DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Jim Attwood, RN Chairperson
Anne McKenzie, RPN Member
Dawn Norling, RPN Member
Bill Dowson Public Member
Faira Bari Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO JUNIOR SIRIVAR AND
) GLYNNIS BURT for
) College of Nurses of Ontario
- and -
) NO REPRESENTATION for
ARCHANA SARKAR Archana Sarkar
Registration No. JA02921
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(Heard: October 5, 2005

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on October 5, 2005 at the College of Nurses of Ontario (the “College”) at Toronto.

The Allegations

After College counsel withdrew a number of allegations, the remaining allegations against Archana Sarkar, RPN (the “Member”) as stated in the Notice of Hearing dated September 8, 2005 were as follows:

1. You have committed an act of professional misconduct as provided by sub-section 51(1)(c) of the Health Professions Procedural Code and defined in paragraph 1.1 of Ontario Regulation 799/93, in that, while employed as a nurse at [the Home], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that you:
(a) On or about January 30, 2003, permitted [client A] to [self-feed] when [client A’s] care plan expressly indicated that [client A] was to be fed by a nurse due to the risk of choking; and/or

(e) On or about May 16, 2003, were with [client B] when [client B] fell to the floor after you attempted to re-direct [client B] from the room [client B] was in and you left the fallen resident unattended while you responded to another resident’s call bell; and/or

(f) In or about early July 2003, pushed a straw into the mouth of [client C] and forced the resident to hold a can of Ensure contrary to [client C’s] desire while gruffly telling [client C] that [client C] had to hold the can and drink; and/or

3. You have committed an act of professional misconduct as provided by sub-section 51(1)(c) of the Health Professions Procedural Code and defined in paragraph 1.37 of Ontario Regulation 799/93, in that, while employed as a nurse at [the Home], you engaged in conduct or performed an act or acts relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional, in that you:

(a) On or about January 30, 2003, permitted a [client A] to [self-feed] when [client A’s] care plan expressly indicated that [client A] was to be fed by a nurse due to the risk of choking; and/or

(e) On or about May 16, 2003, were with [client B] when [client B] fell to the floor after you attempted to re-direct [client B] from the room [client B] was in and you left the fallen resident unattended while you responded to another resident’s call bell; and/or

(f) In or about early July 2003, pushed a straw into the mouth of [client C] and forced the resident to hold a can of Ensure contrary to [client C’s] desire while gruffly telling [client C] that [client C] had to hold the can and drink; and/or

Member’s Plea

Archana Sarkar admitted the allegations set out in paragraphs numbered 1(a), (e), (f) and 3(a), (e), (f) in the Notice of Hearing (that is, each of the allegations that remained). The panel conducted a plea inquiry and was satisfied that the Member’s admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts which provided as follows:

BACKGROUND
1. Ms. Archana Sarkar ("the Member") graduated in 1981 [in another country] with a Bachelor of Science in General Nursing (a Registered Practical Nursing program).

2. After working as a personal support worker and health care aide in the [ ] area, the Member completed a nursing refresher course [in Ontario] in 2000.

3. The Member registered with the College of Nurses of Ontario ("the College") on February 16, 2001.

4. The Member was hired by [the Home] on August 21, 2001 as a part-time Registered Practical Nurse, and was made full-time in November 2002.

5. The Home is a long term care facility which employs a model of nursing care that is a holistic resident/family centred approach. At the time of the incidents described below, the Member worked on a unit which housed 38 residents. The residents on the unit were for the most part at a chronic care level with varying degrees of physical and cognitive deficits.

6. The Member regularly worked the evening shift at the Home from 15:00 to 23:00 hours. On this shift there was 1 Registered Nurse ("RN") responsible for the 2 units (composed of 38 and 39 beds respectively) and 1 Registered Practical Nurse ("RPN"). There were 2 full-time Health Care Aides ("HCAs")/Personal Support Workers ("PSWs") and 1 HCA/PSW who worked a 5 hour shift from 15:00 to 20:30 hours. The HCAs reported to the RPN who in turn reported to the RN.

INCIDENT 1

7. On or about January 30, 2003, the Member allowed [client A] to [self-feed].

8. [Client A’s] care plan clearly indicated that [client A] was to have 1:1 feeding and was to be fed by an RPN at supper because of [a] high risk for choking.

INCIDENT 2

9. On or about May 16, 2003, the Member was administering medications on the second floor unit. [Client B] was following the Member as she administered medications, and was trying to get medications off the cart.

10. The Member attempted to re-direct [client B] back to [client B’s] room but when [client B] pivoted, [client B] fell to the floor.

11. [Client B] sustained a skin tear to [the] right forearm and a haematoma to the back of [the] head.
12. The Member left the resident unattended on the floor while she answered the call bell of another resident.

13. [RN A] arrived on the second floor via the east end stairwell and saw [client B] on the floor. [RN A] called for assistance to lift the resident. The Member then emerged from the other resident’s room.

14. If the Member were to testify she would say that she left [client B] unattended for only a very short period of time to reassure another resident who had overheard the commotion, and was distraught. She would add that she called out for assistance from the HCAs/PSWs on the unit and that none was forthcoming.

INCIDENT 3

15. On or about July 4, 2003, [RN B], a RN at the Home, witnessed the Member forcing a small, frail, [ ] resident, [client C], to hold a full can of Ensure in [client C’s] hands instead of a smaller glass. The resident was obviously distressed.

16. When the resident attempted to put the can down, the Member spoke to [client C] gruffly, stating that [client C] had to hold the can in [client C’s] hands and drink.

ADMISSIONS

17. The Member acknowledges that she committed an act of professional misconduct as provided by sub-section 51(1)(c) of the Health Professions Procedural Code and defined in paragraph 1.1 of Ontario Regulation 799/93, in that, while employed as a nurse at [the Home], she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, in that she:

(i) on or about January 30, 2003, while providing care to [client A], permitted [client A] to [self-feed] when [client A’s] care plan expressly indicated that [client A] was to be fed by a nurse due to the risk of choking; and

(ii) on or about February 16, 2003, while in the presence of [client B] when [client B] fell to the floor after the Member attempted to re-direct [client B] from the room [client B] was in, left the fallen resident unattended while she responded to another resident’s call bell;

(iii) in or about early July 2003, while providing care to [client C], forced the resident to hold a can of Ensure contrary to [client C’s] desire while gruffly telling [client C] that [client C] had to hold the can and drink.

18. The Member also acknowledges that she committed an act of professional misconduct as provided by sub-section 51(1)(c) of the Health Professions Procedural Code and defined in paragraph 1.37 of Ontario Regulation 799/93, in that, while employed as a nurse at [the Home], she engaged in conduct or performed an act or acts relevant to the practice of nursing that, having regard to
all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional, in that she

(i) on or about January 30, 2003, while providing care to [client A], permitted [client A] to [self-feed] when [client A’s] care plan expressly indicated that [client A] was to be fed by a nurse due to the risk of choking; and

(ii) on or about February 16, 2003, while in the presence of [client B], when [client B] fell to the floor after the Member attempted to re-direct [client B] from the room [client B] was in, left the fallen resident unattended while she responded to another resident’s call bell;

(iii) in or about early July 2003, while providing care to [client C], forced the resident to hold a can of Ensure contrary to [client C’s] desire while gruffly telling [client C] that [client C] had to hold the can and drink.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed an act of professional misconduct as alleged in paragraphs 1 (a), (e), (f) and 3 (a), (e), (f) of the Notice of Hearing by failing to maintain the standards of practice of the profession and engaging in conduct or performing an act or acts relevant to the practice of nursing that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that the Member

1. permitted the resident to [self-feed] when the care plan indicated that [the resident] was to be fed by a nurse due to the risk of choking.

2. failed to attend appropriately to a resident in her care who had fallen.

3. pushed a straw into the mouth of a resident and forced the resident to hold a can of Ensure, contrary to the resident’s desire, while at the same time gruffly ordering the resident to drink.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty had been agreed upon. The Joint Submission as to Penalty provides as follows:

Joint Submissions on Penalty

Archana Sarkar (“the Member”) and the College of Nurses of Ontario (“the College”) respectfully submit that, in view of the circumstances set out in the Agreed Statement of Facts and the Member’s admission of professional misconduct, the panel of the Discipline Committee should make an Order as follows:
1. Requiring Ms. Sarkar to appear before the panel to be reprimanded at a date to be arranged but, in any event, within three months of the date that the Order becomes final.

2. Directing the Executive Director to suspend Ms. Sarkar’s certificate of registration for a period of 14 days. The suspension shall commence on the date that the Order of the Discipline Committee becomes final and is not subject to appeal.

3. Directing the Executive Director to impose the following terms, conditions, and limitations on the Member’s certificate of registration:

   (a) The Member shall meet with a College Practice Consultant, at the Consultant’s convenience, to discuss the *One is One Too Many* abuse prevention program as related to the conduct for which the Member was found to have committed an act of professional misconduct with a view to ensuring that no abuse of residents occurs in the future.

   (b) For the first twelve (12) months after the Member returns to practice nursing in a clinical setting, the Member shall:

      (i) provide any employer(s) for whom the Member is engaged in clinical practice with a copy of the Panel’s Penalty Order (including the Agreed Statement of Fact and Joint Submission on Penalty) or, if available, a copy of the Panel’s Decisions and Reasons in this matter; and

      (ii) when practicing nursing in a clinical setting, only work for an employer who agrees to:

         A. write to the Director within seven (7) days of the Member commencing employment indicating that the employer has received a copy of the Panel’s Penalty Order (including the Agreed Statement of Fact and Joint Submission on Penalty) or, if available, a copy of the Panel’s Decision and Reasons in this matter, and;

         B. the employer agrees to notify the Director immediately, in writing, upon receiving any reasonable information that the Member has committed an act of professional misconduct.

Counsel for the College advised the panel that the Member had acknowledged the inappropriateness of her conduct, was remorseful, regretful and accepted responsibility for her actions. The Member was also prepared to meet with the College Practice Consultant to discuss the “One is Too Many” abuse prevention program. The Panel was also reminded that the Member had no history of previous complaints.
Penalty Decision

The Joint Submission as to Penalty reinforces that the dignity of the individual resident remains protected at all times. The panel accepted the Joint Submission as to Penalty given that it meets the requirement of general deterrence, specific deterrence and remediation of the Member as specified by Counsel for the College.

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for her actions. The Joint Submission as to Penalty ensures the protection of the public and reinforces the fact that the College will not tolerate such conduct even in isolated circumstances.

The panel therefore makes a penalty order in the terms of the Joint Submission as to Penalty, set out above.

I, Jim Attwood RN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

_________________________________________  ____________________________
Chairperson                                                        Date

Panel Members:

Anne McKenzie, RPN
Dawn Norling, RPN
Bill Dowson, Public Member
Faira Bari, Public Member