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 PAMELA QUINTIN

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

Discipline Committee: D. Robinson (Chair), K. Bradford, E. Cherney, B. Lalonde, A. Patron

Legal Counsel:

Darcia Schirr, Q.C. (Counselling and Investigation Committee)

Lynsey Gaudin (Discipline Committee)

INTRODUCTION:

On September 9, 2019, the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses ("SALPN") held a hearing concerning allegations of professional misconduct and professional incompetence against Licensed Practical Nurse, Pamela Quintin. By agreement, and due to time constraints on September 9, closing submissions were heard on October 16, 2019 by way of a telephone conference.

At the hearing and its continuation, Ms. Darcia Schirr, Q.C., appeared as legal counsel for the Counselling and Investigation Committee. The Member, Ms. Quintin was present and self-represented.

A pre-hearing case management conference call was held on July 30, 2019 to address any preliminary matters and questions regarding the hearing process, the status of document disclosure and to determine whether Ms. Quintin intended to obtain legal counsel. It was understood that this disciplinary matter was to be bifurcated, meaning that it would proceed in two stages. The hearing on September 9 and its continuation on October 16 proceeded only on the question of liability or guilt regarding the allegations of professional misconduct and professional incompetence. It was understood that following written reasons a subsequent hearing date, if required, would be set to address the issue of appropriate penalties. No other preliminary matters were identified, and the Chair of the Discipline Committee explained the hearing process. Ms. Quintin confirmed she would not be seeking legal counsel.

At the commencement of the hearing, legal counsel for the Counselling and Investigation Committee filed an Affidavit of Service of a process server who affirmed that Ms. Quintin was personally served on August 7, 2019 with a copy of the Notice of Discipline Hearing. At the hearing, Ms. Schirr advised that an additional charge was to be added. Specifically, what is now charge 1(h): "Regarding the residents F.B., M.J, and J.R., you administered PRN pain medication without conducting a clinical assessment or a proper clinical assessment as to whether the medication was necessary and required." Ms. Quintin was advised, in writing, in advance of the hearing date of the Counselling and Investigation Committee's intention to proceed with the addition of charge 1(h) to the Notice of Discipline Hearing.

The allegations against Ms. Quintin in the Notice of Discipline Hearing, as amended, read as follows:

1. While working as a Licensed Practical Nurse at the Gainsborough Health Centre in Gainsborough, Saskatchewan:

   (a) Your charting and documentation was inadequate, insufficient and incomplete as:
      (i) You consistently failed to follow the facility policy regarding charting dates;
      (ii) You consistently failed to chart using the 24 hour clock;
      (iii) On February 27, 2018, a resident sustained a code 3 fall. You failed to document and chart the details of the injuries sustained and the treatment given;
      (iv) Further to (iii), you completed a patient safety report which was inadequate and incomplete as you did not document the resident's transfer to acute care nor did you document whether family members had been contacted;
      (v) In administering PRN medications to residents, you failed to document your assessment of the resident's pain, the proposed intervention, and the effectiveness of the medication once administered.

   (b) Further to charge 1(a)(iv), the facility policy requires that in the case of code 3 or 4 incidents, the manager must be immediately contacted. You did not contact the facility manager to advise of the incident.

   (c) On December 21, 2017, a physician provided a physician's order for "increased Tylenol to 1 gram QID prn". At 16:50 of December 21, 2017, you wrote on the physicians order "Tylenol #2's, ii tabs four times a day for pain – p.o. Dr..". On the patient medication profile, you wrote, "Tylenol #2 – take two tablets PO 4 times a day". You did not document in the nursing progress notes or in any other documentation whether you had received authority from the physician to modify or clarify the physician's original order.

   (d) On March 19, 2018, an individual attended at the outpatient/emergency department facility complaining of weakness, dizziness, nausea, shortness of breath:
      (i) Without consulting a physician and without obtaining a physician's order, you provided the individual with 2 tablets of acetylsalicylic acid;
      (ii) You completed an outpatient form which was incomplete, illegible, and contained contradictory information about the individual's subjective complaints;

(e) On various occasions and during the course of your shifts, you appeared to be sleeping while standing up, unfocused and your speech was slurred;

(f) On at least one occasion, you brought your dog to the facility and allowed the dog to urinate and defecate in the facility;

(g) You failed to respect and protect resident and patient privacy and confidentiality as you provided your opinions to residents about family members of other patients and residents, and health concerns of other patients and residents; and

(h) Regarding the residents F.B., M.J. and J.R., you administered PRN pain medications without conducting a clinical assessment or a proper clinical assessment as to whether the medication was necessary and required.

Ms. Quintin pleaded not guilty to charges 1 (a) to (c), (d)(ii) and (e) through (h) and pleaded guilty to charge 1 (d)(i).

DECISION:

The primary issue before the Discipline Committee is whether, Ms. Quintin's alleged conduct, as set out in the Notice of Hearing, amounts to professional incompetence and/or professional misconduct as defined in the Act. The Act states as follows:

Professional incompetence

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 or 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 a part of the practice of the profession;

is professional incompetence within the meaning of this Act.

Professional misconduct

24 Professional misconduct is a question of fact, but any matter, conduct or thing, whether disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:

(a) it is harmful to the best interests of the public or the members;
(b) it tends to harm the standing of the profession;
(c) it is a breach of this Act or the bylaws; or
(d) it is a failure to comply with an order of the counselling and investigation committee, the discipline committee or the council.

There were five witnesses who testified on behalf of the Counselling and Investigation Committee, four of whom worked directly with Ms. Quintin at the Gainsborough Health Centre,

namely Donna Davis, Brooke Boyes, Jennifer Henderson and Jana Cassidy Dunnigan. The fifth witness was Della Bartzen, Investigator for SALPN. Ms. Quintin called no witnesses but did testify on her own behalf.

Each witness was questioned by Ms. Schirr and then cross-examined by Ms. Quintin. The Discipline Committee had questions for Ms. Boyes and both Ms. Quintin and Ms. Schirr were provided an opportunity to ask any follow-up questions as needed. Documentary evidence was introduced through these witnesses and will be specifically referred to as required.

Although they were not called to testify, counsel for the Counselling and Investigation Committee put into evidence, by way of affidavit, evidence of continuing care aide, Shelby Kinsley (Exhibit P-4) and Cara Brewster, SALPN Registrar (Exhibit P-3, Tab 1).

Given there were eight charges, some with sub-charges, alleged against Ms. Quintin, the written reasons below will deal with each allegation separately, outlining the relevant evidence and the Discipline Committee's findings in relation to each charge.

Background:

Ms. Quintin first registered with SALPN on July 14, 2000. For the years 2001 through 2010, Ms. Quintin held a practicing license and membership with SALPN. In 2011 Ms. Quintin did not renew her membership but was reinstated and remained a practicing member for the license years of 2012 through 2014. Ms. Quintin's license is currently suspended, having been suspended on March 25, 2018.

These proceedings are not Ms. Quintin's first dealings with SALPN as it relates to her competency and conduct as a nurse. The evidence of Ms. Della Bartzen established that Ms. Quintin was the subject of a previous complaint to SALPN for administering medications without following proper protocol while employed as an LPN at the Moose Mountain Lodge in Carlyle. This conduct was addressed by an Alternate Dispute Resolution Agreement, dated November 17, 2014 (the "**ADR Agreement**").

Pursuant to the terms of the ADR Agreement Ms. Quintin was subject to the following terms:

(a) performance appraisals to be conducted by employer at regularly scheduled intervals following the completion of a set number of hours worked;
(b) monthly drug screens upon the request of the Counselling and Investigation Committee investigator;
(c) to remain under the care of Dr. Donald McRae, a psychiatrist; and
(d) to arrange for any current or future employer to immediately report to the Counselling and Investigation Committee any suspension or termination of her employment.

Ms. Quintin was subsequently suspended for 30 days from November 13, 2015 to December 12, 2015, because of allegations of attending her shift while being unfit to work. Pursuant to the terms of the ADR Agreement, the Counselling and Investigation Committee suspended Ms. Quintin's license until such time that the allegations which led to Ms. Quintin's suspension could be investigated and reviewed.

The Counselling and Investigation Committee proceeded with its investigation, which resulted in an addendum to the ADR Agreement, dated July 25, 2016 (the "**Addendum**"), which added the following additional terms to the ADR Agreement:

(a) execute a release in favour of the Committee Chair to allow the Counselling and Investigation Committee to obtain a listing of all prescription drugs dispensed to Ms. Quintin between the period of January 1, 2015 and July 1, 2016;
(b) provide the general physician who prescribed methadone to her and sign a release in favour of the Committee Chair in order that the Committee may obtain a report from the general physician regarding Ms. Quintin's use of methadone.
(c) Ms. Quintin's suspension be lifted only in the event that she be able to provide three consecutive negative drug screens;
(d) Ms. Quintin submits to drug screen as may be randomly requested by the Committee investigator;
(e) abstain from the use of any prescription drugs or medication, unless prescribed by a physician; and
(f) if and when Ms. Quintin return to the practice of nursing, she shall ensure that any future employer will conduct performance appraisals at regularly scheduled intervals following the completion of a set number of hours worked.

Pursuant to the terms of the Addendum, Ms. Quintin was subject to a series of drug tests, which occurred between September 20, 2016 and February 23, 2017. Ms. Quintin obtained three consecutive negative drug tests on November 16, 2016, December 13, 2016 and February 6, 2017, resulting in her license being reinstated on February 22, 2017.

Upon reinstatement, Ms. Quintin commenced employment at the Galloway Health Centre in Oxbow, and pursuant to the terms of the Addendum, Ms. Quintin was subjected to a performance appraisal at the 200-hour increment, which took place on May 30, 2017. It was considered a good performance appraisal.

Ms. Quintin obtained her second performance appraisal pursuant to the Addendum at the 400-hour increment mark on October 17, 2017. The Counselling and Investigation Committee reviewed the performance appraisal as a good performance review.

In August of 2017, Ms. Quintin commenced employment on a casual basis with Gainsborough Health Centre, later becoming full-time on December 8, 2017. The Gainsborough Health Centre is a 16-bed facility providing level 3 & 4 care to its residents. The residents, for the most part, are elderly. It operates on two 12-hour shift basis. There is no physician on-site, but one is readily available by telephone and does attend at the facility on a bi-weekly basis. There are no emergency services provided at the Gainsborough Health Centre.

Pursuant to the terms of the Addendum, Ms. Quintin required her employer to complete a performance appraisal at the 600-hour increment, which occurred on March 27, 2018. Unlike the previous two appraisals, this appraisal was completed by Donna Davis, community health services manager at Gainsborough Health Centre, and was a negative appraisal, which noted Ms. Quinton under-performing in nearly all the categories (the "**Gainsborough Review**").

The terms of the ADR Agreement set out that if a performance appraisal raised concerns of professional incompetence or professional misconduct, the Counselling and Investigation Committee could immediately suspend the member's license until the circumstances were further reviewed by the Committee. After the Gainsborough Review was received, Ms. Quintin's license was suspended immediately, and an investigation into the complaint was undertaken. Following that investigation, Ms. Quintin's matter was referred to this Discipline Committee for a hearing.

What follows is a review of each charge outlined in the Notice of Hearing (as amended) and the facts and evidence submitted at the hearing. In making this decision, the Discipline Committee has reviewed and taken into consideration all testimony and documentary evidence submitted. The failure to refer to a piece of evidence or document does not suggest that it has not been considered by the Discipline Committee.

Charges 1 (a) and 1 (b) – Basic Charting and Incident Report Completion

(a) *Your charting and documentation was inadequate, insufficient and incomplete as:*

- *i. You consistently failed to follow the facility policy regarding charting dates;*
- *ii. You consistently failed to chart using the 24 hour clock;*
- *iii. On February 27, 2018, a resident sustained a code 3 fall. You failed to document and chart the details of the injuries sustained and the treatment given;*
- *iv. Further to (iii), you completed a patient safety report which was inadequate and incomplete as you did not document the resident's transfer to acute care nor did you document whether family members had been contacted;*
- *v. [Charge addressed below with Charge 1(h)]*

(b) *Further to charge 1(a)(iv), the facility policy requires that in the case of code 3 or 4 incidents, the manager must be immediately contacted. You did not contact the facility manager to advise of the incident.*

Evidence:

Basic Charting - Charges 1(a)(i)-(iii)

As a licensed practical nurse, Ms. Quintin was responsible for the accurate and timely charting of her interactions with residents, including but not limited to the distribution of medication, overall assessments (including pain), physician's orders and any other notable occurrences. The evidence at the hearing clearly established that not only is proper charting a focus in nursing

school but is a core competency required of all nursing professionals. In addition to any training received in school, the importance of charting and the standards for charting are reinforced throughout supplemental training, the SALPN Practice Guideline on Documentation (Exhibit P-3, Tab 11) as well as policies prepared by each health region in Saskatchewan (prior to the amalgamation).

Ms. Davis testified that adherence to proper charting standards is expected of nurses and that all charting entries are to be indicated with the 24-hour clock and that dates are to be in two-digit numeric day, alphabetical month, and four-digit year format. It was emphasized that this is charting 101. Ms. Davis' testimony on this point was supported by the Sun Country Health Region policy regarding Guidelines for Documentation (Exhibit P-3, Tab 20). In addition to stressing the importance of charting practices, the policy outlines the expected guidelines, including:

> 15. The date format for hand-written narrative charting is the two digit numeric day, alphabetical month, and four-digit year (DD/MON/YYYY e.g. 04 Apr. 2006)…All entries are recorded using the 24-hour clock and midnight is recorded as 2359 hours. 0000 is the beginning of the next day.

The SALPN Practice Guideline on Documentation also confirms that when charting all "entries are to be timed with the 24hr clock" and that nurses should "Document significant communication with patient, family or other care professionals."

The evidence demonstrated that Ms. Quintin inconsistently used the 24-hour clock. For example, at Exhibit P-3, Tab 15, Ms. Quintin charted that she provided medication at 1:00 but this should have read 13:00. Proper use of the 24-hour clock had previously been addressed with Ms. Quintin in February 2014 while she worked at the Moose Mountain Lodge in Carlyle, Saskatchewan (Exhibit P-6, Letter from Trent Truscott to Della Bartzen).

The documentary evidence illustrated that Ms. Quintin inconsistently and improperly recorded the date while charting. For example, at Exhibit P-3, Tab 13, Ms. Quintin charted that she attended on resident F.B. at "Dec 19/17" and "Dec 21/17". This is one of many examples of charting the date in this fashion. As mentioned above, proper charting of dates is to be in the DD/MON/YYYY (eg. 04 Apr. 2006) format.

Ms. Quintin did not dispute the charting errors as outlined above and instead suggested to the Discipline Committee that not only her, but others who worked at the Gainsborough Health Centre were guilty of this type of conduct and that charting errors were common.

Incident Report Completion – Charges 1(a)(iv) and 1(b)

On February 27, 2018, resident F.S. sustained a code 3 fall as a result of attempting to transfer herself without assistance. F.S. was ultimately transferred to hospital because of the fall. This fall necessitated the completion of a Patient Safety Report by the staff on shift. Ms. Davis testified that a Patient Safety Report (also known as an incident report) is completed when there has been an incident, for example a fall or a medication error.

Regardless of the severity of the incident, immediate family and the physician are to be contacted, and confirmation of this contact is to be recorded in the Patient Safety Report. The incident must also be coded and recorded, and can only be completed by a nurse. If the incident is coded a 3 or a 4, there is a requirement to **immediately** contact the manager. Ms. Quintin did not contact Ms. Davis as required. Ms. Davis testified that she became aware of the fall later that evening when the night nurse notified her. It was not until Ms. Davis reviewed the report sometime later and followed up with Ms. Quintin to obtain further details that the report was completed. In addition to completion of the Patient Safety Report, proper recording of the details of the incident, the injuries sustained, and the treatment given in the resident's chart must also be completed.

Ms. Davis provided evidence that Patient Safety Reports, subject to a few exceptions, are to be completed by the nurse who was on shift when the incident occurred. In this situation, the Patient Safety Report (Exhibit P-3, Tab 14) identified the reporter as Shelby Kinsley. Ms. Kinsley is a continuing care aide at the Gainsborough Health Centre. She did not testify at the hearing, but her evidence was provided via an affidavit (Exhibit P-4). It was not contested that it was Ms. Kinsley who discovered that F.S. had fallen. In Ms. Kinsley's affidavit, it was noted that she completed portions "F. Fall Details", "G. Apparent Harm or Injury" and "H. Additional Factual Information and Reporters Recommendations". Ms. Quintin did not dispute that Ms. Kinsley completed these portions of the form.

It is also not disputed that F.S.'s fall occurred during Ms. Quintin's shift, albeit towards the end of that shift. Ms. Quintin did contact the family and physician but did not record that she had done so on the Patient Safety Report. Ms. Quintin did not deny that she did not complete this portion of the report, providing the justification that she was required to start work in the town of Lampman and needed to leave as soon as her shift ended. Ms. Quintin did not deny that she did not complete the Patient Safety Report but instead testified that she regretted trusting another individual to complete the report. She emphasized that she was in a rush to get going.

Ms. Kinsley did not code the incident, as she did not have authority to do so in her position as a continuing care aide, as this must be completed by a nurse. It was uncontested that Ms. Quintin

did not chart the fall in the nursing progress notes, but the night nurse who came on shift after her completed charting the injury and the treatment provided.

Decision and Analysis:

The Discipline Committee accepts the evidence as outlined in Ms. Kinsley's Affidavit, the testimony of Ms. Davis and the supporting documentation as to charting standards. The Discipline Committee also accepts that Ms. Quintin in her testimony did not deny the allegations but rather provided the justification that others were also guilty of poor charting and that she was simply in a rush to get going as a justification for not completing the Patient Safety Report.

The evidence established that Ms. Quintin displayed on several different occasions charting that fell short of the standards and guidelines expected for a licensed practical nurse. It is plainly obvious that on several occasions Ms. Quintin failed to follow the SALPN Practice Guideline on documentation and the Sun Country Health Region policy re: Guidelines for Documentation. The resident medical charts and other reports put into evidence illustrated instances of failing to chart using the 24-hour clock and use of the improper dating format. The Discipline Committee accepts that charting is a basic skill required of all practical nurses, that they receive training and that this training is reinforced through health region policies and SALPN Guidelines. Charting is of critical importance as it is often the only way in which one shift can speak to another about what occurred the shift before. Errors and/or omissions could result in negative consequences for the resident.

Regarding Ms. Quintin's assertion that other nurses were making the same charting errors, this is simply not a justification for her own personal failing to chart properly. This disciplinary hearing is about Ms. Quintin's conduct specifically and not what other nurses may or may not have done.

In short, the nursing progress notes are one of the key sources of information among the care team. Without clear and accurate charting, any handover to the next shift will be incomplete. This can affect the wellbeing of residents. The quality of charting, whether it be good (or bad) is often a reflection of the standard of care provided. Accuracy and adherence to the standards of charting are marks of a caring and responsible nurse, but poorly written records that lack care and attention to detail may lead one to conclude not only a lack of a core competency but worse an apathy or laziness towards resident care.

The reasoning for proper completion of the Patient Safety Report is obvious. The Discipline Committee heard on several occasions throughout the hearing, that if it is not charted then it simply is assumed to not have happened. Ms. Quintin, by failing to ensure that the Patient Safety Report was completed (fully and accurately) not only provided a disservice to the resident but also to those on shift after her. It is also clear, based on the facts above, that Ms. Quintin, as the

nurse in charge on the shift, failed to contact the manager, Ms. Davis immediately. By not contacting Ms. Davis, it risks proper management of the situation including communicating with the family and in some other circumstances the public.

It is a requirement of the SALPN Regulatory Bylaws that each member shall work within their education preparation, level of competence and scope of practice and comply with the Standards of the Practice for Licensed Practical nurses (section 19). Further, all members must conduct themselves in an honourable and ethical manner while observing the standards of conduct set out in the Code of Ethics for Licensed Practical Nurses.

Charting is a basic nursing requirement and within the scope of knowledge expected for the profession. In failing to chart properly, not only has Ms. Quintin failed at a core competency and therefore is in breach of section 23 of the Act but has also failed to meet several of the principles as outlined in the Code of Ethics for Licensed Practical Nurses, namely: Principle 1: Responsibility to the Public, Ethical Responsibilities 1.1, 1.5 and Principle 2: Responsibility to Clients, Ethical Responsibility, 2.4.

Further, in her failing to properly chart, the Discipline Committee finds that Ms. Quintin, despite coaching, demonstrated a disregard for her professional obligations which reflects poorly on the profession as a whole. This and the risk to the public amounts to a breach of section 24 o of the Act.

Based on these findings of fact, the Discipline Committee concludes that the Counselling and Investigation Committee has proven charges 1 (a)(i) -(iv) and charge 1(b) in their entirety. Ms. Quintin's failure to properly chart, complete the Patient Safety Report and immediately contact Ms. Davis following the incident with resident F.S. amounts to professional incompetence and professional misconduct as defined under the Act.

Charge 1 (c) – Physician Order

> *1 (c) On December 21, 2017, a physician provided a physician's order for "increased Tylenol to 1 gram QID prn". At 16:50 of December 21, 2017, you wrote on the physicians order "Tylenol #2's, ii tabs four times a day for pain – p.o. Dr..". On the patient medication profile, you wrote, "Tylenol #2 – take two tablets PO 4 times a day". You did not document in the nursing progress notes or in any other documentation whether you had received authority from the physician to modify or clarify the physician's original order.*

Evidence:

This charge results from an alleged failure to properly document in the nursing progress notes for resident, F.B., who suffered from dementia and had severe skin cancer on his nose, a modification or clarification to a physician's order for pain medication. The sores on F.B.'s nose caused him pain and as a result he was one of three residents at the Gainsborough Health Centre who received narcotic pain medication. As F.B. is non-verbal, he communicates his level of pain by moaning and groaning. In November of 2017, F.B.'s pain was controlled by a 10 mcg Butrans patch, as well as Lenoltec Number 2 or Tylenol Number 2, two tablets, twice daily, for a total of four tablets of narcotic pain medication a day. Ms. Boyes and Ms. Henderson, both licensed practical nurses, testified that, in their observations, F.B.'s pain was well managed.

It was Ms. Quintin's evidence that on or about December 20, 2017 she noted that F.B. was crying in pain all day and was unable to get comfortable. After the second day of F.B. expressing pain in this way she made the decision to contact the locum physician, Dr. Tuwor, to request an adjustment to F.B.'s pain medication order. Ms. Quintin accomplished her request by preparing and submitting a SBAR on December 21, 2017 at 11:30 a.m.. It read, in part, as follows:

> **Assessment:** Resident crys (*sic*) all day or moans. Touching nose more than usual. Appears to be in a lot more pain. More of nose is being eaten away by the cancer.
>
> **Nursing Recommendation:** Can we get his Butran 10 mcg patch increased. He gets only 2 tylenol #2 twice a day that do nothing for his pain. Also need a PRN order for pain control.

SBAR stands for "situation, background assessment and nursing recommendation". This is a tool used to communicate with the physician when they are not presently at the facility. The Gainsborough Health Centre is served by locum physicians. For example, if a situation arises where there is a need for an adjustment to a medication order, a SBAR would be sent (usually via fax). Ms. Boyes, a licensed practical nurse, confirmed that once a SBAR is received back from the physician, a nurse is to transcribe the order into the physician's orders portion of the resident's chart as well as the nursing progress notes.

Dr. Tuwor, did not testify at the hearing, but it was not disputed that he responded to the SBAR from Ms. Quintin on December 21, 2017. His response read: "(1) Increase Butrans to 15 mcg, (2) increase Tylenol to 1 gram QID PRN, (3) Call back if not better." QID means four times per day.

Ms. Quintin did transcribe this order, albeit on its face incorrectly, into the chart under physician's orders, writing: "Tylenol Number 2's, two tabs four times a day for pain. Increase Butrans to 15 mcg, call back if not better PO Dr. Tuwor/Pamela Quintin". The order was also transcribed this way into F.B.'s Medication Administration Record (also known as a MAR)

(Exhibit P-3, Tab 13). Based on the SBAR the transcription of the order was incorrect. The SBAR did not refer to Tylenol #2, just Tylenol.

Ms. Quintin testified that the reason for the discrepancy in the two orders was that she had called Dr. Tuwor to clarify as she also noted that F.B. was not currently receiving regular Tylenol. It was Ms. Quintin's evidence that he stated (over the phone) to increase the Tylenol #2 to two tablets, four times per day, as needed. She did not document this clarification but put a squiggle line through the (2) of the order on the SBAR. She did not speak to why she made this indication with a squiggle line. Ms. Quintin confirmed that following her telephone conversation with Dr. Tuwor she did not indicate the clarified order on the SBAR and did not chart the change in the medication order in the nursing progress notes. Ms. Quintin acknowledged that she did not chart the change in the nursing progress notes and could not provide an explanation as to why this did not occur.

There was some conflicting testimony at the hearing over what the acronym PO stood for. Ms. Quintin testified that this meant phone order, whereas the other nurses testified that this is a standard short form for "by mouth". The Discipline Committee accepts the acronym to mean "by mouth". Other than the reference to PO there is no other indication in the charting notes to support the proposition that Ms. Quintin called Dr. Tuwor to clarify the order.

The result of this change to the medication order, as recorded by Ms. Quintin, was that F.B. went from receiving four Tylenol #2's per day to a total of eight, a doubling in the amount of pain medication received. On or about February 1, 2018, Ms. Boyes testified that she noticed that the SBAR was different then what had been transcribed by Ms. Quintin in the physician's orders. She noted this was of concern as there is a significant difference between a Tylenol and a Tylenol #2, with the latter containing a narcotic. After discovering this, Ms. Boyes clarified the pain medication order for F.B. with the physician. As a result of this clarification, Ms. Boyes handwrote on the SBAR "order clarified to give Tylenol 1 gram QID PRN. See doctor orders."

Ms. Henderson, a licensed practical nurse, testified that she also had concerns regarding Ms. Quintin and her handling of pain medications at the Gainsborough Health Centre generally. Ms. Henderson testified that the squiggle line on the SBAR was not a proper charting technique as the proper charting technique is to put a clear straight line across and initial the change. This is confirmed in the Sun Country Health Region Guidelines for Documentation which reads in part:

> 7. Errors are corrected by drawing a single line through the entry to be deleted, writing the word "void" and recording the date, time, identification (ID) (your initials if a master signature sheet exists, otherwise first initial and last name) and indicating why the correction was necessary (e.g. wrong chart)…The incorrect information is not to be destroyed, removed or obliterated.

Under cross-examination, when challenged about what the others considered to be a sizable increase in pain medication to an individual whose pain was well managed, Ms. Quintin simply deflected all responsibility to the physician. Ms. Quintin's testimony was that she is not a doctor and that she was just following orders.

Decision and Analysis:

Based on the evidence presented at the hearing, the Discipline Committee finds that Ms. Quintin's conduct as outlined above amounts to professional incompetence and professional misconduct as defined in the Act. The Discipline Committee did not find Ms. Quintin's recollection of events as it relates to this charge credible. The Discipline Committee found both Ms. Boyes and Ms. Henderson to be credible as it related to proper charting following a medication order change and the pain management of F.B., specifically that it was well managed in and around the time that Ms. Quintin submitted the SBAR.

It is acknowledged that the Discipline Committee is at a disadvantage having not heard from Dr. Tuwor directly on this point however, on a balance of probabilities, the Discipline Committee finds that Ms. Quintin did not transcribe the order correctly from the SBAR and that if clarification was sought (as Ms. Quintin testified) that this was not properly recorded either in any event. The Discipline Committee accepts that "PO" does not mean phone order, but rather "per oral". Either scenario exhibits the same pattern of charting deficiencies already addressed above, with the former having potentially serious ramifications for the wellbeing of the resident. Finally, if the squiggle line on the SBAR was to indicate a change to Dr. Tuwor's order, it was done incorrectly and not in accordance with the Sun County Health Region Guidelines on Documentation.

As described previously, charting is a basic nursing requirement and within the scope of knowledge expected for the profession. Putting aside the concern over the request in the first place, what occurred with the charting on the SBAR, MAR and failure to chart on the nursing progress notes contribute to an established pattern of Ms. Quintin failing to meet this core charting competency and therefore is in breach of section 23(b) of the Act, amounting to professional incompetence.

The Discipline Committee has also determined that Ms. Quintin did not display good nursing judgment in recording that F.B.'s pain medication should effectively be doubled, in particular without properly identifying that this was as a result of clarifying phone call with the physician. This is not good nursing practice as there is no clear communication to the rest of the health care team as to the change. Further, on a balance of probabilities, as we do not accept that the order was transcribed correctly in any instance, it was not good nursing practice to increase pain

medication in this fashion. Increases would be more gradual with reassessments occurring along with every increase.

The Discipline Committee does not accept Ms. Quintin's deflection of responsibility in saying that she was just following the doctor's orders and did not question it. The fact that she felt it was within her judgment to ask for an increase in the first place does not reconcile with this deflection of responsibility. Ms. Quintin did not deny that if she did clarify the order, that she failed to indicate as such on the SBAR. She also did not contest that she failed to chart in the nursing progress notes the medication order.

We find that Ms. Quintin engaged in conduct that is harmful to the best interests of the public, because the public must be confident that members will act in accordance with the standards of the profession. This includes not charting the administration of a dose of medication that was not prescribed. As Ms. Quintin did not chart the alleged clarification, it is assumed to have not occurred. When an LPN inconsistently records information as important as a medication order, it can lead to confusion by others resulting in incorrect dosing, which is potentially harmful to the best interests of the resident, as member of the public.

We also find that Ms. Quintin engaged in conduct harmful to the standing of the profession pursuant to section 24(b) of the Act. When Ms. Quintin did not act in accordance with proper procedures for a task as important as transcribing a medication order, in particular for narcotics, such actions can reflect poorly on the profession of nursing as whole.

Lastly, we find that Ms. Quintin is guilty of professional misconduct within section 24(c) of the Act, in that her conduct amounts to a breach of the bylaws, specifically Principle 2.8: Use evidence and judgement to guide nursing decisions and Principle 2.9: Identify and minimize risks to clients. It is our view that Ms. Quintin failed to exercise good judgment when she indicated such a significant increase in narcotic pain medication without proper documentation and authorization from the physician.

On the basis of the evidence presented, the Discipline Committee finds that in addition to amounting to professional incompetence, Ms. Quintin's conduct as it relates to charge 1(c) amounts to professional misconduct as defined under the Act.

Charge 1 (d) – Outpatient Incident

> *On March 19, 2018, an individual attended at the outpatient/emergency department facility complaining of weakness, dizziness, nausea, shortness of breath:*
>
> *i. Without consulting a physician and without obtaining a physician's order, you provided the individual with 2 tablets of acetylsalicylic acid;*

ii. You completed an outpatient form which was incomplete, illegible, and contained contradictory information about the individual's subjective complaints.

Evidence:

The Gainsborough Health Centre is not open to the public for acute care and does not provide emergency services. On March 19, 2018, an individual who was not a resident, R.R. arrived at the Gainsborough Health Centre seeking medical assistance. Ms. Quintin was the nurse on shift. At the hearing, evidence was provided by Ms. Davis and Ms. Quintin. As R.R. was not a resident of the Gainsborough Health Centre, there was no medical history on file and an Emergency/Outpatient Record (Exhibit P-3, Tab 15) was completed to document R.R.'s visit. Ms. Quintin testified that this was her first time dealing with what she considered an emergency and had not previously completed an Emergency/Outpatient Record. There were two versions of the Emergency/Outpatient Record, the first version was incomplete. The Emergency/Outpatient Record is provided to and relied upon by the hospital.

At the hearing, the Discipline Committee was presented with two similar versions as to what occurred on March 19, 2018. The first version is what was described in the second version of the Emergency/Outpatient Record completed on the day in question as well as Ms. Davis' recollection of what was reported to her at the time. In short, R.R. arrived at the nursing station complaining of dizziness and shortness of breath. Ms. Quintin placed him in a wheelchair and took him to the Emergency Room at the Gainsborough Health Centre. R.R. reported his hands were numb and tingly, was feeling nauseated but denied any back/chest pain. Without a physician's order, Ms. Quintin administered two 81 mg tablets of *acetylsalicylic acid* (also known as baby aspirin) to R.R.. The ambulance arrived, and R.R. was transferred to Galloway Health Centre in Oxbow.

The other version was heightened from what was documented. Ms. Quintin testified at the hearing that R.R. was falling when he approached the nurses' station and that he complained of chest pain. Ms. Quintin testified that she was fearful that he would code and that his symptoms were getting worse and resembled those of an individual experiencing cardiac arrest. She admitted to administering the baby aspirin as recorded. She explained that this was her first time in an emergency situation, and that she tried to maintain calm but that she was stressed by the encounter.

Ms. Quintin testified that she had never completed an Emergency/Outpatient Record before and did not understand why Ms. Davis did not stay to help her complete the form. Ms. Davis testified that she was not aware that Ms. Quintin had never filled out the form before but that her expectation would have been for a nurse with her years of experience to be able to accurately complete the record. As described above, two versions of the Emergency/Outpatient Record

were completed by Ms. Quintin to document R.R.'s incident and treatment. There is no question that the first version of the form is incomplete. In Ms. Quintin's second attempt at completing the record there are a number of inconsistencies in comparison to the first version, including the recording of R.R.'s blood pressure and the time it was taken. There were also other inconsistencies as to the symptoms being exhibited and their severity. Ms. Quintin's explanation for the incomplete Emergency/Outpatient Record was that she was stressed.

Regardless of how exactly the events unfolded, what is uncontested is that Ms. Quintin administered two baby aspirin to R.R. and did so without contacting a physician prior and/or in the absence of a standing order to administer the same. Ms. Quintin's explanation, at the time, was that if she had known she could not provide aspirin without a physician's order she would not have administered the medication. It was Ms. Davis' testimony that it is a basic nursing requirement that no medication should be administered by a nurse absent a standing order, or a specific order for a medication especially without knowing the patient's medical history.

Decision and Analysis:

The Discipline Committee accepts the testimony put forward by both Ms. Davis and Ms. Quintin and is of the view that based on the evidence presented, Ms. Quintin's conduct on March 19, 2018 amounts to professional misconduct and professional incompetence as defined in the Act.

Ms. Quintin's actions were improper and displayed a lack of knowledge and/or judgment when she administered two baby aspirin without a physician's order. As noted by Ms. Davis, it is a basic principle of nursing that a nurse cannot administer any medication without either a specific order or a standing order from a physician. Ms. Quintin further displayed a lack of judgment by not seeking assistance when confronted with R.R. in an emergency situation that she was neither familiar nor comfortable with. Ms. Quintin acknowledged that she had made a mistake in failing to call a physician prior to administering the baby aspirin. In her testimony, Ms. Quintin attempted to deflect her responsibility on the basis that the Gainsborough Health Centre did not take in emergency patients and that throughout her career she had never had to deal with such a situation. Pursuant to principle 5 of the Code of Ethics for Licensed Practical Nurses, a licensed practical nurse must recognize their capabilities and limitations and perform only the nursing functions that fall within their scope of practice and for which they possess the required knowledge, skills and judgment. Ms. Quintin's failure to recognize her limitations in this situation led to her engaging in conduct that ran the risk of endangering the welfare of a member of the public, and as such violated the Code of Ethics for Licensed Practical Nurses and further constitutes as professional incompetence as defined in the Act.

As has previously been presented and noted with respect to the other charges, Ms. Quintin has demonstrated a repeated pattern of sub-standard charting skills, which is further evidenced by the

inconsistencies in completing the Emergency/Outpatient Record. While the Discipline Committee acknowledges and accepts that Ms. Quintin had never completed such a form, the information to be completed is nothing outside of the ordinary course of charting, namely, to record vitals and the date and time they were taken, to make note of any medications provided, and provide details of any presenting symptoms.

The Emergency/Outpatient Record acts as a method of communication and is relied upon by the hospital as any information contained therein is supposed to inform the hospital of the steps that have been taken and provide a history of the patient's vital signs. As has been reiterated, the completion of such charts and records are integral to the functioning of the healthcare system and are the means by which medical care providers perform their services. The failure to complete such tasks in a proper manner not only hinders the provision of services, but also has the potential of putting members of the public in danger if done improperly. Ms. Quintin's inability to accurately make note of what occurred had the potential of placing a member of the public in harms way.

For the foregoing reasons, we do find that Ms. Quintin is guilty of professional incompetence and professional misconduct within the meaning of sections 23 and 24 of the Act.

Charge 1 (e) – Sleeping on Shift

(e) On various occasions and during the course of your shifts, you appeared to be sleeping while standing up, unfocused and your speech was slurred;

***Evidence*:**

Ms. Quintin testified that on the day in question, February 27, 2018, she was nervous and anxious about sitting with Ms. Davis to complete a System Management Survey. Ms. Quintin testified that when she is in this state that she may close her eyes from time to time. She denies sleeping while standing up, being unfocussed or that her speech was slurred.

Ms. Davis' observations from the same day were that Ms. Quintin seemed very unfocused and that her speech was slurred. Ms. Davis recalls questioning Ms. Quintin in the moment and that the reasoning provided was the she had not gotten much sleep the night before. No further evidence was presented with respect to any follow-up which was conducted or whether any further steps were taken following Ms. Davis' observations.

On a separate occasion, namely the evening of March 7, 2018 when Ms. Quintin was orienting Ms. Dunnigan at the Gainsborough Health Centre, Ms. Dunnigan made a comment that Ms. Quintin was either sleeping, on her phone, or watching TV while on her shift. Ms. Quintin denies this accusation. No further evidence was presented to substantiate this claim.

***Decision and Analysis*:**

Although we found the testimony of Ms. Davis as to her recollection of Ms. Quintin credible, her observations were subjective in nature and it appears no further steps were taken (e.g. sent home during the shift) nor was any other evidence provided to verify the allegation as charged. The only other reference to Ms. Quintin's sleeping during shifts was noted by Ms. Dunnigan in her testimony, however she could not recall with precision whether Ms. Quintin was in fact sleeping. We also accept Ms. Quintin's testimony that it was her recollection that she was not asleep on shift and that she was not slurring her words.

For these reasons, we find that there is not sufficient evidence, on a balance of probabilities, to establish charge 1(e) as alleged and it is therefore dismissed.

Charge 1 (f) – Dog in Gainsborough Health Centre

(f) On at least one occasion, you brought your dog to the facility and allowed the dog to urinate and defecate in the facility;

Evidence:

Ms. Henderson testified that the Gainsborough Health Centre was a dog-friendly residence and that families of residents will bring in their family pets on occasion. In the past it was acceptable for staff to bring in their pets, but that practice has since stopped. There was no evidence as to when the practice ceased or why. Through Ms. Henderson, a photo of the pee pad that was used by Ms. Quintin's dog was presented into evidence (Exhibit P-3, Tab 19).

Ms. Quintin testified that other staff brought their dogs to the Gainsborough Health Centre from time to time. Ms. Quintin did not dispute that she brought her dog, who was ill, to work but confirmed that bringing a pet was common practice by not only her but other staff. Ms. Quintin admitted that her dog did urinate and defecate on a pee pad but testified that it was immediately disposed of. The pee pad was not any type of medical supply but rather something purchased from a pet store.

***Decision and Analysis*:**

Although it was uncontradicted that Ms. Quintin brought her dog to the Gainsborough Health Centre, it was not established that in doing so she was in breach of any local or regional policy. On the contrary, the evidence established that, at the time of the alleged conduct, this was a dog-friendly facility and was common practice for staff to bring pets to the facility from time to time.

Given there was no clear rule or prohibition on having dogs in the Gainsborough Health Centre, we are hard pressed to conclude that Ms. Quintin, by bringing her small dog to the facility in any way amounts to professional misconduct as alleged. As such, based on the evidence and

testimony submitted during the hearing, it is our decision that charge 1(f) has not been established on a balance of probabilities and is therefore dismissed.

Charge 1 (g) – Patient Privacy Breach

(g) You failed to respect and protect resident and patient privacy and confidentiality as you provided your opinions to residents about family members of other patients and residents, and health concerns of other patients and residents

***Evidence*:**

It was uncontroverted that all staff at the Gainsborough Health Centre are expected to abide by and follow the Sun Country Health Region Privacy/Confidentiality Policy (Exhibit P-3, Tab 21) and that this included Ms. Quintin. It was put into evidence that Ms. Quintin acknowledged reviewing and committing to uphold this policy. Ms. Quintin denied that she would ever discuss private resident information, let alone medical information with other residents. The evidence at the hearing was that G.H., who used to be a registered nurse herself, would often come to the nursing station during shift change to chat and ask questions. The policy includes several examples of what is considered Private and Confidential Information, including:

> …
>
> 3. Observations made about patients, clients and residents and conversations with them or their families.
>
> 4. Information the patient, client or resident discloses about his/her illness, their family members or situation and information acquired in their examination.

Ms. Boyes testified that she was approached by a resident, G.H to let her know that Ms. Quintin had told her that the resident who resided in the room next door to hers rarely had family visitors and when they did visit, it was for brief periods. Resident, G.H. used to be a nurse and it was put into evidence that she was known to express concern about other residents from time to time.

Ms. Quintin testified that this incident was a result of a resident being comforted in her room. The resident was upset and expressed that she missed her children and husband. It was Ms. Quintin's testimony that this conversation was likely overheard by G.H. and then later shared with other staff.

The evidence from Ms. Davis was that G.H. approached her expressing concerns about another resident's family not visiting her. Ms. Davis testified that she coached Ms. Quintin at their March 16th meeting about this incident reminding her to be thoughtful and mindful of what she said to residents. Ms. Davis confirmed that at that meeting Ms. Quintin's stated that she believed that G.H. must have just overheard her comforting the other resident.

Aside from the foregoing, no further evidence was submitted relating to any breach of resident confidentiality.

***Decision and Analysis*:**

The allegation, in summary, is that Ms. Quintin breached the Sun Country Health Region Privacy/Confidentiality Policy and SALPN Standards of Practice when it was reported by one resident, G.H. that Ms. Quintin had shared personal family details about another resident with her. The Discipline Committee considered the testimony of Ms. Davis, Ms. Boyes and Ms. Quintin and finds that the evidence does not support a finding of professional misconduct.

Much of the evidence provided by Ms. Davis and Ms. Boyes is hearsay. They are reporting what G.H. has reported to them about what Ms. Quintin has alleged to have shared with her. It was a common thread of evidence that G.H. was previously a nurse herself and finds herself interested in the comings and goings at the Gainsborough Health Centre. It is just as likely, that Ms. Quintin's evidence that she did not share this information with G.H. and that at best it was overhead given the proximity of the residents' rooms. The Gainsborough Health Centre is not large, it has 16 beds and the residents who live there, do so for extended periods of time. It can be presumed that over time the residents develop a certain level of familiarity.

Confidentiality of medical information is critical, and this Discipline Committee accepts that it is a basic requirement of all health care professionals, including licensed practical nurses to maintain the confidentiality of this information.

It is accurate that as health care professionals nurses should be cautious in their balancing of providing care and perhaps becoming too personally close such that discussions that are had do not respect the boundaries that are in place. Although this charge has not been proven beyond a reasonable doubt, the Discipline Committee considers this circumstance to be on the verge of transgression and would add as a cautionary note to the profession that idle gossip can potentially be harmful and that information about one resident, particularly of a personal nature, should not be discussed or shared with other residents. Nurses should exercise caution when speaking with residents in their care even in a situation such as the one that presented here.

For all these reasons, we find that there is not sufficient evidence to establish charge 1 (g) as alleged and it is therefore dismissed.

Charges 1(a)(v) and 1(h) – Resident Pain Assessment

> *1(a)(v) In administering PRN medications to residents, you failed to document your assessment of the resident's pain, the proposed intervention, and the effectiveness of the medication once administered.*
>
> *1(h) Regarding the residents F.B., M.J. and J.R., you administered PRN pain medications without conducting a clinical assessment or a proper clinical assessment as to whether the medication was necessary and required.*

Evidence:

Ms. Davis testified that in or around January of 2018, several staff members, including fellow LPNs brought forward concerns with respect to residents F.B., M.J. and J.R., with a focus on the amount of PRN medications being administered to patients. As a result of these concerns, Ms. Davis met with Ms. Quintin, with a union representative present, outlining the concerns which had been received, with a particular emphasis on her heightened administration of PRN medications.

The charts and notes further demonstrated (Exhibit P-3, Tab 16), as Ms. Davis testified, that Ms. Quintin was more likely than any other staff member to provide PRN medications to patients at a staggeringly higher rate, and often would not include further notes as to why additional medication was required. Ms. Quintin testified that the reasoning for the higher rate of administration was that she worked more shifts than the other nurses. However, it was noted in Ms. Davis' testimony that Ms. Quintin's provision of PRN medications surpassed the combined total of all other nurses.

Ms. Boyes also provided evidence as to her concerns around Ms. Quintin's administration of PRN medications, specifically in an email to Ms. Davis dated March 28, 2018 (Exhibit P-11), Ms. Boyes noted that there were incidents where other nurses would conduct pain assessments to which residents would respond that they were not having any pain, however, later noted that Ms. Quintin would nevertheless provide PRN medication in spite of this response.

In her testimony, Ms. Henderson also brought forward her concerns with respect to Ms. Quintin's nursing practices, in particular her administration of narcotics, changes in orders and PRN medication doses. It was Ms. Henderson's evidence that upon her review of the MARs of F.B., M.J. and J.R. she became concerned by seeing that more doses of PRN medications were being provided by Ms. Quintin, and further that any order changes seeking an increase in dosage were mostly completed by Ms. Quintin. As a result, Ms. Hendereson brought forward her concerns to Ms. Davis in February 2018 and also wrote a letter (Exhibit P-12) outlining these concerns.

Ms. Dunnigan testified, that while being orientated by Ms. Quintin, she observed that more PRN narcotics were being provided than the nurse she had been orientating with the night before. It was Ms. Dunnigan's evidence that she did not observe Ms. Quintin assessing the residents to determine whether they required PRN medication. This lack of assessment made Ms. Dunnigan uncomfortable.

Another incident caused Ms. Dunnigan concern, specifically the treatment of resident, J.R., who had cancer and was receiving palliative care and narcotics for her pain. In accordance with a

physician's order, J.R. was to receive 3 milligrams of hydromorphone twice a day and 1 milligram to be provided four times a day as needed. On the evening of March 7, 2018 Ms. Quintin charted on the Narcotic Controlled Drug Disposition Record (Exhibit P-3, Tab 16) that she had provided J.R. hydromorphone continuous release 3 milligrams at 20:25, along with Ativan and zopiclone. She was then provided with another 1 milligram of hydromorphone 45 minutes later. Ms. Dunnigan noted that J.R. was restless however, and this was inconsistent with the usual pattern for her. She normally settled well, and Ms. Dunnigan was surprised that someone who had received 4 milligrams within such a short period of time was still in pain. However, upon further assessment of J.R. at approximately 04:30 Ms. Dunnigan determined that her pain was not being well managed and in accordance with the physician's order went to sign out a further 1 milligram of hydromorphone but noted that the narcotic count did not match up and one pill of 1 milligram of hydromorphone was missing. When Ms. Dunnigan questioned Ms. Quintin about the miscount, Ms. Quintin testified that she had administered an additional 1 milligram of hydromorphone at 02:00 and forgot to write it down on the Drug Disposition Record and proceeded to make a late entry. Further, the order was for the narcotic to be provided every four to six hours. The evidence, if the hydromorphone was provided by Ms. Quintin, was that a further 1 milligram of hydromorphone was administered within a two-hour window by Ms. Dunnigan.

Pursuant to the Sun Country Health Region Medication Administration policy (Exhibit P-3, Tab 22) it is an expectation that nurses will conduct clinical assessments prior to increasing PRN medication doses, and must administer dosages in accordance with the time frame provided by a physician's order.

Decision and Analysis:

Based upon the testimony of Ms. Dunnigan, Ms. Boyes, Ms. Henderson and Ms. Davis, and the evidence tendered in their testimony, the Discipline Committee finds Ms. Quintin guilty of professional misconduct and professional incompetence as defined in the Act on charges 1(a)(v) and 1(h).

In line with Ms. Quintin's noted history of failing to chart properly, both Ms. Davis and Ms. Dunnigan testified to Ms. Quintin's failure to consistently perform any clinical assessments and chart any such assessments prior to providing PRN medications. As has been repeatedly noted throughout the charges and analysis, Ms. Quintin's failure to properly chart has been recognized as professional misconduct and professional incompetence and demonstrates either a lack of understanding of a basic skill required in the practice of nursing, or alternatively demonstrates a lack of care and attention to the practice of the profession.

Furthermore, and of particular concern is Ms. Quintin's practice of failing to undertake the appropriate assessments prior to the administration of PRN medication. As noted in Ms. Davis' testimony, the general practice is to monitor pain, ask a patient about their pain on the pain scale, and try other non-medicinal measures to attempt to minimize pain prior to providing PRN medications. However, it was noted that on numerous occasions Ms. Quintin would simply either fail to complete those assessments, or failed to chart undertaking such assessments. Additionally, Ms. Quintin in her testimony noted that she would often provide PRN medication in advance of a patient complaining of pain out of precaution, which Ms. Davis testified as being an uncommon practice amongst the profession. Ms. Quintin's failure to carry out the appropriate assessments prior to providing PRN medications demonstrates a deviation from the standards of the profession and a violation of the Sun Country Health Region Medication Administration policy. Moreover, Ms. Quintin's elevated administration of PRN medications when taken together with her failure to perform the appropriate assessments is not only worrisome but demonstrates conduct that places the safety of members of the public at jeopardy and violates section 1.5 of the Code of Ethics for Licensed Practical Nurses to provide care directed toward the health and well-being of the person. As evidenced by the testimony of Ms. Boyes and Ms. Henderson, such conduct also proved to be concerning to other members of the profession.

By providing residents with PRN medication when they may not be required, Ms. Quintin displayed deficient training and skills, and engaged in conduct which was harmful to the best interests of the public. Licensed practical nurses are provided with the authority to provide PRN medications on the basis that they possess the requisite skills and knowledge to know when it is appropriate to administer such medication. The public relies on licensed practical nurses to use the skills and knowledge that they have acquired when undertaking this determination. By failing to carry out the appropriate assessments, Ms. Quintin failed to exercise the appropriate skills and judgment expected of a licensed practical nurse.

In light of the evidence and testimony presented, the Discipline Committee finds Ms. Quintin's conduct as alleged under charges 1(a)(v) and 1(h) amounts to professional incompetence and professional misconduct as defined under the Act.

DATED at Regina, Saskatchewan, this 13th day of January, 2020.

D. Robinson, Chairperson, Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses on behalf of the Discipline Committee consisting of K. Bradford, E. Cherney, B. Lalonde and A. Patron.

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 PAMELLA QUINTIN

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

Discipline Committee: D. Robinson (Chair), K. Bradford, E. Cherney, B. Lalonde, A. Patron

Legal Counsel:

Darcia Schirr, Q.C. (Counselling and Investigation Committee)

Matthew Klinger (Discipline Committee)

INTRODUCTION:

On January 13, 2020, the , the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses ("SALPN") issued its decision finding Pamella Quintin, (a Licensed Practical Nurse), guilty of a number of charges of professional misconduct and professional incompetence. The charges contained in the Amended Notice of Discipline Hearing with respect to which Ms. Quintin either pled guilty or was found to be guilty are set out below (the numbering reflects the numbering of allegation in the notice of hearing; the omitted numbers reflect charges which were not proven):

1. While working as a Licensed Practical Nurse at the Gainsborough Health Centre in Gainsborough, Saskatchewan:

    (a) Your charting and documentation was inadequate, insufficient and incomplete as:
        (i) You consistently failed to follow the facility policy regarding charting dates;
        (ii) You consistently failed to chart using the 24 hour clock;
        (iii) On February 27, 2018, a resident sustained a code 3 fall. You failed to document and chart the details of the injuries sustained and the treatment given;
        (iv) Further to (iii), you completed a patient safety report which was inadequate and incomplete as you did not document the resident's transfer to acute care nor did you document whether family members had been contacted;
        (v) In administering PRN medications to residents, you failed to document your assessment of the resident's pain, the proposed intervention, and the effectiveness of the medication once administered.

(b) Further to charge 1(a)(iv), the facility policy requires that in the case of code 3 or 4 incidents, the manager must be immediately contacted. You did not contact the facility manager to advise of the incident.

(c) On December 21, 2017, a physician provided a physician's order for "increased Tylenol to 1 gram QID prn". At 16:50 of December 21, 2017, you wrote on the physicians order "Tylenol #2's, ii tabs four times a day for pain – p.o. Dr..". On the patient medication profile, you wrote, "Tylenol #2 – take two tablets PO 4 times a day". You did not document in the nursing progress notes or in any other documentation whether you had received authority from the physician to modify or clarify the physician's original order.

(d) On March 19, 2018, an individual attended at the outpatient/emergency department facility complaining of weakness, dizziness, nausea, shortness of breath:
   (i) Without consulting a physician and without obtaining a physician's order, you provided the individual with 2 tablets of acetylsalicylic acid;
   (ii) You completed an outpatient form which was incomplete, illegible, and contained contradictory information about the individual's subjective complaints;

(h) Regarding the residents F.B., M.J. and J.R., you administered PRN pain medications without conducting a clinical assessment or a proper clinical assessment as to whether the medication was necessary and

The hearing of the allegations against Ms. Quintin had been bifurcated with the initial hearing addressing the question of liability, with the issue of sanctions to be addressed in a further hearing. Therefore on March 25, 2020, the Discipline Committee held a teleconference hearing regarding sanctions. Ms. Darcia Schirr, Q.C., participated in the hearing and made submissions as legal counsel for the Counselling and Investigation Committee. The Member, Ms. Quintin participated in the hearing and made submissions. Ms. Quintin was self-represented.

FACTS:

The facts found by the Discipline Committee in relation to the charges against Ms. Quintin are fully set out in the Discipline Committee's decision dated January 13, 2020. For the purposes of this decision a summary of the facts relating to allegations to which Ms. Quintin either pled guilty or was found guilty are set out below.

Licensing and Previous Discipline History

Ms. Quintin first registered with SALPN on July 14, 2000 and held a practicing license from 2001 through 2010.

On July 14, 2011, Ms. Quintin was found to have committed professional misconduct by the Discipline Committee of SALPN, by taking prescription medication from her employer without the authority to do so. As a result she was subject to sanctions including restrictions on her ability to practice, a requirement to submit to drug screening and participation in counselling.

Ms. Quintin was reinstated and held a practicing license from 2012 through 2014. In 2014 Ms. Quintin was the subject of a complaint to SALPN involving the improper administration of medications, which was resolved through an Alternative Dispute Resolution Agreement dated

November 17, 2014, and subsequently amended on July 25, 2016 (the "ADR Agreement"). Pursuant to the terms of the ADR Agreement, Ms. Quintin was suspended from practice on December 12, 2015 when new allegations were made in 2015 that she attended her shift wile being unfit to work. In accordance with the process set out in the ADR Agreement and its amendment, Ms. Quintin was reinstated on February 22, 2017 after she agreed to be subject to drug testing and obtained three consecutive negative drug tests.

In August of 2017 Ms. Quintin commenced employment as a Licensed Practical Nurse at the Gainsborough Health Centre. The Gainsborough Health Centre provides care to mostly elderly residents. Initially she worked on a casual basis. Commencing December 8, 2017 she worked in that role on a full time basis. On March 27, 2018, a manager at the Gainsborough Health Centre completed a performance appraisal of Ms. Quintin which was subsequently provided to SALPN pursuant to the ADR Agreement. As the performance appraisal raised concerns of professional misconduct and professional incompetence, the Counselling and Investigation committee conducted an investigation which ultimately resulted in these proceedings. During the investigation Ms. Quintin's license was suspended by the Counselling and Investigation Committee, which was acting in accordance with the provisions of the ADR Agreement.

Charges 1(a) and 1(b) - Basic Charting and Incident Report Completion

One of Ms. Quintin's key responsibilities as a licensed practical nurse was charting her interactions with residents (such as distribution of medication, assessments of patients, physician's orders and notable occurrences), in an accurate and timely manner. Proper and timely charting is essential to facilitate the sharing of patient care information among staff members and to ensure proper care for patients.

During the liability hearing this Discipline Committee found that Ms. Quintin fell short of the professional standards for patient charting expected of licensed practical nurses in her work at the Gainsborough Health Centre including by:

a) Failing to consistently and properly report dates in the required format (DD/MON/YYYY);
b) Failing to consistently and properly report the times of interactions using the 24 hour clock; and
c) Failing to note that a resident, F.S., sustained a code 3 fall on February 27, 2018, and failing to immediately report the fall to a manager, and complete required documentation;

The issues noted above were a failure to follow charting practices which are part of the scope of knowledge expected by members of the profession. Ms. Quintin failed to adhere to principles of the Code of Ethics for Licensed Practical Nurses, by failing to show responsibility to clients. The disregard of professional obligations reflects poorly on the profession and created a risk to the public. As a result Ms. Quintin was found to have committed professional misconduct and professional incompetence as defined under the Act.

Charges 1(c) – Physician Order

On December 21, 2017, Ms. Quintin submitted an SBAR (which stands for "situation, background assessment and nursing recommendation), to an off-site physician recommending a change in the pain medication prescribed to a non-verbal patient, F.B. The SBAR process is intended to allow communication with physicians where they are not physically present at a facility. Once a doctor returns an SBAR, the response must be transcribed into the physician's orders portion of the resident's chart as well as the nursing progress notes.

Ms. Quintin had observed F.B. in apparent pain, and submitted the SBAR to recommend a change to the pain medication which F.B. was receiving. The physician responded setting out a change to the F.B.'s medication. However, the response from the physician was not properly recorded in F.B.'s chart. Instead of directly transcribing the response into the patient's chart, Ms. Quintin wrote a version which called for the administration of Tylenol #2, while the physician's order referred only to Tylenol. Ms. Quintin claimed to have clarified the order with the physician, but she did not document any clarification of the order by phone. As a result there was a discrepancy between what F.B.'s chart indicated was prescribed, and what had been prescribed by the treating physician in their SBAR. The failure to follow proper charting practice with relation to this order was professional incompetence.

Ms. Quintin's conduct had the potential to harm the public. When a licensed practical nurse inconsistently records information such as a medication order, it may lead to the incorrect administration of medication by other medical professionals which can harm the health of the affected resident, a member of the public. The Discipline Committee also concluded that the steps taken by Ms. Quintin in requesting to increase F.B.'s medication also reflected poor judgment and a breach of the bylaws, specifically principles 2.8 (use evidence and judgment to guide nursing decisions) and 2.9 (identify and minimize risks to clients). The effect of Ms. Quintin's actions was to double the pain medication being administered to F.B. without using tools of good nursing practice such as gradual increases and reassessments. As a result the Discipline Committee found that Ms. Quintin had committed professional misconduct.

Charge 1(d) – Outpatient Incident

On March 19, 2019, while Ms. Quintin was working at the Gainsborough Health Centre, a non-resident, R.R. arrived at the facility seeking medical assistance. The Gainsborough Health Centre does not provide acute care or emergency services to members of the public. Therefore, R.R. had to be transferred by ambulance to the Galloway Health Centre in Oxbow, Saskatchewan.

As part of the transfer, Ms. Quintin was required to complete an Emergency/Outpatient Record which the receiving hospital would rely on as a history of the vital signs presented by the patient and to record any care that had been provided prior to the transfer. While this was not a form with which Ms. Quintin had experience, the information required was similar to that recorded in the ordinary course of charting (such as the date, time and results, of tests of vital signs, and identifying

any medications provided). Ms. Quintin completed two versions of the form, neither of which were properly completed. The forms contained inconsistencies as to the patient's vital signs and symptoms. The inability to accurately complete the forms had the potential of placing a member of the public in harms way.

More seriously, Ms. Quintin displayed a lack of knowledge and judgment by administering two baby aspirin to R.R. without seeking an order of a physician. A licensed practical nurse may not administer such medication without either a specific order or a standing order from a physician. Ms. Quintin failed to call a physician to confirm whether the medication could be administered to R.R. Ms. Quintin failed to recognize the limitations on her capabilities and appropriate scope of practice as a licensed professional nurse. This was a violation of the Code of Ethics for Licensed Practical Nurses and created a risk to the welfare of a member of the public.

As a result of Ms. Quintin's failure to follow standards of practice for nursing and the risk she created for a member of the public, the Discipline Committee concluded that her actions amounted to professional incompetence and professional misconduct.

Charge 1(a)(v) and 1(h) – Resident Pain Assessment

In January 2018, other staff members at the Gainsborough Health Centre brought forward concerns regarding the amount of PRN medications administered to residents to control pain, particularly by Ms. Quintin. On repeated occasions Ms. Quintin had failed to undertake clinical assessments of residents need for PRN medication prior to administering it. The general practice and expectation was that Ms. Quintin would monitor patients' pain levels, ask a patient about their level of pain, and try non-medicinal measures to attempt to minimize pain prior to providing PRN medications. Such interactions must be included in residents' charts. However, on numerous occasions Ms. Quintin either failed to conduct such an assessment, in some cases administering PRN medication in advance of complaints about pain as a precautionary measure. In other cases Ms. Quintin conducted an assessment but failed to make notes regarding doing so in the residents' chart.

Ms. Quintin's actions deviated from the standards expected of the profession, and risked administering unnecessary medications to residents. A review of the PRN medications dispensed by Ms. Quintin in comparison to other licensed practical nurses at the Gainsborough Health Centre showed that Ms. Quintin was dispensing such medication at a significantly higher rate than other nurses (in fact Ms. Quintin provided more PRN medications than the combined total of all other nurses). Combined with the fact that Ms. Quintin was not consistently performing appropriate assessments of patients prior to administering medication this high rate of dispensing medication showed a deficiency in Ms. Quintin's judgment, and skills.

Her conduct was harmful to the interests of public as members of the public were dispensed medication which may not have been required. Ms. Quintin failed to exercise the appropriate

judgment and skills expected of a licensed practical nurse. Her conduct amounted to professional incompetence and professional misconduct as defined by the act.

POSITIONS OF THE PARTIES ON SANCTION:

Submissions of the Counseling and Investigation Committee

SALPN's Counseling and Investigation Committee emphasized the serious nature of the findings of professional misconduct and professional incompetence in this case. The Committee noted that Ms. Quintin's actions had created risks for members of the public who were relying on Ms. Quintin to provide healthcare.

In particular the Counseling and Investigation Committee submitted that Ms. Quintin had displayed a repeated pattern of substandard charting skills, which is a basic skill required of all licensed practical nurses. Proper charting is an essential tool in communicating among healthcare professionals regarding the health of a patient and the care which was provided to them. In the absence of proper charting there was a potential for confusion and errors regarding the treatment of patients. In the absence of proper charting other health care professionals may never know that something happened in relation to a patient. For this reason charting is a basic skill required of all licensed practical nurses. The Committee submitted that Ms. Quintin's repeated failure to accurately and reliably complete charting information is a serious issue that presents a potential danger to members of the public.

The Counseling and Investigation Committee also emphasized the significance of the findings of professional misconduct and professional incompetence which relate to Ms. Quintin's dispensation of PRN medication. Proper assessment is essential to ensuring unnecessary medications were not dispensed, yet on many occasions Ms. Quintin did not even perform assessments or dispensed medication in advance of a need for that medication, which was a significant deviation from the standards expected from members of the profession, as well as a violation of health region policies. The Committee submitted that the failure to conduct proper assessments, as well as the very high rate of medication which was administered constituted a danger to the public, which called for a significant sanction.

The Counseling and Investigation Committee provided the panel with correspondence and drug testing results relating to Ms. Quintin's suspension from practice in 2011-2012, and referred the panel to the Discipline Committee's 2011 decision regarding Ms. Quintin. The Committee submitted that this information, together with evidence which was before the panel with respect to drug testing of Ms. Quintin pursuant to the subsequent ADR Agreement and Ms. Quintin's use of methadone treatment (including non-compliance with a methadone treatment program in 2014 and testing positive for cocaine metabolites in 2016) showed that if Ms. Quintin was reinstated ongoing drug testing would be necessary to help protect the public and try to prevent future incidents of professional misconduct or professional incompetence by Ms. Quintin. The Committee also submitted that it was appropriate to include provisions in the sanctions order requiring Ms. Quintin

to utilize the support of medical professionals to monitor her use of prescription drugs and to provide ongoing addictions counselling.

The Counseling and Investigation Committee submitted a lengthy suspension was required to address both specific and general deterrence. The Committee noted that Ms. Quintin had a previous disciplinary record with SALPN, including serious findings of professional misconduct. The Committee suggested that given Ms. Quintin's history a case could be made for permanent expulsion, but that in the circumstances it was seeking a minimum suspension of one year, together with a requirement that Ms. Quintin complete remedial educational courses to address the lack of knowledge of nursing standards which she had demonstrated with respect to nursing roles and completion of healthcare documentation. The Committee submitted that there were no significant mitigating factors in the case but that there were a number of aggravating factors. In particular the Committee submitted that the incidents were not isolated but constituted a repeated pattern of misconduct, that, Ms. Quintin's had a serious prior discipline record, and that she continued to demonstrate a lack of insight and accountability for the deficiencies in her practice were all important aggravating factors.

In addition to requesting that Ms. Quintin be suspended, the Counseling and Investigation Committee submitted that it was appropriate that Ms. Quintin repay a significant portion of the costs of the Counseling and Investigation Committee which were incurred in investigating the charges against Ms. Quintin and conducting the hearing. Those costs were estimated to exceed $75,000 (not including costs incurred by the Discipline Committee). The Counseling and Investigation Committee suggested that Ms. Quintin pay at least $25,000 of those costs, and submitted that a larger payment would also be appropriate.

Submissions of Ms. Quintin

Ms. Quintin submitted that this process had affected her employment and already imposed significant hardship on her. She noted that she had not been employed as a licensed practical nurse since her employment was terminated after the complaint was brought against her.

Ms. Quintin provided the panel with information regarding her current employment situation. She indicated she is presently unemployed and receiving disability benefits which amount to less than $1000 a month. She is currently living with her elderly mother. She submitted that being unable to work as a licensed practical nurse for another year would be very difficult for her and would affect her ability to earn a livelihood.

Ms. Quintin submitted that the amount of the costs payment sought by the Counseling and Investigation Committee would be too severe. She submitted that she is living in poverty and that it would take a very long time to be able to pay back $25,000 or some larger amount.

Ms. Quintin did not oppose the Counseling and Investigation Committee's request that any reinstatement of her license be subject to conditions relating to screening for drug use. Ms. Quintin acknowledged having previously had some problems relating to drug use.

Ms. Quintin urged the panel to consider her difficult personal circumstances and the effect the discipline process had already had on her in setting a sanction. She asked that any sanction be manageable and not too severe so that she could realistically seek to return to the licensed practical nursing profession.

DECISION:

The decision before the Discipline Committee is what sanctions are appropriate as a result of the acts of professional misconduct and professional incompetence which it has previously found Ms. Quintin to have committed. *The Licensed Practical Nurses Act, 2000*, SS 2000, c. L-14.2 sets out the remedial authority of the Discipline Committee in section 30:

> 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 counselling 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 counselling 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.

In *Camgoz v College of Physicians and Surgeons (Sask)* (1993), 114 Sask R 161 (QB), the Court of Queen's Bench set out a number of factors which may be relevant in evaluating an appropriate sanction in professional discipline proceedings regarding medical professionals, holding at paras 49-50:

> [49] In my respectful view, in determining an appropriate sentence to be imposed on a member of the medical profession found guilty of unbecoming, improper, unprofessional and discreditable conduct, the factors which the respondent ought to take into account include:
>
> 1. The nature and gravity of the proven allegations;
>
> 2. The age of the offending physician;
>
> 3. The age of the offended patient;
>
> 4. Evidence of the frequency of the commission of the particular acts of misconduct within particularly, and without generally, the Province;
>
> 5. The presence or absence of mitigating circumstances, if any.
>
> 6. Specific deterrence;
>
> 7. General deterrence;
>
> 8. Previous record, if any, for the same, or similar, misconduct; the length of time that has elapsed between the date of any previous misconduct and conviction thereon; and, the member's (properly considered) conduct since that time;
>
> 9. Ensuring that the penalty imposed will, as mandated by s. 69.1 of the Act, protect the public and ensure the safe and proper practice of medicine;
>
> 10. The need to maintain the public's confidence in the integrity of the respondent's ability to properly supervise the professional conduct of its members;
>
> 11. Ensuring that the penalty imposed is not disparate with penalties previously imposed in this jurisdiction, particularly, and in other jurisdictions in general, for the same, or similar acts of misconduct.
>
> [50] The above factors are not to be considered as being an exhaustive list of the factors to be considered by the respondent in its future considerations of like matters. Nor are the factors identified by me listed in order of their importance. The noted factors identified by me are those which I consider to be generally applicable to the consideration of a proper penalty to be imposed following conviction of a member for unbecoming, improper, unprofessional and discreditable conduct. The factors to be considered in a particular case will of course vary, as will their particular relevance, in each case under consideration.

Any penalty which is imposed should further the protections of the public and enhance public confidence in the effective regulation of the licensed practical nursing profession. In the present case the need to fashion an order which protects the public, and to provide specific deterrence are important in light of the current findings of professional misconduct and professional incompetence by Ms. Quintin as well as Ms. Quintin's disciplinary record. Given the serious nature of Ms. Quintin's actions, general deterrence is also an importance consideration in this case.

Ms. Quintin repeatedly demonstrated a lack of knowledge, a failure to follow acceptable practice standards and poor professional decision making, resulting in the findings of professional

misconduct and professional incompetence in this case. The findings against Ms. Quintin do not reflect isolated errors in judgment. Instead they reflect serious deficiencies in the manner in which she has conducted her practice.

Proper charting is a core competency of effective practice as a licensed practical nurse. It is a vital communications tool which, when used properly, can ensure that all of the health care professionals called on to interact with a patient have the information they require to perform their duties safely and effectively. When charting is not completed, or is completed inaccurately, this communication breaks down, creating risks for the patient. Ms. Quintin's pervasive failures to accurately and reliably chart patient interactions, (including important events such as medication orders, pain assessments and a resident falling) put members of the public at risk and would harm the public's confidence in the care provided by the licensed practical nursing profession.

Of even greater concern is Ms. Quintin's careless approach to the administration of medication. This issue arose on multiple occasions, including her requests to rapidly increase the medication provided to F.B. and carelessness in reporting physician orders, her administration of medication without a doctor's order to R.R., and her repeated administration of PRN medication to residents without performing the required assessments to determine if such medication was truly necessary.

The proper administration of medication to patients is an important role of licensed practical nurses. When administered properly medication can form an important part of the care provided to a patient. However when administered improperly or unnecessarily, medication may also cause harm to patients. In order to protect patients from these risks, it is important for licensed practical nurses to follow proper procedures when dispensing medication, understand the limits of their scope of practice, and exercise sound professional judgment. Unfortunately, Ms. Quintin failed in these duties, creating a potential for harm to patients, and acting in a manner that would harm the public's confidence in the care provided by the licensed practical nursing profession.

The repeated nature of Ms. Quintin's misconduct, the significant deviations from professional standards, and the risks for harm to members of the public reflect serious acts of professional misconduct and professional incompetence which requires that a substantial sanction be imposed. It is also an aggravating factor that Ms. Quintin has not demonstrated insight into her shortcomings or demonstrated accountability for those issues. During the course of the hearings Ms. Quintin sought to deflect responsibility by alleging failures by others (such as other failures of charting). Regardless of whether any others may have also failed to comply fully with their own obligations, Ms. Quintin had a professional responsibility to uphold proper standards of practice. There was no real doubt about what her obligations were with respect to any of the allegations where she has been found guilty of professional misconduct or professional incompetence. Her tendency to blame others instead of accepting responsibility for ensuring errors were not repeated and improving her nursing skills points to a need for both specific deterrence and protection of the public.

Ms. Quintin's prior disciplinary record is also relevant in these proceedings. Since 2011, Ms. Quintin has been involved in multiple professional disciplinary proceedings. She was found guilty of professional misconduct in relation taking medications from her employer without authorization in 2011. Further allegations of failing to follow proper protocols in relation to medication resulted in Ms. Quintin entering into the ADR Agreement with SALPN's Counselling and Investigation Committee. While subject to the ADR process Ms. Quintin was temporarily suspended. Ms. Quintin is not addressing charges of professional misconduct and professional incompetence for the first time. In ten years she has been the subject of multiple complaints which resulted in sanctions or limits on her ability to practice. Notwithstanding those sanctions and efforts by SALPN to encourage Ms. Quintin to improve her standard of practice, Ms. Quintin has been found to have been guilty of professional misconduct and professional incompetence. This disciplinary history is a significant aggravating factor in this case.

There are few mitigating circumstances in this case. Ms. Quintin's personal circumstances and the serious impact these discipline proceedings have had on her ability to earn a livelihood do indicate the need for some degree of temperance in imposing a sanction. However, these factors cannot outweigh the gravity of the conduct at issue and the need to protect the public.

In weighing the various factors described above, it is our conclusion that a period of suspension is required. Suspension will protect the public by ensuring that Ms. Quintin does not practice for a period of time which will allow her to address the deficiencies in her knowledge, skills and decision making which resulted in these proceedings. A lengthy suspension will serve as a signal that repeated and serious professional misconduct and professional incompetence such as was demonstrated in this case cannot be tolerated. If Ms. Quintin were to engage in future misconduct of a similar nature, it could (depending on the circumstances) result in expulsion. A lengthy suspension also supports the need for general deterrence by signaling to all licensed practical nurses the importance of following standards relating to patient charting and medication administration. Therefore, we have determined that a one year suspension is an appropriate response. Such a suspension will provide time for Ms. Quintin to improve her knowledge, and decision making, without being unduly long and serving as a permanent bar to returning to work as a nurse.

As noted above, Ms. Quintin's conduct demonstrated serious errors in her knowledge, skills and decision making relating to nursing care, especially in relation to making decisions regarding medication administration and in documentation. In order to fulfill SALPN's mandate to protect the public, any reinstatement of Ms. Quintin following the one year suspension must be subject to Ms. Quintin completing further education regarding these issues. Ms. Quintin expressed concerns regarding her availability to afford such programs prior to returning to work, and suggested that she be permitted to attend such programs after reinstatement. While we understand her concerns

regarding the cost, the protection of the public requires the completion of educational programming prior to resuming practice as a nurse. Of the three courses Ms. Quintin must take (set out in detail in our order), two of them must be completed prior to the reinstatement of her licence. The third course may be completed after her licence is reinstated.

The Counselling and Investigation Committee has requested that Ms. Quintin's reinstatement be subject to complying with conditions relating to drug testing and drug treatment. Ms. Quintin did not oppose such conditions.

There is evidence that Ms. Quintin has previously had problems with the use of drugs and addiction, and that these may have contributed to prior professional discipline issues. There is also evidence that Ms. Quintin has used methadone treatment, and at times has not complied with a methadone treatment program. She has previously been required to comply with conditions relating to drug testing and treatment pursuant to the July 14, 2011 decision of the Discipline Committee and pursuant to the ADR Agreement. On the other hand, it has not been proven that the abuse of drugs was a causal factor in any of the misconduct before the Discipline Committee in the present case.

It appears that conditions relating to drug testing and drug treatment have previously been applied to Ms. Quintin to protect the public and to help ensure her safe return to practice. In the circumstances, including the fact that Ms. Quintin did not oppose that such conditions be included in our order, we have decided that it is appropriate to make Ms. Quintin's reinstatement conditional on negative drug testing and ensuring proper monitoring of her use of medications by medical professionals. Given Ms. Quintin's prior misuse of drugs and discipline history, these conditions will assist in protecting the public while supporting Ms. Quintin's return to the nursing profession following her suspension.

In addition to the suspension and practice conditions set out above, subsection 30(2) of the Act provides authority to order a member to pay the costs of both the Counselling and Investigation Committee and the Discipline Committee within a fixed period, and in the event such costs are not paid, the member's licence may be suspended. In this case, which involved numerous charges and a contested hearing, the actual costs of the Counselling and Investigation Committee exceed $75,000.

The Court of Appeal reviewed the principles applicable to costs awards in a professional discipline context in *Abrametz v The Law Society of Saskatchewan*, 2018 SKCA 37. The court held at paras 44-45 that the purpose of awarding costs in professional discipline proceedings is to ensure that a member bears part of the cost of disciplinary proceedings and that those costs are not borne solely by their fellow members. Such cost orders must not be so prohibitive as to prevent a member from

defending their right to practice in their profession or to dispute misconduct charges. The court endorsed the following principles regarding costs decisions at paras 47-48:

> a. The balance between the effect of a cost award on the Appellant and the need for the Provincial Dental Board to be able to effectively administer the disciplinary process;
>
> b. The respective degrees of success of the parties;
>
> c. Costs awards ought not to be punitive;
>
> d. The other sanctions imposed and the expenses associated therewith;
>
> e. The relative time and expense of the investigation and hearing associated with each of the charges and in particular those on which guilt were entered and those where the Appellant was found not guilty.

In our view it is appropriate that Ms. Quintin contribute towards the costs of these disciplinary proceedings. The disciplinary charges were relatively complex and involved a number of separate charges, which required detailed investigation. Other than with respect to one charge set out in charge 1(d)(i) of the formal notice of hearing, Ms. Quintin contested the charges. She had a right to do so, but having been found to have been guilty of those charges, it is appropriate that she contributes to the costs of the disciplinary process.

Ms. Quintin was found not guilty of three charges (one relating to allegedly sleeping at work, one relating to an alleged breach of a patient's privacy, and one relating to bringing her dog to work). That would support a reduction in the amount of costs awarded. However, Ms. Quintin was found guilty of the majority of the charges against her, and the charges on which she prevailed were generally simpler than those of which she was found to be guilty. As a result, while some reduction in the costs order is appropriate, it is still appropriate for Ms. Quintin to make a significant contribution towards the costs of the discipline proceedings against her.

In fixing the amount of a costs award, we have also considered the other sanctions which have been imposed. Further specific and general deterrence is supported by requiring a significant payment of costs by Ms. Quintin to contribute towards the costs incurred as a result of her professional misconduct and professional incompetence. It is also significant that Ms. Quintin has previously been found guilty of professional misconduct. In these circumstances a more substantial costs award is an appropriate deterrent.

While there are a number of factors supporting a significant costs award, Ms. Quintin's personal circumstances must also be considered. Ms. Quintin is presently unemployed, and will be subject to a lengthy suspension preventing her from practicing her chosen profession. It is not realistic to expect that she could pay a large costs order prior to being reinstated and resuming practice as a nurse. We accept that Ms. Quintin would currently face significant financial hardship if required to pay a costs order. However, we note that her income would be expected to increase if she resumed practicing as a licensed practical nurse following her suspension.

In order to balance the need for a significant order for the payment of costs with the difficulty financial circumstances of Ms. Quintin, we have determined that it is appropriate for the payment of costs to be broken into multiple installments to be paid after Ms. Quintin's licence is reinstated.

CONCLUSION:

For the foregoing reasons, the following Order of the Discipline Committee shall issue in respect of Ms. Quintin's professional incompetence and professional misconduct:

1. Pursuant to subsections 30(1)(b)-(c) and 30(1)(f) of *The Licensed Practical Nurses Act* (the "Act"), Pamella Quintin shall not be entitled to apply for admission and reinstatement for a minimum period of one year from the date of this Order and until such time as the following conditions are met:

    (a) Pamella Quintin must submit drug screen results (which also test for alcohol or ethanol and THC) on both a monthly basis and on a random basis as may be requested by the Registrar. Ms. Quintin must produce six months of consecutive negative screens unless the drug or medication has been prescribed by an authorized prescriber. Ms. Quintin shall bear any and all costs of the screens and the reports.

    (b) Pamella Quintin shall successfully complete and provide verification of successful completion to the Registrar of the Saskatchewan Polytechnic course *Roles Responsibilities and Ethics* (NURS-1667). Ms. Quintin shall bear the direct and indirect costs of the course.

    (c) Pamella Quintin shall successfully complete and provide verification of successful completion to the Registrar of the Saskatchewan Polytechnic Health Record Documentation course (NURS-1685). Ms. Quintin shall bear the direct and indirect costs of the course

    These conditions shall be in addition to the usual requirements of reinstatement as set out in the Act and Bylaws.

2. Upon the expiry of one year and in the event the conditions in paragraph one are met and Pamella Quintin's licence is reinstated, Ms. Quintin's continued practice shall be subject to the following conditions pursuant to subsections 30(1)(d) and 30(1)(f) of the Act:

   (a) Within 60 days of her reinstatement, Pamella Quintin shall complete the CLPNA Nursing Documentation 101 course. Ms. Quintin shall bear the direct and indirect costs of the course.

   (b) For two years after Pamella Quintin is reinstated as a practicing member, Ms. Quintin shall provide drug screen test results (which also test for alcohol or ethanol and THC) to the Registrar as the Registrar may request. Should any drug screen indicate a positive or non-negative result for a substance for which Ms. Quintin does not have a valid prescription, Ms. Quintin's licence shall be immediately suspended and may remain suspended at the discretion of the Counselling and Investigation Committee. Ms. Quintin shall bear any and all costs of the screens and of the reports.

   (c) Pamella Quintin shall engage and remain under the care of primary care physician who is monitoring her use of prescription medications including methadone. Ms. Quintin shall advise the Registrar of the name of the physician and provide a signed release directed to the physician authorizing the release of information to the Registrar for a period of two years following her reinstatement as a practicing member. Ms. Quintin shall bear the costs of any reports.

   (d) For two years following her reinstatement as a practicing member, Pamella Quintin shall abstain from the use of any drug or medication not prescribed by the primary care physician, or other physician to whom Ms. Quintin has been referred to by her primary care physician. Notwithstanding the foregoing, Ms. Quintin may use non-prescription medications including non-prescription drugs or natural health products such as acetaminophen, ibuprofen or OTC topical preparations but she may not use decongestants or exempted codeine products as defined in section 36 of the *Narcotic Control Regulations*.

(e) For so long as Pamella Quintin holds a practicing licence, she shall abstain from the use of any illegal drugs as listed in the *Controlled Drugs and Substances Act*, the *Narcotic Control Regulations* and the *Food and Drug Regulations*.

(f) For so long as Pamella Quintin holds a practising license, she shall immediately advise the Registrar if she is the subject of any discipline sanctions taken by her nursing employer.

(g) For so long as Pamella Quintin holds a practicing license, she shall advise the Registrar if she changes her nursing employer and do so within seven days of the date of the change.

3. Pursuant to section 30(1) (f) of the Act and for a period of two years from the date of her reinstatement as a practicing member, Pamella Quintin shall provide a copy of the Discipline Committee decision and order to her nursing employer or employers. Further, Ms. Quintin shall ensure that each nursing employer will provide written confirmation to the Registrar that the decision and order has been received.

4. Pursuant to section 30(2)(a)(ii) of the Act, Pamella Quintin shall pay the costs of the investigation and hearing, which costs shall be fixed in the total amount of $35,000.00. The costs shall be paid as follows:

(a) Within 6 months of the date that Ms. Quintin is first reinstated as a practicing member, the sum of $5,000.00;

(b) Within 12 months of the date that Ms. Quintin is first reinstated as a practicing member, the sum of $10,000.00;

(c) Within 18 months of the date that Ms. Quintin is first reinstated as a practicing member, the sum of $10,000.00;

(d) Within 24 months of the date that Ms. Quintin is first reinstated as a practicing member, the sum of $10,000.00;

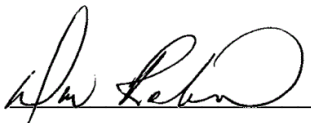
If an installment is not made on the due date or within 5 days of the due date, Ms. Quintin's licence shall be suspended until payment is made pursuant to section 30(3)(b) of the Act.

5. Pursuant to section 30(5) of the Act, a copy of the Discipline Committee order and decision shall be provided to the Gainsborough Health Center, Saskatchewan Health Authority.

6. In the event that the courses Ms. Quintin has been ordered to take pursuant to paragraphs 1(b), 1(c) and 2(a) of this Order are not offered, or if drug testing services are unavailable, Ms. Quintin may apply by letter directed to the chairperson of the Discipline Committee to have this Order varied.

7. A copy of the Discipline Committee order and decision shall be published on the SALPN website.

DATED at Regina, Saskatchewan, this 12th day of May, 2020.



D. Robinson, Chairperson, Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses on behalf of the Discipline Committee consisting of K. Bradford, E. Cherney, B. Lalonde and A. Patron.