Hearing Committee Decision and Order

Complaint # 2019-006

Re: Julia Connors-MacDonald

A Hearing Committee of the College of Registered Nurses of Prince Edward Island (the "Committee") conducted a hearing in Charlottetown, PEI on October 13, 2020 to consider a complaint dated July 22, 2019 against Registered Nurse Julia Connors-MacDonald, Registration number 003315. The Hearing followed a meeting of the Investigation Committee that resulted in a written notice of referral from the Investigation Committee dated August 14, 2020 to proceed to a hearing.

Members of the Committee in attendance at this hearing were Kathy Larter (chair), Patsy Finkle-Barrett (member), and Jim Ross (public representative). Also in attendance were: Respondent Julia Connors-MacDonald, accompanied by her support person, Kim Jay, Prosecutor Gary Demeulenaere, and Legal Counsel and Advisor for the Committee Doug Drysdale. Christine MacDougall from Island Confidential Associates was present to audio-record the hearing.

The purpose of the hearing on October 13, 2020, was to determine if Julia Connors-MacDonald (the "Respondent") engaged in activities that constitute professional misconduct and/or incompetence, as those terms are defined in the Regulated Health Professions Act (the "RHPA"), between April 11, 2019 and June, 24 2019.

The Notice of Formal Hearing was read to attendees by Kathy Larter and identified 7 incidents, as follows:

1. On May 13, and June 12, 13, 24, 2019, while employed as a Registered Nurse ("RN") at the Summerset Manor ("SSM") at 15 Frank Mellish Street, Summerside, Prince Edward Island ("PE"), you engaged in conduct which violated the provisions of the *Act*, in that you accessed a medication cupboard and wasted narcotics unwitnessed while not on duty.

2. On June 9 and June 24, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that:
   (a) On June 9, 2019, you took supplies for personal use, namely a pair of gloves, from a locked medication cupboard.
   (b) On June 24, 2019, you took supplies for personal use, namely a mask, from a clean utility room.

3. On May 20, 2019 and June 12, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that you provided unauthorized foot care to residents on May 20, 2019 and on June 12, 2019 while off duty and did not document the foot care on the residents' medical record.

4. On June 24, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that you accessed the master keys and accessed a locked area of the building while not on duty.

5. On May 13, 2019 and June 12, 13, 24, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that you breached resident confidentiality by accessing narcotic sheets containing resident information while not on duty.

6. Between April 11, 2019 and June 21, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that you did not perform or document the following on resident's records: clinical assessments related to pain management, PRN subcutaneous narcotics administrations, and foot care.

7. Between May 18, 2019 and June 16, 2019, while employed as a RN at the SSM, in Summerside, PE, you engaged in conduct which violated the provisions of the *Act*, in that you primed HDC lines with 1cc ampule and documented no waste as identified on the ward narcotic sheets and Medication Administration Record (MAR) in relation to two (2) residents.

Prosecutor Gary Demeulenaere presented an Agreed Statement of Facts for the Committee's consideration. He also presented a Book of Documents which included the original complaint, Ms. Connors-MacDonald's written responses, the Notice of Formal Hearing, Agreed Statement of Facts and Joint Submission on Disposition (more about this below) as well as the legislation and resource documents. Prosecutor Demeulenaere explained that the Investigation committee had dismissed two of the eight original allegations and had added new allegation number 7 in the Notice of Formal Hearing. The Agreed Statement of Facts was signed by Gary Demeulenaere, and Julia Connors-MacDonald, and is dated October 7, 2020.

In the Agreed Statement of Facts, Ms Connors-MacDonald agreed that she had committed professional misconduct with regards to allegations 1, 2b, 4 and 5, and that her conduct constituted incompetence with regards to allegations 3, 6, and 7. Allegation 2a was dismissed by the committee as requested in the Agreed Statement of Facts.

The Committee recessed to consider the Agreed Statement of Facts, and, when the hearing resumed, Chair Kathy Larter stated that the Committee accepted the Agreed Statement of Facts and agreed that no further presentation of evidence would be necessary. The Committee found Julia Connors-MacDonald guilty of professional misconduct in relation to allegations 1, 2b, 4 and 5, and of incompetence in relation to allegations 3, 6 and 7.

Reasons

The Committee found the Respondent guilty based on the information contained in the Agreed Statement of Facts. For the benefit of the Respondent, Julia Connors-MacDonald, and other members, we offer the following as reasons for our decision. Firstly, the Respondent has admitted that she did the activities alleged against her, and has admitted that four of the allegations were professional misconduct, while three amounted to incompetence on her part. "Professional misconduct" and "incompetence" are both defined in section 57 of the RHPA:

> 57.(1) The conduct of a respondent may be found to constitute professional misconduct if

(a) the respondent contravenes this Act, the regulations, the bylaws, standards of practice, code of ethics or practice directions in a manner that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practise a regulated health profession;

(a.1) in the opinion of the investigation committee or the hearing committee, the conduct is harmful to the best interests of a client or other person, or to the integrity of the profession;

(b) the respondent has been found guilty of an offence that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practise a regulated health profession;

(c) the respondent refuses or fails to cooperate fully in respect of the investigation or hearing of a complaint;

(d) the respondent contravenes an order made under this Act; or

(e) the conduct of the respondent constitutes professional misconduct as set out in the regulations.

(2) The conduct of a respondent may be found to constitute incompetence where

(a) an act or omission of the respondent

(i) demonstrates a lack of knowledge, skill or judgment,

(ii) demonstrates disregard for the safety or welfare of a client, or

(iii) constitutes incompetence as set out in the regulations; or

(b) the respondent is unable to practise a regulated health profession in accordance with accepted professional standards for any reason, including that the respondent is impaired by illness, addiction or other incapacity.

There are a number of activities that are described as "professional misconduct" in section 57, but our decision is that Nurse Connors-MacDonald contravened the standards of practice and the code of ethics, or engaged in conduct that was harmful to the integrity of the profession of nursing, as explained in the following paragraphs.

1. The Committee found the Respondent guilty of professional misconduct under section 57(1)(a). The Respondent did not adhere to the Health PEI Nursing Medication Management Administration Policy which is not consistent with the Code of Ethics (2017); in particular, A -

Providing Safe, Compassionate, Competent and Ethical Care, 1 and G-Being Accountable, 1 & 4. She was not consistent with the Standards of Nursing Practice (Dec 2018) standard 2 –Competent Application of Knowledge, 2.1 and 2.2. When the respondent accessed the medication cart and disposed of narcotics unwitnessed, she ignored the intent of the policies which protect the security of narcotics and prevent the potential abuse of these powerful drugs.

2. The Respondent is guilty of professional misconduct pursuant to the provisions of the Act, namely s.57(1)(a) in relation to count 2b. Her practice was not consistent with Code of Ethics (2017) in particular, A - Providing Safe, Compassionate, Competent and Ethical Care, 1 and G - Being Accountable, 1 & 4. The Respondent took supplies from her employer for her personal use which is, in fact, stealing. Although taken by itself, this incident is minor with minimal financial cost, when considered together with the other allegations, it is one of several examples of disregard for authority and rules which cannot be condoned. As well, it speaks poorly of the Respondent's trustworthiness.

3. The Respondent is guilty of incompetence pursuant to the provisions of the Act, namely s.57(2)(a)(i) and (ii), in relation to failure to document appropriately or at all. Her practice was not consistent with Code of Ethics (2017); in particular, A - Providing Safe, Compassionate, Competent and Ethical Care, 5 and G - Being Accountable, 1. As well, not consistent with the Health PEI Provider Private Providers policy nor Standards of Nursing Practice (Dec18) in particular, Standard 3 - Responsibility and Accountability, 3.4, 3.5, and 3.6 . The Respondent demonstrated a lack of judgment and regard for patient safety when she provided unauthorized footcare on a patient, as well as a lack of knowledge regarding documentation when she neglected to chart what she had done. Charting is obviously vital to proper nursing care.

4. The Respondent is guilty of professional misconduct pursuant to the provisions of the Act, namely s.57(1)(a). Her behavior was not consistent with Code of Ethics (2017); in particular, A - Providing Safe, Compassionate, Competent and Ethical Care, 5 and G - Being Accountable, 1 & 2, nor Standards of Nursing Practice (Dec18); in particular, Standard 3 - Responsibility and Accountability, 3.2, 3.4, 3.5, and 3.6. The Respondent showed a lack of integrity when she accessed her employer's premises and opened a secure area with the employer's master keys while not on duty. This reflects poorly on the nursing profession and leads to lack of trust.

5. The Respondent is guilty of professional misconduct pursuant to the provisions of the Act, namely s.57(1)(a). The Respondent accessed medical records when not on duty which showed a lack of integrity. Patients rely on health care professionals to respect their confidentiality. Her behavior was not in compliance with her Pledge of Confidentiality or Health PEI Resident Record Management & Documentation for Long Term Care Policy, section 1.9 Code of Ethics (2017); in particular, E - Maintaining Privacy and Confidentiality – 1, 3, 4, 7 and 8.

6. The Respondent is guilty of incompetence pursuant to the provisions of the Act, namely s.57(2)(a)(i) and (ii). Her practice was not consistent with Health PEI Pain Management

Assessment for Long Term Care Policy, Health PEI Resident Record Management & Documentation for Long Term Care Policy, Safe and Compassionate, 1 and 12 and G - Being Accountable, 1 & 4 in particular, A - Providing Safe, Compassionate, Competent and Ethical Care 1 and 12 and G - Being Accountable, 1 & 4 nor Standards of Nursing Practice (Dec18); in particular, Standard 2 - Competent Application of Knowledge, 2.6 and standard 3 - Responsibility and Accountability, 3.2, 3.4, 3.5, and 3.6. The Respondent neglected to document a number of critical assessments of her patients which increased the risk of inadequate pain control or being over-medicated. This showed a disregard for patient safety and a lack of knowledge around documentation and the importance of accurate and timely recording of events with a patient. The committee made no finding in relation to foot care as per the prosecutor's recommendation.

7. The Respondent is guilty of incompetence pursuant to the provisions of the Act, namely s.57(2)(a)(i) and (ii). The Respondent failed to document as required by Health PEI Resident Record Management & Documentation for Long Term Care Policy and therefore violated Code of Ethics (2017) Safe, Competent, Compassionate and Ethical Care, 1 and 12 and G - Being Accountable, 1 & 4 and Standards of Nursing Practice (Dec18); in particular, Standard 2- Competent Application of Knowledge, 2.6 and 2.7 and Standard 3 - Responsibility and Accountability, 3.2, 3.4, 3.5, and 3.6. and Standard 5, Continuing Competency, 5.7 The Respondent showed a lack of knowledge around proper process in priming lines with narcotics. She showed a lack of knowledge in regards to documenting waste of narcotics by not charting the waste in the narcotic record as per policy.

ORDER

The Committee considered a number of factors in deciding on appropriate Orders in this case. The Committee recognizes that Ms. Connors-MacDonald cooperated during the investigation and with the creation of an Agreed Statement of Facts which reduced the time required for the hearing. The Respondent had previously received positive internal performance appraisals. The Respondent was viewed positively by a number of her coworkers. A number of the allegations had been occurring over the past number of years without apparent reprimand. The Respondent acknowledged she had become complacent in her clinical practice.

On the other hand, the Respondent is an experienced nurse with 31 years in the profession and therefore should be held to a higher standard. Most of the offences here involved Nurse Connors-MacDonald violating or ignoring rules and practices that are fairly standard in our profession. The Respondent should have been a positive role model for junior coworkers. She should have known that just because others practice a certain way does not mean it is the right way to proceed. A number of the incidents had the potential to cause harm to patients.

It was felt by the Committee that Allegations 1-4 are on the lower end of the spectrum in terms of severity. Allegations 5-7 were more serious and potentially could have resulted in serious patient harm. All of these

offences considered together are concerning because they give the impression that she was breaking these rules for a purpose, and that she intended to do things that she was not supposed to do. The Committee feels it necessary to state that the lack of documentation and poor practices around wasting narcotics at this workplace should be more closely monitored by the employer in future so no one can misappropriate, potentially misuse and/or misplace narcotics.

Section 58(2) of the RHPA allows for a range of different orders to be given. The Committee took into consideration the Joint Submission on Disposition and information contained within the Agreed Statement of Facts. The Committee considered the need to provide deterrence to the Respondent and a general deterrent to the membership at large. The Committee needs to address inappropriate conduct in the nursing profession and protect and maintain public confidence. The Committee has decided on the following Orders:

1. The Respondent will be issued a formal reprimand from the College of Registered Nurses of Prince Edward Island (CRNPEI). The reprimand shall be prepared by the Coordinator of Regulatory Services, for review and approval by the Chair, and will be sent to The Respondent, and a copy will be kept in the Respondent's file at CRNPEI.

2. The Respondent's registration, being Registered Nurse #003315, is suspended for a period of two months effective immediately from the date the decision is delivered to the Respondent. The prosecutor and the Respondent each had different ideas around the length of suspension. The Committee feels that two months is appropriate to act as a deterrent to the Respondent and reduce the risk of harm to clients by giving the Respondent time to begin the refresher training.

3. The Respondent will take refresher training with a nursing expert to be completed within 6 months from delivery of decision.
   Within 1 month of the decision being delivered to the Respondent, the Respondent shall submit a plan for refresher training with a Nursing Expert of her own choosing at her own expense, but subject to the approval of the CRNPEI Coordinator of Regulatory Services.
   To comply, the Respondent is required to ensure that:

   i. The Expert has been provided with a copy of the complaint; notice of formal hearing; the respondent's written responses to the complaint; and this decision.

   ii. Before the first meeting with the Expert, the Respondent shall review the following CRNPEI publications:
   1. CNA Code of Ethics
   2. Standards for Nursing Practice
   and provide the Expert with a short, written statement of at least five hundred (500) words reflecting on the issues identified in the decision issued by the Committee in relation to this matter.

   iii. The Subject of the sessions with the Expert will include:
   1. The acts or omissions for which the Respondent has been found to have committed professional misconduct and/or incompetence;

2. The potential consequences of the misconduct and/or incompetence to the Respondent's patients, colleagues, profession, and self;
3. Strategies for preventing the misconduct and incompetence from recurring;
4. The development of a learning plan in collaboration with the Expert;
5. Review of Health PEI Nursing Documentation Policy;
6. Review of Health PEI Controlled Substances Act.

iv. Within 30 days after the Respondent has completed her last session, The Respondent will make sure that the Expert forwards his/her report to the CRNPEI Coordinator of Regulatory Services, in which the Expert will confirm
1. The dates the member attended the sessions;
2. That the Expert received the required documents from the Respondent;
3. That the Expert reviewed the required documents and subjects with the Respondent;
4. The Expert's assessment of the Respondent insight into her behavior.

v. The CRNPEI Coordinator of Regulatory Services will provide the Expert's report to the Committee, and the Committee will review the report and will decide whether any additional penalty is required based on its content.

4. The Respondent shall complete 2 continuing competency audits coordinated by the CRNPEI Coordinator of Regulatory Services; one shall be completed in February 2021 and one in February 2022, and they shall include assessment of continuing competence related to CRNPEI Standards for Nursing Practice, as well as the CNA Code of Ethics. These audits shall be additional to and are independent of any continuing competency requirements under the RHPA.

5. The Respondent shall pay a fine to CRNPEI in the amount of two thousand dollars ($2000). At the Respondent's option, this payment may be made in consecutive monthly installments of one hundred ($100) dollars each, commencing on the first day of the month after the end of the two-month suspension and continuing on the first day of every month thereafter until paid in full. In deciding on this penalty, the Hearing Committee considered all of the factors mentioned in section 58(2.1) of the RHPA. A fine is necessary to act as a deterrent to the respondent and other members of the profession. The Committee felt this would reassure the public that we take the privilege of caring for them seriously.

6. The Respondent shall ensure that her present and future employers for the next two (2) years will be given a copy of this hearing report.

The Committee's concerns about poor record-keeping and poor practices around wasting narcotics have caused us to request that CRNPEI forward this hearing report to the Chief Nursing Officer at Health PEI. The Committee feel Health PEI should ensure compliance around safe administration and disposal of narcotic in all facilities.

The respondent may appeal this decision or any of the orders noted above to the Supreme Court of Prince Edward Island within thirty days of receiving this decision (section 59 RHPA).

DATED the 4th day of November 2020.

_____

Kathy Larter,
Chair of the Hearing Committee