

**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 MARIA PILAR DIGA**

**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 MARIA PILAR DIGA, LPN #35141, WHILE A MEMBER OF THE COLLEGE OF  
LICENSED PRACTICAL NURSES OF ALBERTA (“CLPNA”)**

**DECISION OF THE HEARING TRIBUNAL**

**(1) Hearing**

The hearing was conducted via videoconference on February 5, 2025 with the following individuals present:

**Hearing Tribunal:**

Jeff Bell, Licensed Practical Nurse (“LPN”) Chairperson  
Jennifer Vloerbergh, LPN  
Kate Freeman, Public Member  
Brett Huculak, Public Member

**Staff:**

Kimberly Precht, Legal Counsel for the Complaints Officer, CLPNA  
Francesca Ghossein, Legal Counsel for the Complaints Officer, CLPNA  
Stephanie Karkutly, Complaints Officer, CLPNA

**Investigated Member:**

Maria Pilar Diga, LPN (“Ms. Diga” or “Investigated Member”)

**(2) Preliminary Matters**

The hearing was open to the public.

When the hearing began, the Chairperson of the Hearing Tribunal advised the Investigated Member she had the right to legal counsel under section 72(1) of the Health Professions Act (“the Act”). The Investigated Member confirmed she wished to proceed with the hearing without legal counsel.

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. Diga 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. Diga was initially licensed as an LPN in Alberta on June 20, 2012.

The College of Licensed Practical Nurses of Alberta (the “CLPNA”) received a complaint dated November 30, 2022 (the “Complaint”) from Anna Andres, Director of Care at Age Care Midnapore (the “Facility”), pursuant to s. 57 of the Act. The Complaint advised that Ms. Maria Diga, LPN, had been terminated from her employment at the Facility.

By way of letter dated November 30, 2022, the Complaints Director of the CLPNA, Sandy Davis (“Complaints Director”), provided Ms. Diga with notice of the Complaint and notified Ms. Diga that she was delegating her powers under Part 4 of the Act to Stephanie Karkutly, 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 Ms. Diga that she had appointed Kathryn Emter, Investigator for the CLPNA (the “Investigator”), to conduct an investigation into the Complaint.

On May 3, 2023, the Complaints Officer recommended that Lynn Borris, Designated Person appointed by the CLPNA Council, impose an interim suspension of or a condition of direct supervised practice on Ms. Diga’s practice permit pending the outcome of disciplinary proceedings. On May 12, 2023, Ms. Diga was notified that a condition of Direct Supervision for Blood Glucose Monitoring and Insulin Administration was placed on her practice permit.

The Investigator concluded the investigation into the Complaint and submitted the Investigation Report dated April 24, 2023, to the Complaints Officer on April 25, 2023.

In June 2023, criminal charges were filed against Ms. Diga in relation to these events. The criminal charges were subsequently withdrawn. There are no outstanding criminal proceedings and no criminal findings against Ms. Diga. However, as a result of the criminal charges, Ms. Diga and the Complaints Officer entered into an agreement to implement an interim suspension on Ms. Diga’s practice permit. The Interim Suspension Agreement remains in effect until the conclusion of these conduct proceedings.

On July 14, 2023, Ms. Diga and the Complaints Officer entered into an agreement to hold the conduct proceedings in abeyance and not take any further steps pending the outcome of the criminal proceedings against Ms. Diga.

Upon the criminal charges against Ms. Diga being withdrawn, the conduct proceedings resumed, and the Complaints Officer, based on a review of the investigation report, 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. Diga 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 July 17, 2024.

A Notice of Hearing, Notice to Attend and Notice to Produce was served upon Ms. Diga under cover of letter dated October 16, 2024.

**(4) Allegations**

The Allegations in the Statement of Allegations (the “Allegations”) are:

“It is alleged that **MARIA PILAR DIGA, LPN**, while practising as a Licensed Practical Nurse engaged in unprofessional conduct by:

1. On or about July 5, July 10, July 29, August 7, September 4, September 12, and October 6, 2022, or any of them, did one or both of the following:
  - a. documented blood glucose values taken on the Point Click Care and/or Medication Administration Record for resident SG as being lower than the values recorded in the glucometer;
  - b. falsely documented values that were below the threshold requiring insulin being given in order to avoid administering insulin to resident SG as required by the physician’s order.
2. On multiple occasions between July 1, 2022, and October 16, 2022:
  - a. failed to take blood glucose levels as required for resident SG;
  - b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident SG without performing a blood glucose check.
3. On or about July 20, 2022 failed to administer Insulin Aspart 1 unit SC to resident SG as ordered for a blood glucose result of 11.0 mmol at 1154 hours.
4. While providing care to resident ER:
  - a. On or about August 8, 2022, documented a blood glucose result of 7.8 mmol at 0830 hours on Point Click Care when the glucometer reading at 0808 hours was 9.3 mmol, or in the alternative, documented a blood glucose result of 7.8 mmol at 0830 without performing a blood glucose check;
  - b. On or about September 5, 2022, documented a blood glucose result of 7.9 mmol at 0832 hours on Point Click Care when the glucometer reading at 0828 hours was 7.4 mmol.
5. On or about June 17, July 29, August 6, and September 15, 2022, or any of them:
  - a. failed to take blood glucose levels as required for resident DG;

- b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident DG without performing a blood glucose check.
6. On or about October 31, 2022, documented the time of resident DG's blood glucose result of 6.7 mmol in the Point Click Care at 0825 hours when the blood glucose result was recorded in the glucometer at 0836 hours.
7. On or about July 23, September 17, September 24 and September 29, 2022, or any of them:
  - a. failed to take blood glucose levels as required for resident DP;
  - b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident DP without performing a blood glucose check."

**(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. Diga 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 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: Agreed Statement of Facts and Acknowledgement of Unprofessional Conduct
- Exhibit #2: 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 #1.

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

The Hearing Tribunal also accepts Ms. Diga'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 Ms. Diga.

**Allegation 1**

Ms. Diga admitted that on or about July 5, July 10, July 29, August 7, September 4, September 12, and October 6, 2022, or any of them, she did one or both of the following:

- a. documented blood glucose values taken on the Point Click Care and/or Medication Administration Record for resident SG as being lower than the values recorded in the glucometer;
- b. falsely documented values that were below the threshold requiring insulin being given in order to avoid administering insulin to resident SG as required by the physician's order.

Resident SG was admitted to the Facility in May 2022. SG was diagnosed with Type 2 diabetes, which required her to attend Hemodialysis from 1230-1730 hours every Tuesday, Thursday, and Saturday.

SG's condition also required that her blood glucose be measured three times per day, and that she receive three scheduled doses of insulin (Turapi) as follows:

- 4 units in the AM;
- 2 units at noon;
- and 2 units at supper time.

In addition to the scheduled doses, SG was to be administered Insulin (Aspart) on a sliding scale basis as follows:

- 0 units if blood glucose is between 4.1-10 mmol/L;
- 1 unit if blood glucose is between 10.1-14 mmol/L;
- 2 units if blood glucose is between 14.1-18 mmol/L; and
- Call physician if blood glucose is over 18 mmol/L.

On days when SG attended hemodialysis, the scheduled blood glucose reading normally done at noon was done earlier, prior to SG being picked up to attend her hemodialysis appointments, which began at 1230, offsite.

On November 1, 2022, while doing morning rounds, the Facility's Director of Care was informed by one of Ms. Diga's colleagues that some blood glucose values appeared to be missing from the Glucometer on various days on which Ms. Diga worked in October of 2022. This prompted the Director of Care to investigate further and conduct a detailed review of SG's blood sugar entries. The investigation revealed various discrepancies between the blood glucose values recorded in the glucometer and the blood glucose values recorded in the PCC and eMAR by Ms. Diga and created a Summary Table containing SG's blood glucose values as recorded in the glucometer, and the values as recorded in the PCC by Ms. Diga, dating from July to October, 2022. Specifically, the discrepancies were as follows:

- a) On July 5, 2022: 11.9 mmol/L in the Glucometer vs 9.7 mmol/L in the PCC.
- b) On July 10, 2022: 12.6 mmol/L in the Glucometer vs 9.7 mmol/L in the PCC.
- c) On July 29, 2022: 13.2 mmol/L in the Glucometer vs 8.1 mmol/L in the PCC.
- d) On August 7, 2022: 10.2 mmol/L in the Glucometer vs 9.2 mmol/L in the PCC.
- e) On September 4, 2022: 7.5 mmol/L in the Glucometer vs 7.2 mmol/L in the PCC.
- f) On September 12, 2022: 14.3 mmol/L vs 9.1 mmol/L in the PCC.
- g) On October 6, 2022: 8.1 mmol/L in the Glucometer vs 7.5 mmol/L in the PCC.

Ms. Diga acknowledges that for all of the dates listed above, Ms. Diga documented blood glucose values taken on the Point Click Care and/or Medication Administration Record for resident SG as being lower than the values recorded in the glucometer.

The values recorded in the glucometer on the dates of July 5, July 10, July 29, August 7, and September 12, 2022, are all above 10.1 mmol/L, which is the threshold requiring insulin to be given.

The eMAR for resident SG shows, however, that on those dates and at the corresponding times, Ms. Diga did not administer insulin to resident SG as required by SG's physician's order.

Ms. Diga acknowledges that she falsely documented values in the PCC that were below the threshold requiring insulin to be given in order to avoid administering insulin to resident SG as required.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting blood glucose values in PointClickCare (PCC) and/or the Medication Administration Record for resident SG that were lower than the readings recorded in the glucometer. This occurred on multiple occasions between July 5, 2022, and October 6, 2022. Failing to accurately record glucometer readings for SG may have directly impacted the appropriate administration of SG's insulin (Aspart) and constituted a direct violation of the Physician's Order. Failure to record correct data and provide care to an individual under the direction of the Physician's Order demonstrates a lack of judgement because it can compromise the health and well-being of the person under care. This action can lead to a loss of trust in healthcare providers.

Healthcare professionals have an ethical duty to promote optimal health and well-being of individuals under their care. Failure to properly record data in order to alter the medication administration of an individual goes against professional ethical standards and can harm the reputation of the individual and their professional standing.

Ms. Diga did not abide by the Code of Ethics for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 3, 2013 and updated the code in 2023 ("CLPNA Code of Ethics") and the 2020 Standards of Practice for Licensed Practical Nurses in Canada, adopted by the CLPNA on June 2022 ("CLPNA Standards of Practice"), as acknowledged by Ms. Diga 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 as set out below and that such breaches are sufficiently serious to constitute unprofessional conduct. The specific provisions and reasons for how they were breached are set out below

#### CLPNA Code of Ethics

Ms. Diga acknowledges that her conduct breached one or more of the following requirements in the CLPNA Code of Ethics:

**Principle 1:** Responsibility to the Public - Licensed Practical Nurses, 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.

**Principle 2:** Responsibility to Clients – Licensed Practical Nurses provide safe and competent care for their clients. Principle 2 specifically provides that LPNs:

- 2.8 Use evidence and judgement to guide nursing decisions.
- 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 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 Practise 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 provides that LPNs:

- 5.1 Demonstrate honesty, integrity and trustworthiness in all interactions.
- 5.3 Accept responsibility for knowing and acting consistently with the principles, practice standards, laws and regulations under which they are accountable.

### CLPNA Standards of Practice

Ms. Diga acknowledges that her conduct breached one or more of the following CLPNA Standards of Practice:

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

- 1.1 Practice within applicable legislation, regulations, by-laws and employer policies.

- 1.8 Are accountable and responsible for their own practice, conduct, and ethical decision-making.
- 1.9 Document and report according to established legislation, regulations, laws, and employer policies

**Standard 2:** Evidence-informed Practice – LPNs apply evidence-informed knowledge in practice. Standard 2 specifically provides that LPNs:

- 2.1. Attain and maintain evidence-informed knowledge to support critical thinking and professional judgment.
- 2.8. Apply the nursing process (assess, diagnose, plan, implement and evaluate).

**Standard 3:** Protection of the public through self-regulation – LPNs collaborate with clients and other members of the healthcare team to provide safe care and improve health outcomes. Standard 3 specifically provides that LPNs:

- 3.3. Lead and contribute to a practice culture that promotes safe, inclusive, and ethical care.
- 3.4. Provide relevant, timely, and accurate information to clients and healthcare team.
- 3.5. Understand and accept the responsibility of self-regulation by following the standards of practice, the code of ethics, and other regulatory requirements.

**Standard 4:** Professional and Ethical Practice – LPNs adhere to the ethical values and responsibilities described in the Canadian Council for Practical Nurse Regulators (CCPNR) Code of Ethics. Standard 4 specifically provides that LPNs:

- 4.6 Demonstrate practice that upholds the integrity of the profession.

Ms. Diga repeatedly failed to document blood sugar entries accurately and admitted to falsely recording values in the PCC that were below the insulin administration threshold to avoid administering insulin to resident SG. As acknowledged in the Agreed Statement of Facts, this demonstrates a failure to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice.

Accurate documentation is essential to ensure that all members of the healthcare team can provide safe and effective care based on reliable data. Healthcare decisions made using incorrect information can lead to poor outcomes and hinder the ability of other team members to engage in evidence-based decision-making, ultimately increasing risk for those receiving care.

Recording inaccurate information also compromises the accountability of self-regulated professionals, who are entrusted to uphold the principles and standards of their profession without direct oversight. Her actions diminished the integrity of the regulated profession, as they fell short of the expectations for an LPN in similar circumstances. Patients under the care of an LPN should be able to trust that their provider is acting in their best interests, delivering safe, competent care while supporting optimal health and well-being.

### Allegation 2

Ms. Diga admitted that on multiple occasions between July 1, 2022, and October 16, 2022 she:

- a. failed to take blood glucose levels as required for resident SG;
- b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident SG without performing a blood glucose check.

The Director of Care's investigation showed, that on numerous dates between July 1, 2022 and October 16, 2022, there were no blood glucose values recorded in the Glucometer for the lunchtime measurement.

The values that were missing from the glucometer are marked as such in the Summary Table. Those dates include: July 1, 9, 15, 19, 21, 23, 24 and 29; August 2, 6, 7, 8, 18; September 3, 4, 5, 8, 13, 15, 17, 18, 19, 21, 22, 23, 24, and 27; and October 11, 13, 15 and 16, 2022.

Ms. Diga worked her regular shift on all of those dates, and was responsible for measuring SG's blood glucose at or around noon on those dates.

Ms. Diga acknowledges that on each of those dates, Ms. Diga failed to measure SG's blood glucose as required, and documented false blood glucose values in the PCC without having performed a blood glucose check.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting blood glucose values in (PCC) and/or the Medication Administration Record for resident SG that were lower than the readings recorded in the glucometer. This occurred on multiple occasions between July 5, 2022, and October 16, 2022. Failing to accurately record glucometer readings for SG may have directly impacted the appropriate administration of SG's insulin (Aspart) and constituted a direct

violation of the Physician's Order. This conduct demonstrates a lack of judgement because it can compromise the health and well-being of the person under care. This action can lead to a loss of trust in healthcare providers.

Ms. Diga repeatedly failed to document blood sugar entries accurately and admitted to falsely recording values in the PCC that were below the insulin administration threshold to avoid administering insulin to resident SG. As acknowledged in the Agreed Statement of Facts, she has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in Unprofessional Conduct, as detailed in Allegation 1. The Hearing Tribunal finds that her conduct breached the CLPNA Code of Ethics and CLPNA Standards of Practice, and that these breaches are sufficiently serious to constitute unprofessional conduct for the reasons provided in relation to Allegation #1.

In addition to the breaches of professional conduct outlined in Allegation #1, unprofessional conduct was further demonstrated by failing to follow the Physician's order to administer a required blood glucose test for SG. Neglecting to carry out an ordered test—one necessary to support an individual's health, well-being, and diagnosed medical condition—can compromise an individual under care and hinder the healthcare team's ability to make informed decisions.

Failing to follow a Physician's directive also undermines the professional accountability of self-regulated healthcare providers, who are entrusted to uphold the principles and standards of their profession without direct oversight. Her actions compromised the integrity of the regulated profession, as they did not align with the expectations of an LPN in similar circumstances. Patients should be able to trust that their LPN is acting in their best interests, ensuring safe, competent care while promoting optimal health and well-being.

### Allegation 3

Ms. Diga admitted that on or about July 20, 2022 she failed to administer Insulin Aspart 1 unit SC to resident SG as ordered for a blood glucose result of 11.0 mmol at 1154 hours.

On July 20, 2022, Ms. Diga worked her regular shift at the Facility from 0645 to 1504 hours.

At around 1156 hours, Ms. Diga measured SG's blood glucose, which was 11 mmol/L. She recorded that value in the PCC.

SG's Sliding Scale order requires 1 unit of Insulin Aspart to be administered for a blood glucose value between 10.1 and 14 mmol/L.

However, SG's eMAR shows that no insulin was administered to SG at that time, despite a blood glucose value of 11 mmol/L

Ms. Diga acknowledges that on July 20, 2022, Ms. Diga failed to administer Insulin Aspart 1 unit to SG as ordered for a blood glucose result of 11 mmol/L.

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.

On July 20, 2022, Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting blood glucose values in (PCC) and/or the Medication Administration Record of 11.0 mmol/L for the care of SG. SG had a specific Physician's Order that directed SG's Sliding Scale order required 1 unit of Insulin Aspart to be administered for a blood glucose value between 10.1 and 14 mmol/L.

Failing the administration of SG's insulin (Aspart) constituted a direct violation of the Physician's Order. Failure to provide care to an individual under the direction of the Physician's Order demonstrates a lack of judgement because it can compromise the health and well-being of the person under care. This action can lead to a loss of trust in healthcare providers.

As acknowledged in the Agreed Statement of Facts, Ms. Diga has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in Unprofessional Conduct, as detailed in Allegation 1. The Hearing Tribunal finds that her conduct breached the CLPNA Code of Ethics and CLPNA Standards of Practice, and that these breaches are sufficiently serious to constitute unprofessional conduct for the reasons provided in Allegation #1.

Ms. Diga's actions undermined the integrity of the regulated profession, as they did not align with the expectations of an LPN in similar circumstances. Those under the care of an LPN should be able to trust that their care provider is acting in their best interests, ensuring safe, competent care while promoting optimal health and well-being.

#### Allegation 4

Ms. Diga admitted that while providing care to resident ER:

- a. On or about August 8, 2022, documented a blood glucose result of 7.8 mmol at 0830 hours on Point Click Care when the glucometer reading at 0808 hours was 9.3 mmol, or in the alternative, documented a blood glucose result of 7.8 mmol at 0830 without performing a blood glucose check;
- b. On or about September 5, 2022, documented a blood glucose result of 7.9 mmol at 0832 hours on Point Click Care when the glucometer reading at 0828 hours was 7.4 mmol.

Resident ER, with whom Ms. Diga worked regularly, was also diagnosed with Type II diabetes and required blood glucose to be measured one time per day every four weeks. On August 8, 2022, Ms. Diga worked her regular shift and was responsible for measuring ER's blood glucose.

On August 8, 2022, the glucometer shows a blood glucose reading at 0808 hours of 9.3 mmol/L. On that date, the glucometer did not show a blood glucose reading at 0830 hours. However, ER's PCC showed an entry of 7.8 mmol/L at 0830 hours.

Ms. Diga acknowledges that on August 8, 2022, Ms. Diga documented a blood glucose result of 7.8 mmol/L at 0830 hours on the PCC when the glucometer reading at 0808 hours was 9.3 mmol/L.

On September 5, 2022, Ms. Diga worked her regular shift and was responsible for measuring ER's blood glucose. A blood glucose value of 7.4 mmol/L was taken in the glucometer at 0828 hours. However, ER's PCC records show a manual entry of 7.9 mmol/L at 0832 hours.

Ms. Diga acknowledges that on September 5, 2022, Ms. Diga documented a blood glucose result of 7.9 mmol/L at 0832 hours on Point Click Care when the glucometer reading at 0828 hours was 7.4 mmol/L.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment during her shift on August 8, 2022, by documenting blood glucose values in PCC and/or the Medication Administration Record for resident ER that were lower than the readings recorded in the glucometer, or in the alternative, documented a blood glucose result without performing a blood glucose check. On September 5, 2022, Ms. Diga demonstrated a lack of knowledge, skill, or judgment during her shift by documenting blood glucose values in PCC and/or the Medication Administration Record for resident ER that were higher than the readings recorded in the glucometer.

Failing to accurately record glucometer readings for ER may have directly impacted their care. Accurate documentation is essential, as failing to record correct data and follow a Physician's order can compromise a patient's health and well-being.

Furthermore, the deliberate choice not to document accurate information can be perceived as misconduct and may undermine the trust of both the healthcare team and the individuals receiving care. Such actions can erode confidence in healthcare providers, ultimately affecting the quality and safety of patient care.

Ms. Diga repeatedly failed to document blood sugar entries accurately and admitted to falsely recording values in the PCC. As acknowledged in the Agreed Statement of Facts, Ms. Diga has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in Unprofessional Conduct, as detailed in Allegation 1. The Hearing Tribunal finds that her conduct breached the CLPNA Code of Ethics and CLPNA Standards of Practice, and that these breaches are sufficiently serious to constitute unprofessional conduct as for the reasons provided in Allegation #1 and Allegation #2.

Ms. Diga's actions undermined the integrity of the regulated profession, as they did not align with the expectations of an LPN in similar circumstances. Those under the care of an LPN should be able to trust that their care provider is acting in their best interests, ensuring safe, competent care while promoting optimal health and well-being.

### Allegation 5

Ms. Diga admitted that on or about June 17, July 29, August 6, and September 15, 2022, or any of them, she:

- a. failed to take blood glucose levels as required for resident DG;
- b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident DG without performing a blood glucose check.

Resident DG, with whom Ms. Diga worked regularly, also suffered from Type II diabetes and required blood glucose to be measured one time per day every eight days.

On June 17, July 29, August 6, and September 15, 2022, Ms. Diga worked her regular shift and was responsible for measuring DG's blood glucose.

For June 17, 2022, there was no morning blood glucose value in the glucometer. There was, however, a manual entry made by Ms. Diga in DG's PCC of 8.1 mmol/L at 0744 hours on that day.

For July 29, 2022, DG's PCC sheet shows a manual entry for a blood glucose result of 8.1 mmol/L at 1216 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

For August 6, 2022, DG's PCC sheet shows a manual entry for a blood glucose result of 10.5 mmol/L at 1214 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

For September 15, 2022, DG's PCC sheet shows a manual entry for a blood glucose result of 11.2 mmol/L at 1209 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

Ms. Diga acknowledges that on each of these dates, she failed to take blood glucose levels as required for resident DG and documented false blood glucose values in the PCC for resident DG without performing a blood glucose check.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting blood glucose values in PCC and/or the Medication Administration Record for resident DG without performing the required blood glucose checks. This occurred multiple times between June 17, 2022, and September 15, 2022.

Failing to conduct the test and recording false values may have directly impacted DG's care. Inaccurate documentation and failure to follow a Physician's order compromises patient well-being and demonstrate poor judgment. Such actions undermine trust in healthcare providers and the integrity of professional practice.

Ms. Diga repeatedly failed to document blood sugar readings accurately and admitted to falsifying entries in PCC, as acknowledged in the Agreed Statement of Facts.

Ms. Diga has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in Unprofessional Conduct, as detailed in Allegation 1. The Hearing Tribunal finds that her conduct breached the CLPNA Code of Ethics and CLPNA Standards of Practice, and that these breaches are sufficiently serious to constitute unprofessional conduct for the reasons noted in Allegation #1 and Allegation #2.

### Allegation 6

Ms. Diga admitted that on or about October 31, 2022, she documented the time of resident DG's blood glucose result of 6.7 mmol in the Point Click Care at 0825 hours when the blood glucose result was recorded in the glucometer at 0836 hours.

On October 31, 2022, Ms. Diga worked her regular shift and was responsible for measuring DG's blood glucose. The glucometer shows a blood glucose result of 6.7 mmol/L at 0836 hours. However, Ms. Diga made a manual entry in the PCC for 6.7 mmol/L at 0825 hours. Ms. Diga acknowledges that on October 31, 2022, Ms. Diga documented the time of resident DG's blood glucose result of 6.7 mmol/L in the PCC at 0825 hours when the blood glucose result was recorded in the glucometer at 0836 hours.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting incorrect times for blood glucose values in PCC and/or the Medication Administration Record for resident DG when compared to the glucometer readings.

Inaccurate documentation of glucometer readings may have directly impacted DG's care. Recording false times in PCC or the Medication Administration Record reflects poor judgment, as accurate data is essential for ensuring proper treatment and patient well-being. Such actions can compromise trust in healthcare providers and the quality of care delivered. Ms. Diga failed to document the time of blood sugar entries accurately and admitted to falsely recording times in the PCC. As acknowledged in the Agreed Statement of Facts, Ms. Diga has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in unprofessional conduct, as detailed in Allegation 1. For the reasons given above, the concerns around accurate documentation with this conduct rises to the degree of unprofessional conduct.

#### Allegation 7

Ms. Diga admitted that on or about July 23, September 17, September 24 and September 29, 2022, or any of them she:

- a. failed to take blood glucose levels as required for resident DP;
- b. documented false blood glucose values in Point Click Care and/or Medication Administration Records for resident DP without performing a blood glucose check.

Resident DP, with whom Ms. Diga worked regularly, also suffered from Type II diabetes and required blood glucose to be measured two times a day, every other day.

On July 23, September 17, September 24, and September 29, 2022, Ms. Diga worked her regular shift and was responsible for measuring DP's blood glucose.

For July 23, 2022, there was no morning blood glucose value in the glucometer. There was, however, a manual entry made by Ms. Diga in DP's PCC of 8.9 mmol/L at 1216 hours on that day.

For September 17, 2022, DP's PCC sheet shows that Ms. Diga made a manual entry for a blood glucose result of 8.7 mmol/L at 1202 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

For September 24, 2022, DP's PCC sheet shows a manual entry made by Ms. Diga for a blood glucose result of 7.9 mmol/L at 0848 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

For September 29, 2022, DP's PCC sheet shows a manual entry made by Ms. Diga for a blood glucose result of 8.9 mmol/L at 1206 hours. However, there was no corresponding blood glucose value taken in the glucometer at that time.

Ms. Diga acknowledges that on each of these dates, Ms. Diga failed to take blood glucose levels as required for resident DP and documented false blood glucose values in the PCC for resident DP without performing a blood glucose check.

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.

Ms. Diga demonstrated a lack of knowledge, skill, or judgment by documenting blood glucose values in PCC and/or the Medication Administration Record for resident DP that were documented without performing a blood glucose check; this took place on multiple occasions between July 23, 2022 and September 29, 2022.

Failing to accurately record glucometer readings for DG may have directly impacted the care for DP. Ms. Diga demonstrated a lack of knowledge, skill, or judgment by not performing a blood glucose check and recording false values in PCC or the Medication Administration record. Failure to record correct data and provide care to an individual under the direction of the Physician's Order demonstrates a lack of judgement because it can compromise the health and well-being of the person under care. This action can lead to a loss of trust in healthcare providers.

Ms. Diga repeatedly failed to document blood sugar entries accurately and admitted to falsely recording values in the PCC. As acknowledged in the Agreed Statement of Facts, Ms. Diga has admitted to failing to adhere to the CLPNA Code of Ethics and the CLPNA Standards of Practice, as well as engaging in Unprofessional Conduct, as detailed in Allegation 1. The Hearing Tribunal finds that her conduct breached the CLPNA Code of Ethics and CLPNA Standards of Practice, and that these breaches are sufficiently serious to constitute unprofessional conduct.

**(9) Joint Submission on Penalty**

The Complaints Officer and Ms. Diga jointly proposed to the Hearing Tribunal a Joint Submission on Penalty, which was entered as Exhibit #2. 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. Ms. Diga's practice permit shall be suspended until Ms. Diga completes all of the requirements set out at paragraphs 3, 5, 6 and 7.
3. Ms. Diga shall pay a fine in the amount of \$250 within 1 month of service of the Decision.
4. Ms. Diga shall pay 25% of the costs, to a cap of \$5000, of the investigation and hearing to be paid over a period of **24 months** from service of the Decision. A letter advising of the final costs will be forwarded to Ms. Diga when final costs have been confirmed by CLPNA;
5. The fine and the costs must be paid to the CLPNA, whether or not Ms. Diga holds an active practice permit with the CLPNA. The fine and the costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.
6. Ms. Diga shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website <http://www.clpna.com/> in the "Knowledge Hub". Ms. Diga shall provide a signed written declaration to the Complaints Director, within **thirty (30) days** of service of the Decision, attesting she 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. The CLPNA Policy: Professional Responsibility and Accountability;
  - d. The CLPNA Policy: Documentation;
  - e. The CLPNA Policy: Medication Management.
7. Ms. Diga shall complete, at her own cost, the following remedial education and provide documentation of successful completion to the Complaint Director **within 6 months** of service of the Decision.
  - a. LPN Ethics course (learningnurse)
  - b. CLPNA Medication Management Module (studywithclpna)

- c. Nursing Documentation Module (studywithclpna)
- d. Health Assessment Learning Module (studywithclpna)
- e. Righting a Wrong – Ethics & Professionalism in Nursing Course (NCSBN)

Should any of the above courses become unavailable, then Ms. Diga shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Officer shall, in her sole discretion, reassign a course. Ms. Diga will be notified in writing by the Complaints Officer of the new course required.

8. If and when the suspension of her practice permit is lifted, Ms. Diga's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, subject to the following:
- a. The supervisor(s) must be a Registered Nurse or a Licensed Practical Nurse;
  - b. Ms. Diga must provide her supervisor(s) with a copy of the Hearing Tribunal's Decision;
  - c. Prior to the commencement of supervised practice, Ms. Diga will provide the Complaints Director with the name of the supervisor(s) and a written acknowledgement signed by her supervisor(s) confirming receipt of a copy of the Decision and willingness to provide supervision in accordance with the terms of the Decision;
  - d. The supervisor(s) must be available and onsite for the duration of all shifts worked by Ms. Diga during the period of supervised practice;
  - e. The supervisor(s) will agree to submit a performance evaluation to the Complaints Director immediately following the completion of the 150 hours of supervised practice confirming whether the supervisor(s) has identified any concerns with respect to the issues raised in the Decision. The performance evaluation must make an overall assessment of whether Ms. Diga's performance is satisfactory or not.
  - f. If the supervisor(s) identify concerns with respect to Ms. Diga's practice, the period of supervised practice may be extended in the sole discretion of the Complaints Director for a further period of 150 hours, subject to the same terms set out above in paragraph 8(e).
  - g. If, at the conclusion of the period of supervised practice or any extended period of supervised practice, the supervisor(s) have any concerns regarding Ms. Diga's practice, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

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

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

- The range of sentence in other similar cases

### **The nature and gravity of the proven allegations:**

This was a significant factor, as these allegations demonstrate a repetitive pattern that shows deficiencies in basic nursing competencies. These deficiencies are in the areas of assessment, documentation, medication administration, professional judgement, as well as responsibility and accountability.

### **The age and experience of the investigated member**

Ms. Diga was initially registered with the CLPNA on June 20, 2012. Ms. Diga started working at the Facility in 2012 in a full-time dayshift position. Ms. Diga was a not a new member of the profession and the expectation was that she would have been proficient in all areas of her practice.

### **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 on Ms. Diga. However, in June 2023, criminal charges were filed against Ms. Diga in relation to these events. The criminal charges were subsequently withdrawn. There are no outstanding criminal proceedings and no criminal findings against Ms. Diga.

### **The age and mental condition of the victim, if any**

Although ages and mental conditions of the Patients / Residents were not given to the hearing tribunal. It was important to note that all Patients / Residents involved in the allegations resided in a Dementia Unit and relied on Ms. Diga to provide safe competent care promoting their overall well-being.

### **The number of times the offending conduct was proven to have occurred**

There were multiple allegations founded during the period of June 2022 and October 31, 2022. These Allegations involved four Patients / Residents SG, DG, DP, ER.

### **The role of the investigated member in acknowledging what occurred**

Ms. Diga 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. This is a mitigating factor.

**Whether the investigated member has already suffered other serious financial or other penalties as a result of the allegations having been made**

The Hearing Tribunal is aware of the following facts: Ms. Diga was terminated sometime in November 2022 regarding the allegations, and her license was suspended as of July 13, 2023. Therefore, she has been unable to work as a Licensed Practical Nurse since that time. The Hearing Tribunal is not privy to any other financial or other penalties.

**The impact of the incident(s) on the victim, and/or**

Regarding the individuals under care, the Hearing Tribunal was not made aware of any specific harm to any residents even though it had asked about that point specifically.

**The presence or absence of any mitigating circumstances**

The Hearing Tribunal was not made aware of any mitigating factors or circumstances.

**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 both specific and general deterrence. Members of the CLPNA must be made aware that the proven allegations in this hearing will not be tolerated and will be addressed in a timely and strict manner. Additionally, Ms. Diga must recognize the seriousness of these allegations, and the sanctions imposed will reflect the gravity of her actions.

**The need to maintain the public's confidence in the integrity of the profession**

The CLPNA addresses the actions of its members when they engage in unprofessional conduct. It responds to any breaches of the Act, the CLPNA Code of Ethics, the CLPNA Standards of Practice, and other relevant enactments in a manner that reflects the seriousness of the conduct and prioritizes public protection. This decision, along with the sanctions imposed, will maintain public confidence and uphold the integrity of the profession by demonstrating the seriousness with which the CLPNA views such breaches.

**The range of sentence in other similar cases**

The sanctions being sought after in this case are in line with other cases of similar nature.

It is important to the profession of LPNs to maintain the Code of Ethics and Standards of Practice, and in doing so to promote specific and general deterrence and, thereby, to protect the public. The Hearing Tribunal has considered this in the deliberation of this matter, and again considered the seriousness of the Investigated Member's actions. The penalties ordered in this case are intended, in part, to demonstrate to the profession and the public that actions and

unprofessional conduct such as this is not tolerated and it is intended that these orders will, in part, act as a deterrent to others.

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

**(11) Orders of the Hearing Tribunal**

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

1. The Hearing Tribunal's written reasons for decision (the "Decision") shall serve as a reprimand.
2. Ms. Diga shall pay a fine in the amount of \$250 within 1 month of service of the Decision.
3. Ms. Diga shall pay 25% of the costs, to a cap of \$5000, of the investigation and hearing to be paid over a period of **24 months** from service of the Decision. A letter advising of the final costs will be forwarded to Ms. Diga when final costs have been confirmed by CLPNA;
4. The fine and the costs must be paid to the CLPNA, whether or not Ms. Diga holds an active practice permit with the CLPNA. The fine and the costs are a debt owed to the CLPNA and if not paid by the deadline indicated, may be recovered by the CLPNA as an action of debt.
5. Ms. Diga shall read and reflect on how the following CLPNA documents will impact her nursing practice. These documents are available on the CLPNA's website <http://www.clpna.com/> in the "Knowledge Hub". Ms. Diga shall provide a signed written declaration to the Complaints Director, within **thirty (30) days** of service of the Decision, attesting she 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. The CLPNA Policy: Professional Responsibility and Accountability;
  - d. The CLPNA Policy: Documentation;
  - e. The CLPNA Policy: Medication Management.
6. Ms. Diga shall complete, at her own cost, the following remedial education and provide documentation of successful completion to the Complaint Director **within 6 months** of service of the Decision.

- a. LPN Ethics course (learningnurse)
- b. CLPNA Medication Management Module (studywithclpna)
- c. Nursing Documentation Module (studywithclpna)
- d. Health Assessment Learning Module (studywithclpna)
- e. Righting a Wrong – Ethics & Professionalism in Nursing Course (NCSBN)

Should any of the above courses become unavailable, then Ms. Diga shall request in writing to be assigned an alternative course **prior to the deadline**. The Complaints Officer shall, in her sole discretion, reassign a course. Ms. Diga will be notified in writing by the Complaints Officer of the new course required.

7. If and when the suspension of her practice permit is lifted, Ms. Diga's practice permit shall be subject to a condition that she engage in supervised practice for a period of 150 hours. During the period of supervised practice, she may practice under indirect supervision, subject to the following:
  - a. The supervisor(s) must be a Registered Nurse or a Licensed Practical Nurse;
  - b. Ms. Diga must provide her supervisor(s) with a copy of the Hearing Tribunal's Decision;
  - c. Prior to the commencement of supervised practice, Ms. Diga will provide the Complaints Director with the name of the supervisor(s) and a written acknowledgement signed by her supervisor(s) confirming receipt of a copy of the Decision and willingness to provide supervision in accordance with the terms of the Decision;
  - d. The supervisor(s) must be available and onsite for the duration of all shifts worked by Ms. Diga during the period of supervised practice;
  - e. The supervisor(s) will agree to submit a performance evaluation to the Complaints Director immediately following the completion of the 150 hours of supervised practice confirming whether the supervisor(s) has identified any concerns with respect to the issues raised in the Decision. The performance evaluation must make an overall assessment of whether Ms. Diga's performance is satisfactory or not.
  - f. If the supervisor(s) identify concerns with respect to Ms. Diga's practice, the period of supervised practice may be extended in the sole discretion of the Complaints Director for a further period of 150 hours, subject to the same terms set out above in paragraph 8(e).

- g. If, at the conclusion of the period of supervised practice or any extended period of supervised practice, the supervisor(s) have any concerns regarding Ms. Diga's practice, the Complaints Director may treat the information as a complaint in accordance with s. 56 of the HPA.

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 26<sup>th</sup> OF FEBRUARY 2025 IN THE CITY OF LETHBRIDGE, ALBERTA.**

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



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Jeff Bell, LPN  
Chair, Hearing Tribunal