IN THE MATTER OF A DISCIPLINE HEARING BY A DISCIPLINE COMMITTEE, ESTABLISHED PURSUANT TO *THE LICENSED PRACTICAL NURSES ACT, 2000* AND BYLAWS TO INQUIRE INTO THE CONDUCT OF LICENSED PRACTICAL NURSE DAISY NOSEWORTHY

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

INTRODUCTION:

On May 25, 2018, the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses ("SALPN") held a hearing concerning allegations of professional incompetence against Licensed Practical Nurse, Daisy Noseworthy.

At the hearing, Ms. Darcia Schirr, Q.C. appeared as legal counsel for the Counselling and Investigation Committee (the "Investigation Committee") of SALPN. Ms. Noseworthy was self-represented.

Legal counsel for the Investigation Committee filed an Affidavit of Service of a process server who affirmed that Ms. Noseworthy was personally served on April 18, 2018 with a copy of the Notice of Discipline Hearing. Appendix A to the Notice of Discipline Hearing dated April 16, 2018 set out the particulars of the allegations against Ms. Noseworthy as follows:

1. While working as a licensed practical nurse at the Dr. F. H. Wigmore Regional Hospital in Moose Jaw and on June 15, 2016, you admitted patient M.B. and completed a General Admission and History. An Interagency Referral identified M.B. at risk for falling, wandering and climbing side rails. You did not document those risks on the General Admission Assessment.

2. Your charting on June 15, 2016 and June 16, 2016 regarding M.B. was inadequate and deficient as:

    (a) You failed to document your assessment, planning and implementation of M.B.'s care.

    (b) You failed to document communication with M.B.'s daughter.

    (c) You failed to fully document communications with your charge nurse.

    (d) You charted M.B.'s pain assessment using numbers and adjectives such as "sharp" and "stabbing" and used the words "no voiced concerns" despite the fact M.B. could not communicate properly.

3. During your shifts on June 15, 2016 and June 16, 2016, you took M.B.'s vital signs only once at 1557 when you admitted M.B.

4. M.B. was found on the floor of her hospital room on June 16, 2016 at 0729. You worked the day shift starting at 0730. Through that shift, you took M.B.'s vital signs only once at 1447.

5. You failed to advocate, sufficiently or at all, with the charge nurse, the unit nurse manager and/or attending physician for proper and timely pain management medication for M.B.

6. Alternatively and if you did communicate with the charge nurse, nurse manager and/or attending physician, you failed to document those communications.

7. You failed to recognize the signs and symptoms of M.B. sustaining a fractured hip.

At the hearing, Ms. Schirr advised the Discipline Committee that charges 5 through 7 were withdrawn and that charge 3 was to be amended to read:

During your shifts on June 15 you took M.B.'s vital signs only once at 1557 when you admitted M.B.

Ms. Noseworthy pleaded guilty to the allegations contained in the Notice of Discipline Hearing as amended.

EVIDENCE:

At the outset of the hearing, the following Agreed Statement of Facts and Documents was filed with the Discipline Committee [the information referenced in the "Appendixes" is not included]:

1. Daisy Noseworthy of the City of Moose Jaw in the Province of Saskatchewan is a licensed practical nurse and a member of the Saskatchewan Association of Licensed Practical Nurses (SALPN). At the times material to these proceedings, Ms. Noseworthy was employed as a licensed practical nurse at the Dr. F.H. Wigmore Regional Hospital (Wigmore Hospital) in Moose Jaw, Saskatchewan.

2. Ms. Noseworthy first registered with SALPN in December 2004 and she has been a practicing member since that date.

3. Ms. Noseworthy obtained her nursing education at SIAST Regina when she was 38 years of age. Her complete employment history as a licensed practical nurse has been at the Moose Jaw Union Hospital and then, Wigmore Hospital.

4. On May 4, 2017, SALPN received an on-line complaint from Melodie Denis which raised a number of concerns about the care provided to her mother M.B. at Wigmore Hospital and in particular, the care provided by Ms. Noseworthy on June 15 and June 16, 2016. Ms. Denis resides in Saskatoon.

5. Upon receipt of the complaint, the Counselling and Investigation Committee (the "Investigation Committee") directed its investigator, Lori Hutchison-Hunter to begin an investigation.

6. Upon completion of the investigation, the Investigation Committee recommended, pursuant to section 26(2)(a) of the Act, that the Discipline Committee hear and determine the complaint. The charges are set out in Appendix A to a Notice of Discipline Hearing dated April 16, 2018.

7. The Investigation Committee seeks to amend Charge 3 so that it reads as follows:

> **During your shifts on June 15 ~~and June 16, 2016~~, you took M.B.'s vital signs only once at 1557 when you admitted M.B.**

8. Daisy Noseworthy admits the allegations described in charges 1, 2, 3 as amended and 4 and admits that the conduct described in those charges constitutes professional incompetence and professional misconduct and a breach of the Regulatory Bylaws, Code of Ethics and Standards of Practice particularized in Appendix A to the Notice of Discipline Hearing,

9. The Investigation Committee withdraws charges 5 through 7 inclusive.

Background to the Complaint

10. If called to testify, Ms. Noseworthy would state that for the period May 2015 —May 2016, she was on a personal leave of absence. The first time she began working at Wigmore Hospital was in May 2016.

11. M.B.'s date of birth was July 2, 1933. She passed away on June 18, 2016 at Wigmore Hospital. She was 82 years old at the time of her death.

12. M.B. was admitted to the medical unit of Wigmore Hospital on June 15, 2016. Prior to that, she had been hospitalized for three weeks at the Regina General Hospital for renal failure. When the Regina General Hospital determined she was stable, she was transferred to the Wigmore Hospital for further stabilization and dialysis.

13. M.B. had a number of health conditions including dementia, COPD, bronchitis, pulmonary emboli, hyperthyroidism, hypertension and gastroesophageal reflux disease.

14. M.B. had limited verbal communication abilities, using one or two words only. On June 15, 2016 at 15:51, Ms. Noseworthy charted "patient is very confused, unable to answer any questions when asked. Patient has dementia."

Charge 1

15. On June 15 and June 16, 2016, Daisy Noseworthy worked the dayshift at the Wigmore Hospital. The hours for the dayshift were from 07:30 to 19:17. At 16:16 on June 15, 2016, Ms. Noseworthy admitted M.B. upon her arrival from the Regina General Hospital. Regina General Hospital completed an Interagency Referral which would have accompanied M.B. Attached at **Appendix A** is the Interagency Referral. The Interagency referral identifies that M.B. was a risk for falling, wandering and climbing side rails.

16. Ms. Noseworthy completed a General Admission Assessment and History which is attached at Appendix B.

17. Ms. Noseworthy did ensure that the bed alarm was activated for M.B.'s bed.

Charge 2

18. The Wigmore Hospital uses a computerized entry system for nurses' notes. Nurses are expected to chart "in real time". Attached at **Appendix C** are the nurses' notes commencing June 15, 2016 at 15:51 and ending on June 16 at 19:02. For June 15, 2016, Ms. Noseworthy charted at 15:51, 16:16 and 17:49. For June 16, 2016, Ms. Noseworthy charted at 07:48, 08:40, 09:55, 11:02, 11:10, 12:16, 13:42, 14:11, 15:48, 16:11, 17:45 and 19:02.

19. Ms. Denis arrived at the Wigmore Hospital on June 16, 2016 at approximately 10:00 am. With the exception of a few breaks, Ms. Denis remained at her mother's bedside until M.B. passed away on June 18, 2016. Ms. Denis voiced a number of concerns about the pain management her mother was receiving. She voiced those concerns to Ms. Noseworthy, the charge nurse and the physician.

20. In June 2016, the policy at Wigmore Hospital was that licensed practical nurses were unable to directly call the physician as such communication had to be made through the charge nurse. If called to testify, Ms. Noseworthy would state that on June 16, 2016, she recalls bringing Ms. Denis's concerns about pain management to the attention of her charge nurse and that she did so a number of times. Ms. Noseworthy's chart documents only one contact with the charge nurse and this is at 09:55 where the entire entry is "charge nurse aware".

21. Attached at **Appendix D** is SALPN Practice Guideline on Documentation. Ms. Noseworthy admits that her documentation was deficient and that it did not meet the practice guidelines of SALPN.

Charge 3

22. The frequency for taking vital signs for M.B. was TID. Through her shift on June 15, 2016, Ms. Noseworthy took M.B.'s vital signs only once at 15:57.

23. The Wigmore Hospital uses a modified early warning score (MEWS) system which is an objective physiologic scoring system for bedside assessment of patients.

24. Attached at **Appendix E** is Patient Document Report — Modified Early Warning Score (MEWS) for M.B. which covers the period June 15, 2016 at 15:57 to June 17, 2016 at 22:13. The Report shows M.B.'s total MEWS scores. At page 3 of the

25. Report, M.B.'s total MEWS scores are listed which show a deterioration in M.B.'s condition. On June 15, 2016, Ms. Noseworthy took and recorded M.B.'s vital signs at 15:57 and the total MEWS score generated was 3 with this narrative description:

> **Consider rechecking vital signs within a minimum of two hours.**

26. Despite this description, Ms. Noseworthy did not take M.B.'s vital signs within a minimum of two hours or at all before her shift concluded at 19:17.

Charge 4

27. Between 05:30 and 06:30 on June 16, 2016, the Wigmore Hospital experienced a complete power failure and because of that, bed alarms were not functioning. At 07:29 on June 16, 2016, a registered nurse charted:

> **Patient found on floor in doorway. Stated had pain to right hip. Right leg appears shorter than left. See vitals flow sheet.**
>
> **Physicina (sic) informed and x-ray ordered, Family not informed yet clue to power outage.**

28. Through the day shift on June 16, 2016, Ms. Noseworthy took and recorded M.B.'s vital signs at 14:47 and the total MEWS score generated was 3 with this narrative description:

> **Consider rechecking vital signs within a minimum of two hours.**

29. If called to testify, Ms, Noseworthy would state that she believes she took M.B.'s vital signs more than once on June 16, 2016 and that she made a note of those vital signs on the "white board" in M.B.'s room. Ms. Noseworthy admits she did not chart the additional vital signs she believes she took.

Complaint History

30. In June 2011, SALPN received a complaint from Carolyn Bremner, director of the Medicine Unit of Moose Jaw Union Hospital. The complaint was investigated and resolved with an Alternative Dispute Resolution Agreement which required Ms. Noseworthy to produce a physical and mental assessment by her physician and to provide periodic performance appraisals. Ms. Noseworthy fulfilled the terms of the Agreement. Attached at **Appendix F** is undated letter from Carolyn Bremner and the Agreement executed on February 21, 2012.

Ms. Schirr and Ms. Noseworthy executed the Agreed Statement of Facts to demonstrate their agreement to the same. Ms. Schirr submitted that the Discipline Committee should accept the facts as set out.

Ms. Schirr also submitted that although it is obvious that Ms. Noseworthy struggles with computerized charting this does not mitigate Ms. Noseworthy's failure to communicate adequately with her healthcare colleagues as well as her failure to demonstrate the requisite skill and knowledge in charting and patient assessments. Ms. Schirr submitted that this constituted "professional incompetence" under the Act and is a breach of the Regulatory Bylaws (sections 19 and 20), Code of Ethics (Principles 1, 2 and 4) and Standards of Practice (Standard 1).

Ms. Schirr also advised the Discipline Committee that Ms. Noseworthy did not readily participate in the investigation process into this matter which resulted in increased cost incurred in the preparation for the hearing.

Based on the foregoing, the following recommendation as to penalty was submitted to the Discipline Committee for its consideration:

1. Pursuant to section 30(1)(e) of *The Licensed Practical Nurses Act, 2000* (the "Act"), Daisy Noseworthy shall be reprimanded.

2. Pursuant to section 30(1)(d)(ii) of the Act, Daisy Noseworthy may continue to practice subject to the following conditions:

   (a) On or before July 1, 2019, she shall successfully complete the CLPNA Nursing Documentation online course.

   (b) On or before July 1, 2019, she shall successfully complete the Health Assessment/LPN (NURS-227CE) course. Ms. Noseworthy shall bear all costs of the course.

3. Pursuant to section 30(2)(a)(ii) of the Act, Daisy Noseworthy shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $3,000.00. The costs shall be paid on or before July 1, 2020. Failing payment in full by that date, Daisy Noseworthy's licence shall be suspended until payment is made pursuant to section 30(2)(b) of the Act.

4. Pursuant to section 30(1)(f) of the Act, Daisy Noseworthy shall be required to provide a written copy of the decision of the Discipline Committee to future nursing employers for a two year period from the date of this Order.

Ms. Noseworthy provided some brief comments as to the remorse she felt for the impact her conduct had on M.B. as well as M.B.'s family. Ms. Noseworthy acknowledged that she

understands the importance of proper communication between nursing staff, patient assessment and charting making note of the old adage of "if it is not charted, it did not happen."

Ms. Noseworthy also spoke to her difficult personal circumstances and financial limitations. The Discipline Committee thanks Ms. Noseworthy for her candor in this regard.

DECISION:

The primary issue before the Discipline Committee is whether the conduct of Ms. Noseworthy, as summarized in the Agreed Statement of Facts is professional incompetence within the meaning of section 23 of the Act, and, if so, whether the proposed submission is appropriate under section 30 of the Act. Sections 23 and 30 of the Act read as follows:

> *23. Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment or a disregard for the welfare of a member of the public served by the profession of a nature to an extent that demonstrates that the member is unfit to:*
>
> > *(a) continue in the practice of the profession; or*
> >
> > *(b) provide one or more services ordinarily provided as part of the practice of the profession;*
> >
> > *is professional incompetence within the meaning of this Act.*
>
> *30(1) Where the discipline committee finds a member guilty of professional misconduct or professional incompetence, it may make one or more of the following orders:*
>
> > *(a) an order that the member be expelled from the association and that the member's name be struck from the register;*
> >
> > *(b) an order that the member's licence be suspended for a specified period;*
> >
> > *(c) an order that the member's licence be suspended pending the satisfaction and completion of any conditions specified in the order;*
> >
> > *(d) an order that the member may continue to practise, but only under conditions specified in the order, which may include, but are not restricted to, an order that the member:*
> >
> > > *(i) not do specified types of work;*
> > > *(ii) successfully complete specified classes or courses of instruction;*
> > > *(iii) obtain medical or other treatment or counseling or both;*
> >
> > *(e) an order reprimanding the member;*
> > *(f) any other order that the discipline committee considers just.*

(2) In addition to any order made pursuant to subsection (1), the discipline committee may order;

(a) that the member pay to the association, within a fixed period:

(i) a fine in a specified amount not exceeding $5,000; and
(ii) the costs of the investigation and hearing into the member's conduct and related costs, including the expenses of the counseling and investigation committee and the discipline committee and costs of legal services and witnesses; and

(b) where a member fails to make payment in accordance with an order pursuant to clause (a), that the member's licence be suspended.

(3) The executive director shall send a copy of an order made pursuant to this section to the member whose conduct is the subject of the order and to the person, if any, who made the complaint.

(4) Where a member is expelled from the association or a member's licence is suspended, the registrar shall strike the name of the member from the register or indicate the suspension on the register, as the case may be.

(5) The discipline committee may inform a member's employer of the order made against that member where that member has been found guilty of professional misconduct or professional incompetence.

In reaching its decision, the Discipline Committee considered the evidence presented in the Agreed Statement of Facts, the submissions of Ms. Schirr and Ms. Noseworthy, as well as Ms. Noseworthy's acknowledgement that her deficiencies as outlined in the Agreed Statement of Facts, in the course of providing care to M.B., failed to meet the standard required of the profession and did amount to "professional incompetence" within the meaning of section 23 of the Act. Ms. Noseworthy's deficient charting of her interactions with the patient and her colleagues resulted in untimely care for the patient and a lack of proper measures in place to address the known risks for this patient.

Ms. Noseworthy failed in the course of her care for M.B. to exhibit the basic charting skills and patient assessment required by the profession and did not meet SALPN Practice Guidelines on Documentation. Further, Ms. Noseworthy did not communicate in an effective manner both internally and with the family of M.B.. By her conduct Ms. Noseworthy did not act with the goal of maximizing patient safety and well-being. Her actions were not in the best interests of the public and were harmful to the best interests of the profession with such conduct reflecting poorly on other licensed practical nurses.

The Discipline Committee understands that the penalty ordered should protect the public and enhance public confidence in the ability of SALPN to regulate licensed practical nurses. This is achieved through a penalty that addresses specific and general deterrence. The Discipline

Committee took into account Ms. Noseworthy's submissions as to her personal circumstances, her expressed shortcomings as it relates to computerized charting and documenting patient assessments properly. The Discipline Committee also considered Ms. Noseworthy's initial failure to participate in the investigation which was deemed to be an aggravated factor when determining the costs ordered.

In addition to the costs ordered, the Discipline Committee has determined that Ms. Noseworthy is in need of further education and training to address her deficient communication, charting and patient assessment skills. As such, in addition to the completion of the two courses submitted by the Complaint's Committee, that it would be in the best interest of the Member and the Public if the Roles, Responsibilities and Ethics course is also completed.

ORDERS:

Upon consideration of the evidence and the submissions of the Ms. Schirr and Ms. Noseworthy, the Discipline Committee issued the following Order on May 28, 2018:

1. Pursuant to section 30(1)(e) of the Act, Daisy Noseworthy shall be reprimanded.

2. Pursuant to section 30(1)(d)(ii) of the Act, Daisy Noseworthy may continue to practice subject to the following conditions:

    a. On or before July 1, 2019, she shall successfully complete the CLPNA Nursing Documentation online course.

    b. On or before July 1, 2019, she shall successfully complete the Health Assessment/LPN (NURS-227CE) course. Ms. Noseworthy shall bear all costs of the course.

    c. On or before July 1, 2019, she shall successfully complete the Roles Responsibilities and Ethics Course (4019CE). Ms. Noseworthy shall bear all costs of the course.

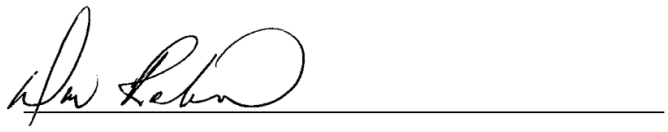
3. Pursuant to section 30(2)(a)(ii) of the Act, Daisy Noseworthy shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $3,000.00. The costs shall be paid on or before July 1, 2020. Failing payment in full by that date, Daisy Noseworthy’s licence shall be suspended until payment is made pursuant to section 30 (2)(b) of the Act.

4. Pursuant to section 30(5) of the Act, a copy of this Order and the written reasons shall be sent to Daisy Noseworthy's current employer, Five Hills Health Region, to the attention of Brenda Nichols.

5. Pursuant to section 30(1)(f) of the Act, Daisy Noseworthy shall be required to provide a written copy of the decision of the Discipline Committee to future nursing employers for a two year period from the date of this Order.

6. A copy of this Order and written reasons shall be published on the Saskatchewan Association of Licensed Practical Nurses website.

DATED at Regina, Saskatchewan, this 17th day of August, 2018.



D. Robinson, Chairperson of the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses on behalf of the Discipline Committee consisting of K. Devries, T. Fuecht and K. Bradford.