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:
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> (a) an order that the member be expelled from the association and that the member's name be struck from the register;
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> (b) an order that the member's licence be suspended for a specified period;
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> (c) an order that the member's licence be suspended pending the satisfaction and completion of any conditions specified in the order;
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> (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:
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> (i) not do specified types of work;
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> (ii) successfully complete specified classes or courses of instruction;
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> (iii) obtain medical or other treatment or counselling or both;
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> (e) an order reprimanding the member;
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> (f) any other order that the discipline committee considers just.
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> (2) In addition to any order made pursuant to subsection (1), the discipline committee may order:
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> (a) that the member pay to the association, within a fixed period:
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> (i) a fine in a specified amount not exceeding $5,000; and
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> (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
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> (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:
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> 1. The nature and gravity of the proven allegations;
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> 2. The age of the offending physician;
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> 3. The age of the offended patient;
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> 4. Evidence of the frequency of the commission of the particular acts of misconduct within particularly, and without generally, the Province;
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> 5. The presence or absence of mitigating circumstances, if any.
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> 6. Specific deterrence;
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> 7. General deterrence;
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> 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;
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> 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;
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> 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;
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> 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.
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> [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;
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> b. The respective degrees of success of the parties;
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> c. Costs awards ought not to be punitive;
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> d. The other sanctions imposed and the expenses associated therewith;
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> 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;

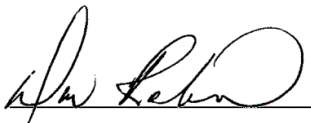
If an installment is not made on the due date or within 5 days of the due date, Ms. Quintin's licence shall be suspended until payment is made pursuant to section 30(3)(b) of the Act.

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.