DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Tanya Dion, RN	Chairperson
	Sylvia Douglas	Public Member
	Terah White, RPN	Member
	Christopher Woodbury	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
PAULAMAE WALKER	)	ANUSHIKA ANTHONY for
REGISTRATION NO. IE02782	)	Paulamae Walker
	)	
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: December 10, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on December 10, 2019 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

The allegations against Paulamae Walker (the "Member") as stated in the Notice of Hearing dated October 3, 2019 are as follows:

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 Practical Nurse at Maple Grove Care Community (the "Facility") in Brampton, Ontario, you contravened a standard of practice of the profession or failed to meet the standards

of practice of the profession, in that, between on or about August 28, 2016 and September 1, 2016:

a. you failed to implement the Facility's bowel protocol in respect of your [patient], [the Patient], after receiving alerts from the Facility's dashboard alerts;

b. you failed to complete appropriate bowel assessments of your [patient], [the Patient];

c. you failed to monitor your [patient], [the Patient], for signs and symptoms of constipation and/or bowel obstruction;

d. you failed to advise the physician of your [patient], [the Patient], of a change in her bowel/abdominal status; and/or

e. you failed to document your assessment and/or care of your [patient], [the Patient] and/or failed to document your client's refusal of care; and/or

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(37) of *Ontario Regulation 799/93*, in that while employed as a Registered Practical Nurse at the Facility, 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, in that, between on or about August 28, 2016 and September 1, 2016:

a. you failed to implement the Facility's bowel protocol in respect of your [patient], [the Patient], after receiving alerts from the Facility's dashboard alerts;

b. you failed to complete appropriate bowel assessments of your [patient], [the Patient];

c. you failed to monitor your [patient], [the Patient], for signs and symptoms of constipation and/or bowel obstruction;

d. you failed to advise the physician of your [patient], [the Patient], of a change in her bowel/abdominal status; and/or

e. you failed to document your assessment and/or care of your [patient], [the Patient] and/or failed to document your client's refusal of care.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), (b), (c), (d) and (e) of the Notice of Hearing. The Member also admitted, in connection with the allegations set out in paragraphs 2(a), (b), (c), (d) and (e) of the Notice of Hearing, that her conduct would reasonably be considered by members to be dishonourable and unprofessional. The Panel received a written plea inquiry which was signed by

the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

College Counsel and the Member's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

THE MEMBER

1. Paulamae Walker (the "Member") obtained a certificate in nursing from Bathurst Heights Secondary, North York in 1994.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on November 30, 1994.

3. The Member was employed at the Maple Grove Care Community (the "Facility"), in 2003 until her termination in September 2016.

THE FACILITY

4. The Facility is located in Brampton, Ontario. The Member worked at the Facility as a full-time staff nurse on the night shift from 1500 hours to 2300 hours.

Facility Policies and Procedures

5. Personal Support Workers ("PSWs") in the Facility are required to monitor and document the frequency of patients' bowel movements on each shift. PSWs then convey the information to the nurse on the shift.

6. The Facility's bowel protocol provides:

    a. If a patient does not have a bowel movement for two days, the nurse working on the evening shift is to administer Milk of Magnesia to the patient;

    b. If the patient does not have a bowel movement for three days, the nurse is to administer a glycerin suppository, and the nurse should also conduct a complete bowel assessment; and

    c. If the patient does not have a bowel movement for four days, the nurse will administer a fleet enema.

7. Patients capable of informed decision-making may refuse the treatment under the bowel protocol. However, any such refusal should be properly documented.

8. The Facility uses a "dashboard" system, which sends alerts to nurses at regular intervals when a patient has not had a bowel movement for a specified period of time.

9. The dashboard alerts will be sent when a patient has not had a bowel movement for 2 days, 3 days, or 5 days. Alerts must be "cleared" by clicking on the alert. If a nurse clears the alert, but does not document taking action for the Patient, the alert would reappear the following day.

THE PATIENT

10. [ ] (the "Patient") was 67 years old years old at the time of the incident.

11. She had a history of coronary artery disease, congestive heart failure, hypertension, and diabetes. In 2012, she was admitted to the Facility, [ ]. Several months prior to the events at issue, the Patient had been hospitalized, [ ].

12. The Patient also had a history of constipation. During the material time, she was receiving narcotics, which may lead to constipation.

13. The Patient was ordered to be on Bowel Protocol, in accordance with the Facility's protocol. She was viewed by staff as "non-compliant", as she often refused bowel protocol steps.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Bowel Concerns

14. The Member worked at the Facility on August 23, 25, 26, 29, 30, 31, and September 1, 2016.

15. The Patient did not have a bowel movement from August 18, 2016 to August 23, 2016, when she received a fleet enema. She then had a bowel movement on August 26, 2016.

16. On August 28, 2016, the dashboard alert went off, indicating that the Patient had not had a bowel movement for two days. The first two alerts appeared on August 28, 2016, on the day shift and the evening shift, and were cleared by another nurse, [Nurse A]. [Nurse A] did not document completing bowel protocol.

17. During the Member's shift on August 29, 2016 the Member cleared the dashboard alert indicating that the Patient had not had a bowel movement in 2 days, which had reappeared, and a subsequent alert that the Patient had not had a bowel movement in 3 days. The Member did not document completing any bowel protocol or taking any other action to respond to the alerts.

18. On August 31, 2016, the Patient was at dialysis, and the nurse, [Nurse B], "endorsed" the alert to the following shift. The Patient returned from dialysis feeling drowsy.

19. During shifts on August 31 and September 1, 2016, other nurses "endorsed" the alerts to be handled by the day shift. The nurses indicated that the Patient was tired during those shifts, and had instructed the nurses not to wake her.

20. On September 1, 2016, the Member was working the shift from 15:00 to 23:00.

21. On September 1 at 14:50, there is a notation of a fleet enema alert. The notation was not electronically signed and reads, "stated she had bowel movement today but staff stated that she did not." The note is not electronically signed and it is not clear who authored the note.

22. At the end of the Member's shift, she documented that the Patient had "had 2 small emesis this shift. Refused to have second blood sugar done."

23. The Member did not take any steps to address the fact that the Patient had not had a bowel movement since August 26, 2016, nor assess why the Patient had had emesis during her shift. She did not document assessments relating to the Patient's bowel concerns and did not follow-up with the Facility's physician.

24. On September 2, the Patient was sent to Brampton Civic Hospital.

25. On September 5, the Patient died of a colon infection.

26. The Member acknowledges and admits that while providing care to the Patient on the dates listed above she:

    a. failed to implement the Facility's bowel protocol in respect of the Patient after receiving the dashboard alerts;

    b. failed to complete appropriate bowel assessments of the Patient;

    c. failed to monitor the Patient for signs of constipation and/or bowel obstruction;

    d. failed to advise the Patient's physician of the change in the Patient's bowel status; and

    e. failed to document her assessment and/or care of the Patient and/or the Patient's refusal of care.

STANDARDS OF PRACTICE

27. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of practice of the profession. A nurse demonstrates this standard by actions such as:

    a. providing, facilitating, advocating and promoting the best possible care for clients;

b. assessing/describing the client situation using a theory, framework or evidence-based tool and identifying/recognizing abnormal or unexpected client responses and taking action appropriately;

c. advocating on behalf of clients;

d. seeking assistance appropriately and in a timely manner;

e. taking action in situations in which client safety and well-being are compromised; and

f. evaluating/describing the outcomes of specific interventions and modifying the plan/approach.

28. CNO's *Documentation* standard provides that nurses are accountable for ensuring their documentation of client care is "accurate, timely and complete." The standard further clarifies that a nurse meets the standard by:

a. ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;

b. documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; and

c. ensuring that relevant client care information is captured in a permanent record.

29. The Facility's policies require a nurse to closely monitor the bowel movements of patients. Implementing bowel protocols and assessing, documenting, and escalating issues with bowel health are important in long-term care facilities. The Member acknowledges and agrees that a patient presenting with no bowel movement for five days and having emesis may indicate a possible issue, and requires intervention or escalation to physician and documentation.

30. The Member admits and acknowledges that it was a breach of the standards of practice to fail to take and document steps to implement the Facility's bowel protocol in respect of the Patient and/or advise the Facility's physician. The Member admits and acknowledges that that nurses have an accountability to assess patients using evidence and theory and recognize abnormal patient responses, and that she failed to complete and document a comprehensive bowel assessment in such circumstances, thereby contravening the standards of practice.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

31. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1 (a) to (e) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 14 to 30 above.

32. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2 (a) to (e) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 14 to 30 above.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), (b), (c), (d) and (e) and paragraphs 2(a), (b), (c), (d) and (e) of the Notice of Hearing. As to paragraphs 2(a), (b), (c), (d) and (e), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

All of the allegations against the Member arise out of the Member's alleged failure in a number of respects to (1) provide appropriate assessment and care to her patient, [the Patient], with regard to [the Patient]'s bowel movements between August 28, 2016 and September 1, 2016 and (2) document her assessment and care of [the Patient] in connection with [the Patient]'s bowel movements.

The Agreed Statement of Facts sets out the evidence related to these allegations at paragraphs 14-25. In addition, the Member admitted the factual circumstances on which the allegations made against her are based at paragraph 26 of the Agreed Statement of Facts. Collectively, this evidence establishes the factual basis for Allegations #1 and #2.

As to whether the Member's conduct constitutes professional misconduct for the purposes of Allegation #1, nurses have an accountability to assess patients using evidence and theory and to recognize abnormal patient responses. The Member's failure to complete and document a comprehensive bowel assessment for [the Patient] in these circumstances contravened the standards of practice and, in particular, the College's *Professional Standards* and *Documentation* standard, as set out in paragraphs 27-28 of the Agreed Statement of Facts. The Member also failed to implement the Facility's bowel protocol, despite having received dashboard alerts indicating that [the Patient] had not had a bowel movement.

The Member admitted in paragraph 30 of the Agreed Statement of Facts that her conduct resulted in a breach of the standards of practice.

For these reasons the allegations in paragraphs 1(a), (b), (c), (d) and (e) of the Notice of Hearing are established.

With respect to the allegations in paragraphs 2(a), (b), (c), (d) and (e) of the Notice of Hearing, the Panel finds that the Member's admitted conduct as described in paragraphs 14-25 of the Agreed Statement of Facts was dishonourable and unprofessional. It was unprofessional in that it demonstrated a serious disregard for her professional obligations, including those set out in the facility's bowel protocol. It was also dishonourable in that the dashboard alert system in use in the Facility provided multiple reminders to the Member to actively provide assessment and care to [the Patient]. The Member's failure to act in the face of these reminders supports the conclusion that she knew or ought to have known what the applicable standards were, but did not take the steps necessary to ensure that those standards were met. Such conduct is dishonourable.

College Counsel made no submissions to the effect that the Member's misconduct was disgraceful, noting that, in the Agreed Statement of Facts, the Member admitted that her conduct was unprofessional and dishonourable.

For these reasons, in connection with Allegation #2, the Panel finds that the Member's conduct, which was clearly relevant to the practice of nursing, would reasonably be regarded by members of the profession to be dishonourable and unprofessional.

Penalty

College Counsel informed the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order as submitted requests that the Panel make an order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

College Counsel and the Member's Counsel also informed the Panel that the Member had entered into an undertaking with the College dated November 26, 2019 (the "Undertaking"). A copy of the Undertaking was provided to the Panel for its review. In the Undertaking, the Member undertook and agreed (among other things) that:

(i) she would permanently resign as a member of the College effective from the date the College accepts the Undertaking;

(ii) she would not apply for membership with the College as a Registered Nurse or Registered Practical Nurse at any time in the future; and

(iii) the public portion of the College's Register would indefinitely reflect that she entered into the Undertaking to permanently resign as part of an agreed resolution of allegations of professional misconduct.

The Member's Counsel informed the Panel that the Member had already delivered her resignation to the College in compliance with the Undertaking.

It was in light of the Member's Undertaking that the parties made a Joint Submission on Order, requesting that the Panel make an order requiring the Member to appear before the Panel to be reprimanded within three months of the date that the Order became final.

Penalty Submissions

Submissions were made by College Counsel and the Member's Counsel.

College Counsel submitted that the penalty proposed in the Joint Submission on Order, which consisted of an oral reprimand, when combined with the Undertaking was appropriate and in the public interest.

College Counsel submitted that a mitigating factor in this case was that the Member had co-operated with the College in the proceeding and avoided the need for a contested hearing. The Member had also taken responsibility for her conduct.

The aggravating factors were that the Member's conduct demonstrated a failure on the part of the Member to respond over a number of days to a patient's needs and provide appropriate care. The Member's failures in this respect shake the public's confidence in the nursing profession.

Given the Member's Undertaking, College Counsel submitted that the penalty goals of specific deterrence, rehabilitation and remediation were not applicable in this instance. However, she submitted that the goal of general deterrence would be met by the finding of misconduct against the Member which sends a message to the profession that this sort of conduct will not be tolerated.

College Counsel further submitted that the proposed penalty, combined with the Member's Undertaking never to practise as a nurse in the future, would maintain public confidence in the College, as well as provide protection to the public.

College Counsel noted that, but for the Undertaking, the College would have sought a significant regulatory response, including a suspension of the Member. Given the Member's particular circumstances, however, the parties had agreed that use of the Undertaking would be a better way to meet the goals of penalty in this situation.

Finally, College Counsel submitted that the Panel has the jurisdiction to accept the Undertaking and impose the requested order. College Counsel provided the Panel with a copy of *CNO v. Cruz* (Discipline Committee, 2017) in support of this submission. While the facts in *Cruz* were completely different from those in the present case, *Cruz* is relevant because the panel in that case accepted a Joint Submission on Order which provided for a reprimand combined with an undertaking to resign permanently. The undertaking in *Cruz* was substantially similar to the Undertaking in this case.

The Member's Counsel confirmed that the Member had agreed to the Joint Submission on Order, had signed the Undertaking and had already delivered her notice of resignation to the College.

Counsel for the Member indicated that the Member was about to turn 75 years old and that this was a factor in her decision to agree to the Undertaking after working as a nurse for 25 years.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the proposed penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concludes that the proposed Order, combined with the Undertaking, leads to a result that is reasonable and in the public interest in these circumstances. The Panel generally agrees with the reasons expressed by the panel in *Cruz* in making the same penalty order, in light of a substantially similar undertaking having been given.

Under the terms of the Undertaking, the Member has agreed to permanently resign her membership with the College and to never reapply. The circumstances that led to the Undertaking being given by the Member will be publicly available so that the profession and the public can understand that the Member's misconduct in this case had serious consequences for the Member. The proposed penalty, combined with the Member's acceptance that she will never reapply for membership in the College at any time in the future sends a strong message to the profession that conduct of this sort will not be tolerated. The public is protected by the fact that the Member has signed the Undertaking never to practise nursing again.

The Panel also accepts that the Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for her actions. Had the Member not agreed to give the Undertaking, however, the Panel would have been inclined to impose a much different penalty in order to fully address the Member's misconduct.

I, Christopher Woodbury, Public Member, sign this decision and reasons for the decision on behalf of the Chairperson and members of the Discipline Panel.