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 TITUS LESIGA

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 TITUS LESIGA, LPN #47377, WHILE A MEMBER OF THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA (THE "CLPNA")

DECISION OF THE HEARING TRIBUNAL

(1) Hearing

The hearing was conducted via teleconference on December 15, 2021 with the following individuals present:

Hearing Tribunal:
Kelly Annesty, Licensed Practical Nurse ("LPN") Chairperson
Nicole Searle, LPN
Juane Priest, Public Member
James Lees, Public Member

Staff:
Jason Kully, Legal Counsel for the Complaints Officer, CLPNA
Daisy Feehan, Legal Counsel for the Complaints Officer, CLPNA
Kevin Oudith, Complaints Officer, CLPNA

Investigated Member:
Titus Lesiga, LPN ("Mr. Lesiga" or "Investigated Member")
Kathie Milne, AUPE Representative for the Investigated Member

(2) Preliminary Matters

The hearing was open to the public.

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

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

(3) Background

Mr. Lesiga 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. Lesiga was initially licensed as an LPN in Alberta on February 20, 2019.

The CLPNA received a complaint on April 28, 2021 (the "Complaint") from Maggie Stoby, Program Manager at Shepherd's Care Barrhead (the "Facility"), pursuant to s. 57 of the Act. The Complaint advised that Mr. Lesiga, LPN, had been suspended and eventually terminated from his employment at the Facility for his failure to properly respond to the fall of a client.

By way of letter dated April 30, 2021, the Director of Professional Conduct/Complaints Director of the CLPNA, Sandy Davis ("Complaints Director"), provided Mr. Lesiga with notice of the Complaint and notified Mr. Lesiga that she was delegating her powers under Part 4 of the Act to Kevin Oudith, Complaints Officer (the "Complaints Officer") pursuant to s. 20 of the Act. In accordance with s. 55(2)(d) of the Act, the Complaints Director also notified Mr. Lesiga that she had appointed Katie Emter, Investigator for the CLPNA (the "Investigator"), to conduct an investigation into the Complaint.

On July 5, 2021, the investigator concluded the investigation into the Complaint and submitted the Investigation Report to the Complaints Officer.

Following receipt of the Investigation Report, the Complaints Officer 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. Lesiga received notice that the matter was referred to a hearing as well as a copy of the Statement of Allegations and the Investigation Report with attachments under cover of letter dated September 9, 2021.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Mr. Lesiga under cover of letter dated October 8, 2021.

(4) Allegations

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

"It is alleged that Titus Lesiga, LPN, while practicing as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about September 15, 2020, failed to appropriately respond to client J.W.'s unwitnessed fall by doing one or more of the following:
    a. Failed to conduct and/or document an adequate head to toe assessment prior to making the clinical decision to move J.W., including failing to complete a lower extremity assessment;
    b. Failed to comply with Alberta Health Services Post-Fall Clinical Pathway by failing to conduct and/or document a reassessment of J.W. after moving J.W. from the floor to a wheelchair using the mechanical lift, even after J.W expressed she was in pain;

c. Failed to conduct and/or document an adequate assessment of J.W. after moving J.W. from a wheelchair to her bed, even after J.W. expressed she was in pain;
d. Failed to document sufficient detail of the fall in J.W.'s Progress Notes;
e. Failed to adequately document assessments, interventions, clinical decisions or care provided to J.W."

(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. Lesiga 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 Officer 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. Lesiga'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. Lesiga.

Allegation 1

Mr. Lesiga admitted on or about September 15, 2020, he failed to appropriately respond to client J.W.'s unwitnessed fall by doing one or more of the following:

a) Failed to conduct and/or document an adequate head to toe assessment prior to making the clinical decision to move J.W., including failing to complete a lower extremity assessment;
b) Failed to comply with Alberta Health Services Post-Fall Clinical Pathway by failing to conduct and/or document a reassessment of J.W. after moving J.W. from the floor to a wheelchair using the mechanical lift, even after J.W expressed she was in pain;
c) Failed to conduct and/or document an adequate assessment of J.W. after moving J.W. from a wheelchair to her bed, even after J.W. expressed she was in pain;
d) Failed to document sufficient detail of the fall in J.W.'s Progress Notes;
e) Failed to adequately document assessments, interventions, clinical decisions or care provided to J.W.

Mr. Lesiga worked an evening shift at the Facility from 1500 hours to 2315 hours on September 15, 2020. As Mr. Lesiga usually worked night shifts, he had not worked an evening shift prior to September 15, 2020. Mr. Lesiga provided care to J.W., a patient diagnosed with dementia.

On September 15, 2020, at some time between 1730 and 1850 hours, client J.W. suffered an unwitnessed fall in C Hallway of the Facility.

At approximately 1850 hours, J.W. was found on the floor in the hallway in a supine position by AP HCA ("AP"). AP notified Mr. Lesiga that J.W. suffered an unwitnessed fall and, at AP 's request, Mr. Lesiga responded to assess client J.W. after her fall.

In conducting his assessment, Mr. Lesiga did not perform an assessment of J.W.'s lower extremities.

The Alberta Health Services Post-Fall Clinical Pathway calls for a post-fall head to toe assessment to be completed by an LPN with some all or some of the following elements: fall description, level of consciousness, cognitive/behavioural changes, vital signs, neurological vital signs, blood glucose monitoring, pain, blood loss, focused system assessment, alignment of extremities, loss of function/deformities, edema, assessment of range of motion, an inspection of the skin for bruising or lacerations, and a palpation of the lower and upper long bones, joints, neck and spinal column.

In conducting his initial assessment of J.W., Mr. Lesiga failed to do a full head to toe assessment as required when he failed to assess J.W.'s lower extremities. Further, Mr. Lesiga did not document a head-to-toe assessment that included assessment of J.W.'s lower extremities in the Progress Notes of client J.W.

Mr. Lesiga made the clinical decision to move J.W. from her position on the floor, notwithstanding the failure to conduct a full assessment. He and AP used a lift to transfer J.W. off the floor and into a wheelchair, during which time J.W. cried out in pain. After J.W. was in the wheelchair, Mr. Lesiga did not reassess her.

Once a resident is moved after a fall, the Alberta Health Services Post-Fall Clinical Pathway calls for reassessment for possible injury and pain, and to provide first aid and comfort measures.

After moving client J.W. into a wheelchair, Mr. Lesiga failed to immediately reassess her as required. Further, Mr. Lesiga did not document any such reassessment in J.W.'s Progress Notes.

AP returned J.W. to her room where she remained in her wheelchair. Mr. Lesiga did not go to J.W.'s room at that time.

AP left J.W. to attend to other residents and informed RM , HCA (" RM ') that J.W. had suffered an unwitnessed fall. RM was the HCA in charge of J.W. RM called Mr. Lesiga to J.W.'s room, where the two transferred her from the wheelchair to her bed using the lift. J.W. again cried out in pain.

Mr. Lesiga undressed J.W., and RM observed a large bruise on J.W.'s right hip and that her leg was obviously improperly aligned. Mr. Lesiga left the room to call someone regarding J.W.'s bruise and her pain. RM also left the room to attend to other residents.

After moving client J.W. for the second time from the wheelchair and into her bed, Mr. Lesiga again failed to immediately reassess her as required. Mr. Lesiga did not conduct an adequate reassessment. Further, Mr. Lesiga did not document any such reassessment in J.W.'s Progress Notes.

Mr. Lesiga called EMS sometime between 1920 hours and 1930 hours and EMS left the Facility with J.W. at or around 1945 hours. Mr. Lesiga called J.W.'s family at approximately 2245 hours.

At the hospital, J.W. was diagnosed with a fractured right femur. J.W. passed away shortly thereafter on September 18, 2020.

In the course of his post-fall treatment of client J.W., Mr. Lesiga failed to include sufficient detail regarding the fall in client J.W.'s Progress Notes and failed to adequately chart assessments, interventions, clinical decisions, or care provided.

The Alberta Health Services Post-Fall Clinical Pathway calls for documentation on the resident's Progress Notes and an Incident Report after a resident suffers a fall. The Shepherd's Care Foundation Fall Prevention and Management Guidelines – SL dictate that the information documented should include time of fall, location of the fall, description of the fall including position of the resident when found, who found the resident, condition and position of any equipment, cause of the fall if known, and any actions taken to prevent reoccurrence. The injury resulting from the fall should also be documented, including the assessment of the injury and any treatment provided.

The entirety of Mr. Lesiga's charting and notes in regard to client J.W.'s fall and subsequent assessments is limited to one line in the Progress Notes and one paragraph in the Incident Report.

In the Progress Notes, there is no mention of the location of the fall, the position of J.W. when she was found, who found J.W. after the fall, or any assessments conducted. The Progress Notes do not document any interventions, clinical decisions or care provided to J.W.

In the Incident Report, there is no mention of the multiple assessments that are required under the Alberta Health Services Post-Fall Clinical Pathway, nor is there mention of who found J.W. after her fall. There is an inadequate description of the position of J.W. when she was found, as the Incident Report indicates she was prone when she was found supine.

The Hearing Tribunal considered the facts included in the Agreed Statement of Facts and Mr. Lesiga'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;
ii. Contravention of the Act, a code of ethics or standards of practice; and
xii. Conduct that harms the integrity of the regulated profession.

Mr. Lesiga displayed a lack of knowledge of or lack of skill or judgement in that Mr. Lesiga failed to conduct a proper assessment with respect to J.W. Mr. Lesiga failed to complete the Alberta Health Services Post-Fall Clinical Pathway, failed to document in accordance with the Facility's

post-fall guidelines, as well as, not documenting a proper incident report. It is expected that an LPN would be aware of policies and procedures of their employer and AHS. Falls are not uncommon in a Long-Term Care setting, and it is expected that staff will know what to do when a resident falls, whether it is witnessed or not.

Mr. Lesiga did not abide by the CLPNA Code of Ethics or the CLPNA Standards of Practice as acknowledged by Mr. Lesiga in the Agreed Statement of Facts and Acknowledgement 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. Mr. Lesiga was required to maintain documentation and reporting according to established legislation, regulations, laws, and employer policies, and in the case, it was clear that Mr. Lesiga's documentation fell below the requirement.

The conduct breached the following principles and standards set out in in the Code of Ethics for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA's Code of Ethics") and the Standards of Practice for Licensed Practical Nurses in Canada adopted by the CLPNA on June 3, 2013 ("CLPNA Standards of Practice"):

<u>CLPNA Code of Ethics:</u>

Mr. Lesiga acknowledges that his conduct breached one or more of the following requirements in the CLPNA Code of Ethics:

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

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

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

- 2.9 Identify and minimize risks to clients.

Principle 3: Responsibility to the Profession – LPNs have a commitment to their profession and foster the respect and trust of their clients, health care colleagues and the public. Principle 3 specifically 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.

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

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

CLPNA Standards of Practice:

Mr. Lesiga acknowledges that his conduct breached one or more of the following CLPNA Standards of Practice:

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Lesiga's conduct harms the integrity of the regulated profession in that Mr. Lesiga did not act in a way which would be expected of another LPN in a similar situation. LPNs are expected to follow policies and procedures that are set out by their employer and to ensure that they have complete and proper documentation with respect to when a resident has a fall. This is an expectation regardless of an LPN's experience, as this is a core competency that it is expected of an LPN.

(9) Joint Submission on Penalty

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

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

2. Mr. Lesiga shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

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

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

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

    g. CLPNA Competency Profile B1: Assessment;

    h. CLPNA Competency Profile B2: Nursing Diagnosis;

    i. CLPNA Competency Profile C9: Informal Leadership; and

j. CLPNA Competency Profile D3: Legal Protocols, Documentation, and Reporting.

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

4. Mr. Lesiga shall complete the following remedial education, at his own cost. Mr. Lesiga shall provide the Complaints Officer with a certificate confirming successful completion of the remedial education within **6 months** of service of the Decision.

    a. **Health Assessment Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    b. **Nursing Documention 101 Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    c. **LPN Code of Ethics Learning Module** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    d. **1.3 Body Structure Terms 50Q Quiz** available online at https://www.learningnurse.org/quizzes/bodystructure-50/

    e. **18.5 Mobility and Falls Quiz** available online at https://www.learningnurse.org/quizzes/mobilityfalls/

    Should any of the above courses/quizes become unavailable, then Mr. Lesiga shall request in writing to be assigned an alternative course/quiz **prior to the deadline.** The Complaints Officer shall, in his sole discretion, reassign a course/quiz. Mr. Lesiga will be notified by the Complaints Officer, in writing, advising of the new course/quiz required.

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

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

        i. Educational Readings;

        ii. Health Assessment Self-Study Course;

        iii. Nursing Documentation 101 Self-Study Course;

        iv. LPN Code of Ethics Learning Module;

        v. 1.3 Body Structure Terms 50Q Quiz; and

vi. 18.5 Mobility and Falls Quiz.

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

6. The conditions on Mr. Lesiga's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 – 4.

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

8. Should Mr. Lesiga 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 Officer.

9. Should Mr. Lesiga 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 Officer 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. Lesiga'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 Mr. Lesiga's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

Legal Counsel for the Complaints Officer 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. Lesiga and the Complaints Officer.

(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. Lesiga has engaged in. In making its decision on penalty, the Hearing Tribunal considered a number of factors identified in *Jaswal v Newfoundland Medical Board* [1986] NJ No 50 (NLSC-TD), specifically the following:

- The nature and gravity of the proven allegations
- The age and experience of the investigated member
- The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions
- The age and mental condition of the victim, if any
- The number of times the offending conduct was proven to have occurred
- The role of the investigated member in acknowledging what occurred
- Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made
- The impact of the incident(s) on the victim, and/or
- The presence or absence of any mitigating circumstances
- The need to promote specific and general deterrence and, thereby to protect the public and ensure the safe and proper practice
- The need to maintain the public's confidence in the integrity of the profession
- The range of sentence in other similar cases

The nature and gravity of the proven allegations: These Allegations relate to conduct that does not appear to be intentional misconduct, which is on the less serious end of the spectrum of unprofessional conduct. However, there is clearly a failure to meet the minimum obligations of the LPN profession. Mr. Lesiga failed to follow proper protocol and policy when it came to a resident who had an unwitnessed fall on the floor and who did have a serious injury.

The age and experience of the investigated member: Mr. Lesiga was initially registered with the CLPNA on February 20, 2019. At the time of the allegation, Mr. Lesiga was an LPN for approximately 18 months, which makes him inexperienced as an LPN at the time of the allegation; however, these Allegations relate to documentation requirements and following important policy and that is expected of any LPN, regardless of their level of experience.

The previous character of the investigated member and in particular the presence or absence of any prior complaints or convictions: There were no prior complaints or convictions with respect to Mr. Lesiga and the CLPNA.

The age and mental condition of the victim, if any: There was no direct information on the age and the mental condition of the victim. However, the Hearing Tribunal did note that J.W. had dementia.

The number of times the offending conduct was proven to have occurred: This allegation took place on a single date with a single patient and a single incident. It is acknowledged that there is no ongoing pattern of conduct.

The role of the investigated member in acknowledging what occurred: Ms. Lesiga did acknowledge the allegation that was brought forward to the CLPNA by his employer. Mr. Lesiga's role in acknowledging what has occurred was a significant mitigating factor considered and Mr. Lesiga did provide the Hearing Tribunal with an Agreed Statement of Facts, which demonstrates that he has taken accountability and responsibility for the error that occurred.

Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made: Mr. Lesiga initially was suspended and placed on paid administrative leave on September 21, 2020, as a result of the complaint. Then, because of the allegation, Mr. Lesiga was subsequently terminated on October 14, 2020.

The impact of the incident(s) on the victim, and/or: The evidence clearly indicates that J.W. was in pain and suffering from stress due to the fall. J.W. did pass away three days later. There is no evidence that Mr. Lesiga's actions in any way contributed or negatively impacted J.W. J.W. was sent to the hospital shortly thereafter and received care at the hospital. The Complaints Officer wanted to make it clear that there is no indication that Mr. Lesiga's conduct in any way contributed to the outcome of J.W.

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: Promoting specific and general deterrence are important factors and are intended to deter Mr. Lesiga from repeating the conduct, as well as, to deter other members of the profession from engaging in similar behavior by sending a message that such conduct is not tolerated by the CLPNA and it is important in maintaining the public's confidence in the profession.

The need to maintain the public's confidence in the integrity of the profession: The CLPNA deals with the actions of its members when they engage in unprofessional conduct. The CLPNA will

deal with any breaches in the CLPNA Code of Ethics and the CLPNA Standards of Practice in a way that reflects the seriousness of the conduct and for the purpose of protecting the public.

The range of sentence in other similar cases: The Hearing Tribunal was not made aware of any other similar cases.

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. Mr. Lesiga shall pay 25% of the costs of the investigation and hearing to be paid over a period of **24 months** from service of the Decision.

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

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

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

g. CLPNA Competency Profile B1: Assessment;

h. CLPNA Competency Profile B2: Nursing Diagnosis;

i. CLPNA Competency Profile C9: Informal Leadership; and

j. CLPNA Competency Profile D3: Legal Protocols, Documentation, and Reporting.

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

4. Mr. Lesiga shall complete the following remedial education, at his own cost. Mr. Lesiga shall provide the Complaints Officer with a certificate confirming successful completion of the remedial education within **6 months** of service of the Decision.

    a. **Health Assessment Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    b. **Nursing Documention 101 Self-Study Course** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    c. **LPN Code of Ethics Learning Module** available online at https://www.clpna.com/members/continuing-education/study-with-clpna/

    d. **1.3 Body Structure Terms 50Q Quiz** available online at https://www.learningnurse.org/quizzes/bodystructure-50/

    e. **18.5 Mobility and Falls Quiz** available online at https://www.learningnurse.org/quizzes/mobilityfalls/

    Should any of the above courses/quizes become unavailable, then Mr. Lesiga shall request in writing to be assigned an alternative course/quiz **prior to the deadline.** The Complaints Officer shall, in his sole discretion, reassign a course/quiz. Mr. Lesiga will be notified by the Complaints Officer, in writing, advising of the new course/quiz required.

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

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

i. Educational Readings;

ii. Health Assessment Self-Study Course;

iii. Nursing Documentation 101 Self-Study Course;

iv. LPN Code of Ethics Learning Module;

v. 1.3 Body Structure Terms 50Q Quiz; and

vi. 18.5 Mobility and Falls Quiz.

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

6. The conditions on Mr. Lesiga's practice permit and on the Public Registry will be removed upon completion of each of the requirements set out above at paragraph 2 – 4.

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

8. Should Mr. Lesiga 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 Officer.

9. Should Mr. Lesiga 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 Officer 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. Lesiga'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 Mr. Lesiga's practice permit until such costs are paid in full or the Complaints Officer is satisfied that such costs are being paid in accordance with a schedule of payment agreed to by the Complaints Officer.

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."

Further, the Hearing Tribunal is of the opinion there are reasonable and probable grounds to believe Titus Lesiga has committed a criminal offence. Therefore, the Hearing Tribunal directs the Hearings Director to send a copy of this written decision to the Minister of Justice and Attorney General in accordance with s. 80(2) of the Act.

DATED THE 23rd DAY OF DECEMBER 2021 IN THE CITY OF EDMONTON, ALBERTA.

THE COLLEGE OF LICENSED PRACTICAL NURSES OF ALBERTA

Kelly Annesty, LPN
Chair, Hearing Tribunal