**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 GETACHEW SASIGA**

# 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 GETACHEW SASIGA, LPN #40342, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA ("CLPNA")**

**DECISION OF THE HEARING TRIBUNAL**

## (1) Hearing

The hearing was conducted at the offices of the CLPNA in Edmonton, Alberta on November 26, 2019 with the following individuals present:

**Hearing Tribunal**:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Marie Concepcion, LPN
Marg Hayne, Public Member

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

**Investigated Member**:
Getachew Sasiga, LPN ("Mr. Sasiga" or "Investigated Member")
Lee Watson, 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. Sasiga was an LPN within the meaning of the *Health Professions Act* (the "Act") at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Mr. Sasiga was initially licensed as an LPN in Alberta on May 8, 2015.

By letter dated June 7, 2018, the College of Licensed Practical Nurses of Alberta (“CLPNA”) received a complaint (the “Complaint”) from Ms. Megan Cox, Care Manager, Alberta Health Services, Edson Continuing Care Facility, pursuant to s. 57 of the Act. The Complaint stated Mr. Getachew (Paul) Sasiga, LPN, had been suspended for a period of one day from his employment at the Edson Healthcare Centre (“EHC”) on April 10, 2018 following an investigation into the alleged failure to complete nursing assessments while employed as an LPN at the EHC.

Ms. Sandy Davis, Complaints Director for the CLPNA (the "Complaints Director"), delegated her authority and powers under Part 4 of the Act to Susan Blatz, Complaints Consultant for the CLPNA (the "Complaints Consultant"), pursuant to s. 20 of the Act. Mr. Sasiga received notice of the Complaint and delegation of power by letter dated June 8, 2018.

Subsequently, in accordance with s. 55(2)(d) of the Act, the Complaints Consultant appointed Kerry Palyga, Investigator for the CLPNA (the “Investigator”), to conduct an investigation into the Complaint. Mr. Sasiga received notice of the investigation, and appointment of the Investigator by letter dated June 15, 2018.

On July 12, 2018, the CLPNA received a second complaint (the “Second Complaint”) from Ms. Megan Cox, Care Manager, Alberta Health Services, Edson Continuing Care Facility, pursuant to s. 57 of the Act. The Second Complaint stated that Mr. Sasiga had been suspended for a three-day period from his employment at the EHC following an investigation into alleged failure to complete nursing assessments and properly recording medication administration.

The Complaints Consultant provided Mr. Sasiga with notice of the Second Complaint and appointment of Kerry Palyga as Investigator to conduct an investigation into the Second Complaint. Mr. Sasiga received notice of the Second Complaint, investigation, and appointment of the Investigator by letter dated July 13, 2018.

The Complaint and the Second Complaint were investigated together.

On July 24, 2019, the Investigator concluded the investigation and submitted the Investigation Report to the CLPNA.

Following receipt of the Investigation Report, the Complaints Consultant determined there was sufficient evidence that the matter should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Sasiga received notice the matter was referred to a hearing, as well as a copy of the Statement of Allegations and Investigation Report on September 19, 2019.

A Notice of Hearing Notice to Attend and Notice to Produce was served upon Mr. Sasiga under cover of letter dated October 15, 2019.

## (4) Allegations

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

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

1. On or about February 26, 2017 failed to complete neurological vital signs on client GD as required after GD suffered a fall.

2. On or about March 21, 2017 did one or more of the following with regards to client EP who suffered a fall:

    a) Failed to document the time of the fall on the Continuing Care Post Fall Assessment;
    b) Failed to document an assessment in the Multidisciplinary Notes;
    c) Failed to complete an incident report as required; and
    d) Failed to report the fall to oncoming staff upon transition of client care.

3. On or about March 28, 2017 did one or more of the following with regards to client BL:

    a) Incorrectly transcribed a Physician's Order for "Plavix 75 mg po daily for 3/52" (3 weeks) as "Plavix 75 mg po TID" (three times a day); and
    b) Failed to fax the Physician's Order to the pharmacy for processing as required.

4. On or about April 8, 2017 documented the administration "1 gm" of Tylenol to client RH at 0205 hours instead of the ordered amount of Tylenol 650 mg.

5. On or about August 17, 2017 did one or more of the following with regards to client RW:

    a) Pre-signed on the Narcotic Control Record as administering M-Eslon 60 mg at 0510 hours; and
    b) Failed to administer M-Eslon 60 mg at 0500 hours as ordered.

6. On or about August 22, 2017 did one or more of the following with regards to client KB:

    a) Applied a Butran patch on August 22, 2017 instead of the scheduled date of August 26, 2017; and
    b) Inaccurately documented on the Medication Patch Record that the previous patch was "not removed."

7. On or about March 18, 2018 did one or more of the following with regards to client TB:

    a) Failed to perform an assessment of client TB's vital signs and/or document vital signs after TB turned blue, vomited a large amount and had a large bowel movement;
    b) Failed to perform a blood glucose test and/or document a blood glucose level after TB, a diabetic, turned blue, vomited a large amount and had a large bowel movement; and
    c) Failed to accurately document client TB's status in the Client Care Communication record.

8. On or about June 20, 2018, did one or more of the following with regards to client VC:

    a) Failed to accurately report client VC's status to the oncoming shift by verbally reporting VC "was sleepy most of the day" rather than informing staff VC was not well, had not eaten, drank or urinated all shift and had been on the couch since 0830 hours; and
    b) Failed to accurately document client VC's status on the Daily Report Sheet by documenting VC "was sleepy most of the day" rather than documenting VC was not well, had not eaten, drank or urinated all shift and had been on the couch since 0830 hours.

9. On or about June 20, 2018 did one or more of the following with regards to client MW:

    a) Failed to reassess and/or document a reassessment of MW's blood glucose level after administering NovoRapid 5 units stat at 1330 hours; and
    b) Failed to document on the Medication Administration Record the administration of:
        a. NovoRapid 5 units at 1145 hours; and
        b. NovoRapid 5 units at 1330 hours."

## (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. Sasiga 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. Sasiga'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 Getachew Sasiga.

### Allegation 1

Mr. Sasiga admitted on or about February 26, 2017, he failed to complete neurological vital signs on client GD as required after GD suffered a fall.

Mr. Sasiga was working at the EHC on February 25 and February 26, 2017 and provided care to client GD during this time.

On February 25, 2017 at approximately 1200 hours, client GD fell and suffered a head injury which required stitches to GD's right eyebrow.

AHS's Post Fall Assessment Policy requires all clients who fall and sustain any level of injury to receive professional physical assessment and monitoring of vital signs, including neurological vital signs, every hour for the first four (4) hours, and then every eight (8) hours, and then for the next 24 to 48 hours. A copy of the AHS Post Fall Assessment Policy which was dated May 2014 was provided in Exhibit 2 under TAB 9.

At approximately 2300 hours on or about February 25, 2017, Mr. Sasiga relieved the previous LPN and took over the care of client GD.

GD's last set of vitals were taken on February 25, 2017 at 1915 hours. Mr. Sasiga should have completed GD's neurological vital signs at around 0315 hours on February 26, 2017. While client GD was in Mr. Sasiga's care from 2300 hours on February 25, 2017 to 0700 hours on February 26, 2017, Mr. Sasiga did not perform any neurological vital sign assessments. A copy of resident GD's multi-disciplinary notes was provided to the Hearing Tribunal in Exhibit 2 under TAB 10, as well as, a copy of resident GD's neurological vital signs chart under TAB 11.

Mr. Sasiga displayed a lack of knowledge and lack of skill or judgment by failing to do a post fall assessment on client GD after he fell and suffered a head injury. Mr. Sasiga did not perform any neurological vital sign assessments regarding client GD. The Post Fall Assessments are required to be completed whenever a resident has a fall, regardless of whether there is an injury. Staff members of all disciplines have access to this intervention within the Edson Healthcare Centre. When a fall occurs, the staff member who is present or who is the first staff member on the scene is responsible to open the Post Fall Assessment and document according to his/her scope of practice. Once the RN/LPN has completed an assessment, then they are to open the Post Fall Assessment and document their findings/observations/actions, while being sure to complete the "Post Event Interventions" section per Practice Process. All residents who fall and who have no apparent harm require a professional assessment and monitoring every eight (8) hours for a minimum of twenty-four (24) hours according to the Post Fall Assessment. Failing to perform this Post Fall Assessment creates risk of harm and demonstrates that Mr. Sasiga did not apply his knowledge and training in the performance of being an LPN. By not performing the appropriate monitoring, this conduct harms the integrity of the LPN profession by undermining the protecting of the public and the provision of skilled care as an LPN. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 2

Mr. Sasiga admitted that on or about March 21, 2017, he did one or more of the following with regards to client EP who suffered a fall:

a) Failed to document the time of the fall on the Continuing Care Post Fall Assessment;
b) Failed to document an assessment in the Multidisciplinary Notes;
c) Failed to complete an incident report as required; and
d) Failed to report the fall to oncoming staff upon transition of client care.

Mr. Sasiga was working at the EHC on March 21, 2017 and during this time provided care to client EP.

While in Mr. Sasiga's care, client EP suffered a fall at approximately 2305 hours. A copy of the AHS Reporting & Learning System for Resident Safety Report describing the fall was provided for the Hearing Tribunal in Exhibit 2, TAB 12.

Mr. Sasiga documented the fall via a Continuing Care Post Fall Assessment, but Mr. Sasiga failed to document the time of the fall in the assessment. A copy of client EP's Continuing Care Post Fall Assessment was provided for the Hearing Tribunal in Exhibit 2, TAB 13.

Further, Ms. Sasiga did not document an assessment of EP after the fall in EP's Progress Notes and failed to complete an incident report detailing the fall. A copy of client EP's Multidisciplinary Progress Notes were provided in Exhibit 2, TAB 14.

Ms. Sasiga did not inform his colleague, CB, LPN, of client EP's fall at the end of his shift when the care of client EP transitioned to CB.

Mr. Sasiga failed to document an assessment of client EP after client EP had a fall while under the care of Mr. Sasiga. Mr. Sasiga also failed to inform his colleague at the end of his shift of EP's fall. Information pertaining to a client post fall is important for assessing treatment of the client and for ensuring that overall documentation of the client's health care is maintained. Failing to maintain such records creates a risk of harm to the client and it can interfere with the client receiving the appropriate care. Failing to perform an assessment after a fall can have significant consequences. An assessment can identify any matters for concern, monitoring or even immediate treatment requirements. If an assessment is not done, all of these can be overlooked to the detriment of the client. These things are essential to providing good care and the failure to carry out this task shows a lack of knowledge, skill or judgment in the practice of an LPN. The

potential for harm created for the client lends itself to diminishing the integrity of the profession which should maintain the highest standards in the application of skills of an LPN. Mr. Sasiga harmed the integrity of the LPN profession by not doing what another LPN would have done in a similar situation. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 3

Mr. Sasiga admitted on or about March 28, 2017, he did one or more of the following with regards to client BL:

a) Incorrectly transcribed a Physician's Order for "Plavix 75 mg po daily for 3/52" (3 weeks) as "Plavix 75 mg po TID" (three times a day); and
b) Failed to fax the Physician's Order to the pharmacy for processing as required.

Mr. Sasiga was working at the EHC on March 28, 2017, and during this time provided care to client BL.

At approximately 1430 hours, client BL received a Physician's Order via fax for "Plavix 75 mg po daily x3/52 [3 weeks]". A copy of the Physician's Order for client BL, dated March 28, 2017, was provided for the Hearing Tribunal in Exhibit 2, TAB 15.

Mr. Sasiga incorrectly transcribed the order onto client BL's Medical Administration Record as "Clopidogrel (Plavix) 75 mg po TID [three times a day]". A copy of client BL's Medical Administration Record dated March 2017 was provided in Exhibit 2, TAB 16.

Medication errors can pose a risk of significant harm to a client. Mr. Sasiga transcribed a medication order that was to be given once a day over a three-week period to giving the client the medication three times a day. This posed a great potential of harm towards this client. Medication transcription is a basic skill of an LPN, and it is expected that LPNs would correctly transcribe medication orders and then ensure that the medication order is processed in the correct order, as well as, subsequently delivered. Failing to provide medication as directed by a physician harms the LPN profession in that it is not in keeping with the high standards for practice which LPNs strive to meet. Mr. Sasiga did not fax the Physician's Order to the pharmacy as required for processing. Mr. Sasiga harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Transcription of physician's orders is a core

competency of an LPN and the outcome of Mr. Sasgia's actions had the potential of posing a great amount of harm to client BL. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 4

Mr. Sasiga admitted on or about April 8, 2017, he documented the administration "1 gm" of Tylenol to client RH at 0205 hours instead of the ordered amount of Tylenol 650 mg.

Mr. Sasiga was working at the EHC on April 8, 2017, and during this time provided care to client RH.

Client RH had an order for Tylenol 2 tablets 650 mg PRN Q4H.

At approximately 0205 hours, Mr. Sasiga documented that he administered "Tylenol 1 gm PO for Pain right Hip" to client RH instead of the ordered amount of 1300 mgs. A copy of client RH's Continuing Care PRN Medication Record dated July 8, 2016 to April 8, 2017 was provided to the Hearing Tribunal in Exhibit 2, TAB 17.

Mr. Sasiga documented that he administered "Tylenol 1 gm PO for Pain Right HIP" to client RH instead of the ordered amount of 1300 mgs. Medication administration is a fundamental skill for an LPN and failure to properly administer medications can pose a risk of harm to clients. Medication is a basic core competency of an LPN. Medication errors harm the integrity of the LPN profession because they can contribute to undermining the LPN profession as delivering skilled and competent services. Mr. Sasiga harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Medication administration is a core competency of an LPN and the outcome of Mr. Sasgia's actions had the potential of posing a great amount of harm to client RH. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

b) Contravention of the Act, a code of ethics or standards of practice; and
c) Conduct that harms the integrity of the regulated profession.

Allegation 5

Mr. Sasiga admitted on or about August 17, 2017, he did one or more of the following with regards to client RW:

a) Pre-signed on the Narcotic Control Record as administering M-Eslon 60 mg at 0510 hours; and
b) Failed to administer M-Eslon 60 mg at 0500 hours as ordered.

Mr. Sasiga was working at the EHC on August 17, 2017, and during this time provided care to client RW.

Mr. Sasiga signed the Narcotic Control Record for client RW indicating that he administered RW's 0500 hours dose of M-Eslon 60 mg at 0510 hours. A copy of client RW's Narcotic Control Record was provided for the Hearing Tribunal in Exhibit 2, TAB 18.

At approximately 0700 hours on August 17, 2017, MC, an RN and colleague of Mr. Sasiga, found an unopened medication package for M-Elson 60 mg for client RW. The medication package indicated that it was to be administered at 0500 hours. A copy of a photograph of the medication package for client RW was provided for the Hearing Tribunal in Exhibit 2, TAB 19.

On August 25, 2017, Mr. Sasiga submitted an AHS Reporting & Learning Systems (RLS) Report for omitting a dose of medication. In the RLS Report, Mr. Sasiga indicated that he failed to administer the dose of M-Elson 60 mg to client RW at 0500 hours on August 17, 2017. A copy of the RLS Report dated August 25, 2017, was provided for the Hearing Tribunal in Exhibit 2, TAB 20.

Mr. Sasiga displayed a lack of knowledge of or lack of skill or judgment by failing to administer a narcotic to client RW even though Mr. Sasiga indicated that he did administer the narcotic on the Narcotic Control Record. LPNs must administer medications as ordered and the failure to do so has the potential to cause harm to a client. LPNs are expected to display their skill and knowledge when working with medications. Failing to administer medications causes harm to the integrity of the profession which is tasked with ensuring professional services of its members are carried out with knowledge and skill. Mr. Sasiga harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Medication administration is a core competency of an LPN and the outcome of Mr. Sasgia's actions had the potential of posing a great amount of harm to client RW. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 6

Mr. Sasiga admitted on or about August 22, 2017, he did one or more of the following with regards to client KB:

a) Applied a Butran patch on August 22, 2017 instead of the scheduled date of August 26, 2017; and
b) Inaccurately documented on the Medication Patch Record that the previous patch was "not removed."

Mr. Sasiga was working at the EHC on August 22, 2017, and during this time provided care to client KB.

Client KB had a medication order that one Butran patch be applied weekly on Saturdays. A Butran patch was applied on August 19, 2017. A copy of the Medication Administration Record for client KB was provided for the Hearing Tribunal in Exhibit 2, TAB 21.

Mr. Sasiga applied a Butran patch to KB on August 22, 2017, in spite of the fact that client KB was not due for a new patch until August 26, 2017. A copy of the Medication Administration Record for client KB was provided for the Hearing Tribunal in Exhibit 2, TAB 21, and a copy of the Medication Patch Record for client KB was attached at TAB 22.

On client KB's Medication Patch Record, Mr. Sasiga documented that the previous patch was "not removed" from Site #2, and that he applied a new patch to "Site #3". A copy of the Medication Patch Record for client KB was provided for the Hearing Tribunal in Exhibit 2, TAB 22.

Upon site examination of KB by a colleague, MC, client KB only had one Butran patch applied at Site #3.

Mr. Sasiga displayed a lack of knowledge, skill or judgment by not referring to client KB's Medication Administration Record, as well as, the Physician's Orders. Mr. Sasiga applied a Butran patch on a date in which the client did not require it nor did Mr. Sasiga remove the Butran patch that the client already had administered on their body. It is important that all parties providing care to a client can determine the status of a client's medication by consulting the Medication Administration Record for each client. Failure to do so demonstrated a lack of skill and judgment. When a Medication Administration Record is not complete and accurate it can pose harm to a client and, in turn, the LPN profession. Mr. Sasiga harmed the integrity of the LPN profession by not doing what another LPN would do in a similar situation. Medication administration is a core competency of an LPN and the outcome of Mr. Sasiga's actions had the potential of posing a

great amount of harm to client RH. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 7

Mr. Sasiga admitted on or about March 18, 2018, he did one or more of the following with regards to client TB:

a) Failed to perform an assessment of client TB's vital signs and/or document vital signs after TB turned blue, vomited a large amount and had a large bowel movement;
b) Failed to perform a blood glucose test and/or document a blood glucose level after TB, a diabetic, turned blue, vomited a large amount and had a large bowel movement; and
c) Failed to accurately document client TB's status in the Client Care Communication record.

Mr. Sasiga was working at the EHC on March 18, 2018, and during this time provided care to client TB, who was a diabetic.

While staff were helping client TB to bed at approximately 1345 hours, client TB turned blue, vomited a large amount, and had a large bowel movement. Mr. Sasiga provided care to client TB and administered Gravol 50 mg. A copy of client TB's PRN Medication Record was provided for the Hearing Tribunal in Exhibit 2, TAB 23.

Mr. Sasiga entered a "Client Care Communication" into client TB's electronic chart, which detailed client TB's vomiting, large bowel movement, and the administration of Gravol. In the Client Care Communication record, Mr. Sasiga documented "HCA reported that resident is vomiting, and trend blue slipped of broad chair". This documentation is not accurate and did not provide accurate information regarding client TB's status to other staff.

In addition, despite being aware of TB's condition, Mr. Sasiga failed to assess or document client TB's vital signs and failed to perform or document a blood glucose test.

Mr. Sasiga communicated client TB's status to oncoming staff during transition of care and indicated that he had completed an assessment of client TB's vitals at approximately 1400 hours.

The vital signs machine in client TB's room had no record of vital signs being taken by Mr. Sasiga on March 18, 2018.

Documentation is a core competency of an LPN, and Mr. Sasiga demonstrated a lack of knowledge or lack of skill or judgment by failing to document any of his assessments of client TB. Proper documentation of a client's status is critical to ensuring that all members of the health care team are aware of what is happening with a particular client and ensures that appropriate care and treatment can be given. This is a basic skill of an LPN. Further, the taking of vital signs is critical to assessing the well-being of a client and the recording of these provides the ability for the whole health care team to understand how a client is doing over time. Failing to do this shows a lack of skill, knowledge, and judgment. This conduct harms the integrity of the profession by undermining the trust in the knowledgeable and skilled profession providing care to members of the public and for the public good. Mr. Sasiga did not document his assessment of client TB in a way that another LPN would have done if they were in the same situation. Documentation is a core competency of LPNs, and this harms the integrity of the profession by not doing what is expected by another LPN in a similar situation. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

Allegation 8

Mr. Sasiga admitted on or about June 20, 2018, he did one or more of the following with regards to client VC:

a) Failed to accurately report client VC's status to the oncoming shift by verbally reporting VC "was sleepy most of the day" rather than informing staff VC was not well, had not eaten, drank or urinated all shift and had been on the couch since 0830 hours; and

b) Failed to accurately document client VC's status on the Daily Report Sheet by documenting VC "was sleepy most of the day" rather than documenting VC was not well, had not eaten, drank or urinated all shift and had been on the couch since 0830 hours.

Mr. Sasiga was working at the EHC on June 20, 2018, and during this time provided care to client VC.

At 1437 hours, Mr. Sasiga documented in client VC's Patient Care Record that client VC was reported to be sleepy since breakfast. Mr. Sasiga further documented that client VC was found

to be on the sofa chair by the dining room, refused her lunch meal, and refused to go to bed although she was sleepy. Mr. Sasiga documented that client VC's vital signs were taken. A copy of client VC's transcribed Patient Care Record dated June 20, 2018 was provided for the Hearing Tribunal in Exhibit 2, TAB 25, as well as, a copy of client VC's Daily Report Sheet dated June 16, 2018 to June 22, 2018 was attached at TAB 26.

Client VC was not well and had been sitting on the couch since 0830 hours, had not eaten, drank or urinated for the entirety of Mr. Sasiga's shift. Mr. Sasiga did not record any of this information in client VC's charting. A copy of client VC's transcribed Patient Care Record dated June 20, 2018 was provided for the Hearing Tribunal in Exhibit 2, TAB 25, and a copy of client VC's Daily Report Sheet dated June 16, 2018 to June 22, 2018 was attached at TAB 26.

At 1445 hours, Mr. Sasiga's colleague HW, an LPN, began her shift and care for client VC. At this time, Mr. Sasiga verbally communicated to HW that client VC had been sleepy for most of the day. Mr. Sasiga did not communicate that client VC was not well, had not eaten, drank, or urinated for the entirety of his shift.

HW assessed client VC shortly thereafter and found that client VC was grey, her appendages were cool and that client VC complained of abdominal pain. Client VC was transferred to emergency shortly thereafter.

Mr. Sasiga displayed a lack of knowledge, skill or judgment by failing to accurately report client VC's status to the oncoming shift as well as failing to document client VC's status on the Daily Report Sheet. Reporting and documenting are core competencies for an LPN. Tracking and properly recording information such as the fact that a client had not eaten, drank or urinated for a long period of time is important to ensuring that the client received appropriate care and that potentially further investigation may need to take place. Failing to communicate the same to team members impedes appropriate health care. This conduct is demonstrative of a lack of skill, knowledge and judgment. Even LPNs with minimal experience are expected to record information and share information such as this with their health care teammates, this is fundamental. This client was needlessly exposed to harm and was required to be transported to emergency. This harms the integrity of the profession and it is not in keeping with the conduct of an LPN for public good. Mr. Sasiga did not document his assessment of client VC in a way that another LPN would have done if they were in the same situation. Documentation is a core competency of LPNs, and this harms the integrity of the profession by not doing what is expected by another LPN in a similar situation. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

a) Displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
b) Contravention of the Act, a code of ethics or standards of practice; and

c) Conduct that harms the integrity of the regulated profession.

Allegation 9

Mr. Sasiga admitted on or about June 20, 2018, he did one or more of the following with regards to client MW:

a) Failed to reassess and/or document a reassessment of MW's blood glucose level after administering NovoRapid 5 units stat at 1330 hours; and
b) Failed to document on the Medication Administration Record the administration of:
    a. NovoRapid 5 units at 1145 hours; and
    b. NovoRapid 5 units at 1330 hours.

Mr. Sasiga was working at the EHC on June 20, 2018, and during this time provided care to client MW.

Mr. Sasiga documented in client MW's Patient Care Record that he administered client MW's scheduled 1145 hours dose of NovoRapid 5 at approximately 1220 hours. Mr. Sasiga did not document the administration of this dose of NovoRapid 5 in MW's Medication Administration Record. A copy of client MW's transcribed Patient Care Record dated June 20, 2018 was provided for the Hearing Tribunal in Exhibit 2, TAB 25, and a copy of client MW's Mediation Administration Record dated June 2018 was attached under TAB 27.

At approximately 1330 hours, Mr. Sasiga administered a stat dose of NovoRapid 5 to client MW in order to lower MW's glucose level as it was high at 24.0. Mr. Sasiga did not document the administration of the 1330 hours dose of NovoRapid 5 in MW's Medication Administration Record. A copy of client MW's Medication Administration Record was provided for the Hearing Tribunal in Exhibit 2, TAB 27.

Mr. Sasiga did not reassess or document client MW's blood glucose level following the administration of NovoRapid 5 at 1330 hours. A copy of client MW's transcribed Patient Care Record dated June 20, 2018 was provided for the Hearing Tribunal in Exhibit 2, TAB 25.

Mr. Sasiga demonstrated a lack of knowledge, skill or judgment by not properly documenting and reassessing blood glucose and the administration of NovoRapid 5. Medication administration must be properly recorded; this is an essential skill for LPNs. It is equally important that medication is administered in accordance with the prescribed schedule and, failure to do so, can result in harm to the client. This is a basic skill of an LPN and is within the basic skill and knowledge of LPNs. The failure to administer medication as required and to record medication administered, has the effect of harming the integrity of the profession because it raises doubt about the qualifications and competencies of the LPN profession. Mr. Sasiga did not document his assessment of client TB in a way that another LPN would have done if they were in the same situation. Documentation is a core competency of LPNs, and this harms the integrity of the

profession by not doing what is expected by another LPN in a similar situation. Mr. Sasiga's conduct also breached the Code of Ethics and Standards of Practice for the reasons set out below.

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:

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

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**

Mr. Sasiga acknowledges that his conduct breached one or more of the following requirements of the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2012, which states as follows:

a. 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 provides 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.

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

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

    - 2.8 Use evidence and judgement to guide nursing decisions.

    - 2.9 Identify and minimize risks to clients.

c. 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.

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

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

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

The Hearing Tribunal finds the Investigated Member breached the CLPNA Code of Ethics in that his actions had the potential to place patients at risk of serious harm by not providing proper care. This resulted in a failure of responsibility to those patients, their families and the community. Mr. Sasiga failed to do what another LPN would do in the same or similar situation. Mr. Sasiga's actions failed to demonstrate a level of practice that corresponds with being a regulated professional. Mr. Sasiga has undermined his trustworthiness and integrity and his actions were not consistent with the principles, standards of practice, laws and regulations to which he is to be held accountable.

**CLPNA Standards of Practice**

Mr. Sasiga acknowledges his conduct breached one or more of the following Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, which states as follows:

a. 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 provides that LPNs:

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

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

- 1.7 Incorporate established client safety principles and quality assurance/improvement activities into LPN practice.

- 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.

b. Standard 2: Knowledge-Based Practice – LPNs possess knowledge obtained through practical nurse preparation and continuous learning relevant to their professional LPN practice. Standard 2 specifically provides that LPNs:

   - 2.1 Possess current knowledge to support critical thinking and professional judgement.

   - 2.2 Apply knowledge from nursing theory and science, other disciplines, evidence to inform decision making and LPN practice.

c. 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 provides that LPNs:

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

   - 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.

d. 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 provides 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.

   - 4.10 Practice with honesty and integrity to maintain the values and reputation of the profession.

The Hearing Tribunal finds that the Investigated Member's conduct breached the CLPNA Standards of Practice in that Mr. Sasiga's conduct and actions are breaches of the Standards of Practice in that Mr. Sasiga failed to ensure that his practice was conducted in accordance of the requirements to which he is bound. Further, his actions placed patients in harm's way rather than trying to minimize the potential of harm to the patients to which he provided care for. Mr. Sasiga failed to apply his knowledge and professional judgement. Mr. Sasiga's actions were such that they diminished the interests of the patient, the public and the profession and did not demonstrate an ethical practice.

## (9) Joint Submission on Penalty

The Complaints Consultant and Mr. Sasiga made a joint submission with respect to penalty, which was entered as Exhibit #3. The parties jointly submitted the following proposal to the Hearing Tribunal for consideration:

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

2. Mr. Sasiga shall pay 25% of the costs of the investigation and hearing over a period of twenty-four (24) months from the date of service of the Decision. A letter advising of the final costs will be forwarded to Mr. Sasiga when final costs have been confirmed.

3. Mr. Sasiga shall read and reflect on how the following CLPNA documents, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact his nursing practice and provide a signed written declaration to the Complaints Consultant within 30 days of service of the Decision, attesting he has read the documents:

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 Practice Policy: Documentation;

e. CLPNA Competency Profile B: Nursing Process;

f. CLPNA Competency Profile D1: Communication and Collaborative Practice;

g. CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting;

h. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;

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

j. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Sasiga shall complete the following nursing quizzes located on website http://www.learningnurse.org/ and provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within 30 days of service of the Decision:

a) Health Assessment; and
b) Mobility and Falls.

If such quiz becomes unavailable, an equivalent quiz may be substituted where approved in advance in writing by the Complaints Consultant.

5. Mr. Sasiga shall complete the following courses available on CLPNA's website http://www.clpna.com and provide the Complaints Consultant with a certificate confirming successful completion of the courses within 60 days of service of the Decision:

a) Nursing Documentation 101; and
b) Medication Administration Self-Study Course.

If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Sasiga shall complete, at his own cost, the Documentation and Reporting course available online at www.coursepark.com and provide the Complaints Consultant with a certificate confirming successful completion of the course within 60 days of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Sasiga shall complete, at his own cost, A Healthcare Provider's Guide to Diabetes course available online at www.nurse.com and provide the Complaints Consultant with a certificate confirming successful completion of the course within 60 days of service of the Decision.

   If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. Should Mr. Sasiga 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.

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

10. Should Mr. Sasiga 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. Sasiga's non-compliance as information under s. 56 of the *Health Professions Act*; or

    (c) In the case of non-payment of the costs described in paragraph 2 above, suspend Mr. Sasiga'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.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Mr. Sasiga 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. Sasiga 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 Hearing Tribunal has carefully weighed each of these factors as follows:

- **The nature and gravity of the proven allegations** – Mr. Sasiga's conduct resulted from either carelessness or a lack of skill. The allegations with regards to Mr. Sasiga are serious in that there are nine (9) allegations over a 16-month time period.

- **The age and experience of the investigated member** – Mr. Sasiga was initially registered with the CLPNA on May 8, 2015. Mr. Sasiga was a regulated member of the CLPNA at all times material to the allegations and worked at the EHC as an LPN. At the time of the allegations, Mr. Sasiga had approximately two (2) years' experience working as an LPN which makes him a more junior LPN.

- **The age and mental condition of the victim, if any** - The Hearing Tribunal was not made aware of the age and the mental condition of any of the clients in Mr. Sasiga's care.

- T**he number of times the offending conduct was proven to have occurred** - There were nine (9) allegations presented to the Hearing Tribunal which took place from February 26, 2017 until June 20, 2018.

- **The role of the investigated member in acknowledging what occurred** – The Hearing Tribunal was pleased to hear that Mr. Sasiga acknowledged his conduct and worked with the CLPNA and Mr. Watson to create an Agreed Statement of Facts and a Joint Submission on Penalty. The first step in improving one's own practice is to recognize what they have done wrong and Mr. Sasiga has done this, along with taking responsibility for his own actions and learning from what he has done wrong. This was a strong mitigating factor in the context of the sanctions towards Mr. Sasiga.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made** – Mr. Sasiga has served two (2) separate unpaid suspensions from EHC. The first suspension was a one (1) day suspension on April 10, 2018, following an investigation into the alleged failure to complete nursing assessments. The second suspension was a three (3) day suspension following an investigation into alleged failure to complete nursing assessments and properly recording medication administration. These were not considered a significant factor to the Hearing Tribunal.

- **The impact of the incident(s) on the victim** – The Hearing Tribunal was not made aware of any impact on any of Mr. Sasiga's clients; however, there was a potential for great risk to those clients.

- **The presence or absence of any mitigating circumstances** – The Hearing Tribunal was not made aware 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** – Regarding specific deterrence, there is a need to impose sanctions on Mr. Sasiga. Mr. Sasiga needs to be aware that this type of behavior is not acceptable for an LPN, nor will it be tolerated by the CLPNA. Mr. Sasiga also needs to be made aware that this type of behavior is dealt with in a serious manner. The sanctions that are imposed with regards to Mr. Sasiga will also act as a deterrent to other LPNs by the CLPNA acknowledging the seriousness of these breaches of conduct and responding with the appropriate orders. These are core duties of an LPN and are basic skill, knowledge base, and a fundamental responsibility of an LPN.

- **The need to maintain the public's confidence in the integrity of the profession** - Documentation and medication administration are core competencies of LPNs and the public needs to be made aware that the lack of skill in these areas is something that the CLPNA takes seriously. CLPNA deals with the actions of its members when they conduct themselves in a way that is not becoming of the LPN profession. LPNs are trusted caregivers for populations that are often vulnerable and require attentive and meticulous care. The public's trust must be maintained by demonstrating that the CLPNA will deal with any breaches in the Act, Code of Ethics and Standard of Practice in a manner that reflects the seriousness of the conduct.

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 decision (the "Decision") shall serve as a reprimand.

2. Mr. Sasiga shall pay 25% of the costs of the investigation and hearing over a period of twenty-four (24) months from the date of service of the Decision. A letter advising of the final costs will be forwarded to Mr. Sasiga when final costs have been confirmed.

3. Mr. Sasiga shall read and reflect on how the following CLPNA documents, located on the CLPNA website at www.clpna.com under the "Governance" tab, will impact his nursing practice and provide a signed written declaration to the Complaints Consultant within 30 days of service of the Decision, attesting he has read the documents:

    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 Practice Policy: Documentation;

    e. CLPNA Competency Profile B: Nursing Process;

    f. CLPNA Competency Profile D1: Communication and Collaborative Practice;

    g. CLPNA Competency Profile D3: Legal Protocols, Documenting and Reporting;

    h. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;

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

    j. CLPNA Competency Profile U2: Medication Preparation and Administration.

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

4. Mr. Sasiga shall complete the following nursing quizzes located on website http://www.learningnurse.org/ and provide the Complaints Consultant with documentation confirming successful completion of the quizzes (a mark of at least 80%) within 30 days of service of the Decision:

    c) Health Assessment; and
    d) Mobility and Falls.

    If such quiz becomes unavailable, an equivalent quiz may be substituted where approved in advance in writing by the Complaints Consultant.

5. Mr. Sasiga shall complete the following courses available on CLPNA's website http://www.clpna.com and provide the Complaints Consultant with a certificate confirming successful completion of the courses within 60 days of service of the Decision:

    c) Nursing Documentation 101; and
    d) Medication Administration Self-Study Course.

    If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

6. Mr. Sasiga shall complete, at his own cost, the Documentation and Reporting course available online at www.coursepark.com and provide the Complaints Consultant with a certificate confirming successful completion of the course within 60 days of service of the Decision.

    If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

7. Mr. Sasiga shall complete, at his own cost, A Healthcare Provider's Guide to Diabetes course available online at www.nurse.com and provide the Complaints Consultant with a certificate confirming successful completion of the course within 60 days of service of the Decision.

    If such course becomes unavailable, an equivalent course may be substituted where approved in advance in writing by the Complaints Consultant.

8. Should Mr. Sasiga 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.

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

10. Should Mr. Sasiga 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:

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

(e) Treat Mr. Sasiga's non-compliance as information under s. 56 of the *Health Professions Act*; or

(f) In the case of non-payment of the costs described in paragraph 2 above, suspend Mr. Sasiga'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 13th DAY OF JANUARY 2020 IN CITY OF EDMONTON, ALBERTA.**

**THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA**

Kelly Annesty, LPN
Chair, Hearing Tribunal