introduced himself, he identified her and checked her band. He told her he would do an assessment. [Patient 1] got a call from her mother and [Patient 1] was sobbing and crying. She was in a lot of pain. She had mentioned the pain to him and mentioned it to her mother. She told her mother that the nurse was there and she had to go. She told the Registrant that her mother was in Arizona. [Patient 1] had an ice pack and was in a gown. Ms. [Witness 5] had informed him that she had an ice pack. He determined that [Patient 1] was alert and oriented to person, place and time.

The Registrant testified that in this first visit, he took [Patient 1]'s vital signs and did a head-to-toe assessment. The Registrant estimated that this took about 10 minutes. The Registrant did a second assessment where he did a spinal assessment. This was done at 2030. He was unable to do some of the tests because [Patient 1] was in so much pain.

The Registrant stated that just as he was about to finish the assessment, he was called on the speaker in the Unit and advised that his fourth patient had arrived. He was charting at the nursing station following the admission of the new patient when Ms. [Witness 4] came to tell him that [Patient 1] needed a catheter. He completed his charting and then went to pick up his supplies. He collected a catheter tray, a catheter, a blue pad and sterile gloves. He put extra gloves in his pocket. The Registrant explained the difference between clean gloves and sterile gloves. He was wearing clean gloves when he entered the curtained area around [Patient 1]'s bed. [Patient 1] was lying supine, with her knees up and a drape over her. The drape is a light blanket used to provide privacy. He removed the bedpan that was under [Patient 1].

The Registrant described the lighting as coming from the window facing the nursing station, above the sink and the light in the room above the sink. He did not think about the level of lighting at that time. He was wearing a mask and goggles. He cleaned the table and set up his sterile field. He opened the catheter tube and taped it to the table. He opened the tray which has a drape, forceps, lubricant, sterile gloves and one pack with three iodine swabs. The sterile gloves in the tray are too small for his hands so he put them in the trash. He did not use the drape. In his training he had learned that the drape can get in the way. He put on the sterile gloves. He pulled out the catheter tube and lubricated it. He placed the tray with the Betadine swabs between [Patient 1]'s thighs. With his nondominant left hand, he separated the labia. He used his elbow to anchor [Patient 1]'s right leg that was closer to him. He used the Betadine swabs to clean the area. One swab is used for each side of the labia minora and then discarded. He used the third swab to clean the area where he thought the urethra was located and then discarded it.

The Registrant testified that he then lifted the end of the tube from the tray and attempted to insert it in the urethra. It went in for about a centimeter and a half and then he felt resistance. He wiggled it a bit to see if it took and then he withdrew it. At that point, he realized that he did not have enough light. He removed his left hand from the labia and was going to turn on the overhead light, but then realized that if he did so, he would break the sterile field. He then brought his left hand back onto the labia. He attempted again and inserted the tube about two inches. He looked down for urine return but there was none. At that point he stopped and said he would go and get someone else to do the procedure. He told [Patient 1] to use the call bell. [Patient 1] pressed the button and he stood there for a few seconds and he did not hear any response. He walked out to look through the window into the hallway and saw that there was no one at the nursing station. He went back and told [Patient 1] that he needed to go get someone and she agreed with him. He packed up his supplies and turned on the overhead light. He saw that there were approximately 10 to 15 mils of urine in the tray and showed this to [Patient 1]. He realized then that he had in fact inserted the tube into the urethra the first time. He put all the supplies in the trash.

The Registrant testified that he did not recall [Patient 1] saying anything except to agree with him that he needed to get somebody. He left the room and saw Ms. [Witness 4], the charge nurse, and a male nurse [Nurse Co-worker] and he told Ms. [Witness 4] that he could not get the catheterization. He went to get [Patient 1]'s medication and brought it to Ms. [Witness 3] who was with [Patient 1]. Ms. [Witness 3] told him to give them to Ms. [Witness 4], so he went back into the hallway and gave them to Ms. [Witness 4]. At that point, Ms. [Witness 4] told him that [Patient 1] no longer wanted him as her nurse. He felt shame that he was not able to do the female intermittent catheterization and that the patient had rejected him. This occurred around 2130. He stayed for the rest of his shift. He gave handover report for his three other patients. He did not give handover report for [Patient 1] because she was no longer his patient. He stayed past his shift, until close to midnight, to complete charting for his [redacted] He admitted that he forgot to chart the attempted catheterization for [Patient 1]. The Registrant testified that given the incident and his failure to chart, he decided to complete a course in documentation. The course was completed in February 2022 (Exhibit 4).

The Registrant clarified that when he wears goggles, they will sometimes fog up. He will hold his breath and pull back from the patient. He clarified that he did not explain to [Patient 1] step by step what he was doing.

The Registrant stated in cross-examination that he asked [Patient 1] about the catheterization, although he did not use the word consent, and she agreed to the procedure. However, he did not explain the procedure or what he was doing throughout the procedure. The Registrant denied that [Patient 1] asked him to turn on the light. However, he agreed that the lighting was not adequate. The procedure was his first independent female intermittent catheterization.

The Registrant confirmed that there is a window above the sink and from the window, you can see the nursing station. There is a light above the window. The window is approximately 2.5 to 3 feet wide by 4 feet tall. He confirmed that he had two 8-hour classroom education days at FMC and nine 12-hour buddy shifts.

Admission of [Patient 1] Statement to CRNA

Registrant's Counsel sought to admit [Patient 1]'s statement to CRNA as an exhibit. Conduct Counsel objected on the basis that the statement was not written by [Patient 1] but rather by the College investigator. Conduct Counsel noted that the Hearing Tribunal heard the testimony of [Patient 1], which was the best evidence. The statement should not be introduced for the truth of its contents. [Patient 1] had already testified that she had an interview with the investigator and so it was not necessary to admit the statement for the purpose of proving that she had made a statement to the investigator.

Registrant's Counsel took the position that the statement included inconsistent statements and given the serious nature of the allegations, the Hearing Tribunal should have the benefit of the statement for its consideration. Registrant's Counsel noted that the statement was not being introduced for the truth of its contents but rather as evidence that the statements were made.

The Hearing Tribunal considered the submissions of each counsel and determined it would enter the statement into evidence and consider the weight to put on the statement in its deliberations. The statement was marked as Exhibit 6.

CLOSING SUBMISSIONS

The parties agreed to provide their closing submissions by way of written submissions.

Submissions by Conduct Counsel:

Conduct Counsel submitted that the evidence demonstrates that Allegation 1, 2, 3 and 5 are proven on a balance of probabilities and that the proven conduct constitutes unprofessional conduct. Conduct Counsel noted that it is not a defence to the allegations regarding competence and breaches of documentation or other standards to say that others have engaged in similar behaviour and therefore the behaviour is not unprofessional conduct.

[redacted]

Conduct Counsel noted that the case turns on issues of credibility and reliability. The Hearing Tribunal may accept all, some or none of a witness's evidence. Conduct Counsel reviewed the factors to consider in assessing credibility of a witness: appearance or demeanor; ability to

perceive; ability to recall; motivation; probability or plausibility; internal consistency and external consistency. Conduct Counsel noted that witnesses are not held to a standard of perfection. When there are inconsistencies in a witness's evidence, the Hearing Tribunal must consider the impact of those inconsistencies on the core issues.

Conduct Counsel reviewed the evidence of the witnesses. With respect to [Patient 1], while there were inconsistencies in her evidence, Conduct Counsel took the position that these were not sufficiently material to negatively impact the overall credibility or reliability of her testimony on the core issues.

Conduct Counsel reviewed aspects of the Registrant's testimony and submitted these cast doubt on his credibility. Conduct Counsel took the position that the Registrant's evidence was implausible on certain points and noted that the Registrant has a compelling reason to remember matters in a particular way.

[redacted]

Conduct Counsel noted that although [Patient 2] presented as a forthright witness, there were inconsistencies in her evidence and her testimony presented reliability concerns. [redacted]

Conduct Counsel reviewed the evidence with respect to each allegation and noted that if the Hearing Tribunal found the allegations to be factually proven, the Hearing Tribunal must consider if the conduct is unprofessional conduct as defined in the HPA. [redacted]

Submissions by Registrant's Counsel:

[redacted]

Registrant's Counsel disputed that [Patient 1]'s evidence was inconsistent in only the ways identified by Conduct Counsel. Registrant's Counsel noted there were concerns with [Patient 1]'s ability to perceive and recall events and stated that [Patient 1]'s version of events was improbable when considered in the overall context and weighed against incontrovertible evidence.

Registrant's Counsel further noted that an honest witness who is trying to tell the truth may be mistaken in their recollection. A sincere and credible witness is not necessarily a reliable one, as such, other factors must be considered when assessing the reliability of a witness, including: demeanour; motivation; external inconsistencies; ability to perceive; ability to recall; internal inconsistencies in the witness's own evidence and the probability or plausibility of the witness's evidence.

Registrant's Counsel noted that the Registrant believes that [Patient 1] was a sincere witness. However, she is mistaken. [Patient 1]'s evidence does not have the indicia of reliability.

Registrant's Counsel noted that where oral testimony based on a witness's memory conflicts with contemporaneously recorded written records, the written records are generally considered to be a more reliable source of evidence. Registrant's Counsel outlined inconsistences between [Patient 1]'s evidence and other evidence, including the medical records.

Registrant's Counsel submitted that prior inconsistent statements made by a witness are admissible for the purpose of undermining a witness's credibility. In this case, prior inconsistent statements by [Patient 1] undermine her credibility.

Registrant's Counsel pointed to several factors in reviewing the reliability of [Patient 1]'s evidence. Counsel submitted that there is evidence in the Record (Agreed Book of Exhibits, Tab G, page 44) which supports that [Patient 1] was experiencing delirium. The side effects of the medications given to [Patient 1] include confusion, changes in behaviour and mistrust or suspiciousness. The evidence is also uncontroverted that [Patient 1] was in excruciating pain. Further, [Patient 1] had impaired sensation in the area of her perineum. The Hearing Tribunal must consider all of these factors in assessing the reliability of [Patient 1]'s evidence.

[redacted]

In terms of the particulars and Conduct Counsel's closing submissions, Registrant's Counsel noted that the Registrant has not been charged with failing to remove his gloves at a specific time or failing to explain the catheterization process to the patient in advance of the procedure. The College bears the onus of proving the conduct as particularized in the allegations. The Amended Notice to Attend does not address when the Registrant took off his medical gloves or the extent to which he discussed the procedure in advance with [Patient 1]. The College cannot argue that he is guilty of unprofessional conduct for these matters.

HEARING TRIBUNAL DECISION

The Hearing Tribunal carefully considered the evidence presented by the parties and the closing submissions. The Hearing Tribunal found that Allegation 1 and 2 were not proven on a balance of probabilities. The Hearing Tribunal found that Allegation 3 was proven but the conduct did not rise to the level of unprofessional conduct. The Hearing Tribunal found that Allegation 4 was not proven on a balance of probabilities. Therefore, the Hearing Tribunal dismissed Allegations 1, 2, 3 and 4.

The Hearing Tribunal found that the particulars in Allegation 5(a), (b), (c), (d) were proven on a balance of probabilities and the conduct constituted unprofessional conduct under section 1(1)(pp)(i) and (ii) of the HPA. The Hearing Tribunal found that the particulars in Allegation 5(e) and (f) were not proven on a balance of probabilities and these were dismissed.

HEARING TRIBUNAL FINDINGS AND REASONS

<u>General Findings of Fact</u>

The Hearing Tribunal generally accepted the facts as agreed to by the parties in Exhibit 2. A summary of the findings of fact by the Hearing Tribunal follow.

Unit 101 is an acute spine unit at FMC. The patients on Unit 101 are largely, but not exclusively, post-operative patients undergoing spinal surgery. The patients are generally broken down into three categories: elective spine surgery patients; emergency spine surgery patients; and spinal cord injury patients. The nurse-to-patient ratio is generally 1:4 on day shift and 1:5 or 1:6 on night shift.

The Registrant started work as an RN on Unit 101, FMC as a staff RN on October 25, 2021. Unit 101 is an 18-bed acute spine unit at FMC. From October 25, 2021 to November 27, 2021, the Registrant was oriented to Unit 101 by way of two eight-hour classroom education days and nine 12-hour buddy shifts. The Registrant was buddied with three RNs during this orientation period.

On December 23, 2021, the Registrant was working 1915 to 2315 on Unit 101 as a staff RN. He was assigned [Patient 1]. At the start of his shift, the Registrant was assigned three patients, including [Patient 1] and a fourth patient was received during the shift as a new admission.

At about 1500 on December 23, 2021, [Patient 1], [Age] years old, had a cervical spinal myelopathy with no complications. [Patient 1] arrived as a patient on Unit 101 at about 1805 from the post-anesthetic care unit on a stretcher and was admitted by [Witness 5] , RN. [Witness 5] admitted [Patient 1] to Unit 101. Ms. [Witness 5] described the patient as alert, awake and in a little bit of pain. Ms. [Witness 5] did not observe any delirium during her assessment of [Patient 1]. Ms. [Witness 5] performed an assessment once [Patient 1] was situated in her room, including sensation testing.

[Patient 1] was in room 23 which was directly across from the nursing station. Room 23 was a semi-private room with two beds. [Patient 1] was in bed 1, closest to the door, and [Patient 2] was in bed 2. [Patient 1]'s bed was surrounded by a privacy curtain. The light over the sink was to the left of [Patient 1]'s bed from the patient's viewpoint if lying down. The sink was to the right, upon entering the room. There was a window above the sink.

The Registrant was assigned to care for [Patient 1] at the start of his shift. Ms. [Witness 5] gave handover report on [Patient 1] to the Registrant between 1900 and 1930. After handover of [Patient 1] was completed, the Registrant entered [Patient 1]'s room and introduced himself as her nurse for the evening. The Registrant completed an assessment of [Patient 1] and charted the assessment between 1935 and 1945.

The charge nurse, Ms. [Witness 4], told the Registrant that [Patient 1] required catheterization. The Registrant did not request assistance. At about 2100, the Registrant entered [Patient 1]'s room for the purpose of completing a female urinary catheterization. The Registrant brought one catheterization tray, one catheter , a blue pad and sterile gloves into [Patient 1]'s room. The Registrant did not bring a second catheter with him to [Patient 1]'s room.

The Registrant did not turn on the light over [Patient 1]'s bed, nor did he turn on the room's overhead light before attempting an intermittent catheterization. The Registrant relied on the light over the sink and light from the hallway. The light over the sink was to the patient's left and the Registrant was situated on the right side of the patient bed. The patient's privacy curtain remained drawn around the sides and foot of the patient's bed throughout the attempted catheterization.

The Registrant did not ask [Patient 1] to bear down or cough while the Registrant was attempting the catheterization. The Registrant did not document his attempted catheterization on [Patient 1] on the patient's chart.

On December 24, 2021, the Registrant was put on administrative leave and an internal investigation was initiated, the Registrant received notice of the same. The Registrant's casual position on Unit 101 was terminated on January 18, 2022.

[Patient 1] was discharged from FMC on December 26, 2021.

Credibility of [Patient 1]

The Hearing Tribunal carefully considered the evidence of [Patient 1].

There were several external inconsistencies between [Patient 1]'s evidence and the evidence of other witnesses, including witnesses called by the Complaints Director, as well as the record.

[Patient 1] testified that she was admitted onto Unit 101 at about 1600, and she had looked at the clock. [Patient 1] also noted that when she first woke up, she was in room 23. Ms. [Witness 5] testified that she first encountered [Patient 1] when she admitted her around 1700 to 1730. [Patient 1] came in on a stretcher. Ms. [Witness 5] met her in the hallway. She transferred her to her bed and then performed an initial assessment of [Patient 1]. She described [Patient 1] as alert, awake and did not remember her being overly confused. The Patient Record (Exhibit 1, pages 69 to 71) confirms that [Patient 1] arrived at 1805 on a stretcher, that Ms. [Witness 5] and a staff transferred her to a bed and that Ms. [Witness 5] proceeded to do an initial assessment. The Hearing Tribunal preferred the evidence of Ms. [Witness 5] which was confirmed by the record.

[Patient 1] testified that she was not wearing a hospital gown but was covered by a sheet that was up to her chest area. Ms. [Witness 5] testified that [Patient 1] was wearing a hospital gown on admission. The Registrant testified that [Patient 1] was wearing a gown. Ms. [Witness 3] testified that [Patient 1] was wearing a gown. The Hearing Tribunal found that [Patient 1] was wearing a gown on admission and when the Registrant performed the attempted catheterization.

[Patient 1] did not recall that the Registrant entered her room twice before the attempted catheterization. The Registrant testified that in his first visit, he took [Patient 1]'s vital signs and did a head-to-toe assessment. The Registrant estimated that this took about 10 minutes. The Registrant did a second assessment where he did a spinal assessment. This was done at 2030. These are confirmed in the record. (Exhibit 1, pages 67, 68 and 89). The Hearing Tribunal preferred the evidence of the Registrant on this point.

[Patient 1] described a large amount of iodine being applied to her. She stated that it felt very wet, there was lots of it and it was applied over a large area. She could feel it on her thighs, her buttocks, her whole genital area. This was not confirmed by other evidence. The evidence was

that the Registrant used one pack of swabs that contained three Betadine iodine gauze swabs. These swabs would not be overly wet. The Registrant used the swabs on her labia and urethra area. Ms. [Witness 3] confirmed that she did not see a large amount of iodine on [Patient 1]. The Hearing Tribunal found that [Patient 1] was incorrect in the amount of iodine used. She could not see the area. The Hearing Tribunal further considered that [Patient 1] had impaired sensation as confirmed in the Spinal Assessment Sheet (Exhibit 1, page 89) which indicates decreased sensation that was documented at 1810 and 2030. The Hearing Tribunal considered that this impaired sensation may account for [Patient 1]'s belief about the amount of iodine she thought was being used.

[Patient 1]'s evidence was that the Registrant first inserted the catheter tube into her vagina and then on the second attempt, into her urethra. The Registrant's evidence was that he first inserted the tube about a centimeter and a half and felt resistance. He removed the tube and then inserted it lower than the first point and it went in about two inches, but there was no urine return. When he turned on the light, he saw that there was urine in the tray, which confirmed that he had at some point inserted the tube into the urethra. [Patient 1] confirmed that the Registrant showed her the tray which contained urine. The Hearing Tribunal accepted the Registrant's evidence on this point. The urine in the tray confirmed that he did insert the catheter into the urethra.

In relation to the call bell, [Patient 1] testified that after the attempted catheterization, she went to use her call bell but the Registrant said that he would get somebody to come in. [Patient 1] stated she did not end up using her call bell. On cross-examination, [Patient 1] testified she had mentioned the call bell to the Registrant and wanted to call, but the Registrant told the patient he would get someone. When further asked about what she told the College during the investigation, [Patient 1] stated she "could not remember if he grabbed the bell – or I should say if he grabbed the bell or if I just didn't press it when he told me he would get someone". [Patient 1] agreed on cross-examination that her recollection at the time of the investigation would have been more recent and probably better than what she remembered on the date she gave testimony in the hearing. On further cross-examination, [Patient 1] testified she did not press the call bell button because the Registrant told her he would go and get someone. When it was put to her that the implication of the statement to CRNA was that the Registrant grabbed the call bell from the patient, [Patient 1] responded, "Oh, I know he stopped me from calling someone". Ultimately, [Patient 1]'s evidence was that she did not recall if the Registrant grabbed the call bell or if he did not grab the call bell. The Hearing Tribunal found that there was insufficient evidence that the Registrant tried to stop her from using the call bell.

[Patient 1] testified that after she asked her roommate, [Patient 2], to use her call bell to call for help, her roommate's nurse, Ms. [Witness 3], entered the room and went to her roommate's bedside. [Patient 1]'s evidence was that her roommate told Ms. [Witness 3] to go see [Patient 1] and when she did so, [Patient 1] told Ms. [Witness 3] everything that happened. [Patient 2] testified that when the male nurse left the last time, [Patient 1] asked her in a stern voice to call the front desk and when Ms. [Witness 3] came, [Patient 2] directed her to [Patient 1]. However, Ms. [Witness 3] testified that she went to [Patient 1]'s room because Ms. [Witness 4], the charge nurse, asked her to do so. This is confirmed by the Patient Record (Exhibit 1, page 61). Ms. [Witness 3] went straight to [Patient 1]'s bed when she went into the room and did not talk to her own patient, being [Patient 2], first. This is consistent with the evidence of Ms. [Witness 4]. The Hearing Tribunal preferred the evidence of Ms. [Witness 3] and found that Ms. [Witness 3] went to [Patient 1]'s room after being directed to do so by Ms. [Witness 4] and not in response to a call bell.

The Registrant advanced the theory that [Patient 1] was suffering from delirium. There was insufficient evidence to establish that [Patient 1] was delirious. However, the Hearing Tribunal found that [Patient 1] may have been confused. She was coming out of anesthesia, had narcotics (page 72, 73, 80) and was in a pain crisis (page 142).

The Hearing Tribunal found that [Patient 1] gave evidence to the best of her ability. However, [Patient 1] had undergone surgery approximately 6 hours prior to the Registrant's attempted catheterization and had been prescribed medications for, among other things, pain management. She was in an incredible amount of pain and could not lift her head to see the area where the catheterization was being attempted. She had impaired sensation, as evidenced by her description of the amount of iodine used by the Registrant. Her recollection was not consistent with that of other witnesses, including the Registered Nurses called by the Complaints Director or the record. As such, the Hearing Tribunal found that there were issues with the reliability of [Patient 1]'s evidence and that limited weight should therefore be placed on [Patient 1]'s evidence.

Credibility of the Registrant

The Registrant's practical experience with female intermittent catheterization consisted of performing the procedure on two occasions under supervision. On the evening of December 23, 2021, the Registrant attempted his first catheterization without supervision. The charge nurse, Ms. [Witness 4], directed the Registrant, as the assigned nurse, to perform the procedure. He proceeded with inadequate light and inserted a single catheter tube into both the patient's urethra and vagina. Some urine was returned but the Registrant did not realize this at the time of inserting the tube into the urethra. The Registrant abandoned his efforts and left [Patient 1]'s room to seek assistance with completing the procedure. He told the charge nurse that he needed help and she directed Ms. [Witness 3] to perform the procedure. The charge nurse told the Registrant that [Patient 1] no longer wanted him as her nurse and the patient was reassigned. The Registrant left the hospital without charting the attempted catheterization.

The Registrant testified about the attempted catheterization. The Registrant's evidence was that he realized partway through the procedure that the lighting was insufficient and moved his hand to turn on the light over the bed, realized he would contaminate his sterile glove hand by touching the light switch, decided against it, and decided to proceed. He realized that he needed assistance and, on his own accord, abandoned the procedure to get help. The Hearing Tribunal accepted the Registrant's version of events on this point.

The Registrant testified that he asked [Patient 1] to press the call bed, which she did and he waited for a few seconds but did not hear any response. So, he walked out to look through the window and saw that there was nobody at the nursing station. The evidence regarding the call bell was inconsistent. There was insufficient evidence to suggest that the call bell was broken. While the Registrant testified that [Patient 1] pressed the call bell, [Patient 1] denied this. Further, there was no evidence from any other witness that the call bell had been pushed. The Hearing Tribunal found that it was not able to determine if [Patient 1] in fact pressed the call bell.

The Registrant testified during cross-examination that he remembered things during his testimony at the hearing that he did not remember at the time of the College's investigation because he had given the events careful thought. While Conduct Counsel suggested this affected the Registrant's credibility, the Hearing Tribunal accepted that the Registrant had spent much time considering the events of December 23, 2021. The Hearing Tribunal did not find that this had a significant impact on the Registrant's credibility.

When it was put to him in cross-examination that he told the College that although he had not done any female catheterizations on Unit 101, he had done enough in his career to know what he was doing, the Registrant testified that the College "must have got it wrong", and what he meant was he had done it before, and he was confident. The Hearing Tribunal found that there was an inconsistency in what was recorded in the College's investigation and the Registrant's evidence. However, the Hearing Tribunal could not determine if this was an error by the College investigator. The Hearing Tribunal did not find that this had a significant impact on the Registrant's credibility.

On cross-examination, the Registrant admitted that the lighting was inadequate when he attempted the catheterization of [Patient 1]. The Registrant agreed, during cross-examination, that turning on the light may have helped the patient feel more comfortable with the procedure. Instead of turning on the light and starting over, which would have been a reasonable thing to do, the Registrant decided to proceed with a sensitive procedure without sufficient lighting.

The Hearing Tribunal considered the evidence of the Registrant. His testimony provided step by step explanations for his actions during the catheterization. His evidence was generally consistent with the record, the evidence of the other nurses and what was more likely to have occurred.

Overall, the Hearing Tribunal found the Registrant to be a credible and reliable witness.

Credibility of [Patient 2]

The Hearing Tribunal placed little weight on [Patient 2's] evidence. She could not see what was occurring in [Patient 1]'s bed. [Patient 2's] evidence demonstrated inconsistencies with the record and other witness testimony. She described herself as wide awake and alert, but the record indicated she was frequently drowsy during the assessments following her surgery. Further, during the AHS investigation, it was determined that [Patient 2] was asleep during most of the relevant times and she was not interviewed. [Patient 2] testified that [Patient 1] told her what happened, which was contrary to the evidence of [Patient 1].

Credibility of Other Witnesses

The Hearing Tribunal found the nurses called by the Complaints Director to generally be credible and reliable witnesses. Many of the witnesses had no first-hand information and as such, limited weight was placed on their testimony. However, Ms. [Witness 3] and Ms. [Witness 4] had direct interactions with the Registrant and [Patient 1] on December 23, 2021 and the Hearing Tribunal found their evidence to be both relevant and reliable.

The Hearing Tribunal placed little weight on the testimony of Ms.[Witness 7]. The Hearing Tribunal found her to be credible and reliable, however, her evidence had little relevance in determining whether the allegations were proven.

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Allegation 5: Further or in the alternative to Allegation 4, the Registrant, while attempting to place an intermittent catheter on [Patient 1], displayed a lack of skill or judgment and/or violated a code of ethics or practice standard when he did one or more of the following:

a) failed to follow his employer's intermittent catheter insertion technique and policy;
b) failed to ensure adequate lighting in [Patient 1]'s room;
c) failed to gather and bring all necessary supplies, including a second catheter;
d) failed to follow appropriate steps when unable to locate [Patient 1]'s urethra, including asking the patient bear down or cough;

[redacted]

The Hearing Tribunal considered each particular.

Allegation 5(a) is that the Registrant failed to follow his employer's intermittent catheter insertion technique and policy. The Hearing Tribunal considered the AHS Policies at Exhibit 1, Tabs J and K.

The Intermittent Catheterization Checklist (Exhibit 1, Tab K), requires a nurse to have certain supplies, including sterile dressing tray and drapes and an adjustable light source. The Registrant did not use a drape and had no adjustable light source. The Registrant did not have a second catheter. He brought a larger pair of sterile gloves as the sterile gloves in the tray are too small for him. He discarded the smaller pair of sterile gloves.

While the Registrant did not have a second catheter or second set of sterile gloves, these are not required by the Policy. An experienced nurse will bring these with them, but they are not requirements.

The Intermittent Catheterization Checklist also requires the nurse to receive consent to proceed. The Registrant's evidence was that while the word consent was not used, he did tell [Patient 1] he would be doing the catheterization. The Registrant acknowledged that he did not provide [Patient 1] information about what he was doing step by step during the process.

The Intermittent Catheterization Checklist also requires the nurse to complete relevant documentation. The Registrant did not complete this.

The Registrant acknowledged that he was not aware of the Intermittent Catheterization Policy until the AHS internal investigation. He did not recall discussing the Policy with his buddy nurse or reviewing it prior to the shift on December 23, 2021.

The Hearing Tribunal considered that catheterization is an entry level competency. That is, it is not a procedure for which orientation or training in a hospital setting should be required unless the nurse identifies a need. In addition, a nurse must be knowledgeable about employer policies.

It was the responsibility of the Registrant to be aware of the AHS Policies. A nurse must be accountable for their practice. If they are inexperienced or unsure of how to perform a procedure, it is the responsibility of the nurse to ask for assistance. The Registrant acknowledged that he was shown where to access policies during orientation.

The Hearing Tribunal found that Allegation 5(a) was proven on a balance of probabilities. The Registrant failed to use the drape. The Registrant did not have an adjustable light source. The Registrant failed to document and to obtain sufficient ongoing informed consent.

The Hearing Tribunal considered Allegation 5(b). The Registrant did not bring an adequate light source, as required by the Intermittent Catheterization Checklist. He did not take steps prior to commencing the procedure to ensure that he had an adequate light source. The lighting was so dim that he did not see the urine return in the tray until he turned on the overhead light. Further, the evidence of Ms. [Witness 3] was that when she entered [Patient 1]'s room, only the dim overhead light was on.

Allegation 5(b) is proven on a balance of probabilities. The Registrant failed to ensure he had adequate lighting in [Patient 1]'s room.

The Hearing Tribunal considered Allegation 5(c). As noted for Allegation 5(a), the Registrant failed to bring an adjustable light source, as required by the Intermittent Catheterization Checklist. Allegation 5(c) is proven on a balance of probabilities.

The Hearing Tribunal also considered that the Registrant acknowledged he did not bring a second catheter. However, this is not required by the Policy or the Intermittent Catheterization Checklist. A more experienced nurse would know to bring a second catheter; however, this is not a requirement of the Policies.

The Hearing Tribunal considered Allegation 5(d). The Hearing Tribunal considered that the Registrant did in fact locate the urethra, as is evidenced by the urine in the tray. However, the Registrant was not aware he had located the urethra. The Intermittent Catheterization Checklist outlines the steps to be followed if a nurse is unable to locate the urethra. The nurse is to ask the patient to bear down or cough to locate, then insert the catheter. The Registrant acknowledged that he did not do this. Further, the Registrant did not landmark appropriately, by leaving the catheter in place in the vagina, as required by the Intermittent Catheterization Checklist and as described by Ms. [Witness 1] and Ms. [Witness 2] in their testimony.

Allegation 5(d) is proven on a balance of probabilities.

[redacted]

[redacted]

The Hearing Tribunal considered whether Allegation 5(a), (b), (c) and (d) constituted unprofessional conduct.

The Hearing Tribunal found that the conduct in Allegation 5(a) to (d) demonstrated a lack of knowledge, skill or judgment in the provision of professional services. The Registrant was inexperienced; however, he knew or should have been aware of the Policies of his employer. He did not follow the proper protocol for a female intermittent catheterization. In addition, he failed to refer to the Policies prior to attempting the procedure. Had the Registrant had appropriate lighting it is likely that he would have seen the urine and known that he had been successful in inserting the catheter tube into the urethra. The Registrant demonstrated a lack of knowledge, skill or judgment constituting unprofessional conduct as defined in section 1(1)(pp)(i) of the HPA.

The Hearing Tribunal considered whether the conduct also breached the Standards of Practice. The Hearing Tribunal found that the following sections of the Standards of Practice were breached:

Standard 1: Responsibility and Accountability

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 2: Knowledge-based Practice

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.

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

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

Standard 4: Service to the Public

4.4 The nurse explains nursing care to clients and significant others.

Standard 5: Self-Regulation

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.

The Hearing Tribunal considered whether the conduct also breached the Code of Ethics. The Hearing Tribunal found that the following sections of the Code of Ethics were breached:

A. Providing Safe, Compassionate, Competent and Ethical Care

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.

6. Nurses practise “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).

C. Promoting and Respecting Informed Decision-Making

3. Nurses ensure that nursing care is provided with the person’s informed consent. Nurses recognize and support a capable person’s right to refuse or withdraw consent for care or treatment at any time (College of Registered Nurses of British Columbia [CRNBC], 2017a). Nurses recognize that capable persons receiving care may place a different weight on individualism and may choose to defer to family, cultural expectations or community values in decision-making while complying with the law of consent.

D. Honouring Dignity

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.

G. Being Accountable

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.*

3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

The Registrant's conduct failed to comply with the requirements of the Standards of Practice and Code of Ethics outlined above. The Registrant attempted an intermittent catheterization without following his employer's policies. He failed to explain to [Patient 1] what he was doing during the procedure. The Registrant failed to practice competently in attempting a female intermittent catheterization without appropriate lighting. The breaches of the Standards of Practice and Code of Ethics are sufficiently serious to constitute unprofessional conduct under section 1(1)(pp)(ii) of the HPA.

For the reasons set out above, the Hearing Tribunal found that the Registrant's conduct constitutes unprofessional conduct under section 1(1)(pp)(i) and (ii) of the HPA.

CONCLUSION

Allegations 1, 2, 3 and 4 are dismissed. The particulars in Allegation 5(a), (b), (c), (d) are proven on a balance of probabilities and the conduct constitutes unprofessional conduct under section 1(1)(pp)(i) and (ii) of the HPA. The particulars in Allegation 5(e) and (f) are dismissed.

The Hearing Tribunal will receive submissions from the parties on sanction. The Hearing Tribunal requests that the parties discuss and determine the timing and method of providing submissions on penalty to the Hearing Tribunal. If the parties are unable to agree on a proposed procedure and timing, the Hearing Tribunal will make further directions as required.

Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: April 24, 2023

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as
COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL
REGARDING SANCTION

RE: CONDUCT OF **EDEM EKPE** AND R.N, REGISTRATION **#112,587**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

ON

JUNE 20, 2023

INTRODUCTION

A hearing was held on November 15, 16, 17, and 18, 2022 at the College of Registered Nurses of Alberta (the "**College**" or "**CRNA**") by the Hearing Tribunal of the College to hear a complaint against Edem Ekpe, R.N., Registration #112,587 ("**Mr. Ekpe**").

After the conclusion of the hearing and the deliberations of the Hearing Tribunal, a written decision was rendered on April 24, 2023 (the "**Merits Decision**"). At the conclusion of the Merits Decision, the Hearing Tribunal ordered that it would receive additional submissions from the parties on sanction.

This decision (the "**Sanction Decision**") will be solely in respect of the sanction phase of the hearing for Mr. Ekpe, which occurred via videoconference on June 20, 2023.

Those present at the hearing via videoconference were:

a. Hearing Tribunal Members:

Bonnie Bazlik, RN Chairperson
Jofrey Wong, RN
Kevin Kelly, Public Representative
Sarita Dighe-Bramwell, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Maya Claire Gordon (counsel for the sanction proceedings)

c. CRNA Representative:

Kate Whittleton, Conduct Counsel

d. Registrant Under Investigation:

Edem Ekpe (sometimes hereinafter referred to as the "**Registrant**" or "**Mr. Ekpe**")

e. Registrant's Counsel:

Tanya Kuehn, KC

f. Registrant's Labour Relations Officer:

Michelle Bogdan

g. CRNA Staff:

Diana Halabi, Complaints Clerk
Jessica Young, Court Reporter

PRELIMINARY MATTERS

At the start of the hearing, Conduct Counsel noted on the record that a potential conflict of interest with a member of the Hearing Tribunal had been raised with both parties in advance of the hearing. Both parties confirmed on the record that they were aware of this potential conflict and that there were no concerns with respect to the composition of the Hearing Tribunal.

There were no other preliminary matters raised by either party.

ALLEGATIONS AND PROVEN CONDUCT

Allegations

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

5. Further or in the alternative to Allegation 4, the Registrant, while attempting to place an intermittent catheter on [Patient 1], displayed a lack of skill or judgment and/or violated a code of ethics or practice standard when he did one or more of the following:

    a) failed to follow his employer's intermittent catheter insertion technique and policy;
    b) failed to ensure adequate lighting in [Patient 1]'s room;
    c) failed to gather and bring all necessary supplies, including a second catheter;
    d) failed to follow appropriate steps when unable to locate [Patient 1]'s urethra, including asking the patient bear down or cough;

[redacted]

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 *Health Professions Act*, including:

1. The conduct underlying Allegations 1, 2, 3, and 5 contravenes one or more of the following: the CNACE; the CPSRM; and the CDSRM; and/or
2. The conduct underlying [redacted] as defined by [redacted] and contravenes one or more of the following: the CNACE; the CPSRM; and the [redacted].

Proven Conduct

In the Merits Decision, the Hearing Tribunal found that Allegations 1, 2, 3 and 4 were dismissed. The particulars in Allegation 5(a), (b), (c), (d) are proven on a balance of probabilities and the Hearing Tribunal found that Mr. Ekpe's proven conduct constituted unprofessional conduct under section 1(1)(pp)(i) and (ii) of the *Health Professions Act*, RSA 2000, c. H-8 (the "***HPA***"). The particulars in Allegation 5(e) and (f) were dismissed.

The proven conduct related to an attempted intermittent catheterization procedure on [Patient 1] by her assigned nurse, Mr. Ekpe. The procedure occurred on Unit 101 of the Foothills Hospital in Calgary,on December 23, 2021. Additional details on the circumstances and the events that unfolded that evening can be found in the Merits Decision.

EXHIBITS

In the Merits Decision, Exhibits 1 to 6 were entered and are itemized in that decision.

The following documents were entered as Exhibits during the sanction portion of the proceeding:

EXHIBIT	**DESCRIPTION**
Exhibit #7:	Joint Recommendations on Sanction
Exhibit #8:	MacEwan University Course Information
Exhibit #9:	*Jaswal v. Medical Board (Nfld.)* 1993 St. J. No. 2225 (NFLD Sup. Ct. Trial Division) ("*Jaswal*")

JOINT RECOMMENDATION ON SANCTION

Submissions of Conduct Counsel

At the commencement of this phase of the hearing, Conduct Counsel advised that the parties had agreed upon a Joint Recommendation on Sanction ("**Joint Recommendation**"). Conduct Counsel reviewed the Joint Recommendation for the Hearing Tribunal.

Conduct Counsel made the following submissions in respect of the Joint Recommendation:

- At paragraph 1, there was a written reprimand for unprofessional conduct.

- At paragraph 2, Mr. Ekpe would be required to take the following two courses at MacEwan University by no later than January 15, 2024:

    - *Relational Practice and Communication* (NURS0173 – MacEwan University); and
    - *Nursing Process* (NURS0167 – MacEwan University).

- At paragraph 3, there was a requirement that Mr. Ekpe must provide to the Complaints Director a self-improvement plan for ensuring competency before initiating new procedures (with details about the plan) by no later than January 15, 2024. The focus would be ensuring competency before initiating new procedures.

- At paragraph 4, there is a requirement that prior to next commencing employment, or otherwise performing any type of nursing practice hours, Mr. Ekpe shall provide a letter to the Complaints Director from Mr. Ekpe's prospective RN or NP Supervisor at their place of employment with information as set out in the Joint Recommendation.

- At paragraph 5, Mr. Ekpe was required to provide the Employer Reference from his Supervisor two hundred forty (240) days after their Practice Setting Letter is approved by the Complaints Director. The Employer Reference must be acceptable to the Complaints Director and confirm that Mr. Ekpe had completed at least five hundred sixty (560) hours of nursing practice, and other details.

- At paragraph 6, until Mr. Ekpe has submitted the Employer Reference to the Complaints Director, as required by paragraph 5, and it is deemed satisfactory to the Complaints Director, Mr. Ekpe shall not be employed in any other setting except the Practice Setting(s) approved by the Complaints Director, with some options for him to add additional practice settings with the agreement of the Complaints Director.

- At paragraph 7, there is clarity that he can still submit research or other scholarly work for publication, which he has indicated that he is interested in.

- Paragraphs 8 through 11 relate to compliance with the Order.

- At paragraph 12, there is additional information about Mr. Ekpe's current employers. Registrant's Counsel may speak to the fact that one employer may not be current anymore (see additional information provided by the Registrant's Counsel, below, regarding Alberta Health Services).

- Paragraph 13 includes a requirement to provide the College with any changes to the Registrant's employers.

- At paragraph 14, five conditions are set out which will be added to Mr. Ekpe's practice permit (current and/or future) and they shall remain until the conditions are satisfied. Once complete, they will be removed.

- Paragraph 15 requires that Mr. Ekpe's conditions be sent out to his current employers, the regulatory college for the Registered Nurses in all Canadian provinces and territories, and other professional colleges with which Mr. Ekpe is also registered (if any).

- Paragraph 16 confirms that once a condition has been complied with, it will be removed. Once all conditions are removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

- And finally, paragraph 17 confirms that the Order takes effect on the date of the Sanction Hearing, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the *HPA*.

After reviewing the terms of the Joint Recommendation, Conduct Counsel discussed the purposes of sanction. Denunciation and deterrence are appropriate, but the ultimate sanction must still be measured, proportionate and reasonable, and Conduct Counsel submitted that in this case, it met the purposes of sanction.

Conduct Counsel then discussed the factors that were outlined in the decision of *Jaswal v. Medical Board (Nfld.)* 1993 St. J. No. 2225 (NFLD Sup. Ct. Trial Division) ("*Jaswal*"). The Court in *Jaswal* came up with a number of factors to take into account.

These factors have been widely applied in the professional discipline context, and they are used as a checklist. Conduct Counsel made the following submissions in relation to the *Jaswal* factors:

1. **Nature and gravity of the proven allegations**: The Hearing Tribunal found unprofessional conduct as set out in the Merits Decision. Catherization was an entry level competency for nurses, there was a failure to use the drape, there was not sufficient and ongoing informed consent, and there was insufficient light to properly execute the procedure. Ultimately, the Hearing Tribunal found that the attempted intermittent catheterization did not meet the applicable Standards of Practice and Code of Ethics, and this conduct was serious.

2. **Age and experience of the offending nurse**: Mr. Ekpe began nursing in October of 2021. The conduct that occurred was on December 23, 2021, only a few months later, and therefore he was a very new registrant with the College.

3. **Previous character of the nurse and in particular the presence or absence of any prior complaints or convictions**: Mr. Ekpe had no prior discipline history with the College, and this is a mitigating factor.

4. **Age and mental condition of the offended patient**: [Patient 1] was [Age] years old and was admitted for spinal surgery. The Hearing Tribunal did not find that [Patient 1] was delirious, but she was coming out of anesthesia, was on narcotics, and was in a pain crisis.

5. **Number of times the offence was proven to have occurred**: In this case, the proven conduct happened on one shift on one day – December 23, 2021. The Hearing Tribunal heard no evidence that there was a pattern of conduct existing here.

6. **Role of the nurse in acknowledging what had occurred**: Although the hearing on the merits in this matter did not proceed by agreement, Mr. Ekpe admitted in the Agreed Statement of Facts and in testimony certain material facts, including the lack of lighting,

and that he did not ask [Patient 1] to bear down or cough during the attempted intermittent catheterization. Conduct Counsel suggested that this was a mitigating factor.

7. **Whether the offending nurse had already suffered other serious financial or other penalties as a result of the allegations having been made**: During the hearing in November, the Hearing Tribunal heard that interim conditions have been in place on Mr. Ekpe's practice permit since February 2022. The Hearing Tribunal also understood from Counduct Counsel's summary that there had not been a full prohibition on Mr. Ekpe's practice, but rather that notification letters would have been required from Mr. Ekpe's prospective employer. There was no requirement of direct or indirect supervision of Mr. Ekpe during this time. During the hearing, Mr. Ekpe had provided testimony to the effect that if he let a prospective employer know about the unproven allegations, it was unlikely he would be hired, and he was also concerned about sullying his name, so it was his decision not to apply for jobs until the conclusion of the hearing on the merits. In addition, his casual position with Unit 101 was terminated within his probation period.

8. **Impact of the incident on the offended patient**: The Hearing Tribunal found that "[Patient 1]'s evidence demonstrates her vulnerability and her perceived vulnerability." She was doing her best to be truthful in her evidence, but her evidence was found to be "not reliable".

9. **Presence or absence of any mitigating circumstances**: Conduct Counsel was not aware of any.

10. **Need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of nursing**: Conduct Counsel noted that ensuring that other registered nurses must ensure competencies and ensuring sufficient knowledge of an important clinical technique is important. This is achieved through both the reprimand and the employer reference.

11. **Need to maintain the public's confidence in the integrity of the nursing profession**: In a self-regulated profession, maintaining confidence is critical. Conduct Counsel submitted that the Joint Recommendation sends the appropriate message to the public that registered nurses must hold sufficient skill and judgment, even as a novice nurse. Conduct Counsel submitted that the Joint Recommendation sufficiently denounces the conduct.

12. **Degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct**: In this case, the Hearing Tribunal found that the conduct that was found was done in a clumsy and inefficient manner, Mr. Ekpe failed to explain to [Patient 1] what he was doing, and he failed to have appropriate lighting for the procedure. The Hearing Tribunal found breaches of the applicable Standards of Practice and Code of Ethics, and found them to be sufficiently serious to constitute unprofessional conduct under the *HPA*. Conduct Counsel submitted that this conduct falls outside the range of permitted conduct.

As this is a Joint Recommendation, Conduct Counsel concluded her submissions by reminding the Hearing Tribunal of the Supreme Court of Canada's decision in *R. v. Anthony-Cook*, 2016 SCC 43 ("*Anthony-Cook*"). In that decision, which was in the criminal law context but has been applied widely in the professional disciplinary context as well, the Supreme Court confirmed the

value of joint recommendations and unequivocally stated that there was deference owed to joint recommendations.

She concluded by submitting that the Joint Recommendation balances rehabilitation and deterrence and is reasonable in all circumstances. If ordered, it would not bring the administration of justice into disrepute, nor is it contrary to the public interest, and thereby meets the standards set out in *Anthony-Cook* and should not be interfered with by the Hearing Tribunal.

Submissions of Counsel for Mr. Ekpe

Registrant's Counsel then made additional submissions on the proposed sanction on behalf of her client, Mr. Ekpe.

Registrant's Counsel began by noting that Mr. Ekpe's current employer Carewest has already reviewed the Merits Decision of the Hearing Tribunal. Mr. Ekpe has the support of Carewest in putting this matter behind him and they are committed to working with him to improve his practice. They are also willing to engage in the requirements of the Joint Recommendation.

In the Joint Recommendation, there are two employers listed for Mr. Ekpe. The first is Carewest, which is the employer that he has met with to discuss the Merits Decision and his employment going forward. However, there is some uncertainty as to whether Mr. Ekpe continues to be employed with COVID-19 vaccination team with Alberta Health Services He did not take training that was required this summer due to the ongoing proceedings with the College, and as a result, he believes the employment has ended, although he has not received anything official in that regard. He has taken steps to update the College's website to that effect.

Registrant's Counsel then noted a few *Jaswal* factors that she felt should be highlighted for the Hearing Tribunal's benefit:

1. **Nature and gravity of the proven allegations**: Registrant's Counsel highlighted the word 'proven' in the *Jaswal* statement. He was charged with some of the most heinous allegations for someone in his situation, but those allegations were not proven on a balance of probabilities. Mr. Ekpe was up front from the beginning about the things that he was found to have done, and that was found in his testimony, his interview, and in the Agreed Statement of Facts.

2. **Whether the offending nurse had already suffered other serious financial or other penalties as a result of the allegations having been made**: It has been almost 18 months since he has been able to work in his chosen field, and this should be a consideration for the Hearing Tribunal.

3. **Age and experience of the offending nurse:** Registrant's Counsel noted that in this case, Mr. Ekpe was a new registrant. It was his second solo shift on Unit 101 at the Foothills Hospital. It was the first time he was attempting this procedure by himself. His training was interfered with by COVID-19, and his practical experience relating to bedside nursing took place largely online, as he was doing his degree online due to the pandemic.

Registrant's Counsel echoed the comments of Conduct Counsel that the Joint Recommendation is fair, proportionate and reasonable in the circumstances. Her client is committed to following it and getting himself back in the profession as soon as he can.

Conduct Counsel had no additional comments arising.

Questions of The Hearing Tribunal

The Hearing Tribunal began by discussing the fact that paragraph 2 of the Joint Recommendation requires two courses which are online offerings with no clinical, in-person component. Mr. Ekpe had been taught largely online during the pandemic, and as such, the Hearing Tribunal asked counsel whether any consideration was given toward having an in-person or clinical learning component within the Joint Recommendation.

In response, Conduct Counsel replied that MacEwan University changed their process in the recent past and it is now exceedingly difficult to register just for a clinical component – it usually has to be taken as part of a broader nursing refresher program. From the perspective of the Complaints Director, a clinical course was not considered in this case. The courses in the Joint Recommendation were deemed to be appropriate and accessible for Mr. Ekpe, who will be returning to work once his Practice Setting Letter is approved.

In addition, Conduct Counsel noted that by adding the 560 hours of practice required for the Employer Reference, which is an extensive duration, the College was attempting to maintain an appropriate level of oversight over his practice. The expectation is that if any concerns arise, the College will hear about them through the Employer Reference requirement.

Therefore, by having the coursework, the Behaviour Improvement Plan, and the lengthy period of practice applicable to the Employer Reference, the Joint Recommendation was deemed to be appropriate in relation to the conduct.

Registrant's Counsel added that the practical component of his remedial education will come through his ongoing employment with Carewest. The employer plans to be actively involved, and they have already stated their desire to schedule Mr. Ekpe on day shifts where there would be other staff available to provide that confidence that he has in fact been exercising and honing those skills, and to give the employer the ability to provide an honest and full reporting to the College. Mr. Ekpe now has a setting where he can practice those skills, and so he is now in a different position from when this conduct occurred, 18 months ago.

The Hearing Tribunal also asked about the oversight available at Carewest Registrant's Counsel confirmed that at Carewest there will be other colleagues to supervise him who can be used as resources for him in his supervision and training.

The Hearing Tribunal offered a final comment about the Joint Recommendation. In paragraph 3, there is quite a bit of content required for the Behaviour Improvement Plan, including reference to a number of standards. The Hearing Tribunal noted that the 500-word limit may be unduly restrictive on Mr. Ekpe, and wondered whether that was considered in the drafting of the Joint Recommendation.

In response, Conduct Counsel noted that the College often receives Plans that exceed the word limit. There is no maximum – it is worded as a minimum, and Mr. Ekpe is encouraged to take as much time and use as many words as required to fully outline his response in the Behaviour Improvement Plan.

Registrant's Counsel added that Mr. Ekpe holds a Masters and a Doctorate Degree, and so the Behavior Improvement Plan is likely to be much longer than the 500-word minimum, there has certainly not been an expectation that it will be on the lean end, and likely quite the opposite.

With that, the Hearing Tribunal had no additional questions.

REASONS OF THE HEARING TRIBUNAL

The Hearing Tribunal considered the submissions of the parties, the Exhibits, and the *Jaswal* decision in considering the Joint Recommendation. The Hearing Tribunal also considered section 82 of the *HPA* which sets out the orders that are within the jurisdiction of the Hearing Tribunal when unprofessional conduct is found.

As a preliminary point, the Hearing Tribunal acknowledges the Supreme Court of Canada's decision in *Anthony-Cook*. Specifically, the Hearing Tribunal acknowledged the "undeniably high threshold" set out by the Supreme Court in that decision, with the Court writing at para. 34:

> [A] joint submission should not be rejected lightly, a conclusion with which I agree. Rejection denotes a submission **so unhinged from the circumstances of the offence and the offender** that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down. This is an undeniably high threshold… [emphasis added]

The Hearing Tribunal is mindful of decisions in the regulatory sphere which use *Anthony-Cook* in respect of joint submissions, and its applicability to agreements such as the Joint Recommendation.

In coming to the Joint Recommendation, the parties both needed to work together and Mr. Ekpe was required to take a high degree of accountability for his actions, which is commended by the Hearing Tribunal. Through the Agreed Statement of Facts, his testimony, and the Joint Recommendation, the Hearing Tribunal found that Mr. Ekpe took responsibility for his actions. In his evidence and from his lawyer's submissions, it was clear to the Hearing Tribunal that Mr. Ekpe took the hearing seriously, and was already working toward his own remediation through courses that were not expressly mandated. This high level of accountability and desire for self-improvement was a mitigating factor that the Hearing Tribunal took account of in its deliberations.

In this case, the Hearing Tribunal finds that the Joint Recommendation is fair, proportionate, reasonable and meets the "public interest test" from *Anthony-Cook* such that the Hearing Tribunal is prepared to accept it, for the reasons set out below.

In considering the Joint Recommendation, the Hearing Tribunal began by considering the circumstances of the proven conduct, and of the Registrant, Mr. Ekpe.

The Joint Recommendation was comprehensive, in that it was tailored carefully to the proven conduct, which consisted of errors that could be remediated by additional education and self-reflection on the part of the Registrant, given the fact that the conduct occurred so early on in his career. An additional factor that was significant to the Hearing Tribunal was the disruption of the Registrant's training caused by the pandemic. Hands-on clinical experience is essential to providing student nurses with the foundation to function as competent professional nurses. The Hearing Tribunal recognized that this disruption may have contributed to the proven conduct and

that the Employer Letter sanction is appropriate to provide support and oversight of the Registrant's practice. It was also tailored to Mr. Ekpe in particular, as he has demonstrated an academic orientation and eagerness toward learning and writing.

In considering the specific deterrence highlighted by *Jaswal*, the Joint Recommendation clearly deters future conduct of this nature on the part of Mr. Ekpe. It includes a written reprimand, and requires significant involvement on his part, through the courses, the Behaviour Improvement Plan, the Practice Setting Letter, and the Employer Reference requirements. The Joint Recommendation clearly takes into account the remediation of the Registrant, and ensures that errors in initiating new procedures do not recur, and that the Registrant has opportunity to develop and improve in the areas of communication and relational practice.

General deterrence is another *Jaswal* factor that was considered by the Hearing Tribunal. The Hearing Tribunal considered whether the Joint Recommendation would deter other nurses from this type of conduct, and found that it was significant enough to ensure that nurses would know the severity of this conduct.

Ultimately, the Hearing Tribunal found that the Joint Recommendation was fair, proportionate and addresses the proven allegations in a way which upholds the integrity of the nursing profession, and holds Mr. Ekpe accountable for his actions. Accordingly, the Hearing Tribunal accepts the Joint Recommendation, in full, as set out below.

ORDER OF THE HEARING TRIBUNAL

SANCTION

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By **January 15, 2024**, the Registrant shall provide a certificate of completion, satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities:

    a. *Relational Practice and Communication (NURS0173 – MacEwan University)*; and

    b. *Nursing Process (NURS0167 – MacEwan University)*.

3. By **January 15, 2024**, the Registrant shall provide to the Complaints Director a self improvement plan for ensuring competency before initiating new procedures ("**Behavior Improvement Plan**") and the Behavior Improvement Plan must be satisfactory to the Complaints Director and must:

    a. Be typed and comply with professional formatting guidelines (American Psychological Association style);

    b. Be at least **five hundred (500)** words in length;

    c. Include a list of **five (5)** goals of self-improvement relating to ensuring competency before initiating new procedures, specifically:

i. Describe how the Registrant will improve their practice, including strategies, plans and supports or resources that may assist their improvement; and

ii. Cite at least **six (6)** applicable standards and responsibilities from the following:

1. the *Documentation Standards*;

2. the *Practice Standards*; and

3. the *Code of Ethics*.

4. 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 Hearing Tribunal's Decision, including the findings and Order; and

e. That the Supervisor agrees to provide to the College **one (1)** Employer Reference following the terms and conditions in paragraph 5 and in the Employer Reference Form attached as **"Schedule A"** to the Joint Recommendation on Sanction.

5. The Registrant shall provide the Employer Reference from their Supervisor **two hundred forty (240) 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 **five hundred sixty (560) hours** of nursing practice;

b. confirmation that such nursing practice hours occur no earlier than the date of the execution of this Agreement; and

c. whether concerns exist about the Registrant's practice as it relates to catheterization technique and patient communications, and whether they met or exceeded the standards expected of a RN.

6. Until the Registrant has submitted the 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 4 and that acknowledges that the Supervisor is prepared to provide outstanding Employer Reference(s) as required in paragraph 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. For certainty and clarity, paragraph 6 does not prohibit the Registrant from submitting research and/or other scholarly work for publication.

(the "**Condition(s)**")

COMPLIANCE

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

9. The Registrant will provide proof of completion of the above-noted Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca or via fax at 780-453-0546.

10. 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.

11. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated noncompliance and any request for an extension.

CONDITIONS

12. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is under an undertaking to not work, is on sick leave or disability leave, or if the Registrant have not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer. The Registrant confirms the following employment:

Employer Name	**Employer Address & Phone Number**
[Employer 1]	[information redacted]
[Employer 2]	[information redacted]

13. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

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

    a. ***Course work required – Arising from Disciplinary Matter;***

    b. ***Behavior Improvement Plan required – Arising from Disciplinary Matter;***

    c. ***Confirmation of Practice Setting(s) required - Arising from a Disciplinary Matter;***

    d. ***Employer Reference(s) (Practice Report) required – Arising from Disciplinary Matter;***

    e. ***Restriction re Practice Setting – Arising from Disciplinary Matter.***

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

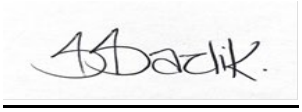
16. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions

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

CONCLUSION

The Hearing Tribunal thanks the parties for their professionalism during the hearing and cooperation in reaching an agreement on the Joint Recommendation. The Hearing Tribunal acknowledges the seriousness of these allegations, and the difficult subject matter of the hearing, and thanks all parties for their thoughtful submissions.

In respect of sanction, the Hearing Tribunal accepts the Joint Recommendation of the parties, in full, and orders as such. This Decision is made in accordance with Sections 80, 82 and 83 of the *HPA*.



Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: July 12, 2023