COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **MARY SYLLA**, R.N. REGISTRATION #**102,834**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

JUNE 4, 2021

INTRODUCTION

A hearing was held on November 3, 2020; December 15, 2020; January 18, 2021 and June 4, 2021 via WebEx videoconference at the College and Association of Registered Nurses of Alberta ("CARNA") by the Hearing Tribunal of CARNA to hear a complaint against Mary Sylla R.N. registration #102,834.

Those present at the hearing were:

a. Hearing Tribunal Members:

Jason Anuik, Chairperson
Rosemary McGinnis
Kelly Osuna
Hugh Campbell, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Mary Marshall
James Hart

c. CARNA Representative:

Mick Wall, Conduct Counsel

d. Registrant Under Investigation:

Mary Sylla (sometimes hereinafter referred to as "the Registrant")

e. Registrant's Labour Relations Officer:

Silvie Montier

PRELIMINARY MATTERS

Conduct Counsel and the Labour Relations Officer for 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. A preliminary application was made on January 18, 2021 to join the hearing of this Registrant with hearings involving two other registrants of CARNA. The application was denied, and a separate written decision with reasons was issued by this Hearing Tribunal. No further preliminary applications were made during the hearing on June 4, 2021.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("HPA"), the hearing was open to the public. No application was made to close the hearing. The Chairperson read the rules for attendance by members of the public.

Conduct Counsel confirmed that the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend dated February 3, 2021 are as follows:

While employed as a Registered Nurse ("RN") at [a hospital in Edmonton AB], your practice fell below the standard expected of an RN when:

1. On or about [Date redacted] you failed to:
   a. Complete an adequate assessment of [Patient 1] when you did not complete a patient assessment on admission of the [Patient 1] to your care on Unit 35 because of the need for insertion of an epidural catheter; and
   b. Document a patient assessment following the insertion of the epidural catheter at 04:08 and throughout the remainder of the time that you provided care to [Patient 1];
   c. Complete adequate documentation of the care provided to [Patient 1], when you:
      i. documented [Patient 1]'s blood pressure once at 04:20 and failed to follow the employer guideline for ongoing monitoring of blood pressure in hypertensive disorders of pregnancy;
      ii. document [Patient 1]'s blood pressure throughout the remainder of the time you provided care to [Patient 1] despite interventions, including but not limited to; medication administration and fetal heart rate changes;
      iii. document your intrauterine resuscitation interventions in response to changes in FHR as low as 55; and
      iv. consistently document consults with or response by [Dr. Co-worker] even when FHR fell to 55;
   d. Complete an adequate assessment of [Patient 1] when you documented administration of oxygen at 8 liters per minute to [Patient 1], but did not assess [Patient 1]'s oxygen saturation because you did not attach a device to measure oxygen saturation to [Patient 1];
   e. Adequately document communication with the Charge Nurse while caring for [Patient 1];
   f. Follow the employer policy for patient chart documentation, requiring contemporaneous and chronological order of charting which was evidenced in the Centricity audit trail print, when you:
      i. on [date redacted] at 06:58, removed documentation created by you to [Patient 1]'s record at 05:24 and entered revised documentation for the same time of 05:24, when you knew or ought to have known that you were required to record corrections clearly and include the date and time the correction was made;
      ii. on [date redacted] at 07:16, removed documentation created by you to [Patient 1]'s record at 05:46 and entered revised documentation for the same time of 05:46, when you knew or ought to have known that you were required to record corrections clearly and include the date and time the correction was made;

iii. on [date redacted] at 07:16, removed documentation created by you to [Patient 1]'s record at 06:20 and entered revised documentation for the same time of 06:20, when you knew or ought to have known that you were required to record corrections clearly and include the date and time the correction was made;

iv. on [date redacted] at 07:17, removed documentation created by you to [Patient 1]'s record at 04:36 and entered revised documentation for the same time of 04:36, when you knew or ought to have known that you were required to record corrections clearly and include the date and time the correction was made; and

v. On [date redacted] at 07:18 entered additional documentation to the entry made at of 06:32, when you knew or ought to have known that you were required to record corrections clearly and include the date and time the correction was made;

g. Failed to follow the employer policy for patient chart documentation requiring that you document only your own actions or observations and clearly identify who is documenting the information, in the late entry documented by you on [date redacted] at 07:52 for [date redacted] 04:30, which was made following a meeting with, and on recommendation from, nursing management.

The Registrant admits to the conduct in the allegations in the Agreed Statement of Facts and Admissions entered as Exhibit #4 ("Allegations") as follows, and admits that they constitute unprofessional conduct.

On or about [date redacted] you failed to:

a) Complete an adequate assessment of [Patient 1] when you did not complete a patient assessment of [Patient 1] on admission to your care because of the need for insertion of an epidural catheter;

b) Document an adequate patient assessment throughout the remainder of the time that you provided care to [Patient 1];

c) Complete adequate documentation of the care provided to [Patient 1], when you:

i. Failed to ensure that [Patient 1]'s blood pressure was monitored according to employer guidelines for on-going blood pressure monitoring in hypertensive disorders of pregnancy; and

ii. Failed to document some of your interventions, including consults with [Dr. Co-worker] and some of your intrauterine resuscitation interventions, even when the fetal heart rate fell to 55.

d) Follow the employer policy for patient chart documentation, which requires that late entries or corrections be clearly identified and that they include the date and time the correction or late entry was made, when you:

i. on [date redacted] at 06:58, added a late entry, "[dr. co-worker] in room viewed strip went to ask for zofran LE", to your contemporaneously recorded documentation on the Patient Chart for 05:24, "patient feeling nauseas", without recording the date and time of the late entry;

ii. on [date redacted] at 07:16, changed your original contemporaneous documentation on the Patient Chart for 05:46 from "[dr. co-worker] room

position of babe is OP" to "[dr. co-worker] room viewed strip position of babe is OP" without indicating the original entry was changed and without recording the time of the change;

iii. on [date redacted] at 07:16, changed your original contemporaneous documentation on the Patient Chart for 06:20 from "[dr. co-worker] in room" to "[dr. co-worker] in room view strip" without any indication the original entry was changed and without recording the time of the change; and

iv. on [date redacted] at 07:17, changed your original contemporaneous documentation on the Patient Chart for 04:36 from "[dr. co-worker] in room checking position" to "[dr. co-worker] viewed strip in room checking position" without any indication the original entry was changed and without recording the time of the change.

EXHIBITS

The following documents were entered as Exhibits:

NUMBER	DESCRIPTION	
Hearing of November 3, 2020		
Exhibit #1:	Affidavit of CARNA Legal Assistant M. Skoreiko (Affidavit of Ms. Marina Skoreiko)	
	Exhibit A	Email from S. Montier to N. Nakai dated October 27, 2020
	Exhibit B	Email from S. Montier to N. Nakai dated October 28, 2020
	Exhibit C	Email from S. Montier to C. Jones dated October 28, 2020

Hearing of January 18, 2021		
Exhibit #1:	CARNA Submissions (Written Submissions of CARNA Conduct Counsel)	
	Statutory Law	*Health Professions Act*, c H-7
	Case Law	College of Nurses of Ontario v. Member, 2013 CanLII 101345 (ON CNO)
		Imperial Oil v. Jacques, 2014 SCC 66
		Law Society of Upper Canada v. Dorothy Elizabeth DeMerchant, 2011 ONLSHP 121 (CanLII)
		Miller v. Council for Licensed Practical Nurses, 1999 CanLII 19805 (NL SC)

Hearing of January 18, 2021		
		Real Estate Council of Alberta v. Henderson, 2006 ABQB 520
		R. v. Last, 2009 SCC 45
		R. v. Sciascia, 2017 SCC 57
		Re Ziaian, 2020 IIROC 34 (CanLII)
	Other	Submissions on Hearing Dates, 2020 DEC 14
Exhibit #2:	UNA Submissions (Response to Joinder Application made by CARNA)	
	Case Law	*The Law Society of Upper Canada v. Dorothy Elizabeth DeMerchant*, (2011) ONLSHP 0121
		Miller v. British Columbia Rapid Transit, (1926) 1 W.W.R. 543
		Chamberland v. Provincial, (2008) O.J. 4505
Hearing of June 4, 2021		
Exhibit #3:	Notice to Attend dated February 3, 2021	
Exhibit #4:	Agreed Statement of Facts and Admission of Unprofessional Conduct	
Exhibit #5:	Joint Recommendations on Sanction	
Exhibit #6:	Excerpt from *Jaswal v. Newfoundland Medical Board*, (1996), 42 Admin L.R. (2d) 233 ("*Jaswal*")	

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. Conduct Counsel reviewed the Agreed Statement of Facts and Admission of Unprofessional Conduct (Exhibit #4). [Patient 1] was transferred into the care of the Registrant early in the morning of [date redacted]. She was documented as being in pain and involuntarily pushing. The Registrant did not conduct an initial assessment as she was getting [Patient 1] situated for an epidural.

The fetal heart rate varied and was abnormal throughout the labour. The Registrant did not document that the fetal heart rate was abnormal, decelerations or accelerations. She did not document that the attending physician viewed the fetal heart rate and was aware of the nature of it. There was no assessment to investigate what may be causing the nature of the fetal heart rate. The Registrant did some interventions including changing the position of [Patient 1] and oxygen, but there were no other interventions or communications about the fetal heart rate with [Patient 1] or her partner. [Patient 1] gave birth to a [baby] who did not have a heartbeat and was not breathing. A heartbeat was started after 18 minutes. The baby passed away in the hospital.

There were significant documentation concerns. There was evidence from an audit that the Registrant went back and amended her entries to the chart. In each case the entries were amended to show that the physician was in the room, and that the physician "viewed strip". In one situation it was noted that it was a late entry, but there were no notations for the others. It appeared that the entries to the chart were made contemporaneously.

Conduct Counsel submitted that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i), (ii) and (xii) of the HPA.

Conduct Counsel noted that the following Practice Standards were applicable: Standards 1.1, 1.2, 1.4, 2.2, 2.3, 2.4, 2.5, 2.7, 3.1, and 4.2.

Conduct Counsel also noted that the following provisions from the Code of Ethics applied: A1, A3, B4, D6, E11, G1, and G4.

Submissions by the Labour Relations Officer for the Registrant:

The Registrant's Labour Relations Officer submitted that this was a documentation issue. The Registrant provided proper care but failed to document her interventions. The alterations to the patient chart appear to be falsifications but that is not the case at all. The Registrant took her guidance from the physician and added information to the chart later. It was poor charting practice and not falsification.

Submissions by Conduct Counsel:

Conduct Counsel submitted that the Agreed Statement of Facts and Admission of Unprofessional Conduct shows that this was not strictly a documentation issue.

Questions from the Hearing Tribunal:

The Hearing Tribunal requested submissions on the applicability of the Documentation Standards for Regulated Members, and specifically Standards 1.1, 1.2, 1.4, and 1.16.

Submissions by Conduct Counsel:

Conduct Counsel submitted that it was not necessary to refer to the Documentation Standards for Regulated Members, and sufficient guidance was provided by Practice Standard 2.5.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer for the Registrant submitted that she was in agreement with the submission made by Conduct Counsel. A Practice Standard is the main guidance for nurses, and the Documentation Standards for Regulated Members do not add anything.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal has reviewed the exhibits and considered the submissions made by the parties. The Hearing Tribunal noted the differences between the allegations in the Notice to Attend dated February 3, 2021 (Exhibit #3) and the Allegations in the Agreed Statement of Facts and Admissions (Exhibit #4), and amended them accordingly so that this hearing will consider the Allegations in the Agreed Statement of Facts and Admissions.

The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that the Allegations are proven and that the Registrant's conduct constitutes unprofessional conduct under section (1)(1)(pp)(i), (ii) and (xii) of the HPA, as follows:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice;
>
> (xii) conduct that harms the integrity of the regulated profession.

The Hearing Tribunal finds that the proven conduct breached the following provisions in the Standards of Practice: 1.1, 1.2, 1.4, 2.2, 2.3, 2.4, 2.5, 2.7, 3.1, and 4.2

Standard One: Responsibility and Accountability

The nurse is personally responsible and accountable for their nursing practice and conduct.

Indicators

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

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

1.4 The nurse practices competently.

Standard Two: Knowledge-Based Practice

The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

2.2 The nurse uses appropriate information and resources that enhance client care and the achievement of desired client outcomes.

2.3 The nurse uses critical inquiry in collecting and interpreting data, planning, implementing and evaluating all aspects of their nursing practice.

2.4 The nurse exercises reasonable judgment and sets justifiable priorities in practice.

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

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Standard Three: Ethical Practice

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

Indicators

3.1 The nurse practices with honesty, integrity and respect.

Standard Four: Service to the Public

The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Indicators

4.2 The nurse collaborates with the client, significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation.

The Hearing Tribunal finds that the proven conduct breached the following provisions in the Documentation Standards for Regulated Members: 1.1, 1.2, 1.4, and 1.16

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

Criteria:

The nurse must:

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***

1.4 Record:

a. legibly, in English, using clear and established terminology

b. accurately, completely and objectively

c. only information relating to own encounter with the client

d. chronologically, the client ***encounter*** with the health system

e. ***contemporaneously***

f. late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy

g. in permanent ink on paper records

h. using only own password/personal access code on electronic entries

i. the date and time that nursing care was provided

j. communication with other care providers, including name and outcomes of discussion

k. communication with clients following discharge from care according to employer policy

1.16 In an electronic client care record:

a. use only personal password (or access card) to access, or enter information into a client care record that is within an electronic documentation system

b. take reasonable steps to maintain the security of user password(s) or access card and use safeguards such as logging off when finished using electronic documentation system

c. correct own documentation, enter the correct information, the date and time of the new entry, so that the author can be clearly identified

The Hearing Tribunal finds that the proven conduct breached the following provisions in the 2017 Code of Ethics: A1, A3, B4, D6, E11, G1, and G4

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

3. Nurses build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a

conscious effort. Such relationships are critical to understanding people's needs and concerns.

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

E. Maintaining Privacy and Confidentiality

Nurses recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship.

Ethical responsibilities:

11. In all areas of practice, nurses safeguard the impact new and emerging technologies can have on patient privacy and confidentiality, **professional boundaries** and the professional image of individual nurses and the organizations in which they work (CNA, 2012). They are also sensitive to ethical conduct in their use of electronic records, ensuring accurate data entry and avoiding the falsification or alteration of documentation.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

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

4. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

The Registrant received [Patient 1] in her care on or about [date redacted] at 03:46. At 06:39 on [date redacted], [Patient 1] delivered a [baby] ("Baby 1"). At birth, [Baby 1] was not breathing and had no detectable heart rate. The Neonatal Intensive Care Unit team began resuscitation efforts and succeeded in establishing a heartbeat after 18 minutes. On [Date redacted], after suffering an occipital lobe hemorrhage and developing seizures, care was withdrawn. Tragically [Baby 1] passed away on [Date redacted]. This hearing concerns the care provided by the Registrant and related documentation.

The Registrant did not assess [Patient 1] on receipt into her care. She explained that she did not perform an initial assessment as she was focused on getting [Patient 1], who was in pain and documented to be involuntarily pushing, situated for her epidural. At 04:08 an epidural was started, and the Registrant performed a patient assessment that did not include a complete fetal heart rate assessment and classification. At approximately 04:20, the Registrant placed the fetal heart rate monitor on [Patient 1]. The Registrant did not, at that time or at any time during [Patient 1]'s active labour, document fetal heart rate variability, accelerations, decelerations, or classify it as normal, atypical, or abnormal. The Registrant failed to complete an adequate assessment of [Patient 1] when she did not complete a patient assessment of [Patient 1] on admission to her care because of the need for insertion of an epidural catheter. The Registrant failed to document an adequate patient assessment throughout the remainder of the time that she provided care to [Patient 1].

At 04:20, the Registrant documented [Patient 1]'s blood pressure as 134/81/99 (Sys/Dia/Mean) and heart rate at 82. No further documentation of [Patient 1]'s vital signs was recorded after 04:20, including blood pressure and heart rate, before [Patient 1] delivered at 06:39. According to the Registrant, the monitor was set to automatically record [Patient 1]'s vital signs at regular intervals but she did not ensure that it was doing so during [Patient 1]'s labour and delivery. The Registrant failed to complete adequate documentation of the care provided to [Patient 1], when she failed to ensure that [Patient 1]'s blood pressure was monitored according to her employer's guidelines for ongoing blood pressure monitoring in hypertensive disorders of pregnancy.

Between 04:36 and 05:24, the fetal heart rate was abnormal with repeated variable decelerations and the documented fetal heart rate baseline rate as follows: 04:36-**105**, 04:40-**110**, 04:44-**140**, 04:50-**95**, 04:56-**70**, 05:02-**55**, 05:07-**95**, 05:10-**150**, 05:15-**110**, and 05:20-**140**. Despite the abnormal fetal heart rate, the Registrant did not document any assessment aimed at investigating the abnormal fetal heart rate to identify a potential cause, nor did the Registrant document any consultations with the charge nurse, [Dr. Co-worker], or [Patient 1] and her partner. The Registrant states that to address the abnormal fetal heart rate, she also directed [Patient 1] to pause pushing. However, other than administering oxygen at 04:30 and 05:02 and re-positioning [Patient 1] at 04:23, the Registrant did not document any assessment to investigate, or other intrauterine resuscitation intervention to address, the abnormal fetal heart rate. The Registrant did document that [Dr. Co-worker] viewed the fetal heart rate strip at 04:30 and 05:47 but did not document consultations with [Dr. Co-worker], or [Patient 1] and her partner. The Registrant failed to complete adequate documentation of the care provided to [Patient 1], when she failed to document some of her interventions, including consults with [Dr. Co-worker] and some of the intrauterine resuscitation interventions, even when the fetal heart rate fell to **55**.

According to the Patient Chart, at 04:36, the Registrant documented that "[dr. co-worker] viewed strip in room checking position". However, the Centricity Audit indicates that the Registrant, in fact, contemporaneously documented "[dr. co-worker] in room checking position" and it was only

at 07:17:36, approximately 38 minutes post-partum, that the Registrant added the words "viewed strip". The Registrant did not indicate that her addition was a correction or otherwise indicate that it was a late entry. The Registrant did not follow the employer policy for patient chart documentation when she changed her original contemporaneous documentation on the Patient Chart for 04:36 from "[dr. co-worker] in room checking position" to "[dr. co-worker] viewed strip in room checking position" without any indication the original entry was changed and without recording the time of the change.

At 05:24, the Registrant documented that "patient feeling nauseas". However, at 06:58, 20 minutes post-partum, the Registrant added the following separate statement to her original note "[dr. co-worker] in room viewed strip went to ask for Zofran LE 11" LE indicates a late entry, though the Registrant did not record the time of the entry, which was only ascertained by the Centricity Audit. The Registrant failed to follow the employer policy for patient chart documentation, which requires that late entries include the date and time the late entry was made.

At 05:46, according to the Patient Chart, the Registrant documented "[dr. co-worker] room viewed strip position of babe is OP". The Centricity Audit indicates, however, that the Registrant contemporaneously documented only "[dr. co-worker] room position of babe is OP". It was only at 07:16:39, approximately 37 minutes post-partum, that the Registrant added the words "viewed strip" to her original documentation. The Registrant did not identify her addition as a correction or otherwise indicate that it was a late entry. The Registrant did not follow the employer policy for patient chart documentation, which requires that a late entry be clearly identified and that they include the date and time the correction or late entry was made, when she changed her original contemporaneous documentation on the Patient Chart for 05:46 from "[dr. co-worker] room position of babe is OP" to "[dr. co-worker] room viewed strip position of babe is OP" without indicating the original entry was changed and without recording the time of the change.

At 06:20, according to the Patient Chart, the Registrant documented "[dr. co-worker] in room viewed strip". According to the Centricity Audit, however, the Registrant contemporaneously documented only "[dr. co-worker] in room". It was only at 07:16, approximately 37 minutes post-partum, that the Registrant added the words "viewed strip" to her original documentation. The Registrant did not indicate that her addition was a correction or otherwise indicate that it was a late entry. The Registrant did not follow the employer policy for patient chart documentation, which requires that late entries be clearly identified and that they include the date and time the correction or late entry was made, when she changed her original contemporaneous documentation on the Patient Chart for 06:20 from "[dr. co-worker] in room" to "[dr. co-worker] in room view strip" without any indication the original entry was changed and without recording the time of the change.

The Hearing Tribunal finds that the proven conduct relating to assessments and documentation demonstrates a lack of skill or judgment in the provision of professional services; a failure by the Registrant to meet the Practice Standards, Documentation Standards for Regulated Members, and Code of Ethics; and is conduct that harms the integrity of the profession, all of which is unprofessional conduct as defined by sections 1(1)(pp)(i), (ii) and (xii) of the HPA. The Allegations refer to the Registrant's failure to adhere to the employer's policy for record-keeping. The Documentation Standards for Regulated Members provide clear guidance regarding record-keeping, and the Registrant's conduct was not in compliance. The Documentation Standards for Regulated Members stipulate that the nurse must record contemporaneously; clearly identify late entries and include any additional requirements as defined by practice setting policy; and record communication with other care providers including name and

outcomes of discussion. The breaches of the Practice Standards, Code of Ethics, and the Documentation Standards for Regulated Members are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA. The Registrant changed and added information to the patient chart without identifying late entries or corrections, and including the date and time the correction or late entry was made.

Accurate patient records are an essential part of good patient care. Poor record-keeping can compromise patient care and have other serious repercussions. The Registrant failed to meet the standards of the profession. Omissions of essential information pertaining to examinations and treatment tarnish the reputation of the profession.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations on Sanction (Exhibit # 5). The Joint Recommendations are the result of extensive discussions and address the conduct that is under consideration.

Conduct Counsel reviewed some of the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case. The only factors that will be mentioned are those that are particularly relevant.

1. *The nature and gravity of the proven allegations*: The allegations all speak to the lack of an adequate assessment and documentation. If something is not documented, it is not taken to be done. There were also instances of retroactive changes to the patient record without identification of late entries, and making the changes look like concurrent documentation. This is problematic from CARNA's perspective and the perception of falsifications can undermine public confidence.

2. *The age and experience of the member*: At the relevant time, the Registrant was a new member of CARNA and relatively inexperienced. She was very young.

3. *The previous character of the member*: There are no previous complaints against the Registrant.

4. *The role of the registered nurse in acknowledging what occurred*: There was no early acknowledgment by the Registrant. However, she did come forward and admit to the facts in advance of the hearing. She deserves credit for not requiring witnesses to appear. The complainant did not have to recount a traumatic event.

5. *The impact on the offended patient*: Changing records after the fact is a serious matter and impacts on the parents' ability to understand what happened and seek civil redress.

6. *The need to promote specific and general deterrence*: Both specific and general deterrence are important in this instance. With the move to electronic medical records, it is imperative that the members of CARNA are aware that records must be done in a timely way.

7. *The need to maintain public confidence*: Failure to properly document care can undermine public confidence.

Conduct Counsel submitted that in light of these factors, the recommended penalty is sufficient to address the Registrant's conduct. Deterrence is important here and there is a large fine. Information is recorded chronologically on paper records. However, with the move to electronic health records, it is important to document and time-stamp patient records. Altering entries on a patient chart can undermine public perception and public confidence in the profession of nursing. In light of all these factors, a $2,000 fine is appropriate. The coursework relates directly to the conduct that was at issue and is rehabilitative and not punitive.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer for the Registrant submitted that it is important to start by looking at what was lacking in the practice of the Registrant, which was adequate documentation. A documentation course is required to educate the Registrant. The Registrant failed to document her communication with the physician. There is also a small problem with assessment and there is a course that addresses assessment.

The biggest problem is documentation which was corrected at a later time. Responsible Nursing is a good course which covers many things, and the Registrant will learn a great deal from this course and the problems will be addressed.

A fine is part of the penalty, and this is expensive for the Registrant.

CARNA is not alleging that the Registrant's conduct contributed to the death of the baby, which was a very grave outcome. Instead, the allegations deal with a lack of assessment and documentation. The Registrant was a young nurse with very little experience.

There were no previous complaints, and no further complaints after this one. The Registrant is a good nurse with good character. The Registrant always admitted to the facts, and she is now admitting that they constitute unprofessional conduct. There is a wide gap between those two admissions. The Registrant was aware of what she did that wasn't right, and she came to an understanding of what is unprofessional conduct in the circumstances. The mitigating factor is that she was a young nurse who was guided by the physician. The Registrant took her cue from that, and she did not have the experience to disagree with the physician if that was necessary.

There are no comparable situations. The Registrant would like to remedy the situation, and she will do so. The goal here is to remediate the situation, and the proposed penalty will achieve exactly that.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal has carefully considered the joint recommendations on sanction, and the submissions of the parties. The Hearing Tribunal has considered the factors noted in *Jaswal v. Newfoundland Medical Board.* The Hearing Tribunal accepts the joint recommended sanction. The joint recommendations take into account the nature of the findings of the Hearing Tribunal. They also address the issues that brought this Registrant before the Hearing Tribunal. The Hearing Tribunal finds that this recommended sanction appropriately considers the factors in *Jaswal.* The Hearing Tribunal also considered the penalty in light of the principle that joint recommendations should not be interfered with lightly.

The Hearing Tribunal finds that a reprimand and fine are appropriate. Deficits in assessments and record-keeping are serious. A reprimand and fine will send a clear message to the membership and the public that they are a vital part of patient care. It will also reinforce to the Registrant that her failure to maintain the standards of practice of the profession is a serious finding. The Registrant should take the comments in the written decision as well as the concerns expressed by the Hearing Tribunal with respect to her conduct as her reprimand. In addition, the Registrant should consider her experiences in dealing with this complaint before this Hearing Tribunal and CARNA, as well as the joint recommendations on sanction, as a reminder of how important it is to practise in accordance with the Practice Standards, the Code of Ethics, and the Documentation Standards for Regulated Members.

The Hearing Tribunal understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. This penalty would serve to remind the profession that proper charting is a necessary obligation related directly to good patient care. To be remiss in recording accurately may result in disciplinary proceedings and, most importantly, compromises safe patient care, putting in jeopardy the well-being of those whom nurses are entrusted to serve. The penalty will assure the public that serious transgressions will be met with sanctions. The Registrant will be deterred from further unprofessional conduct by this penalty. The courses will reinforce high standards for her practice.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Registrant, Mary Sylla, #102,834, (the "**Registrant**") shall receive a reprimand for unprofessional conduct.
2. By no later than **February 1, 2022**, the Registrant shall provide proof satisfactory to the Complaints Director, that the Registrant has successfully completed and passed the following courses of study:
    a. **Responsible Nursing (NURS 0170, MacEwan University)**
    b. **Intro to Health Assessment (NURS 0163, MacEwan University)**
    c. **Relational Practice and Communication (NURS 0173, MacEwan University)**
    d. **The Essentials of Nursing Documentation (CARNA Online Course)**
3. By **June 4, 2022**, the Registrant shall pay a fine in the sum of $2,000.00, via payment to MyCARNA (the "**Fine**"), and noting the following term may apply:
    a. Pursuant to Section 82(3)(c) of the HPA, the Registrant may be automatically suspended for any non-payment; and
    b. 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 CARNA's website including the Registrant's name and registration number and that the Fine arose from a resolution agreement with CARNA (the "Administrative Notice of Non-Payment").

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

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

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

COMPLIANCE

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

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

7. 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.

8. 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.

9. 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.

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

CONDITIONS

11. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is under an undertaking to not work, is on sick leave or disability leave, or if the Registrant have not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor, or volunteer. The Registrant confirms the following employment:

Employer Name	**Employer Address & Phone Number**
[an Edmonton AB hospital]	[an Edmonton AB hospital contact information redacted]
Alberta Health Services	[an Edmonton AB hospital contact information redacted] (Casual)

12. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform CARNA 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 CARNA 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***; and
    b. ***Shall pay fine***
14. Effective on June 4, 2021, 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 June 4, 2021 and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

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

Respectfully submitted,

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Jason Anuik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: June 4, 2021