THE 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 GLENN SALUBRE

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 GLENN SALUBRE, LPN #36048, 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 June 9, 2022 with the following individuals present:

Hearing Tribunal:
Michelle Stolz, Licensed Practical Nurse ("LPN") Chairperson
Jeff Bell, LPN
Patricia Matusko, Public Member
James Lees, Public Member

Staff:
Caitlyn Field, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Glenn Salubre, LPN ("Mr. Salubre" or "Investigated Member")
Ivana Niblett, UNA 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. Salubre was an LPN within the meaning of the *Health Professions Act* ("the Act") at all material times, and more particularly, was registered with the CLPNA as an LPN at the time of the complaint. Mr. Salubre was initially licensed as an LPN in Alberta on February 8, 2013.

By letter dated April 22, 2021, the CLPNA received a complaint from Ms. Dijana Vidra, Director of Care at the Father Lacombe Care Centre in Calgary, Alberta (the "Facility") pursuant to s. 57 of the Act. The Complaint stated that Mr. Salubre, LPN, was terminated for failing to follow the Facility's post-fall protocol after attending to a client who fell.

By way of letter dated April 26, 2021, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Mr. Salubre with notice of the Complaint. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Mr. Salubre that she had appointed Judith Palyga, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

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

On December 30, 2021, the Investigator concluded the investigation into the Complaint.

The Complaints Officer determined there was sufficient evidence that the issues raised in the Complaint should be referred to the Hearings Director in accordance with s. 66(3)(a) of the Act. Mr. Salubre received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report under cover of letter dated March 11, 2022.

A Notice of Hearing, Notice to Attend and Notice to Produce were served upon Mr. Salubre under cover of letter dated April 21, 2022.

(4) Allegations

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

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

1. On or about April 2, 2021, falsely documented in client AB's Progress Notes that AB was transferred from the floor to a wheelchair using a mechanical lift, when AB was not transferred using the mechanical lift.

2. On or about April 3, 2021, failed to do one or more of following, as required, after client AB suffered a fall:

    a) assess AB prior to transferring AB off the floor;
    b) use a mechanical lift to transfer AB off the floor;
    c) assess AB at any time after removing AB from the floor;
    d) document AB's fall in the Progress Notes;

e) follow the Post Fall Monitoring protocol;
f) notify the resident representative and/or Physician after AB's fall;
g) complete a Falls Incident Report;
h) document the fall on the 24-hour report sheet;
i) document the fall on the Nurse-Physician communication sheet;
j) report the fall to the oncoming staff at the conclusion of his shift."

(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. Salubre 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 Director 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. Salubre'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. Salubre.

Allegation 1

Mr. Salubre admitted on or about April 2, 2021, he falsely documented in client AB's Progress Notes that AB was transferred from the floor to a wheelchair using a mechanical lift, when AB was not transferred using the mechanical lift.

On April 2, 2021, Mr. Salubre worked at the Facility and provided care to client AB.

At approximately 1955 hours, client AB fell. Mr. Salubre found client AB lying on the floor in the kitchen area of the Facility, with a small head wound. Mr. Salubre performed a post-fall assessment on AB and physically lifted client AB, with assistance, from the floor to his wheelchair.

Mr. Salubre documented in client AB's progress notes that after completing AB's head to toe assessment, he transferred AB from the floor using the mechanical lift. However, Mr. Salubre did not use the mechanical lift to transfer AB from the floor to his wheelchair. Mr. Salubre falsely documented that he used the mechanical lift to move client AB.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Salubre's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 1 did in fact occur.

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

Mr. Salubre displayed a lack of knowledge, skill and judgement in the provision of professional services by failing to follow procedure to use a mechanical lift when transferring AB from the floor to a wheelchair following AB's fall. Mr. Salubre then falsely documented in the progress notes that a mechanical lift was used. His actions had the potential of causing further injury and harm to AB as well as himself. Documentation is a core competency of all LPNs and is an expectation regardless of experience.

In addition, Mr. Salubre did not abide by the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Code of Ethics") or the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"), as acknowledged by Mr. Salubre in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct, for the reasons set out below under the heading "CLPNA Code of Ethics and CLPNA Standards of Practice".

Allegation 2

Mr. Salubre admitted on or about April 3, 2021, he failed to do one or more of following, as required, after client AB suffered a fall:

a) assess AB prior to transferring AB off the floor;
b) use a mechanical lift to transfer AB off the floor;
c) assess AB at any time after removing AB from the floor;
d) document AB's fall in the Progress Notes;
e) follow the Post Fall Monitoring protocol;
f) notify the resident representative and/or Physician after AB's fall;
g) complete a Falls Incident Report;
h) document the fall on the 24-hour report sheet;
i) document the fall on the Nurse-Physician communication sheet;
j) report the fall to the oncoming staff at the conclusion of his shift.

On April 3, 2021, Mr. Salubre worked at the Facility and provided care to client AB. Mr. Salubre's colleague Vincent Sanchez, HCA ("Sanchez"), also worked in the Facility and provided care to AB.

Client AB was diagnosed with Dementia and progressive Parkinson's disease, among other diagnoses. As a result, AB was at a heightened risk for falls. AB's wheelchair and bed were equipped with alarms which would sound if he fell, to prompt immediate care.

The Facility's "Falls – Post Fall Assessment Policy" requires that LPNs must assess and monitor any resident who has fallen, which is particularly important for unwitnessed falls due to the risk of head injuries. Vital signs and neurological vital signs must be taken at scheduled times, and any client that has fallen must have follow-up assessments and charting immediately after the fall and for the next five consecutive shifts. If two staff members are needed to lift a client from the ground, a mechanical lift must be used. The resident representative and physician must be notified of all falls. Further, all falls must be documented in the progress notes and LPNs must complete a Fall Incident Report after each fall.

The "Falls – Post Fall Assessment Policy" establishes a Post Fall Monitoring Protocol that outlines specific obligations for LPNs to assess the resident for pain and injury, use a mechanical lift, check vital and neurological vital signs, notify the resident representative and physician, and document the fall in the client's progress notes, post fall monitoring assessment, fall incident report, and reporting sheets.

Client AB had an unwitnessed fall in the dining room. AB's wheelchair alarm sounded and both Mr. Sanchez and Mr. Salubre responded to the alarm. AB was lying on the floor, and Sanchez offered to obtain a mechanical lift to lift AB off the floor.

Mr. Salubre told Sanchez that this was not necessary and asked for help to lift AB manually off the floor into his wheelchair. Sanchez and Mr. Salubre lifted AB and placed him in his wheelchair. Mr. Salubre did not perform an assessment of AB for injuries prior to transferring AB off the floor.

After client AB was in his wheelchair, Sanchez pushed him back to his room and assisted in transferring him from his wheelchair to his bed. Sanchez documented that AB had a fall at 1930 hours in client AB's Resident Care Report. Mr. Salubre did not assess AB at any time after lifting him from the floor. He further did not document AB's fall or any assessments relating to the fall in client AB's Progress Notes.

Mr. Salubre did not follow the Post Fall Monitoring protocol as outlined by the Post Fall Assessment Policy and did not notify either the resident representative for client AB or client AB's physician. Mr. Salubre further failed to complete a Falls Incident Report and did not document AB's fall on the 24-hour report sheet. Lastly, Mr. Salubre did not document the fall on the Nurse-Physician communication sheet and did not report the fall to any oncoming staff at the end of his shift.

Mr. Salubre did not acknowledge that he had provided care to client AB after his fall on April 3, 2021, until he was shown a video of him lifting AB from the floor. On April 4, 2021, client AB had increased pain and could not bear any weight on his left leg. AB was ultimately transported by emergency medical services to a hospital and was admitted for a left hip fracture, which required surgical treatment. Due to Mr. Salubre's failure to document and report AB's fall, there was a significant delay in treatment for his injuries.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Salubre's admission of unprofessional conduct. The Hearing Tribunal found that the facts and documents included in Exhibit #2 prove that the conduct for Allegation 2 did in fact occur.

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

Mr. Salubre demonstrated a lack of knowledge, skill and judgement in the provision of professional services by failing to follow post-fall protocols, failing to document the fall, failing to communicate with the physician, oncoming staff, family and others involved in AB's care. He also failed to follow protocols including not properly assessing AB following the fall and failing to use the mechanical lift to transfer AB from the floor to the wheelchair. Assessments are a vital competency of being an LPN. By failing to perform thorough assessments, he put the patient at risk, and it demonstrated a lack of knowledge, skill and judgment on his part.

Documentation and communication are basic core competencies expected of any LPN. They are an essential component to patient care and are required to ensure safe care by not only the LPN, but the entire care team. Mr. Salubre failed to document the fall, inform oncoming staff, the physician, or the family. He put the other staff in a detrimental position of not knowing that AB could have been injured, which could have caused them to lack knowledge about how to provide competent care to AB. Subsequently, AB suffered a delay in treatment and a delayed transport to hospital.

In addition, Mr. Salubre did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice, as acknowledged by Mr. Salubre in the Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct. The Hearing Tribunal finds the conduct breached the CLPNA Code of Ethics and the CLPNA Standards of Practice and that such breaches are sufficiently serious to constitute unprofessional conduct, for the reasons set out below under the heading "CLPNA Code of Ethics and CLPNA Standards of Practice".

<u>CLPNA Code of Ethics and CLPNA Standards of Practice</u>

The conduct in the two allegations breached the following principles and standards set out in the CLPNA Code of Ethics and the CLPNA Standards of Practice, for the reasons set out below:

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 provides that LPNs:

- 1.1 Maintain standards of practice, professional competence and conduct.
- 1.5 Provide care directed toward the health and well-being of the person, family, and community.

Mr. Salubre failed to maintain his responsibility to the public as a self-regulating professional by not providing safe, effective, compassionate and ethical care to client AB. He did not maintain the CLPNA Standards of Practice. He did not provide client AB with care that was directed towards

his health and well-being. Mr. Salubre's actions, by not using the mechanical lift, went against the CLPNA Standards of Practice.

He further failed in his responsibility to the public by not notifying AB's family, resident representative, physician and oncoming staff. The public has an expectation that those in care will be provided with safe, competent care that promotes the client's well-being and give effective transfer of information for all of those providing care to a client. Mr. Salubre failed to provide this to client AB.

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.
- 2.9 Identify and minimize risks to clients.

Mr. Salubre failed twice to use a mechanical lift on client AB following two falls. By failing to use the lift, he did not respond appropriately to a harmful situation. For the incident on April 3, 2021, he did not assess AB and therefore did not identify the risk to the client. Mr. Salubre failed in his responsibility to Client AB as he did not provide safe and competent care for AB.

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

Mr. Salubre failed to maintain a responsibility to the profession as he did not foster respect from AB, nor his oncoming staff. He put the HCA on duty in an awkward position by not adhering to the protocols put in place in terms of using the mechanical lift to transfer AB from the floor back to his chair, even after Sanchez offered to get the mechanical lift. In fact, Mr. Salubre stated it was not necessary and asked Sanchez to help lift AB manually off the floor. Mr. Salubre was in a position of authority over Sanchez and thereby failed to foster respect and trust of his health care colleagues.

Mr. Salubre did not promote practice that facilitated professional practice. He did not document the fall in Allegation 2 and he did not notify the oncoming staff, thereby potentially putting that staff in an unfair position of causing more pain and suffering to AB. Failing to follow the protocols

put in place, including assessment prior to transferring patient, post-fall assessments and notifying oncoming staff and the physician, caused AB to suffer with a fractured hip longer than necessary. It also caused a delay in transport to hospital.

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 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.
- 1.9 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.

Mr. Salubre failed to maintain this standard by choosing to disregard the "Falls - Post Fall Assessment Policy" put in place by the Facility. In Allegation 1, Mr. Salubre lied in his documentation that he used a mechanical lift to transfer AB from the floor to the chair. He not only failed to maintain the standards of practice, professional competence and conduct but put client AB in significant risk by not using the mechanical lift. By not following the protocols put in place, he failed to provide care directed towards the health and wellbeing of AB.

Mr. Salubre also failed to document the fall or notify the oncoming staff, the family, the physician as well as resident representative. LPNs have a responsibility to the public as self-regulating professionals, to commit to provide safe, effective, compassionate and ethical care to members of the public. Mr. Salubre's failure to follow the post-fall protocols at the Facility failed in that responsibility.

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:

- 3.5 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.

Mr. Salubre failed to practice nursing in collaboration with both AB and the other members of his health care team. He did not provide relevant and timely information to his co-workers and the physician regarding AB's fall. In Allegation 1, he intentionally documented inaccurate information by stating he used a mechanical lift. This demonstrated a lack of understanding of

the privilege of self-regulation and the importance of information transfer among health care practitioners. In Allegation 2, he failed to document the fall in multiple areas as required by the "Falls-Post Fall Assessment Policy". Mr. Salubre's actions demonstrated a lack of understanding of, not only the protocols in place at the Facility, but also the CLPNA Standards of Practice and the CLPNA Code of Ethics.

It is an expectation of all LPNs to follow facility protocols, document and provide relevant information to co-workers as well as the client and their families.

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

Mr. Salubre did not practice in a manner consistent with ethical values and obligations of the Code of Ethics for LPNs. He did not communicate in an open, honest and timely manner. By falsely documenting using the mechanical lift in Allegation 1, and then failing to document AB's fall, he did not practice with honesty and integrity.

Mr. Salubre's actions did not maintain the values and reputation of the profession. All LPNs are expected to maintain ethical practice by adhering to the values and beliefs as set out in the CCPNR Code of Ethics. He did not accurately document AB's falls, he did not assess him after the second fall and he failed to notify the physician, the family as well as his co-workers. Mr. Salubre failed to maintain the values and reputation of the profession.

(9) Joint Submission on Penalty

The Complaints Director and Mr. Salubre 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.

1. Glenn Salubre shall pay 25% of the costs of the investigation and hearing to be paid over a period of 30 months subject to the following:

    a) Glenn Salubre will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter").

2. Glenn Salubre shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance" and will be provided to Glenn Salubre. Glenn Salubre shall provide a signed written declaration to the Complaints Director within **thirty (30) days** of service of the Decision, attesting he has reviewed the CLPNA's documents:

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

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

    b. CLPNA Practice Policy: Professional Responsibility & Accountability;

    c. CLPNA Practice Policy: Documentation;

    d. CLPNA Competency Profile A1: Critical Thinking;

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

    f. CLPNA Competency Profile B: Nursing Process;

    g. CLPNA Competency Profile Legal Protocols, Documenting and Reporting.

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

3. Glenn Salubre shall complete the following remedial education, at his own cost. If any of the required education becomes unavailable, Glenn Salubre shall make a written request to the Complaints Director to be assigned alternative education. Upon receiving Glenn Salubre's written request, the Complaints Director, in their sole discretion, may assign alternative education in which case Glenn Salubre will be notified in writing of the new education requirements. Glenn Salubre shall provide the Complaints Director with certificates confirming successful completion within **six months** from service of the Decision:

    a) Health Assessment Self-Study course available online at www.clpna.com:

    b) Document It Right: A Nurse's Guide to Charting available online at www.nurse.com;

    c) Document It Right: would your charting stand up to scrutiny? available online at www.nurse.com;

d) Communications in Healthcare available online at www.pedagogyeduction.com;

e) Improving Critical Thinking and Clinical Reasoning available online at www.nurse.com.

4. The orders set out above at paragraphs 2-4 will appear as conditions on Glenn Salubre's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings outlined at paragraphs 3-4 will appear as "CLPNA Monitoring Orders (Conduct)", on Glenn Salubre's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. Health Assessment Self-Study Course;

        iii. Document It Right: A Nurse's Guide to Charting;

        iv. Document It Right: would your charting stand up to scrutiny?;

        v. Communications in Healthcare;

        vi. Improving Critical Thinking and Clinical Reasoning.

    b) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Glenn Salubre's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

5. The conditions on Glenn Salubre's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 5.

6. Glenn Salubre 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. Glenn Salubre will keep his contact information current with the CLPNA on an ongoing basis.

7. Should Glenn Salubre be unable to comply with any of the deadlines for completion of the penalty orders identified above, Glenn Salubre may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Director shall, in her sole discretion, determine whether a time

extension is accepted. Glenn Salubre will be notified by the Complaints Director, in writing, if the extension has been granted.

8. Should Glenn Salubre 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 Director 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 Glenn Salubre'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 2 above, suspend Glenn Salubre's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

9. The parties agree that the Joint Submission on Penalty may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

Legal Counsel for the Complaints Director 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. Salubre and the Complaints Director.

(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. Salubre 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 considered the following relevant factors in this case:

- **The nature and gravity of the proven allegations**: Client AB suffered a hip fracture, had delayed treatment, including but not limited to transport to hospital and subsequent surgery for AB's hip fracture. Although it cannot be said that Mr. Salubre's conduct caused the need for the surgery, it is clear that there was a delay and less than optimal treatment of client AB after his fall. Mr. Salubre did not adhere to or demonstrate the basic core competencies such as assessment, documentation and communication. These are all expected competencies of all LPNs, regardless of how long they have been practicing. Therefore, the Hearing Tribunal placed a lot of weight on this factor.

- **The age and experience of the investigated member:** Mr. Salubre was an experienced LPN at the time of these allegations. He had been a practicing member of the CLPNA for seven years and had worked with the Facility for six years. He was not a new LPN and was very aware of protocols and expectations of the Facility, the CLPNA, as well as the public. The Hearing Tribunal took this factor into consideration as Mr. Salubre was not a new LPN and had worked at the Facility for six years. He should have followed all protocols and policies.

- **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 made aware of any prior complaints or convictions for Mr. Salubre.

- **The age and mental condition of the victim:** AB was an 84-year-old with Dementia, Parkinson's Disease. AB was in a vulnerable position and relied on Mr. Salubre to provide safe and competent care. The Hearing Tribunal did place a considerable amount of weight on this factor.

- **The number of times the offending conduct was proven to have occurred:** There were two separate incidents over two days that involved one client (AB). Therefore, it was not necessarily a long-standing pattern of misconduct over a long period of time, but it does suggest by multiple occasions that Mr. Salubre was not recognizing his obligations to the profession repeatedly.

- **The role of the investigated member in acknowledging what occurred:** Initially Mr. Salubre denied the allegations until he was shown a video demonstrating that he did not follow protocols, including using a mechanical lift. Following that, he did acknowledge his actions and that they did demonstrate unprofessional conduct. As per his representative at the time of the hearing, Mr. Salubre did write a letter expressing that he was sorry for failing to follow protocols and that he takes full responsibility for his actions. The Hearing Tribunal did place a moderate amount of weight on this. We did note that Mr. Salubre was not forthright when first confronted but was then remorseful and cooperated with the investigation and subsequent admission of unprofessional conduct. In addition, he did enter into an Agreed Statement of Facts and Acknowledgment of Unprofessional Conduct, as well as a Joint Submission on Penalty, suggesting a respect for and cooperation with the regulatory process.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made:** Mr. Salubre was terminated from his position at the Facility due to breach of trust and employee misconduct, including violation of the Facility policies. As per Ms. Niblett, his representative, Mr. Salubre has not worked as an LPN since his termination. When considering the financial penalties, the Hearing Tribunal did place a moderate amount of weight on this factor.

- **The impact of the incident(s) on the victim:** Due to the lack of communication and documentation by Mr. Salubre, AB had delayed treatment for his hip fracture. He suffered prolonged pain and suffering as he was not properly assessed at the time of his fall, and Mr. Salubre did not communicate with the physician, family, and oncoming staff. The Hearing Tribunal placed a lot of weight on this factor. Client AB suffered needlessly due to the actions of Mr. Salubre. This suffering and delay in treatment were directly related

to the failure of Mr. Salubre to follow protocols that were in place and that he had recently been educated on.

- **The presence or absence of any mitigating circumstances:** The Hearing Tribunal was not made aware of any mitigating circumstances. Therefore, no weight was placed on this factor.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice:** There is a significant need to impose sanctions and penalties to ensure there is both specific and general deterrence. Mr. Salubre needs to understand that the allegations are serious, and that the CLPNA will not tolerate such conduct. The other members of the profession also need to be deterred from such conduct and the penalty imposed to Mr. Salubre needs to ensure that deterrence. The Hearing Tribunal placed significant weight on this factor. Both Mr. Salubre and the other members of the CLPNA need to understand that these actions will not be tolerated and that penalties will be imposed that will reflect this.

- **The need to maintain the public's confidence in the integrity of the profession:** The public needs to know that the CLPNA takes unprofessional conduct very seriously and needs to have confidence that such behavior will not be tolerated. Mr. Salubre failed to practice in a manner that is consistent with the CLPNA Standards of Practice and the CLPNA Code of Ethics. The sentence must reflect how serious the CLPNA takes Mr. Salubre's actions. The Hearing Tribunal place significant weight on this factor as it is imperative that the public's confidence is maintained in the integrity of the profession. The penalties imposed need to reflect that the CLPNA takes these matters very seriously.

- **The range of sentence in other similar cases:** The Complaints Director presented two cases with similar sanctions. The two cases were both CLPNA Hearings in which the members were each sanctioned to pay 25% of the costs of the hearings, and to take additional education and courses. The Hearing tribunal reviewed both cases and took them both under advisement while reviewing the Joint Submission on Penalty.

It is important to the profession of LPNs to maintain the CLPNA Code of Ethics and the CLPNA 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. Glenn Salubre shall pay 25% of the costs of the investigation and hearing to be paid over a period of 30 months subject to the following:

    a) Glenn Salubre will be provided with a letter advising of the final costs once the same have been confirmed (the "Costs Letter").

3. Glenn Salubre shall read and reflect on how the following CLPNA documents will impact his nursing practice. These documents are available on the CLPNA's website http://www.clpna.com/ under "Governance" and will be provided to Glenn Salubre. Glenn Salubre shall provide a signed written declaration to the Complaints Director within **thirty (30) days** of service of the Decision, attesting he has reviewed the CLPNA's 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 A1: Critical Thinking;

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

    g. CLPNA Competency Profile B: Nursing Process;

    h. CLPNA Competency Profile Legal Protocols, Documenting and Reporting.

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

4. Glenn Salubre shall complete the following remedial education, at his own cost. If any of the required education becomes unavailable, Glenn Salubre shall make a written request to the Complaints Director to be assigned alternative education. Upon receiving Glenn

Salubre's written request, the Complaints Director, in their sole discretion, may assign alternative education in which case Glenn Salubre will be notified in writing of the new education requirements. Glenn Salubre shall provide the Complaints Director with certificates confirming successful completion within **six months** from service of the Decision:

a) Health Assessment Self-Study course available online at www.clpna.com:

b) Document It Right: A Nurse's Guide to Charting available online at www.nurse.com;

c) Document It Right: would your charting stand up to scrutiny? available online at www.nurse.com;

d) Communications in Healthcare available online at www.pedagogyeduction.com;

e) Improving Critical Thinking and Clinical Reasoning available online at www.nurse.com.

5. The orders set out above at paragraphs 2-4 will appear as conditions on Glenn Salubre's practice permit and the Public Registry subject to the following:

    a) The requirement to complete the remedial education and readings outlined at paragraphs 3-4 will appear as "CLPNA Monitoring Orders (Conduct)", on Glenn Salubre's practice permit and the Public Registry until the below sanctions have been satisfactorily completed;

        i. Readings;

        ii. Health Assessment Self-Study Course;

        iii. Document It Right: A Nurse's Guide to Charting;

        iv. Document It Right: would your charting stand up to scrutiny?;

        v. Communications in Healthcare;

        vi. Improving Critical Thinking and Clinical Reasoning.

    b) The requirement to pay costs, will appear as "Conduct Cost/Fines" on Glenn Salubre's practice permit and the Public Registry until all costs have been paid as set out above at paragraph 2.

6. The conditions on Glenn Salubre's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 5.

7. Glenn Salubre 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. Glenn Salubre will keep his contact information current with the CLPNA on an ongoing basis.

8. Should Glenn Salubre be unable to comply with any of the deadlines for completion of the penalty orders identified above, Glenn Salubre may request an extension. The request for an extension must be submitted in writing to the Complaints Director, prior to the deadline, state a valid reason for requesting the extension and state a reasonable timeframe for completion. The Complaints Director shall, in her sole discretion, determine whether a time extension is accepted. Glenn Salubre will be notified by the Complaints Director, in writing, if the extension has been granted.

9. Should Glenn Salubre 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 Director 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 Glenn Salubre's non-compliance as information for a complaint under s. 56 of the Act; or

    (f) In the case of non-payment of the costs described in paragraph 2 above, suspend Glenn Salubre's practice permit until such costs are paid in full or the Complaints Director is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Director.

10. The parties agree that the Joint Submission on Penalty may be signed in any number of counterparts, which taken together shall constitute one and the same Agreement. This Agreement may be delivered by original, facsimile, or by email in portable document format (PDF) and shall be deemed to be an original.

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 JUNE 27, 2022 IN THE CALGARY, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

M.Stolz

Michelle Stolz, LPN
Chair, Hearing Tribunal