COLLEGE OF REGISTERED NURSES OF ALBERTA (the “**College**”)

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **NOLI REYES**, R.N. REGISTRATION #**90,737**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

FEBRUARY 14, 2024

INTRODUCTION

A hearing was held on **February 14, 2024,** via Microsoft Teams videoconferencing by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**") to hear a complaint against **Noli Reyes**, R.N. registration #90,737.

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, RN Chairperson
John Bradbury, RN
Sarita Dighe-Bramwell, Public Representative
Vince Paniak, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. CRNA Counsel:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Noli Reyes (sometimes hereinafter referred to as "the **Registrant**")

e. Registrant's Labour Relations Officer:

Pippa Cowan

f. CRNA Staff

Lisa Legaspi, Hearings Coordinator attending as Clerk, supporting the Chair of the Tribunal in procedural management of virtual proceeding technology.

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. No preliminary applications were made.

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. There were members of the public attending the hearing as observers, including Hearing Tribunal members attending for educational purposes.

Conduct Counsel confirmed that the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend are as follows:

1) On or around June 12, 2020, the Registrant displayed a lack of knowledge, skill and/or judgment and/or violated a code of ethics or practice standard when they failed to adequately assess and/or ensure their competency to provide care to [Patient 1] when they did one or more of the following:

    i. Failed to provide adequate care to [Patient 1] pre-birth, during birth and/or post-birth;

    ii. Failed to provide adequate and/or appropriate support for [Patient 1] pre-birth, during birth and/or post-birth.

2) On or around June 12, 2020, the Registrant displayed a lack of knowledge, skill and/or judgment and/or violated a code of ethics or practice standard when they failed to adequately adhere to one (1) or more employer policies when providing care to [Patient 1].

3) On or around June 12, 2020, the Registrant failed to sufficiently document their care of [Patient 1].

It is further alleged that the Registrant's conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the *Health Professions Act*, including:

The conduct underlying Allegations 1, 2 and 3 contravenes one (1) or more of the following: the Canadian Nurses Association (CNA) Code of Ethics ("**CNACE**"); the CARNA's Practice Standards for Regulated Members (2013) ("**CPSRM**"); and the CARNA's Documentation Standards for Regulated Members (2013) ("**CDSRM**").

The Registrant has admitted to the conduct in the allegations in the Agreed Statement of Facts and Liability (Exhibit #2).

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend a Hearing

Exhibit #2 – Agreed Statement of Facts and Liability

Exhibit #3 – Joint Recommendations on Sanction

Exhibit #4 – Course Outlines

Exhibit #5 – *Jaswal* v. *Newfoundland Medical Board*, 1996 CanLII 11630 (NL SC).

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. Conduct Counsel thanked the Registrant and the Labour Relations Officer for their cooperation in reaching an agreement.

Conduct Counsel noted that the task of the Hearing Tribunal was to determine if the allegations were proven and whether the conduct constituted unprofessional conduct and if so, to determine what sanction should be imposed on the Registrant. Conduct Counsel reviewed the Agreed Statement of Facts and Liability (Exhibit #2).

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

Conduct Counsel noted that the following CPSRM were applicable: Standards 1.2, 1.4, 2.2, 2.4, 2.5, 2.7, 3.4, 4.2, 4.4, 5.3, 5.5 and 5.6. Conduct Counsel also noted that the following provisions from the CNACE applied: A1, A2, A3, A6, B1, B2, C1, C6, D6, G1 and G3. Conduct Counsel noted that the following provisions from the CDSRM applied: 1.1, 1.2 and 1.4.

Submissions by the Labour Relations Officer for the Registrant:

The Registrant's Labour Relations Officer advised that she had no submissions on the allegations.

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 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) 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.

The following facts and admissions are from the Agreed Statement of Facts and Liability.

<u>Background</u>

In October 2003, the Registrant graduated with a Bachelor of Science in Nursing from University of La Salette, Philippines. In December 2009, the Registrant graduated from the Bridge to

Canadian Nursing Program from Mount Royal University. In March 2011 the Registrant registered with the College.

On November 3, 2022, the Complaint Director received a written complaint (the "Complaint") from [Patient 1]. The Complaint alleged that the Registrant did not provide adequate medical care to [Patient 1] during her pregnancy in June 2020, by failing to provide hands on care and assistance to her and her neonate during and after delivery, failing to call a physician to assist with the delivery, and failure to provide her with care regarding the retained placenta despite significant hemorrhaging.

Following an investigation, the Complaints Director determined that a Hearing be held pursuant to the HPA and referred three allegations to a hearing.

The Registrant does not have a discipline history with the College.

Factual and Liability Admissions

At the time [Patient 1] was assigned as his patient, the Registrant had worked as a full-time RN at Unit 5 East of the Misericordia Hospital (the "**Unit**"), a surgical unit, for approximately seven years. The Unit managed all births with a gestational age of less than twenty (20) weeks. On the Unit there is a Compassion Room (the "Room") which is used for both an end-of-life room for patients as well as fetal demise. The Room is not specifically set up for fetal demise.

The Registrant was oriented into the Unit, has received continuing education and was aware of the following policy and materials:

- RN Job Description
- Covenant Health Policy: Fetal Demise/Miscarriage < 20 weeks
- Covenant Health Policy: Supporting Perinatal Loss in a Primary Healthcare Setting- Information and Strategy for Care Providers
- AHS Code of Conduct
- Covenant Health Policy: Misericordia and Grey Nuns Surgery Programs-Instructions for use of the Nursing Assessment and Care Record.

The relevant Unit policies and materials are included at Appendix A to this decision.

The Registrant had experience with fetal demise in the form of buddying with other staff when they cared for a fetal demise and his own self-study. In June 2020, education on fetal demise was not included during orientation. The Registrant did not participate in any formal education on fetal demise.

[Patient 1] was initially sent to the obstetrical unit by her obstetrician, then she was sent to the emergency room, until she was eventually sent to the Unit. [Patient 1] was admitted to the Unit on June 11, 2020.

[Patient 1] was approximately eighteen and a half weeks pregnant when she was admitted to the Unit. On June 3, 2020, the exam date, an obstetrical ultrasound confirmed that [Patient 1] had a single live intrauterine gestation with an estimated gestational age of eighteen weeks and three days.

The Registrant was assigned to care for [Patient 1] on the Unit on June 12, 2020, the date [Patient 1] gave birth, due to him being the RN on duty with the most experience with fetal demise. The Registrant was [Patient 1]'s primary nurse on June 12, 2020, and received the patient into care at 0730 hours. [Patient 1] delivered a live birth at 0928 hours on June 12, 2020, in the Room. [Patient 1]'s partner, the father, was present during the birth. The Registrant was [Patient 1]'s primary nurse on June 13, 2020, when the patient was discharged at 1020 hours.

On June 12, 2020, a plan of care (the "**Plan**") was formulated for [Patient 1] as indicated in the progress notes and patient care orders. At 0730 hours on June 12, 2020, [Patient 1] was seen by a resident physician, with a plan for cerclage. At 0735 hours on June 12, 2020, the night nurse wrote "Prometrium…can give a dose this AM" in the Patient Care Orders. At 0748 hours on June 12, 2020, it was determined by a resident physician that [Patient 1] was cramping and bleeding and this needed to stop before cerclage was attempted. [Patient 1] was to be observed, and to start prometrium.

The Registrant failed to review the Plan and consequently was unaware of the Plan in place for [Patient 1]. The Registrant was not aware of the physician's direction regarding stopping the bleeding and then attempting cerclage, nor that prometrium was to be administered in the AM. The Medical Administration Record indicates that the prometrium was processed by an RN to be given at 1000 hours. The prometrium was never administered prior to the birth.

On the Unit the assessment and care provided for a patient is documented in the Nursing Assessment and Care Record. The totality of the Registrant's documented assessment and care provided between the time the Registrant received [Patient 1] into care at 0730 hours on June 12, 2020, and the time [Patient 1] was discharged on June 13, 2020, at 1020 hours is contained in the Nursing Assessment and Care record. The Instructions for Nursing Assessment and Care Record requires narrative notes on any areas that are exceptions to the patient's care and/or asterisked.

At 0805 hours on June 12, 2020, the Registrant charted that [Patient 1] had "broke her bag". The Registrant did not assess the fluid, nor did he call the doctor, when delivery was imminent. The Registrant failed to page the appropriate physician, for history, physical examination, consent, orders, and administration of misoprostol, nor did he reassure the patient that he would be available throughout the difficult process, contrary to the Supporting Perinatal Loss Policy, Anticipatory Guidance. The Registrant also failed to adhere to section 4.1 of the Fetal Demise Policy which delineates that when a mother is in labor and contracting regularly the physician is called under section 4.1.1. The Supporting Perinatal Loss Policy also requires a nurse to page the appropriate physician when delivery is imminent. The Registrant failed to communicate with the physician in a timely and appropriate manner contrary to principle two of the AHS Code of Conduct.

At 0915 on June 12, 2020, the Registrant charted that the patient was in "a lot of pain" but did not chart the care provided to address the pain in the Nursing Assessment and Care Record, and how [Patient 1] responded.

On June 12, 2020, prior to the birth, the Registrant did not educate [Patient 1] on the potential outcome of either a live birth or a fetal demise. Section 5.9 of the Fetal Demise Policy requires that any teaching given be documented on the narrative notes. The Registrant did not provide any teachings prior to the birth.

At 1000 hours on June 12, 2020, the Registrant charted that the "patient delivered the fetus around 0928 hours". The Registrant also charted that the obstetrician was "paged and informed". There is no mention of a live birth, how the delivery took place, the care or support provided to [Patient 1], nor the care or support provided surrounding the birth, aside from a statement that the Registrant "stayed with the patient and provided comfort". The charting does not indicate what, if any, psychosocial support was provided to [Patient 1]. Section 5.8 of the Fetal Demise Policy requires documentation of the psychological state of mother, father and/or significant other and to record support given/offered. The Registrant did not document the psychological state of [Patient 1], the father, or the support given/offered. The Registrant failed to reassure that support is available as required by section 6.5 of the Fetal Demise Policy. The Registrant also failed to provide any teachings after the birth. Section 5.9 of the Fetal Demise Policy requires that on the narrative notes document any teaching given. The Registrant did not provide the teachings required under 6.1, 6.2, 6.4 of the Fetal Demise Policy. The charting also does not indicate that the Registrant adhered to the Supporting Perinatal Loss Policy.

The Registrant enlisted the help of an RN clinical educator from the Unit (the "**RN CE**") and an RN surgical float (the "**RN SF**") nurse shortly after the delivery. The Registrant was not prepared for a live birth and consequently required help. When the RN SF arrived in the room, the neonate was between [Patient 1]'s legs and the Registrant was standing by [Patient 1]'s feet and was not doing anything apparent. [Patient 1] delivered the neonate in bed on her knees. The RN CE was already in the room when the RN SF arrived. When the neonate was still attached to the placenta, the Registrant did not cut the umbilical cord due to discomfort with the procedure. The Registrant did not follow the steps delineated in 4.2.1, 4.2.2 and 4.2.3 of the Fetal Demise Policy. Instead, the Registrant brought in the RN CE to cut the umbilical cord. After the neonate stopped breathing, the RN CE weighed the neonate, took handprints, footprints, made memory cards and filled out a card for the patient. After the preparation was complete, the RN CE informed the Registrant that the neonate was left in the service room.

The Registrant did not clean the neonate at any point, nor did he wrap the neonate in a small towel or blanket before or after the neonate stopped breathing, contrary to section 4.4 of the Fetal Demise Policy.

As [Patient 1]'s primary nurse, the Registrant did not register the neonate as a live birth, nor did he ensure the neonate was registered as a live birth. The Covenant Health Policy: Supporting Perinatal Loss in a Primary Healthcare Setting- Information and Strategy for Care Providers and the Covenant Health Policy: Fetal Demise/Miscarriage < 20 weeks do not indicate the process for registering a live birth.

The obstetrician assessed [Patient 1] at approximately 1000 hours on June 12, 2020, and [Patient 1] was started on an oxytocin infusion at 1000 hours. At 1230 the patient passed a "huge clot" and a physician was paged. The placenta was undelivered. [Patient 1] was sent to the operating room at 1430 hours.

The placenta was manually removed successfully from [Patient 1] during surgery.

The Registrant received [Patient 1] into care from the recovery room at 1620 hours on June 12, 2020. The Registrant conducted a head-to-toe assessment at 1630 hours. Another nurse received [Patient 1] into care at 1910 hours.

At 0915 hours on June 13, 2020, [Patient 1] was received back in to care by the Registrant. At 1000 hours pastoral care came in to see the patient. At 1020 hours the patient was discharged home.

Findings of the Hearing Tribunal

The Hearing Tribunal finds that Allegations 1 to 3 are proven based on the agreed facts and supporting materials and the admissions made by the Registrant in Exhibit #2 (Agreed Statement of Facts and Liability) and at the hearing.

The Hearing Tribunal finds that the Registrant failed to adequately assess and ensure his competency to provide care to [Patient 1] when he failed to provide adequate care to [Patient 1] pre-birth, during birth and post-birth. The Registrant failed to adequately adhere to his employer policies when providing care to [Patient 1]. Finally, the Registrant failed to sufficiently document his care of [Patient 1].

The Hearing Tribunal finds that the conduct in Allegations 1, 2 and 3 display a lack of knowledge, skill and judgment in the provision of professional services, contrary to section 1(1)(pp)(i) of the HPA. The Registrant displayed a lack of knowledge, skill and judgment with respect to his failure to adequately assess and ensure his competence to provide care and support to [Patient 1] pre-birth, during birth and post birth. He also failed to follow Covenant Health policies. The Registrant was aware of the policies but did not follow them. The Registrant's failure to document also displayed a lack of knowledge, skill and judgment.

Registrants are expected to assess and ensure their competence. Nurses are accountable to identify situations that are outside of their competencies, and seek support in a timely fashion. The failure to do so in this case displayed a serious lack of judgment by the Registrant. The Registrant also displayed a lack of judgment or knowledge by failing to follow employer policies. Policies for patient care are in place to ensure that patients receive appropriate, compassionate and consistent care. The failure to follow such policies was serious. Finally, the failure to appropriately document also displays a lack of knowledge, skill or judgment. Documentation is a basic and fundamental skill that is required of all registrants. The Registrant not only displayed charting that lacked depth and substance, but also contained breaches against the standards such as the use of time frames, as set out below.

In addition, the Hearing Tribunal finds that the conduct in Allegations 1, 2 and 3 breach the following Standards of Practice and Code of Ethics, contrary to section 1(1)(pp)(ii) of the HPA.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards (CPSRM): 1.2, 1.4, 2.2, 2.4, 2.5, 2.7, 3.4, 4.2, 4.4, 5.3, 5.5 and 5.6, as follows:

Standard 1: Responsibility and Accountability

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

Indicators

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

1.4 The nurse practices competently.

Standard 2: 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.

2.4 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 3: Ethical Practice

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

Indicators

3.4 The nurse communicates effectively and respectfully with clients, significant others and other members of the ***health care team*** to enhance client care and safety outcomes.

Standard 4: 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.

4.4 The nurse explains nursing care to clients and significant others.

Standard 5: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

Indicators

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

5.5 The nurse practices within their own level of ***competence***.

5.6 The nurse regularly assesses their practice and takes the necessary steps to improve personal competence.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Code of Ethics (CNACE): A1, A2, A3, A6, B1, B2, C1, C6, D6, G1 and G3, as follows:

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**.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

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.

6. Nurses practice "within their own level of competence and seek [appropriate] direction and guidance . . . when aspects of the care required are beyond their individual competence" (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island, & Prince Edward Island Health Sector Council, 2014, p. 3).

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:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.

2. Nurses work with persons receiving care to explore the range of health-care choices available to them, recognizing that some have limited choices because of social, economic, geographic or other factors that lead to inequities (Registered Nurses' Association of Ontario [RNAO], 2011). Nurses recognize the social determinants of health in their assessments, diagnoses, outcomes planning, implementations and evaluations with individuals, families and communities, collaborating with others in and outside of the health sector (CNA, 2013).

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical responsibilities:

1. Nurses provide persons receiving care with the information they need to make informed and autonomous decisions related to their health and well-being. They also work to ensure that health information is given to those persons in an open, accurate, understandable and transparent manner.

6. Nurses provide education to support the informed decision-making of capable persons. They respect the decisions a person makes, including choice of lifestyles or treatment that are not conducive to good health, and continue to provide care in a non-judgmental manner.

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.

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, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

3. Nurses practice within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Documentation Standards (CDSRM): 1.1, 1.2 and 1.4, as follows:

Standard 1

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

…

- 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

…

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

The breaches of the Practice Standards and Code of Ethics are serious. The Registrant failed to practice within his own level of competence. He was aware of the employer policies but did not consult them. Within the policies were requirements to address not only the physical needs of the patient, but also the emotional needs and facilitate in the moment and ongoing support. The clinical context of fetal demise places the patient in a very vulnerable situation where attending to their emotional needs, displaying behaviors that instill confidence in the care being provided, and clear communication as the situation unfolds are of paramount importance. Failure to meet the needs of the patient by not following policy was especially pertinent in a clinical scenario of a live birth that ended in fetal demise.

In addition, the breaches of the Documentation Standards are serious. Record keeping is a fundamental skill expected of all registrants. It is not possible to tell from the patient record what occurred or when events, including treatment, occurred. Improper record keeping puts the patient at risk and jeopardizes the ability of the health care team to provide appropriate care. The Hearing Tribunal noted that the Registrant's narrative documentation included time frames. The time recorded on the narrative record should reflect the specific time that the nurse is charting the information. A time frame is not appropriate and contravenes the Documentation Standards.

The breaches of the Practice Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

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 (Exhibit #3).

Conduct Counsel reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case.

1. The nature and gravity of the proven allegations: the allegations in this case are serious.

2. The age and experience of the member: the Registrant has been registered since 2011 and should have been aware of his responsibilities and ethical obligations.

3. The previous character of the member: the Registrant has no prior findings of unprofessional conduct.

4. The age and mental condition of the offended patient: [Patient 1] was [age] years of age.

5. The number of times the offence was proven to have occurred: the conduct occurred on June 12, 2020.

6. The role of the registered nurse in acknowledging what occurred: the Registrant has admitted to the allegations and that the conduct constitutes unprofessional conduct. This is a significant mitigating factor.

7. Whether the member has already suffered other serious financial or other penalties: Conduct Counsel noted he was not aware of any financial or other penalties.

8. The impact on the offended patient: Parental loss is a significant impact which can impact the wellbeing of the patient.

9. The presence or absence of any mitigating factors: Conduct Counsel noted he was not aware of any other mitigating factors.

10. The need to promote specific and general deterrence: Conduct Counsel noted that the recommended sanction addresses both specific and general deterrence.

11. The need to maintain public confidence: It is critical to maintain public confidence. the recommended sanction sends the appropriate message.

12. Degree to which offensive conduct is outside the range of permitted conduct: the conduct here was clearly unacceptable and the Registrant has acknowledged this.

Conduct Counsel noted that the sanction sends the appropriate message to other registrants of the profession. There are aspects of denunciation and deterrence in the sanction which are appropriate. The sanction must also be fair and reasonable to the Registrant.

Conduct Counsel noted the case of *R. v. Anthony Cook*, 2016 SCC 43 and the need for deference to a joint recommended sanction. Significant deference is owed and a joint recommended sanction should only be rejected if the proposed sanction would bring the administration of justice into disrepute or is contrary to the public interest.

Statement by the Registrant:

The Registrant was affirmed and made a statement expressing his remorse. He apologized for his actions and noted that he loves the profession of nursing and it has been a very important part of his life. It is important to him to be of service to others and to be part of their journey.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer noted that the Registrant was the only staff member on June 12 with experience in infant demise. His experience was previously limited to buddying with other nurses. It is very rare in a case of fetal demise to deliver a live baby. The Labour Relations Officer also noted that the Registrant did enlist the help of the clinical educator.

The Registrant has no history of discipline with the College and no employment discipline issues. He has acknowledged the conduct and has learned from this process.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal considered the proposed sanction and the submissions of the parties, as well as the factors in *Jaswal,* as outlined by Conduct Counsel.

The Hearing Tribunal agreed with the *Jaswal* factors as set out by Conduct Counsel. The Registrant was not a new registrant. He has been registered with the College since 2011. He would be expected to understand the need to assess and evaluate his competence, to follow employer policies and to understand the importance of documentation and how to create entries in the patient record.

The Hearing Tribunal reviewed each proposed order. The reprimand is appropriate to denounce the conduct of the Registrant. The orders include remediation by the Registrant, including course work and a Behaviour Improvement Plan. These are aimed at helping the Registrant learn from this experience and ensure that the conduct is not repeated in the future. The orders relating to the employer reference letters are also appropriate and serve to further protect the public. The Hearing Tribunal believes that the sanctions will provide the Registrant with opportunities to reflect and grow specifically in the areas of communicating with patients, navigating unexpected situations, and accountability for meeting documentation standards.

The Hearing Tribunal considered whether the proposed sanction reflects the seriousness of the findings and whether the proposed sanction protects the public interest. The Hearing Tribunal is aware that it should not depart from a joint submission on sanction unless the proposed sanction would bring the administration of justice into disrepute or would otherwise be contrary to the public interest. In light of this standard, the Hearing Tribunal accepts the proposed joint submission on sanction.

The Hearing Tribunal finds that the proposed sanction is reasonable and protects the public. The proposed sanction serves as an appropriate deterrent for the Registrant and the membership generally. The proposed sanction will serve to maintain the public's confidence in the integrity of the profession.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

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

2. By **September 5, 2024**, the Registrant shall provide a certificate of completion, satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities**:**

    i. Responsible Nursing (NURS0170 – MacEwan University); and

    ii. Documentation in Nursing (NURS0162 – MacEwan University).

3. By **May 15, 2024**, the Registrant shall provide to the Complaints Director a self-improvement plan for improving communication with patients ("**Behavior Improvement Plan**") and the Behavior Improvement Plan must be satisfactory to the Complaints Director and must:

    i. Be typed and comply with professional formatting guidelines (American Psychological Association style);

    ii. Be at least five hundred (500) words in length;

    iii. Include a list of three (3) goals of self-improvement relating to improving communication with patients, specifically:

        1. Describe how the Registrant will improve their practice, including strategies, plans and supports or resources that may assist their improvement; and

        2. Cite at least four (4) applicable standards and responsibilities from the following:

            a. the *Documentation Standards;*

            b. the *Practice Standards;* and

            c. the *Code of Ethics.*

4. Within **fifteen (15) days** of the Hearing Order, the Registrant shall provide a letter ("**Practice Setting Letter"**) to the Complaints Director from the Registrant's RN or Nurse Practitioner ("**NP**") Supervisor (the "**Supervisor"**) at their current place of employment ("**Practice Setting"**), confirming:

    i. The Supervisor's name and contact information;

    ii. The Practice Setting;

    iii. The Registrant's role of employment;

    iv. That the Supervisor has read the Hearing Order; and

    v. That the Supervisor agrees to provide to the College **one (1) Employer Reference** following the terms and conditions in paragraph 5 and in the Employer Reference Form attached as "**Schedule A**" to this Agreement.

5. The Registrant shall provide the First Employer Reference from their Supervisor **one hundred eighty (180) days** after their Practice Setting Letter is approved by the Complaints Director and the Employer Reference must be acceptable to the Complaints Director and confirm the following:

    i. whether the Registrant has completed at least **five hundred sixty (560) hours** of nursing practice within the last **one hundred eighty (180) days**;

    ii. confirmation that such nursing practice hours occur no earlier than the date of the Hearing Order; and

    iii. whether concerns exist about the Registrant's practice and whether they met or exceeded the standards expected of a RN.

6. Until the Registrant has submitted the final Employer Reference to the Complaints Director, as required by paragraph 5, and it is deemed satisfactory to the Complaints Director, the Registrant shall not be employed in any other setting except the Practice Setting(s) approved by the Complaints Director, unless:

    i. The Registrant submits an updated Practice Setting Letter to the Complaints Director from their prospective employer detailing the new Practice Setting, and following the requirements in paragraph 4 and that acknowledges that the Supervisor is prepared to provide any outstanding Employer Reference(s) as required in paragraph 5, or as directed by the Complaints Director; and

    ii. The Complaints Director, acting reasonably, acknowledges receipt of the letter and deems it satisfactory.

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

COMPLIANCE

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 Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca or via fax at 780-453-0546.

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 HPA.

10. 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

11. The Registrant understands and acknowledges:

    a. pursuant to section 119 of the HPA, and section 33(1) of the *Registered Nurses Profession Regulation*, Alta Reg 232/2005, it is the Registrant's professional obligation to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment; and

    b. employment is defined in section 57(3) of the HPA as being engaged to provide professional services as a RN on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer.

12. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is self-employed, under an undertaking to not work, is on sick leave or disability leave, or if the Registrant had not been called to do shifts, but could be called:

Employer Name	Employer Address & Phone Number
Covenant Health	Misericordia Community Hospital 16940 87 Avenue Edmonton, AB T5R 4H5

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

    a. ***Course work required – Arising from Disciplinary Matter***;

    b. ***Behavior Improvement Plan required – Arising from Disciplinary Matter;***

    c. ***Employer Reference(s) (Practice Report) required – Arising from Disciplinary Matter;***

    d. ***Confirmation of Practice Setting(s) required - Arising from a Disciplinary Matter;***

    e. ***Restriction re Practice Setting – Arising from Disciplinary Matter.***

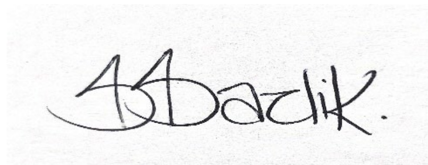
14. Effective on the date of the Hearing, or the date of this Order if different from the date of the Hearing, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, 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 the date of the Hearing 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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Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: February 14, 2024

Appendix A

The Covenant Health Policy: Fetal Demise/Miscarriage < 20 weeks (“**Fetal Demise Policy**”) provides the following relevant clauses to [Patient 1]’s care under sections 2.0 General Information, 4.0 Procedure, 5.0 Documentation on Patient Record and 6.0 Patient and Family Teaching:

> Covenant Health Policy: Fetal Demise/Miscarriage < 20 weeks
>
> 4.1 When Mother is in labor and contracting regularly.
>
> 4.1.1 Call Physician
>
> 4.2 If the fetus is delivered but remains attached to the placenta which is retained in the uterus.
>
> 4.2.1 Open the cord set, put on the sterile gloves.
>
> 4.2.3 With the scissors (from the cord set) cut the cord on the fetus side of cord clamp. (May offer the father to cut cord if he wishes). Leave forceps clamped on the end of the cord that is attached to the placenta.
>
> 4.4 Clean fetus, wrap it in a small towel or blanket. Allow parent to hold, or hold for parents to view, if they wish. This can be offered immediately and at anytime before the baby is sent to the lab. Ensure you communicate with the parents and determine what their needs are. Be cautious about telling parents the sex of the fetus as that is difficult to determine at early gestation.
>
> 5.8 Psychological state of mother, father and/or significant other. Record support given/offered. (May require one to one support for awhile)
>
> 5.9 On narrative notes document any teaching given.
>
> 6.1 Amount of vaginal flow to expect and for how long.
>
> 6.2 Perineal cleaning after voiding.
>
> 6.4 To sit up slowly and to request assistance before getting out of bed if experiencing light-headed feeling or dizziness.
>
> 6.5 Reassure that support is available. An early pregnancy loss package can be customized for the needs of the patient.
>
> This package may include any of the following…
>
> - Early Pregnancy Loss Program (EPLP) pamphlet (Please fill out a Reproductive Mental Health Referral Form for any patient who would like to be referred to this program; copies available under Referral Forms tab.)

- Annual Memorial Services leaflet
- For Parents handout
- Caring for Yourself after a Loss handout
- *Additional handouts that are unique to each patient's condition may be added to the package. These include…
- What to expect after your miscarriage Ectopic Pregnancy
- What to expect with a Dilation and Curettage (Copies of these materials are under the Patient Teaching Materials tab in the Early Pregnancy Loss binder.)

Covenant Health Policy: Supporting Perinatal Loss in a Primary Healthcare Setting- Information and Strategy for Care Providers ("**Supporting Perinatal Loss Policy**") provides the following relevant information and strategies which are relevant to [Patient 1]'s care:

> Covenant Health Policy: Supporting Perinatal Loss in a Primary Healthcare Setting- Information and Strategy for Care Providers
>
> Anticipatory Guidance: Creating a Companioning Environment
>
> - Is soft and unobtrusive
> - Acknowledges the family as a unit
> - Is open, accepting and dependable
>
> Guidelines for Care Providers: Work to individualize care
>
> - Rather than trying to fit parents into a rigid protocol, or deciding whether they should see their baby, or directing their involvement with their baby, ask parents about their needs and preferences and accommodate each f process and time frame.
> - Let them teach you what they need and want.
>
> Guidelines for Care Providers: Follow the parents' lead
>
> - Be an unbiased sounding board for their thoughts and feelings.
> - Offer them options and individualized guidance.
> - Address their concerns.
> - Leave the decision-making to them.
> - You do this by listening, responding, and respecting their choices.
>
> Guidelines for Care Providers: Encourage parents to do what is meaningful to them
>
> - Some parents will have lots of ideas and engage freely in rituals and nurturing behaviours.
> - Others will be grateful for your culturally sensitive suggestions and reassurance.

- Offer ideas that expand on their own and fit with their expressed preferences; this individualized can help them consider their options and explore possibilities.

Anticipatory Guidance

- Page appropriate physician, for history, physical examination, Consent, orders, and administration of misoprostol.
- Reassure patient/family that you will be available throughout this difficult process.

When Delivery is Imminent

- Page appropriate physician

The **AHS Code of Conduct** provides the following Code of Conduct Principles:

AHS Code of Conduct

Principle 2: Be open, honest and loyal

Being open, honest and loyal is fundamental to fostering an atmosphere of trust where people share and learn from each other and work together to achieve common goals. Being open, honest and loyal includes:

- Communicating in a timely and appropriate manner

Principle 3: Act ethically and uphold professional standards

Acting ethically and upholding professional standards includes:

- Upholding all standards, codes of conduct and codes of ethics that apply to us
- Upholding applicable AHS bylaws, principles, directives, policies, procedures, protocols, standards, codes of practice and any other applicable guidelines, regulations and directives

The Covenant Health Policy: Misericordia and Grey Nuns Surgery Programs-Instructions for use of the Nursing Assessment and Care Record ("**Instructions for Nursing Assessment and Care Record**") provides the following which is relevant to [Patient 1]'s care under the heading "Narrative nursing notes":

Covenant Health Policy: Misericordia and Grey Nuns Surgery Programs-Instructions for use of the Nursing Assessment and Care Record.

- Provide narrative notes on any areas that are exceptions to the patient's care and/or asterisked