Hearing Committee Notice of Determination and Order

Complaint # 2019-005

Re: Yvonne Mariwande, Member Registration #004722

A Hearing Committee of the College of Registered Nurses of Prince Edward Island (the "Committee") conducted a hearing in Charlottetown, PE on August 3rd, 4th, and 5th 2020, to consider a complaint dated July 15, 2019 against Registered Nurse Yvonne Mariwande, registration number 004712. The Hearing followed a meeting of the Investigation Committee which resulted in a written notice of referral from the Investigation Committee dated June 12, 2020 to proceed to a hearing.

Members of the Committee in attendance at this hearing were: Anita McCabe (Chair); Ellen Christie, NP (member); and Craig MacDowell (public representative). Also in attendance were: Respondent Yvonne Mariwande; prosecutor Gary Demeulenaere; and Legal Counsel and Advisor for the Committee, Doug Drysdale. A representative from Island Confidential Associates audio recorded the formal hearing.

At the commencement of the hearing, the respondent indicated she was not represented by legal counsel. She stated that she already had personal debt, was a single person paying bills and had financial commitments to her family here and in Africa; and could not afford a lawyer. The hearing proceeded after the respondent declined the opportunity to delay in order to seek legal counsel.

The purpose of the hearing on August 3-5, 2020 was to determine whether Yvonne Mariwande engaged in activities that were professional misconduct and/or incompetence as those terms are defined in the *Regulated Health Professions Act* ("RHPA"), between approximately March 2019 and February 2020. The allegations considered were:

1. On March 4, 2019, while employed as a Registered Nurse ("RN") at the Medical/Palliative Unit of the Prince County Hospital ("PCH"), the respondent engaged in conduct which violated the provisions of the *Act,* in that the respondent altered information on a narcotic record during her shift;

2. On March 2, 2019 and on December 4-5 2019, while employed as a RN at the Medical/Palliative Unit of PCH, the respondent

engaged in conduct which violated the provisions of the *Act*, in particular that:

(a) On March 2, 2019, the respondent was rude, confrontational, demeaning berating or belittling in her actions with (then) nursing student, Laura Thomas; and

(b) On December 4-5, 2019, the respondent belittled LPN June Deagle and did not provide patient information to her while on shift together;

3. On or about February 17 and 23, 2020, while employed as a RN at the Medical/Palliative Unit of PCH the respondent engaged in conduct which violated the provisions of the Act, in that:

(a) On or about February 17, 2020, she did not check on a patient who was reporting burning and tingling at the site of an IV potassium infusion until about 20-30 minutes after reporting of symptoms by Laura Thomas and LPN Danielle Peters; and

(b) On or about February 23, 2020, the respondent moved a Patient Controlled Analgesic out of reach of a terminally-ill patient in his room;

4. Between December 3, 2019 and February 23, 2020, while employed as a RN at the Medical/Palliative Unit of PCH, the respondent engaged in conduct which violated the provisions of the Act, in that:

(a) On or about December 3-4, 2019, the respondent was critical of a patient's use of diet soda and questioned her use of pain pills despite approval of the patient's physician to which a written complaint was generated;

(b) During the week of December 23, 2019 the respondent berated a patient's grandson to which an incident report dated December 30, 2019 was generated;

(c) During the week of December 23, 2019 the respondent spoke aggressively to a patient within inches of her face;

(d) On or about February 3, 2020, the respondent told an elderly patient with dementia to “shut up” in a loud voice several times while the patient was located near the nursing station in a rocking chair; and

(e) On or about February 23, 2020, the respondent told a terminal patient that he was dirty, filthy stunk and/or smelled

“Professional misconduct” and “incompetence” discipline offences are defined in Section 57 of the RHPA:

Professional Misconduct

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 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.

Incompetence

(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 in 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.

The Notice of Formal Hearing included excerpts from the College of Registered Nurses of Prince Edward Island ("CRNPEI") Standards for Nursing Practice (2018); and Canadian Nurses Association ("CNA") Code of Ethics for Registered Nurses (2017). The committee has considered these in its assessment of evidence presented at the hearing:
The hearing committee considered the following Standards for Nursing Practice (2018) to be relevant in reaching its determination:

STANDARD 3 – Responsibility and Accountability

Each nurse demonstrates responsibility and accountability to the public by providing competent, safe, and ethical nursing practice.

Indicators:

3.4 Is responsible and accountable for her/his actions and decisions at all times
3.5 Exercises reasonable judgment in decision making
3.6 Follows established policies and procedures

STANDARD 4 – Advocacy

Each nurse demonstrates advocacy for clients in their relationship with the health system by responding to their needs in a way that supports, protects, and safeguards the client's rights and interests.

Indicators

Each nurse:

4.1 Acts as an advocate to protect and promote a clients' right to self-determination, autonomy, respect, privacy, dignity and access to information

And;

As well, the following parts of the Code of Ethics for Registered Nurses (2017) relate to the conduct of Nurse Mariwande:

Part I, Nursing Values and Ethical Responsibilities

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person

Ethical Responsibilities:

1. Nurses, in their professional capacity, relate to all persons receiving care with respect.
2. Nurses support persons receiving care in maintaining their dignity and integrity.

G. Being Accountable
Nurses are accountable for their actions and answerable for their practice.

Ethical Responsibilities:
1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice
2. Nurses are honest and practise with integrity in all of their professional interactions. Nurses represent themselves clearly with respect to name, title, and role.

As will be explained below, the committee has decided that the respondent is guilty of professional misconduct and incompetence in relation to several of the charges against her, and not guilty of several others. Where we found guilt, it was due to her failure to comply with the requirements of these excerpts from the Standards and the Code, which is professional misconduct. The incompetence findings are due to section 2(a) of section 57 of the RHPA.

The Hearing

The hearing lasted for three (3) days. The prosecutor presented evidence through eleven (11) witnesses and nineteen (19) documents. The complainant gave evidence when called by the prosecutor, Gary Demeulenaere. The respondent Yvonne Mariwande's written response to Complaint was included in the booklet of documents submitted by the prosecutor. The respondent did testify in her own defence; she did not present any additional documents or witnesses at the hearing. The respondent did not object to any of the exhibits or witnesses presented by the prosecutor.

The following witnesses were called by the prosecutor:

1. Laurie Thomas, RN – former student and current RN on the Medical/Palliative Unit at PCH;
2. Brittany Savoie, LPN – employee on Medical/Palliative Unit at PCH;
3. June Deagle, LPN – employee on Medical/Palliative Unit at PCH;
4. Danielle Peters, LPN – currently employed on Medical/Palliative Unit; formerly Medical/Surgical float LPN
5. Melanie Butler, RN – employee on Medical/Palliative Unit at PCH
6. Jana Corish, Nurse Manager – manager of Medical/Palliative Unit since January 2019

7. [redacted] – former patient on Medical/Palliative Unit at PCH; received care from member Yvonne Mariwande
8. Rachel Cooper, LPN – employee on Medical/Palliative Unit at PCH
9. Melissa Sonier, PCW – employee on Medical/Palliative Unit at PCH
10. Joanne Dennis, RN - Clinical Leader on Medical/Palliative Unit at PCH
11. Andrew Ellsworth, LPN – employee on Medical/Palliative Unit at PCH

Allegation 1

Melanie Butler testified that was asked to perform a narcotic count on the morning of March 4th, 2019. She explained that there was one less hydromorphone than there should have been. After searching for the missing medication, she asked Ms. Mariwande to witness the count with herself and Rachel Cooper. Ms. Butler explained that upon return to the "B hallway" she saw Ms. Mariwande altering the narcotic record to make it appear as if the error occurred on a previous shift. She stated that she talked with Ms. Cooper, and that on the next shift, they took a photocopy of the narcotic sheet and they filled out an incident report. Ms. Cooper testified she also participated in the narcotic count. She testified the document was altered after she'd completed the count with Ms. Butler and Ms. Mariwande. Ms. Cooper stated she and Ms. Butler talked to Joanne Dennis, Clinical Leader, and they submitted an incident report to the manager, Jana Corish. Ms. Dennis stated she spoke to Ms. Mariwande regarding being seen to have altered the document to make it look like it happened on a previous shift.

In the Member's Response to Complaint, Ms. Mariwande wrote "my error was to change the number of the reflective count". During cross-examination, Ms. Mariwande stated she was aware of necessity of recording documents accurately. She admitted that she altered the number on the record. She replied that she was aware of the incident reporting policy. When asked about why she didn't submit an incident report, she responded that she believed the finders filed a report and that Joanne Dennis filled in an incident report so she didn't. In the Member's response to complaint, Ms. Mariwande also states "I did not do an incident report as one had been filled by the counting nurses".

During her closing statements, Ms. Mariwande reported that she'd attempted to go back and find the error. She reported that a nurse on a shift prior to hers had given the wrong medication to a patient. The chair, Anita McCabe asked the respondent if she had counted the medication at the time she removed the dose she'd administered. She reported she hadn't. The chair also noted that the two previous counts on the same record were consistent and didn't indicate that any narcotic was missing. Ms. Mariwande responded that she believed the incident had occurred on a prior shift, she

was trying to trace backwards to where she believed the error occurred. She explained that she reported that the narcotic was missing to the Pharmacy. She reported that she did change the number on the record to accurately reflect the corrected count with the missing narcotic.

Allegation 2

While working as a fourth year student on March 2, 2019, (then student) Laura Thomas attended to a patient assigned to Ms. Mariwande during her 1AM rounds; who was on isolation precautions. She reported the patient was sweaty and needed a new johnny shirt. She explained she had to come out of the room for a gown. She had to remove her personal protective equipment (PPE) and it had taken a while to get things done. She wanted to check the patient's temperature but there was no thermometer in the room. Ms. Thomas reported she went to Ms. Mariwande to ask about using a portable machine on the patient. She didn't recall the specific conversation but stated that Ms. Mariwande became angry and grabbed the shirt and stated "I'll just do it myself". Ms. Thomas carried on with her shift and didn't tell anyone at that time. Ms. Thomas stated that following their morning rounds, Ms. Mariwande again spoke rudely to her; this time in front of co-workers regarding things she'd stated Laura wasn't doing and stated that Ms. Mariwande told her she was of no help. Ms. Thomas stated she felt "mortified" and "embarrassed" and felt that she didn't want to work on that floor anymore. She stated a LPN on the shift with them witnessed the second encounter and told her it was OK to tell someone and recommended she let her preceptor know. She stated she's never discussed the events that occurred on that day with Ms. Mariwande. Ms.Thomas verified she submitted a handwritten note to the manager Jana Corish a few days following the incidents.

Andrew Ellsworth reported working nights on the date of March 2, 2019; on the "A team". Mr. Ellsworth reported witnessing Ms. Mariwande speaking to Ms. Thomas. He reported not hearing the exchange but recalled Ms. Mariwande saying "I'll do it" and taking the gown. Mr. Ellsworth reported being up the hallway, about 50 feet away. He stated he witnessed Yvonne grab the shirt out of Laura's hands. He spoke to Laura after the event but did not speak to Yvonne.

During her cross examination with Ms. Thomas, Ms. Mariwande recalled that Ms. Thomas seemed rather tired of going into the room. She asked Ms. Thomas if she recalled that vital signs had been done earlier in the night and a thermometer and blood pressure cuff were already in the room. Ms. Thomas recalled that she was looking for the "sat monitor". During her cross-examination with Mr. Ellsworth recalled he heard voices then saw Ms. Mariwande pull the johnny shirt from Ms. Thomas but did not see her dismiss Ms. Thomas that night.

During cross-examination, Ms. Mariwande stated that she may have been perceived as being rude to Laura but was trying to educate. Ms. Mariwande referred to Ms. Thomas as emotional. She stated she took over the situation on the night in question. Ms. Mariwande stated that she took the gown; disagreeing with Ms. Thomas's account that she grabbed it. She didn't recall whether Ms. Thomas offered her the gown. Ms. Mariwande challenged Mr. Ellsworth's location and stated Mr. Ellsworth wouldn't be able to see their location from where he stated he was standing. Mr. Demeulenaere reviewed Mr. Ellsworth's statement that he took a few steps away from the cart. The respondent replied she didn't see him. When cross-examined about the events on morning rounds, Ms. Mariwande stated she mentioned that they round as a team; to go together to round. She reported she mentioned she had to go behind them and finish tasks. She did agree that she questioned whether Ms. Thomas was a 4th year student.

During her closing statements, Ms. Mariwande restated that she didn't dismiss Ms. Thomas. She reported she asked Ms. Thomas to assess the patient and she didn't dismiss her; and stated she would go do it herself after Laura had been in and out several times. She reported that on the morning of the shift, Laura and Sarah took off for rounds ahead of her instead of speaking with her and she that she had to change a patient's incontinent pad after they had already rounded. Ms Mariwande raised issues of prejudice and bullying toward her at the workplace and referred to being called names in relation to her skin colour, but provided very little detail about these concerns and did not present evidence that racism or harassment on the part of the others explained her actions in some way.

The prosecutor Gary Demeulenaere withdrew allegation 2(b) prior to the conclusion of the hearing.

Allegation 3(a)

Allegation 3 (a) states that on or about February 17, 2020, the respondent Yvonne Mariwande did not check on a patient who was reporting burning or tingling at the site of an IV potassium infusion until 20-30 minutes after reporting of symptoms by Laura Thomas, RN and Danielle Peters, LPN.

Ms. Peters stated that the patient rang the bell and she went to the patient's room. She explained that the patient was reporting stinging and burning at IV site. She also stated that there was no swelling. She stated she reported the IV site to Laura Thomas, RN. She explained that Ms. Thomas asked Ms. Mariwande about the IV and returned with update not to slow the rate down. Ms. Peters explained she returned to the patient and told her the nurse was on break and would be down to check on the patient. She stated

that she witnessed Ms. Mariwande attending to the patient 15-20 minutes after the issue was reported.

Ms.Thomas stated she was sitting at the nursing desk and Ms. Mariwande was on break. Ms. Peters approached Ms. Thomas with concerns about the patient's IV infusion. She reported that she asked Ms. Mariwande if she could look at the site and if she could lower the rate. Ms. Thomas stated that Ms. Mariwande said not to change rate and stated she was not going to look at it. She recalled Ms. Mariwande did not leave to look at the IV site.

On cross-examination, Ms. Mariwande asked Ms. Peters if she recalled her [the respondent] being encouraged to go to supper break early because she didn't have a full lunch break. Ms. Peters agreed Ms. Mariwande did have a shortened break at lunch time. Ms. Mariwande asked Ms. Peters if Ms. Thomas knew she'd attended to that patient. Ms. Peters stated she didn't know.

On cross-examination, Ms. Mariwande was unsure of how long it took her to respond but she recalled cutting her break short. She started a new IV site and took care of the problem. She felt that she got up immediately after reporting to go and check. Evidence from Danielle Peters was that Ms. Mariwande attended to the patient 15-20 minutes after being notified. During closing statements, Ms. Mariwande restated that she did attend to the potassium drip. She stated she resited the IV, cut her break short and reminded the committee that Ms. Peters admitted that. She also stated that this same patient came to look for her when she was discharged to thank her for the care.

There were no health record or incident report documents entered into evidence pertaining to this allegation.

Allegation 3(b) and 4(e)
These allegations are being considered together as they pertain to the same patient. Allegation 3(b) alleges that on or about February 23, 2020, the respondent Yvonne Mariwande moved a Patient Controlled Analgesic out of reach from a terminally ill patient in his room at the PCH. Allegation 4(e) alleges on the same date, Ms. Mariwande told a patient that he was dirty, filthy, stunk and/or smelled.

Melissa Sonier stated that the incident was reported a day after the event. The patient H.S. reported having the bolus [button] taken from him by Nurse Mariwande and hung on the IV pole. She stated that the patient didn't want to get anyone in trouble and also told her that Ms. Mariwande told him that he was filthy, he stunk. Ms. Sonier stated she reported the incident to the clinical leader. She stated she asked Brittany Savoie to fill

out a complaint form with him. Yvonne Mariwande asked if Ms. Sonier recalled that she talked with the patient and told him that he was all “spiffied up”. Ms. Mariwande asked if this was when the comment was taken out of context. Ms. Sonier stated, no, it was the day before.

Brittany Savoie stated that she helped to fill out a complaint form with H.S. and took it to the nurse manager. H.S. told her that Nurse Mariwande said he smelled bad and after they were finished, she allegedly threw the PCA remote on top of the IV pole and he couldn’t reach it. He said that in order to reach the remote, he had to raise the bed to the highest level to retrieve it. Ms. Savoie stated H.S. didn’t want to complain but didn’t want Ms. Mariwande doing it to somebody else. She described him as upset, quiet, and didn’t want to go into detail. The written statement taken from Mr. H.S. was entered into evidence. Ms. Savoie stated she wrote the document and confirmed it accurately reflected what H.S. told her stating that she listened, restated, and wrote. The complaint form identified Nurse Mariwande and stated that she “called the patient dirty in a mocking way” and “she huffed and chucked the remote to where he couldn’t reach it on top of the IV pole”. It also stated “pt [patient] concerned with other peoples cares, i.e. they may not be able to reach it and be in pain”

Jana Corish stated she completed a follow up interview with patient H.S. She stated although there was a delay with follow up due to his condition, she described H.S. as recalling vividly. She stated the patient’s recollection of the events was consistent with the contents of the complaint form. She recalled he came forward he expressed concern not for himself but the behaviour toward someone else. Ms. Corish described the patient as competent and his demeanour as hesitant.

Allegation # 4 (a), 4(b) and 4(c)

For allegation # 4, the hearing committee have considered Allegations 4(a), 4(b), and 4(c) together; as they pertain to witness, [redacted].

[redacted] testified that she was a patient on the Medical/Palliative unit at PCH during the month of December 2019. She stated in her dealing with the respondent, Yvonne Mariwande, she found she was not very compassionate and very bossy. She complained that Nurse Mariwande repeatedly told her that she should not be drinking Diet Pepsi, and should not be using so much pain medication, which [redacted] felt was inappropriate. During her stay, [redacted] heard Ms. Mariwande chastising her adult grandson loudly (‘giving him hell’) outside the room for not removing his isolation gown when he left the room, which was upsetting because her grandson has special needs. [redacted] stated that Nurse Mariwande was loud and obnoxious in any event. She recalled she heard Ms. Mariwande tell her grandson that he should have known better,

and asked him if he could read (posted signs). [redacted] was upset about these incidents, and filed a written complaint with the hospital. Ms. Mariwande tried to apologize, but got too close to [redacted] at one point and spoke loudly, causing further upset. She stated she asked the respondent to get out of her room and not to come back. [redacted] reiterated her statement that she told Yvonne she was rude to her grandson and Ms. Mariwande denied it and it kept getting louder. [redacted] confirmed she put a complaint in the complaint box upon discharge. Ms. Mariwande stated to [redacted] that she apologized to her once she realized that her grandson was challenged. Ms. Mariwande stated she was showing her grandson the signage after he had gone to the kitchen with mask, gloves and gown. Ms. Mariwande stated [redacted] allowed her to apologize. [redacted] replied it was because she was scared. Ms. Mariwande asked [redacted] if she recalled telling her that her stomach was upset. Ms. Mariwande explained that she had asked about pop because of the acid in pop and its effect on [redacted] upset stomach.

June Deagle stated she was in a room a couple of doors down from (then) patient [redacted] on that day and heard yelling. She stated that a patient in the room she was tending to, thought there was fighting going on because of the commotion. Ms. Deagle went to patient [redacted]'s room, and found Nurse Mariwande crying. She observed Ms. Mariwande and the patient, [redacted], were both very upset. She reported that when she went back to the room to speak to [redacted], [redacted] stated didn't want Ms. Mariwande back in the room and reported [redacted] told her that Yvonne was within inches of her face during the exchange. She stated [redacted] was upset about the way Ms. Mariwande had spoken to her grandson. During cross-examination, Ms. Mariwande asked if she was yelling, or was it her tone of voice. Ms. Deagle responded it was the respondent's tone and that she heard Ms. Mariwande yelling.

Ms. Mariwande stated she didn't recall what she said to [redacted] but recalled that [redacted]'s grandson was an adult and that he'd traveled to the kitchen while wearing PPE. Ms. Mariwande stated she said she told [redacted]'s grandson he should remove PPE and stated she showed him signs on the inside and outside of room. When asked about raised voices, Ms. Mariwande responded that she was providing education. She did agree her voice was raised perhaps when talking to [redacted] but didn't recall if it was the first or second incident with [redacted]. When asked about denying pain medication, Ms. Mariwande didn't recall denying [redacted] any medication. Ms. Mariwande stated that she told [redacted] that if her stomach was upset, pop would have acid and would upset her stomach. During her closing statement, Ms. Mariwande stated she did not have a raised voice initially. She stated she apologized to [redacted] multiple times after the incident pertaining to her misunderstanding that [redacted]'s grandson could not

read the signage. She also made reference again to having a strong voice and a firm tone and people misunderstanding her accent.

Allegation 4(d)

Laura Thomas stated that during her shifts on/about February 22-23, 2020, she and Ms. Mariwande had a patient with dementia at the nursing station; that was not normally oriented to place and had vision impairments. She described the patient has having trouble settling at night and/or falling asleep or staying asleep. She explained that the patient could be loud or disruptive to other patients. She took the patient out of her room to allow her roommate to sleep. She explained that she and Ms. Mariwande had this patient at the desk with them. On the first night, nothing in particular occurred. On the second night, Ms.Thomas reported that the patient was calling out and she witnessed Ms. Mariwande repeatedly telling the patient to “shut up”. She stated she witnessed the patient would try to get Ms. Mariwande’s attention and would tap her arm. She stated that Ms. Mariwande would pull her arm away and said “don’t touch me”. Ms. Thomas stated she didn’t recall if anyone else was around to witness these incidents.

Mariwande did not speak to this allegation in her testimony, but during her closing statements, she stated that it’s normal to remove patients if restless, and she did not tell the patient to shut up. There were no documents from the patient’s health record or incident reports submitted into evidence pertaining to this allegation, and no other witnesses.

Decision

Allegation 1

The Committee has determined that member Yvonne Mariwande is guilty of professional misconduct and incompetence in Allegation 1. As a nurse, Ms. Mariwande must be aware of her accountability as a professional and her ethical obligation to ensure accurate documentation. It is the committee’s determination that Ms. Mariwande has violated Section G under the Code of Ethics, responsibilities (1) and (2). Under Standards for Nursing Practice, the committee has determined the respondent’s actions are also a violation of Standard 3, indicator 3.4. Although the carry-forward total remained accurate, the evidence was clear that Ms. Mariwande attempted to create the appearance that the error had occurred during a prior shift. Ms. Mariwande seemed focused on her statement she did not take (i.e. remove) the medication; rather than understanding the implications of altering a legal document; despite no accusations that she did take it.

Regarding the allegation that Ms. Mariwande was obligated to report the incident, the committee acknowledges that it is not explicitly clear on this point, and this was not part

of the charge in any event. Section 5.1.a.i. of Health PEI's policy, *Patient Safety Incident Reporting and Management* states "a healthcare provider who discovers, witnesses, or is involved in an incident…".Ms. Mariwande testified she was aware that the Clinical Leader, Joanne Dennis had created an incident report and believed it was taken care of. Regardless, as Ms. Mariwande was aware that the incident occurred, it would be her responsibility to follow up and be certain, but we do not find her guilty of failing to report. Altering a document is deceiving and dishonest and per Section 57(1)(a.1) such action is harmful to the integrity of the profession of nursing, and is professional misconduct. It is also incompetence due to lack of knowledge or judgment because accurate record-keeping is so important to quality health care, nurses must not alter records to reflect circumstances which are not correct.

Allegation 2(a)
The committee lacked consensus on Allegation 2(a). There was some concern regarding the respondent's lack of clarification of her co-workers titles, roles and responsibilities until the next morning when she had the alleged second altercation with Ms. Thomas. There was some concern for the testimony of Andrew Ellsworth. In the email submitted by Mr. Ellsworth on March 17, 2019, he did not speak about witnessing the event; however, reported he witnessed the exchange between Ms. Thomas and Ms. Mariwande during the hearing. No witnesses were introduced that heard either of the exchanges between Ms. Thomas and the respondent Ms. Mariwande. Further, although it was reported that a second verbal incident occurred in front of witnesses, none were called to provide a statement about the second verbal exchange during the morning rounds on March 2, 2019. Due to the lack of additional witnesses to testify to Ms. Mariwande's tone or exchange during either incident, consensus could not be reached. It is noteworthy that the prosecutor, Gary Demeulenaere, did successfully demonstrate a pattern of behaviour regarding the respondent's poor communication, but the allegation presented to the committee was specific to the incidents that occurred on March 2, 2019 only and the committee was compelled to rule on this specific incident only; rather than a pattern of behaviour. The committee has determined the evidence was not sufficient to convince the committee that the respondent is guilty of this allegation. This allegation is dismissed.

Allegation 2(b)
The prosecutor Gary Demeulenaere withdrew allegation 2(b) prior to the conclusion of the hearing

Allegation 3(a)
The committee has determined that there is insufficient evidence to support a guilty verdict with regards to the failure to check on IV potassium on or about February 17,

2020. Both Ms. Thomas and Ms. Peters stated they did not see Ms. Mariwande leave the break room. Ms. Peters did indicate that she recalled Ms. Mariwande took an earlier supper break as due to her shortened lunch break on the date in question. Ms. Mariwande stated that she responded immediately to the patient and changed the IV site. In the Report of Investigation Complaint in Exhibit # 1, it is noted that Laura Thomas reported she did assess the site and there were no signs of infiltration; as does the statement from Ms. Peters in the same report. Due to a lack of witnessing how long after receiving the report of the IV site that Ms. Mariwande responded, and in light of Mariwande's assertion that she attended fairly quickly, the statements from both witnesses in the Report of Investigation that the site did not appear infiltrated, the committee feels there is insufficient evidence to determine guilt in respect of this allegation. Further, no documentation or incident reports were received to support or refute the timing of the respondent's response to the IV site. This allegation is dismissed.

Allegation 3(b) and 4(e)

Per section 57(1)(a.1) and 57(2)(ii) of the RHPA, Ms. Mariwande is guilty of professional misconduct and incompetence The committee has determined the member to be guilty of professional misconduct and incompetence in allegations 3(b) and professional misconduct in allegation 4(e). For allegation 3(b), the committee finds Ms. Mariwande has violated Standards for Nursing Practice, Standard 3, Indicators 3.4 and 3.5. For Allegation 4(e), Ms. Mariwande has violated Standards for Nursing Practice, Standard 4, indicator 4.1. Ms. Mariwande has also violated Section D, responsibilities 1 and 2. The evidence from Ms. Savoie, Ms. Sonier and Ms. Corish is consistent, and supports evidence from H.S. himself which is contained in the investigation report (he is deceased). We conclude that Nurse Mariwande made derogatory comments to H.S. and he was hurt by them.

It is the opinion of the hearing committee that Ms.Mariwande's words used to describe the patient were harmful to the best interests of her patient, H.S; as well as the integrity of the profession. Ms. Mariwande spoke in a manner that was harmful to the nurse-client relationship. Further, Ms. Mariwande, whether intentionally or unintentionally, moved H.S.'s pain control out of his reach; causing further potential for harm. As a Registered Nurse, Ms. Mariwande is in a position of trust and our clients are vulnerable by the very nature of the power imbalance we can have. It is imperative that clients feel safe receiving care. As professionals, we are expected to communicate in a way that is not perceived as demeaning to our clients.

Incompetence in this situation relates to Nurse Mariwande's disregard for the welfare of H.S. The statements received from the complainant Jana Corish and PCW Brittany Savoie on behalf of patient H.S. are highly consistent with the incident report and the statement from Mr. H.S. in the Report of Investigation. The repeated statements that Mr. H.S. was hesitant to report the incident; that he didn't want to get anyone in trouble and that he reported the incident to protect others was very compelling and this sentiment was consistent in all statements. Ms. Mariwande failed to treat her vulnerable and dependent patient with care and dignity.

Allegation 4

The committee felt there was insufficient evidence to prove allegation 4(a). Ms. Mariwande's responses to these allegations are plausible given that [redacted] did agree that she had a conversation with the respondent about an upset stomach. She denied ever withholding any medications from the witness [redacted]. It was also noted that no complaint of withholding medications was submitted in [redacted]'s handwritten complaint. There was no documentation to support or refute these allegations; aside from the mention in [redacted]'s letter of complaint. It is as likely that Nurse Mariwande was simply attempting to offer helpful advice as it is that she was overstepping her scope of practice, and we are not able to decide conclusively which it was, so the respondent is not guilty of this allegation, and it is dismissed.

The committee lacked consensus to determine guilt in allegation 4(b). Although the committee agrees that an incident occurred, no testimony was heard about what exchange occurred between Nurse Mariwande and [redacted]'s grandson during this precipitating event. [redacted] did report that she heard a commotion outside her room and asked Ms. Mariwande to bring the discussion inside her room; no details were presented to the committee regarding what specifically was stated to [redacted]'s grandson; aside from questioning his ability to read the signage. Although Ms. Mariwande acknowledged she would have spoken differently if she'd known he was challenged, she stated she was educating [redacted]'s grandson after he'd worn his PPE to the kitchen. The committee has determined the evidence was not sufficient to convince the committee that the respondent is guilty of this allegation. This allegation is dismissed.

The committee has determined that Ms. Mariwande is guilty of professional misconduct in allegation 4(c). The committee has determined that Ms. Mariwande's actions violated Code of Ethics, Standard D, responsibility 1, and 2. Ms. Deagle testified that she heard [redacted] and Ms. Mariwande arguing and proceeded to the room when she heard the exchange. The concern of this committee is that Ms. Mariwande has referenced she'd

have spoken differently to [redacted]'s grandson had she known he was challenged; however, we find that she was disrespectful to [redacted] herself during the course of the exchange. We are expected to communicate in a way that is not perceived as threatening or demeaning to our clients. Ms. Deagle testified that she heard yelling from down the hall between the witness, [redacted], and the respondent Ms. Mariwande. As professionals, we are expected to conduct ourselves at all times in a way that honours the profession of nursing. Raising one's voice to the point of yelling demonstrates a serious lack of respect for those under our care. The respondent is guilty of this allegation.

Penalty

Section 58(2) and (2.1) of the RHPA allows the committee to determine penalties including counselling, a reprimand, terms and conditions on the registration of the respondent, an order suspending registration, canceling the registration of the respondent, an order requiring the respondent to pay all or part of the costs of the hearing committee, a fine, and any other sanction that the hearing committee considers appropriate. Factors to determine the fine include the extent of the member's awareness of the fault; degree of risk or harm to the client; potential for further risk to the public; potential effect on the member's profession; potential effect upon the member's ability to earn a livelihood; any restriction or remediation voluntarily undertaken by the member; or any other prescribed factor. The committee has decided that the following penalty is appropriate in the circumstances of this case and so orders:

1. Yvonne Mariwande's registration to practice nursing shall be suspended for a period of one (1) month, effective the date this decision is delivered to her.

2. Within one year of the date of this decision issued by the Hearing Committee, Ms. Mariwande shall complete at least four (4) professional development courses in communication training, at her own expense; related to:
    a. Effective Communication
    b. Teamwork
    c. Conflict resolution skills
    d. Safe and respectful workplace
        i. The member must obtain prior approval from the Coordinator of Regulatory Services for the College of Registered Nurses of Prince Edward Island before taking the courses, and she is responsible to provide written proof of successful completion of the courses to the Coordinator of Regulatory Services, on or before March 31, 2021. Should circumstances directly related to the current Covid-19 crisis impact the member's ability to complete these courses, direction is to be obtained from the committee.

3. Yvonne Mariwande shall have the following conditions placed on her nursing registration, effective the date this decision is delivered to her:

a. Ms. Mariwande shall attend training with a Regulatory Expert ("the Expert") at her own expense and within six months from the date that this order becomes final. To comply, Yvonne Mariwande is required to ensure that:
    i. The Expert has expertise in nursing regulation and has been approved by the CRNPEI Coordinator of Regulatory Services to provide refresher training;
    ii. The Expert has been provided with a copy of the complaint; notice of formal hearing; the respondent's written response to the complaint; and this decision;
    iii. Before the first meeting, the Yvonne Mariwande reviews the following CRNPEI publications
        1. CNA Code of Ethics
        2. Standards for Nursing Practice

    and has provided 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 Hearing Committee in relation to this matter;
    iv. The Subject of the sessions with the Expert will include:
        1. The acts or omissions for which the member has been found to have committed professional misconduct and/or incompetence
        2. The potential consequences of the misconduct and/or incompetence to the Member's patients, colleagues, profession, and self;
        3. Strategies for preventing the misconduct from recurring;
        4. The development of a learning plan in collaboration with the Expert;
        5. Training regarding appropriate communication with colleagues, clients, and other health professionals;
    v. Within 30 days after the Member has completed her last session, the Member will confirm 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 Member;
        3. That the Expert reviewed the required documents and subjects with the Member; and
        4. The Expert's assessment of the Member's insight into her behaviour;
    vi. If Ms. Mariwande does not comply with any one or more of the requirements above, the Expert may cancel any scheduled session, even if that results in a breach of a term, condition, or limitation on Ms. Mariwande's certificate of registration.
    vii. The Committee will review the Expert's report and will decide whether any additional penalty is required based on its content. If

satisfied that the Member has met the requirements of these conditions, the Committee will notify her that the conditions have been removed.

4. Yvonne Mariwande shall be required to pay a fine in the amount of five hundred dollars ($500), which fine shall be paid in full no later than October 31, 2021.
5. Yvonne Mariwande shall be required to pay CRNPEI the amount of five hundred dollars ($500), in respect of the expenses associated with the investigation and adjudication of this complaint, and which expenses shall be paid in full no later than October 31, 2021.
6. Yvonne Mariwande shall provide a copy of any written decision rendered in relation to this matter to her employer or employers, or to any employer who offers her employment as a Registered Nurse, and shall provide written verification to CRNPEI from the employer that the employer has received this decision. This obligation will continue until all of the conditions of her registration have been removed;
7. In the event that Yvonne Mariwande fails to comply with any of the above conditions, the Committee may suspend her registration or may decide that she will be ineligible to apply for registration with CRNPEI.

The committee has decided the above penalty because Yvonne Mariwande's conduct happened over a period of time. At the hearing, Ms. Mariwande did not seem to understand the extent to which her own conduct impacted these events. Yvonne Mariwande seemed focused on cultural factors as the cause in all of these circumstances with exception to Allegation 1, as opposed to her own unprofessional behaviour. Her conduct has had a significant impact on her professional relationships and her vulnerable clients, dependent on Ms. Mariwande for her care. Her conduct has been proven to have broken the trust of her patients on more than one occasion. Ms. Mariwande's behaviours and poor communication constitute behaviours unbecoming to the profession of nursing. Although there was insufficient evidence to convict Ms. Mariwande on the complaint against Laura Thomas, prosecutor Gary Demeulenaere was able to establish that Yvonne Mariwande has an extensive history of poor relationships with many of her peers. This was also a factor in determining educational recommendations for Yvonne.

Some mitigating factors in this committee's sentence include Yvonne Mariwande's statement pertaining to her difficult financial situation and fiscal obligation to family both here and in Africa and these were considerations for the committee in determining an appropriate sentence. It is the committee's belief that financial deterrents would have a potentially negative impact on those dependent upon her for her livelihood and that education-focused learning would better serve to improve her professional conduct. The committee also notes some concern regarding follow-up to many of the complaints against Yvonne Mariwande. Many of the complaints the hearing committee was asked to hear weren't included in the respondent's letter of discipline from PCH. Further, many of the witnesses stated they didn't discuss their concerns with Ms. Mariwande. Ms. Mariwande testified that she was only made aware of most of the complaints some time

after the complaints were submitted; for example, at the discipline meeting and while meeting with the investigator. The hearing committee have some concern with the lack of consistent and timely response in the workplace, and believe these delays may have had a role to play in respondent's behaviour and performance.

Yvonne Mariwande may appeal the determination of this Hearing Committee or the penalty order to the Supreme Court of Prince Edward Island within 30 days after being served with notice of this determination and order, and may refer to section 59 of the Regulated Health Professions Act if she wishes to appeal.

Respectfully submitted at Charlottetown, Prince Edward Island this 2nd day of October, 2020.

Anita McCabe, Chair of the Hearing Committee