DECISION COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL: Art Osborne Chairperson
        Lori McInerney, RN Member
        Cheryl McMaster, RPN Member
        Sue Silver, RN Member
        Joan King Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO ) KAREN JONES for
                                      ) College of Nurses of Ontario
                                      )
- and - )

ANNE ELIZABETH DEY ) MARY HART for
Registration No. 0191445 ) Anne E. Dey
                                      )
                                      )
                                      ) Heard: February 26, 2007

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on February 26, 2007 at the College of Nurses of Ontario (the “College”) at Toronto.

The Allegations

The allegations against Ms Anne Elizabeth Dey (the “Member”) as stated in the Notice of Hearing dated January 24, 2007, Exhibit 1, are as follows:

1. [WITHDRAWN]

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, (the “Code”) and defined in subsection 1(37) of Ontario Regulation 799/93, in that on or about February 20, 2005, while employed as a Registered Nurse at [the facility], you engaged in conduct or performed an act, relevant to the practice of nursing that, having regard to all of the circumstances would reasonably be regarded by members of the profession as disgraceful, dishonorable or unprofessional with respect to your care of [the client].
3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of Ontario Regulation 799/93, in that on or about February 20, 2005, while employed as a Registered Nurse at [the facility], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession with respect to your care of [the client].

College Counsel informed the panel that allegation #1, as set out in the Notice of Hearing, had been withdrawn.

Member’s Plea

The Member admitted the allegations set out in paragraph number 3 in the Notice of Hearing. The Member specifically admitted to unprofessional conduct with respect to allegation number 2 in the Notice of Hearing. The panel conducted an oral plea inquiry and accepted a written plea inquiry. The panel 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, Exhibit #3, which provided as follows:

THE MEMBER

1. Anne Dey (the “Member”) became an RPN in 1969 and worked in a variety of hospital and community home care settings for 30 years. Her employment in nursing included working in intensive care, emergency, obstetrics, gynecology, pediatrics, medical, surgical, palliative and chronic care.

2. The Member completed a three year nursing diploma from [ ] College in 2001 and became a registered nurse member of the College of Nurses of Ontario (“College”) the same year. The Member worked as an RN on a medical units at [a hospital] until 2004.

3. In April 2004, the Member began working on a full-time basis as a staff nurse at [the facility].

THE FACILITY

4. [The facility] is a 160 bed long term care facility in [ ] Ontario. It has six units, including a unit designated for residents with cognitive impairment known as [Unit A].

5. In May 2004, the Member began working on [Unit A]. She only worked evening shifts, along with two full time and one part time Personal Service Workers.
6. As the RN on [Unit A], the Member was responsible for conducting hourly checks on residents, administering all medications, treatments and wound care, assisting with family concerns, feeding residents, and performing any required nursing assessments. The Member was also responsible for preparing and updating care plans and other resident documentation.

**[THE CLIENT]**

7. [The client] was receiving palliative care on [Unit A].

8. As of February 2005, [the client] was 73 years old. She had multiple medical diagnosis including peripheral vascular disease, and Type 1 diabetes mellitus. [The client] had also been diagnosed with a paranoid personality disorder and schizophrenia. [The client’s] right leg had been amputated and she had recently developed an infection of the bone in her right leg, which required hospitalization and treatment with antibiotics.

9. The stump of [the client’s] right leg had visible bone, necrotic tissue, and purulent exudate. The apex of the stump was very painful to touch. [The client] also had a number of serious decubitus ulcers, including on her left heel, coccyx, and inner groin.

10. [The client] was experiencing significant pain at the amputation site. That pain was severely exacerbated during dressing changes, and when the stump was moved. As a result of [the client’s] severe pain, she was ordered both regular and as needed (“prn”) Dilaudid by either oral administration or subcutaneous injection, and a Fentanyl patch.

11. Despite the pain medication, [the client] frequently continued to experience significant breakthrough pain, especially during dressing changes and with movement. The Member was regularly assigned to the evening shift and had responsibility for [the client’s] dressing changes. The Member was aware of and concerned about the management of [the client’s] pain, particularly during dressing changes. The Member advocated on behalf of [the client] on the issue of pain control.

**FEBRUARY 20, 2005**

12. The Member was assigned to care for [the client] on the evening shift of February 20, 2005. Early in the shift, the Member attended [the client] to assess her blood sugar and give her medication. [The client] was alert and responsive when the Member took her blood sugar and when she administered oral medication.

13. However, once [the client] had the oral medication in her mouth, she did not swallow it.

14. [The client] did not respond to requests to swallow the medication, although both the Member and [the client’s] daughter, who was visiting her mother, encouraged her to do so.
15. Had the Member testified, she would have said she was concerned about [the client’s] level of consciousness, and about [the client] aspirating the medication. The Member attempted both verbal and physical stimuli with the goal of arousing [the client]. [The client] did not respond.

16. The Member then moved [the client’s] stump off its supporting pillow in an attempt to rouse her and make her swallow the medication.

17. Had the Member testified, she would have said she did not think moving [the client’s] stump off the supporting pillow would cause pain. The Member would also say that she did consider repositioning [the client] to her side. The Member was aware, however, that such transfers were very painful for [the client].

18. The Member’s moving of [the client’s] stump did cause pain. [The client] cried out a number of times. She then swallowed the medication.

19. Had [the client’s] daughter testified, she would have said the Member said words to the effect that she hated to do this but had to, and then reached under the covers to [the client’s] stump, saying she was applying pressure so that [the client] would associate the pain and swallow her pain medication. [The client] then screamed several times, and, when told by the Member to swallow, did so. After, the Member told [the client’s] daughter that she was sorry she had to do that.

20. The Member left the room. She returned a short time later to try administer another medication by mouth. [The client’s] daughter was able to assist [the client] in swallowing the oral medication.

21. Had [the client’s] daughter testified, she would have said [the client] refused to swallow when the Member attempted to give her the second medication. The Member then started to raise [the client’s] blanket again and began to say she was sorry. At that time, [the client’s] daughter asked the Member not to do it again, and took over administering the medication to [the client].

22. Had the Member testified, she would have said that upon returning to the room she lifted the blanket in order to draw it up around [the client]. She apologized to the daughter and expressed that she had been concerned [the client] would aspirate.

**EVENTS FOLLOWING FEBRUARY 20, 2005**

23. The Member’s employment at [the facility] was terminated as a result of the February 20, 2005 incident with [the client].

24. Since that time, the Member has voluntarily taken a number of nursing courses, including:
a. a one day Pain Management Workshop on October 16, 2006, sponsored by [ ] Hospital;

b. a one day Interdisciplinary Pain Education Day on November 27, 2006, sponsored by [ ] Hospital;

c. a two day Palliative Care Pain and Symptom Management course on December 7-8, 2006, sponsored by [ ] Hospital; and

d. a one day Palliative Care Psychosocial and Spiritual Care course on December 11, 2006, sponsored by [ ] Hospital.

ADMISSIONS

25. The Member admits that she should have, and failed to, initiate the appropriate nursing interventions when she became concerned that [the client] was not swallowing and could aspirate. She therefore admits that she failed to meet the standards of practice of the profession with respect to her care of [the client] on the evening of February 20, 2005, and admits she committed an act of professional misconduct as set out in Allegation #3 in the Notice of Hearing.

26. The Member also admits that her treatment of [the client] was conduct relevant to the performance of nursing that, having regard for all the circumstances, would reasonably be regarded by member of the profession as unprofessional. The Member admits she committed an act of professional misconduct as set out in Allegation #2 of the Notice of Hearing, and specifically that her conduct was unprofessional.

27. The College withdraws allegation #1 in the Notice of Hearing.

Decision

The panel accepts the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct. In particular, the panel finds that there is sufficient evidence to find that the Member committed an act of professional misconduct. The panel finds that the Member’s conduct in relation to the client, [ ], failed to meet the standards of practice of the profession and would reasonably be regarded by members of the profession as unprofessional, in contravention of subsection 51(1)(c) of the Code and as defined by subsections 1(1) and 1(37) of the Ontario Regulation 799/93.

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:
The College of Nurses of Ontario (the “College”) and Anne Dey (the “Member”) jointly submit that, in view of the facts and admissions set out in the Agreed Statement of Facts, the panel of the Discipline Committee should make an Order, which will take effect when it becomes final:

1. Requiring the Member to appear before the panel to be reprimanded; and

2. Directing the Executive Director to suspend the Member’s certificate of registration for 14 days, such suspension to take effect upon the Member’s return to the practice of nursing; and

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

   i. That within 90 days of the date of the panel’s decision in this matter, the Member will meet with a College Practice Consultant (“Practice Consultant”). Prior to meeting with the Practice Consultant, the Member will have read the College’s Ethics Practice Standard and have completed the Therapeutic Nurse Client Relationship and the Medication on-line learning modules from the College web site, and have completed the On-Line Participation Form. The Member will also have completed a Self-Reflective exercise that focuses on the issues of client assessment, pain management and medication administration. The Member will provide the Practice Consultant with a copy of the completed College’s On-Line Participation Form, will review with the Practice Consultant the results of the Self-Reflective exercise and the College’s Standards of Practice, and will discuss the issues that arose in this case as they relate to the Member and her practice;

   ii. Until the Member has completed 12 months of practice following the date this Order becomes final, the Member shall only practice nursing where:

      (a) she has provided her employer’s chief nursing officer, or equivalent, with a copy of the Agreed Statement of Facts and Joint Submission on Penalty or, if available, the Discipline Committee’s Decision and Reasons. The Member will provide a letter from the employer to the Director within 21 days of the Member engaging in professional practice following the date that this Order becomes final, confirming:

          (i) receipt of the Agreed Statement of Facts and Joint Submission on Penalty, or Decision and Reasons;

          (ii) that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has failed to meet a standard of practice of the profession; and
(iii) that the employer agrees to provide the Director with performance appraisals regarding the Member’s nursing practice completed by a member of the College as set out below in paragraph 3. ii.(b) after 6 months, and 1 year of employment; and

(b) The Member’s employer provides to the Director performance appraisals completed by a member of the College after 6 months, and 1 year of employment regarding the Member’s nursing practice.

Oral Submissions by Counsel regarding Penalty

Counsel for the College submitted that the penalty meets the purpose of protecting the public, addresses the Member’s professional misconduct and provides both specific and general deterrence as well as remediation and monitoring. Counsel further submitted that the proposed penalty is within the appropriate range for misconduct of this nature.

Counsel for the College submitted that several mitigating factors were present that were relevant to the determination of an appropriate penalty. In particular, the Member acknowledged her unprofessional conduct; and voluntarily took steps to change conduct through education.

Counsel for the Member agreed with the College’s submissions as to penalty but submitted that there were additional mitigating factors, those being that the Member has been practicing as an RPN, then as an RN, for close to forty years in a wide variety of settings; has a commitment and love of the profession which has never wavered; and has taken the allegations seriously.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly orders that:

1. the Member shall appear before the panel to be reprimanded;

2. the Executive Director is directed to suspend the Member’s certificate of registration for 14 days, such suspension to take effect upon the Member’s return to the practice of nursing; and

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

i. That within 90 days of the date of the panel’s decision in this matter, the Member will meet with a College Practice Consultant (“Practice Consultant”). Prior to meeting with the Practice Consultant, the Member will have read the College’s Ethics Practice Standard and have completed the Therapeutic Nurse Client Relationship and the Medication on-line learning modules from the College web site, and have completed the On-
Line Participation Form. The Member will also have completed a Self-Reflective exercise that focuses on the issues of client assessment, pain management and medication administration. The Member will provide the Practice Consultant with a copy of the completed College’s On-Line Participation Form, will review with the Practice Consultant the results of the Self-Reflective exercise and the College’s Standards of Practice, and will discuss the issues that arose in this case as they relate to the Member and her practice;

ii. Until the Member has completed 12 months of practice following the date this Order becomes final, the Member shall only practice nursing where:

   (a) she has provided her employer’s chief nursing officer, or equivalent, with a copy of the Agreed Statement of Facts and Joint Submission on Penalty or, if available, the Discipline Committee’s Decision and Reasons. The Member will provide a letter from the employer to the Director within 21 days of the Member engaging in professional practice following the date that this Order becomes final, confirming:

      (i) receipt of the Agreed Statement of Facts and Joint Submission on Penalty, or Decision and Reasons;

      (ii) that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has failed to meet a standard of practice of the profession; and

      (iii) that the employer agrees to provide the Director with performance appraisals regarding the Member’s nursing practice completed by a member of the College as set out below in paragraph 3. ii.(b) after 6 months, and 1 year of employment; and

   (b) The Member’s employer provides to the Director performance appraisals completed by a member of the College after 6 months, and 1 year of employment regarding the Member’s nursing practice.

**Reasons for Penalty Decision**

The panel finds that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by admitting to the facts and agreeing to the Joint Submission as to Penalty, has accepted responsibility for her actions.

The penalty provides specific deterrence for the Member and general deterrence for the Membership.
Rehabilitation will be assured through completion of the educational components of the penalty. The monitoring provisions provide protection to the public and insure that a future employer is aware of these findings and is partnering with the College to monitor the Member’s practice.

I, Art Osborne, Public Member, 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:

Lori McInerney, RN  
Cheryl McMaster, RPN  
Sue Silver, RN  
Joan King, Public Member