Association of Registered Nurses of PEI (ARNPEI) Professional Conduct Review Committee

Formal Inquiry Panel Decision

Complaint # 2016-005

Re: Leila Coughlin, Member Registration # 003238

A Formal Inquiry Panel of the Professional Conduct Review (PCR) Committee of the Association of Registered Nurses of Prince Edward Island (the "panel") conducted a hearing in Charlottetown, PE on April 24, 2018, to consider a complaint dated October 11, 2016 against Registered Nurse Leila Coughlin, registration number 003238. The Hearing followed a meeting of the Investigation Panel of the PCR Committee which was held on October 19, 2017, that resulted in the committee's decision to proceed to a formal inquiry.

The purpose of the formal inquiry was to determine whether Leila Coughlin engaged in activities that were either or both professional misconduct and/or conduct becoming the profession of nursing, between approximately February 2014 and October 2016. The conduct to be reviewed occurred during approximately two and a half years of working at Public Health Nursing in Summerside, PE. The Panel also had the task of deciding an appropriate penalty, if warranted. A Notice of Formal Hearing was the basis of the hearing, and it alleged:

1. That during the relevant time period the Respondent failed to perform planned interventions in accordance with appropriate policies, procedures and service standards and failed to document nursing activities and client outcomes in an accurate, timely and thorough manner, as follows:
    a. In or about March, 2014, the Respondent failed to follow up as required with an infant following post-partum discharge;
    b. Prior to July 22, 2014, the Respondent failed to follow up as required subsequent to the referral of an infant to you on or about January 9, 2014 for the purpose of monitoring that child's growth;
    c. In or about June, 2015, the Respondent failed to follow up as required regarding an infant who was not gaining weight sufficiently, and who presented with significant risk factors requiring urgent follow up;
    d. On or about August 5, 2015, the Respondent failed to accurately document the weight of an infant without first removing clothes and diaper and/or recording the infant's weight as being a "best guess";
    e. Prior to September 3, 2015, the Respondent failed to follow up as required regarding a child who was not gaining weight sufficiently;
    f. In or about September of 2015, the Respondent failed to follow up and/or contact the parents of two children as required for the purpose of prompting them to complete and/or update required immunizations;

g. In or about September of 2015, you failed to follow up as required regarding a child who required a hearing recheck;
h. In or about September of 2015, the Respondent failed to follow up as required subsequent to a referral from a clinic dated July 2, 2015, for the purpose of monitoring an infant's weight;
i. In or about October of 2015, the Respondent failed to follow up as required with the family of a twelve (12) year old child for the purpose of ensuring that the child's immunizations were brought up to date;
j. In or about January of 2016, you failed to follow up as required with the family of a six (6) year old child for the purpose of ensuring that the child's immunizations were brought up to date; and
k. On or about October 5, 2016, the Respondent failed to intervene appropriately or in a timely fashion as required to obtain access to mental health services and/or make necessary inquiries on behalf of a patient following a request for an urgent referral from a family member of that patient

2. That between February of 2014 and October of 2016, the Respondent failed to appropriately communicate, collaborate and consult with nurses and other members of the health team regarding the provision of service in that:
    a. On or about July 14, 205, the Respondent failed to appropriately communicate with a patient and/or co-workers to ensure appropriate follow up in relation to a patient during a planned absence from the office; and
    b. On or September 3, 2016, the Respondent failed to provide required maternal/newborn referrals on a timely basis to colleagues located in Charlottetown, resulting in unnecessary delay.

Members of the panel in attendance at this hearing were: Tara Roche (chair), Meghan MacDonald (member), Heather Rix (member) and Richard Collins (public representative). Also in attendance were Complainant Kathy Linton, Respondent Leila Coughlin, Adducer Tom Keeler, Legal Counsel for Respondent Coughlin Matt Walters, and Legal Counsel and Advisor for the Committee, Doug Drysdale. A representative from the Office of the Future (Christine MacDougall) audio recorded the formal hearing. Chad MacQuaid, Articled Clerk, and June Howard, friend of Leila Coughlin, were also in attendance as observers.

At the beginning of the hearing Tara Roche reviewed the complaint, and made note that written notice of this Hearing was sent by registered mail on April 9, 2018. Respondent (Leila Coughlin) questioned the receipt of the notice of Formal Hearing by mail. Legal Counsel for Respondent (Matt Walters) confirmed receipt of the notice on her behalf.

Tara Roche asked the Complainant and Respondent if there were any objections to the inclusion of any of the Committee Members. Tom Keeler indicated he was the son-in-law of panel member Heather Rix, but felt it was reasonable to proceed. Matt Walters agreed to proceeding. The panel, including Heather

Rix, agreed to proceed, in light of the fact that the parties appeared to have agreed on the facts, and the respondent and her lawyer had no concerns about Ms. Rix's participation.

Tara Roche confirmed that all in attendance had copies of the binder (Exhibit 1) which had been distributed by the adducer. The Table of Contents was reviewed.

Tom Keeler, adducer of evidence on behalf of ARNPEI, presented the evidence. He did an overview of the complaint, Leila Coughlin's response and the investigation report by Mary MacSwain. Tom Keeler indicated he and Matt Walters had prepared an Agreed Statement of Facts (Exhibit 2) for the panel's consideration. This document was circulated and the Panel recessed to consider it. The Agreed Statements of Facts was signed by Tom Keeler, Matt Walters and Leila Coughlin and dated April 24, 2018. At the resumption of the hearing, Chair Tara Roche stated that the panel accepted the Agreed Statement of Facts and that no further presentation of evidence would be necessary.

In the Agreed Statement of Facts, Leila Coughlin admitted that she failed to perform planned interventions in accordance with appropriate policies, procedures and service standards and failed to document nursing activities and client outcomes in an accurate, timely and thorough manner. She also admitted to failing to appropriately communicate, collaborate and consult with nurses and other members of the health profession regarding the provision of services. Leila Coughlin admits to the allegations and admits these allegations consist of professional misconduct as defined in section 1(t) of the Registered Nurses Act and conduct unbecoming the Profession of Nursing, both of which are contrary to section 30(4) of the Registered Nurses Act.

In accepting the Agreed Statement of Facts, the panel found Leila Coughlin to be guilty of professional misconduct and conduct unbecoming the profession of nursing.

Tom Keeler then presented a recommendation on penalty to the panel. The Recommendation on Penalty (Exhibit 3) was signed by Tom Keeler but not by Leila Coughlin; it was not a joint recommendation.

Matt Walters, legal counsel for the Respondent, then was given an opportunity to respond to the recommendations for penalty. Mr. Walters spoke to the Respondent's intention to surrender her license, both for the public's best interest and for herself. Mr. Walters noted that the Respondent has acknowledged the seriousness of this matter and has cooperated throughout this process. The Respondent has agreed with the Statement of Facts and accepts responsibility for her actions. Mr. Walters stated that a "fine on top of everything else is a bitter pill to swallow" and that "public is protected if the Respondent surrenders her license". Mr. Walters asked the panel to consider applying a penalty only if the Respondent intended to re-apply for her license.

The Complainant, Kathy Linton, made no submissions.

At this point, Mr. Keeler, Mr. Walters, the Respondent and the Complainant were dismissed from the hearing and the hearing was adjourned to allow the Panel to reach its final decision.

Following the adjournment of the hearing, the Panel met to review and consider the submissions on penalty.

The Panel noted the mitigating factors outlined in the Agreed Statement of Facts. The Respondent, Leila Coughlin, has accepted responsibility for professional misconduct and conduct unbecoming the profession of nursing. The Panel recognized the allegations presented in this review were serious and non-professional and considered the nature and gravity of the allegations and the impact of the incident on individuals (patients, patient's family, employer, co-workers) and agrees that a license suspension is warranted. Also, some improvement in Ms. Coughlin's practice abilities is needed in the event that she ever returns to practice. However, the panel has considered the fact that the Respondent has decided not to practice again, and the panel has decided to make some changes to the recommendations on penalty to make the penalty more suitable to the circumstances. The Panel decided that the following penalty shall be issued to the Respondent, Leila Coughlin:

1. Leila Coughlin's license shall be suspended for the remainder of the licensing year (ending October 31, 2018). Following the completion of this licensing year, if Leila Coughlin wishes to re-apply all conditions listed in section 2 below are to be met before a license will be issued.
2. The Respondent, Leila Coughlin is required to satisfy the following conditions before re-applying for a license:
    a. the Respondent shall provide ARNPEI's Coordinator of Regulatory Services with written medical clearance from her family physician to perform duties associated with a registered nurse, in a form satisfactory to ARNPEI. The physician must consider the issues mentioned in paragraph 8 of the Agreed Statement of Facts, including memory issues, inability to concentrate on tasks, inability to critically assess situations and perform complex tasks, and inability to interact with the public.
    b. the Respondent shall complete refresher training with a Nursing Expert at her own expense. There should be a minimum of 6 sessions and the sessions should be completed within 3 months. To comply, the Respondent is required to ensure that:
        i. the Expert has expertise in nursing regulation and has been approved by the ARNPEI Coordinator of Regulatory Services to provide refresher training;
        ii. the Expert has been provided with a copy of:
            1. this decision;
            2. The Notice of Hearing; and
            3. The Agreed Statement of Facts

        iii. the Respondent has reviewed the ARNPEI Standards of Practice and CNA Code of Ethics (2017), and at least seven days before meeting with the Expert has provided the Expert with a short written statement of at least five hundred words reflecting on the issues identified in this decision issued

by the Formal Inquiry Panel in relation to this matter, and explaining her understanding of what good nursing practice required in the circumstances;

iv. the subject of the sessions (minimum of 6), with the Expert will include:
    1. a discussion of any acts or omissions committed by the Respondent as identified in the decision, including any misconduct or violations of the ARNPEI Standards of Practice and CNA Code of Ethics (2017);
    2. a discussion of the potential consequences of the misconduct to the Respondent's clients, colleagues, profession and self;
    3. strategies for preventing the misconduct from recurring;
    4. refresher training in medical documentation and data entry systems; and
    5. the development of a learning plan in collaboration with the Expert.

v. within thirty days (30) of the completion of the final session with the Expert, the Respondent shall confirm that the Expert has forwarded a report to the ARNPEI Coordinator of Regulatory Services, in which the Expert has confirmed:
    1. the dates of the completed sessions;
    2. that the Respondent reviewed the ARNPEI Standards of Practice and CNA Code of Ethics (2017) prior to meeting with the Expert;
    3. that the Expert reviewed or confirmed appropriate review of the required documents and subjects with the Respondent; and
    4. the successful completion of the required learning plan

vi. if the Respondent does not comply with any one or more requirements above, the Expert may cancel any scheduled session, even if that results in a breach of a term, condition or limitation of the Respondent's certificate of registration.

c. Upon satisfactory completion of conditions 2(a) and (b), as determined by this panel, the Respondent may apply for a license.

d. The Respondent shall be required to pay a fine to ARNPEI in the amount of One Thousand Dollars ($1,000), on or before September 1, 2019.

3. The Respondent shall be required to pay ARNPEI the amount of Two Thousand Dollars ($2,000) in partial reimbursement of the expenses associated with the investigation and adjudication of this complaint. At Leila Coughlin's option, the amount in total (items 2(d) and 3) can be paid in twelve consecutive monthly installments of $250, which payments shall commence on the first day of September, 2018 and end on the first day of August, 2019.

4. The Respondent shall provide a copy of this decision to any future employer who offers her employment as a Registered Nurse and shall provide written verification to ARNPEI from the employer that the employer has received this report. This obligation will continue until removed by the panel, and the Respondent may request removal after a reasonable period of time has passed after she resumes practicing as a Registered Nurse.

5. Failure to comply with any of the above conditions will result in inability to apply for a license with ARNPEI.

Respectfully submitted at Charlottetown, Prince Edward Island this 13th of July, 2018.

Tara Roche, Chair of the Formal Inquiry Panel