COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **MARK WADE**, R.N. REGISTRATION **#86,531**

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

JUNE 22, 2020

INTRODUCTION

[1] A hearing was held on June 22, 2020 by Webex videoconference before a Hearing Tribunal of the College and Association of Registered Nurses of Alberta (”CARNA”) to hear a complaint against Mark Wade, R.N. registration #86,531. This was a continuation of a hearing commenced on November 12, 2019.

[2] Those present at the hearing were:

a. **Hearing Tribunal Members:**

Jason Anuik, Chairperson
Kelly Osuna
Roxine Wright
Nancy Brook, Public Representative

b. **Independent Legal Counsel to the Hearing Tribunal:**

Julie Gagnon

c. **CARNA Representative:**

Jason Kully, Conduct Counsel

d. **Regulated Member Under Investigation:**

Mark Wade (sometimes hereinafter referred to as “the Regulated Member”) (absent)

e. **Observers**

Vita Wensel, Conduct Counsel
Natasha Nakai, Conduct Counsel

PRELIMINARY MATTERS

[3] 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.

[4] The Chairperson noted that there were two CARNA employees present as observers.

[5] Conduct Counsel 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.

[6] Conduct Counsel confirmed that the matter was proceeding by Consent Agreement. Conduct Counsel advised that the Regulated Member was aware of the hearing, as confirmed by the Consent Agreement. Conduct Counsel advised that he had spoken with the Regulated Member last week, who indicated he was not planning on attending the hearing. Conduct Counsel advised that pursuant to the HPA, the hearing could proceed in the Regulated Member's absence.

[7] The Hearing Tribunal found that the Regulated Member was properly served with the Notice of Hearing and that the hearing could proceed in the absence of the Regulated Member pursuant to section 79(6) of the HPA. The Regulated Member was advised of section 79(6) of the HPA and that the hearing may proceed in his absence in the Consent Agreement (Exhibit #3).

ALLEGATIONS AND ADMISSION

[8] The allegations in the Amended Amended Notice to Attend a Hearing (Exhibit #2) are as follows:

1. On or about December 6, 2017, you failed to follow appropriate medication and narcotic control practices when you removed Hydromorphone for [Patient 1] from the narcotic cupboard, and

    a. Left the unit with the medication syringe in your pocket when you should not have done so, and
    b. Failed to document the Hydromorphone was not administered thereby implying that the medication had been administered to the patient when you had not done so.

[9] Conduct Counsel noted that Allegation 1(b) was withdrawn. The Regulated Member has admitted to the conduct in Allegation 1(a) in the Consent Agreement.

EXHIBITS

[10] The following documents were entered as Exhibits:

Exhibit #1 – Binder Containing Correspondence between Conduct Counsel, Representative for the Member, and the Hearings Director (entered during the hearing on November 12, 2019);

Exhibit #2 – Amended Amended Notice to Attend a Hearing by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta;

Exhibit #3 – Consent Agreement between Mark Wade, #86,531 and Jason Kully, Conduct Counsel;

Exhibit #4 – CARNA Practice Standards for Regulated Members ("Practice Standards");

Exhibit #5 – 2017 Edition of the Canadian Nurses Association Code of Ethics for Registered Nurses ("Code of Ethics");

Exhibit #6 – Joint Recommendations for Sanction;

Exhibit #7 – Excerpt from *Jaswal* v. *Newfoundland Medical Board.*

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

[11] Conduct Counsel reviewed the facts as noted in the Consent Agreement. Conduct Counsel submitted that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i) and (ii) of the HPA.

[12] Conduct Counsel noted that the conduct displayed a lack of knowledge of or a lack of skill or judgment in the provision of professional services. While the conduct is not on the most serious end of the spectrum, it does demonstrate a lack of knowledge or skill on the part of the Regulated Member. The conduct deals with an error in the administration of medication. Errors in dealing with medication, in particular narcotics, are serious. In this case, the error was sufficiently serious to constitute unprofessional conduct.

[13] Conduct Counsel noted that the following Practice Standards were applicable: Standards 1.1, 1.2, 1.4, 2.4, 2.7, 3.4, 4.1, 5.2, and 5.3. Conduct Counsel also noted that the following provisions from the Code of Ethics applied: A1, A5, B1, D6 and G1. Conduct Counsel submitted that the breaches were sufficiently serious to constitute unprofessional conduct.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

[14] The Hearing Tribunal has reviewed the exhibits and considered the submissions made at the hearing. The Hearing Tribunal finds that Allegation 1(a) is proven and that the conduct constitutes unprofessional conduct. The Hearing Tribunal confirms that Allegation 1(b) is withdrawn.

[15] The Hearing Tribunal accepts the following facts from the Consent Agreement.

1. On or about December 6, 2017, the Regulated Member was working a morning shift on Unit 41.

2. Staffing for, and other functioning of, Unit 41 at the time of the conduct is described as staffing was fully staffed and normal census and acuity.

3. The Regulated Member removed Hydromorphone for [Patient 1] from the narcotic cupboard at approximately 1030 hours.

4. When he removed the Hydromorphone, the Regulated Member logged the removal of the medication on the Controlled Drug Administration Sheet.

5. The Regulated Member did not administer the Hydromorphone to [Patient 1]. Instead, the Regulated Member left Unit 41 to assist with an IV on another unit. The Regulated Member put the Hydromorphone in his pocket prior to leaving Unit 41.

6. A Licensed Practical Nurse (the "LPN"), was also working a morning shift on Unit 41.

7. At around 1040 hours, [Patient 1] rang his call bell and asked for his pain mediation, Hydromorphone.

8. The LPN went to the computer and noted that Hydromorphone had been withdrawn at 1030 hours. She advised [Patient 1] that he had received the medication. [Patient 1] was adamant that he did not receive the medication. [Patient 1] was not confused.

9. The Regulated Member returned to Unit 41 at approximately 1100 hours. The LPN informed the Regulated Member that [Patient 1] had been asking for Hydromorphone and that it was logged as removed, which indicated it had been given.

10. The Regulated Member informed the LPN that the Hydromorphone was in his pocket and that he did not administer it to [Patient 1].

11. The Hydromorphone was wasted at approximately 1115 hours.

12. From approximately 1030 hours to 1100 hours, the Regulated Member was on a different unit with the Hydromorphone in his pocket.

13. The Regulated Member should have administered the Hydromorphone to [Patient 1] and then left to assist on the other unit.

14. Copies of the relevant policies and procedures of AHS that were in effect at that time of Allegation 1, and the most relevant parts of those policies, include:

    Policy 2.3.11: Controlled Substances, November 2009 (the "Controlled Substances Policy"): The Controlled Substances Policy states: "1.1 All controlled substances shall be kept in a designated locked storage cabinet in all patient care areas. 1.1.1 Exceptions: - When a controlled substance in possession of a patient/family member or qualified staff accompanying a patient while on temporary transfer to/from another care provider. – When a controlled substance in the possession of a staff member accompanying patients going to other departments for tests or procedures". It also states "2.1 For each dose of a controlled substance withdrawn from the storage area, the following information must be recorded on the daily record of controlled substance administration, VAX or automated dispensing cabinet record as outlined in 2.2. below…" "2.2 The qualified staff who removes the medication from the secure storage area must complete the daily record of controlled substance administration with the exception

> of automated dispensing cabinets and VAX where the information is automatically recorded."

[16] The Regulated Member was registered with CARNA in 2008. The Registered Member is not currently employed as a Registered Nurse.

[17] The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that Allegation 1(a) admitted to by the Regulated Member is proven and that the Regulated Member's conduct constitutes unprofessional conduct under section (1)(1)(pp) of the HPA, 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;

[18] The Regulated Member's conduct demonstrates a lack of knowledge of, or a lack of skill or judgment in the provision of professional services. Registered Nurses are taught about appropriate medication and narcotic control practices from the beginning and these are fundamental skills expected of all registered nurses. This type of error in administering medication would not be expected of a regulated member who has been registered since 2008. The conduct of the Regulated Member in leaving the unit with the medication syringe in his pocket demonstrates a lack of knowledge of or a lack of skill or judgment in the provision of professional services.

[19] In addition, the Hearing Tribunal finds that the conduct constitutes a breach of the Practice Standards and Code of Ethics.

[20] The Hearing Tribunal finds that the Regulated Member breached the following provisions of the Practice Standards: Standards 1.1, 1.2, 1.4, 2.4, 2.7, 3.4, 4.1, 5.2, and 5.3:

Standard One: Responsibility and Accountability

The nurse is personally responsible and accountable for their nursing practice and conduct.

Indicators

1.1 The nurse is accountable at all times for their own actions.

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

1.4 The nurse practices competently.

Standard Two: Knowledge-Based Practice

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

Indicators

2.4 The nurse exercises reasonable judgment and sets justifiable priorities in practice.

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Standard Three: Ethical Practice

The registered nurse complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of *Health Professions Act* and CARNA bylaws (CARNA, 2012).

Indicators

3.4 The nurse communicates effectively and respectfully with clients, significant others and other members of the ***health care team*** to enhance client care and safety outcomes.

Standard Four: Service to the Public

The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Indicators

4.1 The nurse coordinates client care activities to promote continuity of ***health services***.

Standard Five: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

Indicators

5.2 The nurse follows all current and relevant legislation and regulations.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

[21] The Hearing Tribunal finds that the Regulated Member breached the following provisions of the Code of Ethics: A1, A5, B1, D6 and G1:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

5. Nurses are honest and take all necessary actions to prevent or minimize **patient safety incidents**. They learn from **near misses** and work with others to reduce the potential for future risks and preventable harms (see Appendix B).

B. Promoting Health and Well-Being

Nurses work with persons who have health-care needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care**.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

[22] The Regulated Member's conduct in this case breached the Practice Standards and Code of Ethics, as well as the employer's policies. Registered Nurses are responsible for understanding and complying with their obligations in the Practice Standards and Code of Ethics. The Regulated Member's conduct also put the LPN in an awkward position with respect to her response to the patient and whether he had received his medication. Finally, the Regulated Member's conduct caused the patient to have to wait to get narcotic medication which he should have received without delay. While not on the most severe end of the spectrum of unprofessional conduct, the conduct is still serious. The breaches of the Practice Standards and the Code of Ethics constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

SUBMISSIONS ON SANCTION

[23] The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

[24] Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations (Exhibit #6). There were three aspects to the proposed sanction: a reprimand, course work and a practice improvement plan.

[25] Conduct Counsel noted that a primary purpose of sanction is the protection of the public. A reprimand is appropriate in this case. The course work and practice improvement plan are remedial in nature and serve the purpose of protecting the public.

[26] 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: Conduct Counsel noted that there was no intentional misconduct by the Regulated Member. The conduct is on the lower end of the spectrum of severity. There are potential risks for patients and for the institution in dealing with controlled substances. The conduct demonstrated a lack of judgment or knowledge.

2. The age and experience of the Regulated Member: The Regulated Member has been registered with CARNA since 2008. He is a relatively long-standing member. The Complaints Director would not expect this conduct from someone who has been practicing for this length of time.

3. The previous character of the Regulated Member: There is a prior finding of unprofessional conduct from August 2014. Conduct Counsel submitted that the prior finding should not increase the penalty in the present case, but that the Hearing Tribunal should be aware of it.

4. The number of times the offence was proven to have occurred: There was a single incident.

5. The role of the Regulated Member in acknowledging what occurred: The Regulated Member acknowledged the conduct. This is a significant factor in favour of the Regulated Member.

6. Whether the Regulated Member has already suffered other serious financial or other penalties: Conduct Counsel noted he was not aware of any financial or other penalties applied to the Regulated Member.

7. The impact on the offended patient: Conduct Counsel noted that medication was delayed in being received by the patient, but there was no evidence of significant harm, other than the delay.

8. The presence or absence of any mitigating factors: Conduct Counsel did not note any mitigating factors.

9. The need to promote specific and general deterrence: Conduct Counsel submitted that the proposed penalty will deter the Regulated Member from engaging in similar conduct and will serve as a message to other members of the profession.

10. The need to maintain public confidence in the integrity of the profession: This is an important factor in sanction.

[27] Conduct Counsel noted that the Complaints Director believes the joint submission on sanction is reasonable and appropriate in the circumstances of this case. Conduct Counsel reviewed the law regarding joint submissions. A joint submission should not be rejected unless it would bring the administration of justice into disrepute or is contrary to the public interest.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

[28] The Hearing Tribunal considered the exhibits and submissions made. The Hearing Tribunal finds that the proposed sanction is reasonable and appropriate in the circumstances. The proposed sanction protects the public interest and preserves the integrity of the profession.

[29] The reprimand will serve as an important sanction to denounce the conduct of the Regulated Member. The course work and practice improvement plan will protect the public interest by ensuring the Regulated Member is aware of his professional responsibilities. The practice improvement plan also provides the Regulated Member the opportunity to reflect on his practice. The course work and practice improvement plan can be done even while the Regulated Member is not working as a Registered Nurse.

[30] The proposed sanction promotes specific and general deterrence, maintains the public's confidence in the integrity of the profession and protects the public interest. The Hearing Tribunal finds it is appropriate and reasonable having considered the factors in the *Jaswal* decision and their application to this case.

ORDER OF THE HEARING TRIBUNAL

[31] The Hearing Tribunal orders that:

1. The Regulated Member shall receive a reprimand.

2. By no later than **December 22, 2020**, the Regulated Member shall provide proof satisfactory to the Complaints Director, that the Regulated Member has successfully completed and passed the following course of study:

   a. CNA Code of Ethics Modules (https://www.cna-aiic.ca/en/on-the-issues/best-nursing/nursing-ethics).

3. The Regulated Member shall create and provide to the Complaints Director a Practice Improvement Plan by **September 22, 2020.** The Practice Improvement Plan shall consist of the following:

   a. The Regulated Member shall create a list of at least 5 challenges related to the administration and handling of medications, including narcotics, that do or could potentially cause him to not perform all of his RN duties at a satisfactory level, or cause an employer to perceive he is not.

   b. For each of those 5 challenges, the Regulated Member shall explain the challenge, and why it is or could cause him a problem personally.

   c. For each of those challenges, the Regulated Member shall prepare a written plan of how he will address each of those challenges to successfully remediate his practice, where there are deficits, and to successfully address any potential issues that may cause an employer to question his practice.

   d. The Regulated Member shall create a list of indicators that will tell him that his strategies for addressing the challenges are successful.

   e. The Regulated Member shall submit to Complaints Director a self-assessment of the implementation of his Practice Improvement Plan, with specific examples of how he put the plan into practice, and how he knows his strategies are successful. The self-assessment is due **December 22, 2020.**

4. For clarity and certainty, the Regulated Member is, in addition to what is set out in this Order, required to complete any and all requirements as have or may be imposed from CARNA's Registration Department. This Order does not supersede or, if complied with, serve to satisfy any such requirements from CARNA's Registration Department.

COMPLIANCE

5. 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.

6. Proof of compliance with all requirements under this Order must be received by the Complaints Director of CARNA by the deadlines set out in the Order. Should the Regulated Member be unable to comply with any of the deadlines for completion set out herein, the deadline(s) may, upon written request, be extended for a reasonable period of time with the written consent of the Complaints Director. The Regulated Member must provide written reasons for the extension request. Decisions to extend timelines will be in the sole discretion of the Complaints Director.

7. Should the Regulated 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 the *Health Professions Act* ("*HPA*"), and, in so doing, may rely on any non-compliance with the this Order as grounds to make a recommendation under 65 of the *HPA* which may include suspension of the Regulated Member's practice permit.

8. 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

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

    a. Course work required (Call CARNA);

    b. Practice Improvement Plan required (Call CARNA).

10. Effective **June 22, 2020** or the date of this Order if different from the date of the Hearing, should the above condition remain unfulfilled, 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).

11. Once the Regulated Member has complied with a condition listed above, it shall be removed. Once the condition has been removed, the Registrar will be requested to notify the regulatory college of the other Canadian jurisdictions.

12. This Order takes effect **June 22, 2020** 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: June 22, 2020