B E T W E E N:

COLLEGE OF NURSES OF ONTARIO

- and -

JOY MCKENZIE
REGISTRATION NO. 07298649

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 employed as a Registered Nurse at Unity Health Toronto – St. Joseph's Health Centre in Toronto, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession as follows:

    a. on or about November 12-13, 2018 and January 3, 2019, you were observed sleeping while on shift;

    b. on or around November 13, 2018, you failed to:

        i. provide nursing care in a timely manner when [Patient A], who was identified as in need of close observation by her primary nurse during Transfer of Accountability for break, was found naked and urinating on the floor; and/or

        ii. conduct check(s) of [Patient A] between 0100 and 0300 hours;

    c. on, about or between November 12-13, 2018, you failed to ensure that your documentation of patient care was accurate, timely and complete as follows:

        i. with respect to [Patient B], you documented an irregular heart rate at 2158 hours but failed to document the intervention undertaken until 0816 hours and failed to indicate that it was a late entry;

ii. with respect to [Patient C], you failed to assess the patient and/or document such an assessment for the first approximately four hours of your shift;

iii. with respect to [Patient D], you failed to assess the patient and/or document such an assessment for the patient until 10 hours into your 12-hour shift;

iv. with respect to [Patient E], you failed to document the Transfer of Accountability until four hours after your shift started and/or your documented assessments of the patient with respect to neurological, skin, and gastrointestinal body systems were incomplete, inconsistent and/or inaccurate; and/or

v. with respect to [Patient F], you failed to assess the patient and/or document such an assessment until approximately seven hours after your shift started; and/or

d. on or around January 2, 2019, you failed to provide appropriate patient care to [Patient G] and put the patient's safety at risk when you failed to follow the relevant code blue policy;

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 Unity Health Toronto – St. Joseph's Health Centre in Toronto, Ontario, you failed to keep records as required when on, about or between November 12-13, 2018, you failed to ensure that your documentation of patient care was accurate, timely and complete as follows:

a. with respect to [Patient B], you documented an irregular heart rate at 2158 hours but failed to document the intervention undertaken until 0816 hours and failed to indicate that it was a late entry;

b. with respect to [Patient C], you failed to assess the patient and/or document such an assessment for the first approximately four hours of your shift;

c. with respect to [Patient D], you failed to assess the patient and/or document such an assessment for the patient until 10 hours into your 12-hour shift;

d. with respect to [Patient E], you failed to document the Transfer of Accountability until four hours after your shift started and/or your documented assessments of the patient with respect to neurological, skin, and gastrointestinal body systems were incomplete, inconsistent and/or inaccurate; and/or

e. with respect to [Patient F], you failed to assess the patient and/or document such an assessment until approximately seven hours after your shift started;

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 Unity Health Toronto – St. Joseph's Health Centre in Toronto, 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, as follows:

a. on or about November 12-13, 2018 and January 3, 2019, you were observed sleeping while on shift;

b. on or around November 13, 2018, you failed to:

i. provide nursing care in a timely manner when [Patient A], who was identified as in need of close observation by her primary nurse during Transfer of Accountability for break, was found naked and urinating on the floor; and/or

ii. conduct check(s) of [Patient A] between 0100 and 0300 hours;

c. on, about or between November 12-13, 2018, you failed to ensure that your documentation of patient care was accurate, timely and complete as follows:

i. with respect to [Patient B], you documented an irregular heart rate at 2158 hours but failed to document about the intervention undertaken until 0816 hours and failed to indicate that it was a late entry;

ii. with respect to [Patient C], you failed to assess the patient and/or document such an assessment for the first approximately four hours of your shift;

iii. with respect to [Patient D], you failed to assess the patient and/or document such an assessment for the patient until 10 hours into your 12-hour shift;

iv. with respect to [Patient E], you failed to document the Transfer of Accountability until four hours after your shift started and/or your documented assessments of the patient with respect to neurological, skin, and gastrointestinal body systems were incomplete, inconsistent and/or inaccurate; and/or

v. with respect to [Patient F], you failed to assess the patient and/or document such an assessment until approximately seven hours after your shift started; and/or

d. on or around January 2, 2019, you failed to provide appropriate patient care to [Patient G] and put the patient's safety at risk when you failed to follow the relevant code blue policy.

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 **a date to be determined**, 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.