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 JOAQUIM NGETICH

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 JOAQUIM NGETICH, LPN #30937, 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 Videoconference on February 16, 2021 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Marie Concepcion, LPN
Nancy Brook, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Consultant, CLPNA
Susan Blatz, Complaints Consultant, CLPNA

Investigated Member:
Joaquim Ngetich, LPN ("Mr. Ngetich or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated 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 Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Mr. Ngetich was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Mr. Ngetich was initially licensed as an LPN in Alberta on January 1, 2009.

The CLPNA received a complaint dated August 25, 2020 (the "First Complaint") from Linda Bell, Care Manager at CapitalCare Dickinsfield in Edmonton, Alberta, pursuant to s. 57 of the *Health Professions Act* (the "Act"). The First Complaint advised CapitalCare Dickinsfield had terminated the employment of Mr. Ngetich, LPN as a result of Mr. Ngetich continuing to work for more than one health care facility after April 23, 2020.

The Complaints Director, Sandy Davis ("Complaints Director"), delegated her authority and powers under Part 4 of the Act regarding the First Complaint to Susan Blatz, Complaints Consultant for the CLPNA ("Complaints Consultant"), pursuant to s. 20 of the Act.

The Complaints Consultant determined that she would conduct a preliminary investigation into the First Complaint. The Complaints Consultant also informed Mr. Ngetich that due to the nature of the alleged conduct, she was recommending to Jeanne Weis, Chief Executive Officer for the CLPNA, that Mr. Ngetich's practice permit be immediately suspended under s. 65(1)(b) of the Act. Mr. Ngetich received notice of the First Complaint, notice of investigation, and the recommendation for a suspension by letter dated September 1, 2020.

The Complaints Consultant requested that Ms. Weis impose an immediate suspension of Mr. Ngetich's practice permit under s. 65(1)(b) of the Act by letter on September 1, 2020. Mr. Ngetich received a copy of this letter and its corresponding attachments.

By letter dated September 2, 2020, Ms. Weis granted the request for an interim suspension of Mr. Ngetich's practice permit and notified Mr. Ngetich accordingly.

The CLPNA received a second complaint dated September 8, 2020 (the "Second Complaint") from Angelika Clarke, Site Administrator, Program Manager, at Shepherd's Care Vanguard in Edmonton, AB pursuant to s. 57 of the Act. The Second Complaint stated Shepherd's Care Vanguard had terminated the employment of Mr. Ngetich as a result of Mr. Ngetich working for two sites when this was prohibited.

The Complaints Director delegated her authority and powers under Part 4 of the Act regarding the Second Complaint to the Complaints Consultant pursuant to s. 20 of the Act. By way of letter dated September 10, 2020, the Complaints Director provided Mr. Ngetich with notice of the Second Complaint, notice of preliminary investigation, and notice of the delegation of authority to the Complaints Consultant.

On September 21, 2020, in accordance with s. 55(2)(d) of the Act, the Complaints Consultant appointed Kerry Palyga, Investigator for the CLPNA (the "Investigator"), to conduct a further investigation into the First Complaint and the Second Complaint.

On October 29, 2020, the Investigator concluded the investigation into the First Complaint and the investigation into the Second Complaint. The Investigator submitted two Investigation Reports to the CLPNA.

Following receipt of the Investigation Reports, the Complaints Consultant determined there was sufficient evidence that the issues raised in the First Complaint and the Second Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Ngetich received notice the matters were referred to a hearing, as well as a copy of the Statement of Allegations and the Investigation Reports, on November 23, 2020.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Ngetich under cover of letter dated January 7, 2021.

(4) Allegations

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

"It is alleged that JOAQUIM NGETICH, LPN, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about April 2020, failed to disclose to his employer, CapitalCare Dickinsfield, that he worked at a second health care facility in contravention of CMOH 10-2020.

2. On or about April 2020, failed to disclose to his employer, Shepherd's Care Vanguard, that he worked at a second health care facility in contravention of CMOH 10-2020.

3. Between April 23, 2020 and July 30, 2020, worked at two health care facilities, Shepherd's Care Vanguard and CapitalCare Dickinsfield, in contravention of CMOH 10-2020."

(5) Admission of Unprofessional Conduct

Section 70 of the Act permits an investigated member to make an admission of unprofessional conduct. An admission under s. 70 of the Act must be acceptable in whole or in part to the Hearing Tribunal.

Mr. Ngetich acknowledged unprofessional conduct to all the allegations as evidenced by his signature on the Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and verbally admitted unprofessional conduct to all the allegations set out in the Statement of Allegations during the hearing.

Legal Counsel for the Complaints Consultant submitted, where 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: Statement of Allegations
Exhibit #2: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
Exhibit #3: 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 #2.

(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 #2 and finds as facts the events as set out in the Agreed Statement of Facts.

The Hearing Tribunal also accepts Mr. Ngetich's admission of unprofessional conduct as set out in the Agreed Statement of Facts as described above. 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 Mr. Ngetich.

Allegation 1

Mr. Ngetich admitted that on or about April 2020, he failed to disclose to his employer, CapitalCare Dickinsfield, that he worked at a second health care facility in contravention of CMOH 10-2020.

After CMOH Order 10-2020 was introduced on April 10, 2020, CMOH Order 10-2020 was also posted on the CapitalCare website for all staff to see and access. All staff, including Mr. Ngetich, also received a form to complete regarding their choice of worksite as per CMOH Order 10-2020.

In addition, CapitalCare Dickinsfield staff were contacted by CapitalCare Dickinsfield's Care Manager and informed about the requirements of CMOH Order 10-2020, including the

requirement to disclose the health care facilities where they provided services and the restriction of staff working at more than one health care facility for the duration of the COVID-19 pandemic.

Linda Bell, Care Manager at Capital Care Dickinsfield, contacted Mr. Ngetich to inquire if Mr. Ngetich worked at another health care facility. Mr. Ngetich advised Ms. Bell that he did not work "anywhere else". After further discussion, Mr. Ngetich advised he worked casual shifts at the Glenrose Rehabilitation Hospital, which was not a "health care facility" as defined by CMOH Order 10-2020.

Gurbandhan Sidhu, Care Manager at Capital Care Dickinsfield, also had a conversation with Mr. Ngetich and it was not disclosed to Mr. Sidhu that Mr. Ngetich worked at a second health care facility.

In contravention of CMOH Order 10-2020, Mr. Ngetich did not disclose to CapitalCare Dickinsfield that he also worked at Shepherd's Care Vanguard.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, 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;
iii. Contravention of another enactment that applies to the profession, and
xii. Conduct that harms the integrity of the regulated profession.

Mr. Ngetich displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services as a health care professional in an environment where there is a risk of exposure to the COVID-19 virus and the serious harm resulting from it. Mr. Ngetich had an obligation to follow the mandate, but he chose not to follow the CMOH Order 10-2020. This demonstrated to the Complaints Consultant a lack of skill or judgment in the provision of Licensed Practical Nursing services in these circumstances. Mr. Ngetich did not disclose to his employer, CapitalCare Dickinsfield, that he was working at two separate health care facilities despite the CMOH Order 10-2020 which stated that employees had to complete a declaration form stating that they would work at only one health care facility. Mr. Ngetich stated to Ms. Bell that he did not work anywhere else. It was after some discussion that Mr. Ngetich did state that he also worked at the Glenrose Rehabilitation Hospital which was not a "health care facility" as defined by the CMOH Order 10-2020. This willful omission amounts to a serious lack of judgment, especially considering the harm which could have resulted.

Mr. Ngetich was in contravention of another enactment that applied to the profession in that Mr. Ngetich did not adhere to the CMOH Order 10-2020 which was implemented to prevent the spread of COVID-19 among seniors and vulnerable groups with pre-existing health conditions which includes seniors. The order was an enactment that applied to the Licensed Practical Nurse profession. Mr. Ngetich breached this by failing to inform his employers that he was working at

more than one facility. Mr. Ngetich put others at risk, and these were some of the more vulnerable members of the population who could have suffered serious consequences if they were exposed to a virus. By not complying with the order, Mr. Ngetich increased their exposure to the virus. One of the facilities that Mr. Ngetich was working at was on a COVID-19 outbreak for a period which created an elevated risk of transmission and exposure.

Mr. Ngetich's conduct harms the integrity of the regulated profession in that Mr. Ngetich did not act in a manner which would be expected of another LPN in a similar situation. Mr. Ngetich did not inform his employers that he was working at more than one facility. LPNs are expected to follow the mandate of the Chief Medical Officer of Health for Alberta especially when dealing with a worldwide pandemic such as with COVID-19. It is expected that LPNs will follow the mandate of both the CLPNA as well as the Chief Medical Officer of Health for Alberta.

The conduct breached the following principles and standards set out in CLPNA's Code of Ethics ("CLPNA Code of Ethics") and CLPNA's Standards of Practice for Licensed Practical Nurses in Canada ("CLPNA Standards of Practice"):

CLPNA Code of Ethics:

Principle 1: Responsibility to the Public – LPNs, as self-regulating professionals, commit to provide safe, effective, compassionate, and ethical care to members of the public. Principle 1 specifically states that LPNs:

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

- 1.5 Provide care directed to the health and well-being of the person, family, and community.

Principle 2: Responsibility to Clients – LPNs have a commitment to provide safe and competent care for their clients. Principle 2 specifically states that LPNs:

- 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. Principle 3 specifically provides that 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.

Principle 4: Responsibility to the Profession – LPNs develop and maintain positive, collaborative relationships with nursing colleagues and other health professionals. Principle 4 specifically states that LPNs:

- 4.2 Collaborate with colleagues in a cooperative, constructive, and respectful manner with the primary goal of providing safe, competent, ethical, and appropriate care to individuals, families, and communities.

Principle 5: Responsibility to Self – LPNs recognize and function within their personal and professional competence and value systems. Principle 5 specifically states that LPNs:

- 5.1 Demonstrate honesty, integrity, and trustworthiness in all interactions.

- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

CLPNA Standards of Practice:

Standard 1: Professional Accountability and Responsibility – LPNs are accountable for their practice and responsible for ensuring that their practice and conduct meet both the standards of the profession and legislative requirements. Standard 1 specifically states that LPNs:

- 1.1 Practice to their full range of competence within applicable legislation, regulations, by-laws and employer policies.

- 1.4 Recognize their own practice limitations and consult as necessary.

- 1.6 Take action to avoid and/or minimize harm in situations in which client safety and well-being are compromised.

- 1.9 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for Licensed Practical Nurses.

- 1.10 Maintain documentation and reporting according to established legislation, regulations, laws, and employer policies.

Standard 3: Service to the Public and Self-Regulation – LPNs practice nursing in collaboration with clients and other members of the health care team to provide and improve health care services in the best interests of the public. Standard 3 specifically states that LPNs:

- 3.3 Support and contribute to an environment that promotes and supports safe, effective and ethical practice.

- 3.4 Promote a culture of safety by using established occupational health and safety practices, infection control, and other safety measures to protect clients, self and colleagues from illness and injury.

- 3.5 Provide relevant and timely information to clients and co-workers.

- 3.6 Demonstrate an understanding of self-regulation by following the standards of practice, the code of ethics and other regulatory requirements.

Standard 4: Ethical Practice – LPNs uphold, promote and adhere to the values and beliefs as described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically states that LPNs:

- 4.1 Practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs.

- 4.7 Communicate in a respectful, timely, open, and honest manner.

- 4.8 Collaborate with colleagues to promote safe, competent, and ethical practice.

- 4.9 Support and contribute to healthy and positive practice environments.

Mr. Ngetich did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Mr. Ngetich. The Hearing Tribunal finds the conduct breached the provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice set out above and that such breaches are sufficiently serious to constitute unprofessional conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice by failing to adhere to the CMOH Order 10-2020. Mr. Ngetich also failed to be truthful when asked if he worked at other health care facilities. By knowingly placing those he was caring for and those he worked with at risk, he acted without respect for others and in a manner which was not supportive of them. This conduct does not display an understanding of the obligations and responsibilities of a self regulated professional.

<u>Allegation 2</u>

Mr. Ngetich admitted that on or about April 2020, he failed to disclose to his employer, Shepherd's Care Vanguard, that he worked at a second health care facility in contravention of CMOH 10-2020.

On April 14, 2020, Angelika Clarke, Site Administrator, Program Manager, at Shepherd's Care Vanguard placed an "Employee Single Site Declaration" in the Shepherd's Care Vanguard Communication Book. This form required all Shepherd's Care Vanguard employees who worked

at other health care facilities to disclose the other facilities they worked at and to declare which single facility the employee would work at in compliance with CMOH Order 10-2020.

On April 20, 2020, Ms. Clarke placed a memo in the Shepherd's Care Vanguard Communication Book to "All Staff" which stated that employees were required to "Please fill out an employee single site declaration".

Mr. Ngetich was aware of the requirement to disclose the other health care facilities that he worked at and was aware of the requirement to complete a Single Site Declaration and declare which single health care facility he would work at.

In contravention of CMOH Order 10-2020, Mr. Ngetich never completed a Single Site Declaration and did not disclose to Shepherd's Care Vanguard that he also worked at CapitalCare Dickinsfield.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, 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;
iii. Contravention of another enactment that applies to the profession, and
xiii. Conduct that harms the integrity of the regulated profession.

Mr. Ngetich displayed a lack of knowledge of or lack of skill or judgment as a health care professional in an environment where there is a risk of exposure to the COVID-19 virus and the risk of serious harm. Mr. Ngetich had an obligation to follow the mandate, but he chose not to follow the CMOH Order 10-2020. This demonstrated to the Hearing Tribunal a lack of skill or judgment in the provision of Licensed Practical Nursing services in these circumstances.

Mr. Ngetich did not disclose to his employer, Shepherd's Care Vanguard, that he was working at two separate health care facilities despite the CMOH Order 10-2020 which stated that employees had to complete a declaration form stating that they would only be working in one health care facility. Mr. Ngetich never completed a Single Site Declaration and did not disclose to Shepherd's Care Vanguard that he also worked at CapitalCare Dickinsfield. In doing so, Mr. Ngetich was in contravention of another enactment that applied to the profession. The CMOH Order 10-2020 which was implemented to prevent the spread of COVID-19 among vulnerable groups with pre-existing health conditions which includes seniors. This was an enactment that applied to the Licensed Practical Nurse profession. By failing to advise his employers and by failing to limit his work to only one facility, Mr. Ngetich put others at risk. These were some of the more vulnerable members of the population who could have suffered serious consequences if they were exposed to the COVID-19 virus. One of the facilities that Mr. Ngetich was working at, was in fact, under a COVID-19 outbreak during this time which created an elevated risk of transmission and exposure.

Mr. Ngetich did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons given above.

Mr. Ngetich's conduct harms the integrity of the regulated profession in that Mr. Ngetich did not act in a manner which would be expected of another LPN in a similar situation. LPNs are expected to follow the mandate of the Chief Medical Officer of Health for Alberta especially when dealing with a worldwide pandemic such as with COVID-19. It is expected that LPNs will follow the mandate of both the CLPNA as well as the Chief Medical Officer of Health for Alberta.

Allegation 3

Mr. Ngetich admitted that between April 23, 2020 and July 30, 2020, he worked at two health care facilities, Shepherd's Care Vanguard and CapitalCare Dickinsfield, in contravention of CMOH 10-2020.

Mr. Ngetich was aware of CMOH Order 10-2020 and Mr. Ngetich had read the information about the requirement to only work at one health care facility as of April 23, 2020.

On July 28, 2020, Ms. Clarke at Shepherd's Care Vanguard received a report from Alberta Health Services which advised Mr. Ngetich had been working at more than one health care facility in contravention of CMOH 10-2020.

Ms. Sidhu at CapitalCare Dickinsfield was then advised by Shepherd's Care Vanguard that Mr. Ngetich was working in a full time LPN position at Shepherd's Care Vanguard. Ms. Sidhu confirmed that Mr. Ngetich was also working as an LPN at CapitalCare Dickinsfield.

Mr. Ngetich worked at both CapitalCare Dickinsfield and Shepherd's Care Vanguard after the single site requirement in CMOH Order 10-2020 came into effect on April 23, 2020 and continued to do so until July 29, 2020 when he was placed on a paid administrative leave by Shepherd's Care Vanguard.

A COVID-19 outbreak was declared at CapitalCare Dickinsfield on July 10, 2020. During this outbreak, Mr. Ngetich continued to work at both health care facilities.

The Hearing Tribunal finds that the conduct admitted to amounts to unprofessional conduct as defined in s. 1(1)(pp) of the Act, 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;
iii. Contravention of another enactment that applies to the profession, and
xiv. Conduct that harms the integrity of the regulated profession.

By working in two health care facilities despite the CMOH Order 10-2020, Mr. Ngetich displayed a lack of judgment in the provision of professional services. Mr. Ngetich had an obligation to follow the mandate, but he chose not to. This demonstrated to the Hearing Tribunal a serious lack of judgment by Mr. Ngetich.

Mr. Ngetich did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice. The Hearing Tribunal finds the conduct breached the same provisions of the CLPNA Code of Ethics and the CLPNA Standards of Practice as set out above and that such breaches are sufficiently serious to constitute unprofessional conduct for the same reasons given above.

Again, by failing to abide by the CMOH Order 10-2020, Mr. Ngetich failed to follow an enactment binding on him in his profession. As already noted, the CMOH Order 10-2020 was enacted for the express purpose of preventing the spread of COVID-19 amongst Alberta's most vulnerable. It is obvious Mr. Ngetich engaged in unprofessional conduct in doing so.

Mr. Ngetich's conduct harms the integrity of the regulated profession in that Mr. Ngetich did not act in a manner which would be expected of another LPN in a similar situation. It would have been clear to him that his actions could jeopardize the health and safety of people under his care. This is in direct opposition to the core of what the public trust LPNs to do. This undermines the confidence of the public and thereby harms the integrity of the profession.

(9) Joint Submission on Penalty

The Complaints Consultant and Mr. Ngetich jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #3. The Joint Submission on Penalty proposed the following sanctions to the Hearing Tribunal for consideration:

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

2. Mr. Ngetich's practice permit shall be suspended for a period of **five and a half (5.5)** months. This suspension period shall be deemed to have been satisfied by virtue of the period of time during which Mr. Ngetich's practice permit was subject to an interim suspension and his practice permit shall be reinstated on the date of the hearing.

3. Mr. Ngetich shall pay a fine of $1,500.00 within **36 months** of service of the Decision.

4. Mr. Ngetich shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

5. Mr. Ngetich shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on CLPNA's website

http://www.clpna.com/ under "Governance". Mr. Ngetich shall provide a signed written declaration to the Complaints Consultant attesting that he has reviewed the CLPNA documents within **30 days** of service of the Decision:

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

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

c. CLPNA Practice Policy: Professional Responsibility & Accountability;

d. CLPNA Policy: Expectations and Obligations During Emergencies;

e. CLPNA Competency Profile A1: Critical Thinking;

f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making; and

g. CLPNA Competency Profile C4: Professional Ethics.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

6. Mr. Ngetich shall complete the **LPN Ethics Course** available online at https://www.learninglpn.ca/index.php/e-learning/lpn-code-of-ethics. Mr. Ngetich shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

7. The sanctions set out above at paragraphs 3-6 will appear as conditions on Mr. Ngetich's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings outlined at paragraphs 5-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Mr. Ngetich's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings; and

        ii. LPN Ethics course;

    b) The requirement to pay the fine and costs outlined at paragraphs 3-4 will appear as "Conduct Cost/Fines" on Mr. Ngetich's practice permit and the Public Registry until all fines and costs have been paid as set out above at paragraphs 3-4.

8. The conditions on Mr. Ngetich's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

9. Mr. Ngetich shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Mr. Ngetich will keep his contact information current with the CLPNA on an ongoing basis.

10. Should Mr. Ngetich be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Mr. Ngetich 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 Consultant 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 Mr. Ngetich's non-compliance as information for a complaint under s. 56 of the Act; or

    (c) In the case of non-payment of the costs described in paragraph 4 above, suspend Mr. Ngetich's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

Legal Counsel for the Complaints Consultant 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 Act sets out the available orders the Hearing Tribunal is able to make if unprofessional conduct is found.

The Hearing Tribunal is aware, 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 defer 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 Mr. Ngetich and the Complaints Consultant.

(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 Mr. Ngetich 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 investigated member
- The previous character of the investigated 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 investigated member in acknowledging what occurred
- Whether the investigated 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

The nature and gravity of the proven allegations: This is serious conduct in that vulnerable individuals were put at serious risk due to Mr. Ngetich's failure to abide by the clear direction of the Chief Medical Officer of Health for Alberta in a time of pandemic. All individuals are to abide by the directions of the Chief Medical Officer of Health for Alberta and that is even more important when the individual is a health care professional who is engaged in care of the vulnerable members of the public. This was not conduct that was based on a mistake or carelessness as Mr. Ngetich was aware of the order and chose to continue to work at both facilities. This conduct was intentional as opposed to an accidental breach or carelessness.

The age and experience of the investigated member: Mr. Ngetich was initially registered with the CLPNA on January 1, 2009. At all times material to the allegations, Mr. Ngetich was a regulated member of the CLPNA. This type of conduct would not be excused by way of Mr. Ngetich being new to the LPN profession as this was a violation of an order from the Chief Medical Office of Health for Alberta.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: The Hearing Tribunal was not presented with any information in regard of this factor.

The age and mental condition of the victim, if any: Mr. Ngetich was working in facilities which offer long term care who are by that nature more vulnerable.

The number of times the offending conduct was proven to have occurred: The conduct in question relates to an interrelated course of events; however, the Hearing Tribunal notes that the nature of Mr. Ngetich's failure to comply with the CMOH Order 10-2020 was such that it was ongoing over a period of months.

The role of the investigated member in acknowledging what occurred: Mr. Ngetich acknowledged the conduct that was brought forward.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Mr. Ngetich had an interim suspension since September 2, 2020. Mr. Ngetich was terminated from his position at CapitalCare Dickinsfield on August 19, 2020. His position with Shepherd's Care Vanguard was terminated on September 1, 2020.

The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice: Specific deterrence is required to keep Mr. Ngetich from repeating the same conduct in the future. General deterrence is required to ensure that other members of the LPN profession do not engage in similar conduct as well as to make sure that it is known that this type of conduct will not be tolerated by the CLPNA. LPNs are recognized as independent and capable members of the healthcare team and follow self-regulation and the public needs to be reassured that this standard is upheld.

The need to maintain the public's confidence in the integrity of the profession: The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will deal with any breaches in the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

The range of sentence in other similar cases: This was one of the first cases brought forward by the CLPNA and relates to a novel issue.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

After considering the proposed orders for penalty, the Hearing Tribunal finds the Joint Submission on Penalty is appropriate, reasonable and serves the public interest and therefore accepts the parties' proposed penalties.

(11) Orders of the Hearing Tribunal

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

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

2. Mr. Ngetich's practice permit shall be suspended for a period of **five and a half (5.5)** months. This suspension period shall be deemed to have been satisfied by virtue of the period of time during which Mr. Ngetich's practice permit was subject to an interim suspension and his practice permit shall be reinstated on the date of the hearing.

3. Mr. Ngetich shall pay a fine of $1,500.00 within **36 months** of service of the Decision.

4. Mr. Ngetich shall pay 25% of the costs of the investigation and hearing to be paid over a period of **36 months** from service of the Decision.

    a) A letter advising of the final costs will be forwarded when final costs have been confirmed.

5. Mr. Ngetich shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on CLPNA's website http://www.clpna.com/ under "Governance". Mr. Ngetich shall provide a signed written declaration to the Complaints Consultant attesting that he has reviewed the CLPNA documents within **30 days** of service of the Decision:

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

    d. CLPNA Policy: Expectations and Obligations During Emergencies;

    e. CLPNA Competency Profile A1: Critical Thinking;

    f. CLPNA Competency Profile A2: Clinical Judgment and Decision Making; and

g. CLPNA Competency Profile C4: Professional Ethics.

If such documents become unavailable, they may be substituted by equivalent documents approved in advance in writing by the Complaints Consultant.

6. Mr. Ngetich shall complete the **LPN Ethics Course** available online at https://www.learninglpn.ca/index.php/e-learning/lpn-code-of-ethics. Mr. Ngetich shall provide the Complaints Consultant with a certificate confirming successful completion of the course within **30 days** of service of the Decision.

7. The sanctions set out above at paragraphs 3-6 will appear as conditions on Mr. Ngetich's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings outlined at paragraphs 5-6 will appear as "CLPNA Monitoring Orders (Conduct)" on Mr. Ngetich's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings; and

        ii. LPN Ethics course;

    b) The requirement to pay the fine and costs outlined at paragraphs 3-4 will appear as "Conduct Cost/Fines" on Mr. Ngetich's practice permit and the Public Registry until all fines and costs have been paid as set out above at paragraphs 3-4.

8. The conditions on Mr. Ngetich's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 7.

9. Mr. Ngetich shall provide the CLPNA with his contact information, including home mailing address, home and cellular telephone numbers, current e-mail address and current employment information. Mr. Ngetich will keep his contact information current with the CLPNA on an ongoing basis.

10. Should Mr. Ngetich be unable to comply with any of the deadlines for completion of the penalty orders identified above, the deadlines may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Consultant.

11. Should Mr. Ngetich 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 Consultant 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 Mr. Ngetich's non-compliance as information for a complaint under s. 56 of the Act; or

(c) In the case of non-payment of the costs described in paragraph 4 above, suspend Mr. Ngetich's practice permit until such costs are paid in full or the Complaints Consultant is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Consultant.

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),(b) and 87(2) of the Act, the Investigated 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 29th DAY OF MARCH 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal