COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **[NAME REDACTED]**, R.N. REGISTRATION #**85,106**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

June 8, 2021

INTRODUCTION

A hearing was held on **June 8, 2021** at the College and Association of Registered Nurses of Alberta ("CARNA") by the Hearing Tribunal of CARNA to hear a complaint against **[name redacted]** R.N. registration #**85,106.**

Those present at the hearing were:

a. **Hearing Tribunal Members:**

Bonnie Bazlik, Registered Nurse, Chair
Terrie Tietz, Registered Nurse
Nancy Brook, Public Representative
David Rolfe, Public Representative

b. **Independent Legal Counsel to the Hearing Tribunal:**

Matthew Woodley

c. **CARNA Representative:**

Vita Wensel, Conduct Counsel

d. **Regulated Member Under Investigation:**

[name redacted] (sometimes hereinafter referred to as "the Regulated Member")

e. **Regulated Member's Labour Relations Officer:**

Katie McGreer

PRELIMINARY MATTERS

Conduct Counsel and the Labour Relations Officer ("LRO") for the Regulated Member confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

The Chair noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("HPA"), the hearing was open to the public. No application was made to close the hearing. The Labour Relations Officer waived a reading of the allegation.

Conduct Counsel confirmed that the matter was proceeding by an agreed statement of facts and admission of unprofessional conduct.

ALLEGATIONS AND ADMISSION

The allegation in the Notice to Attend (marked as exhibit 1 by agreement) is:

While employed as a Registered Nurse ("RN") at [an Edmonton AB hospital]:

1. *On or about December 21, 2018, the Regulated Member failed to adequately document their discussion with Patient 1's family member, contrary to the Practice Standards for Regulated Members (2013) ("**CPSRM**"), the Canadian Nurses Association Code of Ethics (2017) ("**CNACE**") and the Documentation Standards for Regulated Members (2013) ("**CDSRM**").*

The Regulated Member has admitted to the conduct in the allegation as reflected in the agreed statement of facts and liability, marked as exhibit 2 by agreement ("ASFL"). The appendices to the ASFL was marked as exhibit 3 by agreement, which included a copy of the relevant patient charts and regulatory material (addressed below).

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend

Exhibit #2 – ASFL

Exhibit #3 – Appendices to the ASFL, including CARNA Practice Standards for Regulated Members ("Practice Standards"), 2017 Edition of the Canadian Nurses Association Code of Ethics for Registered Nurses ("Code of Ethics") and the *Documentation Standards for Regulated Members (2013)* ("Documentation Standards")

Exhibit #4 – Joint Sanction Agreement

Exhibit #5 –*Jaswal v Newfoundland Medical Board*

SUBMISSIONS ON THE ALLEGATION

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. She noted that the ASFL clearly sets out that the Regulated Member failed to document an interaction which took place between the Regulated Member and the [family member] of a patient following an adverse event in which the patient suffered a displaced hip. Conduct Counsel stated that it was a fundamental responsibility for a registered nurse to document patient-related interactions, and that this was a failing by the Regulated Member to record any information about that interaction. Although the patient was no longer under her direct care, she still had a responsibility to chart the interaction. Given the context, it was particularly important to ensure that there was an accurate record of the interaction, and that this was not done. Conduct Counsel submitted that the admitted conduct constitutes unprofessional conduct under sections 1(1)(pp)(i) and (ii) of the HPA, and specifically that this was as violation of Practice Standards 1.1, 2.5, 2.7 and 5.3; Code of Ethics A.5, G.1 and G.4; and Documentation Standards 1.2, 1.3 and 1.4.

Submissions by the Labour Relations Officer/Legal Counsel for the Regulated Member:

The LRO for the Regulated Member indicated that the Regulated Member wished to make a statement, and the Regulated Member was administered an oath. Conduct Counsel had no objection to the Regulated Member making a statement at this stage. The Regulated Member testified that she took great pride in being a nurse and that she loves her job. She stated that she has taken this process as a learning experience and that she wanted to provide excellent care to her patients. She stated that she wants to continue to grow as a nurse and to provide the best care that she can. Conduct Counsel confirmed that she had no questions arising from that testimony.

The LRO for the Regulated Member noted that the Regulated Member had admitted her conduct and taken responsibility for it. She stated that this was a significant thing and that the Hearing Tribunal should take that into consideration, confident that she will take these events and abide by her obligations in the future.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal has reviewed the exhibits and considered the submissions made by the parties.

The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that the Allegation is proven and that the Regulated Member's conduct constitutes unprofessional conduct under section (1)(1)(pp) of the Health Professions Act, as follows:

(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

(ii) contravention of this Act, a code of ethics or standards of practice.

In general, the Hearing Tribunal finds that appropriate documentation is a core aspect of the profession of nursing, and that it is incumbent upon all regulated members to ensure that they carefully, accurately and diligently record information relating to patient care. Given the particular circumstances at issue here, including the very recent patient adverse event relating to the patient and the apparent injury suffered by the patient, it was vital to ensure that any interaction with the patient's family be recorded in the medical records. A failure to do so was more than an oversight or trifle, and instead represents conduct which displays a lack of judgment in the provision of professional services.

Further, and for similar reasons, the Hearing Tribunal finds that the following sections of the Practice Standards, Code of Ethics and Documentation Standards were violated:

Practice Standards:

1.1 The nurse is accountable at all times for their own actions.

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

Code of Ethics: G.1 Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice.

Documentation Standards:

1.2 Document the following aspects of care:
   a. relevant objective information related to client care

1.3 Ensure all entries made in the client care record (whether in person or by phone, by means of dictation/transcription) are authenticated and dated (CHIA, 2008).

1.4 Record:
   b. accurately, completely, and objectively …
   e. contemporaneously …

For the reasons set out above, it is clear that the Regulated Member's conduct in failing to record the interaction with the patient's [family member] does not comply with the obligation to document relevant objective information or to record accurately, completely, or contemporaneously as set out in the Documentation Standards or Practice Standard 2.5. Further, a failure to do so demonstrates a failing to abide by regulatory responsibilities, and therefore is conduct inconsistent with the Code of Ethics and Practice Standards 1.1 and 5.3. Although the Hearing Tribunal considered the other sections referred to by Conduct Counsel (Practice Standards 2.7; Code of Ethics A.5 and G.4), it determined that these were not violated based on the facts before it.

The breaches of the Practice Standards, Documentation Standards and the Code of Ethics noted above are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA. The Hearing Tribunal therefore makes a finding of unprofessional conduct pursuant to section 80 of the HPA.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the joint recommendation on sanctions (entered as exhibit 4 by agreement). Conduct Counsel indicated that the Complaints Director believed that an appropriate sanction in this context was a caution, pursuant to section 82(1)(a) of the HPA. Conduct Counsel reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* (exhibit 5 by agreement) and how those factors applied to the present case.

1. The nature and gravity of the proven allegations: documentation is a fundamental part of nursing, and the seriousness of the need for documentation is a matter that is set out not only during a nurses' education but also during practice. This was not a case where the Regulated Member did not document at all, but was rather a gap in documentation. This was one issue, and was not at the most serious end of the scale.

2. The age and experience of the member: The Regulated Member has practiced since 2008 and is [age] years old. She is not a brand-new member, but is still relatively young.

3. The previous character of the member: The Regulated Member has a perfect record as a registered nurse, which is a significant mitigating factor.

4. The age and mental condition of the offended patient: While this was in relation to a child patient, there is no evidence that there was any harm to the patient that arose from the lack of documentation.

5. The number of times the offence was proven to have occurred: This was a single incident of unprofessional conduct, and was not an instance of repeated failings by the Regulated Member.

6. The role of the registered nurse in acknowledging what occurred: This is a significant mitigating factor as the Registered Member clearly took responsibility for what occurred, cooperated in the investigation, and entered into an admission of unprofessional conduct. This was therefore a significant mitigating factor.

7. Whether the member has already suffered other serious financial or other penalties: Conduct counsel noted that going through the investigation and this process should be noted.

8. The need to promote specific and general deterrence: The proposed sanction of a caution was sufficient to communicate to the Regulated Member the seriousness of the conduct, and would therefore act as a specific deterrent. The publication of the facts would also communicate to members the importance of careful documentation and the consequences for failing to meet those standards.

9. The need to maintain public confidence: The transparency of the process and the clear acceptance of responsibility on the part of the Regulated Member was significant here, and the caution should be seen as a way in which to maintain the confidence of the public in the profession and its ability to regulate unprofessional conduct by its members.

Submissions by the Labour Relations Officer:

The LRO indicated her agreement with the submissions by Conduct Counsel, and stated that the Hearing Tribunal should be satisfied that the sanction will fulfil the purposes of sentencing, and that the Regulated Member will go forward and practice in accordance with the applicable standards.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal carefully considered the submissions made by the parties, and it finds that the proposed order under section 82 of the HPA is reasonable and appropriate. The sanction of a caution is arguably the least serious sanction that can be ordered by a Hearing Tribunal, but it still represents an admonishment for the Regulated Member's conduct. Although the Hearing Tribunal accepts the submissions made in relation to the *Jaswal* factors noted above, it expresses particular emphasis on the fact that this was a one-time incident which arose in an otherwise flawless professional record. Although it is clear that a failure to document in these circumstances is serious, the Hearing Tribunal is satisfied that the public confidence in the nursing profession will not be harmed by the imposition of a caution. The

Regulated Member clearly took responsibility for the misconduct, and there were no issues before the Hearing Tribunal relating to the hands-on nursing care provided by the Regulated Member. These strong mitigating factors, along with the absence of any aggravating factors identified by the parties, indicates that a sanction on the less serious end of the scale is warranted. The Hearing Tribunal has no doubt based on the facts and the testimony of the Regulated Member that the imposition of the caution will serve as a sufficient deterrent for the Regulated Member, and that it is not in the public interest to impose a more serious sanction.

The Hearing Tribunal is confident that the Regulated Member has learned an important lesson, and that she will carry on with a successful practice for many years in compliance with the standards of the profession. Although the Hearing Tribunal notes that the parties have addressed the issue of publication in the proposed order, the ultimate discretion with respect to publication rests with the Registrar pursuant to the HPA; it includes that aspect of the order at the request of the parties and based on the fact that it was presented as part of the joint submission.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Regulated Member shall receive a caution from the Tribunal.

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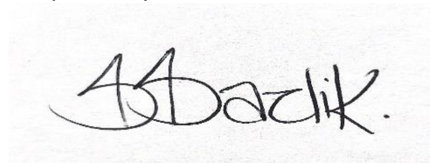
2. This Order will be published on CARNA's website under the Regulated Member's registration number only.

3. This Order takes effect on the date of the Hearing, which is to be determined, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the *HPA*.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,



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Bonnie Bazlik, Chair
On Behalf of the Hearing Tribunal

Date of Order: June 8, 2021