IN THE MATTER OF THE HEALTH PROFESSIONS ACT,
R.S.A. 2000, c.H-7;

AND IN THE MATTER OF A HEARING INTO THE CONDUCT
OF [redacted] RSW, A MEMBER OF THE
ALBERTA COLLEGE OF SOCIAL WORKERS;

AND INTO THE MATTER OF A COMPLAINT BY [redacted]
[redacted] INTO THE CONDUCT OF [redacted]
PURSUANT TO S. 77(a) OF THE HEALTH PROFESSIONS ACT

REASONS FOR DECISION

Pursuant to a public hearing held on December 12, 2014 and September 4, 2015 at the Edmonton offices of Parlee McLaws, LLP, the Alberta College of Social Workers Hearing Tribunal is issuing its reasons for its decisions.

A hearing into the conduct of [redacted] was held on December 12, 2014 and September 4, 2015 pursuant to the *Health Professions Act,* R.S.A. 2000, c.H-7 as amended (the "Act").

The members of the Hearing Tribunal were:

Stanley Haroun, RSW (Chair)
Pat Gerrie, RSW
Ann Henry, RSW
Peter Kawalilak (Public Member)

The hearing was a public hearing pursuant to s. 78 of the Act.

CONSENT ORDER

The investigated member [redacted], provided a written admission of unprofessional conduct to the Hearing Tribunal dated November 27, 2014 pursuant to s. 70(1) of the Act.

The Hearing Tribunal accepts parts of the admission of the investigated member.

The allegations in the Notice of Hearing arise from a complaint from [redacted] dated May 8, 2014.

The allegations in the Notice of Hearing are as follows:

Findings of unprofessional conduct

Informed Consent

1. That in or about December 2013 to February 2014, [redacted] failed to obtain informed consent from the patient prior to obtaining and collecting personal information about the patient.
2. That without the consent or knowledge of the patient, [redacted] on January 14, 2014 wrote a generic letter regarding a patient's inability to handle her own affairs.

Such conduct contravenes s. B.4(a) & (b), and D.5(B) of the standard of practice and value 1 and 5 of the code of ethics and in accordance with the Health Professions Act such conduct constitutes unprofessional conduct.

Misuse of information

3. That [redacted] wrote a letter containing information regarding the patient's inability to manage her own affairs which contained incorrect and inappropriate conclusions.

Such conduct contravenes s, E.1(b) & (c) of the standard of practice and value 5 of the code of ethics and in accordance with the Health Professions act such conduct constitute unprofessional conduct.

Record keeping

4. That [redacted] failed to document relevant information in the patient's chart specifically she failed to document discussions between herself and the sister of the patient.
5, That [redacted] failed to document discussions with the boyfriend of the patient.
6, That [redacted] failed to document the fact that she had provided a letter with respect to the patient's inability to manage her own affairs,
7. That [redacted] failed to include a copy of the letter in the patient's chart.
8. That [redacted] failed to document or provides a copy of the document relating to the Temporary Trusteeship of the patient.
9. When infonnation came to [redacted] she failed to correct information relating to the patient.
10. When information came to [redacted] contrary to steps already taken by [redacted] she failed to access assistance to ensure appropriate information was on file.

Such conduct contravenes s. D.2(a) and (d)iv. Of the standard of practice and in accordance with the Health Professions Act such conduct constitutes unprofessional conduct.

The Hearing Tribunal heard from the following witness and other individuals present at the Hearing:

[redacted]

- Ms. Karen Smith, legal counsel for the college.
- Ms, Sheryl Pearson, complaint director, ACSW.

No exhibits were presented at the hearing.

Allegations

Allegation #1. *That in or about December 2013 to February 2014, [redacted] failed to obtain informed consent from the patient prior to obtaining and collecting personal information about the patient.*

General findings of facts:
The Tribunal finds that there is evidence that [redacted] did, in fact, obtain informed consent from the patient on January 23, 2014. Clinical notes dated January 14, 2014 indicated that the patient was drowsy, disorientated to time and suffered from impaired cognition, [redacted] obtained informed consent from the patient when the patient was cognitively able to do so.

Conduct does not constitute unprofessional conduct.

Allegation #2. *That without the consent or knowledge of the patient, [redacted] on January 14, 2014, wrote a generic letter regarding a patient's inability to handle her own affairs.*

General findings of facts:
The Tribunal has determined that [redacted] did author a generic letter regarding the patient, the circumstances surrounding the writing of the letter were such that exigent concerns for the patient's welfare, who was not able to provide consent at that time, dictated the need for the letter. It is a common and in most cases, a directed practice for letters to be written by Social Workers as part of the healthcare team.

Conduct does not constitute unprofessional conduct.

Allegation #3 *That you wrote letter containing information regarding the patient's inability to manage her own affairs which contained incorrect and inappropriate conclusions.*

General findings of fact:
In the course of her employment;

- On January 14, 2014, the member wrote a letter regarding the patient's hospitalization, her condition and her inability to manage her own affairs. It stated:

"To Whom it may concern. This is to advise that this patient was admitted to the U of A Hospital on December 31, 2013 with a head condition and is unable to handle her own affairs."

- The member wrote this letter at the request of the patient's next of kin. She understood the letter was to be used for banking purposes and home management. She knew that the patient was comatose on admission and was unable to manage her own affairs at the time of the issuing of the generic letter.
- The member's usual practice, as is common practice for most medical social workers is to provide a letter for the next of kin, when the patient is unable to tend to their own affairs, in order to preserve and maintain the client's home environment.

- Typically, such a letter would be purposely vague, so as to obtain the assistance needed but to provide as little confidential information as possible. In this letter, the member failed to put any parameters on the letter, and instead addressed it "To Whom It May Concern". The language used in this letter was vague and non-clinical.
- The member had no way of knowing that the letter would be used for any other purpose or that it could even be considered in a court of law as proof of the patient's lack of mental capacity. In her training as a government designated capacity assessor, the member would have been trained to understand that a capacity assessment report would be required by the courts in order to deem an adult incapacitated.
- The member's letter does not contain incorrect or inappropriate conclusions, Albeit the wording is vague and non-clinical, the patient was suffering from a condition in her head and she was unable to handle her own affairs at that time. The member did not state or clarify if the patient's inability/infirmity was caused by the patient's physical or mental condition.
- At the time the letter was written, the patient's capacity was fluctuating and she was showing improvement in her condition. As a government designated capacity assessor, the member would have known that any capacity assessment cannot be initiated or completed until a physician writes a note stating that the patient's condition is stable, and not likely to improve.

Weight of Evidence

- It is well known to be common practice for medical social workers to issue letters to next of kin in order to preserve a patient's home situation, when the patient is unable to manage her own situation and there is a risk of the situation being placed in jeopardy. These letters are intended to be used to pay bills, protect a home, assist with application for income but not in any legal matters with the exception being when the patient is unable to appear in court because of the hospitalization,
- The member has worked in her capacity as a social worker since 1986. She would have regularly provided such letters in her career. There is no indication that she ever used this practice for anything other than the intended purpose.
- The member has been a government Designated Capacity Assessor in good standing since 2009. She would have been instructed and would have believed that this letter would not be acceptable as a capacity assessment for the courts. Furthermore, she knew that the client's capacity was undetermined at the time she wrote the letter, that the client was showing improvement, that the patient had not been declared stable and unlikely to improve, and that other professionals had been consulted regarding a capacity assessment.
- There is no evidence that the letter written by the member contained incorrect or inappropriate conclusions.

This conduct does not constitute unprofessional conduct.

Allegation #4. That [redacted] failed to document relevant information in the patient's chart specifically she failed to document discussions between herself and the sister of the patient.

General findings of facts

- By [redacted] omission, she acknowledged she had not documented all pertinent interactions pertaining to this file.
- Initial Assessment completed by [redacted] was not documented in the file.
- [redacted] did not document her planned interventions although she refers to "formulating a plan".
- [redacted] failed to document that she had provided a letter to neither the sister nor the purpose of this letter. Nor had [redacted] documented why she had not waited for the Occupational Therapist cognitive assessment that was requested by her before writing this letter,
- [redacted] failed to place the letter on the file that she had written for the sister.
- **Even though, [redacted] had stated she had informed the patient of the sister's** proposed temporary trusteeship application; [redacted] failed to neither document she had told the patient nor her reaction.
- [redacted] had failed to document if she had or attempted to talk with the patient about her relationship with neither the sister nor the status of her financial situation.
- [redacted] stated she had difficulty keeping up with her casework and sometimes would come in on the weekend to complete some of her charting.

Allegation #5. That [redacted] failed to document discussions with the boyfriend of the patient.

Allegation #6. That [redacted] failed to document the fact that she had provided a letter with respect to the patient's inability to manage her own affairs.

Allegation #7. [redacted] failed to include a copy of the letter in the patient's chart.

General findings of facts:

- [redacted] had documented that she had a conversation with the boyfriend and advised him that he had no rights. There was no further documentation by [redacted] that she had any additional interactions with the patient's boyfriend despite clinical notes indicating his presence at the bedside each day.
- [redacted] did not place the letter in the patient's chart nor had she documented this fact.

Weight of Evidence

- Clinical documentation is the core of every patient encounter, and in order to be meaningful it must be accurate, timely, and complete and reflect the scope of services provided. It helps to plan care, protects the patient, the worker and their workplace. It is recognized that a worker does not have to document all interactions. It is it the workers professional responsibility to weigh which interactions are meaningful and which ones to document in the clinical notes. It is acknowledged that [redacted] had documented some conversations that she had with the patient and her sister and these notes contained pertinent information. However, [redacted] failed to capture the full scope of services she had provided when she did not record she had provided a letter to the sister. As a

result, the rest of the treatment team were not aware of it existence and therefore could not be expected to act in order to rectify the situation when it became apparent that there were issues between the patient and sister.

- [redacted] did state she did tell the patient about the trusteeship, but again by not including such interactions in the file, [redacted] failed her obligation in terms of completeness of the file.
- Social Workers need to provide their own assessment in any given situation and document such. Despite being a Designated Capacity Assessor, [redacted] did not document whether she had assessed the patient herself before writing the letter. [redacted] did request that the Occupational Therapist to do a "cognitive assessment" on that day. For completeness of the file, [redacted] would have needed to document the rationale for providing the letter and detailed why patient consent could not be obtained to provide this letter to the sister.
- Although [redacted] had acknowledged in the clinical record that she would complete a plan of care, there was no record of such. As part of her continuing role with the patient, it would have been prudent on her outline her plan of care. It would have allowed her to weigh the information in front of her and potential steps she should have taken to insure the patient's best interests had been represented. Therefore she failed to meet her obligation to ensure the file was accurate and complete.
- It is acknowledged that social workers do provide letters to patients and their families for a variety of situations, it is important that copies of letters written by clinical staff are placed on the file. By not including the letter on the file, other members were not aware of it existence nor could act to rectify the situation. By not including the letter, it exposes the healthcare site to potential litigation especially if the original letter is altered or used in a way that it is not intended.
- [redacted] did acknowledge that she was not always timely in her recording due to workload. She stated she would come in the weekend to "catch up". It exposed [redacted] to risk as she was relying on memory to recall her actions surrounding this patient. It made it difficult for her to weigh the information as it came forward and exposed her to risk as a practitioner. It is imperative that workers are timely in their documentation to ensure accuracy and completeness as it becomes easy to forget relevant details with the passage of time, Timely documentation reduces the risk to the patient, the worker and the organization. Workers need to organize their time to ensure that their documentation is a priority and is completed in a timely manner.
- Although [redacted] had stated she had spoken to her supervisor about her workload and did not come to a resolution, she could have taken the added step by contacting the ACSW to discuss her situation. It would have served as record to the college and would have shown that [redacted] was trying to address her current workload and potentially may be included as a mitigating factor when the complaint came in.

This conduct constitutes unprofessional conduct.

Allegation #8. That [redacted] failed to document or provides a copy of the document relating to the Temporary Trusteeship of the patient.

General findings of facts:
The Temporary Trusteeship documents were not received by [redacted] or by the hospital.

Weight of evidence:
Following the patient's transfer to another institution and during the course of the employer's investigation of [redacted] conduct in March 2014, [redacted] immediate supervisor went to the courthouse to obtain a copy of the Temporary Trusteeship, Therefore, [redacted] would not have been able to document or place a document in the patient's file that was not received by her or by the hospital.

This conduct does not constitute unprofessional conduct

Allegation# 9. When information came to [redacted] she failed to correct information relating to the patient.

General finding of facts:
This allegation is rather vague. There is no explanation of what is meant by information and how it relates to the patient.

Allegation# 10. When information came to [redacted] contrary to steps already taken by [redacted] she failed to access assistance to ensure appropriate information was on file.

General findings of facts:
This allegation is rather vague. There is no explanation of what is meant by "information contrary to steps taken by [redacted] or "how she has failed to access assistance to ensure appropriate information was on file".

Conclusion

[redacted] patient suffered an aneurism, was in a coma on admission and suffered a stroke shortly after. It was obvious that [redacted] could not obtain consent from the patient to collect information and to communicate with the next of kin. At the time of the issuing of the generic letter, clinical notes stated that the patient was drowsy, disorientated to time and suffered from impaired cognition due to infection. [redacted] acted professionally when she met with the next of kin and provided a generic letter to the patient's sister due to exigent concerns presented to her by the next of kin,
[redacted] has no way of knowing that the generic letter would be used for any other purpose or that it would be even considered in a court of law as proof of the patient's lack of mental capacity.
In her training as a Government designated capacity assessor, [redacted] would have been trained to understand that a capacity assessment report would be required by the courts in order to deem an adult incapacitated.

The main issue and concern however, is [redacted] failure to document relevant information in the patient's file. [redacted] did not document her planned intervention, pertinent

interactions with significant others in the patient's life, the generic letter or the patient's reaction to the sister's proposed temporary trusteeship application.

It is acknowledged that [redacted] had documented some conversations that she had with the patient, her sister and her boyfriend and these notes contained pertinent information. However, [redacted] failed to capture the full scope of services that she had provided when she did not document that she had provided a letter to the sister. As a result, the rest of the treatment team were not aware of its existence and therefore could not be expected to act in order to rectify the situation, when it became known that there were issues between the patient and her sister.
[redacted] should have recorded and provided a rational for providing the generic letter and detailed why patient consent could not be obtained prior to providing the letter to the patient's sister.
[redacted] did acknowledge that she was not always timely in her recording due to high workload. Although [redacted] had stated that she had spoken to her supervisor about her workload and did not come to a resolution, she could have taken the added step by contacting the ACSW to discuss her situation. It would have served as a record to the college and would have shown that [redacted] was trying to address her current workload and potentially may be included as a mitigating factor when the complaint came in.
[redacted] should have addressed the generic letter to the bank and not to whom it may concern. The unintended consequence of this letter may have been avoided.

The investigative report

The Tribunal wishes to express its concern regarding what was seen as an incomplete investigative report. The report did not present clear timelines to indicate when the patient was able to provide an informed consent. The report did not focus on what were practice issues versus employer employee issues. Several statements provided during the course of the investigation were contradictory and were not challenged. The report did not conclude that the Temporary Trusteeship order was not to be found in the medical records and hence was not placed in the patient's chart.
The occupational Therapist who had initiated the complaint to [redacted] supervisor and who "had heard through the grapevine that [redacted] had been working with the sister of the patient to gain trusteeship or guardianship of the patient" was not interviewed and challenged to proof his allegations.
The Tribunal was also in the dark regarding a statement made by a social work advisor, [redacted], stating that "the employer's investigation is part of a larger investigation into [redacted]. There was no explanation of the term" larger investigation".
[redacted] stated that "she feels her employer was targeting her, she said that she has been framed"

Orders as to sanctions

1. A reprimand is issued concerning [redacted] The Hearing Tribunal's written decision shall serve as the reprimand. The reprimand is to be kept in [redacted] file for a maximum of three years.

2. [redacted] social work practice shall be subject to supervision for a period of six month from the date of this order, the cost of which will be the responsibility of [redacted]. The supervision may be within or outside the context of [redacted] employment. The supervisor shall be approved by ACSW and the ACSW shall be entitled to such reporting and disclosure from the supervisor as the ACSW deems necessary from time to time,
3. Within 30 days of the date of this order, [redacted] shall provide proof of a wellness exam from her family physician stating she is appropriately fit to practice social work and provide professional services to the public.
4. [redacted] shall be obliged to complete the provisions of an Alberta Health Services Learning and action Plan dated October 8, 2014 within 6 month of the date of this order and provide ACSW with verification of that completion.
5. [redacted] shall pay cost in the amount seven hundred and fifty ($750,00) dollars within one year from the date of this order.
6. There shall be publication of this order on a "no names" basis.

Stanley Haroun
2015 Chair, Hearing Tribunal

October 20,