DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:
Grace Isgro-Topping Chairperson
Anne McKenzie, RPN Member
Bill Dowson Public Member

BETWEEN:

GLYNNIS BURT for College of Nurses of Ontario

COLLEGE OF NURSES OF ONTARIO - and -

CAROL STEPHENSON for Kathleen Thompson

KATHLEEN THOMPSON Registration Nos. 0288233 & JJ13565

Heard: May 31, 2007

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on May 31, 2007 at the College of Nurses of Ontario (the “College”) at Toronto.

The Allegations

College counsel informed the panel that she would not be leading evidence with respect to allegations #1 (a),(c),(d),(e),(g) pertaining to failing to meet the standards of practice; allegation #2 pertaining to the physical, verbal and physical abuse of a client; and allegation #3 dealing with disgraceful, dishonourable or unprofessional conduct of the Member, as stated in the Notice of Hearing dated February 26, 2007 (Exhibit #1). The remaining allegations against Kathleen Thompson (the “Member”) as stated in the Notice of Hearing are 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, on or about May 14, 2004, while employed as a nurse at [a Hospital], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

   (a) dismissed;
(b) you failed or neglected to call or delayed in calling for an anaesthetist to administer an epidural to [the client], when you had indicated that you would do so; and/or
(c) dismissed;
(d) dismissed;
(e) dismissed;
(f) you failed to apply continuous electronic fetal monitoring to the client during her labour in spite of the fact that her labour had been induced, contrary to Hospital policy; and/or
(g) dismissed.

2. 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 1.7 of Ontario Regulation 799/93, in that, on May 14, 2004, while employed as a nurse at [a Hospital], you abused a client verbally, physically or emotionally, in that:
   (a) dismissed;
   (b) dismissed;
   (c) dismissed.

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 [a Hospital], 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:
   (a) dismissed;
   (b) dismissed;
   (c) dismissed;
   (d) dismissed;
   (e) dismissed;
   (f) dismissed; and
   (g) dismissed.

Member’s Plea
Kathleen Thompson, RN admitted the allegations set out in paragraphs numbered #1 (b) and (f) of the Notice of Hearing. The Member pleaded not guilty to the allegations set out in paragraphs numbered #1 (a), (c), (d), (e) and (g), #2 and #3 of the Notice of Hearing. The panel conducted an oral 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 (Exhibit #2), which provided as follows:

THE MEMBER

1. The Member, Kathleen Thompson (“the Member”), is a registered practical nurse and registered nurse. The Member has been registered with the College of Nurses of Ontario (“the College”) since 2000 and 2002, respectively.

2. The Member worked on the Labour and Delivery Unit at [a Hospital] (“the Hospital”) as a registered nurse commencing June 2002. The Member commenced work on a permanent part-time basis. The Member resigned from the Hospital on October 21, 2004.

3. The Member has no prior history of discipline or other complaints at the College.

THE HOSPITAL

4. On May 14, 2004, the Member was working a day shift, from 07:30 hours (“h”) to 19:30h, in the Labour and Delivery Unit of the Hospital.

5. At the relevant time, the Labour and Delivery Unit had six private delivery rooms and 2-3 triage beds, and could hold up to 10 patients. It handled approximately 200 births per month. There were generally 4-5 registered nurses on day shift.

THE CLIENT

6. On May 14, 2004, [the client], age [], was admitted to the Hospital at approximately 08:00h for a pre-scheduled induction of labour. She was pregnant with the first child for each of her and her spouse.

7. The Member received [the client] in the Labour and Delivery Unit at approximately 10:45h. [The client] was the Member’s only patient. The Member cared for [the client] throughout her labour and delivery on May 14, 2004.
ALLEGATION 1 (b) – FAILURE TO CALL AN ANAESTHETIST TO ADMINISTER AN EPIDURAL

8. On April 7, 2004, [the client] had been provided with information about epidural anaesthesia. [the client] completed the Anaesthesia Patient Questionnaire in anticipation of receiving an epidural. [The client] did not sign the Epidural Anaesthesia Patient Information Sheet.

9. The Labour and Delivery Admission order for [the client] dated May 14, 2004 indicates that she was to receive an Epidural “prn”, indicating that she should be administered the anaesthetic medication whenever necessary.

10. At approximately 11:25h Dr. [A] performed an artificial rupture of [the client’s] membranes.

11. The Member charted that at approximately 11:30h there was slight uterine activity noted and that [the client] was “not feeling anything”. The Member charted these observations in the nursing notes.

12. At approximately 11:45h, Pitocin (Oxytocin) drip was commenced to induce [the client’s] labour.

13. At approximately 11:55h, [the client] was given lunch, as charted by the Member in the nursing notes.

14. If [the client] were to testify she would say that:

   (a) Dr. [A] performed a vaginal examination at approximately 13:00h, and at that time she expressly requested an epidural, and in response, Dr. [A] indicated that [the client] could have the epidural whenever she was ready;

   (b) The Member was also present in [the client’s] room when [the client] made the request for the epidural, and the Member expressed her view to Dr. [A] that [the client] should not have an epidural until she was in active labour; and

   (c) [The client] did not receive an epidural at or about 13:00h.

15. If Dr. [A] were to testify he would say that:

   (a) He has little recollection of the incidents alleged; and

   (b) The Member resisted giving [the client] an epidural because [the client] was not in active labour.

16. If the Member were to testify she would say that [the client] did not request that an epidural be administered at 13:00h and she does not recall the events related in paragraph 14 or 15(b).
17. Dr. [A] left after performing the vaginal examination. He did not request that the Member call Anaesthesia.

18. The Member charted at 13:15h that there was no uterine activity.

19. The Member charted in the nursing notes that at approximately 13:45h, [the client] was reading, her husband sleeping and [the client] complained of “slight cramps in the abdomen”.

20. The Member charted in the nursing notes that at approximately 14:15h, [the client’s] contractions were 3 – 5 minutes apart.

21. At approximately 14:30h, [the client] began to ambulate.

22. From approximately 14:30h until 15:50h, [the client] ambulated.

23. If [the client] were to testify she would say that at or about 15:00h:
   (a) [the client] again requested an epidural;
   (b) at this time, [the client] felt that the pain was getting quite strong; and
   (c) the Member told [the client] that she would call Anaesthesia.

24. The Member does not recall the facts set out in paragraph 23 above, but does not contest [the client’s] recollection.

25. At approximately 15:50h, [the client] demanded an epidural due to the pain she was experiencing. If [the client’s] husband, [,] were to testify he would say that at that time he reminded the Member of her earlier assurance that she would call Anaesthesia.

26. At 15:50h, the Member performed a vaginal examination. [The client] was 4 cm dilated and her contractions were 2 – 4 minutes apart and moderate on palpation. The Member charted these findings in the nursing notes.

27. The Member called Anaesthesia at approximately 15:50h. Dr. [B], the on-call Anaesthetist at the Hospital, was in the operating room at the time and told the Member that she would be able to attend in about 30 minutes.

28. Dr. [B] attended and administered the epidural to [the client] at or about 16:20h.

29. If [the client] were to testify she would say that:
   (a) Moments after the epidural was administered, [the client] noted that it didn’t seem to be working. When [the client] later asked another nurse why the epidural wasn’t working she was told that the epidural was administered “too late”; and
(b) She believes that although the cannula for the epidural was inserted she does not believe any medication was fed through it.

30. [The client] was fully dilated at 16:40h.

31. [The client] delivered a healthy baby girl at 16:52h.

32. [The client] feels that she was forced to undergo the full pain of childbirth, contrary to her expressed wishes.

33. [RN “A”] was Nurse Manager of the Labour and Delivery Unit at the Hospital on May 14, 2004, but was not on site that day. If [RN “A”] were to testify, she would say that she does not believe that [the client] got the full benefit of the epidural, but thinks it likely that she got some benefit.

34. If the Member were to testify, she would say that she could not have known that [the client’s] labour would progress as quickly as it did, and with the benefit of hindsight she would have called locating to request another anaesthetist.

ALLEGATION 1(f) – FAILURE TO APPLY CONTINUOUS ELECTRONIC FETAL MONITORING AFTER INDUCTION OF LABOUR, CONTRARY TO HOSPITAL POLICY

35. [The client’s] labour was induced using Oxytocin.

36. The applicable Hospital policy, “Oxytocin Induction/Augmentation”, stated: “[c]ontinuous fetal monitoring is required for all patients receiving Oxytocin”.

37. Given the foregoing, [the client’s] labour ought to have been conducted with continuous electronic fetal monitoring from the time of induction (11:45h) to the time of delivery (16:52h), and the Member ought to have been aware of this fact.

38. The clinical records of [the client] confirm continuous electronic fetal monitoring was carried out from 10:45h until 14:30h, with the exception of a brief period (13:00h to 13:06h) when the monitor was removed to permit [the client] to go to the bathroom. The hospital chart contains a printout of the electronic fetal monitoring tracing strip for this time period. The Member made handwritten notations on the tracing strip of events as they coincided with the tracing.

39. The Member also charted the fetal heart rate at 15 minute intervals from 10:45h until 14:30h on a labour and delivery flow sheet, called a partogram.

40. The Member’s clinical notes on May 14, 2004, regarding fetal monitoring of the heart rate of [the client’s] fetus indicate the following:

   (a) at 10:45h, a fetal heart rate of 135-145 beats per minute (“b.p.m.”) “accelerations noted”;
(b) at 11:25h, a fetal heart rate of “135-145 b.p.m EFM continuous”;
(c) at 11:45h, a fetal heart rate of 150 b.p.m.;
(d) at 12:10h, toco adjustment (this is part of the EFM which is placed on the abdomen of the woman who is in labour);
(e) at 12:30h, a “reassuring” fetal heart rate;
(f) at 13:00h, removal of the electronic fetal monitor (“EFM”) because [the client] was going to the bathroom;
(g) at 13:06h, re-application of the EFM;
(h) at 14:15h, toco adjustment;
(i) at 14:30h, a change from the EFM to the telemetry unit because [the client] was ambulating; and
(j) at 15:50h, application of the EFM for assessment, with a fetal heart rate of 120 b.p.m., and accelerations.

41. At approximately 14:30h, [the client] told the Member that she wanted to ambulate. The Member obtained an order from Dr. [A] to permit [the client] to ambulate with continuous fetal monitoring by way of a telemetry unit (“a portable monitor”). The Member charted this order in the nursing notes.

42. The Member changed [the client] from a stationary fetal monitor to a portable monitor. The Member attached the portable monitor. However, the portable monitor kept slipping out of position and could not produce a reading.

43. If the Member were to testify she would say that:

(a) As she was unable to maintain a good position of the portable unit and in order to comply with the patient’s wishes to continue walking, she permitted [the client] to ambulate without the portable monitor from approximately 14:30h until 15:50h;

(b) During that time she had [the client] return to her room at approximately 10 – 15 minute intervals and checked her on the stationary fetal monitor. The Member found the heart rate reassuring every time she checked and permitted [the client] to continue ambulating.

44. The Member did not chart any fetal monitor results between 14:30h and 15:50h.

45. If [the client] were to testify she would say that:

(a) Initially, when [the client] began ambulating, the Member could not find a portable fetal monitor;
When the Member found a portable fetal monitor she had difficulties attaching the portable telemetry unit to [the client] and did not ask any of her nursing colleagues for assistance;

On several occasions, while attempting to attach the portable fetal monitor, the Member advised [the client] that she had difficulty locating the fetal heartbeat. These statements elevated [the client’s] anxiety.

If the Member were to testify she would say that she denies the statements and [the client’s] version of events in paragraph 45.

At approximately 15:50h, [the client] returned to bed and the Member reattached the stationary continuous fetal monitor which remained on [the client] thereafter until the end of her labour and delivery. The Member charted the re-application of the continuous fetal monitor at 15:50h in the nursing notes. The continuous fetal monitoring tracing strip for the time period from 15:50h until the end of the labour and delivery is in the patient’s chart. The Member also charted events on the tracing strip during this time period.

If [RN “A”], Nurse Manager of the Labour and Delivery Unit at the Hospital were to testify, she would say that the Member did not meet the standard of care expected of her with respect to fetal monitoring during the course of [the client’s] labour and delivery on May 14, 2004. In particular, she would say that the Member failed to meet the standard of practice in that [the client] should not have been ambulating without monitoring while on Oxytocin.

If she were to testify, the Member would:

(a) not contest that she delayed in calling an anaesthetist to administer an epidural to [the client] on May 14, 2004 when she indicated that she would do so; and

(b) admit that she failed to apply continuous electronic fetal monitoring to [the client] on May 14, 2004 while she ambulated, in spite of the fact that [the client’s] labour had been induced, contrary to Hospital policy; and

(c) admit her failure to call an anaesthetist in a timely fashion to administer an epidural to [the client] on May 14, 2004 and her failure to apply a continuous electronic fetal monitor to [the client] after her labour was induced, was a breach of the standards expected of her as a nurse in all the circumstances.

The Member admits 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, on or about May 14, 2004, while employed as a nurse at [the Hospital], she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

(a) she failed or neglected to call or delayed in calling for an anaesthetist to administer an epidural to [the client] when she had indicated that she would do so; and

(b) she failed to apply continuous electronic fetal monitoring to [the client] during her labour (in particular, while she ambulated) in spite of the fact that [the client’s] labour had been induced, contrary to Hospital policy.

51. The College and the Member jointly request that the Discipline Committee dismiss allegations # 1(a), (c), (d), (e), (g), 2 and 3 as set out in the Notice of Hearing.

Decision

The panel dismissed allegations #1 (a),(c),(d),(e),(g) pertaining to failing to meet the standards of practice; allegation #2 pertaining to the physical, verbal and physical abuse of a client; and allegation #3 dealing with disgraceful, dishonourable or unprofessional conduct of the Member, as set out in the Notice of Hearing.

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 (b) and (f) of the Notice of Hearing in that:

(a) the Member failed or neglected to call or delayed in calling for an anaesthetist to administer an epidural to [the client] when she had indicated that she would do so; and/

(b) the Member failed to apply continuous electronic fetal monitoring to [the client] during her labour in spite of the fact that [the client] labour had been induced, contrary to Hospital policy;

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty (Exhibit # 3) had been agreed upon. The Joint Submission as to Penalty requests that the panel make an Order:

1. Requiring the Member to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date this Order becomes final;

2. Directing the Executive Director to suspend the Member’s Certificate of Registration for thirty (30) days. The suspension shall take effect on June 15, 2007 and shall run continuously without interruption;
3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member’s Certificate of Registration:

(a) Requiring the Member to meet with a Practice Consultant at the Practice Consultant’s convenience, and within three (3) months of the date this Order becomes final. The Member will meet with the Practice Consultant to discuss the standards of practice and the materials referred to in 3(a)(i), 3(a)(ii) and 3(a)(iii) below, as they relate to the conduct for which the Member was found to have committed professional misconduct and to discuss how to prevent such conduct from occurring in the future. Prior to meeting with the Practice Consultant, the Member shall:

(i) review the College Standards and Guidelines – “Professional Standards”, “Therapeutic Nurse-Client Relationship”, “Ethics” and “Managing Conflict”; and

(ii) purchase and complete the College’s self-directed learning package, One is One Too Many, at her own expense; and

(iii) review any other relevant College Standards or documents which the Practice Consultant may direct.

(b) For a period of twelve (12) months following the date upon which the Member’s appeal rights end as a result of exhaustion, expiry or waiver, the Member shall:

(i) communicate to the Director of the Investigations and Hearings Department at the College of Nurses of Ontario (the “Director”), in writing, the name, address, and telephone number of all employer(s) for whom the Member is employed as a nurse within fourteen (14) days of the date the Member commences or resumes employment in any nursing position, such communication to be delivered by a verifiable means such as courier or registered letter and the Member shall retain proof of the College’s receipt of the communication;

(ii) provide all of her employer(s) with a copy of the Panel’s Penalty Order together with the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Penalty and any attachments to those documents or, if available, the Panel’s written Decision and Reasons, together with any attachments, and provide proof of its delivery to the employer(s) to the Director within 14 days from the date the member commences employment, to be delivered by a verifiable means such as courier or registered letter and the Member shall retain proof of the College’s receipt of the communication;

(iii) only practice nursing for an employer(s) who agrees to, and does advise the Director in writing, within fourteen (14) days of the commencement or resumption of the Member’s employment, that the employer agrees to notify the Director immediately upon receipt of any reasonable
information that the Member has breached the standards of practice of the profession.

Both counsel agreed that there were several mitigating factors present in this case that were relevant to the penalty to be imposed in this case. Those mitigating factors were:

(a) the Member’s inexperience at the time of the allegations
(b) the Member’s admission of professional misconduct
(c) the Member has no prior history of discipline or complaints with the College; and
(d) the incident was a single occurrence, involving a single client

Defence Counsel submitted that a further mitigating factor was the fact that the Member could not predict that [the client’s] labour was going to progress rapidly and, had she known, she would have called for an anaesthetist sooner.

Counsel for the College indicated that there were aggravating factors present in this case relevant to penalty, those being the Member’s failure to meet the standards of practice by delaying to call the anaesthetist, and by failing to apply continuous electronic fetal monitoring. The Member ignored the very person that she was there to protect.

**Penalty Decision**

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

1. The Member is to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date this Order becomes final;

2. The Executive Director is directed to suspend the Member’s Certificate of Registration for thirty (30) days. The suspension shall take effect on June 15, 2007 and shall run continuously without interruption;

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

   (a) The Member shall meet with a Practice Consultant at the Practice Consultant’s convenience, and within three (3) months of the date this Order becomes final. The Member will meet with the Practice Consultant to discuss the standards of practice and the materials referred to in 3(a)(i), 3(a)(ii) and 3(a)(iii) below, as they relate to the conduct for which the Member was found to have committed professional misconduct and to discuss how to prevent such conduct from occurring in the future. Prior to meeting with the Practice Consultant, the Member shall:
(i) review the College Standards and Guidelines – “Professional Standards”, “Therapeutic Nurse-Client Relationship”, “Ethics” and “Managing Conflict”; and

(ii) purchase and complete the College’s self-directed learning package, *One is One Too Many*, at her own expense; and

(iii) review any other relevant College Standards or documents which the Practice Consultant may direct.

(b) For a period of twelve (12) months following the date upon which the Member’s appeal rights end as a result of exhaustion, expiry or waiver, the Member shall:

(i) communicate to the Director of the Investigations and Hearings Department at the College of Nurses of Ontario (the “Director”), in writing, the name, address, and telephone number of all employer(s) for whom the Member is employed as a nurse within fourteen (14) days of the date the Member commences or resumes employment in any nursing position, such communication to be delivered by a verifiable means such as courier or registered letter and the Member shall retain proof of the College’s receipt of the communication;

(ii) provide all of her employer(s) with a copy of the Panel’s Penalty Order together with the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Penalty and any attachments to those documents or, if available, the Panel’s written Decision and Reasons, together with any attachments, and provide proof of its delivery to the employer(s) to the Director within 14 days from the date the member commences employment, to be delivered by a verifiable means such as courier or registered letter and the Member shall retain proof of the College’s receipt of the communication;

(iii) only practice nursing for an employer(s) who agrees to, and does so advise the Director in writing, within fourteen (14) days of the commencement or resumption of the Member’s employment, notify the Director immediately upon receipt of any reasonable information that the Member has breached the standards of practice of the profession.

In accepting the Joint Submission as to Penalty, the panel considered both the aggravating and mitigating circumstances presented by both counsel. The panel agrees that the 30-day suspension is both fair to the Member, and at the same time providing for a deterrence to the general membership. The remediation and monitoring aspects of the penalty order also send a message to the general membership that the standards of practice must be adhered to, as well as ensuring public safety.

**Reasons for Penalty Decision**
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 and has avoided unnecessary expense to the College.

Following the signing of the penalty order, defence counsel requested that the penalty order include the allegations that had been dismissed. The panel sought advice from independent legal counsel (ILC), Mr. Chris Wirth. After consideration of the submissions, the panel ruled that the penalty order will contain only the findings of professional misconduct of allegations # 1 (b) and (f). The reference to the dismissed allegations were clearly reflected in the Agreed Statement of Facts (paragraph 51), and also in the panel’s oral decision.

I, Grace Isgro-Topping, 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:

Anne McKenzie, RPN
William Dowson, Public Member