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 KALEIGH SMITH

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 KALEIGH SMITH, LPN #36787, 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 February 25, 2020 with the following individuals present:

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

Staff:
Jason Kully, Legal Counsel for the Complaints Director, CLPNA
Sandy Davis, Complaints Director, CLPNA

Investigated Member:
Kaleigh Smith, LPN ("Ms. Smith or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

There were no objections to the members of the Hearing Tribunal hearing the matter, and no Hearing Tribunal member identified a conflict. There were no objections to the jurisdiction of the Hearing Tribunal.

The Hearing was conducted by way of an Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct and a Joint Submission on Penalty.

(3) Background

Ms. Smith was an LPN within the meaning of the Act at all material times, and more particularly, was registered with CLPNA as an LPN at the time of the complaint. Ms. Smith was initially licensed as an LPN in Alberta on June 18, 2013.

By letter dated November 26, 2018, the CLPNA received a complaint (the "First Complaint") from Ms. Catherine Garon, Site Manager, at the Cold Lake Health Care Centre in Cold Lake, AB pursuant to s. 57 of the *Health Professions Act* (the "Act"). The First Complaint stated that Ms. Smith, LPN, received a three-day unpaid suspension for sharing confidential and highly sensitive patient information with an RN.

In accordance with s. 55(2)(d) of the Act, the Complaints Director determined she would conduct an investigation into the First Complaint. Ms. Smith received notice of the First Complaint and the investigation by letter dated November 26, 2018.

Prior to completion of the investigation into the First Complaint, by letter dated December 3, 2018, the CLPNA received a further complaint (the "Second Complaint") from AC, pursuant to s. 54 of the Act, stating that Ms. Smith had breached confidentiality by sharing her personal and private health information without authorization.

The Complaints Director determined she would investigate the Second Complaint. Ms. Smith received notice of the Second Complaint and the investigation by letter dated December 4, 2018.

The Complaints Director investigated the First Complaint and the Second Complaint together.

In August 2019, the Complaints Director concluded the investigation and 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. Ms. Smith 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 October 22, 2019.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Smith under cover of letter dated November 8, 2019.

(4) Allegations

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

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

1. On or about October 18, 2018, breached her duty to maintain confidentiality by sending a text message containing the sensitive patient medical information of patient AC to another staff member without justification."

(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.

Ms. Smith acknowledged unprofessional conduct to all the allegations as evidenced by her 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 the Investigated Member'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 the Investigated Member.

Allegation 1

The Investigated Member admitted on or about October 18, 2018, she breached her duty to maintain confidentiality by sending a text message containing the sensitive patient medical information of patient AC to another staff member without justification.

On October 18, 2018, AC was admitted to the Emergency Department at the Cold Lake Health Centre for the removal of vaginal warts as a result of a sexually transmitted infection.

Ms. Smith was not assigned to provide care to AC. Upon AC's arrival at the Cold Lake Health Care Center, Ms. Smith saw AC and recognized her. AC was currently in a relationship with an individual who had previously been in a relationship with Ms. Smith's friend KB. KB was an RN who was also employed at the Cold Lake Health Centre. Ms. Smith proceeded to read AC's chart, which contained the reason that AC was at the Centre and what procedure AC was having.

On October 18, 2018, after Ms. Smith learned of the reason for AC's admission to the Cold Lake Health Centre, Ms. Smith sent a text message to her friend KB advising of the fact that AC was currently at the Cold Lake Health Centre for the removal of vaginal warts.

As neither Ms. Smith nor KB had any involvement in providing care to AC, there was no reason or justification for Ms. Smith to share AC's sensitive patient medical information via text message.

KB showed the text message received from Ms. Smith containing the sensitive patient medical information of AC to the four other staff members who were present at a shift report.

AC feared the disclosure of the information would have an effect on her reputation in the community, on her job, and on her family. AC stated she could not walk into the Cold Lake Health Care Centre again in the future and that she would have to seek medical attention in a different community.

Ms. Smith displayed a lack of knowledge, a lack of skill or judgement by sending the text message to KB with AC's personal health information. This is not something that is acceptable by any health professional for any reason. Ms. Smith was dealing with confidential information and was not responsible for providing care to AC; therefore, Ms. Smith should never have looked at AC's information or shared it with anyone. This caused AC to distrust Ms. Smith and the Cold Lake Health Care Centre and changed how AC views the healthcare system; this undermines the integrity of the profession. It is understood that when a patient is receiving treatment that all their medical information remains confidential and Ms. Smith breached this trust. This conduct

also constitutes a breach of the code of conduct 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;
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:

Ms. Smith acknowledges that her conduct breached one or more of the following requirements in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013, 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 states that LPNs:

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

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

    - 2.3 – Respect and protect client privacy and hold in confidence information disclosed except in certain narrowly defined exceptions.

    - 2.3.1 – Safeguard health and professional information by collecting, storing, using and disclosing it in compliance with relevant legislation and employer policies.

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 states 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.

The Hearing Tribunal finds the Investigated Member breached the CLPNA Code of Ethics in that her actions have not maintained the professionalism that is expected of an LPN by not respecting AC's confidentiality within the Cold Lake Health Care Centre. This conduct does not demonstrate to the public that LPNs provide ethical and compassionate care. Ms. Smith also violated AC's confidentiality by accessing AC's medical record without the proper authority to do so and then disclosed the information to a co-worker who was not working at the time nor did they provide care to AC. This breached the ethical responsibilities that Ms. Smith owes to clients or persons seeking care, it did not demonstrate conduct which is consistent with the privilege and responsibility of self-regulation nor did it uphold the integrity of the profession.

CLPNA Standards of Practice:

Ms. Smith acknowledges that her 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.

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

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

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

    - 3.8 – Practice within the relevant laws governing privacy and confidentiality of personal health information.

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

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

The Hearing Tribunal finds that the Investigated Member's conduct breached the CLPNA Standards of Practice in that Ms. Smith failed to practice in a manner which minimized harm and which was conducted in accordance with applicable legislation and the Code of Ethics. Further, her actions caused distrust in the competency of both an LPN and the Cold Lake Health Care Centre. This conduct also failed to demonstrate an understanding of self-regulation and did not display practice in accordance with the requirements to maintain confidentiality. This breach of confidentiality could have a great effect on AC's reputation in the community, her job, and her family. Everyone is deserving of the ability to seek medical attention without fear of their underlying health conditions becoming the subject of discussion outside of what is needed to provide care.

(9) Joint Submission on Penalty

The Complaints Director and Ms. Smith 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. Ms. Smith shall pay a fine of $1,500.00 within twenty four (24) months of service of the Decision.

3. Ms. Smith shall pay 25% of the costs of the investigation and hearing in equal monthly installments over a period of thirty six (36) months from the date of service of the Decision, or over such other period of time as agreed to by the Complaints Director.

4. Ms. Smith 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 her nursing practice within thirty (30) days of service of the Decision:

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

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

    c. CLPNA Practice Policy: Professional Responsibility & Accountability;

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

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

f. CLPNA Competency Profile C: Professionalism and Leadership;

g. CLPNA Interpretive Document: Privacy Legislation in Alberta; and

h. CLPNA Practice Guideline: Confidentiality.

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

5. Ms. Smith shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its successful completion to the Complaints Director within sixty (60) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

6. Ms. Smith shall complete the **HIA Awareness Course** offered by Alberta Health Services and available online at https://www.albertahealthservices.ca/info/Page3962.aspx and provide a certificate confirming its successful completion to the Complaints Director within sixty (60) days of service of the Decision.

   If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

7. Should Ms. Smith 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 Director.

8. Ms. Smith shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Smith will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Smith 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 Ms. Smith'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 3 above, suspend Ms. Smith'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.

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.

The Hearing Tribunal therefore carefully considered the Joint Submission on Penalty proposed by Ms. Smith 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 Ms. Smith 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
- 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 following factors below:

- **The nature and gravity of the proven allegations –** Ms. Smith's conduct resulted from a lack of judgement. The allegation that is made with respect to Ms. Smith is quite serious in that it deals with a breach in patient confidentiality for a patient that was not in her care. This breach not only resulted in AC's lack of trust within the health care professionals, but also the Cold Lake Health Care Centre to which AC stated that she would never be able to go to again and that she would have to seek medical attention in a different community.

- **The age and experience of the investigated member –** Ms. Smith began working at the Cold Lake Health Care Centre on April 14, 2014 and was initially registered with the CLPNA on June 18, 2013. At the time of the allegation, Ms. Smith had approximately five years' experience as an LPN. The allegation that was made against Ms. Smith was a core competency that is expected of an LPN regardless of their experience.

- **The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions** – Ms. Smith has no prior complaints or convictions.

- **The number of times the offending conduct was proven to have occurred** – As far as the Hearing Tribunal is aware this allegation was a single isolated incident.

- **The role of the investigated member in acknowledging what occurred** – The Hearing Tribunal was pleased to hear that Ms. Smith acknowledged her conduct and worked along with the CLPNA as well as her representative from AUPE.

- **Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made –** As a result of her actions Ms. Smith did receive a three-day suspension without pay from her employer.

- **The impact of the incident(s) on the victim** – The victim feared the disclosure of her health information could have had an effect on her reputation in the community, her job, and on her family. As a result of the allegation, AC stated that she could not walk into the Cold Lake Health Care Centre again in the future and that she would have to seek medical attention in a different community. This is a significant impact.

- **The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice -** There is a need to impose sanctions with respect to Ms. Smith. Ms. Smith needs to be made aware that this type of conduct is not acceptable of an LPN, nor will it be tolerated by the CLPNA. Ms. Smith also needs to be made aware that this type of behavior is dealt with in a serious manner. The sanctions that are imposed with regard to Ms. Smith 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.

- **The need to maintain the public's confidence in the integrity of the profession** – Confidentiality of patient medical information is a core competency of an LPN and the public needs to be made aware that the lack of judgement and skill that Ms. Smith displayed with respect to this 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. 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. Ms. Smith shall pay a fine of $1,500.00 within twenty four (24) months of service of the Decision.

3. Ms. Smith shall pay 25% of the costs of the investigation and hearing in equal monthly installments over a period of thirty six (36) months from the date of service of the Decision, or over such other period of time as agreed to by the Complaints Director.

4. Ms. Smith 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 her nursing practice within thirty (30) days of service of the Decision:

    a. Code of Ethics for Licensed Practical Nurses in Canada;
    b. Standards of Practice for Licensed Practical Nurses in Canada;
    c. CLPNA Practice Policy: Professional Responsibility & Accountability;
    d. CLPNA Competency Profile A1: Critical Thinking and Critical Inquiry;
    e. CLPNA Competency Profile A2: Clinical Judgment and Decision Making;
    f. CLPNA Competency Profile C: Professionalism and Leadership;
    g. CLPNA Interpretive Document: Privacy Legislation in Alberta; and
    h. CLPNA Practice Guideline: Confidentiality.

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

5. Ms. Smith shall complete the **LPN Ethics Course** available online at http://www.learninglpn.ca/index.php/courses and provide a certificate confirming its successful completion to the Complaints Director within sixty (60) days of service of the Decision.

    If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

6. Ms. Smith shall complete the **HIA Awareness Course** offered by Alberta Health Services and available online at https://www.albertahealthservices.ca/info/Page3962.aspx and provide a certificate confirming its successful completion to the Complaints Director within sixty (60) days of service of the Decision.

    If such course becomes unavailable an alternative course may be substituted where approved in advance in writing by the Complaints Director.

7. Should Ms. Smith 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 Director.

8. Ms. Smith shall provide the CLPNA with her contact information, including her home mailing address, home and cellular telephone numbers, current e-mail address and her current employment information. Ms. Smith will keep her contact information current with the CLPNA on an ongoing basis.

9. Should Ms. Smith 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 Ms. Smith'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 3 above, suspend Ms. Smith'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.

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.
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> **(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 3rd DAY OF MARCH 2020 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal