COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **DANICA LISTHAEGHE**, R.N. REGISTRATION #**101,942**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

JANUARY 27, 2021

INTRODUCTION

A hearing was held on January 27, 2021 via WebEx videoconference by the Hearing Tribunal of CARNA to hear a complaint against Danica Listhaeghe, R.N. registration #101,942.

Those present at the hearing were:

a. Hearing Tribunal Members:

Jason Anuik, Chairperson
Stephen Caron
Christa Eaton
Hugh Campbell, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Mary Marshall

c. CARNA Representative:

Natasha Nakai, Conduct Counsel

d. Regulated Member Under Investigation:

Danica Listhaeghe (sometimes hereinafter referred to as "the Regulated Member")

e. Regulated Member's Labour Relations Officer:

Martin d'Entremont, Labour Relations Officer of the United Nurses of Alberta

PRELIMINARY MATTERS

Conduct Counsel and the Labour Relations Officer for the Regulated Member confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("HPA"), the hearing was open to the public. No application was made to close the hearing. The Chairperson noted that members of the public were present and read the rules of behaviour for the public.

Conduct Counsel confirmed that the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend are as follows:

While employed as a Registered Nurse ("RN") at the Foothills Medical Centre in Calgary, AB.

1. On May 9, 2018, while working as a casual staff member on the [unit redacted] at the Foothills Medical Centre, the Regulated Member failed to adequately document the care they provided to a patient.

The Regulated Member has admitted to the conduct in the allegations in the Agreed Statement of Facts and Liability (Exhibit #2).

EXHIBITS

The following documents were entered as Exhibits:

NUMBER	DESCRIPTION
Exhibit #1:	Notice to Attend a Hearing by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta dated December 18, 2020
Exhibit #2:	Agreed Statement of Facts and Liability
Exhibit #3:	Appendices to Agreed Statement of Facts and Liability
	A Resume of Danica Listhaeghe
	B Letter of Complaint dated May 9, 2019
	C CARNA Documentation Standards for Regulated Members dated January 2013
Exhibit #4:	Joint Recommendations on Sanction
Exhibit #5:	Certificate of Completion of D. Listhaeghe - The Essentials of Nursing Documentation on Saturday, December 19, 2020
Exhibit #6:	Excerpt from *Jaswal v. Newfoundland Medical Board*, (1996), 42 Admin L.R. (2d) 233 ("*Jaswal*")

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. Conduct Counsel reviewed the Agreed Statement of Facts and Liability (Exhibit #2). This matter is proceeding by way of a consent agreement and joint recommendations on sanction. Documents are being entered as exhibits by way of consent. Conduct Counsel acknowledged that the Regulated Member was fully engaged and accountable.

Conduct Counsel submitted that the Hearing Tribunal should accept the factual admissions in Exhibit #2. The events occurred on [unit redacted] which helps patients who are experiencing complex pain influencing quality of life. The goal is to have a team-based approach. There is a detailed letter from the complainant outlining a number of concerns. The Regulated Member's employer did not find that her conduct did not follow protocol except for inadequate documentation, with concerns around details including vital signs, oxygen levels, care provided, patient responses, conversations with other health care professionals and communications with the patient's family.

Conduct Counsel submitted that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i), (ii) and (xii) of the HPA. Inadequate documentation adversely affects subsequent care by other health care providers and leaves the patient's family with a negative

impression of the care received by the patient. Further, inadequate documentation breaches the following provisions in the Documentation Standards for Regulated Members (Exhibit #3): 1.1(b) and (d), 1.2(b), 1.4(e) and (j). The Regulated Member admits her behaviour constitutes unprofessional conduct.

Submissions by the Labour Relations Officer for the Regulated Member:

The Regulated Member's Labour Relations Officer advised he had no submissions.

Questions from the Hearing Tribunal:

The Chairperson requested further submissions regarding the applicability of Practice Standard 2.5, and the following provisions in the Documentation Standards for Regulated Members: 1.1 a, e and f; 1.2 a, c, e, and f; and 1.4 b. Conduct Counsel submitted that the first part of Practice Standard 2.5 could apply. The Registered Member did not document contemporaneously. It is within the Hearing Tribunal's discretion to add Practice Standards, and it is acceptable to Conduct Counsel that Practice Standard 2.5 is included. It was not included initially because the entire wording does not fully reflect the Allegations. Regarding Documentation Standards for Regulated Members 1.1 a, e and f; and 1.2 a, c, e, and f; Conduct Counsel takes no position. Documentation Standard 1.4 b is acceptable.

The Labour Relations Officer for the Regulated Member had no objections to the inclusion of Practice Standard 2.5, and the following provisions in the Documentation Standards for Regulated Members: 1.1 a, e and f; 1.2 a, c, e, and f; and 1.4 b.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal has reviewed the exhibits and considered the submissions made by the parties. There were a number of concerns that were raised in the Letter of Complaint dated May 9, 2019 (Exhibit #3B). The Complaints Director found that there was sufficient evidence regarding appropriate documentation to proceed to a hearing on those matters. This hearing is narrow in focus and pertains only to the Allegations relating to documentation as outlined in the Notice to Attend a Hearing (Exhibit #1), and not to other matters that were in the background information provided to the Hearing Tribunal. The role of the Hearing Tribunal is to decide whether the Allegations relating to documentation are proven, and if so whether that conduct constitutes unprofessional conduct as defined in section 1(1)(pp) of the HPA.

The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that the Allegations are proven and that the Regulated Member's conduct constitutes unprofessional conduct under section (1)(1)(pp) of the *Health Professions Act*, as follows:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice;

(xii) conduct that harms the integrity of the regulated profession.

The Hearing Tribunal finds that the Regulated Member breached the following provisions of the Practice Standards: Practice Standard 2.5, as follows:

Standard Two: Knowledge-Based Practice

The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

The Hearing Tribunal finds that the Regulated Member breached the following provisions from the Documentation Standards for Regulated Members (Exhibit #3): 1.1 a, b, d, e and f; 1.2 a, b, c, e, and f; 1.4 b, e and j, as follows:

Standard One: Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

Criteria:

The nurse must:

1.1 Record a complete account of nursing assessment of the client's needs, including:

a. identified issues and concerns

b. assessment findings

d. plan of care

e. intervention(s) provided

f. evaluation of the client care outcomes

1.2 Document the following aspects of care:

a. relevant objective information related to client care

b. the time when assessments and interventions were completed

c. follow-up of client assessments, observations or interventions that have been completed

e. formal and informal educational/teaching activity provided to the client and family

f. any adverse event or ***adverse outcome***

1.4 Record:

b. accurately, completely and objectively

e. ***contemporaneously***

j. communication with other care providers, including name and outcomes of discussion

The Hearing Tribunal finds that the proven conduct demonstrates a lack of skill or judgment in the provision of professional services, a failure by the Regulated Member to meet the Documentation Standards for Regulated Members, and is conduct that harms the integrity of the profession, all of which is unprofessional conduct as defined by sections 1(1)(pp)(i), (ii) and (xii) of the HPA.

Accurate patient records are an essential part of good patient care. Poor record-keeping can compromise patient care and have other serious repercussions. The Regulated Member failed to meet the standards of the profession. Omissions of essential information pertaining to examinations and treatment tarnish the reputation of the profession.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations (Exhibit #4). Conduct Counsel submitted that the sanction is appropriate. The course, The Essentials of Nursing Documentation, deals with methods of documentation, principles, and a test at the end. The Registered Member has taken the initiative to complete the course in December.

Conduct Counsel reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case.

1. *The nature and gravity of the proven allegations*: The proven allegations are on the higher end of spectrum. The Regulated Member is part of a team of professionals, and failure to document care affects subsequent care.

2. *The age and experience of the member*: The Regulated Member is [age redacted] and is familiar with requirements for care in this setting.

3. *The previous character of the member*: The Regulated Member has no history with CARNA.

4. *The age and mental condition of the offended patient*: The elderly patient was vulnerable, and in an advanced state of illness. She experienced a sudden shortness of breath and rapid deterioration on the day of expected discharge.

5. *The number of times the offence was proven to have occurred*: There is no pattern of conduct and the events that are at issue in this hearing occurred on one day. The

documentation on that day was lacking and was not sufficiently detailed to reflect care. There is no allegation of insufficient care before the Hearing Tribunal.

6. *The role of the registered nurse in acknowledging what occurred*: The Regulated Member admitted that the documentation was insufficient, and came to a consent hearing.

7. *Whether the member has already suffered other serious financial or other penalties*: CARNA is unaware of financial or other penalties.

8. *The impact on the offended patient*: The complaint alleges that the care contributed to death of patient. The Regulated Member was the primary nurse and there were a number of other health professionals, including specialists, providing care. The review by the Regulated Member's employer does not conclude that care was deficient. The outcome of the care was tragic and the patient passed away.

9. *The presence or absence of any mitigating factors*: The Regulated Member had focused on patient care at the expense of documentation. She worked a 12-hour shift without a break and then stayed for an additional 2-hour shift in order to complete documentation. There is a need for clear communication with a patient and their family.

10. *The need to promote specific and general deterrence*: The proposed sanction meets both goals. Specific deterrence is dealt with by the course component of the sanction. Publication of the Hearing Tribunal decision promotes both specific deterrence and general deterrence.

11. *The need to maintain public confidence*: The proposed sanction holds the Regulated Member accountable for her conduct.

12. *Degree to which offensive conduct is outside the range of permitted conduct*: The lack of full documentation is unacceptable.

The circumstances reveal a tragic situation for the patient and her family, and the sanction is appropriate for the situation. The Regulated Member has been exceptionally cooperative and has finished as much as she can prior to the hearing. She is compliant with the course requirement in the proposed sanction. The Complaints Director is not seeking costs.

Submissions by the Labour Relations Officer for the Regulated Member:

The Labour Relations Officer for the Regulated Member stated that there was agreement with the sanctions, and thanked the Hearing Tribunal for their consideration.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal has carefully considered the joint recommendations on sanction, and the submissions of the parties. The Hearing Tribunal has considered the factors noted in *Jaswal v. Newfoundland Medical Board.* The Hearing Tribunal accepts the joint recommended sanction. The joint recommendations take into account the nature of the findings of the Hearing Tribunal. They also address the issues that brought this Regulated Member before the Hearing Tribunal. The Hearing Tribunal finds that this recommended sanction appropriately considers the factors in *Jaswal.* The Hearing Tribunal also considered the penalty in light of the principle that joint recommendations should not be interfered with lightly.

The Hearing Tribunal finds that a reprimand is appropriate. Deficits in record-keeping are serious and merit a reprimand. It will send a clear message to the membership and the public that record-keeping is a vital part of patient care. It will also reinforce to the Regulated Member that her failure to maintain the standards of practice of the profession is a serious finding. The Regulated Member should take the comments in the written decision as well as the concerns expressed by the Hearing Tribunal with respect to her conduct as her reprimand. In addition, the Member should consider her experiences in dealing with this complaint before this Hearing Tribunal and CARNA, as well as the joint recommendations on sanction, as a reminder of how important it is to practise in accordance with the Practice Standards, and the Documentation Standards for Regulated Members.

The Hearing Tribunal 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.

This penalty would serve to remind the profession that proper charting is a necessary obligation related directly to good patient care. To be remiss in recording accurately may result in disciplinary proceedings and, most importantly, compromises safe patient care, putting in jeopardy the well-being of those whom nurses are entrusted to serve. The penalty will assure the public that serious transgressions will be met with sanctions. The Regulated Member will be deterred from further unprofessional conduct by this penalty. The course will reinforce high standards for her practice. The Regulated Member is in compliance with the course requirement in paragraph 1 of the Order below.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Regulated Member, Danica Listhaeghe, #101,942 (the "**Regulated Member**"), shall receive a reprimand for unprofessional conduct:

    a. By no later than **April 15, 2021**, the Member shall provide proof satisfactory to the Complaints Director, that the Regulated Member has successfully completed and passed the following course of study:

        i. ***The Essentials of Nursing Documentation (CARNA online learning module)***.

    (the "**Condition(s)**")

2. The Regulated Member will provide proof of completion of the above-noted Condition(s) to the Complaints Director via e-mail to procond@nurses.ab.ca.

COMPLIANCE

3. Compliance with this Order shall be determined by the Complaints Director of CARNA. All decisions with respect to the Regulated Member's compliance with this Order will be in the sole discretion of the Complaints Director.

4. Should the Member fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of HPA.

5. The responsibility lies with the Regulated Member to comply with this Order. It is the responsibility of the Regulated Member to initiate communication with CARNA for any anticipated non-compliance and any request for an extension.

CONDITIONS

6. The Regulated Member confirms the following list sets out all the Regulated Member's employers and includes all employers even if the Regulated Member is under an undertaking to not work, is on sick leave or disability leave, or if the Regulated Member has not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer.

The Regulated Member confirms the following employment:

Employer Name	**Employer Address & Phone Number**
Foothills Medical Centre **[Unit redacted]**	**Address:** **1403 29 St NW** **Calgary, AB T2N 2T9** **Phone:** **(403) 944-1110**

7. The Regulated Member understands and acknowledges that it is the Regulated Member's professional responsibility to immediately inform CARNA of any changes to the Regulated Member's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the *HPA*.

8. The Registrar of CARNA will be requested to put the following condition against the Regulated Member's practice permit (current and/or future) and shall remain until the condition is satisfied:

    a. **Course work required.**

9. Effective January 27, 2021, or the date of this Order if different from the date of the Hearing, notifications of the above condition shall be sent out to the Regulated Member's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Regulated Member is also registered (if any).

10. Once the Regulated Member has complied with the condition listed above, it shall be removed. Once the condition has been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

11. This Order takes effect on January 27, 2021, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the *HPA*.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,

Jason Anuik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: **January 27, 2021**