COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as

COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

RE: CONDUCT OF **TINA FODOR,** R.N., REGISTRATION **#77,647**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as

COLLEGE OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

October 5-8, 2021,
October 14, 2021,
October 19, 2021, AND
December 15, 2021

INTRODUCTION

A virtual hearing was held on October 5, 6, 7, and 8, 2021, October 14, 2021, October 19, 2021, and December 15, 2021 before a Hearing Tribunal of the College and Association of Registered Nurses of Alberta also known as College of Registered Nurses of Alberta ("**College**") to hear complaints against Tina Fodor, R.N. registration #77,647 (the "**Registrant**").

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, Chairperson
Jofrey Wong
Naz Mellick, Public Representative
Doug Dawson, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon
Maya Gordon (October 6, 2021, in the morning)

c. College Representative:

Mick Wall, Conduct Counsel

d. Registrant Under Investigation:

Tina Fodor (sometimes hereinafter referred to as "the **Registrant**")

f. Observers

Claire Mills

PRELIMINARY MATTERS

Preliminary Matters

On the morning of October 5, 2021, the Registrant was not present when the Chair convened the hearing to order at 10:02 a.m. The Registrant had been present briefly before the hearing was called to order but appeared to have technical difficulties and exited the meeting. The Chair made some preliminary remarks and then adjourned the hearing so that the College Hearings Coordinator and Conduct Counsel could attempt to contact the Registrant. The hearing was adjourned until noon.

The hearing reconvened at 12:02 p.m. and Conduct Counsel advised that he had not been able to contact the Registrant although he attempted to reach her by telephone and email. The Chair noted on the record that she was advised by the Hearings Coordinator that the Hearings Coordinator had tried to email and call the Registrant over 20 times and had not reached her. The Hearing Tribunal determined that it would adjourn the hearing until October 6, 2021, and if

the Registrant was not present, the Hearing Tribunal was prepared to hear and consider an application pursuant to section 79(6) of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**") to proceed in the absence of the Registrant.

On October 6, 2021, the hearing reconvened at 9:32 a.m. and the Registrant was present. The Registrant provided an explanation for not being present or responding to calls and emails the day before and expressed that she was nervous and anxious.

The Registrant was not represented by a Labour Relations Officer or legal counsel. The Registrant confirmed that she was aware of her right to be represented and was waiving the right to legal counsel and was prepared to proceed with the hearing.

Conduct Counsel and the Registrant 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 Chairperson noted that pursuant to section 78 of the HPA the hearing was open to the public. No application was made to close the hearing. No members of the public were present during the hearing.

The Chairperson noted that there was a Hearing Tribunal member present as an observer, for educational purposes for certain portions of the hearing.

Additional Matters that Arose during the Hearing

Throughout the hearing, on numerous occasions, the Registrant experienced issues with technology. The Chair paused the hearing during witness evidence or submissions and ensured that any evidence, submissions or directions from the Chair were repeated as needed so that the Registrant heard all evidence, submissions and directions. The Hearing Tribunal also adjourned the hearing at various times to ensure that the Registrant was connected to the virtual platform and could hear and see the proceedings.

The Registrant expressed she was anxious and nervous at certain times during the hearing. She also expressed that being required to have her camera on created anxiety for her. The Hearing Tribunal determined that it would not require the Registrant to be seen on camera while other witnesses were presenting their evidence. The Registrant was asked and did have her camera on when she gave her evidence and made her closing submissions.

The Hearing Tribunal took several steps to ensure the hearing was fair to the parties. The Hearing Tribunal recognized that the Registrant was unrepresented and was prepared to grant adjournments throughout the proceeding to assist the Registrant in dealing with her anxiety, to consider her position and responses to issues that arose, and to deal with any technology issues. The Hearing Tribunal also granted adjournments to Conduct Counsel to permit him to consult with his client as needed.

These steps led to the hearing being prolonged over several days, however, the Hearing Tribunal felt these adjournments were necessary to ensure fairness of the process.

On October 14, 2021, after several days of hearing, the Registrant raised that she was unrepresented by legal counsel. The Chair reminded her that at the beginning of the hearing she had confirmed her right to legal counsel. The Registrant indicated she could not afford legal

counsel. The Registrant was asked about having a Labour Relations Officer, but she noted that these are not lawyers. She stated she did not have confidence in the union and decided to deal with the matter on her own. The Registrant did speak to a Labour Relations Officer but could not find someone to step in mid-hearing. There were also discussions on the record about a potential agreement on the facts and admissions by the Registrant. The Hearing Tribunal decided it would adjourn the hearing to allow the Registrant and Conduct Counsel to discuss how the hearing would proceed. When the hearing reconvened, it was noted on the record that communications occurred between Conduct Counsel and the Registrant, although not the details of such communications and no agreement was presented to the Hearing Tribunal.

Issue that Arose Following the Evidence and Closing Submissions

Following the evidence being heard and the closing submissions being presented by the parties but prior to the Hearing Tribunal starting its deliberations, Conduct Counsel raised an issue of a potential apprehension of bias. The Chair had applied for and been interviewed for the position of investigator with the Complaints Director's office following the evidence portion of the hearing.

The hearing was reconvened, and the parties were provided a chance to make submissions. Conduct Counsel noted that this may inadvertently have raised a reasonable apprehension of bias. The parties were given a chance to address the issue and raise any concerns. The Chair noted that she was not offered the position and stated she did not view that this had impacted her ability to be objective and impartial and to decide the case on the evidence before her, however, she wanted to provide the parties an opportunity to advise if they had any concerns. It was clarified on the record that the Hearing Tribunal had not yet started its deliberations. As well, it was noted that if the Chair recused herself, the HPA provided that the remaining Hearing Tribunal members could still complete the hearing, by deliberating and issuing a written decision.

The Registrant indicated that she did not have any concerns and could not see the potential for bias. Conduct Counsel advised that if the Registrant did not have concerns, the Complaints Director was prepared to proceed.

The Hearing Tribunal adjourned the hearing and indicated it would proceed with its deliberations.

ALLEGATIONS

The allegations in the Notices to Attend a Hearing are as follows:

While employed as a Registered Nurse ("**RN**") at [a hospital in Edmonton AB].

First Amended Notice to Attend a Hearing ("First Notice to Attend"):

1. On or about July 20, 2018, the Registrant failed to provide compassionate care to [Patient Witness 1] post-[treatment], when, after [Patient Witness 1] requested help for her headache, the Registrant told her to ask someone else.

2. On or about August 5, 2018, the Registrant:

a. failed to properly prepare [Patient Witness 2's] [treatment] machine and prematurely commenced [Patient Witness 2's] [treatment], which resulted in [Patient Witness 2] losing an unanticipated amount of blood;

b. disposed of [Patient Witness 2's] blood that had been pulled into the lines of [Patient Witness 2's] [treatment] machine, without consulting with one or more of their colleagues to see if disposal was the only option;

c. failed to do or document an adequate assessment of [Patient Witness 2] following the blood loss; and

d. failed to adequately document the incident including [Patient Witness 2's] blood loss on the [Treatment] Log, or elsewhere.

3. On or about August 30, 2018, the Registrant inappropriately expressed personal opinions about indigenous persons in the presence of patients which caused distress to [Patient Witness 3].

4. On or about January 4, 2019, the Registrant engaged in unprofessional behaviour when they inappropriately confronted [Patient Witness 1] during active [treatment] about the complaint she made to the Registrant's Unit Manager arising from a July 20, 2018 incident.

Second Notice to Attend a Hearing ("Second Notice to Attend"):

1. On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment when they failed to appropriately prime [Patient 4's] [treatment] machine, contrary to the Canadian Nurses Association Code of Ethics (2017) ("CNACE") and the Practice Standards for Regulated Members (2013) ("CPSRM").

2. On January 9, 2020, the Registrant failed to accurately document their patient care for [Patient 4], specifically regarding their troubleshooting and priming of a [treatment] machine, contrary to the CNACE, the CPSRM, the Documentation Standards for Regulated Members (2013) ("CDSRM") and applicable Alberta Health Services policies ("AHS policies").

3. On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment and failed to use appropriate information to enhance patient care and the achievement of desired patient outcomes when they tried to initiate [Patient 4] [treatment] before the [treatment] machine was properly primed, contrary to the CNACE, the CPSRM and AHS policies.

4. On January 15, 2020, the Registrant failed to demonstrate adequate clinical judgment when they drew blood from [Patient 5] and sent the blood to the lab for testing, without a physician's order to do so, contrary to the CNACE and the CPSRM.

EVIDENCE

The following documents were entered as Exhibits:

Exhibit #1 – Notices to Attend a Hearing by the Hearing Tribunal of the College

Exhibit #2 –[Patient Witness 1] Email dated August 27, 2018 (Redacted)

Exhibit #3 – Appendix K –[LPN Witness] Email dated September 3, 2018 (Redacted)

Exhibit #4 – Appendix C –[Treatment] Nurse Job Description (Redacted)

Exhibit #5 – Appendix D –[Treatment] Orientation (Redacted)

Exhibit #6 – Appendix B1 – Complaint October 4, 2018 (Redacted)

Exhibit #7 – Appendix G (Unredacted) –[Treatment] Log

Exhibit #8 – Appendix L (Unredacted) – Chart of [Patient Witness 2]

Exhibit #9 – Appendix M – [RN Witness 2] Notes [Patient Witness 3] Complaint (Redacted)

Exhibit #10 – Appendix B2 – Complaint March 22, 2019 (Redacted)

Exhibit #11 – Appendix N –[RN Witness 2's] Notes Incident January 4, 2019 (Redacted)

Exhibit #12 – Exhibit A (From Tina Fodor) – Letter of Warning dated July 14, 2016

Exhibit #13 – Exhibit J – [Treatment Machine 1] Formula Orientation Manual (Redacted)

Exhibit #14 – Appendix H – [Patient 4] Medical Record

Exhibit #15 – Complaint February 28, 2020

Exhibit #16 – Appendix F – Email from [RN Witness 6] to [RN Witness 4] January 9, 2020

Exhibit #17 – Appendix J – BMT Email Re BBox (Redacted)

Exhibit #18 – Appendix G – TMS – AKC – Apheresis – HD – PPD - Management – Troubleshooting (Redacted)

Exhibit #19 – Appendix I – Copy of BBox (Redacted)

Exhibit #20 – Appendix Q – [Patient 5] Medical Record

Exhibit #21 – Appendix R – Assignment Sheet, Yellow Board 15 Jan 2020

Exhibit #22 – Affidavit of [RN Co-worker 2], sworn September 28, 2020

Exhibit #23 – Alberta Health Services Code of Conduct

Exhibit #24 – Appendix I - Alberta Health Services Code of Conduct

The following individuals were called as witnesses:

[Patient Witness 1]
[RN Witness 1]
[LPN Witness]
[Patient Witness 3]
[RN Witness 2]
[RN Witness 3]
[Patient Witness 2]
[RN Witness 4]
[RN Witness 5]
[RN Witness 6]
Tina Fodor

The following is a summary of the evidence given by each witness:

[Patient Witness 1]

[Patient Witness 1] is a [treatment] patient and has required [treatment] for over 20 years. She currently attends [treatment], for three hours per treatment. In 2018, she attended [treatment] at [Unit] at [a hospital in Edmonton AB] (the "**Unit**") where the Registrant worked.

[Patient Witness 1] described that patients spend so much time in treatment that the doctors, nurses and patients become like a family. [Patient Witness 1] described the [treatment] and the treatment area of [Unit]. The treatment area is quite open with eighteen individual treatment areas, divided by curtains. You can see and hear quite well.

The nurses work in a buddy system. Two nurses have six patients. One nurse will put three patients on their [treatment] machine while the other nurse puts the other three patients on their [treatment] machine, then the nurses will go and check each other's work. They check the machines, the medication and that everything is as the doctor has ordered. The buddy system was in place in the summer of 2018.

[Patient Witness 1] noted that [treatment] patients are often symptomatic, including low blood pressure, being uncomfortable, and headaches. It is very common for nurses to give Tylenol for a headache if a patient needs it. It is not unusual for [Patient Witness 1] to get symptoms, including headaches. She also receives an antibiotic following the [treatment] run after she is off the [treatment] machine, which is received through an IV. The IV is connected to an IV pole, so she is able to walk around with the IV pole. She is still under a nurse's care at that point because she is receiving this medication.

In 2018, the Registrant was not frequently [Patient Witness 1's] nurse. The nurses rotated and it was sporadic. [Patient Witness 1] indicated she really liked the Registrant and believed the feeling was mutual. They were very friendly. However, [Patient Witness 1] noticed a change in the Registrant's attitude and the Registrant became less friendly and a little bit cold. [Patient

Witness 1] described being aware of things going on in the Registrant's personal life and hearing concerns from other patients and so she decided to "step up" with her complaint.

[Patient Witness 1] described an incident in July 2018 when she asked the Registrant for a couple of Tylenols for a headache. [Patient Witness 1] was done the [treatment] and was hooked up to the IV getting her antibiotic. The Registrant told her that she was technically done [treatment] so she could not give her Tylenol, but if the charge nurse was okay with giving her Tylenol, then it was fine. [Patient Witness 1] then confirmed what the Registrant said. [Patient Witness 1] said "if charge is okay with giving me Tylenol, you will give me the Tylenol" and the Registrant said, "no, if charge is okay with giving you Tylenol, then charge can give you Tylenol." [Patient Witness 1] did not understand this and thought it was bizarre.

[Patient Witness 1] said there had been many incidents by this time with the Registrant and the Registrant's personality had changed, so she decided not to argue. The charge nurse, [RN Witness 1], was standing a few feet away with the Registrant's buddy, [RN Co-worker 2]. [Patient Witness 1] started to ask [RN Witness 1] for the Tylenol and she did not even finish the sentence, [RN Witness 1] said "yes, [RN Co-worker 2] will get you your Tylenol." [Patient Witness 1's] evidence was that [RN Witness 1] and [RN Co-worker 2] had overheard everything. [RN Co-worker 2] gave her two Tylenols. [Patient Witness 1] did not recall [RN Co-worker 2's] last name, but knew she was the Registrant's buddy.

[Patient Witness 1] could not make any sense of why she was refused. She noted that the giving of Tylenol was not an issue. It was not against doctor's orders and is very common. She has never experienced a similar response from another nurse in the past. [Patient Witness 1] stated she has also been given Gravol after [treatment] if she feels nauseous.

[Patient Witness 1] stated this was another example of the Registrant being less friendly, becoming more cold and it felt like another rejection. Because there had been other incidents, she decided to report to the Unit Manager, [RN Witness 2]. [RN Witness 2] asked [Patient Witness 1] to put the incident in writing. [Patient Witness 1] was apprehensive of doing this and felt intimidated and nervous. [RN Witness 2] assured her that the Registrant would not be assigned to her. [Patient Witness 1] wrote an email on August 27, 2018 describing the incident (Exhibit 2). [Patient Witness 1] stated she felt uncomfortable, intimidated, scared, reluctant and hesitant getting [treatment] after that.

Months later, the Registrant approached her while she was getting [treatment]. Her nurse had put her on the [treatment] machine and went for a break. The Registrant approached her, swung the curtain around them and knelt down beside her and said that she did not know why [Patient Witness 1] felt the need to go to [RN Witness 2] about the Tylenol but the Registrant wanted her to know that she knew. The Registrant also told her that someone from the College would be contacting her.

[Patient Witness 1] noted she felt scared or guilty and asked the Registrant what she wanted her to tell them. The Registrant said "just tell your side of the story" and that she would leave it up to her but to "just tell them what happened." She then opened the curtains and walked away. [Patient Witness 1] felt intimated and threatened.

[Patient Witness 1] told [RN Witness 2] about the interaction and [RN Witness 2] was very apologetic and told her this is a form of bullying and an intimidation tactic. [Patient Witness 1] never had the Registrant as her nurse again but described that it became even more awkward to attend for [treatment].

Cross-Examination

[Patient Witness 1] was asked if she recalled the Registrant saying she was walking on eggshells at the time of the Tylenol incident. [Patient Witness 1] did not recall this. [Patient Witness 1] did not recall being tearful or crying. [Patient Witness 1] did not know if the Registrant was under a time constraint at the time.

[Patient Witness 1] had to leave the hearing for a [treatment] appointment. She returned the next day, so the cross-examination could be completed and the Hearing Tribunal could ask questions.

Upon reconvening, the Registrant indicated she had no further questions for [Patient Witness 1].

Re-examination

[Patient Witness 1] confirmed the reason that the Registrant gave her for not giving her Tylenol was that “technically you are done [treatment].”

Questions from the Hearing Tribunal

[Patient Witness 1] confirmed that she had a standing order for Tylenol. [Patient Witness 1] also confirmed another incident where the Registrant had told her she could not help her because she was the charge nurse at the time. She did note there are times where a nurse has her hands full, for example, with setting up the [treatment machine] and will ask another nurse for help. She has never been told by another assigned nurse to go ask somebody else for help.

[RN Witness 1]

[RN Witness 1] has been a Registered Nurse since 1987. In 2018, she worked on [Unit] as a [treatment] nurse. At times, she was also charge nurse. [RN Witness 1] described [Patient Witness 1] as funny, kind, thoughtful and personable. She speaks her mind and is not afraid to ask questions, especially about her health.

[RN Witness 1] recalled the incident in the summer of 2018 when [Patient Witness 1] asked for the Tylenol. [RN Witness 1] was the charge nurse. [Patient Witness 1] would have been coming off her [treatment] around approximately 4:30 p.m. and received an antibiotic post-[treatment]. [Patient Witness 1] came to [RN Witness 1] and told her she had requested Tylenol from her nurse, the Registrant, who had refused her. [Patient Witness 1] did not understand why she was being refused. [RN Witness 1] stated that she was still under their care, because they were administering an antibiotic and that entitled [Patient Witness 1] to any of her standing medications, which included Tylenol.

It is not unusual for a patient to ask for Tylenol during or after [treatment]. The standard practice for the nurse is to confirm it is the correct patient, correct dosage and whether the patient has already received Tylenol (which has a standing order as needed every four hours).

The incident occurred during changeover time, which is very busy. There is a group of 18 patients coming off [treatment] and another 18 patients who are beginning their [treatment]. [RN Witness 1] asked [Patient Witness 1] if she had already received Tylenol. [RN Witness 1] noted

that is all she did and then she was on her way. She later came by to see [Patient Witness 1] who told her that [RN Co-worker 2] had given her the Tylenol.

[RN Witness 1] indicated she was not surprised to hear about this incident because this type of action was not unusual for the Registrant.

Cross-Examination

At the time of the incident, [RN Witness 1] was doing the rounds, making sure patients were coming off [treatment] on time, and checking to see if any of the nursing staff needed assistance. She was walking past where [Patient Witness 1] was, close to her chair, and [Patient Witness 1] stopped her. [RN Witness 1] indicated she did not have a conversation with [RN Co-worker 2]. [RN Witness 1] denied telling [Patient Witness 1] to get the Tylenol from [RN Co-worker 2].

[RN Witness 1] recalled [Patient Witness 1] having an IV pole and being distressed about not being given Tylenol when she had requested it. [Patient Witness 1] told her that the Registrant had refused the Tylenol because she was no longer on [treatment].

[RN Witness 1] stated it would take one to two minutes to administer Tylenol, including doing the checks, retrieving the Tylenol and providing it to the patient.

Re-Examination

[Patient Witness 1] was standing when she spoke to [RN Witness 1].

Questions from the Hearing Tribunal

The time of changeover of patients is very busy and nurses will ask each other for assistance. There is no time that is more appropriate than another to ask for assistance. There is no exact protocol for when the patient assignment ends, however, when the patient leaves the Unit, they have completed their care.

In this specific case, if the Registrant was too busy, it would be appropriate for her to ask the patient to wait for a few minutes and for the Registrant to then go ask the charge nurse for help rather than communicating to the patient to go ask another nurse.

[LPN Witness]

[LPN Witness] is a Licensed Practical Nurse. She worked on [Unit] in the summer of 2018 with the Registrant. [LPN Witness] sent an email to [RN Witness 2], Unit Manager, on September 3, 2018 (Exhibit 3).

[LPN Witness] described the incident from August 5, 2018 that prompted her to send the email. She was reviewing the treatment and medications for [Patient Witness 2] and noticed one of the medications was scheduled every single run, which is much more than the maximum dose that would be administered on a regular basis. She asked the patient if he was aware he was on such a high dose and he said, yes. [Patient information redacted].

[LPN Witness] asked the patient when the incident took place and then she looked at the service log, as there is a protocol to follow once blood loss occurs. There was no documentation

indicating what had happened. There was nothing recorded in the paper charting (i.e. the progress notes and [Treatment] Log). There was nothing recorded in the electronic charting system, called the [Information System]. The paper charting documented what happened during the treatment, but contained no reference to what had happened before the treatment. There was no mention of the blood loss. The blood loss would be considered a significant event and should have been documented on the paper charting or [Information System].

[LPN Witness] gave evidence about potential health impacts from decreased hemoglobin. [LPN Witness] stated she had never seen a patient lose blood through this sort of incident. She has never seen treatment be forced when the machine was not ready. She found the incident very unusual and decided to write an email to [RN Witness 2] (Exhibit 3). As a result of the email, she was called into a human resource meeting to give more details about the incident.

[LPN Witness] also explained the Report and Learn System ("**RLS**") and noted that every significant event must be reported to the manager and hopefully they learn from it. The reporting on the RLS must be done the same day. She discovered the incident months later, so could not access it or report it herself.

[LPN Witness] noted that a significant event such as this one should be documented in the paper charting and the [Information System] and also reported in the RLS.

Cross-Examination

The Registrant indicated she had no questions in cross-examination.

Questions from the Hearing Tribunal

[LPN Witness] clarified that there was an unsuccessful run on the date in question, which was followed up by a second run that was successful. The patient was assigned to another nurse that day named [RN Co-Worker] and [RN Co-Worker] provided successful treatment.

[LPN Witness] also noted that she spoke to [RN Co-worker 2], who was charge nurse on the day of the incident, and she was not aware of the incident.

The Registrant asked some questions of [LPN Witness] arising from the Hearing Tribunal's questions. [LPN Witness] was unsure what drop in blood requires the nurse to contact the doctor in accordance with the anemia protocol. [LPN Witness] also confirmed that [Patient Witness 2] was not her primary patient.

<u>[Patient Witness 3]</u>

[Patient Witness 3] was a [treatment] patient on [Unit] in 2018. The Registrant was his nurse at times on [Unit].

[Patient Witness 3] recalled an incident in the summer of 2018 involving the Registrant. He testified he remembered the incident quite clearly. He was sitting in his chair getting [treatment] as usual. The Registrant was not his nurse that day, but was with a patient in the next chair over from him. He could hear their conversation clearly and see them as the curtains were open. The patient next to him was watching television, where there was coverage of the pipeline protests. The patient was making comments about it. The Registrant made comments about Indigenous people saying "they don't own the rivers, the creeks and the trees" and "if you give them money,

all they want is more money." [Patient Witness 3] spoke up and said he did not like what they were talking about. His nurse came by about five minutes later and he asked to speak to the floor manager. His nurse told him he could go see the floor manager, [RN Witness 2], when he was done. He went to [RN Witness 2's] office that day and she took a statement from him.

[Patient Witness 3] is Indigenous. The Registrant's comments hurt his feelings. He stated that being in [treatment] for such a long time, you get to know everyone well and you are like a big family. To hear those comments from a professional was very upsetting. He stated the Registrant looked at him with a smirk on her face, like she did not care and this really upset him.

Before the incident, he had a good relationship with the Registrant but afterward he did not care to say anything to her and did not speak to her.

Cross-Examination

The Registrant acknowledged that [Patient Witness 3] was very upset that day and during the hearing she apologized for offending him.

[Patient Witness 3] noted that the Registrant was speaking to the other patient, not to him directly. The Registrant suggested to [Patient Witness 3] that he misunderstood her comments, which he denied.

The Hearing Tribunal had no questions for [Patient Witness 3].

[RN Witness 2]

[RN Witness 2] has been a Registered Nurse since 1989. She was the Unit Manager of [Unit] for a period of four years, starting in November 2015 and the Registrant was one of her direct reports. [RN Witness 2] and the Registrant were both [treatment] nurses together prior to 2015.

[RN Witness 2] believes the Registrant started on [Unit] in 2005. [RN Witness 2] outlined the orientation that takes place when a nurse is hired on [Unit], which she described as fairly rigorous. The Job Description of a [Treatment] Nurse and Orientation Guide were entered into evidence as Exhibits 4 and 5. [RN Witness 2] also outlined the ongoing continuing education that is required and ongoing professional development that occurs. There are also Clinical Nurse Educators ("**CNE**") on the Unit.

There are two or three different types of machines on [Unit]. During 2018, there were the [Treatment Machine 1] and [Treatment Machine 2] machines and she believed there were the [Treatment Machine 3] machines as well. When a new machine is brought on the Unit, nurses are trained for two full days. There is often a company representative present and the CNE team. There is an assessment for proficiency on the new machine. There are also biomedical engineers on staff that help with the machines throughout the day. If a machine is malfunctioning, it will be pulled and a different one will be used.

[RN Witness 2] gave evidence of charting and documentation systems used on [Unit] in 2018. There was a combination of paper charting (the [Treatment] Log, also referred to as a run sheet) and electronic charting (the [Information System]). The [Treatment Log] indicates the pre-assessment, post-assessment and patient checks while the patient is on the [treatment] machine. Medications are recorded in the Medication Administration Record and would also be

listed in the [Information System]. If there is any sort of incident during the [treatment] run, it would be noted in the [Information System].

The [Information System] was the legal record of care at the time. There is an audit trail for the [Information System] if someone goes in and changes information. If there are error corrections or amendments, they can be removed from view, but will always be in the background and can be retrieved.

[RN Witness 2] also described the RLS, which is a voluntary system and can be anonymous. It is a system to record incidents and is meant as an operational system for looking at trends and guiding policy, practice changes and improvements to patient safety.

[RN Witness 2] reviewed the complaint to the College (Exhibit 6).

[RN Witness 2] also described her interaction with [Patient Witness 1] on July 20, 2018. [Patient Witness 1] told her she had her [Patient information redacted], she was receiving an IV antibiotic and she was wandering around the Unit. She found the Registrant and asked her if she could get some Tylenol for a headache. The Registrant told her that she could not give her that kind of care because technically she was not on [treatment] anymore and told her that if she wanted Tylenol she would have to ask a different nurse or the charge nurse. [RN Witness 2] asked [Patient Witness 1] to write down the event as well and [Patient Witness 1] sent her an email describing the event (Exhibit 2).

[RN Witness 2] reached out to the human resources advisor for advice and to advise she wanted to file a complaint. The complaint was investigated and [RN Witness 2] conducted interviews. [RN Witness 2] noted that the Registrant stated in the interviews that because she had taken the patient off [treatment], she was unsure if she was allowed to give Tylenol. [RN Witness 2] did not think this explanation made sense since the patient was still definitely in the Unit's care as she was attached to an IV. Unless the patient had just been given Tylenol or unless the Registrant was busy hands-on with another patient, [RN Witness 2] could not think of any other reason for not providing Tylenol to the patient. [Patient Witness 1] had a standing order for Tylenol. [RN Witness 2] did not recall a reference to this happening during changeover time when the Unit was busy.

[RN Witness 2] confirmed from the chart that the Registrant was the nurse who put [Patient Witness 1] on [treatment]. She could not tell which nurse took her off [treatment]. There was a buddy system of two nurses to six patients. It was fluid and the nurses could organize between them how to put patients on [treatment].

[RN Witness 2] was asked about the incident on August 5, 2018. [RN Witness 2] learned of this incident from an email from [LPN Witness] (Exhibit 3). There was an investigation of this incident and again [RN Witness 2's] role was to ask questions. [RN Witness 2] also reviewed the [Treatment] Log and [Information System] for that particular date. [RN Witness 2] identified the [Treatment] Log for the patient (Exhibit 8). The [Treatment] Log confirms another nurse, [RN Co-Worker], started the run and took the patient off the machine. The [Treatment] Log does not show that there was an aborted run. An aborted run would be expected to be documented.

[RN Witness 2] confirmed there should also have been a report to the charge nurse and documentation on the [Information System]. [RN Witness 2] confirmed she checked the [Information System] as part of the investigation. There was no charting in the [Information System] or progress notes indicating a blood loss incident.

[RN Witness 2] noted that it is not unusual [information redacted], although they try to prevent it. In such a case, the nurse should chart that they advised the charge nurse, should check the patient's most recent hemoglobin, should consider whether to notify the physician [information redacted].

[RN Witness 2] testified that she would not expect documentation of having asked for troubleshooting help, as it is such a common occurrence.

[RN Witness 2] could not recall the particulars of the interview with the Registrant but did note that the Registrant acknowledged the blood loss incident of August 5, 2018. The Registrant had hooked up the patient a little prematurely. [RN Witness 2] noted that it is not very common, but it does happen. [Patient information redacted]. [RN Witness 2] noted that this is something that can happen, but the big concern for her was the lack of documentation. [RN Witness 2] noted that the fact the Registrant did not discuss the incident with the charge nurse or enter an alert to do a hemoglobin pre-[treatment] on the next run indicated that an assessment was not done.

[RN Witness 2] was asked about the incident involving [Patient Witness 3] on August 30, 2018. [Patient Witness 3] reported the incident to her. He was very angry and visibly shaken. [RN Witness 2] made notes of the meeting (Exhibit 9). [RN Witness 2] reached out to the human resources advisor and filed a complaint. She was again in the role of asking questions during the investigation. [RN Witness 2] noted that during the interview, the Registrant stated she could not recall making the comments.

[RN Witness 2] was asked about the incident on January 4, 2019. The Registrant entered [Patient Witness 1's] treatment area, closed the curtain and notified her that due to the previous complaint she had received a suspension. [RN Witness 2] learned of this when [Patient Witness 1] came to her office to tell her. [RN Witness 2] was shocked, apologized to [Patient Witness 1] and told her they would take it seriously. [RN Witness 2] filed a complaint. [RN Witness 2] notes of her discussion with [Patient Witness 1] were entered as an exhibit (Exhibit 11).

[RN Witness 2] confirmed that during the verbal portion of an interview in the investigation process, the person is told at the beginning that matters must be kept confidential and they are reminded again about the confidentiality at the end of the interview.

[RN Witness 2] stated that the Registrant suggested in the interview that because she knew [Patient Witness 1] so well that it would be fine. She did not seem to think it was an issue that she had spoken to [Patient Witness 1] alone like that. [RN Witness 2] stated that the Registrant was very defensive to all the allegations.

Cross-Examination

[RN Witness 2] was asked to describe her role as Unit Manager. She noted that formal performance evaluations were not done annually. [RN Witness 2] was asked about a letter of warning dated July 14, 2016 (Exhibit 12) arising from allegations that the Registrant was intoxicated during a CPR course. The Registrant suggested that the allegation at the time was ludicrous and that it took three weeks after the incident for a complaint to be made. [RN Witness 2] indicated she did not have a good recollection of the incident.

Re-Examination

[RN Witness 2] was asked to clarify the allegation from 2016. She believed that the result of the human resources investigation was that the Registrant was disrespectful during the CPR class.

Questions from the Hearing Tribunal

[RN Witness 2] clarified that changing a [treatment] machine is common, as is losing the blood for one reason or another. Hooking up the patient too early when the machine is not ready is not as common, but it does happen. It is a human error and human error cannot be taken out of the equation at all times.

[RN Witness 2] noted that she did not speak to [RN Co-worker] about the incident of August 5, 2018, as he was out of the country at the time. She did not question the Registrant about how she disposed of the blood lines or her preparation for the run.

[RN Witness 3]

[RN Witness 3] has been a Registered Nurse since 1982. [RN Witness 3] was a CNE in [treatment] from 1995 to 1999 and from 2002 to 2020. A CNE does orientation for nurses and educates service workers and nurses. Nurses are oriented to preparation of a [treatment] machine, programming, monitoring patients, assessing patients pre, during and post-[treatment] and troubleshooting equipment. [RN Witness 3] gave detailed evidence regarding the orientation and training for nurses on [treatment] machines.

On [Unit] from 2017 to 2019, the [treatment] machines were the [Treatment Machine 1] , the [Treatment Machine 3] and the [Treatment Machine 2]. There are manuals for the machines, including troubleshooting and orientation manuals (Exhibit 13).

[RN Witness 3] gave detailed evidence regarding preparing the [treatment] machines and the [treatment] process. The newer machines such as the [Treatment Machine 3] are very sophisticated and computerized. The instructions are spelled out on the screen.

[RN Witness 3] provided information regarding the [Treatment Machine 1] and noted that it is clear when the machine is done priming. There is also a help key. You can push the help key at any time and it will tell you what alarm you have currently, the things that could have caused it and how to go about rectifying it. The [Treatment Machine 3] has the help key as well. [RN Witness 3] believed the [Treatment Machine 2] had it as well, but they had those machines only briefly.

[RN Witness 3] was asked what happens if a patient is hooked up before priming is complete. [Patient information redacted].

[RN Witness 3] testified about an incident in January 2020 when the Registrant asked for her assistance. The Registrant approached her and asked for advice on a machine situation. She went with the Registrant. [RN Witness 3] looked at the machine, and believes it was an [Treatment Machine 3] machine. [Information redacted]. The patient was not in any distress. [RN Witness 3] believes she advised the Registrant to [Information redacted], scrap the used supplies, get new ones, set up again and hook the patient up again.

[RN Witness 3] was asked to review the [Treatment] Log for the incident. The [treatment] started at 18:00 and resumed at 18:50. The patient lost 55 minutes of treatment. [RN Witness 3] reviewed the [Information System] note. [RN Witness 3] noted it looked like the machine had been completely prepared and was ready to go when the patient was hooked up but the [information redacted] was inadvertently selected in error instead of the resume treatment button. [Patient information redacted] so the patient was moved to another machine. [Patient information redacted]. The patient's record was entered as an exhibit (Exhibit 14).

[RN Witness 3] noted that it would be unusual to put a patient on a [treatment] machine before it is finished priming. [RN Witness 3] stated again that there are no adverse effects for the patient, except that they are putting in time but no treatment is happening.

The patient's treatment was ordered for four hours, but he had two and a half hours of treatment given the issues. He could have stayed for the four hours if that was needed as there is always a nurse on call for emergencies.

[RN Witness 3] stated the paper charting for the incident was a bit vague but the [Information System] showed her what had occurred. She stated that the details are in the [Information System] log.

Cross-Examination

The Registrant suggested to [RN Witness 3] that the machine was an [Treatment Machine 3] machine. The Registrant could not get the patient connected. The Registrant identified that the patient was not getting [treatment], [Patient information redacted].

[RN Witness 3] was asked questions regarding the Canadian Nurses Association [Certification] but could not confirm the percentage of [nurses] who have this certification.

There were no questions in re-examination and the Hearing Tribunal had no questions for [RN Witness 3]

<u>[Patient Witness 2]</u>

[Patient Witness 2] was a [treatment] patient on [Unit] for approximately one and a half years. The Registrant was his nurse from time to time. [Patient Witness 2] was asked about an incident in the summer of 2018. He stated that he believes he was hooked up to the machine a little early. [Patient information redacted]. He took medication but that was something he did with every run. He does not know if he was temporarily removed from the [medical procedure] list.

[Patient Witness 2] noted he did not make a complaint and did not think it was a big issue. He noted the Registrant has always been a good nurse to him.

Cross-Examination

The Registrant asked if [Patient Witness 2] remembered the first time she was his nurse. [Patient Witness 2] noted he could not remember.

Questions from the Hearing Tribunal

[Patient Witness 2] [Patient information redacted]

[RN Witness 4]

[RN Witness 4] has been a Registered Nurse in Canada since 2004. He was a nurse in the Philippines previously. He first met the Registrant in 2011 on [Unit] and was the temporary Unit Manager from November 2019 until May 2021.

[RN Witness 4] made a complaint to the College relating to incidents that occurred on January 9 and 10, 2020 (Exhibit 15).

[RN Witness 4] received an email from [RN Witness 6] who brought to his attention the incident that happened on January 9, 2020 (Exhibit 16). [RN Witness 6's] email indicated this was a patient safety issue. [RN Witness 4] took steps to investigate the matter. He confirmed that the Registrant was assigned to the patient. He reviewed the [Treatment] Log and the progress notes in the [Information System]. He pulled out the machine black box of the second machine that the patient was on. He emailed [AHS Co-worker], an Alberta Health Services biomedical technologist and asked that the black box be run and a summary of the assessment prepared. [AHS Co-worker] sent the black box to the manufacturer where the black box was interpreted. [RN Witness 4] received an email from [AHS Co-worker] attaching the report from the black box.

[RN Witness 4] confirmed his understanding that the patient's lines were reversed, [Information redacted], the patient was switched to another machine. At that time, there was a message at 1910 of prime not complete. This was the machine that the black box was pulled from.

[RN Witness 4] indicated that based on the charting, the troubleshooting steps had not taken place in accordance with the practice direction. While not every step needs to be documented, he would expect a notation that there was management in accordance with the protocol and that it was not effective. He stated he would chart the assessment and something to the effect of "management on CVC troubleshooting PPD as per protocol followed, nothing was effective."

[RN Witness 4] reviewed the email from the biomedical technologist (Exhibit 17) and the charting (Exhibit 14).

The patient was first hooked up to [treatment] at about 1840. Approximately 5 minutes later, there is documentation [information redacted]. [RN Witness 4] believes there was a pressure alarm that caused the Registrant to reverse the [information redacted]. As part of the investigation, [RN Witness 4] determined that the Registrant [information redacted]. Once confirmed, there is no way to go back and resume [treatment]. [Information redacted].

At 1850, the Registrant moved the patient to another machine, which is the machine that had the black box interpreted. The machine was set up at 1856. The priming began at 1908 for a total of 8.8 minutes. So at 1850, the patient was connected to a machine that had not been properly primed. The priming did not begin until 1908. At 1910, based on the Registrant's charting, there was a message that came up that the prime was not completed. [Information redacted]. [RN Witness 4] noted this was a patient safety issue [information redacted].

[RN Witness 4] stated that the information available to him confirmed that the Registrant tried to initiate the treatment before the machine was properly primed. [Information redacted]. The prime was completed at 1917 and then extra prime completed at 1918 and the patient was connected at 1925. In looking at the charting, at 1920 a new setup was done and the Registrant initiated the treatment. The third attempt went smoothly. The patient only received about 3 hours and 5

minutes rather than the prescribed 4 hours. [RN Witness 4] noted there can be some medical side effects from this.

The email from the biomedical technologist had an attached excel spreadsheet with the black box information. [RN Witness 4] acknowledged that he was not sure what the columns were and that was why he asked to have the data analyzed. Ms. Fodor objected to the black box spreadsheet being marked as an exhibit on the basis that [RN Witness 4] is not a biomedical technologist. The Hearing Tribunal determined it would mark it as an exhibit and then determine the weight to place on it (Exhibit 19).

[RN Witness 4] noted that the investigation showed that the Registrant was not accepting the mistakes or showing self-reflection regarding this incident.

[RN Witness 4] was asked to give evidence about an incident on January 15, 2020. A staff member brought to his attention that the Registrant had collected blood work from a patient where there was no order for blood work on that day. He reviewed the documentation, charting, doctor's orders and he found there was no doctor's order for blood work. There was nothing in the [Information System] to indicate blood work was to be done. The patient chart did indicate that blood work was completed and initialed by the Registrant (Exhibit 20). The patient assignment sheet was reviewed, which had no indication of a doctor's order (Exhibit 21). [RN Witness 4] stated that if it was an honest mistake it should be acknowledged but the Registrant would not admit to the mistake during the investigation process.

Cross-Examination

[RN Witness 4] was asked about the Registrant's termination from employment and the human resources investigation into the complaints. [RN Witness 4] was asked about the RLS system and [RN Witness 4] confirmed the manager receives an RLS report in the form of an email. [RN Witness 4] acknowledged he was not present during the incident on January 9, 2020. [RN Witness 4] was asked how troubleshooting could be an error.

Re-Examination

[RN Witness 4] confirmed that troubleshooting the [treatment] machine is not an error.

Questions from the Hearing Tribunal

[RN Witness 4] was asked how time is documented on the [Treatment] Log. Nurses can use their own clock or the clock on the Unit. [RN Witness 4] confirmed that the log was from the [Treatment Machine 3] machine only. [Patient information redacted].

[RN Witness 4] confirmed the incident on January 9, 2020. The patient was on the first machine, which was primed correctly, but the wrong button was hit and [Information redacted]. The patient was hooked to a second machine, where something occurred and the [information redacted] to the patient and then on the same machine there was a successful third run. The black box analysis came from the second machine.

[RN Witness 5]

[RN Witness 5] has been a Registered Nurse since 1994. She has worked on [Unit] since 2009. She recalled an incident in early January 2020 where she overheard a conversation and went to see if she could help. [Patient information redacted]. The Registrant had approached a service worker, who set up the machines. [RN Witness 5] observed a message on the machine, which indicated “priming in progress”. The machine was an [Treatment Machine 3]. [Information redacted].

[RN Witness 5] indicated she tried to see if there was something under special procedures in trying to troubleshoot. She went to talk to the charge nurse, [RN Witness 6], who came and all three of them tried to troubleshoot. They were unable to troubleshoot and so the patient was started on another machine and the [treatment] run proceeded smoothly as far as she is aware.

Cross-Examination

The Registrant indicated she had no questions in cross-examination.

Questions from the Hearing Tribunal

[RN Witness 5] did not recall anyone else coming into the room and only remembers the Registrant, herself and [RN Witness 6] trying to troubleshoot. She noted that she left the room at one point so there might have been someone else present during that time.

[RN Witness 6]

[RN Witness 6] has been a Registered Nurse for 28 years. She has worked on [Unit] for approximately four years.

[RN Witness 6] confirmed she sent an email to [RN Witness 4] on January 9, 2020 regarding an incident that day. [RN Witness 6] noted her recollection was not 100 percent, but that she does remember [RN Witness 5] coming to her and telling her there was a problem with the machine. She went over, the patient was hooked up and the machine indicated “priming in progress”. They were trying to figure out how that could have happened.

[RN Witness 3] came over at one point. The Registrant was trying to fix the machine, but was not listening or did not appear to be listening to what [RN Witness 3] was explaining to her. She was tapping her pen on the machine, trying to do a cassette repositioning but [RN Witness 3] was trying to explain to her why that would not work. [Information redacted]. The machine was re-primed and the run was completed, although it was a shortened run. The Registrant was flustered and a little defensive.

Typically, a patient is not hooked up to a machine before the priming process is completed. There is a message on the machine to indicate that the priming process is done.

[RN Witness 6] decided to write the email as she viewed this as a patient safety issue. She viewed that while mistakes happen, it seemed to her that the Registrant was not willing to own the mistake or learn from it, which can lead to patient safety issues.

Cross-Examination

[RN Witness 6] confirmed that when the Registrant was tapping the screen, she was using the touch screen. [RN Witness 6] stated she could not recall if the patient was or was not in [treatment] mode at that time.

The Hearing Tribunal did not have any questions of the witness.

Affidavit of [RN Co-worker 2]

The Affidavit of [RN Co-worker 2] was entered as Exhibit 22. The Affidavit addresses the incident with [Patient Witness 1] on July 20, 2018.

The Registrant indicated she did not object to the Affidavit, except to note that the reference to the incident occurring at 3 p.m. was a concern as the patient would have been in treatment [patient information redacted]. The patient would not be able to get up and walk around.

[RN Co-worker 2's] Affidavit indicates that she did not directly witness the interaction between the Registrant and [Patient Witness 1]. [Patient Witness 1] approached her just after her shift started around 3 p.m. and told [RN Co-worker 2] she had a headache and that the Registrant had refused to give her Tylenol because she was no longer the Registrant's patient. [Patient Witness 1] was attached to her IV and was walking around. She was upset and crying. [RN Co-worker 2] reviewed the [Treatment] Log, confirmed there was nothing written about the patient's headache or medication and after confirming the patient had not been given medication, gave her two Tylenol tablets.

[RN Co-worker 2] noted the Registrant watching her when she took the medication out of the drawer of the medication cart and when she gave the medication to [Patient Witness 1]. She recalled that the rest of the shift was very busy.

[RN Co-worker 2's] standard practice is to chart medication administration on the [Treatment] Log but she does not recall doing so in this case.

Tina Fodor

The Registrant graduated from the Grant MacEwan accelerated nursing diploma program in 2004. Most of her experience is in [treatment]. She worked on [Unit] starting in 2005. She noted that for many years on [Unit], there was no management.

The Registrant provided general comments regarding the allegations and then addressed each allegation separately.

With respect to the First Notice to Attend, the Registrant stated that she accepted the allegation as worded in Allegation 1. The Registrant noted that she had a hard time accepting the medication error because she did not feel like she gave the medication. There are many ways that she could have handled the situation differently, including [information redacted] she could have walked with [Patient Witness 1] to the charge nurse to ask her if she had time to get the Tylenol. If she had done that, she believes that [Patient Witness 1] would not have felt that there was a gap in her care or that the Registrant did not care that [Patient Witness 1] had a headache.

With respect to Allegation 2 in the First Notice to Attend, the Registrant noted that she disposed of the blood because the [treatment machine] was not properly rinsed. The Registrant acknowledged gaps in her charting, but stated she asked her Labour Relations Officer if they could access the RLS. She noted it is mandatory to do an RLS so it would have been helpful to have that.

The Registrant stated she fully accepted Allegation 3 in the First Notice to Attend. She noted she was still upset by about having upset the patient. She has learned from that incident that her personal opinions and views have nothing to do with nursing or caring for a patient. In the future, she will not express her personal opinions in any way because that has nothing to do with patient care.

The Registrant stated she accepted Allegation 4 in the First Notice to Attend. The Registrant stated that she did not discuss the complaint with [Patient Witness 1]. She mentioned it to identify it, saying, “I’m just giving you the heads up my college and association will be doing an investigation, so someone will probably be contacting you.” The Registrant denied telling [Patient Witness 1] she had received a suspension.

The Registrant then addressed the Second Notice to Attend. With respect to the incident on January 9, 2020, the Registrant stated the evening of January 9, 2020 was one of the busiest shifts she has had in her 16-year career. The Registrant noted that the first machine was human error. With the second machine, the patient was not receiving [treatment], they tried to troubleshoot, [information redacted] therefore the patient was not getting [treatment]. They needed to go to a third machine. With the third machine, he received his treatment safely, but did lose 55 minutes of his treatment time. [Information redacted].

She stated that she did not accept Allegation 2 in the Second Notice to Attend because there is evidence of documentation. There is charting on the run sheet and the [Information System] note. She also noted that the RLS was not able to be retrieved.

With respect to Allegation 4 in the Second Notice to Attend, the Registrant noted she accepted that allegation. She stated that she believed at the time that the order was in Alerts and also thought she had seen it on the yellow board and that is why she drew the tube of blood.

Cross-Examination

The Registrant confirmed she had no complaints in her career as a nurse until the complaints in 2018.

The Registrant had known [Patient Witness 1] for over 5 years. The Registrant believed they had a good rapport prior to the incident. [Patient Witness 1] is very knowledgeable about her care and her health. The Registrant noted that [treatment] patients in general are high needs. [Patient Witness 1] was a typical patient in terms of her needs.

The Registrant stated that when you are taking patients off the [treatment] machine, this is the busiest time on the Unit, generally speaking. The Registrant stated she asked [Patient Witness 1] if she could get her Tylenol from the charge nurse. She was moving to the next patient, as her patients had coming off times that were pretty close. She saw [Patient Witness 1] walk to the front of the Unit and speak to [RN Co-worker 2]. She saw [RN Co-worker 2] walk to the medication cart. [Information redacted].

The Registrant stated that she was apprehensive at the time, based on the culture of the Unit and she was afraid to make a mistake. She stated she knew that the Tylenol was a PRN and that there was a standing order. She understood that she could give her the medication, but [Patient Witness 1] felt there was a lack of care and that the Registrant just passed her onto the next nurse.

The Registrant does not believe she told [Patient Witness 1] that she was not her patient. She believes she said that she felt she was walking on eggshells and that she was a target. She noted that if she had given the Tylenol, she would have needed to have the charge nurse start [Patient information redacted] on her other patient. She stated that perhaps she was thinking out loud. She knew she could give her Tylenol. She was not trying to withhold medication from the patient nor did she have any malice towards the patient. She did direct [Patient Witness 1] to the charge nurse to receive the medication. She did not recall saying to [Patient Witness 1] that she was no longer her patient. The Registrant noted that it is known that they are their patients until they actually exit the Unit.

With respect to Allegation 2, the Registrant acknowledged that she failed to prime the [treatment] machine or allow the priming process to complete itself before putting the patient on it. She noted the patient had only been on a few minutes before she stopped the treatment. [Information redacted]. The Registrant stated she contacted the [medical procedure] people and the woman she spoke to had never heard of a drop of hemoglobin resulting in someone being removed from the [medical procedure] list.

She noted that her partner that day was [RN Co-Worker]. She stated that she did put a note in the [Information System] and also did an RLS and Alert for the CBC to be drawn next run. She acknowledged that there was no charting on the [Treatment] Log or the paper chart for the initial failed run. She stated that she documented it in the [Information System] and the RLS. She acknowledged there should have been an entry for the failed run on the [Treatment] Log. She did not document on the [Treatment] Log any steps that she took prior to hooking him up on the first machine or document the blood loss.

The Registrant stated that she made the decision herself to discard the blood. She did not consult with her colleagues before making this decision. [Information redacted].

With respect to Allegation 4, the Registrant denied closing the curtain roughly. She did crouch down beside [Patient Witness 1]. She did not discuss the details of the incident with [Patient Witness 1] but told her the College would be doing an investigation and that she would probably be getting a call. She denied saying anything to [Patient Witness 1] about receiving a suspension. She referenced the complaint to remind [Patient Witness 1] but they did not talk about the complaint. She did not believe she was breaking confidentiality by saying the College was going to contact her because they were doing an investigation. In hindsight and hearing from [Patient Witness 1], she acknowledged that it was not appropriate.

With respect to the allegations relating to January 9, 2020, the Registrant indicated that she could not remember the error message exactly. However, it looked like it was in bypass and that it was not providing ultrafiltration. She felt the patient was not going to receive adequate [treatment] on the machine. She asked a few people to take a look. [Information redacted].The Registrant stated that [AHS Co-Worker] had indicated during the human resources investigation that the black box was fine.

Re-Examination

The Registrant noted that [Unit] was a very difficult Unit to work on. There had been transition of staff for many years. She also indicated that the lack of management led to a general lack of respect for the Unit. Some people worked well as a team, but when she asked, it never seemed like teamwork.

One of the proudest moments of her life was becoming an RN. She has recently been told that how you view yourself if very different than how others view you. She has taken a step back and tried to reflect and learn from the incidents.

Questions from the Hearing Tribunal

The Registrant provided additional detail regarding charting. If a system was lost, she indicated it would be entered in the longhand chart ([Treatment] Log).

For January 9, 2020, the Registrant believes she charted in the RLS the events of the evening, although she did not remember the specifics.

CLOSING SUBMISSIONS

Closing Submissions of Conduct Counsel:

Conduct Counsel submitted there was an ample factual foundation to demonstrate that the Registrant had engaged in the conduct alleged in the Notices to Attend and that the conduct amounts to unprofessional conduct. The standard to be applied in determining if an allegation is proven is the balance of probabilities.

The HPA defines unprofessional conduct to include 1(1)(pp)(i) conduct that displays a lack of knowledge, skill or judgment in the provision of professional services; (ii) conduct that contravenes the Act, a code of ethics or standards of practice; and (xii) conduct that harms the integrity of the regulated profession.

In this case, the Standards of Practice that are implicated are the College's Nursing Practice Standards for Regulated Members, 2013, Standard 1, including 1.1, 1.2 and 1.4, Standard 2, including 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, Standard 3, including 3.1, 3.2, 3.4, Standard 5, including 5.3 and 5.6.

The following Code of Ethics provision are also engaged: A1, A2, A3, A5, A14; D1, D2, D3, D7, D8, D13; F1, F2, F3, F8; G1, G2, G4, and G8.

First Notice to Attend

The facts regarding [Patient Witness 1] are largely undisputed. What is in dispute is the reason the Registrant did not provide her the Tylenol. [RN Witness 2] and [RN Witness 1] testified that there was no reason not to provide the Tylenol. The Registrant agreed she recognized that the patient had a PRN order for Tylenol and agreed she did not provide it. The Registrant's rationale changed and she indicated she was scared of making a mistake, however, the stated rationale at the time was that [Patient Witness 1] was no longer her patient.

With respect to [Patient Witness 2], the evidence is that the Registrant did not properly prime the machine before hooking up [Patient Witness 2]. He lost blood because of this and could have had health consequences. The Registrant also agreed that she did not seek advice before disposing of the blood. She did not document the incident or the initial run on the [Treatment] Log. While the Registrant believes she documented this in the [Information System], there is no evidence of that. The evidence of [LPN Witness] and [RN Witness 2] is that they did not find anything in the [Information System]. An audit revealed that nothing had been deleted from the [Information System] for this time period.

[Patient Witness 3's] evidence regarding remarks made by the Registrant is uncontradicted.

Similarly, it is not disputed that the Registrant approached [Patient Witness 1], while she was getting [treatment] to speak to her alone, drew a curtain around her and brought up the complaint that [Patient Witness 1] had made, whether directly using those words or alluding to it. [Patient Witness 1] gave evidence she felt intimidated.

Second Notice to Attend

Conduct Counsel noted that many facts are not in dispute. With respect to the allegations regarding the January 9, 2020 incident, the Registrant's own charting indicated that the [Treatment Machine 3] displayed a message on it that priming was still in progress while the patient was hooked up to it. This charting aligns with the evidence from [RN Witness 5], [RN Witness 6] and [RN Witness 4] as well as the black box analysis. The Registrant's own charting indicates she did not chart any of the troubleshooting steps that she took regarding the [Treatment Machine 3].

The Registrant also admitted that she drew the blood of a patient and sent it to the lab without an order.

Closing Submissions of the Registrant:

The Registrant agreed that her professional standards fell below practice standards. In dealing with patients [Patient Witness 1] and [Patient Witness 3], certain boundaries that she took for granted resulted in more of a casual relationship with patients. For [Patient Witness 3], there is no excuse for the incident and no place for personal opinion in the practice setting.

The Registrant acknowledged that her charting did fall below practice standards.

The Registrant stated she was ultimately terminated by her employer because of the three complaints. She has always loved nursing and takes pride in her patients. She has enjoyed the relationships that she has had with them. She believes she has always been safe, competent and ethical.

HEARING TRIBUNAL FINDINGS AND REASONS

The Hearing Tribunal found that the following allegations were factually proven and constitute unprofessional conduct: First Notice to Attend: Allegations 2(c) and (d), 3, and 4.

The Hearing Tribunal found that the following allegations were not proven or do not constitute unprofessional conduct: First Notice to Attend: Allegations 1 and 2(a) and (b) and Second Notice to Attend: Allegations 1, 2, 3 and 4.

The Hearing Tribunal carefully considered the testimony of the witnesses, the exhibits and the submissions of the parties. The Hearing Tribunal applied the balance of probabilities in considering the evidence and determining if the allegations were proven. The findings and reasons of the Hearing Tribunal are set out below.

First Notice to Attend

Allegation 1 - On or about July 20, 2018, the Registrant failed to provide compassionate care to [Patient Witness 1] post-[treatment], when, after [Patient Witness 1] requested help for her headache, the Registrant told her to ask someone else.

The following witnesses gave evidence relating to this allegation: [Patient Witness 1], [RN Witness 1], [RN Witness 2] and the Registrant. The following exhibits were also relevant to this allegation: Exhibit 2, 6, 7 and Exhibit 22 (Affidavit of [RN Co-worker 2]).

The following facts are uncontested. On July 20, 2018, the Registrant was providing care to [Patient Witness 1]. [Patient Witness 1] had finished her [treatment], was receiving an antibiotic through IV and had a headache. She requested Tylenol from the Registrant who did not provide her with Tylenol. The Registrant directed [Patient Witness 1] to ask the charge nurse for the Tylenol. [RN Witness 1] was the charge nurse. The evidence of [Patient Witness 1] and the Registrant was that [RN Co-worker 2] was the Registrant's buddy nurse.

There are some differences in the accounts of the witnesses as to why the Registrant did not provide the Tylenol and the conversations that occurred. However, the only two people involved in the conversation were the Registrant and [Patient Witness 1]. [Patient Witness 1] understood the Registrant to have denied giving her Tylenol because she was no longer receiving [treatment]. This was reflected in her evidence and in her email to [RN Witness 2] (Exhibit 2). In her testimony, [Patient Witness 1] recalled that the Registrant directed her to ask the charge nurse and when she started asking [RN Witness 1] for the Tylenol, [RN Witness 1] said that [RN Co-worker 2] would get her the Tylenol.

[RN Witness 1's] evidence was that [Patient Witness 1] approached her while [RN Witness 1] was doing the rounds and told her she had requested Tylenol from her nurse, the Registrant, who had refused her and [Patient Witness 1] did not understand why she was being refused. [RN Witness 1] denied telling [Patient Witness 1] to get the Tylenol from [RN Co-worker 2] and stated she did not have a conversation with [RN Co-worker 2].

[RN Co-worker 2's] Affidavit indicates that [Patient Witness 1] approached her and told her the Registrant had refused to give her Tylenol because she was no longer the Registrant's patient and that [Patient Witness 1] was upset and crying. [RN Co-worker 2] reviewed the [Treatment] Log, confirmed there was nothing written about the patient's headache or medication and after confirming the patient had not been given medication, gave her two Tylenol tablets. [RN Co-worker 2] noted that she remembers the Registrant watching her when she took the medication out of the drawer of the medication cart and gave the medication to [Patient Witness 1]. She recalls that the rest of the shift was very busy.

[RN Witness 2] received the complaint from [Patient Witness 1] and asked her to put it in writing. [RN Witness 2] stated that during the human resources investigation, the Registrant indicated that she was unsure if she could give the patient Tylenol since she was taken off [treatment]. [RN Witness 2] indicated the patient was definitely in the Unit's care as she was attached to an

IV. [RN Witness 2] could not think of a reason to not provide the Tylenol unless the patient had already received it or the Registrant was busy hands-on with another patient.

The Registrant indicated that at the time, she felt she was walking on eggshells and she was afraid of making a mistake. She was also busy taking another patient off [treatment]. She noted that in retrospect she could have asked the charge nurse to start [treatment] on her other patient or could have walked with [Patient Witness 1] to the charge nurse to ask her to get the Tylenol.

Although there were some differences in the accounts, the Hearing Tribunal found that the witnesses were credible, in that they were relaying information to the best of their recollection. The only two witnesses to the interaction were [Patient Witness 1] and the Registrant and so the Hearing Tribunal placed significant weight on their evidence. The Hearing Tribunal accepts the evidence of [Patient Witness 1] as to what she understood but also accepts the evidence of the Registrant that she was busy taking another patient off [treatment] and that she felt that she was walking on eggshells.

With respect to the Affidavit evidence of [RN Co-worker 2], the Hearing Tribunal generally accepted the evidence of [RN Co-worker 2]. The Registrant did not have any concerns with the Affidavit, except for the time the incident occurred. [RN Co-worker 2] believed the incident happened shortly after 3:00 p.m., but this does not accord with other evidence. The Registrant and [RN Witness 1] both gave evidence that the incident occurred at changeover time, which accords with [Patient Witness 1] being on the IV antibiotics. As such, the Hearing Tribunal found that the incident occurred at changeover time.

The Registrant was taking a patient off [treatment] and redirected [Patient Witness 1] to the charge nurse. She watched as [Patient Witness 1] was given Tylenol by [RN Co-worker 2]. This accords with the evidence of [RN Co-worker 2].

The Hearing Tribunal found that on July 20, 2018, the Registrant did ask the patient to ask someone else for Tylenol for her headache, following the patient's [treatment] but while the patient was hooked up to an IV, receiving antibiotics. There is no question that [Patient Witness 1] could be given Tylenol.

The Hearing Tribunal then considered whether this incident showed a lack of compassionate care by the Registrant. The Registrant stated she asked [Patient Witness 1] if she could get her Tylenol from the charge nurse. She was moving to the next patient, as her patients had coming off times that were pretty close. She saw [Patient Witness 1] walk to the front of the Unit, and speak to [RN Co-worker 2]. She saw [RN Co-worker 2] walk to the medication cart. This is confirmed by [RN Co-worker 2's] Affidavit who states that the Registrant was watching when she took the medication out of medication cart and gave it to [Patient Witness 1]. [RN Co-worker 2] was the Registrant's buddy nurse that day. [Patient information redacted].

Both the Registrant and [RN Witness 1] described the incident occurring during changeover and describe this as a very busy time on the Unit.

The Hearing Tribunal considered the evidence of [Patient Witness 1] that there had been a deterioration in the relationship with the Registrant. This was described by [Patient Witness 1] in her testimony, and also is found in her email to [RN Witness 2], Exhibit 2, where there is a list of complaints about the Registrant. [Patient Witness 1], and other witnesses, described that patients, nurses and doctors on the Unit become like family. [Patient Witness 1] noted the incident was another example of the changes she had witnessed in the Registrant's personality

(that she was more distant and cold). [Patient Witness 1's] testimony and her email (Exhibit 2) evidence an erosion of the nurse - client relationship between the patient and Registrant. This particular incident appears to have been the tipping point for the patient who then reported the incident to the Unit Manager.

The Hearing Tribunal considered that [Patient Witness 1] was a patient who had been on the Unit for many years. She was described as very knowledgeable about her care and someone who would speak her mind. On the day in question, she was hooked up to an IV and walking around. The Hearing Tribunal considered that [Patient Witness 1] was very familiar with all the nurses, would know that changeover is a busy time for nurses and likely would not be someone who would be intimidated to ask another nurse for Tylenol.

The Hearing Tribunal also considered that there was a buddy system for nurses where two nurses were assigned to six patients. The Registrant did ask [Patient Witness 1] to ask someone else, here the charge nurse, for the Tylenol. [Patient Witness 1] in fact received the Tylenol from the Registrant's buddy, [RN Co-worker 2]. In this manner, the Hearing Tribunal found that the Registrant did not refuse care.

The Hearing Tribunal also considered the evidence of [RN Witness 2]. [RN Witness 2] noted that if a nurse is busy with another patient, then this may be a reason to not provide Tylenol.

The Hearing Tribunal found that the Registrant did not fail to provide compassionate care. She was about to take another patient off a [treatment] machine, in the middle of changeover which is the busiest time, and redirected [Patient Witness 1] to the charge nurse. The Hearing Tribunal recognizes that [Patient Witness 1] was confused by this response and felt rejected, however, the Hearing Tribunal considered that there were many other things happening from [Patient Witness 1's] perspective with respect to the Registrant at that time.

In addition, the Hearing Tribunal accepted the explanation by the Registrant that she felt she was under a microscope at this time. The Hearing Tribunal accepts that it would take longer to get the Tylenol for someone who feels that their work is being scrutinized and that the Registrant was busy with taking her patient off their [treatment] machine during changeover.

The Hearing Tribunal found that the Registrant did not communicate to [Patient Witness 1] in the clearest manner what her reasons were for directing her to another nurse. However, the Hearing Tribunal found that redirecting [Patient Witness 1] to the charge nurse, in the circumstances of this case is not sufficient to constitute a failure to provide compassionate care. The Registrant did not ignore the request or abandon the patient. She watched as [Patient Witness 1] obtained Tylenol from the Registrant's buddy nurse. The Hearing Tribunal found that the Registrant did not fail to provide compassionate care. As such, Allegation 1 is not proven on a balance of probabilities.

Allegation 2 On or about August 5, 2018, the Registrant:

a. failed to properly prepare [Patient Witness 2's] [treatment] machine and prematurely commenced [Patient Witness 2's] [treatment], which resulted in [Patient Witness 2] losing an unanticipated amount of blood;

b. disposed of [Patient Witness 2's] blood that had been pulled into the lines of [Patient Witness 2's] [treatment] machine, without consulting with one or more of their colleagues to see if disposal was the only option;

c. failed to do or document an adequate assessment of [Patient Witness 2] following the blood loss; and

d. failed to adequately document the incident including [Patient Witness 2's] blood loss on the [Treatment] Log, or elsewhere.

The following witnesses gave evidence relating to this allegation: [LPN Witness], [RN Witness 2], [Patient Witness 2] and the Registrant. The following exhibits were also relevant to this allegation: Exhibit 3, 4, 5, 6, and 8.

With respect to Allegation 2(a), the Hearing Tribunal considered the evidence of the patient [Patient Witness 2] who stated that he believed he was hooked up to the machine a little early. The Registrant acknowledged she had prematurely commenced the patient's treatment and failed to properly prime the machine which resulted in the patient losing an unanticipated amount of blood. No other direct evidence was presented regarding how the machine was prepared on August 5, 2018 or how much blood was lost.

The Hearing Tribunal considered the evidence of [LPN Witness]. The Hearing Tribunal placed less weight on her testimony. Much of it was hearsay as she was not present for the incident and only found out about it some time later.

The Hearing Tribunal also considered the evidence of [RN Witness 2] who stated that human error can occur and that the main concern, from her perspective, was the Registrant's failure to document the incident.

The Hearing Tribunal placed little weight on what effect there was on the patient from the incident or the blood loss. The patient was not concerned about the incident and did not indicate that he suffered any negative consequences. The evidence regarding whether he had been removed temporarily from the [medical procedure] list was speculative.

The Registrant acknowledged the conduct in Allegation 2(a) occurred. The Hearing Tribunal found that the Registrant prematurely commenced the patient's [treatment] and failed to properly prime the machine, which resulted in the patient losing an unanticipated amount of blood. The Hearing Tribunal found that this was human error on the part of the Registrant. There was insufficient evidence to establish that this conduct was anything other than human error and the Hearing Tribunal accepted the Registrant's explanation. The Hearing Tribunal considered whether such conduct constitutes unprofessional conduct. The Hearing Tribunal found that Allegation 2(a) does not rise to the level of unprofessional conduct. Errors can occur and registered nurses are not held to a standard of perfection. An error, even one that results in a consequence for the patient (here blood loss), does not on its own amount to unprofessional conduct.

The Hearing Tribunal then considered Allegation 2(b). The Registrant acknowledged the conduct in Allegation 2(b). She acknowledged disposing of the blood without consulting with her colleagues. Her evidence was that she discarded the blood because she felt that the sterilant had not been removed out of the [treatment machine]. The Hearing Tribunal found that the Registrant disposed of the blood without consulting with one or more colleagues.

However, insufficient evidence was presented to show that there was a duty on the Registrant to consult with her colleagues before making the decision to dispose of the blood. The Registrant was an experienced [treatment] nurse at the time. Registered Nurses have the

capacity to make independent decisions about treatment within their scope and are not required to seek another colleague's opinion before exercising their professional judgment. There were no policies or procedures presented to show a requirement or expectation that the Registrant would have consulted with colleagues prior to making the decision. In addition, there was insufficient evidence presented to show that the decision to dispose of the blood was the wrong decision. The Hearing Tribunal found that Allegation 2(b) does not rise to the level of unprofessional conduct.

The Hearing Tribunal considered Allegation 2(c) and 2(d). The Hearing Tribunal reviewed the patient chart (Exhibit 8) which is for the second successful run. Although the Registrant stated in her testimony that she entered information on the [Information System] and the RLS about the incident, the Hearing Tribunal accepted the evidence of [LPN Witness] and [RN Witness 2] that they reviewed the [Information System] and there was no documentation of the incident.

There is also no evidence of a patient assessment being documented on the [Treatment] Log or the [Information System] following the blood loss. There is no charting of the incident. The Hearing Tribunal found that the incident was not documented in the patient chart ([Treatment] Log) or the [Information System].

While the Registrant may have documented the incident in the RLS, this would not be appropriate documentation. The RLS is not part of the patient chart. It is a reporting and learning system designed to capture patient adverse events, close calls and/or hazards and provides a tool for learning and improvement. The RLS is not a form of charting.

The Hearing Tribunal found Allegation 2(c) and (d) proven and that the conduct constitutes unprofessional conduct.

The Hearing Tribunal considered the following Standards of Practice:

Practice Standards for Regulated Members

Standard Two: Knowledge-Based Practice

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

Documentation Standards for Regulated Members

Standard One: Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner

1.1 Record a complete account of nursing assessment of the client's needs, including:
- **a.** identified issues and concerns
- **b.** assessment findings
- **c.** diagnosis
- **d.** plan of care
- **e.** intervention(s) provided
- **f.** evaluation of the client care outcomes

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

b. the time when assessments and interventions were completed
c. follow-up of client assessments, observations or interventions that have been completed
d. the administration of medications after administration
e. formal and informal educational/teaching activity provided to the client and family
f. any adverse event or ***adverse outcome***

The conducting of assessments is at the core of nursing practice. Depending on the field of practice or nature of the professional services, the assessment will focus on different things. The Hearing Tribunal found that an assessment would be expected to be conducted and documented where a blood filled set was lost. In addition, the fact that a blood filled set was lost would be critical information in a patient chart for a patient receiving [treatment].

The Hearing Tribunal considered what would constitute an adverse event and found that where there is an unexpected outcome or deviation from the treatment planned, this would constitute an adverse event. In this case, there was an adverse event in that a blood filled set was lost.

The Hearing Tribunal found Indicator 2.5 of the Practice Standards for Regulated Members and Indicators 1.1 and 1.2 of the Documentation Standards for Regulated Members were clearly breached. Issues and concerns, assessment findings, interventions and evaluation of the client care outcomes were not charted. Interventions were provided when the blood filled set was lost and the Registrant did not chart those interventions. Once the run was started it ran smoothly, but the pre-[treatment] run which was unsuccessful and resulted in blood loss needed to be documented.

The Registrant did not document the time when assessments and interventions were completed. There was an adverse event, in that there was a deviation from the expected care and treatment. There was a clear obligation to document this event.

Nurses are taught that if it something is not charted, it did not happen. The importance of documenting assessments and treatments is clear, as is the need to document where something has not gone according to the plan for treatment. These breaches are serious and constitute unprofessional conduct under section 1(1)(pp)(ii) of the HPA as being breaches of the standards of practice.

The failure to document in this case is also conduct that displays a lack of knowledge, skill or judgment in the provision of professional services and is unprofessional conduct under section 1(1)(pp)(i) of the HPA. Another health care professional reviewing the chart would have no idea that the incident occurred. Documentation is a basic skill expected of all registered nurses. The failure to appropriately document is serious.

Allegation 2(c) and (d) is proven and constitutes unprofessional conduct for the reasons set out above.

Allegation 3 – On or about August 30, 2018, the Registrant inappropriately expressed personal opinions about indigenous persons in the presence of patients which caused distress to [Patient Witness 3].

[Patient Witness 3], [RN Witness 2] and the Registrant provided testimony relating to this allegation. Exhibits 6 and 9 are relevant to this allegation.

The evidence regarding this allegation was generally agreed to by the witnesses. [Patient Witness 3] confirmed in the hearing he was very upset by the comments made by the Registrant regarding Indigenous persons in the context of the pipeline protests. [RN Witness 2] confirmed that [Patient Witness 3] was distressed about the incident. She described him as visibly shaken and angry. The Registrant accepted responsibility for the statements made in her testimony and expressed regret for having stated personal opinions while providing nursing services.

The Hearing Tribunal found that on August 30, 2018, the Registrant expressed inappropriate personal opinions regarding Indigenous persons while providing treatment to patients and in the presence of patients and specifically [Patient Witness 3]. The Hearing Tribunal found that this caused distress to [Patient Witness 3]. There is ample evidence to support that this allegation is proven on a balance of probabilities.

The Hearing Tribunal considered if the conduct in Allegation 2 constitutes unprofessional conduct.

The Hearing Tribunal considered the following provisions of the Code of Ethics:

> **F. Promoting Justice**
>
> Nurses uphold principles of justice by safeguarding **human rights**, equity and **fairness** and by promoting the **public good**.
>
> **Ethical responsibilities:**
>
> 2. Nurses respect the special history and interests of Indigenous Peoples as articulated in the Truth and Reconciliation Commission of Canada's (TRC) *Calls to Action* (2012).
>
> 3. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other.

Registered Nurses are expected to be aware of broad societal issues. They must promote justice and respect the special interest of Indigenous people. The comments made by the Registrant were pertaining to Indigenous people in the context of pipeline protests. The Registrant should have recognized this as a controversial societal issue and refrained from expressing any personal opinions.

The Hearing Tribunal found that the Registrant breached sections F2 and F3 of the Code of Ethics. The Hearing Tribunal considered that the Code of Ethics indicates it is aspirational, but in the view of the Hearing Tribunal, the breaches of the Code of Ethics were clear and serious. The Hearing Tribunal also considered that the Registrant apologized during the hearing and stated how she would do things differently proceeding forward. However, this does not excuse the Registrant making those comments at the time. The Registrant should have recognized at the time that the comments were not appropriate. Such comments erode the trust a patient would have towards nurses.

The Hearing Tribunal viewed that the conduct was sufficiently serious to constitute unprofessional conduct. Further, the Registrant, as a health care provider, is in a position of power regarding a vulnerable patient receiving treatment. Although [Patient Witness 3] was not

her patient that day, the comments were made while the Registrant was providing treatment, while [Patient Witness 3] was receiving [treatment] and was sitting close by. [Patient Witness 3] is confined to the treatment area because he is attached to the [treatment] machine. He was unable to remove himself from this situation and as such, was especially vulnerable.

The conduct is serious and the Hearing Tribunal found that the conduct constitutes unprofessional conduct, under section 1(1)(pp)(ii) of the HPA as a breach of the Code of Ethics.

Allegation 4 - On or about January 4, 2019, the Registrant engaged in unprofessional behaviour when they inappropriately confronted [Patient Witness 1] during active treatment about the complaint she made to the Registrant's Unit Manager arising from a July 20, 2018 incident.

The following witnesses gave evidence relating to this allegation: [Patient Witness 1], [RN Witness 2] and the Registrant. The following exhibits were also relevant to this allegation: Exhibits 10 and 11.

The following facts are undisputed. On January 4, 2019, the Registrant entered [Patient Witness 1's] treatment area while [Patient Witness 1] was in treatment, closed the curtain, crouched down by the patient and discussed the investigation by the College relating to the incident on July 20, 2018.

[Patient Witness 1] and the Registrant's evidence differed on how the curtain was closed or exactly what was said by the Registrant. However, the Hearing Tribunal found that it was not necessary for it to determine how the curtain was closed or exactly what was said. The allegation is proven on a balance of probabilities.

Patients receiving care are in a vulnerable position and there is an inherent power imbalance between the patient and nurse. Registrants must recognize this power imbalance and the need to maintain appropriate professional boundaries.

[Patient Witness 1] testified that she felt intimidated and unnerved. She was hooked up to her [treatment] machine and could not remove herself from the situation. Because she was a patient on the Unit, she had to return for treatment several times per week. It is clear that the Registrant disregarded the inherent power differential and acted in a manner that would be intimidating to a patient.

Further, the Registrant spoke to [Patient Witness 1] despite being told by human resources not to speak about the incident.

The Hearing Tribunal considered the following provisions of the Practice Standards for Regulated Members and the Code of Ethics:

Practice Standards for Regulated Members

Standard Three: Ethical Practice

The registered nurse complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of HPA and CARNA bylaws (CARNA, 2012).

Indicators

3.2 The nurse protects and promotes a client's right to autonomy, respect, privacy, dignity and access to information.

3.3 The nurse ensures that their relationships with clients are therapeutic and professional.

Code of Ethics

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.

7. Nurses maintain appropriate professional **boundaries** and ensure their relationships are always for the benefit of the person. They recognize the potential vulnerability of persons receiving care and do not exploit their trust and dependency in a way that might compromise the **therapeutic relationship**. They do not abuse their relationship for personal or financial gain and do not enter into personal relationships (romantic, sexual or other) with persons receiving care.

There is a power differential between a nurse and patient and the Registrant abused this power. She showed very poor judgment in engaging with [Patient Witness 1] in this manner. By virtue of her position, the Registrant's conduct constituted intimidation towards a patient regardless of the Registrant's intentions. The Registrant failed to respect [Patient Witness 1's] right to autonomy, respect, privacy and dignity and did not maintain appropriate professional boundaries.

The Hearing Tribunal found that the Registrant breached the Standards of Practice indicators 3.2 and 3.3 and the Code of Ethics sections D1, D2, and D7. These breaches are egregious and blatant. The Hearing Tribunal found that the conduct constitutes unprofessional conduct, under section 1(1)(pp)(ii) of the HPA as a breach of the standards of practice and Code of Ethics.

Second Notice to Attend

Allegation 1 - On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment when they failed to appropriately prime [Patient 4's] [treatment] machine, contrary to the *Canadian Nurses Association Code of Ethics (2017)* ("CNACE") and the *Practice Standards for Regulated Members (2013)* ("CPSRM").

The following witnesses gave evidence relating to this allegation: [RN Witness 3], [RN Witness 4], [RN Witness 5], [RN Witness 6] and the Registrant. The following exhibits were also relevant to this allegation: Exhibits 13 to 19, 23 and 24.

The Hearing Tribunal considered the evidence regarding the incident on January 9, 2020. The Registrant is the only witness with first hand evidence of what occurred with the first machine. The Registrant gave evidence that January 9, 2020 was one of the busiest shifts of her career. The patient was connected to the first machine and the Registrant accidentally pushed the wrong button. The patient was then connected to a second machine, an [Treatment Machine 3] machine. There was an issue with the second machine and she did not believe the patient was receiving [treatment]. [Patient information redacted].

[RN Witness 5] also provided evidence about the incident. [RN Witness 5] heard something and went over to see if she could help. [Patient information redacted]. [RN Witness 5] observed a message on the machine that indicated “priming in progress”. She went to speak with [RN Witness 6] who also came over. All three of them tried to troubleshoot. [RN Witness 5] did not remember [RN Witness 3] being there.

[RN Witness 6] indicated that [RN Witness 5] came to tell her there was a problem with the machine. She went over and saw that the patient was hooked up and the machine indicated “priming in progress.” [RN Witness 6] recalled [RN Witness 3] trying to explain to the Registrant who was tapping her pen on the machine trying to do a cassette repositioning that what she was doing would not work.

[RN Witness 3] gave evidence that the Registrant asked her for assistance. She went with the Registrant. [RN Witness 3] looked at the machine. [Patient information redacted].

[RN Witness 3’s] evidence is that it would be unusual to put a patient on a [treatment] machine before it is finished priming. However, nothing happens if a patient is hooked up before priming is complete. [Patient information redacted]. She noted that the patient could have stayed for the four hours if that was needed as there is always a nurse on call for emergencies.

The Hearing Tribunal considered the evidence of [RN Witness 4]. He did not have first hand knowledge of the incident as he was not present at the time of the incident. [RN Witness 4] gave evidence about the steps he took to investigate the incident once it was reported to him. [RN Witness 4] gave evidence regarding the results of the black box investigation for the machine and reviewed an email he received regarding the black box analysis. He noted that the patient was connected to the machine that had not been properly primed. [Patient information redacted].

The Hearing Tribunal found there were discrepancies in the evidence of the witnesses and it was not clearly established what occurred with the [Treatment Machine 3].

The Hearing Tribunal found that with the first machine, there was a human error, as acknowledged by the Registrant. With the second machine, the [Treatment Machine 3], the patient was connected and there was an alarm noting that there was priming in progress. The Registrant tried to troubleshoot and went to ask [RN Witness 3] for assistance.

The Hearing Tribunal found that the [Treatment Machine 3] screen indicated “priming in progress.” However, the Hearing Tribunal found that the evidence did not establish whether the Registrant put the patient on the [treatment] machine too early or whether there was a machine error.

The Hearing Tribunal placed the most weight on the evidence of [RN Witness 3] who was a CNE for [Unit]. The Hearing Tribunal found her to be knowledgeable and consistent in her

evidence. She gave her testimony in a neutral and impartial manner. [RN Witness 3's] evidence was that there was no harm to a patient [information redacted].

The Hearing Tribunal placed no weight on Exhibit 19. The Hearing Tribunal had no expertise to analyze the information and found that [RN Witness 4] did not have the technical skill to interpret the results.

The Hearing Tribunal found that there was insufficient evidence that the Registrant failed to properly prime the machine. The evidence was that when the Registrant experienced issues with the second machine, she asked for assistance. In addition, and as stated elsewhere, a human error is not necessarily unprofessional conduct. Human error is not in itself proof of a failure to demonstrate adequate clinical judgment.

The Hearing Tribunal found that this allegation was not proven on a balance of probabilities.

Allegation 2 - On January 9, 2020, the Registrant failed to accurately document their patient care for [Patient 4], specifically regarding their troubleshooting and priming of a [treatment] machine, contrary to the *CNACE,* the *CPSRM*, the *Documentation Standards for Regulated Members (2013)* ("CDSRM") and applicable Alberta Health Services policies ("AHS policies").

This allegation relates to the same incident as Allegation 1. The following witnesses gave evidence relating to this allegation: [RN Witness 3], [RN Witness 4], [RN Witness 5], [RN Witness 6] and the Registrant. The following exhibits were also relevant to this allegation: Exhibits 13 to 19, 23 and 24.

[RN Witness 4] stated that he would not expect every single step to be documented but would expect the nurse to document "management on CVC troubleshooting PPD as per protocol followed, nothing was effective."

The Hearing Tribunal considered the patient chart for this incident (Exhibit 14). The Hearing Tribunal considered that [RN Witness 3] was able to understand what had occurred when she reviewed the [Information System] during the hearing.

The entry in the [Information System] (Exhibit 14) entered by the Registrant states: "[Patient information redacted]".

The Hearing Tribunal placed significant weight on the entry in the [Information System]. The Hearing Tribunal also placed significant weight on the testimony of [RN Witness 3] who reviewed the entry during the hearing and was able to advise the Hearing Tribunal what had occurred based on this entry.

In addition, no specific evidence was presented of what should have been documented. The evidence of [RN Witness 4] was general and not based on any specific documentation standard. [RN Witness 2], while not testifying directly about this incident gave evidence generally regarding documentation expectations and stated "it wouldn't be a common thing to document, that you asked for troubleshooting help. It's such a common occurrence."

The Hearing Tribunal also considered the Alberta Health Services Management/ Troubleshooting [information redacted] (Exhibit 18) and there is no mention in the document of a requirement to document troubleshooting. The Alberta Health Services Code of Conduct

(Exhibit 23 and 24) does not require documentation of troubleshooting. The CNA Code of Ethics does not require documentation of troubleshooting. The Standards of Practice do not require documentation of troubleshooting. Finally, the Documentation Standards for Regulated Members does not contain a specific requirement to document troubleshooting.

The Registrant did document the incident with sufficient detail that [RN Witness 3] understood what had occurred. The Hearing Tribunal found that this allegation was not proven on a balance of probabilities.

Allegation 3 - On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment and failed to use appropriate information to enhance patient care and the achievement of desired patient outcomes when they tried to initiate [Patient 4's] [treatment] before the [treatment] machine was properly primed, contrary to the *CNACE*, the *CPSRM* and AHS policies.

The Hearing Tribunal considered the evidence of the witnesses and exhibits as noted for Allegations 1 and 2 above.

This allegation is very similar to Allegation 1. The Hearing Tribunal's findings and reasons in Allegation 1 apply to this allegation as well.

The Registrant acknowledged human error occurred on January 9, 2020. As noted above, registrants are not held to a standard of perfection. With the second machine, the [Treatment Machine 3], the patient was connected and there was an alarm noting that there was priming in progress. The Registrant tried to troubleshoot and went to ask [RN Witness 3] for assistance. The Registrant did demonstrate clinical judgment by seeking assistance and using the information and resources available to her, including asking [RN Witness 3] (the CNE) and the charge nurse for assistance.

Further, the Hearing Tribunal found that insufficient evidence was presented regarding what information the Registrant should have used to enhance patient care or achieve desired patient outcomes.

The Hearing Tribunal found that this allegation was not proven on a balance of probabilities.

Allegation 4 - On January 15, 2020, the Registrant failed to demonstrate adequate clinical judgment when they drew blood from [Patient 5] and sent the blood to the lab for testing, without a physician's order to do so, contrary to the *CNACE* and the *CPSRM.*

The following witnesses gave evidence relating to this allegation: [RN Witness 4] and the Registrant. The following exhibits were also relevant to this allegation: Exhibits 20 and 21.

At the hearing, the Registrant acknowledged her error with respect to drawing blood for a patient where there was no order to do so. The Registrant believed there was an alert for an order to draw blood but was mistaken.

Exhibits 20 and 21 establish that there was no order. [RN Witness 4] gave evidence that there was no order. [RN Witness 4] also acknowledged that it was an honest mistake.

There is no question that the error happened. The Registrant drew blood where there was no order to do so. [RN Witness 4's] concern appeared to be that the Registrant would not take

ownership of her errors. However, the allegation is not that the Registrant failed to admit an error or take ownership of it.

Insufficient evidence was presented on how the Registrant failed to demonstrate adequate clinical judgment in this situation. An error in drawing blood where there was no order is not in itself a failure to demonstrate adequate clinical judgment. Again, a registrant is not held to a standard of perfection.

The Hearing Tribunal found that this allegation was not proven on a balance of probabilities.

CONCLUSION

The Hearing Tribunal finds that the following Allegations are proven on a balance of probabilities: First Notice to Attend, Allegations 2(c) and (d), 3, and 4.

The Hearing Tribunal finds that the following Allegations have not been proven or do not constitute unprofessional conduct: First Notice to Attend: Allegation 1, 2(a) and (b) and Second Notice to Attend, Allegations 1, 2, 3, and 4.

The Hearing Tribunal will receive submissions from the parties on sanction relating to the First Notice to Attend, Allegations 2(c) and (d), 3, and 4.

The Hearing Tribunal requests that the parties discuss and determine the timing and method of providing submissions on penalty to the Hearing Tribunal. If the parties are unable to agree on a proposed procedure and timing, the Hearing Tribunal will make further directions as required.

Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: February 22, 2022

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as

COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL ON SANCTION

RE: CONDUCT OF **TINA FODOR,** R.N., REGISTRATION **#77,647**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as

COLLEGE OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

May 19, 2022

INTRODUCTION

A virtual hearing was held on May 19, 2022 before a Hearing Tribunal of the College and Association of Registered Nurses of Alberta also known as College of Registered Nurses of Alberta (the "**College**") to hear submissions on sanction regarding Tina Fodor, R.N. registration #77,647 (the "**Registrant**").

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, Chairperson
Jofrey Wong
Naz Mellick, Public Representative
Doug Dawson, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. College Representative:

Mick Wall, Conduct Counsel

d. Registrant Under Investigation:

Tina Fodor (sometimes hereinafter referred to as "the **Registrant**")

PRELIMINARY MATTERS

Preliminary Matters

The Hearing Tribunal issued its decision on the allegations on February 22, 2022 (the "**Decision on Allegations**").

In the Decision on Allegations, the Hearing Tribunal found the following allegations in the Notice of Hearing had been proven and constituted unprofessional conduct.

First Amended Notice to Attend a Hearing ("First Notice to Attend"):

2. On or about August 5, 2018, the Registrant:

…

c. failed to do or document an adequate assessment of [Patient Witness 2] following the blood loss; and

d. failed to adequately document the incident including [Patient Witness 2's] blood loss on the [Treatment] Log, or elsewhere.

3. On or about August 30, 2018, the Registrant inappropriately expressed personal opinions about indigenous persons in the presence of patients which caused distress to [Patient Witness 3].

4. On or about January 4, 2019, the Registrant engaged in unprofessional behaviour when they inappropriately confronted [Patient Witness 1] during active [treatment] about the complaint she made to the Registrant's Unit Manager arising from a July 20, 2018 incident.

The Hearing Tribunal found, in the Decision on Allegations, that the following allegations were not proven or did not constitute unprofessional conduct:

First Notice to Attend:

1. On or about July 20, 2018, the Registrant failed to provide compassionate care to [Patient Witness 1] post-[treatment], when, after [Patient Witness 1] requested help for her headache, the Registrant told her to ask someone else.

2. On or about August 5, 2018, the Registrant:

    a. failed to properly prepare [Patient Witness 2's] [treatment] machine and prematurely commenced [Patient Witness 2's] [treatment], which resulted in [Patient Witness 2] losing an unanticipated amount of blood;

    b. disposed of [Patient Witness 2's] blood that had been pulled into the lines of [Patient Witness 2's] [treatment] machine, without consulting with one or more of their colleagues to see if disposal was the only option;

Second Notice to Attend a Hearing ("Second Notice to Attend"):

1. On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment when they failed to appropriately prime [Patient 4's] [treatment] machine, contrary to the Canadian Nurses Association Code of Ethics (2017) ("CNACE") and the Practice Standards for Regulated Members (2013) ("CPSRM").

2. On January 9, 2020, the Registrant failed to accurately document their patient care for [Patient 4], specifically regarding their troubleshooting and priming of a [treatment] machine, contrary to the CNACE, the CPSRM, the Documentation Standards for Regulated Members (2013) ("CDSRM") and applicable Alberta Health Services policies ("AHS policies").

3. On January 9, 2020, the Registrant failed to demonstrate adequate clinical judgment and failed to use appropriate information to enhance patient care and the achievement of desired patient outcomes when they tried to initiate [Patient 4's] [treatment] before the [treatment] machine was properly primed, contrary to the CNACE, the CPSRM and AHS policies.

4. On January 15, 2020, the Registrant failed to demonstrate adequate clinical judgment when they drew blood from [Patient 5] and sent the blood to the lab for testing, without a physician's order to do so, contrary to the CNACE and the CPSRM.

EVIDENCE AND DOCUMENTS PROVIDED:

The following documents were entered as Exhibits in the hearing on sanction:

Exhibit #1 – James T. Casey - *Regulation of the Professions in Canada* (Online ed., continuously updated) at 14.3
Exhibit #2 – *Jaswal v. Medical Board (Nfld.)*, 1996 CanLII 11630 (NL SC)
Exhibit #3 – *College of Nurses of Ontario v Harper*, 2021 CanLII 132039 (ON CNO)
Exhibit #4 – *College of Nurses of Ontario v Lento*, 2017 CanLII 84917
Exhibit #5 – *College of Nurses of Ontario v Mcinnes*, 2014 CanLII 99449 (ON CNO)
Exhibit #6 – *Makis (Re)*, 2018 CanLII 127231 (AB CPSDC)
Exhibit #7 – *Kuny v College of Registered Nurses of Manitoba*, 2017 MBCA 111
Exhibit #8 – *James v. Real Estate Council of Alberta*, 2004 ABQB 871
Exhibit #9 – *Al-Ghamdi v College of Physicians and Surgeons of Alberta*, 2020 ABCA 71
Exhibit #10 – *Facey v Bantrel Management Services Co.,* 2019 AHRC 4
Exhibit #11 – *CRNA v Mehra*, May 4, 2021
Exhibit #12 – *Regulation of the Professions*, James T Casey at 14-3
Exhibit #13 – Course Outline – Professional Boundaries in Nursing
Exhibit #14 – Affidavit of Tabitha Potts, May 19, 2022
Exhibit #15 – Affidavit of Tabitha Potts, October 5, 2021
Exhibit #16 – Affidavit of Amy Payne, October 6, 2021
Exhibit #17 – Estimated Statement of Costs dated May 19, 2022

The Registrant objected to entering as exhibits any cases dealing with a profession other than nursing. Case law does not necessarily need to be entered as an exhibit, but is typically done in College hearings for ease of referring to the various cases. The Hearing Tribunal held that the cases would be entered as exhibits and the Registrant would have the ability to make submissions on the cases. The Hearing Tribunal would consider all of the submissions in determining whether to rely on any particular case.

The Registrant further objected to entering the Estimated Statement of Costs as an exhibit. She did not contest the validity of the costs, but rather that she be required to pay costs. The Hearing Tribunal determined it would enter the Estimated Statement of Costs as an exhibit for reference on the amount of costs of the hearing and advised the Registrant that she would have an opportunity to make submissions on the appropriate amount of costs to be ordered by the Hearing Tribunal. The Hearing Tribunal would consider all submissions in determining what amount of costs to order.

SUBMISSIONS

Submissions by Conduct Counsel

Conduct Counsel noted that the following sanction was being sought by the Complaints Director:

SANCTION

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By no later than November 19, 2022, the Registrant shall provide proof, satisfactory to the Complaints Director, that the Registrant has successfully completed and passed the following course of study:

   a. **Professional Boundaries in Nursing (John Collins Consulting)**
   b. **Relational Practice and Communication - NURS 0173 (MacEwan)**
   c. **The Essentials of Nursing Documentation (CRNA Learning Module)**

3. By May 19, 2023, the Registrant shall pay a fine in the sum of $1,500.00, via payment to the College (the "Fine"), and noting the following terms may apply:

   i. pursuant to Section 82(3)(c) of the HPA, the Registrant may be automatically suspended for any non-payment;
   ii. if the Registrant fails to pay the Fine by the deadline indicated, the Complaints Director may publish an administrative notice regarding non-payment of the Fine on the College's website including the Registrant's name and registration number and that the Fine arose from a resolution agreement with the College (the "Administrative Notice of Non-Payment");
   iii. the Registrant must pay the Fine owed to the College, whether or not the Registrant has an active practice permit with the College; and
   iv. the Fine is a debt owed to the College and if not paid, may be recovered by the College by an action of debt.

4. The Registrant shall pay $25,000.00 for the costs of the hearing, pursuant to section 82(1)(j) of the HPA, to the College by May 31, 2027. The costs may be paid in full at any time before the deadline. However, the Registrant must make minimum payments in the following installments:

   a. $5000.00 due on May 31, 2023;
   b. $5000.00 due on May 31, 2024;
   c. $5000.00 due on May 31, 2025;
   d. $5000.00 due on May 31, 2026; and
   e. $5000.00 due on May 31, 2027.

   (the "**Condition(s)**")

5. The Registrant will provide proof of completion of the above-noted Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca .

COMPLIANCE

6. For clarity and certainty, the Registrant is, in addition to what is set out in this Order, required to complete any and all requirements as have been, or may be, imposed from the College's Registration Department. This Order does not supersede, or if complied with serve to satisfy, any such requirements from the College's Registration Department.

7. Compliance with this Order shall be determined by the Complaints Director of the College. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

8. The Registrant will provide proof of completion of the above-noted Condition(s) by the dates set out therein, to the Complaints Director, via e-mail at procond@nurses.ab.ca or confidential fax to 780.453.0546. If the Complaints Director deems it appropriate, and for the sole purpose of permitting the Registrant to proceed toward compliance with this Order, the Complaints Director may in her sole discretion make other minor adjustments to the Order that are in keeping with this Hearing Tribunal Order, without varying the substance of the Order.

9. Upon written request by the Registrant, any timelines outlined in this Order may be extended at the unfettered discretion of the Complaints Director, acting reasonably.

10. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of the *HPA*, or the information may be treated as reasonable grounds under section 56 of the *HPA* and subject to a new complaint under Part 4 of the *HPA*.

11. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated non-compliance and any request for an extension.

CONDITIONS

12. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

13. The Registrar of the College will be requested to put the following condition against the Registrant's practice permit (current and/or future) and shall remain until the condition is satisfied:

    a. ***Course work required – Arising from Disciplinary Matter;***
    b. ***Shall pay fine – Arising from Disciplinary Matter; and***
    c. ***Shall pay costs – Arising from a Disciplinary Matter.***

14. Effective on May 19, 2022, or the date of this Order, if different from the date of the Hearing, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

15. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

16. This Order takes effect on May 19, 2022, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

Conduct Counsel reviewed the sentencing factors set out in *Jaswal* v *Medical Board (Nfld)* and noted the following:

The nature and gravity of the proven allegation:

The first finding of unprofessional conduct relates to a failure to document and assess. Failure to assess is an inherently serious issue. It creates continuity of care issues and in some cases could endanger patient care.

The Hearing Tribunal also found that the Registrant made inappropriate comments. The comments were culturally insensitive, which is very problematic. The patient involved was in a vulnerable position. The testimony of [Patient Witness 3] showed that this had a lasting emotional impact on him. This conduct is serious.

The Registrant also approached a patient who had made a complaint. The manner in which the interaction took place demonstrates not only poor judgment but is very serious conduct. The self-regulating function of a College can only work when participants feel free to come forward and participate in the complaint process. The Registrant's conduct on this allegation had the possibility of undermining self-regulation and the ability of the College to self-regulate.

Age and experience of registrant: The Registrant has been registered since 2004.

The presence or absence of any prior complaints or findings: There are no prior discipline complaints or findings against the Registrant.

The age and mental condition of the offended patients: The patients were part of a particularly vulnerable group. Two witnesses referenced in their evidence that they were very vulnerable because [information redacted] during [treatment].

The role of the Registrant in acknowledging what occurred: In this instance, the Registrant fell short of the requisite insight. As is her right, she fully contested the allegations and the facts of the hearing. She indicated a willingness to admit some facts, but only late in the hearing when two witnesses were left. For five days of hearing, all of the facts were disputed. She ultimately admitted facts or did not dispute them. Had she recognized those facts, or admitted to them earlier, this would have allowed for a more streamlined hearing. This demonstrates a lack of insight into the nature of the process, nature of the allegations and what it means to admit to facts but not misconduct.

Whether the Registrant has suffered other serious financial or other penalties: The Registrant was fired or resigned from AHS. However, CRNA did not put any conditions on her practice permit and she was not prevented by CRNA from finding another position.

The impact on the offended patients: While there was no adverse physical or health impacts arising from conduct, there was an emotional impact on both patients involved in the findings in Allegations 3 and 4.

The presence or absence of any mitigating circumstances: The Registrant has a clean discipline history and long experience as a nurse. She did show remorse for her comments to [Patient Witness 3] and [Patient Witness 1].

The need to promote specific and general deterrence: This is an important factor in that a sanction that is appropriately punitive for the misconduct demonstrates that the CRNA takes the conduct seriously. The proposed sanction is an appropriate vehicle to express the denunciation of the conduct by the Hearing Tribunal.

The range of sentence in similar cases: This is a difficult factor in this case. There are some cases that provide guidance, but it is recognized that social mores can change over time. Conduct Counsel reviewed cases in *College of Nurses of Ontario v Harper*, *College of Nurses of Ontario v Lento* and *College of Nurses of Ontario v McInnis.* The Complaints Director in the present case considered that the conduct was less severe than in some of the cases cited.

Conduct Counsel also made submissions respecting the costs to be ordered. Conduct Counsel pointed to the decisions in *Al-Ghamdi v College of Physicians and Surgeons of Alberta*, 2020 ABCA 71, *Facey v Bantrel Management Services Co.*, 2019 AHRC 4 and *CRNA v Mehra*, May 4, 2021. The CRNA is funded by its members and the membership should not have to bear the costs of the hearing.

Conduct Counsel noted the factors listed in J. Casey, *Regulation of Professions*, regarding costs, as follows:

1. Legislative provisions differ significantly with respect to the nature of the costs that may be awarded by a discipline committee so the specific provisions must be considered.
2. The amount of the time and expenses associated with the investigation and hearing.
3. The focus of a cost award is to ensure that a member found to have committed unprofessional conduct bears the costs of the process as opposed to the membership as a whole. Bearing the burden of an award of costs reflects the consequences of being a member of a self-regulating profession and having engaged in unprofessional conduct.
4. There is a need to find an appropriate balance by considering the impact of the cost award on the member. Costs should not be punitive in nature.
5. Potential costs awards should not be so large so as to prevent individuals from raising reasonable defences to allegations of unprofessional conduct.
6. The member's personal financial circumstances and the impact of a cost award. In appropriate cases consideration should be given to providing time to pay the costs.
7. The impact of the other sanctions imposed should be considered as part of the context.
8. Whether there has been "mixed success" in that the member has successfully defended some of the allegations. In particular, it is appropriate to consider the relative seriousness of the allegations which were proven and the relative seriousness of those which were successfully defended. It is also appropriate to consider what proportion of the cost was attributable to the allegations that were successfully defended.
9. The extent to which the conduct of each of the parties resulted in costs accumulating or conversely being saved.
10. Any other factors considered relevant given the particular circumstances of the case.

Conduct Counsel noted the attempts made by the College to contact the Registrant in advance of the hearing. There was a six day hearing, but ultimately very few facts were in dispute. The manner of how things were done was very inefficient. The Registrant attended briefly on the first day and then did not respond to 36 attempts to contact her by the College by email and telephone. A courier was sent to her home.

Additionally, during the hearing, the Registrant did indicate she wanted to have a representative. The proceedings were adjourned. She ultimately chose not to have representation.

The proposed costs represent approximately one third of the total costs. This recognizes the Registrant's success in defending herself on some allegations. The proposed costs are not unduly onerous. The proposal recognizes that she has not worked as a nurse for a couple of years and sends the appropriate message to the membership.

Submissions by the Registrant

At the outset of the Registrant's submissions, it appeared that she had not read the Decision on Allegations. She was making submissions regarding allegations not found to be proven. The Chair briefly adjourned the hearing so that the Registrant could review the Decision on Allegations prior to making her submissions.

The Registrant noted that she felt the proposed orders were outrageous and obscene.

The Registrant inquired about the ability to take courses through the CRNA. She noted that she had initially been offered to take the courses. She felt at the time that the courses and fine were appropriate but could not sign off on what she was being asked to agree to. She felt that it would be dishonest to admit to things that she did not think were wrong.

The proposed order of costs of $25,000 is unimaginable. She noted the punishment should fit the crime. The Registrant noted she had struggled, but she was human. She felt she was not being humanized by this process and that this had taken her passion away for the profession of nursing.

The Registrant noted she would agree to a fine of $1,000 and the courses. She would prefer to do CRNA courses rather than paying for the Grant McEwan and John Collins Consulting course.

The Registrant noted she has been forthcoming and honest. She was truthful in her testimony. The discipline process has taken a long time and affected her life negatively. She felt as though she was guilty until proven innocent.

The Registrant noted that she understands the importance of protecting the public and that this is the primary goal. She noted that self-representation is difficult and will take this experience as a lesson learned.

Reply Submissions by Conduct Counsel

Conduct Counsel noted that the Registrant's comments regarding the prior offer of the fine and courses was part of settlement discussions that occurred prior to the hearing. Such discussions are typically without prejudice with a view to settlement.

Conduct Counsel also noted that the Registrant had the Decision on Allegations since February 24, 2022. The failure by the Registrant to read the Decision on Allegations was part of a pattern of misconduct. Conduct Counsel noted that decisions made by the Registrant about how she conducted her defence was what had led them to this outcome.

DECISION AND REASONS

The Hearing Tribunal finds that the reprimand and proposed courses are proper. A fine is warranted, in the amount of $1,000. The Hearing Tribunal also determined that an order of costs was appropriate in the amount of $5,000 payable over a period of five years.

The reasons of the Hearing Tribunal are set out below**.**

REASONS

The Hearing Tribunal carefully considered the submissions of the parties and the exhibits entered in the hearing.

The Hearing Tribunal considered the purpose of sentence and in particular placed emphasis on the protection of the public. The Hearing Tribunal also recognizes that denunciation of the conduct is important, as is the need to deter the conduct specifically with respect to the Registrant and the membership generally. It is also important to maintain the public's confidence in the profession by showing that registrants who engage in unprofessional conduct will be held accountable.

The Hearing Tribunal considered the factors in *Jaswal*. The conduct was serious. The Hearing Tribunal found that the conduct in Allegations 3 and 4 (respecting communications with [Patient Witness 3] and [Patient Witness 1]) to be the more egregious conduct. The Hearing Tribunal agreed that the patients were vulnerable and that there was evidence of the impact of the conduct on both [Patient Witness 3] and [Patient Witness 1]. The Hearing Tribunal also considered the Registrant's long career as a nurse and that she had no prior findings of unprofessional conduct. The Hearing Tribunal considered that the Registrant lost her employment as a result of the incidents and has not worked as a registered nurse since that time. The Hearing Tribunal recognized that this was not due to any restrictions by the College, but accepted this would have had an impact on her financially.

In terms of the acknowledgment of the conduct by the Registrant, the Hearing Tribunal considered that the Registrant acknowledged much of the conduct, including the conduct in Allegations 3 and 4 of the First Notice to Attend. She further acknowledges that she had made mistakes. During the hearing, she appeared to the Tribunal to be genuinely sorry for the pain she had caused to [Patient Witness 3] and [Patient Witness 1]. The Hearing Tribunal does believe she has learned from this experience.

Having considered all of these factors, the Hearing Tribunal views that a reprimand is appropriate in this case. The reprimand serves to denounce the conduct. This is an appropriate aspect in maintaining the public's confidence in the integrity of the profession of nursing.

The Hearing Tribunal then considered the issue of courses. It is important to ensure the protection of the public. Course work to remediate practice issues is an important component to achieving the protection of the public. The courses proposed specifically address areas of the Registrant's practice that were of concern to the Hearing Tribunal in making the findings of unprofessional conduct. The Hearing Tribunal also considered the submissions of the Registrant. She did not oppose the taking of courses, but proposed to take CRNA learning modules. The Hearing Tribunal considered this request. However, from the submissions made and information provided, the Hearing Tribunal finds that the Grant McEwan and John Collins Consulting courses will be more robust than CRNA learning modules. In addition, the John Collins Consulting course involves a feedback mechanism from a nursing consultant to review and strengthen the participant's progress. This is in contrast to the CRNA online modules which are entirely self-study and do not have feedback from a nursing professional to facilitate and support knowledge integration of the course contents. While there is a cost to these courses, the Hearing Tribunal viewed the proposed courses as appropriate in the circumstances of this case. The Hearing Tribunal viewed Allegations 3 and 4 as the more serious findings. The conduct at issue in these allegations involved

communication and professional boundaries. The Grant McEwan and John Collins Consulting courses will directly address these skills and competencies.

The Hearing Tribunal also considered the proposal for a fine. The Hearing Tribunal agrees that an aspect of sanction is to denounce the conduct and to deter the Registrant specifically and the membership generally from engaging in this type of conduct. The Hearing Tribunal considered the submissions of Conduct Counsel in support of a fine of $1,500 and the submissions of the Registrant for a $1,000 fine. The Hearing Tribunal views that a fine of $1,000 is appropriate. The fine denounces the conduct and serves as a punitive order. In considering the amount of the fine, the Hearing Tribunal considered the costs of the courses being ordered and the need to achieve a sanction that is fair and appropriate. The Hearing Tribunal finds that a $1,000 fine is sufficient to achieve the goals of denunciation and deterrence.

The Hearing Tribunal then considered the amount of costs to be ordered. The Hearing Tribunal did not accept the submissions by Conduct Counsel that the Registrant bears significant responsibility for the length of the hearing or delays in the hearing.

The Hearing Tribunal found that some of the delay was caused by the Registrant. There were times where she was not available or not fully prepared. For example, during the first day of hearing, the Registrant attended briefly and then could not be reached by the College or Conduct Counsel. This caused delay in the hearing process. Another example was the Registrant appearing to not have read the decision of the Hearing Tribunal in advance of the hearing on sanction. The Chair adjourned to allow the Registrant time to review the decision. The Registrant explained that she had very high anxiety with respect to this matter. The Hearing Tribunal accepts this explanation but notes that if a Registrant chooses to represent themselves in a hearing, they are responsible for attending the hearing, coming prepared to the hearing, and responding to communications from the College and Conduct Counsel in a timely manner. As such, some delay was attributable to the Registrant.

However, there were other delays in the hearing, which were not attributable to the actions of the Registrant. There were technical difficulties on many occasions, where the Registrant could not hear or could not be heard or had trouble accessing documents. The Chair paused the hearing several times to ensure that the Registrant was able to fully see and hear the proceedings and to access all documentation. This was necessary in order to ensure the fairness of the process. During the COVID-19 pandemic, virtual hearings were necessary to ensure the timeliness of proceedings, but they do carry risks associated with the use of technology. The Hearing Tribunal was also mindful that registrants may have varying levels of technical comfort and abilities. The Registrant in this case appeared at times to struggle with the virtual hearing platform. The Hearing Tribunal was satisfied that the process was fair to the parties, but is not prepared to attribute the costs relating to technological issues to the Registrant.

The Hearing Tribunal also considered the Registrant's conduct during the seven days of hearing. She did not ask for lengthy breaks and did not engage in prolonged questioning of witnesses. The Registrant did not engage in conduct that unnecessarily prolonged the hearing.

Finally, the Hearing Tribunal considered that several allegations were not found to be proven. Five of the eight allegations in the two Notices to Attend were not proven. A further two particulars of Allegation 2 from the First Notice to Attend were not proven. Much hearing time was spent on the allegations that were not proven. Several witnesses were called for the allegations that were not proven.

The Hearing Tribunal viewed that the Complaints Director, having assessed the case and witnesses that were going to provide evidence, should have reasonably anticipated the results, especially with respect to the Allegations in the Second Notice to Attend. Some of the Complaints Director's witnesses were not necessary, gave hearsay evidence that was not relied on by the Hearing Tribunal, or in the case of [RN Witness 4], gave evidence about areas of expertise where the witness did not have the technical skill to give expert evidence. (*Jaswal*, paragraph 50).

The Hearing Tribunal also considered that the Registrant could not be faulted for refusing to proceed with admissions on allegations that were ultimately not found to be proven. If a Registrant is presented with the possibility of an agreement with admissions of unprofessional conduct, these must be reasonable admissions. In this case, 5 of the 8 allegations were found by the Hearing Tribunal to not be proven.

Finally, the Hearing Tribunal considered the financial impact of a cost award. A costs award is not meant to be punitive. It is meant to recognize that registrants who engage in unprofessional conduct and proceed with a contested hearing where there are findings of unprofessional conduct will bear a cost consequence of this decision. This is appropriate otherwise the membership bears the entire costs of discipline hearings.

Having considered all of these factors, the Hearing Tribunal finds that it is appropriate for the Registrant to be responsible for a portion of costs. The Hearing Tribunal finds that $5,000 of costs with a period to pay the costs is reasonable and just in the circumstances.

The Hearing Tribunal finds that the Registrant must be held accountable and must be responsible for a portion of costs, but wants to set the Registrant up to succeed in complying with the sanction and have her return successfully to the profession of nursing. The sanctions and cost award, with time to pay, are reasonable and attainable.

ORDERS

The Hearing Tribunal makes the following orders:

SANCTION

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By no later than November 19, 2022, the Registrant shall provide proof, satisfactory to the Complaints Director, that the Registrant has successfully completed and passed the following course of study:

    a. **Professional Boundaries in Nursing (John Collins Consulting)**
    b. **Relational Practice and Communication - NURS 0173 (MacEwan)**
    c. **The Essentials of Nursing Documentation (CRNA Learning Module)**

3. By May 19, 2023, the Registrant shall pay a fine in the sum of $1,000.00, via payment to the College (the "Fine"), and noting the following terms may apply:

    i. pursuant to Section 82(3)(c) of the HPA, the Registrant may be automatically suspended for any non-payment;
    ii. if the Registrant fails to pay the Fine by the deadline indicated, the Complaints Director may publish an administrative notice regarding non-payment of the Fine

on the College's website including the Registrant's name and registration number and that the Fine arose from a resolution agreement with the College (the "Administrative Notice of Non-Payment");

iii. the Registrant must pay the Fine owed to the College, whether or not the Registrant has an active practice permit with the College; and

iv. the Fine is a debt owed to the College and if not paid, may be recovered by the College by an action of debt.

4. The Registrant shall pay $5,000.00 for the costs of the hearing, pursuant to section 82(1)(j) of the HPA, to the College by May 31, 2027. The costs may be paid in full at any time before the deadline. However, the Registrant must make minimum payments in the following installments:

a. $1,000.00 due on May 31, 2023;
b. $1,000.00 due on May 31, 2024;
c. $1,000.00 due on May 31, 2025;
d. $1,000.00 due on May 31, 2026; and
e. $1,000.00 due on May 31, 2027.

(the "**Condition(s)**")

5. The Registrant will provide proof of completion of the above-noted Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca .

COMPLIANCE

6. For clarity and certainty, the Registrant is, in addition to what is set out in this Order, required to complete any and all requirements as have been, or may be, imposed from the College's Registration Department. This Order does not supersede, or if complied with serve to satisfy, any such requirements from the College's Registration Department.

7. Compliance with this Order shall be determined by the Complaints Director of the College. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

8. The Registrant will provide proof of completion of the above-noted Condition(s) by the dates set out therein, to the Complaints Director, via e-mail at procond@nurses.ab.ca or confidential fax to 780.453.0546. If the Complaints Director deems it appropriate, and for the sole purpose of permitting the Registrant to proceed toward compliance with this Order, the Complaints Director may in her sole discretion make other minor adjustments to the Order that are in keeping with this Hearing Tribunal Order, without varying the substance of the Order.

9. Upon written request by the Registrant, any timelines outlined in this Order may be extended at the unfettered discretion of the Complaints Director, acting reasonably.

10. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of the HPA, or the information may

be treated as reasonable grounds under section 56 of the HPA and subject to a new complaint under Part 4 of the HPA.

11. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated non-compliance and any request for an extension.

CONDITIONS

12. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

13. The Registrar of the College will be requested to put the following condition against the Registrant's practice permit (current and/or future) and shall remain until the condition is satisfied:

    a. ***Course work required – Arising from Disciplinary Matter;***
    b. ***Shall pay fine – Arising from Disciplinary Matter; and***
    c. ***Shall pay costs – Arising from a Disciplinary Matter.***

14. Effective on the date of this Order, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

15. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

16. This Order takes effect on the date of this Order, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: June 10, 2022