Complaint # 2019-002
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 February 10, 11, 12, and 13, 2020, to consider a complaint dated February 4, 2019 against Registered Nurse Tonya Llewellyn, registration number #004971. The hearing followed a meeting of the Investigation Committee which resulted in a decision on November 13, 2019 to refer the complaint to a Hearing Committee to proceed with a hearing.

Members of the Committee in attendance at this hearing were Cynthia Bryanton (Chair), Carol Walker (member) and Gerry MacPhee (Public Representative). Also in attendance were Respondent Tonya Llewellyn, adducers of evidence Tom Keeler and Chera-Lee Gomez, and legal counsel and advisor for the Committee, Doug Drysdale. The hearing was recorded.

The purpose of the hearing on February 10-13, 2020, was to consider evidence relating to three allegations against Tonya Llewellyn as described in the Notice of Formal Hearing, as follows:

1. On December 15 and 16 , 2018 , while visiting a family member who was ill at the Kings County Memorial Hospital ("KCMH") , you engaged in conduct which violated the provisions of the Act, in that you failed to follow established policies and procedures with respect to Infection Prevention and Control while visiting this family member and providing related nursing care;

2. On December 15 and 16 , 2018 , while visiting a family member who was ill at the KCMH, you engaged in conduct which violated provisions of the Act ,

in that you treated nursing staff and other health care providers in a demeaning, disrespectful and unprofessional manner; and

3. On or about January 14, 2019, after becoming aware of complaints regarding your conduct at the KCMH on December 15 and 16, you engaged in conduct which violated the provisions of the Act, in that you left a voicemail with the complainant, Sandra MacKay, which was both threatening and unprofessional in nature.

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 has decided that Tonya Llewellyn is guilty of professional misconduct in all three allegations and also guilty of incompetence in the first allegation. We will now explain our decision.

"Professional misconduct" and "incompetence" are discipline offences under section 57 of the RHPA:

> **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;
>
> (a.1) in the opinion of the investigation committee or the hearing committee, the conduct is harmful to the best interests of a client or other person, or to the integrity of the profession;
>
> (b) the respondent has been found guilty of an offence that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practice a regulated health profession;
>
> (c) the respondent refuses or fails to cooperate fully in respect of the investigation or hearing of a complaint;
>
> (d) the respondent contravenes an order made under this Act; or
>
> (e) the conduct of the respondent constitutes professional misconduct as set out in the regulations.

Incompetence

(2) The conduct of a respondent may be found to constitute incompetence where

(a) an act or omission of the respondent

(i) demonstrates a lack of knowledge, skill or judgment,

(ii) demonstrates disregard for the safety or welfare of a client, or

(iii) constitutes incompetence as set out in the regulations; or

(b) the respondent is unable to practice a regulated health profession in accordance with accepted professional standards for any reason, including that the respondent is impaired by illness, addiction or other incapacity.

The Notice of Formal Hearing included excerpts from the Standards for Nursing Practice and the Code of Ethics, 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.

G. Being accountable

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

STANDARDS FOR NURSING PRACTICE -2018

Standard 2 - Competent Application of Knowledge

Each nurse demonstrates competency relevant to area of nursing practice.

Indicators

Each nurse:

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.

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

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.

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). For example, if there were policies and procedures in place at KCMH which Tonya Llewellyn knew about and failed to follow, section 3.6 above indicates that that would be professional misconduct. Whether the member is also guilty of incompetence in relation to the first allegation depends on whether the evidence establishes that she did something or failed to do something that demonstrated a lack of knowledge, skill or judgment, or which demonstrated a disregard for the safety or welfare of a client (section 57(2)(a)(i) and (ii)).

The hearing lasted for four days. The adducers, Mr. Keeler and Ms. Gomez, presented evidence through seven witnesses and two documents. It is worth noting that the first exhibit was a Joint Book of Documents, which includes numerous records and documents and which was presented on behalf of both the adducers and the respondent member, Ms. Llewellyn. The following people were called by the adducers:

1. Sandra MacKay, Director of Nursing at Kings County Memorial Hospital ("KCMH"). Ms. MacKay filed the complaint with CRNPEI;
2. Dr. Scott Campbell;
3. Staff of KCMH:
    - Julie Grant, RN

- Tanya Young, RN
- Wendy Rudzki, RN
- Ashley Montgomery, RN
- Stephanie Creed, PCW

Tonya Llewellyn presented evidence through eight witnesses and five documents, in addition to documents which were included in the Joint Book of Documents. All of these eight witnesses were members of Ms. Llewellyn's family:

- Roxanne Llewellyn, mother
- Tammy Stevenson, sister
- Dakota Llewellyn, son
- Jody Llewellyn, brother
- Alexis Stevenson, niece
- Blake Stevenson, nephew
- Grant Llewellyn, nephew
- Tonya Llewellyn, member respondent

The events which were the subject of the hearing took place at the KCMH during the evening of December 15, 2018 and into the morning of December 16, 2018. The first two allegations in the Notice relate to those events. The events also caused Tonya Llewellyn to leave a voicemail message for the complainant, Sandra MacKay, approximately one month later, on January 14, 2019. That phone call is the subject of the third allegation in the Notice.

Objection

Before delving into a review of the evidence of what transpired on December 15th and 16th, 2018, we wish to note that the Respondent, Tonya Llewellyn, has objected to the process we have used in deciding this complaint. As noted above, the hearing was held on four days in February, 2020. Unfortunately, four days was barely enough time to hear all of the evidence that the parties wanted to provide to us. No additional time had been scheduled, and the members of the Committee were not available to hold another hearing day in the near future. On

the fourth day of the hearing, evidence from both parties was completed by the end of the day – after 5p.m., in fact. Mr. Keeler requested an opportunity to make submissions on penalty (which would have been followed by submissions from Tonya Llewellyn), but the Committee decided that it was too late in the day. The day concluded with a thank you to both parties and that the Committee would be in touch.

On March 16, 2020, we asked the CEO of the College to schedule a date for the resumption of the hearing to give our decision, and to provide the parties with an opportunity to tell us what penalty we should impose, if we concluded that Tonya Llewellyn was guilty of anything. Dates in mid-April, 2020, were proposed, and everyone agreed that the meeting would take place on April 15, 2020. However, several days later, Ms. Llewellyn wrote to the CEO to ask if the April 15th date was "beyond the 60 day deadline?" Also, on March 15th, 2020, Tonya Llewellyn sent an email to the CEO to ask whether "being called back" was standard procedure. The CEO asked legal counsel, Mr. Drysdale, to respond to Ms. Llewellyn, and on March 16th, 2020, she referred to a section in the RHPA which requires the notice and reasons for the Committee's decision to be made within 60 days after the completion of the hearing, and she asked why she was being called back to a hearing which she thought had been completed. Mr. Drysdale and Ms. Llewellyn exchanged a number of emails, which were provided to the Committee. Ms. Llewellyn's two concerns were that the April 15th date was more than 60 days after the last hearing day had been held, and there was no express authority in the RHPA for a person to be called back to a hearing after the parties had made final argument. In her view, the hearing had finished on February 13, 2020.

On March 26, 2020, I wrote to Ms. Llewellyn and copied my letter to Mr. Keeler to inform the parties that the Committee had decided to ask the parties to make their submissions with respect to an appropriate penalty in writing, and that a meeting would not take place, because the COVID-19 pandemic had occurred. The parties were asked to make written submissions on penalty by April 8, 2020.

Ms. Llewellyn objected that this process was not authorized by the RHPA, but she did send in a submission on April 8, 2020 suggesting that no penalty should be imposed in this case since some people had changed their evidence under oath, she had lost money because of the complaint, and had incurred legal costs. On that same date, Ms. Llewellyn wrote to the Committee's legal counsel and to Tom Keeler after reading Mr. Keeler's submission on penalty, and asked that the matter be adjourned to allow her to seek legal advice. On April 14, 2020, I wrote to the parties to allow each party to respond to the other's submissions on penalty, by April 24, 2020. The Committee did not grant an adjournment.

On April 21, Tonya Llewellyn sent an email to Mr. Drysdale to express concern about the process used by the Committee. On April 24th, Ms. Llewellyn send a letter outlining her concerns and Mr. Keeler indicated that he had nothing to add to his earlier submissions. Tonya Llewellyn did not comment on the penalty submissions which Mr. Keeler had made on April 8, 2020.

It is the Committee's view that we provided a fair hearing to Tonya Llewellyn in difficult circumstances. We attempted to finish the hearing in the four days scheduled, and then scheduled another day, and then changed our plan to have another hearing day when Ms. Llewellyn raised her concerns, and the COVID-19 crisis happened. In our view, the hearing was not completed until both Tonya Llewellyn and Tom Keeler were given an opportunity to make submissions on the appropriate penalty to be given in the event of a finding of guilt on Ms. Llewellyn's part. We would have preferred to issue our decision on guilt or innocence first, and then to discuss penalty, but that simply was not workable.

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 order it chooses to make, on the parties, within 60 days after the completion of a hearing. If the hearing was completed when the evidence was completed, this decision should have been issued by mid-April 2020. As to that requirement, the Committee states that despite its best efforts, it was not possible to meet that deadline: the four-day hearing involved many witnesses

and documents, and the Committee members are not lawyers, and did not have an abundance of time to decide the matter. In addition, the worldwide Covid-19 pandemic occurred in mid-March 2020, and made meeting the deadline impossible.

Regardless, it is our view that the requirement to issue decisions and an order, if any, within 60 days after the completion of a hearing refers to the time when all of the evidence has been submitted and each party has told the Committee what penalty should be imposed in the event of a finding of guilt. The submissions from the parties were received by April 24, 2020, which means that the Committee had until June 24, 2020 to comply with the requirements of the Act.

The Committee tried its best to provide a fair process to Tonya Llewellyn as required by the RHPA. We tried to finish the hearing in the allotted time, but were not able to hear from the parties about what sort of penalty should be imposed in the event of a finding of guilt. We then scheduled another hearing day to provide our decision to the parties before asking them to comment on penalty, but Ms. Llewellyn objected to being "called back" in front of the panel, and argued that the dates selected did not comply with the Act. Then the Committee decided that written submissions would have to suffice, influenced largely by the onset of the COVID-19 pandemic. Although Ms. Llewellyn was not satisfied with this process, she participated. It was the best that we could do. The Committee does not agree with Ms. Llewellyn's objections.

Evidence at the Hearing

The Director of Nursing at the Kings County Memorial Hospital filed a complaint with the College of Registered Nurses of PEI after family members of a sick patient caused a disruption at the hospital on December 15th and 16th, 2018. The following circumstances were described by various witnesses at the hearing.

Tonya Llewellyn's mother was ill and attended at the KCMH emergency department on December 14, 2018, and was then admitted to the inpatient unit

of the hospital that same day with unknown etiology of her illness. She was placed on infection control precautions in room number 1044, which is an isolation room with an adjoining anteroom. Located directly across the hall from room number 1044 was another patient room that was being used as a clean utility room at the time.

During the course of her stay, Roxanne Llewellyn did not improve, became more symptomatic and quite ill—she testified at the hearing that she does not remember her stay at KCMH. Tonya Llewellyn visited with her mother at KCMH and stayed with her in her mother's hospital room from approximately 6 p.m. on Saturday, December 15, 2018, until Sunday, December 16, 2018 at approximately 8 a.m., when Roxanne Llewellyn was transferred to the Queen Elizabeth Hospital ("QEH").

Various members of Roxanne Llewellyn's (and Tonya Llewellyn's) family were present at the KCMH in the afternoon of Saturday December 15, 2018, and others arrived later, and several departed during the evening. Most were in the hospital during the events which transpired.

The allegations against Tonya Llewellyn relate to care and assistance she provided or attempted to provide to her mother during the evening of December 15, 2018, interactions she had with KCMH nursing staff, and her attitude and demeanor at the time. These interactions occurred because of Tonya Llewellyn's concern for her mother, but also because the members of her family were also interacting with KCMH nursing staff.

These facts are not controversial and were not disputed by anyone. The evidence that <u>was</u> in dispute at the hearing will be discussed below.

It is also not disputed that Tonya Llewellyn left a voicemail message for Sandra MacKay on January 14, 2019; a copy of the recorded message was played at the hearing, and Ms. Llewellyn acknowledged that she had left the message. The only real issues with respect to this third allegation are whether the statements said by

Tonya Llewellyn in that voicemail message were “threatening and unprofessional in nature”, and whether such conduct is professional misconduct.

The Committee considered all the evidence that was presented through the witnesses and the documents in making this decision. There were two groups of witnesses. The first group (for the adducer) were members of the KCMH staff, including the Director of Nursing Sandra MacKay (the complainant), and Dr. Scott Campbell, Physician. The second group of witnesses (for the member Respondent) was Tonya Llewellyn herself and her family members who had been at the hospital visiting her mother.

It is important to note that the Committee heard a lot of evidence over the four days, but a significant portion of the evidence was not relevant to any of the three allegations contained in the Notice of Formal Hearing. This evidence was presented, we believe, to divert this Committee’s attention away from what Tonya Llewellyn did on those two days at KCMH and to create the impression that Ms. Llewellyn was simply an innocent bystander in an environment where emotions were running very high. The Committee listened carefully to all of the evidence, but has decided that Ms. Llewellyn was not simply a bystander—she was and is a registered nurse with specific responsibilities.

Allegation 1

Tonya Llewellyn was accused of failing to follow established policies and procedures with respect to Infection Prevention and Control. The evidence from both groups of witnesses established that Tonya Llewellyn visited her mother in the evening of December 15th, 2018 and through the night on December 16, 2018, and at that time, she provided nursing care to her mother. She attempted to start an IV, she took vitals and made suggestions to KCMH nursing staff regarding care for her family members, one of whom – her son – was quite sick, although not a patient. We did not hear evidence with respect to any established policies and procedures for making suggestions to staff regarding care for a family member, but we did receive evidence that Roxanne Llewellyn was in an isolation room

because it was believed that she had an infectious condition. A policy concerning "Routine Practices" was included in the evidence, and it stated that certain standards of infection control practice are required to prevent transmission of infection in all health care settings. Gloves should be put on immediately before any activity for which they are required. Gowns should only be worn when providing care for patients. When use of a gown is indicated, the gown should be put on immediately before the task is carried out.

Both Dr. Scott Campbell and Wendy Rudzki, RN testified that Roxanne Llewellyn was on isolation precautions during the time that Tonya Llewellyn was present with her mother. These precautions meant that family members, including Tonya Lewellyn, were required to wear precautions gear. Exhibit 1 Tab 26 page 85 of 154 pages. Exhibit 1 Tab 26 page 93 of 154 pages. Director of Nursing Sandra MacKay testified that the Health PEI "Routine Practices" policy was in use at KCMH at the time of the incidents. The Routine Practices policy outlines the proper use of Personal Protective Equipment. Exhibit 1 Tab 8 pages 4 and 5 of 13 pages. Exhibit 1 Tab 8 Appendix C pages 12 and 13 of 13 pages. Stephanie Creed and Wendy Rudzki gave evidence that the isolation room where Roxanne Llewellyn was being cared for was properly labeled as required by isolation precautions. Exhibit 1 Tabs 9 and 10 outlines the signage and labeling used.

Dr. Campbell testified that he spoke to Tonya Llewellyn on the evening of December 15th, 2018 and she was wearing Personal Protective Equipment in the hallway when she was speaking with him. Similarly, Stephanie Creed testified that Tonya Llewellyn returned to the nursing station after placing her son in the clean utility room, and that she was wearing a gown and gloves at the time.

Tonya Llewellyn herself confirmed that she was aware that the room where her mother was a patient was subject to isolation precautions, and she admitted that she left this room wearing her PPE on at least one occasion (when an altercation in the clean utility room between family members and nurse Young occurred). She testified that she put on a clean gown and gloves before going to the Nursing

Station. With respect to the PPE, she stated that she did not touch anything when she was out in the hallway with the PPE on.

Evidence was heard that hospital staff had informed various members of the family of the need to observe isolation procedures, and whether every family member was specifically told about these requirements is unclear. Several family members disputed the evidence that labels related to isolation precautions were in place, but we are satisfied that Tonya Llewellyn was aware of the policies and procedures concerning infection control because she was in communication with KCMH staff, she admitted to wearing PPE, and she is, after all, a registered nurse. She was familiar with measures designed to prevent the spread of infection but argued that she should not be expected to behave like a nurse on duty when she was present to help her mother and was concerned about her mother's health. We do not accept that argument.

Another policy was presented to us (Exhibit 1, Tab 7) – "Initiation, Maintenance and Removal of Adult Peripheral Intravenous ("IV"). Although this policy does not specifically say that an IV cathlon should only be used once when attempting an IV start and properly discarded in a sharps container it is basic nursing knowledge and practice that you use one cathlon per IV attempt, you do not reuse it for a second attempt.

Sandra MacKay testified that this policy was in use at KCMH at the time of the events on December 15th and 16th, 2018. Nurse Rudzki testified that she passed IV supplies to Tonya Llewellyn through the patient room door and then proceeded through the anteroom before entering the patient room, and was surprised to see Tonya Llewellyn attempting to start an IV on her mother. An incident report written on December 24, 2018 describes what occurred (Exhibit 1, Tab 18):

> … The daughter that is an RN in QEH had voiced to her cousin another RN working in KCMH that she wanted to start a new site. Writer was given this information from the cousin, and decided to try a new IV site; The daughter was at the doorway to the room and took the IV supplies from writer at the door,

> writer advised the daughter that she did not have to start the IV, and writer proceeded to the connecting ante room to gown up as the client was on isolation. Writer found upon entering that the daughter had attempted the IV. Supplies were not all ready. Writer noticed possibly 2 to 3 spots where the daughter possibly had attempted the IV on the left wrist area, with the same cathlon.

Tammy Stevenson, Tonya Llewellyn's sister, who is also a registered nurse, testified that she was in Roxanne Llewellyn's room when she saw Tonya Llewellyn attempt an IV on her mother, and Tonya herself testified that she made two attempts to start an IV on her mother and she used only one cathlon for the two attempts.

Wendy Rudzki testified at the hearing that she was surprised to see Tonya Llewellyn attempt an IV, which implies that Tonya Llewellyn was not asked to perform this nursing task, and the incident report written by Nurse Rudzki in late December 2018 states that Nurse Rudzki told Tonya that she did not have to start the IV. However, it was not an unreasonable conclusion for Tonya to make that her help was appreciated. Tonya Llewellyn testified that KCMH staff was not providing adequate care to her mother and she needed to step in. She stated that the nurses were busy, and she was offering to help start the IV.

Allegation 2

The Committee heard evidence from both groups that there were several interactions between Tonya and her family members, and Tonya and the KCMH staff. The Committee acknowledges that it was an emotional and stressful time for Tonya and her family as Roxanne Llewellyn was ill with unknowns. Generally-speaking, the family members appeared to feel that their mother was deathly ill and was not being properly monitored and cared for. On the other hand, generally-speaking, staff at KCMH felt that the family and Tonya Llewellyn in particular, were not observing necessary safety requirements and were being disruptive and rude.

As noted earlier, the Committee listened to all of the testimony, and reviewed the documentation which was entered into evidence. The staff members described a very disruptive scene which was close to chaos at times, while the family members described a fairly calm scene, although there was disagreement between family members and staff members, and the family members felt that their relative had not been receiving good care. Where there is conflict between evidence from family members and the evidence from KCMH staff, we are inclined to accept the evidence from KCMH staff because it is supported by health records that were prepared at or close to the time of the events, and is consistent with the evidence given by staff members. Documents created by staff at the time the events were happening were made under a legal duty to accurately record events, and they were made before anyone knew that a complaint was being considered or would be filed with CRNPEI. In other words, that evidence, supported by the testimony of witnesses at the hearing, is likely true. As an example, documentation written by Tanya Young on December 15, 2018 at 22:20 hrs (partial excerpt), and we accept that this is a fairly accurate description of what occurred:

> PCW Stephanie came to writer very frustrated and informed writer of what just happened (Family members were taking over the back part of the hospital and using staff washroom, taking 2 wheelchairs and racing around the back hallway, going into the back storage room and sleeping in clean chairs, being rude to nursing staff and neglecting everything nursing staff nicely advised them not to do because it was unsanitary, etc.). PCW informed RN that the young man would not get out of a Pt's chair in the back room because he felt unwell and his mother (Tonya) advised him to go in there and sleep due to his HR = 146. Writer went down to the back room to speak to the young man and find out if he was ok or if he need to be taken to the QEH for further assessments since we did not have a Dr at the hospital at this hour. The only word writer got out was hello when the young man laying in the chair shouted "get the hell out now". Writer informed the young man that this was a hospital and that he is to lower his voice. Writer then asked the young man if he was ok to which he replied "no I'm not now get the hell out". at this time an older man was standing in the hallway and began yelling at writer to walk the F#### away and that they will do what they want here while in the hospital with the Pt. Writer then told the older man that he was being disrespectful and that there was no need for his rude behaviour. Writer then informed Pt that this is our hospital and that their inappropriate language and bullying behaviour were not wanted. The older man

> then began to walk into writers personal space and up to their face yelling at writer and writer then backed away from older man until the man backed writer in the wall. At this point another man was blocking the doorway of the back room leaving writer now in the back room with three of the men yelling and degrading writer. Mother (Tonya) then came out of the Pt's room and rudely told writer that the young man (son) was sick and that he was staying there in the chair if writer liked it or not. …

On the part of the family members, we understand that they were concerned and upset about their mother, and they might sincerely have felt that their mother was not being well taken care of, but the evidence from the family members is not supported by hospital records made at the time, and seems to be surprisingly similar about certain facts. On occasion, it appeared to us that members of the family were looking to Tonya Llewellyn for guidance for what evidence to give. In fact, one family member, Tammy Stevenson, stated "I don't know what you want me to say" when it appeared that Tonya was not satisfied with an answer. We regard the evidence from family members as less reliable than evidence from staff because the family was protecting the family unit.

The incident of most concern occurred on the evening of December 15th, 2018 when family members were upset and KCMH staff members (including Stephanie Creed and Tanya Young, among others) were intimidated and fearful. This is the situation described in the progress notes referred to above. At this time, Tonya Llewellyn's son, Dakota Llewellyn, was feeling unwell and was resting in a clean isolation room. KCMH staff made several attempts to remove him and family members resisted these efforts and tempers flared. At one point, Tonya's brother, Jody Llewellyn, stated "It was the closest I ever came to hitting a woman", which gave the Committee some idea of the intensity of the situation.

Tonya Llewellyn was in her mother's room across the hallway and exited the room with personal protective equipment ("PPE") on, and rather than taking steps to calm people down, she chose to criticize KCMH staff and echoed the sentiments which were being expressed by other family members about the quality of care that her mother was receiving. Her actions and behaviors were

not professional and were disrespectful to the staff involved and were not what is expected of a registered nurse, whether that nurse is on duty or not. Tonya Llewellyn helped create the situation of tension and conflict, and failed to act properly to lower it. Specifically, the Committee finds that Tonya Llewellyn was rude, demeaning, disrespectful and unprofessional towards nursing staff. Examples of this are found in Exhibit 1 Tab 15 incident report documented by Tanya Young RN titled verbal use/threat, Exhibit 1 Tab 13 incident report documented by Julie Grant RN titled verbal abuse /threat.

There were several interactions between Tonya Llewellyn and the KCMH nursing staff and other health care providers on December 15th and 16th, 2018, which concern the Committee including:

- When she arrived at KCMH, Tonya testified, she went directly to her mother's room and did a brief assessment and then advised her family of two things: her mother was dying, and they needed to get her out of KCMH. Tonya stated in evidence that she can be quite authoritative in tone and very direct in her communication;
- Dr. Scott Campbell stated that the family members looked to Tonya Llewellyn for direction;
- Tonya Llewellyn spoke to Julie Grant, RN, on the telephone on December 15th, 2018 before she arrived at the hospital and asserted that "You missed all the signs". Tonya cut Nurse Grant off when Nurse Grant was explaining treatment;
- Tonya Llewellyn went to the nursing station to demand that her mother be transferred to the QEH, was loud, rude and used a demanding tone of voice. Nurse Julie Grant filed an incident report about this, and about a telephone call Tonya Llewellyn had made before arriving at the hospital. The report is dated December 15, 2018 at 18:30 hrs (Exhibit 1, Tab 13);
- On the morning of December 16th, 2018, when Roxanne Llewellyn was being transferred to the Queen Elizabeth Hospital, Tonya Llewellyn was verbally aggressive and kept cutting Nurse Grant off

when she was giving report to EMS, and argued with Nurse Grant that her mother was not allergic to ASA;

- Nurse Grant testified that she had never experienced anyone so disrespectful and unprofessional in her 14 years of nursing service;
- Nurse Rudzki heard the altercation on the evening of December 15th, 2018 in the clean utility room and described Tonya Llewellyn as being aggressive towards nurse Tanya Young;
- Nurse Young filed the incident report referred to earlier about the altercation in the clean utility room, and noted that Tonya Llewellyn had come out of her mother's room and told Nurse Young to leave the area and told her family members that they could stay where they were, in the clean utility room;
- Nurse Young testified that she called Dr. Scott Campbell to come to the hospital, which the Committee regards as evidence of the significance of the atmosphere that had developed. Fortunately, Dr. Campbell came to the hospital, spoke to the family members, after which several of them left the hospital and things calmed down;
- Tonya Llewellyn acknowledged in her testimony that her family members were loud and disruptive at KCMH on the evening of December 15th, 2018. She stated that she did not raise her voice, she was calm, and stated that "whoa, whoa, we can't be doing this now". Evidence received from KCMH staff members conflicts with this assertion, and the Committee finds that Ms. Llewellyn was not as calm as she claimed to be; and
- The evidence from Tonya Llewellyn and her family members was that they acted as they did out of concern for their mother. Be that as it may, it does not excuse behavior by a registered nurse which interferes with the proper execution of duties of other nurses who are engaged in work.

In the circumstances described by the witnesses, including her own family members, Tonya Llewellyn did not assist KCMH staff in keeping family members

calm and in compliance with hospital policies; rather, it appears that she emboldened them.

Allegation 3

As noted above, the third allegation relates to a voicemail message that Tonya Llewellyn left for Sandra MacKay, who is a person in a position of authority at KCMH (the Director of Nursing). Ms. Llewellyn threatened legal action, accused KCMH staff of lying ("telling glorious lies") about her, and stated that she would contact a lawyer and would be charging slander and libel. The allegation is that Tonya Llewellyn left a voicemail message on January 14, 2019 which was threatening and unprofessional. The voicemail itself was played at the hearing and it was obvious that Tonya Llewellyn was not happy about the care her mother had received at KCMH, nor with how her behaviour had been described by staff members. The committee heard evidence from Ms. Llewellyn that Sandra MacKay refused to call her back despite many requests to do so. This is what prompted her to leave the voice mail. Sandra MacKay testified that that she had spoken with Tonya Llewellyn on December 20, 2018 regarding concerns about her mothers care. Exhibit 1 Tab 14 documented by Sandra Mac Kay titled follow up actions. The Committee heard evidence from KCMH staff members at the hearing that they were upset and traumatized by their involvement with Tonya and her family members. With that background, this voicemail message could have done nothing other than to escalate the situation. It is not how a member of the nursing profession should carry themselves. The question is whether it was "threatening and unprofessional."

Decision

Tonya Llewellyn is guilty of professional misconduct and incompetence with respect to the first allegation. She chose to act as a nurse when she felt the circumstances required it, but also claimed to be acting simply as a family member when it suited her (leaving an infected person's room without changing out of the PPE, wearing PPE in the hallways and then returning into the patient's

room without changing). She has violated Code of Ethics A and G. The Committee finds it was not safe practice for a daughter to provide nursing care to her mother in the first place, attempting an IV twice with the same cathlon and not following proper PPE infection control measures. With respect to G of the Code of Ethics Tonya Llewellyn has not shown accountability for her actions, preferring to focus entirely on what she felt was inadequate care for her mother at KCMH. She did not consider that perhaps her actions and behaviour were inappropriate.

Tonya Llewellyn has also violated several Standards for Nursing Practice. Practice Standard 2, indicators 2.2 and 2.7, and Standard 3, indicators 3.2, 3.3, 3.4, 3.5 and 3.6**.** Standard 2, indicator 2.2 and 2.7 Tonya Llewellyn failed to use nursing knowledge and professional judgement related to established policies and procedures with respect to infection prevention and control while visiting family member at KCMH and providing related nursing care. Failed to follow proper infection control measures related to isolation precautions, PPE and IV insertion. She failed to demonstrate competency relevant to this area of nursing practice by using a cathlon twice for an IV attempt and wearing PPE on more than one occasion out in the hallway after exiting a patient 's room who was on isolation precautions. Standard 3 indicators 3.2 3.3 3.4 3.5 3.6 Tonya Llewellyn failed to demonstrate responsibility to the public by providing competent safe and ethical nursing practice. She failed to demonstrate current knowledge and judgement related to isolation precautions, PPE and IV insertion. She failed to follow established policies and procedures with respect to infection prevention and control measures related to isolation precautions and PPE. She failed to demonstrate responsibility and accountability for her decisions and actions related to isolation precautions, PPE and IV insertion. By failing to do so she has placed herself and others in an unsafe situation and at risk of harm. These are the elements of professional misconduct.

As for incompetence, Tonya Llewellyn demonstrated lack of knowledge and professional judgment when she initiated an IV on her mother. She exposed her mother to risk by attempting to use the same cathlon twice, contrary to basic nursing practice. The Committee is concerned that Tonya Llewellyn would

attempt the IV while another nurse was donning PPE to come in to the patient room for that purpose. Attempting to insert an IV on her mother was not safe, competent or ethical care.

On a broader scale, it is not acceptable nursing practice for a registered nurse to perform invasive procedures on family members. Although it is permissible for a registered nurse to assist a family member in a health care setting such as a hospital by performing such tasks as bathing or ambulation, invasive procedures are different. Even if nursing staff on duty requests help, a registered nurse should take care to only provide the help that is sought, and not to act as the family member's nurse. Acting as she did in this case, Tonya Llewellyn showed poor judgment, and lack of knowledge about proper policy.

In addition to the treatment that Tonya Llewellyn attempted to provide to her mother, the Committee also finds that she did not follow safe practice when she came out of her mother's isolation room while wearing PPE. The Committee has found that there were appropriate written labels or posters outside of the isolation room to inform people that PPE was required, but even without these, an experienced nurse such as Tonya Llewellyn should have sufficient knowledge and experience to know that a nurse must remove PPE before leaving a patient's isolation room as the PPE is considered dirty or contaminated. She is expected to know and comply with the Routine Practices policy which was in evidence. The same consideration applies to putting gloves and a gown on just prior to providing nursing care, rather than whenever it suits the nurse. In her evidence, Tonya Llewellyn stated that she did not touch anything when she was out in the hallway with the PPE on "knowing that I did not touch anything, I would not be infecting anything". This is not the standard we expect of nurses exposed to possible infectious material. This rationale demonstrates lack of accountability and responsibility to provide safe, competent ethical care. Tonya Llewellyn posed significant risks to herself and others by wearing her PPE out in the hallway on more than one occasion.

With respect to the second allegation, Tonya Llewellyn is guilty of professional misconduct. She violated Code of Ethics A and G. We have described above why we have concluded that Tonya Llewellyn treated nursing staff in a demeaning, disrespectful and unprofessional way. Nurses have a responsibility to always be respectful and professional to patients, families, communities, groups, and other members of the health care team. In addition, nurses should strive to prevent or minimize all forms of violence by anticipating and assessing the risks of violent situations, and by working together with others to establish preventative measures. Tonya did not act this way in her interaction with staff, particularly during the altercation outside the clean utility room. Far from collaborating with other members of the nursing profession, Tonya defended the actions of her family and allowed them to stay where they were, contrary to the wishes of the nursing staff. This was a volatile situation and KCMH staff felt threatened and at risk, and we empathize with them. There was no evidence that Tonya supported her colleagues, or took steps to prevent risk. She used poor judgment and decision-making when she told the staff to leave and decided that her family would stay. In particular, the Committee heard nothing from Tonya that sounded like remorse or even an acknowledgement that she had done anything wrong with respect to her involvement in this altercation.

Two KCMH staff in particular noted that Tonya had spoken to them in a loud, rude, aggressive tone, cut them off in mid-conversation, intimidated them and challenged the information that they were giving.

Nurses are expected to refrain from judging, labeling, demeaning, stigmatizing and humiliating behaviours towards persons receiving care, other health care professionals and each other. This is what respect means. We have concluded that Tonya lacks knowledge and understanding that the profession's Code of Ethics requires that she act in a respectful and professional manner at all times, whether she is working or not. She did not seem to realize the effect her actions or words were having on members of the KCMH staff.

As per Standards of Practice Standard 2, Indicator 3.4

Nurses must be held responsible and be accountable for their actions at all times, and Tonya Llewellyn failed in this regard.

With respect to allegation three, the Committee finds Tonya Llewellyn guilty of professional misconduct because she failed to uphold the requirements of Code of Ethics A and G. The voicemail for Sandra MacKay was both threatening and unprofessional in nature. Her tone (we listened to the voicemail during the hearing) was aggressive and demanding, and it threatened legal action, including charges of slander and libel, which is another way of accusing other people of lying. In fact, in the message, Ms. Llewellyn does accuse staff at KCMH of lying. We reject Tonya's assertion that she was acting out of concern for her mother. At the hearing, Tonya Llewellyn stated "Sandra MacKay herself very likely violates the Code of Ethics by engaging in conversations with the nurse manager in regards to my personal HR information", and we believe that Ms. Llewellyn was attempting to avoid consequences of her actions by being aggressive. The voicemail was an attempt to threaten a potential complainant and potential witnesses by causing them to believe that they would be in trouble if they attempted to complain about Tonya Llewellyn's behaviour. We acknowledge that the behaviour was not threatening in the sense of physical violence, but it was verbally aggressive in a way that nurses should not conduct themselves and was unprofessional for that reason.

We are most concerned that this aggressive voicemail was left for the Director of Nursing at KCMH, because nurses must recognize the leaders in the profession and treat them with deference and respect. In short, this conduct is professional misconduct because it was simply disrespectful and inappropriate.

Penalty

1. Tonya Llewellyn's registration to practice nursing shall be suspended for a period of two (2) months, effective the date this decision is delivered to her.

2. Tonya Llewellyn shall have the following conditions placed on her nursing registration, effective the date this decision is delivered to her:

   (a) Within six months of the date of this decision issued by the Hearing Committee, Ms. Llewellyn shall complete ethics training with a Nursing Expert ("Expert"), at her own expense. To comply, Ms. Llewellyn is required to ensure that:
      (i) the Expert has expertise in nursing regulation and has been approved by the CRNPEI Coordinator of Regulatory Services to provide refresher training;
      (ii) the Expert has been provided with a copy of the complaint; Notice of Formal Hearing; Agreed Statement of Facts; and this decision;
      (iii) she has reviewed the CRNPEI *Standards of Practice* and the *Code of Ethics*, and at least seven days before meeting with the Expert has provided the Expert with a short written statement of at least five hundred (500) words reflecting on the issues identified in the decision issued by the Hearing Committee in relation to this matter;
      (iv) the subject of the sessions with the Expert will include:
         (a) any acts or omissions committed by Ms. Llewellyn as identified in the decision of the Hearing Committee, including any misconduct or violations of the CRNPEI *Standards of Practice* or the *Code of Ethics*;
         (b) the potential consequences of the misconduct to Ms. Llewellyn's clients, colleagues, profession and self;
         (c) strategies for preventing the misconduct from recurring;
         (d) training regarding appropriate and ethical communication with colleagues and other health care professionals; and
         (e) the development of a learning plan in collaboration with the Expert, if necessary.

(v) within thirty (30) days of the completion of the final session with the Expert, Ms. Llewellyn shall confirm that the Expert has forwarded a report to the CRNPEI Coordinator of Regulatory Services, in which the Expert has confirmed:

(a) the dates of any completed sessions;

(b) that Ms. Llewellyn reviewed the CRNPEI *Standards of Practice* and the *Code of Ethics* prior to meeting with the Expert;

(c) that the Expert reviewed or confirmed appropriate review of the required documents and subjects with Ms. Llewellyn;

(d) the successful completion of any required learning plan and communication training; and

(e) the Expert's independent assessment of Ms. Llewellyn's insight into her behaviour.

(vi) if Ms. Llewellyn does not comply with any one or more of the requirements above, the Expert may cancel any scheduled session, even if that results in a breach of a term, condition or limitation on Ms. Llewellyn's certificate of registration.

(b) Tonya Llewellyn shall be required to pay a fine in the amount of Five Thousand Dollars ($5,000.00), which fine shall be paid in full no later than March 1, 2022.

(c) Tonya Llewellyn shall be required to pay CRNPEI the amount of Ten Thousand Dollars ($10,000.00), in respect of the expenses associated with the investigation and adjudication of this complaint, and which expenses shall be paid in full no later than March 1, 2022.

(d) Tonya Llewellyn shall provide a copy of any written decision rendered in relation to this matter to her employer or employers, or to any employer who offers her employment as a Registered Nurse, and shall provide written verification to CRNPEI from the employer

that the employer has received this decision. This obligation will continue until all of the conditions on her registration have been removed;

3. In the event that Tonya Llewellyn fails to comply with any of the above conditions, she will be ineligible to apply for registration with CRNPEI.

The Committee has decided on the above penalty in that Tonya Llewellyn's conduct was serious and happened over a period of time given that she misbehaved in mid-December, and left an unprofessional voicemail with Sandra MacKay one month later. Tonya Llewellyn clearly failed to follow proper infection prevention and control procedures, and hid behind her concern for a family member as justification for ignoring her responsibilities. Her conduct had a significant impact on nursing colleagues who felt both disrespected and unsafe while at their place of employment. We expected more of a nurse of some 14 years of experience, since junior nurses look up to their seniors as role models.

Tonya Llewellyn's lack of remorse is of significant concern for the Committee. She did not take responsibility or accountability for her conduct. Even when given the opportunity to address the penalty which might be imposed if the Committee found her guilty of anything, she could not bring herself to suggest an appropriate penalty.

The penalty we have decided on is designed to deter Tonya Llewellyn and other members of the nursing profession from acting as she did, and to protect the public interest. The Committee has concluded that the proposed penalty is reasonable and in the public interest. The penalty sends a clear message to the member and the profession that these behaviours are not acceptable and will not be tolerated.

The penalty reminds the member and nurses of their fundamental responsibility to treat nursing colleagues and others with respect. The penalty provides

opportunities for the member to improve her practice. The public is protected by the provisions in this penalty.

Respectfully submitted,

Cynthia Bryanton
Chair of the Committee
June 16, 2020