

NOTICE OF DETERMINATION AND ORDERS

Complaint #2021 – 002

Tonya Llewellyn, Registration Number #004971

Introduction

A Hearing Committee of the College of Registered Nurses of Prince Edward Island (the "Committee") conducted a hearing in Charlottetown, P.E.I. on July 18 and 19, 2022, to consider a complaint dated July 26, 2021 against Registered Nurse Tonya Llewellyn, registration number 004971. The hearing followed a meeting of the Investigation Committee which resulted in a decision on May 2, 2022 to refer the complaint to a Hearing Committee. Members of the Committee at this hearing were Tara Roche (Chair), Melanie MacDonald (member) and Bob Clow (Public Representative). Also, in attendance were Respondent Tonya Llewellyn, her legal counsel, Catherine Fawcett, legal counsel retained by the College to present evidence, Ron MacLeod and, and legal counsel and advisor for the Committee, Doug Drysdale. The hearing was audio-recorded. The purpose of the hearing on July 18 and 19, 2022, was to consider evidence relating to the following allegation against Tonya Llewellyn as described in the Notice of Formal Hearing dated July 17, 2022:

On July 18, 2021, while interacting with a resident being returned to the South Shore Villa by EMS personnel, you engaged in conduct that violated section 57(1)(a) of the *Act*, the following excerpts of the Nursing Standards of Practice:

1.4, 1.6,
2.1, 2.2, 2.3, 2.4, 2.6, 2.7, 2.9,
3.2, 3.3, 3.4, 3.5, 3.6, 3.8,
4.1, 4.4, 4.7,
5.1, 5.2, 5.3, 5.5, 5.8;

and the following excerpts from the Canadian Nurses Association Code of Ethics for Registered Nurses:

A. 1, 2, 3, 4, 5, 6, 7, 8, 12, 13;
B. 1, 4;
C. 1, 2, 6, 7;
F. 1, 3.

The "Act" referred to in these allegations is the Regulated Health Professions Act, R.S.P.E.I. 1988, Cap. R-10.1 ("RHPA").

The Committee, after reviewing all of the testimony, all of the exhibits and all of the written submissions from the two lawyers (submissions on guilt or innocence and submissions on penalty) has decided previously that Tonya Llewellyn is guilty of professional misconduct, and this was communicated to the parties on September 21, 2022. We will now explain our decision and make certain orders.

"Professional misconduct" is one of two discipline offences under the RHPA (the other is incompetence), and is defined under section 57 of the Act:

Professional misconduct

(1) The conduct of a respondent may be found to constitute professional misconduct if

(a) the respondent contravenes this Act, the regulations, the bylaws, standards of practice, code of ethics or practice directions in a manner that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practice a regulated health profession;

There are numerous other parts of the definition in section 57(1), but this is the part that applies to the circumstances of this complaint.

The Notice of Formal Hearing included excerpts from the Standards for Nursing Practice and the Code of Ethics which are attached to this document as Schedule A, and the Committee has considered these in its assessment of the evidence that was presented at the hearing.

CODE OF ETHICS

- A. Providing Safe, Compassionate and Ethical Care. Nurses provide safe, compassionate, competent ethical care.
- B. Promoting Health and Well-Being
- C. Promoting and Respecting Informed Decision Making
- F. Promoting Justice

STANDARDS FOR NURSING PRACTICE -2018

Standard 1 – Unique Body of Knowledge

Each nurse possesses and continually strives to improve upon the specialized body of knowledge based on nursing science relevant to area of nursing practice.

Indicators

Each nurse:

- 1.4 Recognizes the various nursing roles and their relationship to one another
- 1.6 Presents an informed view of the nursing profession and its relationship to the health care system to clients, colleagues, students, other professionals and the public.

Standard 2 - Competent Application of Knowledge

Each nurse demonstrates competency relevant to area of nursing practice.

Indicators

Each nurse:

- 2.1 Uses comprehensive assessment, critical inquiry, technology and research to provide competent nursing services relevant to the area of practice

2.2 Uses current theoretical knowledge and professional judgement, critical inquiry and reflection in making decisions and implements actions relevant to the needs of the client and area of practice.

2.3 Uses communication processes to establish, maintain and conclude therapeutic and professional relationships.

2.4 Designs and develops action plans to address client's needs in collaboration with the client and relevant others.

2.6 Documents assessment, nursing activities, and client outcomes in accurate, timely and thorough manner.

2.7 Performs planned interventions in accordance with appropriate policies procedures and service standards.

2.9 Uses current literature/research and performance indicators to support and direct practice.

Standard 3 – Responsibility and Accountability

Each nurse demonstrates responsibility and accountability to the public by providing competent, safe and ethical nursing practice.

Indicators

Each nurse

3.2 Practices in accordance with the RHPA and its Regulations and Bylaws; the CRNPEI Standards for Nursing Practice; the CNN Code of Ethics; other relevant CRNPEI documents; other relevant Acts and legislation; and individual competence and ability to evaluate own practice.

3.3 Has the current knowledge, skill and judgment needed to practice in her or his setting.

3.4 Is responsible and accountable for her/his actions and decisions at all times.

3.5 Exercises reasonable judgment in decision making.

3.6 Follows established policies and procedures.

3.8 Responds to and reports situations which may be adverse for clients and/or health care providers, including incompetence, misconduct and incapacity of registered nurses and/or other health care providers

Standard 4 – Advocacy

Each nurse demonstrates advocacy for clients in their relationship with the health system by responding to their needs in a way that supports, protects and safeguards the client's rights and interests.

Indicators

Each nurse:

- 4.1 Acts as an advocate to protect and promote a clients' right to self-determination, autonomy, respect, privacy, dignity and access to information
- 4.4 Supports the client to make informed decisions regarding health.
- 4.7 Communicates, collaborates and consults with nurses and other members of the health team about the provision of health care services.

Standard 5 – Continuing Competency

Indicators

Each nurse:

- 5.1 Maintains and enhances current knowledge by investing time, effort, or other resources to attain the knowledge and skills required for practice.
- 5.2 Models commitment to continuing competence through life-long learning, reflective practice and integration of learning into practice.
- 5.3 Seeks out and uses feedback from others in assessing own practice and provides feedback to others to support their professional development.
- 5.5 Demonstrates theoretical knowledge related to own practice area.
- 5.8 Assesses personal competence and assumes responsibility in meeting own professional learning needs and assumes responsibility to acquire knowledge and skills to improve personal practice.

The Committee considered all of these requirements in its review of the evidence and concluded that Tonya Llewellyn contravened a number of them on July 18, 2021, as outlined and explained below under the heading "Decision".

The Committee has interpreted the Notice of Formal Hearing as alleging that the respondent member, Tonya Llewellyn, contravened excerpts from the Code of Ethics and Standards for Practice and so is guilty of professional misconduct (section 57(1)(a) of the RHPA). We reviewed the evidence with this in mind at the time that we decided that Tonya Llewellyn was guilty.

Bifurcation of Hearing

Section 58(4) of the RHPA requires a hearing committee to serve written notice of and reasons for its determination of guilt or innocence, together with a copy of any penalty orders it chooses to make, on the parties, within 60 days after the completion of a hearing. We have done our very best to comply with this timeline, but we are not lawyers. In addition, we encountered a number of practical problems along the way, including the fact that our legal counsel was taken ill for a period of time and unavailable, and we also had some trouble communicating by email for a time. We felt an obligation to be complete and clear in our decision, and this took time. We hope the parties will understand.

Prior to the hearing commencing on July 18th, 2022 the Committee was notified that the lawyers for the College (Mr. MacLeod) and the Respondent (Ms. Fawcett) had reached an agreement to bifurcate the hearings – meaning that the hearings held on July 18 and 19th, 2022 were to be with respect to the complaint alone and that any evidence in relation to penalty would be heard only in the event of a finding of Ms. Llewellyn’s misconduct or incompetence by the committee. The Committee accepted that this was a reasonable way to proceed.

The Hearing

The hearing lasted 2 days. The lawyers presented evidence through 4 witnesses and 4 documents. The following people were called by Mr. MacLeod:

1. Rachel Little – Island EMS
2. Sarah Tibbetts – Island EMS

The following people were called by Ms. Fawcett:

3. Tonya Llewellyn – Member Respondent
4. Bini Thomas – RCW (South Shore Villa)

The following documents were presented with the agreement of both lawyers:

1. Exhibit 1 – The Complaint by Pauline Hood
2. Exhibit 2 – Member’s response
3. Exhibit 3 – Agreed Partial Statement of Facts
4. Exhibit 4 – Joint Book of Documents, which included the majority of the documentary evidence

After the final witness provided her evidence on July 19th, 2022, the hearing adjourned to allow the lawyers to make their final arguments in writing. The Summary Statement from Mr. MacLeod on behalf of the College of Nurses dated Wednesday, August 10th, 2022 was received by the Committee on August 10th, 2022 and the Summary Statement from Ms. Fawcett dated August 12, 2022 was received by the Committee on Monday, August 15th, 2022.

A written notice of the Committees’ finding of Ms. Llewellyn’s professional misconduct was sent to Mr. MacLeod on behalf of the College of Registered Nurses and Ms. Fawcett on behalf of Respondent Ms. Llewellyn on September 21, 2022. The written notice provided an invitation for evidence on the matter of penalty.

Evidence at the Hearing

The events which were the subject of the hearing took place at the South Shore Villa during the day shift of July 18, 2021.

The Director of Nursing (DON), Pauline Hood submitted a complaint to the College of Registered Nurses (CRNPEI) after a complaint was made to her from staff at Island EMS in relation to Ms. Llewellyn’s treatment of a client being transferred back to SSV from the Emergency Department at the Queen Elizabeth Hospital. The following are the findings of the Committee with respect to what happened that day, as gleaned from the witnesses and the documents.

A client known by the staff at the SSV to have had experienced a severe head injury as a result of a motor vehicle crash (MVC) in 1981, had a documented history of angry outbursts, use of foul language and slamming of fists when frustrated. He had a care plan for aggressive behavior. The client had written a document "My Life and Support Plan at a Glance" and stated that he can get frustrated when he can't communicate effectively due to expressive aphasia especially when time is not taken to try to understand him. He also can be forgetful and has difficulty recalling names. The client demonstrated an episode of aggressive behavior on July 18, 2021.

The client was described as "slight", approximately 5'7" and approximately 150lbs. Due to the MVC he has decreased mobility and his gait is unsteady. He has left-sided weakness and uses either a walker or a cane to mobilize. He has a history of falls. He also receives tube feeding via a G-tube, during the day, so has a pump on a pole, that can be wheeled around if up ambulating, during the time his feeds are being administered.

On July 18, 2021, the client had requested medication for loose bowel movements and when he did not receive them after a period, he approached the nurse's station and demonstrated agitated behavior. He shoved his walker in Ms. Llewellyn's legs and began to lift his hand to strike. Ms. Llewellyn was able to have the client return to his room without any further incident, but due to this aggressive behavior, Ms. Llewellyn rapidly decided that police and an ambulance were required to control the situation. Police apparently did not feel their intervention was required at the time and did not go to SSV. The client calmly left the SSV via ambulance for an assessment in the Emergency Department.

Ms. Llewellyn testified that she attempted to contact the on-call physician and Pauline Hood (DON) without success, to make them aware of the transfer to the Emergency Department. Pauline Hood stated in her complaint that she had not received any texts or phone calls from Ms. Llewellyn on July 28.

The Emergency Department physician assessed the client and he was found to not have any psychiatric behavior or delusions. He was cooperative with the assessment and his behavior was appropriate. The client did express remorse for his behavior to the physician. He did express frustration with the situation at SSV. The decision was made, along with on-call physician at SSV, that the client be returned to SSV.

Island EMS was responsible for the transfer back to the SSV. EMS providers, Rachel Little and Sarah Tibbetts were the two paramedics that were present for the client's transfer back to SSV. It was stated in testimony that one paramedic had some prior information about the client and his propensity for aggressive behavior, but she had not witnessed this herself. Both paramedics testified that the client was calm and appropriate during the transfer. They also both testified that upon arriving at SSV at approximately 1900h on July 18, 2021 (i.e. returning the client to SSV), they were met outside the doors of the building by Ms. Llewellyn, who stopped them at the entrance.

At the entrance of SSV, Ms. Llewellyn spoke to the client about his behavior. She did this while standing in front of the client's elevated stretcher and while waving her hand at him. The client was becoming agitated as this interaction was occurring. During testimony, the EMS personnel felt that the way Ms. Llewellyn was communicating with the client was non-therapeutic and was interpreted by them as threatening and inappropriate. One paramedic stepped in between Ms. Llewellyn and the client and addressed with Ms. Llewellyn that the way she was speaking to the

client was inappropriate and stated that the client was in an unsafe position on an elevated stretcher. The paramedics were concerned regarding the client's safety.

The stretcher was repositioned to a safer position and Ms. Llewellyn continued to communicate in what the EMS paramedics described as an aggressive way. Ms. Llewellyn told the client that if his behavior did not improve, he could be evicted and that she could "needle him with Haldol. The Committee understands "needle with Haldol" as referring to an intra-muscular injection of a medication that can be used for acute agitation and/or behavioral problems. It can be referred to as a chemical restraint. Ms. Llewellyn testified that she felt it was necessary to communicate at the entrance of the SSV so that the plan was clear. Ms. Llewellyn also felt the phrase "needle him with Haldol" was not an offensive/aggressive way of describing her possible actions as this was a reference that emergency personnel would be familiar with.

The Committee heard Ms. Llewellyn's testimony which did not agree in all respects with the EMS witnesses' description of events but felt that she was attempting to put herself in a positive light in response to the accusation against her, and where it differs, the Committee prefers the evidence of the EMS witnesses to the evidence from Ms. Llewellyn. More will be said about the conflicts in evidence below.

Following the incident at the entrance of the SSV, the paramedics took the client to his room inside the building and settled him. Ms. Llewellyn did not go into the client's room as it was the end of her shift at 1900h and she gave report to an RN coming on shift. The paramedics returned to the ambulance and drove down the road a bit and stopped to make a call to their supervisor because they were concerned about what had happened. They proceeded to report the interaction between Ms. Llewellyn, themselves and the client. The supervisor then contacted Pauline Hood to share his concerns.

As noted, there were some discrepancies in evidence and those facts in dispute and considered carefully by the Committee will now be discussed.

Both EMS paramedics described the interaction between Tonya Llewellyn and the client outside the entrance of the SSV as aggressive and threatening. They said that Tonya Llewellyn was shaking a pointed finger at the client while talking to him with a raised voice, with her body invading the client's personal space, while the client was on an elevated stretcher in which the client had belts across his legs and chest. EMS personal described this as unsafe, as the client was beginning to become agitated and could fall off the stretcher. EMS personnel testified that Tonya Llewellyn was telling the client in a raised voice and body positioning/actions that were threatening, that if his behavior did not change, he would be evicted from the SSV and that she would "needle him with Haldol". One paramedic described stepping in between Tonya Llewellyn and the client to deescalate the situation. She described the situation as "wildly inappropriate" and that the location of this interaction was also inappropriate. The EMS personnel left the client at SSV but with so much discomfort that they drove down the road only a short distance before stopping to call a supervisor.

Tonya Llewellyn testified that she did confront the client and the EMS personal outside the SSV as she felt the discussion needed to happen before allowing the client back into the facility. Tonya Llewellyn testified that she did raise her hand but only to demonstrate a bulleted list of points. Tonya Llewellyn did not see the interaction as inappropriate and did not think the manner in which she described giving him medication ("needle him with Haldol") if needed, to control agitation, was inappropriate as that phrase is used in Emergency services all the time. Her explanation was that

she had been hurt when the client ran into her with his stroller, and she feared for the safety of herself and others.

There was also considerable discussion regarding Tonya Llewellyn's attempt to contact the Director of Nursing and the on-call physician prior to and following transfer of the client to the QEH. Pauline Hood (DON) at SSV was made aware of the situation on July 19, 2021 as she received a phone call from Tonya Llewellyn. At that time, Pauline Hood made Tonya aware that she (Ms. Hood) was supposed to be notified before transferring a client to hospital, as this had not happened on July 18.

In reviewing Ms. Fawcett's arguments that her client, Tonya Llewellyn, is not guilty, the Committee has not accepted some of the evidence that she relies on and in other cases the evidence outweighs Ms. Fawcett's arguments. The Committee felt that Tonya Llewellyn did not take every reasonable step to obtain interventions through her employer before sending the client unnecessarily to the hospital and did not make multiple requests for help. Also, the paramedics at the door despite having previous information that the defense argued influenced their interpretation of the interaction outside South Shore Villa, were witnesses to an interaction between a Registered Nurse and a patient that in the Committee's view was unprofessional and not reflective of certain parts of the Standards of Care or the Code of Ethics.

Decision

Based on all of the evidence presented and after considering the submissions of the parties, the Committee has decided Tonya Llewellyn contravened Standards of Practice 2.1, 2.3, 2.6, 3.2, 3.4, 3.5, 4.1, 4.4 and 5.8, and Code of Ethics A.2, A.3, A.5, A.13, C.1, and F.3. These violations amount to professional misconduct under section 57(1)(a) of the RHPA.

Standard of Practice 2.1 – Uses comprehensive assessment, critical inquiry, technology and research to provide competent nursing services relevant to the area of practice.

The Committee is of the view, based on Tonya Llewellyn's acknowledged history of being employed in an Emergency Department (ED), that transferring a non-urgent patient to the ED often results in a disruptive and long wait for the patient and would add to the demand of an already strained system. The Committee does not accept that the transfer to the ED would have accomplished anything of real value in the circumstances, and decides it was not patient centered. The angry outbursts that the client displayed were not an acute situation. The pattern was consistent for this client, the only difference was the incident had now happened in a more common area (i.e. not his room).

The angry outbursts were likely a result of a traumatic brain injury (TBI). The Committee notes that, given Ms. Llewellyn's years of experience and acknowledgement that she had dealt with many experiences of violent patients in the past that she would have used critical inquiry to determine the best course of action. Conflict management/resolution is a skill she did not utilize in this situation. Rather than considering other options such as de-escalation, calming techniques for herself and/or the client or sending someone else to try to explain things to the client, she promptly decided to transfer him out of the facility and she then confronted him herself upon return even though she acknowledged in testimony that she seemed to be a "trigger" for the client. TBIs can cause agitation and aggressive

behavior as a result of the area of the brain controlling emotion and behavior being damaged. Ms. Llewellyn made more than one mention in her testimony that the client knew what he was doing and that he was manipulative. Statements such as these do not demonstrate knowledge of TBIs or a comprehensive assessment of the client's cognitive status. Her assessment of imminent risk does not match with objective evidence presented. There was also rounds scheduled for the following day of the incident where the house physician would be present, and a care plan could have been created or altered. Nurse Llewellyn's conduct contravened this standard of practice.

Standard of Practice 2.3 – Uses communication processes to establish, maintain and conclude therapeutic and professional relationships.

The Committee decided that rather than attempting to resolve the conflict, Ms. Llewellyn made the decision to transfer the patient out of the facility without communicating this to the appropriate administrative staff, family or the patient. She claimed that she made attempts to text Pauline Hood but didn't ever follow-up to see if texts were received after not receiving any response and Pauline Hood reported in her complaint that she did not receive any text messages from Ms. Llewellyn on the day of the incident. Ms. Llewellyn was using her personal cellphone to send this communication. There was no attempt to call from the facility landline. Pauline Hood requested 2 meetings with Ms. Llewellyn following the incident and neither of those meetings were accepted by Ms. Llewellyn. The Committee finds that when Ms. Llewellyn confronted the client at the entrance of the SSV following his visit to the ED, she demonstrated non-verbals that were not conducive to developing a therapeutic relationship. She also used a raised voice and threatened to have the client evicted if he did not correct his behavior. Raising her voice, waving her hand near the patient, blocking entrance into the building (EMS personal shared they would have to "move Ms. Llewellyn over to get into the building") and telling him that if his behavior did not change, she would "needle him with Haldol" are not effective communication processes and contravene this standard of practice. There was no awareness by Ms. Llewellyn of the impact of poor non-verbal communication or of best practice strategies related to communication. When Ms. Llewellyn was asked if she considered having another RN speak to the client upon his return, she felt that was "passing the buck". Dr. MacKinnon indicated that he had to calm Ms. Llewellyn down. Tonya Llewellyn contravened this standard.

Standard of Practice 2.6 – Documents assessment, nursing activities and client outcomes in an accurate, timely and thorough matter

Ms. Llewellyn provided evidence that she had experienced outbursts by the client previously but there is no documentation made by her of these incidents. In testimony, Ms. Llewellyn stated that notes were not going to make a difference. She also indicated she didn't think it would be fair to document every verbal altercation. Ms. Llewellyn has documentation on the client's chart that is related specifically to her actions and justification for same, it has nothing to do with the client. This is not appropriate patient charting. There was also no indication in documentation that report was given to the EMS or the ED when transferring the client out of the facility. Ms. Llewellyn received a physician's order for Haldol and this was not documented on a Physician Order Form. Her

documentation is missing the time in many entries. The documentation evidence did not provide a clear picture of what transpired on the day of the incident especially as it relates to Ms. Llewellyn. All of the above contravenes this standard of practice.

Standard of Practice 3.2 – Practices in accordance with the RHPA and its Regulations and Bylaws; the CRNPEI Standards for Nursing Practice; the CNA Code of Ethics; other relevant CRNPEI documents; other relevant Acts and legislation; and individual competence and ability to evaluate own practice.

Ms. Llewellyn responded to a challenging situation in a rapid, emotion-focused manner. Throughout testimony it was shared that she felt that the client knew what he was doing, was manipulative and could control himself. These statements do not correlate with a TBI as well as the client's repeated outbursts despite attempts to have them cease. Ms. Llewellyn did not display any remorse or identify any responsibility in regard to the incident. She feels that her actions were appropriate. When asked specifically about the use of "needle him with Haldol", she described this as being an appropriate term that is understood by emergency medical personal. The EMS personal that were present in this incident felt that term was threatening. There is lack of self-awareness and introspection on the part of Tonya Llewellyn. The Committee has concerns regarding her fitness to practice because of the manner in which she handled the situation. She portrayed the initiating event where the patient rolled his walker into her, striking her, as dangerous to the point that the patient had to be removed from the care facility and police and EMS had to be called. The committee does not accept that there was such danger, and regards Ms. Llewellyn's response as an over-reaction, especially on the part of a seasoned nurse. Ms. Llewellyn identified the date of incident as a "migraine day" and also shared that she does not take sick days. Ms. Llewellyn has not practiced in accordance with The Standards of Practice and Code of Ethics as evidenced by the situations described in this document.

Standard of Practice 3.4 – Is responsible and accountable for her/his actions and decisions at all times.

Ms. Llewellyn testified that felt she did not act inappropriately in any way. She did not feel the way she approached the client was threatening. She does not believe her actions contravened the Standards of Practice or Code of Ethics. She throughout her testimony, deflected responsibility and blamed her decisions/actions on being busy, not having care plans and being ill. Ms. Llewellyn resigned on the day of the incident and also called personnel from EMS following the incident to report to them that there were what she deemed to be inaccuracies in the information shared and in the documentation. She made sure all others involved knew, in her opinion, what they had done wrong. We believe that Ms. Llewellyn was attempting to avoid consequences of her actions. This is not consistent with the standard of practice.

Standard of Practice 3.5 – Exercises reasonable judgement in decision-making.

Ms. Llewellyn's response to this situation was not carefully considered and seemed to be emotion-focused. Ms. Llewellyn did not take into account the client's pathophysiology, pattern of behavior or level of risk - the client was described as being "slight", with weakness on one side and unsteady gait. He often used a cane or walker to ambulate and during the day also had a feeding tube which would be attached to a pole that the client would be traveling with. The assessment related to how much damage the client

could do, does not seem congruent with imminent danger that requires police and EMS. Also, if she was in fact ill on the day of the incident, it would be her responsibility to report that she was not able to work.

Standard of Practice 4.1 – Acts as advocate to protect and promote a clients' right to self-determination, autonomy, respect, privacy, dignity and access to information.

The client advocated for himself to receive Imodium for which he had a PRN (as needed) order. The request made by the client seemed to be interpreted by Ms. Llewellyn as being manipulative. Ms. Llewellyn also made many references to the client lying, being like a child and being aware of what he was doing. Her approach at the entrance of SSV did not exemplify respect or privacy. Her approach was threatening and demeaning. The EMS personnel shared in testimony that they were afraid for the patient's safety under her care due to her disrespect, lack of dignity and also as evidenced by their immediate report of the situation to their supervisor. When asked if the Haldol was administered, Ms. Llewellyn shared it had not been given. The Committee asked if the client had refused the medication what would she have done, she shared she would have proceeded in giving it without his consent if there could be harm to self or others under the Mental Health Act. The client has not been deemed incompetent to consent to treatment nor been diagnosed with any psychiatric illness. Following the incident with Ms. Llewellyn, one of the EMS personnel reported that the client, upon transfer back to his room, stated "I will be a good boy". This statement reflects that the interaction between Ms. Llewellyn and the client was disrespectful and affected his perceived dignity as a competent adult. Ms. Llewellyn contravened her responsibility to consider the client's interests.

Standard of Practice 4.4 – Supports the client to make informed decisions regarding health.

Ms. Llewellyn did not provide the client with any information as to the transfer to the QEH. If she had provided him with her assessment and plan, he could have possibly deescalated. The client was not given the opportunity to provide input. Ms. Llewellyn shared in her testimony that she would have administered the Haldol without needing the client's consent. This was concerning to the Committee as the client has the capacity to consent and the incident with the client did not require administration of an injection typically used for severe behavior problems. The incident stemmed from the client advocating for himself to receive an anti-diarrheal medication for which he had an order. The Committee was concerned about the delay in administering the requested medication. It is not clear when the client requested the medication as documentation is not clear, but EMS received the call for the client to go the QEH at 1331 and EMS documented that they asked for the medication be given before transport at 1422. It is safe to assume that there was a delay of over an hour to administer the medication that the client requested. Ms. Llewellyn did not involve the client and did not support him. If it was because of the circumstances as she alleged, she should have considered other options rather than to take the option which, we feel, was designed to address Ms. Llewellyn's concerns, rather than the client's. The Committee wonders, where was the support for the client?

Standard of Practice 5.8 – Assesses personal competence and assumes responsibility in meeting own professional learning needs and assumes responsibility to acquire knowledge and skills to improve personal practice.

As described under Standard of Practice 3.4 Ms. Llewellyn has not taken responsibility for any of her actions. Ms. Llewellyn did not acknowledge in any way that her actions contravened the Standards of Practice or Code of Ethics. She blamed her actions on busyness of the SSV, the client being manipulative and lying, lack of policies, her supervisor, EMS and the QEH ER. She stated in testimony "I feel strongly that my actions throughout have complied with both the text and spirit of those guiding documents". Ms. Llewellyn also referred to the day of the incident as being a "migraine day", if in fact she was suffering from a migraine, why was she at work? Ms. Llewellyn has not made any apologies, only defended herself and subsequently quit her job at the SSV. She has failed to comply with the requirements of this Standard.

Code of Ethics A.2 – Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health care needs.

The Committee repeats its findings under Standard of Practice 2.3

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

Ms. Llewellyn shared that she had not reviewed the client's chart to determine his likes/dislikes and history, she claimed she did not do this due to busyness. Without knowing information like this, how does one develop a relationship? Rather, Ms. Llewellyn identified that she knew she was a trigger for the client and that they seemed to have "gotten off on the wrong foot". She did not describe any attempts to work on the relationship. She identified in testimony that not being fully aware of his background perhaps explained some of the interaction between them. It is not appropriate to use busyness as an excuse for failure to learn of a client's history. The client presented a need for a medication to control bowel movements and Ms. Llewellyn delayed the administration of same for over an hour. This would be frustrating for the client. Ms. Llewellyn's attitude towards the client certainly contributed to a lack of relationship. She saw the client as being manipulative and a liar. She did not seem to recognize his disability and medical history nor display any empathy for same. She contravened this section of the Code.

Code of Ethics A.5 – Nurses are honest and take all necessary actions to prevent or minimize patient safety incidents. They learn from near misses and work with others to reduce the potential for future risks and preventable harms.

Lack of clear documentation is one thing that stands out as being prohibitive in reducing possible future incidents such as this. There was mention in the case presented on behalf of Ms. Llewellyn in the hearing that the client has a pattern of behavior, but there was minimal documentation, including incidents reports to support this. It is noted that the member's legal counsel was aware of the opportunity to obtain subpoenas from the Committee if needed. The RN was responsible for documenting any changes or incidents reported to them from other staff. Ms. Llewellyn shared on more than one occasion that documentation was not completed due to busyness and also that her feeling was it was not fair to document every verbal altercation. When asked about care plan development for the client, Ms. Llewellyn indicated that she had not time to get into care plans and that you need a complete history of the client, which she did not have. This also then created

a situation in which Dr. MacKinnon did not have a clear understanding of the patient situation. Ms. Llewellyn had concern enough to send the client to the ER, but not enough time or concern to document or assist in care planning. She failed to take all necessary actions to prevent or minimize safety incidents, contrary to this section of the Code.

Code of Ethics A.13 – Nurses work towards preventing and minimizing all forms of violence by anticipating and assessing the risk of violent situations and by collaborating with others to establish preventative measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk and to protect others and themselves.

As mentioned in Code of Ethics A.5, lack of documentation by Ms. Llewellyn contributed to the inability to avoid continuing incidents. The Committee finds that Ms. Llewellyn approached the client in a threatening manner when EMS brought him back to the facility. Threatening behavior always carries a risk of the possibility of violence. Ms. Llewellyn also threatened to administer medication to the client without needing consent, and a threat of eviction from his home. Ms. Llewellyn breached this section of the Code.

Code of Ethics C.1 – Nurses provide persons receiving care with the information they need to make informed and autonomous decisions related to their health and well-being. They also work to ensure that health information is given to those persons in an open, accurate, understandable and transparent manner.

The Committee repeats its findings under Standards of Practice 4.1 and 4.4.

Code of Ethics F.3 – Nurses refrain from judging, labelling, stigmatizing and humiliating behaviors toward persons receiving care or toward other health care providers, students, and each other.

Ms. Llewellyn described the client as knowing what he was doing, being manipulative and a liar. These statements are judgements and humiliating, which are not appropriate at any time but certainly not where a person has had a TBI and a history of becoming easily frustrated, requiring reminders that his behavior is unacceptable. Ms. Llewellyn did not display any empathy or respect for the client's situation. She breached this section of the Code.

Penalty

The Committee reviewed submissions from Mr. MacLeod and Ms. Fawcett received on October 17, 2022 regarding penalty. The Committee was persuaded to rely mostly on Mr. MacLeod's submission. Mr. MacLeod shared the 2020 Wan Fu decision which contains facts that have some similarity to Ms. Llewellyn's circumstances including a raised voice, finger pointing, and threats related to medication. That misconduct led to two-month suspension for a Member without prior discipline. He also shared 2019 Klein decision although the facts are not the same, they are similar, and it includes the fact that it contained multiple incidents with more than one individual. The Committee notes that this is Ms. Llewellyn's second finding of professional misconduct for comparable behavior. In addition, the conduct in both the Klein decision and Ms. Llewellyn's circumstance involved comments that were inappropriate or unprofessional in nature. The language and tone of voice used by Ms. Llewellyn was problematic. Similarly, in Ms. Llewellyn's case her speech and her behavior, including her body language, was aggressive and threatening.

As noted, Ms. Llewellyn has had a previous complaint and subsequent hearing in which there were conditions placed on her license. The decision was appealed and there was a reduction in the amount of money she was to pay, however, all other conditions in regard to her eligibility to practice as a registered nurse remained. These conditions have not been met by Ms. Llewellyn and she has been continuing to practice as a registered nurse. This certainly supports the view that she has not taken responsibility/accountability for her previous actions and this attitude is consistent in what she has presented in this hearing.

The Hearing Committee requires Tonya Llewellyn to comply with the following orders:

1. Tonya Llewellyn's registration to practice nursing shall be suspended for a period of four (4) months, effective the date this decision is delivered to her.
2. Tonya Llewellyn must complete an anger management course through a recognized program acceptable to CRNMPEI at her expense. To comply, Ms. Llewellyn is required to ensure that:
 - a. the course and program have been approved by the CRNMPEI Coordinator of Regulatory Services;
 - b. the person responsible for conducting the program or authorized delegate has expertise in anger management therapy
 - c. the person responsible for conducting the program or authorized delegate has been provided with a copy of the complaint; Notice of Formal Hearing; Agreed Statement of Facts; and this decision, prior to the start of the program;
 - d. within thirty (30) days of the completion of the final session of the anger management course, Ms. Llewellyn shall confirm to CRNMPEI that the person responsible for conducting the program or authorized delegate has forwarded a report to the CRNMPEI Coordinator of Regulatory Services, in which the person or delegate has provided:
 - ii. the dates of any completed sessions;
 - iii. the person or delegate's independent assessment of Ms. Llewellyn's insight into her behavior;
 - iv. Ms. Llewellyn's brief written assessment of the anticipated impact of this course on her future behavior and professional conduct.
3. Beginning at the end of the suspension and every six (6) months for the next three (3) years, Tonya Llewellyn will make herself available and will submit to a workplace audit to be scheduled and conducted by the Coordinator of Regulatory Services for the College of Registered Nurses and Midwives of Prince Edward Island, and the Coordinator will provide reports on Ms. Llewellyn's practice outlining: work performance, use of appropriate communication and interactions with co-workers, patients/residents and their families, the ability to work effectively with other members of the health care team, conflict resolution skills and respect for patients/residents and their families. These reports will be placed on Ms. Llewellyn's file at CRNMPEI and copy sent to the members of this Committee for further action, if circumstances warrant.
4. Tonya Llewellyn shall pay CRNMPEI the amount of ten thousand dollars \$10,000 to cover a portion of the expenses associated with the investigation and hearing of this complaint. This amount shall be paid in full no later than 24 months from the date this decision is delivered to Tonya Llewellyn or her legal counsel.

5. Tonya Llewellyn shall provide a copy of this decision and any other subsequent written decision rendered in relation to this matter to her employer or employers immediately, or to any employer who offers her employment as a Registered Nurse, and shall provide written verification to CRNMPEI from the employer that the employer has received this decision. This obligation will continue until all of the conditions on her registration have been satisfied;
6. Tonya Llewellyn must complete all outstanding conditions which were placed on her registration by the decision in Complaint #2019-002 by April 31st, 2023. The Committee is aware that the appeal of that decision is under appeal, so this condition is subject to the court's ruling at the conclusion of the appeal.
7. In the event that Tonya Llewellyn fails to comply with any of the above conditions or if the results of any of the performance audits are not satisfactory, the Committee will review the circumstances at that time and may suspend Tonya Llewellyn's registration for a further period of time or add other orders.

The Committee has decided on this penalty because Tonya Llewellyn's conduct was serious and not her first offense. The decision for suspension of her registration was not taken lightly. The Committee felt it was necessary given the lack of responsibility as well as lack of effort on her part to meet the conditions placed on her previous Complaint #2019-002

Tonya Llewellyn did have several letters of support which she offered to the Committee as evidence. The Committee did not find them persuasive as they were not provided in a format that could identify who wrote them, they were not signed by the supposed authors and the Committee were not privy to what was shared with the authors that could have influenced what was written in the letters.

Tonya Llewellyn may appeal this decision or any of the orders noted above to Supreme Court of Prince Edward Island within thirty (30) days of receiving this decision as outlined in Section 59 of the RHPA.

Respectfully submitted,

Tara Roche

Chair of the Hearing Committee

January 16, 2023