B E T W E E N:

COLLEGE OF NURSES OF ONTARIO

- and -

ANDREA ANNEMARIE GAYLE
REGISTRATION NO. 9606443

NOTICE OF HEARING

IT IS ALLEGED THAT:

1. 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 while you were employed as a Registered Nurse at Mackenzie Health in Richmond Hill, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to the following incidents:

    a. on or around October 26 and 27, 2015, you failed to notify the physician when [Patient A]'s international normalized ratio was less than 2 as required by the physician's order;

    b. on or around November 12, 2015, after [Patient B] fell, you:

        i. failed to appropriately monitor and/or assess [Patient B]; and/or

        ii. failed to complete sufficient documentation;

    c. on or around February 4, 2016, with respect to [Patient C], you:

        i. failed to administer Digoxin as ordered in that you administered it at 1015 hours when it was due at 0800 hours;

        ii. failed to administer the correct dose of Digoxin when you administered 0.625mg instead of 0.0625mg or you documented an incorrect dose when you documented the administered dose of Digoxin as 0.625mg instead of 0.0625mg;

iii. failed to accurately document the administration of Digoxin in that you documented it was administered at 0800 hours when it was administered at or around 1015 hours;

iv. failed to assess and/or act on [Patient C]'s tachycardia; and/or

v. failed to reassess [Patient C] after she was treated for tachycardia;

d. on or around February 13, 2016, with respect to [Patient D], you:

i. administered the incorrect medication when you administered Humalog at or around 2100 hours when there was no order for Humalog at that time of day;

ii. failed to reassess [Patient D]'s blood sugar following insulin administration; and/or

iii. failed to properly prepare [Patient D]'s Plaquenil dose when you attempted to administer 400 mg rather than the 300 mg ordered and/or used your bare hands to break one of the Plaquenil tablets in half;

e. on or around February 14, 2016, with respect to [Patient D], you:

i. prepared and attempted to administer two types of insulin (Lantus and Humalog) when only Lantus was prescribed at 2100 hours and/or failed to label the syringes;

ii. advised [Patient D] that she should have told you that she did not want Humalog as now it was a waste, or words to that effect;

iii. failed to reassess [Patient D]'s blood sugar following insulin administration; and/or

iv. failed to appropriately dispose of one or more medications in that you left medication on the floor of [Patient D]'s room after it had fallen;

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, and defined in subsection 1(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Mackenzie Health in Richmond Hill, Ontario, you failed to keep records as required with respect to the following incidents:

    a. on or around November 12, 2015, after [Patient B] fell, you failed to complete sufficient documentation; and/or

    b. on or around February 4, 2016, with respect to [Patient C], you:

        i. failed to accurately document the administration of Digoxin in that you documented it was administered at 0800 hours when it was administered at or around 1015 hours; and/or

        ii. documented the administered dose of Digoxin as 0.625mg instead of 0.0625mg;

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(37) of *Ontario Regulation 799/93*, in that, while you were employed as a Registered Nurse at Mackenzie Health in Richmond Hill, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, with respect to the following incidents:

    a. on or around October 26 and 27, 2015, you failed to notify the physician when [Patient A]'s international normalized ratio was less than 2 as required by the physician's order;

    b. on or around November 12, 2015, after [Patient B] fell, you:

        i. failed to appropriately monitor and/or assess [Patient B]; and/or

        ii. failed to complete sufficient documentation;

    c. on or around February 4, 2016, with respect to [Patient C], you:

i. failed to administer Digoxin as ordered in that you administered it at 1015 hours when it was due at 0800 hours;

ii. failed to administer the correct dose of Digoxin when you administered 0.625mg instead of 0.0625mg or you documented an incorrect dose when you documented the administered dose of Digoxin as 0.625mg instead of 0.0625mg;

iii. failed to accurately document the administration of Digoxin in that you documented it was administered at 0800 hours when it was administered at or around 1015 hours;

iv. failed to assess and/or act on [Patient C]'s tachycardia; and/or

v. failed to reassess [Patient C] after she was treated for tachycardia;

d. on or around February 13, 2016, with respect to [Patient D], you:

i. administered the incorrect medication when you administered Humalog at or around 2100 hours when there was no order for Humalog at that time of day;

ii. failed to reassess [Patient D]'s blood sugar following insulin administration; and/or

iii. failed to properly prepare [Patient D]'s Plaquenil dose when you attempted to administer 400 mg rather than the 300 mg ordered and/or used your bare hands to break one of the Plaquenil tablets in half;

e. on or around February 14, 2016, with respect to [Patient D], you:

i. prepared and attempted to administer two types of insulin (Lantus and Humalog) when only Lantus was prescribed at 2100 hours and/or failed to label the syringes;

ii. advised [Patient D] that she should have told you that she did not want Humalog as now it was a waste, or words to that effect;

iii. failed to reassess [Patient D]'s blood sugar following insulin administration; and/or

iv. failed to appropriately dispose of one or more medications in that you left medication on the floor of [Patient D]'s room after it had fallen;

4. 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 while you were employed as a Registered Nurse at Coleman Care Centre in Barrie, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to the following incidents:

   a. on or around November 10, 2018, you documented that you administered Clobazam to [Patient E] at 0700 hours when it had not been administered;

   b. on or around February 8, 2019, with respect to [Patient F], you:

      i. inaccurately documented in [Patient F]'s chart that she was to receive a B12 injection every 96 hours when the order was for her to receive the injection monthly on the 15th of each month; and/or

      ii. you administered a B12 injection to [Patient F] on February 8, 2019 when it was not ordered for administration until February 15, 2019;

   c. on or around April 21, 2019, you completed a New Admissions Order Form for [Patient G] and included Rivastigmine when it had been discontinued;

   d. on or around September 7, 2019, you failed to document a timeframe for an order of Cephalexin for [Patient H]; and/or

   e. on or around October 21, 2019, when inputting the order into [Patient I]'s medication administration record for [Patient I]'s Nitroglycerin patch, you failed to document the time for removal of the patch;

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the Act, and defined in subsection 1(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Coleman Care Centre in Barrie, Ontario, you failed to keep records as required with respect to the following incidents:

    a. on or around November 10, 2018, you documented that you administered Clobazam to [Patient E] at 0700 hours when it had not been administered;

    b. on or around February 8, 2019, with respect to [Patient F] you inaccurately documented in [Patient F]'s chart that she was to receive a B12 injection every 96 hours when the order was for her to receive the injection monthly on the 15th of each month;

    c. on or around April 21, 2019, you completed a New Admissions Order Form for [Patient G] and included Rivastigmine when it had been discontinued;

    d. on or around September 7, 2019, you failed to document a timeframe for an order of Cephalexin for [Patient H]; and/or

    e. on or around October 21, 2019, when inputting the order into [Patient I]'s medication administration record for [Patient I]'s Nitroglycerin patch, you failed to document the time for removal of the patch; and/or

6. 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(37) of *Ontario Regulation 799/93*, in that, while you were employed as a Registered Nurse at Coleman Care Centre in Barrie, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, with respect to the following incidents:

    a. on or around November 10, 2018, you documented that you administered Clobazam to [Patient E] at 0700 hours when it had not been administered;

    b. on or around February 8, 2019, with respect to [Patient F], you:

i. inaccurately documented in [Patient F]'s chart that she was to receive a B12 injection every 96 hours when the order was for her to receive the injection monthly on the 15th of each month; and/or

ii. you administered a B12 injection to [Patient F] on February 8, 2019 when it was not ordered for administration until February 15, 2019;

c. on or around April 21, 2019, you completed a New Admissions Order Form for [Patient G] and included Rivastigmine when it had been discontinued;

d. on or around September 7, 2019, you failed to document a timeframe for an order of Cephalexin for [Patient H]; and/or

e. on or around October 21, 2019, when inputting the order into [Patient I]'s medication administration record for [Patient I]'s Nitroglycerin patch, you failed to document the time for removal of the patch.

The allegations respecting professional misconduct on your part will be heard by a panel of the Discipline Committee of the College of Nurses of Ontario ("CNO"), pursuant to the *Nursing Act, 1991*, S.O. 1991, c.32, as amended, and subsection 38(1) of the *Health Professions Procedural Code,* on **July 9, 2024 at 0930 hours or as soon after that time as the hearing can be commenced**, via electronic hearing by way of teleconference or videoconference.

The details for participating in the electronic hearing will be provided to you by a Hearings Administrator. If you have not heard from a Hearings Administrator at least 48 hours in advance of the hearing, you should contact the Hearings Administration Team at: Admin-Business.Support-Hearings@cnomail.org to obtain the details for participating in the electronic hearing.

If you believe that holding an electronic hearing rather than an oral hearing is likely to cause you significant prejudice, please communicate in writing the basis for asserting such prejudice to the Hearings Administration Team at the email address listed above. To ensure the claim of prejudice can be considered by the Discipline Committee, any such concerns should be communicated to the Hearings Administration Team as soon as possible, and no later than 21 days in advance of the hearing.

Take notice that at least 48 hours before the electronic hearing is scheduled to commence, you must provide notice to the Hearings Administration Team, at the email address listed above, of the telephone number and email address where you can be reached for the electronic hearing.

If you fail to participate in the electronic hearing in person or by representative, the panel of the Discipline Committee may proceed in your absence and you are thereafter not entitled to any further notice of the proceedings.

Where the panel of the Discipline Committee finds a member has committed an act of professional misconduct, it may make an Order doing any one or more of the following:

1. directing the Registrar to revoke the member's certificate of registration;

2. directing the Registrar to suspend the member's certificate of registration for a specified period of time;

3. directing the Registrar to impose specified terms, conditions and limitations on the member's certificate of registration for a specified or indefinite period of time;

4. requiring the member to appear before the panel to be reprimanded;

5. requiring the member to pay a fine of not more than $35,000.00 to the Minister of Finance;

6. requiring the member to reimburse CNO for funding provided for a program of therapy and counselling for a person if the act of professional misconduct was the sexual abuse of that person; and

7. requiring the member to post security acceptable to CNO to guarantee the payment of any amounts the member may be required to reimburse CNO for a program of therapy and counselling for a person who was sexually abused by the member.

Furthermore, the panel may suspend the effect of its Order for a specified period of time and on specified conditions and where it makes an Order under paragraph 2 or 3 above, it may specify criteria to be satisfied for the removal of a suspension or the removal of terms, conditions and limitations imposed by the Order on the member's certificate of registration.

Where a panel of the Discipline Committee finds a member has committed an act of

professional misconduct, it may make an Order requiring the member to pay all or part of the following costs and expenses:

1. CNO's legal costs and expenses;

2. CNO's costs and expenses incurred in investigating the matter; and

3. CNO's costs and expenses incurred in conducting the hearing.

CNO intends to introduce as business records, under section 35 of the *Evidence Act*, any writings or records that were made in the usual and ordinary course of business. Without limiting the generality of the foregoing, and where applicable, CNO intends to introduce as business records medical and hospital charts.