COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF
A HEARING UNDER *THE HEALTH PROFESSIONS ACT,*

AND IN THE MATTER OF A HEARING REGARDING
THE CONDUCT OF ISOKEN AIGBE

DECISION OF THE HEARING TRIBUNAL
OF THE
COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

IN THE MATTER OF A HEARING UNDER THE *HEALTH PROFESSIONS ACT* REGARDING THE CONDUCT OF ISOKEN AIGBE, LPN #48234, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via teleconference on August 7, 2025, with the following individuals present:

Hearing Tribunal:
Kunal Sharma, Licensed Practical Nurse ("LPN") Chairperson
Rhonda Roach, LPN
Andrew Otway, Public Member
Brett Huculak, Public Member

Staff:
Gregory Sim, Legal Counsel for the Complaints Director, CLPNA
Allie Quigley, Legal Counsel for the Complaints Director, CLPNA
Sanah Sidhu, Director of Professional Conduct, CLPNA

Regulated Member:
Isoken Aigbe, LPN ("Ms. Aigbe" or "Regulated Member" or "Investigated Member")
Kent West, Counsel for the Regulated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

The Agreed Statement of Facts and Admission of Unprofessional Conduct (the "ASF") addresses a complaint received and handled under Part IV of the Health Professions Act ("HPA") about Ms. Aigbe, a regulated member of CLPNA.

The Regulated Member has been registered as an LPN with the CLPNA since July 12, 2019, Registrant #48234, and was registered at all times material to the allegations.

On June 14, 2024, the CLPNA received a notice from Intercare Corporate Group Inc – Southwood Care Center in Calgary, Alberta (the "Facility") of discipline issued to the Regulated Member following an incident with a client on May 26, 2024. The notice was treated as a complaint (the "Complaint") under s. 54(1) of the HPA.

The Complaints Director for the CLPNA delegated their powers and duties under the HPA to Stephanie Karkutly, Complaints Officer and appointed Judith Palyga, Investigator, to investigate the complaint.

Following the receipt and review of the Investigation Report, the Complaints Officer determined that there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of HPA. The Regulated Member received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations dated March 12, 2025.

On July 12, 2024, Ms. Aigbe's practice permit was suspended pending the outcome of hearing following a decision by the CLPNA Council's designate pursuant to section 65 of the HPA.

On June 16, 2025, the suspension was determined to be no longer required for the protection of the public. The suspension was rescinded and a condition requiring "Direct Supervision" of Ms. Aigbe's practice pending the outcome of the hearing was substituted.

A Notice of Hearing was served upon Ms. Aigbe on June 9, 2025.

(4) Allegations

The Allegations in the Statement of Allegations (the "Allegations") are:

> "It is alleged that **Isoken Aigbe, LPN** while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about May 26, 2024, while working at Southwood Care Centre in Calgary, Alberta (the "Facility") behaved in an unprofessional manner in relation to Client RS, particulars of which include one or more of the following:

   a. pushed Client RS into an armchair;
   b. pushed a table into Client RS;
   c. failed to follow Facility policies regarding restraints when they inappropriately restrained Client RS by pushing a table into Client RS's body;
   d. removed a pen or pencil from Client RS's hand in a forceful and inappropriate manner;
   e. verbally mocked and/or intimidated Client RS; and
   f. used excessive force to grab Client RS's wrist contributing to a risk of physical injury.

2. On or about May 26, 2024, while working at the Facility, failed to provide appropriate care to Client RS, the particulars of which include one or more of the following:

   a. failed to follow Client RS's care plan;
   b. inappropriately delegated a medication administration to a Health Care Aide; and
   c. failed to respond or assess Client RS in response to their complaints of injury to their right wrist.

3. On or about May 26, 2024, while working at the Facility, failed to adequately document interactions with Client RS, the particulars of which include one or more of the following:

   a. failed to accurately document the events including the use of restraints on Client RS; and
   b. failed to report Client RS' reports of an injury sustained to their right wrist.

It is further alleged that this conduct constitutes "unprofessional conduct" as defined in s.1(1)(pp)(i), (ii) and (xii) of the *Health Professions Act*, RSA 2000 c H-7 (the "HPA") and in particular, this conduct breaches one or more of the following:

1. Standards of Practice for Licensed Practical Nurses in Canada, Standard 1: Professional Accountability and Responsibility, Indicators 1.1, 1.6, 1.8, and 1.9;
2. Standards of Practice for Licensed Practical Nurses in Canada, Standard 3: Protection of the Public Through Self-Regulation, Indicators 3.3 and 3.5;

3. Standards of Practice for Licensed Practical Nurses in Canada, Standard 4: Professional and Ethical Practice, Indicators 4.5 and 4.6;
4. Standards of Practice for Licensed Practical Nurses on Boundary Violations, Standard 8: Other Boundary Violations, Indicator 1;
5. Code of Ethics for Licensed Practical Nurses in Canada, Principal 1: Responsibility to the Public, Ethical Responsibility, Indicator 1.1;
6. Code of Ethics for Licensed Practical Nurses in Canada, Principal 2: Responsibility to the Clients, Indicators 2.4, 2.7, 2.8 and 2.9; and
7. Code of Ethics for Licensed Practical Nurses in Canada, Principal 3: Responsibility to the Profession, Indicators 3.1, 3.3 and 3.4."

(5) Admission of Unprofessional Conduct

Section 70 of the HPA permits a Regulated Member to make an admission of unprofessional conduct. An admission under s. 70 of the HPA must be acceptable in whole or in part to the Hearing Tribunal.

Ms. Aigbe acknowledged unprofessional conduct to all the allegations as evidenced by her signature on the Agreed Statement of Facts and Admission of Unprofessional Conduct. Mr. West, legal counsel for Ms. Aigbe, verbally admitted that Ms. Aigbe admitted admission of unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Mr. Sim, legal counsel for the Complaints Director, submitted when there is an admission of unprofessional conduct, the Hearing Tribunal should accept the admission absent exceptional circumstances.

(6) Exhibits

The following exhibits were entered at the hearing:

Exhibit #1: Agreed Statement of Facts and Admission of Unprofessional Conduct
Exhibit #2: Joint Submission on Penalty

(7) Evidence

The evidence was adduced by way of Agreed Statement of Facts, and no witnesses were called to give *viva voce* testimony. The Hearing Tribunal accepts the evidence set out in the Agreed Statement of Facts which was admitted as Exhibit #1.

(8) Decision of the Hearing Tribunal and Reasons

The Hearing Tribunal is aware it is faced with a two-part task in considering whether a regulated member is guilty of unprofessional conduct. First, the Hearing Tribunal must make factual findings as to whether the alleged conduct occurred. If the alleged conduct occurred, it must then proceed to determine whether that conduct rises to the threshold of unprofessional conduct in the circumstances.

The Hearing Tribunal has reviewed the documents included in Exhibit #1 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Ms. Aigbe's admission of unprofessional conduct as set out in the Agreed Statement of Facts and Admission of Unprofessional Conduct, within Exhibit 1. Based on the evidence and submissions before it, the Hearing Tribunal did not identify exceptional circumstances that would justify not accepting the admission of unprofessional conduct from Ms. Aigbe.

Allegation 1

Ms. Aigbe admitted on or about May 26, 2024, while working at the Facility, she behaved in an unprofessional manner in relation to Client RS, particulars of which include one or more of the following:

a. pushed Client RS into an armchair;
b. pushed a table into Client RS;
c. failed to follow Facility policies regarding restraints when they inappropriately restrained Client RS by pushing a table into Client RS's body;
d. removed a pen or pencil from Client RS's hand in a forceful and inappropriate manner;
e. verbally mocked and/or intimidated Client RS; and
f. used excessive force to grab Client RS's wrist contributing to a risk of physical injury.

The Hearing Tribunal reviewed Exhibit #1 and below is the Hearing Tribunal's summary of the evidence provided by the parties and accepted by the Hearing Tribunal relating to Allegation 1. The full text of the Agreed Statement of Facts can be found within Exhibit #1.

On May 26, 2024, Ms. Aigbe worked a day shift at the Facility. Client RS was a resident at the facility in the dementia unit. RS suffered from advanced dementia and could exhibit responsive behaviors, including physical and verbal aggression. The Facility had a care plan in place to guide staff on specific de-escalation strategies.

The Hearing Tribunal reviewed video evidence from the incident, which was included in the ASF at Tab 6. RS was seated in the dining area in an armchair. At 0757 hours, Ms. Aigbe came into the dining area with a medication cart. RS and Ms. Aigbe said hello and good morning to each other. RS asked if Ms. Aigbe was her nurse and Ms. Aigbe stated, "Yes I am the nurse today". RS stated, "I don't like this" pointing to something on the table in front of her. Ms. Aigbe responded by stating, "I am sorry madam you have no choice". RS then asked Ms. Aigbe, "What did you bring me". Ms. Aigbe stated, "I did not bring you anything I am here for all the residents so just sit tight when I am ready for you, I will come see you okay". After hearing this RS became physical and verbally aggressive stating "not okay" approximately 7 times. RS started to hit the table in front of her with a pen or pencil she was holding. After a few minutes RS got up from the chair and walked to Ms. Aigbe with her walker. Ms. Aigbe told RS at least 5 times to go back and sit on her chair and do some coloring. However, RS's behavior continued to get more aggressive towards Ms. Aigbe.

RS struck the medication cart numerous times and threatened to kill Ms. Aigbe. RS stated to Ms. Aigbe, "You are not my boss", to which Ms. Aigbe responded, "I am the boss of here".

At 0802 hours, Ms. Aigbe told RS if she continued to hit the medication cart, she would have to take that pen or pencil away from her. Ms. Aigbe told RS she was "a cute old lady" and again advised RS to sit on her chair. RS continued to hit the medication cart so Ms. Aigbe forcefully removed the pen or pencil RS was holding in her right hand. Ms. Aigbe then left the dining room and RS followed her, RS continued to scream and was being very aggressive both physically and verbally. Another staff member heard the commotion and came to assist, she told RS to return to her chair multiple times. RS continued to scream "you are hurting me" and "you are not my boss". RS spat on Ms. Aigbe and her aggression continued to escalate.

Ms. Aigbe continued to verbally direct RS to go back and sit on the chair, however RS was not receptive. At 0806 hours, Ms. Aigbe led RS to sit on the chair and pushed her into the chair. When RS attempted to get up from the chair, Ms. Aigbe pushed a dining table into RS as a physical restraint. Ms. Aigbe held that table against RS for 1 minute and 3 seconds. After that Ms. Aigbe used a second table against the first table as a restraint to keep RS in the chair. This caused RS to become even louder and aggressive towards Ms. Aigbe. Ms. Aigbe stated, "This is music to my ears". At 0809 hours, the video evidence shows that RS was showing her right wrist to another resident possibly pointing an injury. Ms. Aigbe told RS not to hurt that resident, RS stated, "I am not going to hurt her, I am going to hurt you, I am going to kill you". At 0810 hours, RS aggressively rammed her walker into the floor many times. Ms. Aigbe then led RS back to the chair by holding her arm. At 0811 hours, Ms. Aigbe pushed both tables into RS a second time and tried to physically restrain her. RS continued to be very physically and verbally aggressive towards Ms. Aigbe by slamming her hand on the table and stating, "Look what she did to me". RS was able to push both tables into the middle of the dining room. It looked like RS was trying to hit Ms. Aigbe with the tables.

At 0812 hours, Ms. Aigbe passed RS and RS tried to hit her with her right hand. Ms. Aigbe again led RS to sit back into her chair. Ms. Aigbe asked RS, "What are you trying to do". RS stated, "I am trying to kill you". Ms. Aigbe then left the dining room area and RS followed her. RS could be heard screaming at Ms. Aigbe and banging. RS was yelling and wanted to call the police. The video evidence ended at 0815 hours.

Ms. Aigbe's documentation of the incident, which was included in Exhibit 1 at Tab 10, indicates the police were called when other residents were getting hurt. The responding officer was also stabbed with a spoon while talking with RS RS settled shortly close to lunch.

After reviewing the evidence provided in Exhibit #1, the Hearing Tribunal found that Ms. Aigbe pushed RS into an armchair. Twice Ms. Aigbe pushed two tables into RS trying to physically restrain her and failed to follow the facility policies regarding restraints. Ms. Aigbe forcefully removed a pen or pencil from RS's right hand. Ms. Aigbe verbally mocked and intimidated RS Ms. Aigbe used force to grab RS, contributing to a risk of physical injury to her right wrist.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Ms. Aigbe's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #1 prove that the conduct for Allegation 1 did in fact occur.

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

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

ii. Contravention of the Act, a code of ethics or standards of practice;

xii. Conduct that harms the integrity of the regulated profession.

The Hearing Tribunal believes that the video evidence provided shows that Ms. Aigbe used physical force to remove the pen or pencil from RS's right hand. Ms. Aigbe again used physical force by pushing RS to sit in the chair and pushed two tables against RS twice to restrain her from getting up. Ms. Aigbe used no de-escalation strategies to help calm RS down. Instead, Ms. Aigbe only made the bad situation worse by verbally mocking and intimidating RS The Hearing Tribunal recognizes the challenges inherent in working with dementia patients when they are showing physical and verbal aggression towards staff. However, as a professional nurse it is expected that Ms. Aigbe had the knowledge and skills of how to respond in such situations. Ms. Aigbe could have called code white or sought assistance from another staff member. Ms. Aigbe could have left the area to allow RS to calm down or offered her ice cream as written in her care plan. Ms. Aigbe took no such measures.

The Hearing Tribunal finds that Ms. Aigbe's conduct harms the integrity of the regulated profession because Ms. Aigbe did not act in a manner which would be expected of an LPN. LPNs are expected to exhibit effective and respectful communication in their interactions with patients, contributing to safe and positive practice. The video evidence shows laughter, mockery,

and disregard towards a vulnerable patient. These actions directly compromise the LPN profession and the ability to form trusting and therapeutic relationships with patients.

Ms. Aigbe did not abide by the provisions of the Code of Ethics for Licensed Practical Nurses in Canada (2013) ("CLPNA Code of Ethics") or the 2020 Standards of Practice for Licensed Practical Nurses in Canada (the "2020 LPN Standards of Practice") and the Standards of Practice for Licensed Practice Nurses on Boundary Violations (2023) (the "2023 Standards of Practice on Boundaries") (together, the "CLPNA Standards of Practice"), as acknowledged by Ms. Aigbe in the Agreed Statement of Facts and Admission of Unprofessional Conduct. The Hearing Tribunal finds the conduct in question breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and did not demonstrate the competence expected of an LPN.

The conduct breached the following principles and standards set out in the CLPNA Standards of Practice and the CLPNA Code of Ethics :

2020 LPN Standards of Practice:

Standard 1: Professional Accountability and Responsibility – LPNs are accountable and responsible for their practice and conduct to meet the standards of the profession and legislative requirements:

1.1 Practice within applicable legislation, regulations, by-laws, and employer policies.

1.6 Adhere to established client safety principles and quality assurance measures to anticipate, identify and evaluate, and promote continuous improvement of safety culture.

1.8 Are accountable and responsible for their own practice, conduct, and ethical decision-making.

1.9 Document and report according to established legislation, regulations, laws, and employer policies.

Standard 3: Protection of the public through self-regulation. Licensed Practical Nurses collaborate with clients and other members of the health care team to provide safe care and improve health outcomes.

3.3 Lead and contribute to a practice culture that promotes safe, inclusive, and ethical care.

3.5 Understand and accept the responsibility of self-regulation by following the standards of practice, the code of ethics, and other regulatory requirements.

Standard 4: Professional and Ethical Practice. Licensed Practical Nurses adhere to the ethical values and responsibilities described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics

4.5 Demonstrate effective, respectful, and collaborative interpersonal communication to promote and contribute to a positive practice culture.

4.6 Demonstrate practice that upholds the integrity of the profession.

2023 Standards of Practice on Boundaries

Standard 8: Other Types of Boundary Violations,

1. An LPN must maintain professional boundaries in the LPN-patient relationship at all times. Boundary violations:

- can be related to behaviours between an LPN and a patient in areas such as cultural insensitivity, gift giving or receiving, emotional or financial abuse, and
- may occur physically and verbally.

CLPNA Code of Ethics

Principle 1: Responsibility to the Public - Licensed Practical Nurses, as self-regulating professionals, commit to provide safe, effective, compassionate, and ethical care to members of the public.

Ethical Responsibilities:

LPNs:

1.1 Maintain standards of practice, professional competence, and conduct.

Principle 2: Responsibility to Clients – Licensed Practical Nurses provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

Ethical Responsibilities:

LPNs:

2.4 Act promptly and appropriately in response to harmful conditions and situations, including disclosing safety issues to appropriate authorities.

2.7 Develop trusting, therapeutic relationships, while maintaining professional boundaries.

2.8 Use evidence and judgement to guide nursing decisions.

2.9 Identify and minimize risk to clients.

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

Ethical Responsibilities:

LPNs:

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

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

3.4 Promote workplace practice and policies that facilitate professional practice in accordance with the principles, standards, laws, and regulations under which they are accountable.

LPNs are required to reflect and recognize when they need to improve their practices and to ensure they are not overstepping in the nurse patient relationship. An LPN must always maintain professional boundaries. Doing so is an integral aspect of self-regulation which requires that all regulated members participate in ensuring they are providing safe and effective care to patients within the guidelines set out by CLPNA. Failing to do so undermines their ability to practice for the good of their clients which then impacts the ability of the whole health care team to provide care. It is unacceptable to push a dementia patient into a chair and then push tables to restrain her multiple times. This conduct falls below the requirements of the CLPNA Standards of Practice and CLPNA Code of Ethics. For these reasons, the Hearing Tribunal concluded that Ms. Aigbe has also breached the CLPNA Code of Ethics and the CLPNA Standards of Practice.

Allegation 2

Ms. Aigbe admitted that on or about May 26, 2024, while working at the Facility, she failed to provide appropriate care to Client RS, the particulars of which include one or more of the following:

a. failed to follow Client RS's care plan;
b. inappropriately delegated a medication administration to a Health Care Aide; and
c. failed to respond or assess Client RS in response to their complaints of injury to their right wrist.

On May 26, 2024, Ms. Aigbe worked a day shift at the Facility. RS's care plan included several de-escalation strategies to help calm and redirect her. One such strategy was offering RS an ice cream bar when she was agitated. However, Ms. Aigbe refused to allow RS to have an ice cream bar while she was in an agitated state.

RS had scheduled medication to be administered at 0800 hours. RS was physically and verbally aggressive towards Ms. Aigbe so Ms. Aigbe gave the medication administration task to a health

care aide. Ms. Aigbe documented the administration in the medication administration record. Ms. Aigbe did not perform the task herself, nor did Ms. Aigbe observe the administration of medication.

Ms. Aigbe grabbed RS's right wrist forcibly to remove the pen or pencil as seen in the video evidence from the incident, which was included in the ASF at Tab 6. RS verbally indicated many times that she was hurt and even showed her right wrist to another resident. Ms. Aigbe failed to assess or respond to RS's complaint of injury to her right wrist.

The Hearing Tribunal considered and found that the evidence included in Exhibit #1 proves that the conduct for Allegation 2 did in fact occur.

The Hearing Tribunal finds that the conduct amounts to unprofessional conduct as defined in s. 1(1)(pp) of the HPA, in particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

The Hearing Tribunal found that Ms. Aigbe displayed a serious lack of professionalism and judgment when she failed to follow RS's care plan to help deescalate an aggressive situation. Ms. Aigbe was in a position of authority and trust. This conduct falls well below the expectations of an LPN. Ms. Aigbe's conduct harms the integrity of the regulated profession as Ms. Aigbe did not act in a manner which would be expected of an LPN.

Ms. Aigbe did not abide by the provisions of the CLPNA Code of Ethics or the CLPNA Standards of Practice.

For the reasons discussed above, this conduct also harms the integrity of the profession. Ms. Aigbe's conduct breaches the principles and standards of the CLPNA Code of Ethics and the CLPNA Standards of Practice, as set out above under Allegation 1, and the same reasoning expressed there applies to Allegation 2 as well. Such breaches are sufficiently serious to constitute unprofessional conduct.

<u>Allegation 3</u>

Ms. Aigbe admitted on or about May 26, 2024, while working at the Facility, she failed to adequately document interactions with Client RS, the particulars of which include one or more of the following:

a. failed to accurately document the events including the use of restraints on Client RS; and
b. failed to report Client RS' reports of an injury sustained to their right wrist.

On May 26, 2024, at 1225 hours, Ms. Aigbe documented in RS's chart about the incident that took place earlier. Ms. Aigbe also completed an incident report at 1254 hours outlining the incident and the actions taken. However, Ms. Aigbe failed to accurately document that she used tables as restraints to keep RS in the chair. Ms. Aigbe also failed to report that RS sustained an injury to her right wrist during the incident.

The Hearing Tribunal considered and found that the evidence included in Exhibit #1 proves that the conduct for Allegation 3 did in fact occur.

The Hearing Tribunal finds that the conduct amounts to unprofessional conduct as defined in s. 1(1)(pp) of the HPA, in particular, the Hearing Tribunal considered the following definitions of unprofessional conduct:

i. Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
ii. Contravention of the Act, a code of ethics or standards of practice;
xii. Conduct that harms the integrity of the regulated profession.

The Hearing Tribunal found that Ms. Aigbe displayed a serious lack of professionalism and judgment when she failed to document in RS's chart and on the incident report about the use of tables as restraint and injury to RS's right wrist. Ms. Aigbe's failure to accurately document an injury that occurred during an incident and missing critical information in her reporting about that incident falls below the expectations of an LPN. Ms. Aigbe's conduct harms the integrity of the regulated profession as Ms. Aigbe did not document in a manner which would be expected of an LPN.

Ms. Aigbe did not abide by the provisions of the CLPNA Code of Ethics or the CLPNA Standards of Practice.

For the reasons discussed above, this conduct also harms the integrity of the profession. Ms. Aigbe's conduct breaches the principles and standards of the CLPNA Code of Ethics and the CLPNA Standards of Practice, as set out above under Allegation 1, and the same reasoning expressed there applies to Allegation 3 as well. Such breaches are sufficiently serious to constitute unprofessional conduct.

(9) Joint Submission on Penalty

The Complaints Officer and Ms. Aigbe jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.

2. A "Direct Supervision" condition shall be imposed on the Regulated Member's practice permit, requiring them to be supervised by another authorized practitioner or regulated health professional (except for a provisional registrant) who is physically present at the point of care when providing professional services as a Licensed Practical Nurse in Alberta. This condition shall be in place until completion of all orders set out in paragraphs 3 to 4.

3. Within **30 days** of the date of the Hearing Tribunal's decision, the Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice:

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

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

    c. Standards of Practice for Licensed Practical Nurses on Boundary Violations – Standard 8;

    d. CLPNA Policy: Client and Coworker Abuse; and

    e. CLPNA Policy: Professional Responsibility and Accountability.

    These documents are available on CLPNA's website and will be provided. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer.

4. Within **6 months** of the date of the Hearing Tribunal's decision, the Regulated Member shall complete the following remedial education, at their own cost, and shall provide the Complaints Officer with documentation confirming successful completion:

    a. John Collins Consulting Course – Licensed Practical Nurse Module: Nursing Clients with Dementia, available online https://www.jcollinsconsulting.com/index.php/courses-modules/licensed-practical-nurse

    If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Officer.

5. The Regulated Member shall pay a portion of the costs of the investigation and hearing, in the amount of $2,000.00, to be paid over a period of **48 months** of the date of the Hearing Tribunal's decision.

a. The costs must be paid to the CLPNA, whether or not the Regulated Member holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered as an action in debt.

6. The sanctions set out above at paragraphs 3 to 5 will appear as conditions on the Regulated Member's practice permit and the Public Registry subject to the following:

    a. The requirements at paragraph 2 will appear as "Direct Supervision";

    b. The requirements at paragraphs 3 – 4 will appear as "CLPNA Monitoring Orders (Conduct)";

    c. The requirement at paragraph 5 will appear as "Conduct Cost/Fines".

7. The conditions on the Regulated Member's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraphs 3-5. The CLPNA will provide the required notices in accordance with s. 119 of the HPA.

8. The Regulated Member shall ensure their contact information with the CLPNA, including home mailing address, telephone number(s), e-mail address and employment information, is up to date.

9. Should The Regulated Member be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.

10. Should the Regulated Member fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

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

    b. Treat the Regulated Member's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or

    c. In the case of non-payment of the costs described in paragraph 5 above, suspend the Regulated Member's practice permit until such costs are paid in

full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

Legal Counsel for the Complaints Officer submitted the primary purpose of orders from the Hearing Tribunal is to protect the public.

The Hearing Tribunal is aware that s. 82 of the HPA sets out the available orders the Hearing Tribunal can make if unprofessional conduct is found. The Hearing Tribunal is aware that while the parties have agreed on a joint submission as to penalty, the Hearing Tribunal is not bound by that submission. Nonetheless, as the decision-maker, the Hearing Tribunal should give deference to a joint submission unless the proposed sanction is unfit, unreasonable, or contrary to public interest. Joint submissions make for a better process and engage the member in considering the outcome. A rejection of a carefully crafted agreement would undermine the goal of fostering cooperation through joint submissions and may significantly impair the ability of the Complaints Director to enter into such agreements. If the Hearing Tribunal had concerns with the proposed sanctions, the proper process is to notify the parties, articulate the reasons for concern, and give the parties an opportunity to address the concerns through further submissions to the Hearing Tribunal.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Aigbe and the Complaints Officer.

(10) Decision on Penalty and Conclusions of the Hearing Tribunal

The Hearing Tribunal recognizes its orders with respect to penalty must be fair, reasonable and proportionate, taking into account the facts of this case.

The orders imposed by the Hearing Tribunal must protect the public from the type of conduct that Ms. Aigbe has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board*, [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the Regulated Member
- The previous character of the Regulated Member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the Regulated Member in acknowledging what occurred
- Whether the Regulated Member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or

- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

Applying those factors to this case:

The nature and gravity of the proven allegations:

The Hearing Tribunal considers the nature and gravity of Ms. Aigbe actions as being very serious. As an LPN, Ms. Aigbe was in a position of trust over RS It was Ms. Aigbe's responsibility to uphold professional boundaries with RS LPNs are expected to always maintain professional boundaries with patients. However, Ms. Aigbe failed to do so when she pushed RS into chair and used tables as restraints. The Hearing Tribunal considers this a failure to meet the minimum obligations of maintaining professional boundaries with resident RS This demonstrates a need for significant penalties to address these failures. Accordingly, this conduct is grave and the sanction chosen must reflect the gravity of this conduct.

The age and experience of the investigated member:

Ms. Aigbe was initially registered as an LPN with the CLPNA on July 12, 2019. At the time of the incident, she had been an LPN for approximately five years. As such, this is not a case where allegations have been made against a young or new member of the profession who is unaware how to maintain professional boundaries in a nurse-patient relationship. Based on Ms. Aigbe's knowledge and experience as an LPN, she should have known that her conduct was unacceptable. The Hearing Tribunal considers this an aggravating factor demonstrating the need for significant sanctions, particularly with a remedial focus, given that Ms. Aigbe may remain in the profession.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions:

The Hearing Tribunal is not aware of any prior complaints or convictions against Ms. Aigbe.

The age and mental condition of the victim, if any:

The Hearing Tribunal is aware that resident RS was elderly, vulnerable, and suffered from advanced dementia. RS had a care plan with strategies in place to deal with her physical and verbal aggression. Ms. Aigbe did not follow this care plan or use any strategies to help deescalate the situation. The appropriate sanction must take this into account.

The number of times the offence was proven to have occurred:

Ms. Aigbe's conduct was a matter of a single anomalous incident that took place on one shift.

The role of the investigated member in acknowledging what occurred:

The Hearing Tribunal takes into consideration that Ms. Aigbe acknowledged that the conduct found relating to the allegations was unprofessional. Ms. Aigbe worked with the Complaints Officer on an Agreed Statement of Facts and a Joint Submission on Penalty. Ms. Aigbe cooperated during the investigation. This demonstrates accountability and Ms. Aigbe's willingness to take responsibility for her actions.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:

The Hearing Tribunal takes into consideration that Ms. Aigbe has paid greatly due to her actions.

After the incident, Ms. Aigbe was transferred from part-time to casual position. Ms. Aigbe's practice permit was suspended for 11 months. Ms. Aigbe's practice permit was reinstated with a condition of direct supervision. The Hearing Tribunal finds that Ms. Aigbe has likely suffered financial penalties due to her being unable to seek employment as an LPN during the period when her practice permit was suspended.

The presence or absence of any mitigating circumstances:

The Hearing Tribunal was not made aware of any mitigating circumstances.

The impact of the incidents on the victim:

The Hearing Tribunal believes due to RS's elderly age, advanced dementia, and vulnerable conditions this incident certainly had a negative impact. This is therefore considered an aggravating factor.

The need to promote specific and general deterrence and, thereby to protect the public and ensure safe and proper practice:

The Hearing Tribunal believes that there is a need to impose a sanction that deters Ms. Aigbe from repeating this conduct again, as well as a sanction that would deter other LPNs from engaging in similar conduct. The sanctions that are ordered should send a message to both Ms. Aigbe, as well as other LPNs, that this type of conduct will not be tolerated. There are two aspects to deterrence. The first is specific deterrence, meaning that the orders imposed ought to deter the member from repeating conduct in the future. The second aspect of deterrence is general deterrence, meaning that the orders ought to deter other members of the profession from engaging in similar conduct. A professional discipline hearing involves not just the individual, but it also affects the individual's conduct on their patients, colleagues, and the profession. This public dimension is of critical significance.

However, Ms. Aigbe should have been aware of the boundary violations with resident RS The orders sought by the Complaints Officer are designed to assist Ms. Aigbe to avoid conducting herself in such a manner again by imposing a remedial sanction. The orders also reflect an appropriate response to the unprofessional conduct at issue and will also serve as general deterrence for other members of the profession. It will send a message to other members of the

profession that this conduct is unacceptable and that such conduct will not be tolerated, and it will be addressed with appropriate sanctions.

The need to maintain the public's confidence in the integrity of the profession:

LPNs are recognized as independent and capable members of the healthcare team that appreciate the privilege of being a self-regulating profession. The public needs to be reassured that this standard is upheld in each case. The Hearing Tribunal understands that it is important to hold the members of the CLPNA to the standards and obligations expected of them. This is particularly the case regarding fundamental aspects of an LPNs practice, including the maintenance of proper professional boundaries with patients. The Hearing Tribunal must consider what message it will send to the public to maintain confidence in the profession. The public would therefore expect a Hearing Tribunal to sanction Ms. Aigbe in a manner that would deter such conduct from occurring again and which demonstrates that the regulator has taken the conduct seriously. The orders sought by the Complaints Officer will maintain the public's confidence in the integrity of the profession.

The range of sentences in other similar cases:

Counsel for the Complaints Director provided three prior decisions with respect to members of the CLPNA in furtherance of the Complaints Director's submissions.

In College of Licensed Practical Nurses of Alberta in the matter of Bukola Abiona, #38059 (June 2022), the member admitted to multiple allegations of patient abuse. The parties agreed to a sanction including a reprimand and 25% of the costs of the investigation and hearing to be paid within 24 months.

In College of Licensed Practical Nurses of Alberta in the matter of Edna Dayrit, #28993 (April 2022), the member admitted to a single allegation of patient abuse. The parties agreed to a sanction including a reprimand, 25% of the costs of the investigation and hearing, to be paid within 30 months.

In College of Licensed Practical Nurses of Alberta in the matter of Claudette Abudi, #38762 (March 2022), the member admitted two allegations of patient abuse. The parties agreed to a sanction including a reprimand, 25% of the costs of the investigation and hearing to be paid within 30 months.

The Hearing Tribunal has considered the sentencing in similar cases. The decisions provided by counsel for the Complaints Director indicate that a sanction focusing on remedial education and an order for costs are appropriate in similar situations.

It is important for the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA Standards of Practice, and in doing so, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter and again considered the seriousness of Ms. Aigbe's actions.

The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that unprofessional conduct such as this will not be tolerated and it is intended that these orders will, in part, act as a deterrent to others.

The Hearing Tribunal is of the view the proposed penalties adequately balance the factors referred to in the Jaswal decision and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure the public is protected. After considering the proposed orders for penalties, the Hearing Tribunal finds the submission on penalties is appropriate, reasonable and serves the public interest and therefore accepts the proposed penalties.

(11) Orders of the Hearing Tribunal

The Hearing Tribunal is authorized under s. 82(1) of the HPA to make orders in response to findings of unprofessional conduct. The Hearing Tribunal makes the following orders pursuant to s. 82 of the HPA:

1. The Hearing Tribunal's written decision (the "Decision") shall serve as a reprimand.
2. A "Direct Supervision" condition shall be imposed on the Regulated Member's practice permit, requiring them to be supervised by another authorized practitioner or regulated health professional (except for a provisional registrant) who is physically present at the point of care when providing professional services as a Licensed Practical Nurse in Alberta. This condition shall be in place until completion of all orders set out in paragraphs 3 to 4.
3. Within **30 days** of the date of the Hearing Tribunal's decision, the Regulated Member shall read and reflect on how the following Educational Readings will impact their nursing practice:
    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. Standards of Practice for Licensed Practical Nurses on Boundary Violations – Standard 8;
    d. CLPNA Policy: Client and Coworker Abuse; and
    e. CLPNA Policy: Professional Responsibility and Accountability.

    These documents are available on CLPNA's website and will be provided. If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Officer.
4. Within **6 months** of the date of the Hearing Tribunal's decision, the Regulated Member shall complete the following remedial education, at their own cost, and shall provide the Complaints Officer with documentation confirming successful completion:
    a. John Collins Consulting Course – Licensed Practical Nurse Module: Nursing Clients with Dementia, available online

https://www.jcollinsconsulting.com/index.php/courses-modules/licensed-practical-nurse

If such course(s) become unavailable, an equivalent course(s) may be substituted where approved in advance in writing by the Complaints Officer.

5. The Regulated Member shall pay a portion of the costs of the investigation and hearing, in the amount of $2,000.00, to be paid over a period of **48 months** of the date of the Hearing Tribunal's decision.

    a. The costs must be paid to the CLPNA, whether or not the Regulated Member holds an active practice permit with the CLPNA. Any outstanding costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered as an action in debt.

6. The sanctions set out above at paragraphs 3 to 5 will appear as conditions on the Regulated Member's practice permit and the Public Registry subject to the following:

    a. The requirements at paragraph 2 will appear as "Direct Supervision";

    b. The requirements at paragraphs 3 – 4 will appear as "CLPNA Monitoring Orders (Conduct)";

    c. The requirement at paragraph 5 will appear as "Conduct Cost/Fines".

7. The conditions on the Regulated Member's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraphs 3-5. The CLPNA will provide the required notices in accordance with s. 119 of the HPA.

8. The Regulated Member shall ensure their contact information with the CLPNA, including home mailing address, telephone number(s), e-mail address and employment information, is up to date.

9. Should The Regulated Member be unable to comply with any of the deadlines for completion of the orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Officer.

10. Should the Regulated Member fail or be unable to comply with any of the above orders for penalty, or if any dispute arises regarding the implementation of these orders, the Complaints Officer may do any or all of the following:

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

b. Treat the Regulated Member's non-compliance as information for a complaint under s. 56 of the *Health Professions Act*; or

c. In the case of non-payment of the costs described in paragraph 5 above, suspend the Regulated Member's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

The Hearing Tribunal believes these orders adequately balances the factors referred to in Section 10 above and are consistent with the overarching mandate of the Hearing Tribunal, which is to ensure that the public is protected.

Under Part 4, s. 87(1)(a) and (b) and 87(2) of the HPA, the Regulated Member has the right to appeal:

> **"87(1)** An investigated person or the complaints director, on behalf of the college, may commence an appeal to the council of the decision of the hearing tribunal by a written notice of appeal that
>
> (a) identifies the appealed decision, and
>
> (b) states the reasons for the appeal.
>
> **(2)** A notice of appeal must be given to the hearings director within 30 days after the date on which the decision of the hearing tribunal is given to the investigated person."

DATED THE 18th of August 2025, IN THE CITY OF CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kunal Sharma, LPN
Chair, Hearing Tribunal