IN THE MATTER OF THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183

BETWEEN:

The British Columbia College of Nurses and Midwives

(the "College" or "BCCNM")

AND:

Shannon Whieldon

(the "Respondent")

RECONSIDERATION DECISION AND REASONS

Hearing Dates:	In writing
Discipline Committee Panel:	Sheila Cessford, Chair Edna McLellan, Non-Practising RN
Counsel for the College:	Jennifer Groenewold
Counsel for the Respondent:	Preston Parsons
Counsel for the Panel:	Susan Precious

A. INTRODUCTION

1. This panel of the Discipline Committee (the "Panel") of the British Columbia College of Nurses and Midwives (the "College" or "BCCNM") conducted a hearing to determine, pursuant to section 39 of the *Health Professions Act* RSBC 1996 c.183 (the "Act" or the "HPA"), whether the Respondent, Shannon Whieldon failed to comply with the Act, failed to comply with a standard imposed under the Act, and/or committed professional misconduct or unprofessional conduct.

2. The Panel issued a written decision on September 11, 2019 (the "Conduct Decision") in which the Panel found that allegations 1(a)(i)(ii)(iv), (c), (d), (f), (g)(i)(ii), (h)(i)(iii), and (j) of the citation dated April 16, 2019 (the "Citation") were proved to

the requisite standard. The Panel determined that the Respondent breached standards imposed under the Act, that she committed professional misconduct, and that she had incompetently practiced the profession. The Panel dismissed allegations 1(a)(iii), (b), (e) and (h)(ii) and h(iv) of the Citation.

3. On October 11, 2019, the Respondent filed a petition in the Supreme Court of British Columbia appealing the findings in relation to allegations 1(c), 1(a)(i), 1 (g)(i) and 1 (h)(i) of the Citation. On September 16, 2020, the Respondent filed an amended petition in her appeal. The appeal was heard on February 16, 17, and May 25, 2021.

4. On April 14, 2020, after hearing from the parties in writing, the Panel delivered its decision on penalty and costs (the "Penalty Decision"). The Respondent did not appeal the Penalty Decision.

5. On August 20, 2021, the Court delivered its reasons for judgment in the appeal of the Conduct Decision (the "Judgment Reasons"). The Court reversed the Panel's decision with respect to allegation 1(c) of the Citation. The Panel's findings regarding allegations 1(a)(i), 1(g)(i), and 1(h)(i) (the "Oxytocin Allegations") were quashed and remitted to the Panel for reconsideration.

6. At paragraph 4 of the Judgment Reasons, the Court confirmed that the Respondent's appeal did not contest all of the Panel's findings against her in the Conduct Decision. The Panel's findings in the majority of the proven allegations were not appealed and remain intact; namely allegations 1(a)(ii)(iv), (d), (f), g(ii), h(iii) and (j) of the Citation.

7. The Court also confirmed that the Respondent did not appeal the Penalty Decision and issued no directions in relation to penalty or costs.

8. The College and the Respondent delivered written submissions in relation to the reconsideration of the Oxytocin Allegations.

9. The Panel has considered all of the evidence, the submissions of the parties, and the guidance of the Court in arriving at its reconsideration decision. This task has been complex given that the parties' summaries of evidence in their reconsideration

submissions are lengthy and contain inconsistencies. This has required the Panel to systematically and thoroughly review the record to resolve those inconsistencies.

10. Also, one of the Panel members died. The remaining two Panel members render this reconsideration decision, which is unanimous. For the reasons that follow, the Panel finds that the Oxytocin Allegations are proved to the requisite standard. The Panel has determined that the Respondent has not complied with a standard imposed under the Act and has incompetently practiced the profession.

B. THE COURT'S DIRECTIONS

11. In the Judgment Reasons, the Court summarizes the Respondent's submissions relating to her leave of absence from work from 2011 to 2013 as follows:

> [67] The petitioner submits that by failing to consider her leave from November 2011 to June 2013 (during which the Oxytocin Protocol was changed) and any lack of subsequent training upon her return from that particular leave, the Panel made a material misapprehension of evidence or an error in fact in relation to allegations 1(a)(i), 1(g)(i), and 1(h)(i) of the Citation. The Oxytocin Protocol was significantly changed in 2012, during the petitioner's absence, and training was given to perinatal staff members around that time. The petitioner submits that the Decision indicates that the Panel either found or inferred that the petitioner was *not* on leave during this time and that she had received this training, even though her leave is firmly established by the evidence. She further argues that the Panel erred by suggesting that the Oxytocin Protocol documents were available for her to read at her leisure, and that she would have been fully informed regarding the Oxytocin Protocol had she read them.

12. In relation to the Respondent's arguments about her 2011 to 2013 absence, the Court held the following:

> [70] Based on the Panel's extended discussion of the petitioner's 2015 absence in the Decision, I cannot accept that the Panel would have, without stating any reason as to why, deemed the petitioner's absence from 2011 to 2013 immaterial. The Panel explicitly noted that there were no material changes to the Oxytocin Protocol relevant to the allegations at issue during the petitioner's 2015 absence, though they did note that such changes occurred in 2012. If the coinciding of a change to the Protocol and a leave of absence is relevant, which the Panel appears to acknowledge, it would seem just as significant for the Panel to address the 2011 to 2013 leave of absence.
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> [71] In explaining its determination of professional incompetence in relation to allegations 1(a)(i), 1(g)(i), and 1(h)(i) of the Citation, the Panel states at para. 199 of the Decision:

> The Panel accepts Ms. Whieldon's submission that her re-orientation following [the 2015 5 month absence] due to a traumatic family event could have been improved. Ms. Whieldon requested additional orientation, and was promised certain supports which were not provided. Having said that, as discussed above, the Panel does not find this to be a defence in the circumstances. **The changes made to the Oxytocin Protocol were released several years before Ms. Whieldon took her leave of absence, those changes were rolled out to staff, and the key documents were readily available to her in hard copies and electronically.** Moreover, Ms. Whieldon did participate in numerous learning opportunities offered through LMH in respect of Oxytocin.
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> [emphasis added in Judgment Reasons]

[72] If the fact that the 2012 changes referred to here were rolled out to staff and made readily available is important to the consideration of whether the petitioner practiced her profession incompetently, surely evidence that the changes were not rolled out to her due to her absence in 2012 warrants meaningful consideration. It may well be that the Panel would nonetheless have come to the same determination based on the availability of training, the accessibility of the relevant documents, and the professional duty of the petitioner to stay up to date. However, I am unable to draw such a conclusion from the Decision as it is written given the Panel's apparent acknowledgement of the relevance of (i) the petitioner's leave of absence coinciding with material changes to the Protocol and (ii) the "rolling out" of training related to those changes.

[73] Thus, the Panel's findings regarding these three allegations appear to be premised on a misapprehension or overlooking of certain facts material to their decision. This error is palpable in that relevant evidence of the 2012 leave is conspicuously absent from the Decision. It is overriding in that, as I have noted, certain findings of the Panel appear to have been impacted to a potentially significant degree by a failure to apprehend or consider this evidence. As I find that the error is palpable and overriding, I need not consider whether it is a "material misapprehension of fact" amounting to an error in law, though I am inclined to believe that it would.

13. The Court wrote the following regarding the Respondent's other grounds of appeal:

> [75] The petitioner raises several other issues on appeal in relation to the Panel's determinations on allegations 1(a)(i), 1(g)(i), and 1(h)(i), including:
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> - whether the Panel erred by omitting or materially misapprehending evidence related to the absence of an express requirement for the completion of a 20 to 30-minute heart rate tracing prior to increasing oxytocin;
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> - whether the Panel erred in fact in its reasoning regarding allegation 1(h)(i) of the Citation by ignoring material, relying on impeached expert evidence, or irrelevantly considering the "Titrating Requirement" when evaluating the petitioner's adherence to the "Decrease by ½ Requirement";

> • whether the Panel erred by concluding that the petitioner was aware of and wilfully departing from the Oxytocin Protocol; and
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> • whether the Panel erred by failing to clarify the petitioner's admissions relating to her oxytocin administration, given their importance to several of the Panel's determinations.

> [76] The Panel's failure to consider the petitioner's absence from 2011 to 2013, encompassing the period in which changes to the Oxytocin Protocol occurred, may well have impacted the Panel's findings on these other impugned actions and determinations. For example, the petitioner's apparent absence during a major change in the Oxytocin Protocol (itself a potential explanation for the petitioner's lack of knowledge of those changes), combined with the unwritten nature of certain Oxytocin Protocol requirements, may well provide an answer to certain breaches of standards of practice found by the Panel, particularly those related to responsibility and knowledge-based practice.
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> [77] I therefore refrain from thoroughly evaluating these grounds for appeal as I am unsure of the ways in which a consideration of the relevant absence might have impacted the Panel's determinations on those matters. I cannot properly evaluate their reasoning on these issues in the face of this uncertainty, nor do I think that I should given that the Panel will be afforded an opportunity to consider the impact of the relevant absence on their determinations upon remittal.

14. The Court then set out three suggestions for the Panel to keep in mind with regard to its reconsideration of the impugned determinations:

> [78] That being said, I would suggest that the Panel keep the following in mind with regard to its reasoning on its impugned determinations for allegations 1(a)(i), 1(g)(i), and 1(h)(i). Even without an explicit consideration of the petitioner's absence on the determinations appealed by the petitioner, the reasoning offered in the Decision in support of those determinations is often opaque and confusing. For example:
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> > • The Panel's analysis of allegation 1(h)(i) seems to suggest that Ms. Whieldon's testimony that she was unaware of the "Decrease by ½ Requirement" at the time of the events in allegation 1(a)(i) is inconsistent with her statement that she was aware of the requirement at the time of the events in allegation 1(h)(i), even though she explicitly stated (in testimony that is noted in the Decision) that she learned of the requirement between those two events.
> >
> > • The Panel's decision regarding allegation 1(h)(i) is in part premised upon a finding that a decrease in oxytocin two hours after a failure to properly apply the "Decrease by ½ Requirement" provided further evidence of the petitioner's departure from that requirement without explaining the significance of this seemingly unrelated decrease to their determination.
> >
> > • The Panel's determination that the petitioner practiced her profession incompetently is in part premised upon the statement that she "continued to assert that she [was] justified in departing from the Oxytocin Protocol". It is unclear to me whether this statement amounts to a finding that the

> petitioner deliberately contravened established professional standards. That ambiguity is problematic given the role of this statement in the Panel's reasoning regarding incompetence, the significant professional impacts of a finding of incompetence, and the prejudice associated with a finding of deliberate departure from professional standards.

15. The Panel notes that at paragraphs 28 and 67 of the Judgment Reasons, the Court referred to the Respondent's leave of absence from the Perinatal Unit as running from November 2011 until June 2013; however, the Respondent's evidence during the Discipline Hearing was that her leave ended in August 2013. The Respondent's summary of evidence in her closing submissions on reconsideration also state that the leave ended in August 2013. The Panel asked the parties about this discrepancy, and both agreed that the June 2013 date in the Judgment Reasons is an error and that the correct date is August 2013. The Panel agrees, particularly given that the Respondent's absence was related to her son's surgery which took place in July 2013. Accordingly, in following the Court's directions the Panel will be treating this leave as having ended in August 2013.

C. CITATION ALLEGATIONS

16. The particulars in the Citation are set out below. The Oxytocin Allegations for reconsideration are contained in paragraphs 1(a)(i), 1(g)(i) and 1(h)(i) and are bolded:

> **1. The purpose of the hearing is to inquire into your conduct regarding a number of incidents that occurred from April 2016 to January 2017 while you were employed as a perinatal nurse at the Langley Memorial Hospital. These incidents include the following:**
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> **a) on or about April 28, 2016, while caring for Patient #1 (O.M.):**
>
> > **i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically you made infusion rate changes that were not based on Patient #1's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders;**
> >
> > ii. you did not accurately interpret the external electronic fetal heart monitor strip when you classified the strip as "normal" when it was atypical at or about 1100;
> >
> > iii. you did not follow BCCNP's nursing standards and Fraser Health Policy regarding the administration and management of epidural medications when you made changes to the epidural infusion rate that were not

supported by the epidural protocol, Patient #1's clinical presentation, or by an anesthetist's orders; and

iv. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding documentation when you:

1) did not correctly date entries on the April 28 partogram and in the nursing progress notes;

2) documented in a narrative "block" in the nursing progress notes;

3) did not document assessment findings and clinical rationale(s) for changes you made to the epidural and/or Oxytocin infusion rates; and/or

4) did not document every required assessment on the Oxytocin management Checklist.

b) on or about April 28, 2016, you performed a vaginal examination on Patient #2 (J.L.) that caused pain and you did not communicate appropriately with her during the exam, or at all, and you did not adequately explain the findings of the vaginal examination and/or communicate the results of your assessment to her;

c) on or about May 6, 2016, during the bath of Patient #3, an infant (B.G.M.), you observed and documented signs and symptoms that may have indicated seizure activity by stating, "strange movements with hands, clenching, splaying fingers, gripping & internally rotating wrists – will need to observe". B.G.M. was 1 day old and you were involved in her delivery, which was vacuum-assisted due to fetal tachycardia greater than 170 beats per minute. B.G.M.'s one minute Apgar score was 1 and her 5 minute Apgar score was 9. Despite your knowledge regarding B.G.M.'s birth events and Apgar scores, your observation regarding the "strange movements" and your documentation regarding same, you did not appropriately advise Patient #3's parents of your observations or escalate the infant's care by notifying the charge nurse, patient care coordinator, or physician; further, you did not perform any additional assessments of infant Patient #3.

d) On or about 1930 on May 7, 2016, you documented a late entry for infant Patient #3 after you were advised that the infant was transferred to a higher level of care for seizures earlier that day at or around 0930. Your "late entry" outlined that you had performed further assessments on the infant on May 6, 2016 after you observed signs and symptoms that may have indicated seizure activity. Your documentation states that you sought status updates from the infant's parents, consulted with colleagues, and were reassured of the patient's neurological status. Your documentation was inappropriate and was not in keeping with BCCNP documentation standards that states, in part, that documentation facilitates communication between team members, provides a comprehensive record of the care the nurse provides, and represents a comprehensive record of care provided to a client that demonstrates how a nurse has applied their nursing knowledge and their skills and judgment according to BCCNP's Standards of Practice. Further, you completed the "late entry" documentation in an effort to provide a justification for not escalating infant Patient #3's care when you initially observed what could have been seizure activity and to provide a justification for not charting contemporaneously on May 6, 2016.

e) on or about May 7, 2016, while caring for Patient #4 (S.H.) and her premature infant, you failed to support Patient #4 with her breastfeeding plan for her infant by criticising her parental choices regarding breast pumping as well as her effort by saying "most mothers want their children to go home" and "people who have done this for years are able to do this" or words to that effect. You did not wake Patient #4 for an 0530 feed and as a result her infant was bottle fed instead; and further, when you were asked for an explanation for your communication style you instead attributed the patient's complaints about your conduct to what you characterized as conflict regarding the breastfeeding plan for the infant.

f) on or about June 07, 2016, while caring for Patient #5 (B.R.) and her newborn male infant, you documented that the mother had refused the administration of erythromycin eye ointment however, you did not complete any of the required steps following an informed refusal which included the lnformed Refusal form and documentation in the narrative notes of this variance. Further, Patient #5, who is also a nurse, denied that she made an informed refusal of erythromycin for her infant, but rather, when she asked you if the drug was given, you told her "no" and that it was "too late" to give it as her infant son was already approximately three hours old;

g) on or about August 28, 2016, while caring for Patient #6 (A-J. B), who was admitted to hospital overdue after Cervidil induction and in the early period of the first stage of labour:

> **i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically you made infusion rate changes that were not based on Patient #6's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders; and**
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> ii. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding documentation when in your narrative charting you used judgemental statements, did not consistently use medical terminology, and failed to consistently use approved abbreviations and graphics on flow sheets;

h) on or about September 16,2016, you were caring for Patient #7 (A.L.) who had elevated blood pressure in pregnancy. The obstetrician ordered the administration of an infusion of Oxytocin for induction of labour. During the course of Patient #7's labour:

> **i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically, you made infusion rate changes that were not based on the appropriate parameters of Patient #7's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders; and**
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> ii. you did not initiate physician's orders for an epidural in a timely and patient centred manner;
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> iii. you did not follow the applicable BCCNP nursing standards and Fraser Health policy regarding documentation when in your narrative charting you

used judgemental statements, did not consistently use medical terminology, and failed to consistently use approved abbreviations and graphics on flow sheets;

iv. you did not follow Fraser Health Authority's policy and procedure regarding “baby pauses" consistently;

j) on or about October 27, 2016, you discharged Patient #9 (A.R.), a post partum patient, without a physician's order. When faced with your error, you deflected responsibility for the unauthorized patient discharge onto patient #8; and

It is alleged:

2. that you failed to comply with a standard imposed under the Act, that is BCCNP’s standards for the practice of nursing by registrants and standards of professional ethics for registrants, including

Standards 1, 2, 3, and for 4 of BCCNP's Professional Standards of Registered Nurses and Nurse Practitioners;

3. that you have not complied with the Act; and

4. that you have committed professional misconduct or unprofessional conduct.

D. THE RESPONDENT’S ADMISSIONS

17. The Court summarized the Respondent’s admissions regarding the Oxytocin Allegations in the Judgment Reasons as follows:

> [17] The petitioner made six separate admissions in relation to the allegations made by the College, certain of which addressed knowledge gaps relevant to allegations 1(a)(i), 1(g)(i), and 1(h)(i). The relevant admissions are as follows:
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> **Patient #6 – A-J.B.**
>
> **Administration of Oxytocin**
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> 179. Ms. Whieldon stated at the Hearing that she completed the Oxytocin Management Checklist and understood from that that she needed to have “Moderate Variability for 10 of the past 30 minutes” in order to increase it, which she did generally (except in two instances for A-J.B. at 15:00 and 16:40 which she admitted were in error). This is what the Oxytocin Management Checklist says. She also said that she now understands from the evidence given during the Hearing from different witnesses that prior to increasing Oxytocin there must also be 20-30 minutes of normal EFM immediately prior to the increase, despite this not being expressly stated on the Oxytocin Management Checklist or in the Oxytocin Protocol.
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> . . . .

> **Citation Allegation 1(a)(i), 1(g)(i), an 1(h)(i): Oxytocin administration and Management (Patients O.M., A-J.B. and A.L.); FHS interpretation for 1(a)(i)**
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> 275. Despite the foregoing, Ms. Whieldon concedes that her practice fell below the standard of care on April 28th, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

18. The Respondent's reconsideration submissions on her admissions were brief. The Panel asked the Respondent to provide two clarifications with respect to her admissions. The Respondent's clarifications are as follows:

1) <u>Does the Respondent agree with Justice Masuhara's summary of her admissions at paragraph 17 of his decision?</u>

No, as we outline here, Justice Masuhara's paragraph 17 is not entirely clear or accurate. He opens paragraph 17 by writing, "The petitioner made *six separate admissions* in relation to the allegations made by the College, certain of which addressed knowledge gaps relevant to allegations 1(a)(i), 1(g)(i), and 1(h)(i)." [italicized emphasis added]. It would have been accurate for him to have written that the petitioner <u>admitted to breaching a standard in relation to six of the allegations</u> made by the College. This is a distinction with a difference.

The six citation allegations that the Respondent admitted to having breached a standard in regards to were:

- 1(a)(i), 1(g)(i), and 1(h)(i), together the Oxytocin Allegations; and
- 1(a)(iv), 1(g)(ii), and 1(h)(iii), together the Documentation Standards Allegations.

The petitioner <u>acknowledged more than six specific errors</u> during the course of her testimony, but <u>her admissions related to the six Citation allegations</u> set out above (this is discussed more in answer to question 2 below).

As for the remainder of paragraph 17 of Justice Masuhara's decision, he excerpted part of paragraph 124 from <u>the Panel's September 11, 2019 Liability Decision</u>. At paragraph 124 of the Panel's Liability Decision, the Panel itself excerpted pieces of Ms. Whieldon's June 11th 2019 Closing Submissions (three subheadings, plus paragraphs 179 and 275). Paragraphs 179 and 275 touch upon parts of the Respondent's admissions; those two paragraphs do not detail all of the oxytocin admissions. Paragraph 179 deals with a specific admission regarding Citation allegation 1(g)(i), while para 275 contains broad admissions in a concluding, summary fashion for all three Oxytocin allegations.

In your e-mail below, paragraph 16 of the Respondent's November 16th, 2021 Reconsideration Submissions is cited. In her Reconsideration Submissions, just before that paragraph at paragraph 15, the applicable paragraphs of the Respondent's June 11, 2019 Closing Submissions that outlined the evidence,

admissions, explanations, and apologies that she made regarding the Oxytocin Allegations are cited for the Panel's reference and review. As those original submissions were drafted without counsel having the benefit of a copy of the transcripts, there are no citations to transcript evidence. Should the Panel wish for me to locate transcript cites to align with those submissions, I will need more time to do so – please advise. I note however that the Respondent's November 16th 2021 Reconsideration Submissions already have citations to some parts of the transcript evidence that relate to this at pages 23-26.

2) Can the Respondent clarify whether she considers that she is making partial admissions or complete admissions to the allegations set out at paragraphs 1(a)(i), 1(g)(i) and 1(h)(i) of the Citation?

Yes.

In relation to each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), Ms. King's report identified multiple sub-points at various times of the patient charts where she opined that the Respondent erred. For example, in relation to 1(a)(i), Ms. King's report identified six different sub-points at which she believed the Respondent to have erred. Those six sub-points within 1(a)(i) are identified at pages 10-12 of Ms. King's Expert Report, and at paragraph 32 of the Panel's Liability Decision. A full summary of the evidence in relation to those, including which points the Respondent admitted to and why, were summarized at paragraph 59 of the Respondent's June 11, 2019 Closing Submissions and track the same six sub-points.

Given that Ms. King raised six different sub-points under 1(a)(i), the College only needed to prove 1 of 6 sub-points for the Panel to find the Respondent breached a standard regarding Citation Allegation 1(a)(i). The Respondent admitted that she erred in relation to 2 of the 6 points for 1(a)(i) raised by Ms. King, and again, explained why she erred. The Respondent did not agree with and admit all of Ms. King's sub-points and gave her evidence in response to the areas where she disagreed with Ms. King's report and why; however, as she admitted to erring on at least one sub-point under each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), she also admitted the College had established a breach of [the Medication Administration Standards in relation to] Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i).

The Respondent's submission highlighted below in yellow therefore remains accurate. In specific response to the Panel's question #2 then, the Respondent admitted to some of the sub-points raised within each of the Oxytocin Allegations, but did not admit to all of the sub-points. In other words, she did not completely agree with the totality of the allegations made under each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), but agreed that she had erred under each – in particular ways at particular times – thereby establishing breaches of a standard for each Oxytocin Allegation. Notably, on a part of one of the sub-points under 1(a)(i) where the Respondent refuted Ms. King's conclusion, the Panel accepted Ms. Whieldon's evidence over Ms. King's (see paragraph 45 of the Liability Decision).

The reasons for *why* the breaches occurred – including what the Respondent was unaware of at particular moments in time – go to the heart of the matter, but we do

> not repeat them here as we do not believe that to be the thrust of the Panel's questions below, and because the reasons why were exhaustively detailed in the Respondent's June 11, 2019 Closing Submissions, in the concerns expressed in Justice Masuhara's decision, and in the Respondent's November 16 h, 2021 Reconsideration Submissions.
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> [emphasis in original]

19. The Respondent also states in her consideration submissions: "it is important that the Panel understand that the Registrant's appeal and this subsequent reconsideration is not an attempt to overturn the Oxytocin Allegations in their entirety, thereby clearing the Registrant of any wrongdoing in regard to the Oxytocin Allegations. The Registrant repeats that she admitted in the hearing and in her submissions that she erred in her administration of oxytocin in the Oxytocin Allegations in particular ways, at particular times. She maintains those admissions now – as a reasonable, professional and accountable nurse should do – and as such, the Panel does not need to be put to a detailed analysis of the evidence to find that the College has proven a breach of the Medication Administration Practice Standard in relation to each of the Oxytocin Allegations." It was, however, not open to the Panel to conduct a cursory review of some of the evidence, given that the Respondent opposes some of the particulars at issue, and the College argues there was a pattern of problematic conduct evident in the totality of the evidence.

E. APPLICABLE LAW

Burden of Proof

20. The College submits that it has the burden of proof and that the standard of proof in professional discipline matters is on a "balance of probabilities". The College relies upon *F.H. v. McDougall*, 2008 SCC 53 and notes that this has been relied upon by several past discipline committees (*Re Hansen* CRNBC 2018; *Re McLellan* CRNBC 2018; and *Re Tinkham* CRNBC 2017).

21. The Respondent argues that a "high standard of justice" is required in professional disciplinary cases; relying upon *Kane v. Board of Governors of University of British Columbia*, [1980] 1 SCR 1105 and *Ridge v. Baldwin*, [1962] 1 All E. R. 834 (C.A.).

The Respondent also agrees with the College's submission that *F.H. v. McDougall*, guide the Panel's findings.

22. The Panel finds that the College bears the burden of proof and must prove its case on a balance of probabilities. The leading authority is *F.H. v. McDougall* which made clear that there is only one standard in civil matters – on a balance of probabilities. In *F.H. v. McDougall*, the Supreme Court of Canada held that the "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test." This approach has been repeatedly adopted in professional disciplinary cases including by past panels of the College's Discipline Committee, and by other professional regulators across British Columbia and throughout Canada.

Credibility

23. The College submits that in assessing credibility, the Panel should be guided by the reasoning in *Bradshaw and Stenner*, 2010 BCSC 1398:

> [186] Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Faryna v. Chorny*, 1951 CanLII 252 (BC CA), [1952] 2 D.L.R. 354 (B.C.C.A.) [*Farnya*]; *R. v. S.(R.D.),* 1997 CanLII 324 (SCC), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).
>
> [187] It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed

> person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 1993 CanLII 7140 (AB KB), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.

24. The Panel agrees with this approach to the assessment of credibility.

Similar Fact Evidence

25. The College submits that while the Panel was ordered to reconsider its findings regarding the Oxytocin Allegations, the Panel can and should consider the charges of the Citation that the Panel found to have been proven – and that were not disturbed by the appeal –as evidence that the Respondent demonstrated a concerning pattern of behaviour in her nursing practice. The College submits that the Respondent consistently ignored facility policies, procedures, and protocols, and substituted her judgment for evidence based clinical practice; and was, at least on one occasion, untruthful about her conduct even when confronted with significant evidence up to and during the discipline hearing. The College submits that the Panel is not obliged to consider the evidence relevant to each individual allegation within a silo that is strictly separated from the evidence of the other charges on the Citation that were proved. The Panel may consider the facts of several allegations and how they all relate to the Respondent's pattern of behaviour where she did not follow hospital and regional protocols, specifically the administration of erythromycin to an infant, untruthful or inaccurate communication to parents in the post-partum period, and poor, incomplete, and inaccurate documentation practices.

26. The College also notes that the Panel is not bound by court rules of evidence. It may consider all relevant evidence. It relies on *Re: Hansen*:

> 78. The Panel is not bound by court rules of evidence. It may consider all relevant evidence. It has more latitude than a court, when deciding an allegation, to consider evidence relating to other allegations – evidence courts call "similar fact" evidence.
>
> 79. The Panel is aware it must be cautious when considering a body of several allegations together. The Panel should not find Ms. Hansen guilty of failing to meet standards in a specific situation only because she also faces other allegations of below-standards conduct. When different people assert different acts that have similar features, however, such as a failure to apply aseptic techniques, the fact of many allegations becomes relevant, due to the unlikelihood of different people making assertions of similar features except due to truth, unless of course the

> Panel has reason to believe the witnesses conspired with each other. The more similar the different acts asserted by witnesses, the greater their relevance to each other.

27. The Respondent submits that similar fact evidence is by default presumptively inadmissible and great caution must be used when applying it. She submits that the Panel must be careful to ensure the College has met its burden of proof regarding each individual allegation, some of which have various sub-components alleged by the College, not all of which are common to each Oxytocin patient. The Respondent also submits that given the specific admissions she made that her practice fell below the standard of care and constituted a breach of the Medication Administration Practice Standard in relation to the Oxytocin Allegations, there is no need for a similar fact evidence application in this case and it is submitted that to do so would be to err.

28. The Panel did not need to rely on similar fact evidence in this case, however it is permissible to do so in appropriate circumstances.

Adverse Inference

29. The College submits that an adverse inference may be drawn if, without sufficient explanation, a litigant fails to call a witness who might be expected to give supporting evidence. The College relies upon *Barker v. McQuahe* (1964), 1964 Canlii 755 (BCCA) and *Hodgins v Street*, 2009 BCSC 673. The College also cites *Wigmore on Evidence* (Chadbourn rev.1979) vol II at 192 which describes that the natural inference of failing to bring a witness or document before the Tribunal is that “the party fears to do so, and this fear is some evidence that the circumstance or document or witness, if brought, would have exposed facts unfavourable to the party.” The rationale for the principle is that the failure amounts to an implied admission that the evidence from the absent witness would be contrary to the litigant’s case.

30. The Respondent disputes where the College suggests adverse inferences ought to be drawn but does not dispute the Panel’s ability to draw such inferences in appropriate circumstances.

31. The Panel agrees when a party fails to provide relevant evidence without sufficient explanation, an adverse inference may be drawn. In such circumstances the Panel assumes that a party failed to provide relevant evidence because the missing evidence would not support their case.

HPA

32. Under section 39(1) of the HPA, on completion of a hearing, the Discipline Committee may dismiss the matter, or determine that the Respondent:

> 39(1)…
>
> (a) has not complied with this Act, a regulation or a bylaw,
>
> (b) has not complied with a standard, limit or condition imposed under this Act,
>
> (c) has committed professional misconduct or unprofessional conduct,
>
> (d) has incompetently practised the designated health profession, or
>
> (e) suffers from a physical or mental ailment, an emotional disturbance or an addiction to alcohol or drugs that impairs their ability to practise the designated health profession.

33. Section 16 of the HPA sets out the College's duties to at all times serve and protect the public and exercise its powers and discharge its responsibilities under all enactments in the public interest.

College's Bylaws and Standards of Practice

34. Section 19(8) of the HPA provides that registrants must not practice a designated health profession except in accordance with the bylaws of the College. Pursuant to section 19(1)(k) of the HPA, health profession colleges may enact professional standards through their bylaws.

35. Section 8.01 of the College's Bylaws at the material times required that registrants conduct themselves in accordance with the standards of practice and the standards of professional ethics. As such, a failure to comply with the standards of practice is contrary to the College's Bylaws.

36. The College has established both professional and practice standards. The Practice Standard for Medication Administration requires nurses to administer medication within their scope of practice, and provides, amongst other things:

Medication Administration

Principles

3. Nurses adhere to “seven rights” of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.

6. Nurses act upon pre-printed orders when the authorized health professional has made those orders client-specific by reviewing them, adding the client’s name, customizing them, signing, and dating them.

Applying the Principles

1. Read BCCNP’s Scope of Practice for Registered Nurses: Standards, Limits and Conditions to ensure you understand the standards, limits and conditions under which nurses administer medications.

37. The Professional Standards set out the expected and achievable level of performance against which actual performance can be compared. It is a minimum level of acceptable performance. There are four Professional Standards:

    a. Professional Standard 1, Professional Responsibility and Accountability

    b. Professional Standard 2, Knowledge-Based Practice

    c. Professional Standard 3, Client-Focused Provision of Service

    d. Professional Standard 4, Ethical Practice

38. These standards provide, amongst other things:

Standard 1: Professional Responsibility and Accountability

1. Is accountable and takes responsibility for own nursing actions and professional conduct.

Standard 2 Knowledge-Based Practice

2. Knows how and where to access information to support the provision of safe, competent and ethical client care.

3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.

5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.

9. Uses decision support tools appropriately to assess and make decisions about client status and plan care.

Unprofessional Conduct and Professional Misconduct

39. Section 26 of the HPA contains the following definitions:

> "professional misconduct" includes sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession;
>
> […]
>
> "unprofessional conduct" includes professional misconduct.

40. The term unprofessional conduct is defined in the HPA to include professional misconduct. Professional misconduct is defined to include others forms of misconduct. No other definitions are provided. Unprofessional conduct is broader than professional misconduct.

41. The College cites *Re McLellan* which described unprofessional conduct as that "which violates the ethical code or rules of a profession or such conduct which is unbecoming a member of the professional in good standing" (citing from *Millar v. College of Physicians and Surgeons of British Columbia*, 1994 Canlii 1010 (BCSC)).

42. The Respondent refers to *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 S.C.R. 869 which held that "a professional's conduct should be measured against the judgment of other members of the profession who are competent and in good standing", and that "[i]n this case, the Registrant's conduct should be measured against the judgment of a competent registered nurse."

43. The Panel agrees that *Pearlman* and *Re McLellan* assist in the interpretation and measure of unprofessional conduct. The Panel also recognizes that in assessing whether conduct is unprofessional, it may draw on its own judgment, experience, and expertise. It is guided by the standards of the profession and consider what is expected of a professional person in the circumstances. While nursing standards should be considered, those standards are not determinative. The standards of the profession do not need to be in writing. A minor or inadvertent failure to comply with professional standards will generally not constitute unprofessional conduct. Ultimately, it is for the disciplinary body of a professional organization - such as this

Panel - to decide on the appropriate standards for members of the profession and whether there has been a departure from those standards.

44. The Respondent relies upon *Strom v. Saskatchewan Registered Nurses' Association*, 2020 SKCA 112. The Respondent argues that the Saskatchewan Court of Appeal found that the disciplinary committee's analysis of contextual factors in its determination of whether the registrant's social media posts constituted professional misconduct failed to take adequate account of key factors and the committee made several errors in its analysis. The Respondent cites the Court of Appeal's comments that ""[g]rief can bring people low or cause them to rage. Those hearing of such comments would understand that context, reducing their potential impact on other nurses or the profession". The Respondent argues that the discipline committee in *Strom* failed to properly examine the tone, content and purpose of the posts overall when answering the question of whether they constituted professional misconduct. The Respondent also refers to the Court of Appeal's findings that the discipline committee "cherry picked the most critical portions of the posts", "harshly and simplistically summarized her statements", "made a passing comment about a mitigating factor (anger or grief) but gave it no weight", "erred in principle by failing to accord sufficient or any weight to important criteria that governed the exercise of their discretion", "performed a "one dimensional" analysis", and "did not reflect the complete contextual inquiry necessary".

45. The College notes that it is not seeking a determination of professional misconduct in relation to the Oxytocin Allegations. The College also submits that while the *Strom* decision refers to "context" it does so with respect to a completely different factual matrix. That case involved expectations of civility and professionalism with respect to a registrant's online communications in the context of *Charter* arguments. As such, it does little to assist this Panel in determining whether the Respondent's conduct amounts to a breach of the applicable nursing standards, constitutes unprofessional conduct and/or incompetence in a clinical setting. The College argues that little weight should be given to the Respondent's submissions in this regard.

46. The Panel recognizes the *Strom* decision and considers that the individual circumstances and context in each case are always relevant. The particular facts in *Strom* differ from this case for the reasons outlined by the College above. This case differed in the number, scope and severity of allegations.

Incompetence

47. As noted above, among the determinations available to the Panel in section 39(1) of the HPA are that a respondent committed unprofessional conduct, or that they incompetently practiced the designated profession.

48. Section 26 of the HPA does not have a definition for the term "incompetence". Both parties made submissions as to the meaning of incompetent practice.

49. The College cites *Mason v. Registered Nurses Association of British Columbia*, 1979 Canlii 419 (BCSC). The following quote from *Mason* refers to incompetence as a "want of ability suitable to the task" and was adopted by the legacy College's Discipline Committee in *Re Hansen*:

> … 'want of ability suitable to the task, either as regards natural qualities or experience, or deficiency of disposition to use one's abilities and experience properly. Incompetency connotes the converse of reliability. The term may include something more than physical and mental attributes; it may include want of qualification generally, such as habitual carelessness, disposition, and temperament'."…

50. The College notes that incompetence typically involves a pattern of incompetent behaviour rather than a single instance of negligence; see *Re Hansen* and *Reddy v. Association of Professional Engineers and Geoscientists of British Columbia*, 2000 BCSC 88.

51. The College also submits that a failure to respond to advice or constructive criticism is a factor to consider in the assessment of incompetent practice. In *Mason*, the Court stated:

> [26] From my study of the above authorities, I have concluded that for the purposes of this statute the word "incompetent" falls within the definition set out in *Crotwell v. Cowan,* supra. Thus, while a nurse may be fully qualified and able, if her conduct demonstrates a pattern of carelessness and she is of a disposition or

> temperament whereby she fails to respond to advice as to her shortcomings, she may be found guilty of incompetence.
>
> [27] Without dwelling on the question of disposition or temperament, it seems to me that the failure to respond to advice or constructive criticism is a major factor for consideration, for several reasons. Firstly, if the evidence indicates that a nurse is not disposed to accept criticism or to respond to advice, the disciplinary tribunal may take such a matter into account in determining the issue of incompetence. Secondly, as a matter of procedural fairness it seems to me that, as a general rule, if a nurse is to be cited for incompetence the record should show that she was made aware of any alleged acts of incompetence within a reasonable time of their occurence. Otherwise she may reach the conclusion that the alleged acts of incompetence were not considered by her superiors to be matters of consequence. I point out, moreover, that if a nurse is made aware of alleged acts of incompetence at the date of the alleged commission of acts of incompetence she will be better able to deny, explain or defend her conduct. In this case, as already held by me, Mrs. Kearney did discuss Mrs. Mason's shortcomings with her, and Mrs. Mason failed to respond to the advice given to her by Mrs. Kearney. I point out, however, that as a matter of administrative procedure it would be better if a summary of such discussions were recorded in writing.

52. The College submits that *Mason* has been widely adopted in professional disciplinary decisions such as *Reddy*, *Goldberg v. Law Society of British Columbia*, 2009 BCCA 147, and *Re Hansen*. The Respondent also cites *Mason* and submits that a nurse may be found guilty of incompetence if she fails to respond to advice as to her shortcomings, and that the failure to respond to constructive criticism is a major factor for consideration.

53. The Panel agrees with the parties that *Mason* is a leading and applicable authority. The definition that "Incompetence ....connotes want of ability suitable to the task, either as regards natural qualities or experience, or deficiency of disposition to use one's abilities and experience properly" has been repeatedly cited by numerous professional regulatory bodies in this province. The Panel notes, however, that the definition of incompetence from *Mason* which was adopted by the British Columbia Court of Appeal in *Goldberg* only referred to a "want of ability" and not to a failure to respond to advice or constructive criticism (see paragraph 39 quoting and accepting the definition found in paragraph 15 of the original Benchers decision). The Panel considers that the failure to respond to advice or constructive criticism is a relevant

factor in the assessment of incompetence, but it is not determinative. The absence of same does not preclude a finding of incompetence.

F. EVIDENCE

The Respondent's Time on the Perinatal Unit and Leaves of Absences

54. The Respondent practiced as a registered nurse from 1992 until January 4, 2017. Prior to that, she worked as a Licensed Practical Nurse. She received her 25-year pin from Fraser Health. The Respondent predominantly worked in the Perinatal Unit at Langley Memorial Hospital ("LMH").

55. The Respondent had some absences from the Perinatal Unit during that period. The Respondent was absent from the Perinatal Unit when she worked in IV Therapy from November 2011 to August 2013 (the "2011 to 2013 Leave"). The Respondent testified that she switched areas to have a position which afforded her more time to support her son who underwent surgery on July 30, 2013. The Respondent testified that she did not receive any orientation shift on her return to the Perinatal Unit in 2013. She described that time as being a time of flux and chaos, with renovations and changing managers.

56. The Respondent testified that from late October 2015 to early April 2016 she also took a leave of absence following an assault on her son (the "2015 to 2016 Leave"). She testified that this was a very difficult time.

57. The Respondent testified that she went on stress leave in November 2016 (the "November 2016" Leave).

The Protocols at LMH

58. Demaris Grunert, a Clinical Nurse Educator ("CNE") at LMH, testified about the protocols in the Perinatal Unit at LMH. Nurse Grunert testified that protocols are used to standardize patient care.

59. Nurse Grunert testified that there are numerous protocols in perinatal nursing. Both Nurse Grunert and Shalynn Smith, another CNE at LMH who also testified at the hearing, confirmed that the administration and management of Oxytocin is a protocol at LMH (the "Oxytocin Protocol").

60. Nurse Grunert, Nurse Smith, and the Respondent testified that nurses are meant to follow protocols. The College also called Angela King, a registered nurse, as an expert witness. Nurse Grunert and Ms. King testified that nurses cannot choose whether to follow the protocols. Nurse Grunert and Nurse Smith testified that if a nurse considers that there is a reason to depart from a protocol for a particular patient, the nurse must speak with the patient's physician. Protocols may be customized by a patient's most responsible physician ("MRP"). Nurse Grunert testified that registered nurses cannot customize the Oxytocin Protocol.

61. Nurse Smith testified that the expectation was that nurses would align their practice with protocols and that nurses have a positive obligation to remain up to date on all current protocols and procedures to deliver evidence-based care to patients.

62. The Respondent agreed that when faced with a clinical situation where, in the nurse's view, continuation with a protocol may not be safe for her patient, the nurse must contact the MRP or midwife. The Respondent noted that if the nurse is at a patient's bedside, they often liaise with the charge nurse.

63. Nurse Grunert and Nurse Smith testified that new policies and procedures at LMH were rolled out with education for unit nurses. Changes to policies and procedures were communicated at staff meetings, through emails to staff, and through updates at shift changes. The education involved PowerPoint presentations or one to one teaching with the CNEs, depending on the nature of the change. The length of the rollout depended upon the significance of the change. The CNEs would also make themselves available to answer questions about the new protocol during working hours.

64. Nurse Grunert and Nurse Smith testified that all policies, procedures and protocols were available at the material times on the Fraser Health intranet platform which is referred to as "Maternity Central". Maternity Central is accessed by clicking on the Fraser Health home page which contains links to all the protocols, procedures, and clinical skills. Nurse Grunert testified that if a nurse cannot locate a protocol on Maternity Central, the nurse may go to an educator or a patient care coordinator ("PCC") for assistance.

65. The Respondent acknowledged on cross-examination that in addition to rollouts given at monthly staff meetings, changes to policies and protocols were also distributed by email to all staff at LMH. The Respondent conceded that throughout her time at LMH, if she was having trouble with her clinical skills or if she was unsure of where to locate policies and procedures, she could speak with the CNE and the charge nurse for assistance.

66. Nurse Grunert testified that the Oxytocin Protocol went through a significant change in 2012. The protocol was regionalized across eight different hospitals. This change introduced the Pre-Oxytocin Checklist and the Oxytocin Management Checklist. Nurse Grunert testified that there is a standardized order set contained in the Oxytocin Protocol. Nurse Grunert testified that these checklists standardized the initiation, administration and management of Oxytocin. Previously, dose adjustments had been left up to the nurse at LMH:

> It really made it a lot clearer on what we were supposed to do because before that it was kind of left up to the nurse. At Langley anyways, it was left up to the nurse on [sic] if she wanted to go up one or down one. Here it [the Oxytocin Protocol] tells you when to decrease the oxytocin, which causes the contractions, and by how much.

67. Nurse Grunert testified that the 2012 Oxytocin Protocol changes were rolled out in PowerPoint presentations at in-services that were conducted in small groups and with individuals.

68. Nurse Grunert testified that the Oxytocin Protocol was also revised in 2015. This involved relatively minor changes. The definition of tachysystole was changed, and some other small modifications were made.

69. Nurse Grunert and Nurse Smith testified that the MRP is responsible for ordering the Oxytocin and the registered nurse is responsible for the administration and management of Oxytocin according to the Oxytocin Protocol. The Oxytocin Protocol requires the nurse to complete the Pre-Oxytocin Checklist prior to initiating Oxytocin. The Pre-Oxytocin Checklist requires 20 minutes of electronic fetal monitoring tracing that is classified as normal before initiating Oxytocin. Once Oxytocin has been initiated, the nurse must complete the Oxytocin Management Checklist every 30

minutes. If the nurse documents an “X”, the reverse side of the Oxytocin Management Checklist provides the nurse with instructions on what to do.

Orientation and Training

70. Dacia Howard-Jovanovic, the Manager of Clinical Operations in the maternal infant, child and youth program at LMH, also testified as a witness in the Discipline Hearing. She began that role in approximately mid-January 2016. Ms. Howard-Jovanovic testified that she is physically located on the Perinatal Unit and staff know that they can reach her on her cell phone or by email for matters which are not time sensitive. The clinical day to day oversight is handled by the PCC. The Unit is made up of 14 single room maternity beds, a nursery, and a triage area. While nurses are often assigned to specific care areas on a given shift, the changing nature and needs of the Perinatal Unit requires fluidity and flexibility in staffing planning. Ms. Howard-Jovanovic testified that prior to her arrival the Unit had gone from eight nurses to seven nurses. When asked whether the Unit was “chronically short staffed”, she responded that there were quite a few maternity leaves, however, they were all filled and when Ms. Howard-Jovanovic arrived there were no vacant lines.

71. Ms. Howard-Jovanovic testified that the Respondent attended regular staff meetings on the Unit, and specifically recalled that the Respondent was in attendance when she was on leave from work.

72. Ms. Howard-Jovanovic testified that she met with the Respondent on April 20, 2016, prior to the Respondent’s return to work. Ms. Howard-Jovanovic had reached out to the Respondent to invite her to have a conversation about what her needs would be on her return. The purpose of that meeting was to gain insights into any supports that the Respondent may require on her return to work. Ms. Howard-Jovanovic testified that the Respondent said that she did not require any additional supports at that time because she was attending the staff meetings and was aware of any updates that had occurred in her absence. Ms. Howard-Jovanovic testified that no re-orientation was arranged for the Respondent because the Respondent did not feel as though she needed it. Ms. Howard-Jovanovic also testified that it would be contrary to her practice to assign the Respondent to only a certain area upon her

return as that would constitute informal accommodation. Ms. Howard-Jovanovic testified that if someone requires accommodation, they must have documentation to support that request and the request is processed through workplace health. She provided examples of what those supports may look like if someone were to make a formal accommodation request upon their return.

73. When asked on cross-examination whether she knew that this was a traumatic period for the Respondent, Ms. Howard-Jovanovic responded that she did not know that it was traumatic as she was not provided with any medical documentation to support that label.

74. Ms. Howard-Jovanovic did not recall during the April 20, 2016 meeting that the Respondent had requested the breaks in the collective agreement (she did recall such conversations taking place later). She did not recall “at all” that the Respondent requested orientation shifts during the April 20, 2016 meeting such that the Respondent would be placed in postpartum care for the first four shifts of her return.

75. Ms. Howard-Jovanovic explained that if an individual were to work only in one segment of their competency, that would constitute an accommodation. Had the Respondent requested an accommodation, the preferred route would be to have the Respondent do orientation shifts with supernumerary status.

76. Ms. Howard-Jovanovic testified that it is inaccurate to describe postpartum care as an area with a lighter workload. In labour, there is a one patient to one nurse ratio; whereas in postpartum care, there is a one nurse to four patient ratio (or rather, one nurse to eight patients if one counts the babies and if no babies are in the nursery).

77. On cross-examination, Ms. Howard-Jovanovic agreed that the Respondent was told she would be given orientation sessions later, following formal meetings which addressed gaps in the Respondent’s practice. Ms. Howard-Jovanovic agreed on cross-examination that the Respondent was not given those two orientation shifts.

Practice Concerns

78. Ms. Howard-Jovanovic testified that practice concerns arose with the Respondent shortly after her return in April 2016. This was initially addressed via an informal

meeting. Thereafter, Ms. Howard-Jovanovic noticed more significant gaps and held a formal meeting on May 30, 2016. A June 7, 2016 letter of expectation was placed on the Respondent's file. A learning plan was to be developed in partnership with the CNE and the Respondent. The nurse educator at that time was Tanya Jantzen. The Respondent did not complete this learning plan because Nurse Jantzen left to take another position, and some of the learning plan's components were never signed off.

79. Ms. Howard-Jovanovic agreed on cross-examination that the June 7, 2016 letter of expectation to the Respondent also included certain coursework which was promised but not scheduled or provided. Eight orientation shifts in nursery were also referenced in the letter (four shifts at a higher level of care site and four shifts at LMH) but not delivered. Ms. Howard-Jovanovic explained this was not provided because the clinical leadership felt that the Respondent was struggling in postpartum and labour care and adding additional layers in nursery and higher acuity care would not be in the Respondent's interest.

80. Ms. Howard-Jovanovic testified that further concerns arose leading to a second formal meeting. Through that process, the Respondent agreed to have a third party, Sara Kaufmann, conduct chart audits. Nurse Kaufmann is the Clinical Nurse Specialist for the Maternal, Infant, Child and Youth Program. Nurse Kaufmann was chosen because the Respondent had filed a complaint against Ms. Howard-Jovanovic for bullying and harassment. Ms. Howard-Jovanovic testified about the outcome of the audit report.

81. Ms. Howard-Jovanovic testified that the Respondent took a medical leave of absence at the end of October 2016. Following the Respondent's return in November 2016, further issues arose. Ms. Howard-Jovanovic testified that due to the pattern of behaviour, a meeting was held in November 2016 to address, amongst other things, additional concerns that had come up around Oxytocin management. A two-day suspension was imposed, and Ms. Howard-Jovanovic asked that two of the educators create a learning plan before the Respondent practiced independently on the Unit.

82. Ms. Howard-Jovanovic noted it was of significant concern that all the events were discussed with the Respondent, but that she did not acknowledge any professional responsibility or accountability for the care she provided or insight as to what steps she may need to take in order to improve her practice.

83. Ms. Howard-Jovanovic testified that the learning plan was originally scheduled for five days in which two educators would support the Respondent. Within the first two days both educators voiced concerns that this would be an insufficient amount of time and the learning plan was extended to seven days.

84. Nurse Grunert testified that on receiving feedback the Respondent would express many rationales for why she had done certain things and Nurse Grunert questioned the extent to which the Respondent was consistently implementing the feedback. Nurse Grunert testified that the Respondent's learning needs were not being met as she struggled with documentation, communication, and following certain clinical skills and procedures.

85. Nurse Smith testified that the Respondent's engagement was inconsistent.

86. Ms. Howard-Jovanovic testified that she asked the two educators at the end of the plan whether the Respondent's practice was safe and was told "no". It was decided that additional days would not be of benefit and the decision was made to remove the Respondent from her rotation with pay.

87. Towards the middle of March 2017, the Respondent attended a CAEN assessment (competency assessment and enhancement for nursing) at Kwantlen Polytechnical Institute. Ms. Howard-Jovanovic testified that the Respondent was not successful in the CAEN assessment and scored lower than an entry level perinatal nurse. The results indicated that while she scored high marks in theory, she was not successful and in order to meet entry level practice for an RN in British Columbia, the Respondent required further education in clinical practice. Specific gaps were identified in professional responsibility, maternal newborn nursing knowledge and pharmacology.

The Respondent's Testimony

88. The Respondent testified that following her return from the 2011 to 2013 Leave, she did not receive any orientation shifts on the Perinatal Unit. The Respondent testified about the re-orientation that she undertook to refamiliarize herself with the changes that occurred during her absence.

89. The Respondent testified that during her 2015 to 2016 Leave, she attended some staff meetings. She said that while those meetings were an opportunity to connect with her peers, they were professional meetings.

90. On cross-examination, the Respondent acknowledged that rollout of new protocols and policies on the Unit could occur at staff meetings. The Respondent described "rollout" of protocols at staff meetings as, "when we got these binders, Tanya put it on the table and said: Here's these policies, you need to start following these as of tomorrow."

91. The Respondent testified that Tanya Janzen, a CNE, had printed off the following Fraser Health policies and protocols for the Respondent and put them in a pink binder for the Respondent to review at home: acute care standards antepartum, acute care standards triage, acute care standards intrapartum, acute care standards postpartum, the acute care standards related to neonatal level 1A, 1B. The Respondent testified that she reviewed and highlighted the documents. In addition, the Respondent confirmed the contents of her September 22, 2016 letter to Ms. Howard-Jovanovic in which the Respondent advised Ms. Howard-Jovanovic that she completed her review of those and other documents since returning to work on April 27, 2016.

92. The Respondent testified that she met with Ms. Howard-Jovanovic and a patient care coordinator (PCC) on April 20, 2016, following a staff meeting. The Respondent testified that her understanding of the meeting was that the purpose was to discuss the changes that had occurred during her absence. She testified that did not occur. The Respondent said that it was a short meeting during which Ms. Howard-Jovanovic provided her overall philosophy and described how she managed the Unit and asked the Respondent whether she had any concerns about returning to work.

The Respondent testified that she told Ms. Howard-Jovanovic that she did and that she wanted to be given breaks in accordance with her collective agreement. She described her concerns based upon past experience where breaks were combined. The Respondent testified that Ms. Howard-Jovanovic responded that they would of course follow the collective agreement and she told the PCC to ensure this was done.

93. The Respondent testified that she asked for a re-orientation shift because she had been away for quite a time and she “heard that there was [sic] numerous changes.” The Respondent stated that there were several different computer systems that were implemented at the time.

94. The Respondent testified that Ms. Howard-Jovanovic told her that an orientation was not necessary as the Respondent had been on the Unit for 19 years. The Respondent testified that it was agreed she would be placed on the postpartum unit for her first four shifts back as that was slower, and it would allow her time to reacquaint herself.

95. The Respondent testified that her first shifts back to work were not scheduled in accordance with that agreement. Rather, the first shift back was scheduled in postpartum, the second shift was scheduled in labour, the third was scheduled in postpartum and the fourth shift was scheduled in labour. The Respondent testified that the labour and delivery shifts are very intensive. She testified that there is no time to access a computer or look at a binder.

96. The Respondent testified that she was “shocked” with her first days back to work. She testified that the staff were “distressed”, and that the Unit was “completely short-staffed”. She described being shuffled between five different care areas. The Respondent said there was no opportunity to “network” or speak with other staff. The Respondent testified that she was placed with a high-risk labouring patient. The Respondent testified that she spoke with the charge nurse and told her she was supposed to be on a “working orientation”. The charge nurse replied that she was not familiar with that term and did not know that the Respondent had been on leave.

97. On cross-examination, the Respondent testified that:

    a. in order to practice safely for nearly two decades of nursing, nurses need to adapt their practice to changes;

    b. RNs are obliged to keep current;

    c. The current policies were available to the nursing staff to access by the black binder and if nurses needed something in a patient room and could not access it (which the Respondent testified occurred to her), they could access the charge nurse. The charge nurse could access the computer and print it off and provide the pages to the nurse in the patient room. This was a strategy that the Respondent utilized at LMH;

    d. Every single maternity room also had a red binder containing the fetal heart surveillance documents and clinical decision support tools:

> Q I'd like to just ask some questions about the red binder if that's okay.
>
> In every single maternity room where women labor and give birth to their babies hopefully they're not going to the OR, there's a red resource binder in the room?
>
> A Correct.
>
> Q In addition to the fetal health surveillance tab, there's two other tabs with the clinical decision support tools? Do I have that right?
>
> A Correct.
>
> Q So even though there's not a computer in every single maternity room, there is a resource binder in the maternity room, correct?
>
> A Correct.
>
> Q This is the red binder, right? It looks like this and there's one in every room?
>
> A Right.

    e. RNs are responsible for their own continued education and learning throughout their nursing careers; and

    f. RNs are responsible for their own professional practice.

98. The Respondent testified that Nurse Smith began her role as CNE in August 2016. The Respondent requested that Nurse Smith conduct a chart audit looking at

Oxytocin. The audit was given out on August 22, 2016 and the Respondent received feedback on November 25, 2016.

99. The Respondent testified about her stress leave in November 2016.

100. The Respondent testified about her experience with the learning plan with Nurse Grunert and Nurse Smith. She described finding it challenging as she felt they were looking for perfection. The Respondent provided an example of disagreeing with the CNEs use of the terms “not met” or “in progress” in circumstances where some but not all the Respondent’s documentation was correct. The Respondent also disagreed with the use of those terms on days where certain items were not discussed. The Respondent thought that in those circumstances, the entry should have been recorded as “not applicable”.

101. The Respondent testified about her concerns with vacant shifts, distress, and chaos. She filed professional responsibility forms (PRFs), patient safety learning system reports (PSLSs) and grievances raising her concerns.

Expert Evidence

Angela King, R.N.

102. The College called Ms. King, a registered nurse, who was qualified as an expert in perinatal nursing, inclusive of the nursing roles of triage, labour and delivery, including the interpretation of fetal health monitoring strips, as well as post partum nursing. Ms. King is licensed to practice in Ontario, where she has worked in obstetrical nursing since 1993.

103. Ms. King delivered an expert report and gave oral testimony at the hearing. Her evidence was that Oxytocin is a synthetic hormone commonly used to induce or augment labour by causing the uterus to contract. It is administered intravenously. The dose of medication is controlled by a pump which is programmed by the nurse according to the hospital policy and physicians’ orders.

104. When using Oxytocin, the pregnant patient and her fetus are monitored by an external electronic fetal monitor. The nurse monitors the woman’s vital signs, fetal heart rate, quality of uterine contractions, and presence of vaginal bleeding or

leaking of fluid, and presence and control of pain in accordance with the standard of care and hospital policy. There is an increased risk of uterine rupture with the use of Oxytocin.

105. Ms. King testified that a nurse must have a clear tracing of both the fetal heart rate and uterine contraction to appropriately interpret the tracing as normal, atypical, or abnormal to determine the management of Oxytocin.

106. Ms. King testified that there are two methods for assessing the fetal heart rate in labour: intermittent auscultation and external fetal monitoring. External fetal monitoring is the continuous assessment of the fetal heart rate and uterine contractions. In terms of equipment, there is a monitor placed on a bedside table (or similar) and two transducers are applied to the pregnant patient's abdomen. One records the contractions and the other records the fetal heartbeat. The electronic monitoring provides a continuous tracing.

107. Ms. King testified that the continuous tracing is assessed, interpreted and documented by the nurse on the labour flow sheet. Ms. King testified that nurses are taught how to classify fetal heart strips as part of their training. On observation of repetitive (3) uncomplicated decelerations, complicated variable decelerations or late decelerations, intrauterine resuscitation is required. Intrauterine resuscitation involves the following steps: changing the pregnant patient's position, decreasing or turning off Oxytocin if it is infusing, giving IV fluid bolus, putting oxygen on the pregnant patient and calling the physician.

108. Ms. King gave evidence that perinatal nurses must have 20 to 30 minutes of clear fetal heart rate tracing in order to ensure fetal and maternal wellbeing prior to initiating or adjusting Oxytocin.

109. Ms. King testified that throughout the entire period of Oxytocin administration, the fetus is monitored with electronic fetal heart monitor ("EFM"). The EFM may be disconnected to allow the patient to use the washroom or to walk briefly once the contraction pattern and fetal heart tracing are reassuring and no changes are being made to the infusion. The EFM must be reconnected and assessed for a period of

20 to 30 minutes before adjusting the Oxytocin. Prior to increasing the Oxytocin infusion all criteria on the Oxytocin Management Checklist must be met.

Dr. Elaine Mah

110. The Respondent called Dr. Elaine Mah who works at LMH. Dr. Mah was qualified as an expert in obstetrics and gynecology. She was not qualified as an expert in fetal health surveillance.

111. Dr. Mah provided evidence that there are some subjective overtones to the interpretation of fetal heart rate monitoring which involve the physician and the patient and may be informed by the stage of labour or the desired outcome (ex. vaginal birth versus a caesarian section).

112. Dr. Mah agreed with the first nine pages of Ms. King's expert report.

113. Dr. Mah did not provide an opinion on the fetal heart rate tracing of any of the patients involved in this hearing.

114. Dr. Mah did not provide an opinion on the fetal heart rate tracing of any of the patients involved in this hearing.

115. On cross-examination, Dr. Mah agreed that she would expect a nurse to follow the interventions listed in the Oxytocin Protocol.

116. Dr. Mah gave evidence that her expectation of perinatal nurses administering and managing Oxytocin for her labouring patients includes:

    a. The Pre-Oxytocin checklist must be completed by the attending nurse before Oxytocin can be started;

    b. The nurse would repeat the non-stress test prior to starting Oxytocin if there had been several hours between the non-stress test and the time when the Oxytocin could be initiated to ensure fetal wellbeing;

    c. The nurse will decrease the Oxytocin infusion by half if faced with excessive uterine activity that did not resolve after 10 minutes;

    d. The nurse will turn off an Oxytocin infusion if they observe an abnormal heart rate pattern on the EFM;

e. The nurse will notify the MRP or midwife who is in charge of patient if they observe an abnormal fetal heart rate;

f. Perinatal nurses are specially trained to assess labouring mothers and their fetuses; and

g. Perinatal nurses are relied on to monitor and assess maternal signs, fetal signs, and to act as “eyes and ears” for physicians who are not in the room all the time.

G. ANALYSIS

Allegation 1(a)(i)

> 1. The purpose of the hearing is to inquire into your conduct regarding a number of incidents that occurred from April 2016 to January 2017 while you were employed as a perinatal nurse at the Langley Memorial Hospital. These incidents include the following:
>
> a) on or about April 28, 2016, while caring for Patient #1 (O.M.):
>
> > i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically you made infusion rate changes that were not based on Patient #1's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders;

117. The Panel finds the evidence of Nurse Grunert, Nurse Smith, Ms. King and Dr. Mah to be clear, convincing and cogent. Based upon their evidence outlined above, the Panel finds that the administration and management of Oxytocin is done through the Oxytocin Protocol at LMH. Nurses are required to comply with the standardized care set out in the Oxytocin Protocol, the Pre-Oxytocin Checklist, and the Oxytocin Management Checklist and can not customize the protocol.

118. The Panel finds that their evidence also establishes that the Oxytocin Management Checklist provides that the following steps should be taken to manage an atypical fetal heart rate pattern:

i. Initiate intrauterine resuscitation

ii. Decrease Oxytocin dose until fetal heart pattern becomes normal (initially decrease by half).

iii. Change maternal position to left or right lateral, or all fours

iv. If indicated, give IV bolus of normal saline from mainline

v. If indicated, perform vaginal examination

vi. Conduct baby pause

vii. Support pregnant patient and coach to modify her breathing or pushing techniques

viii. Notify physician/midwife when Oxytocin has been decreased

119. Further, the College's expert, Ms. King, also gave evidence that:

a. On April 28, 2016, the Respondent increased the Oxytocin infusion rate at 10:00 am when the fetal heart rate tracing was not interpretable due to loss of contact from 9:53 am to 10:06 am. With the inability to appropriately assess the fetal heart rate and uterine contractions, it was below the standard of care to increase Oxytocin at 10:00 am. She would have been expected to adjust the position of the patient and adjust the fetal heart monitor transducers on the patient's abdomen to ensure an accurate tracing of the fetal heart rate and uterine contractions before increasing the rate of Oxytocin infusion.

b. At 10:45 am, the Respondent increased the Oxytocin infusion rate. There were three consecutive uncomplicated variables. As a result, the tracing should have been interpreted as atypical. The Respondent failed to interpret the tracing as atypical and failed to follow the Oxytocin Management Checklist interventions for management of an atypical heart rate pattern, which fell below the standard of care.

c. At 11:30 am, the Respondent increased the rate of Oxytocin infusion. With consecutive uncomplicated variables the fetal heart rate tracing should have been interpreted as atypical. Rather than decreasing the infusion rate, the Respondent increased the infusion rate. The Respondent failed to interpret the fetal heart rate tracing as atypical, failed to follow the Oxytocin Management Checklist interventions for management of an atypical heart

rate pattern, and failed to notify the physician, which fell below the standard of care.

d. From 11:30 am to 12:15 pm, the Respondent maintained the Oxytocin infusion rate. With repetitive uncomplicated variables and two complicated variables, the fetal heart rate should have been interpreted as atypical. The Respondent did change the patient's position however she did not decrease the Oxytocin infusion rate or notify the physician of the fetal heart rate tracing. Not interpreting the fetal heart rate tracing appropriately and failing to respond to an atypical fetal heart rate tracing fell below the standard of care and did not follow the Oxytocin Management Checklist.

e. At 2:00 pm, the Respondent increased the Oxytocin infusion rate. With repetitive uncomplicated variables, the fetal heart rate tracing should have been interpreted as atypical. Rather than decreasing the Oxytocin infusion rate and following interventions listed on the Oxytocin Management Checklist, the Respondent increased the Oxytocin infusion rate. Not interpreting the fetal heart rate tracing appropriately and failing to respond to an atypical fetal heart rate tracing fell below the standard of care and did not follow the Oxytocin Management Checklist.

f. At 4:30 pm, the Respondent interpreted the fetal heart rate tracing as atypical but documented it as normal. She increased the infusion rate at 5:30 pm. Increasing the Oxytocin infusion rate with the recognition of an atypical fetal heart rate tracing fell below the standard of care and did not follow the Oxytocin Management Checklist or physician orders for Oxytocin to be increased.

120. Ms. King was asked on cross-examination whether accelerations could cause the appearance of a rise in baseline when the baby is active. She agreed that it could but that the baseline would not remain elevated for long. Rather, the steady increase in baseline indicates something is going on. When asked whether a rise in sugar could do the same thing, Ms. King responded, "not to [her] knowledge". Ms. King testified that baseline is determined over the span of 10 minutes and contractions

are not counted. Nurse Smith was asked the same question about juice and answered that there is no “current evidence to suggest that either ice water or sweet solutions can alter the tracing,” though it may be attempted in practice.

121. Dr. Mah agreed with the first nine pages of Ms. King’s expert report. Dr. Mah did not provide an opinion on the fetal heart rate tracing of any of the patients involved in the hearing, including O.M. Dr. Mah testified that when a baby is very active, its baseline usually becomes elevated. Dr. Mah’s elaboration on that point was more nuanced. She explained: “when a baby is very active there actually could be elevations of the baseline. But not all the time. So that's what I mean, it could cause elevation of the baseline but not always.” Dr. Mah was not asked whether juice (or sugar) could cause the appearance of a rise in a baby’s baseline. On cross-examination, Dr. Mah agreed that she would expect a nurse to follow the interventions listed in the Oxytocin Protocol.

122. The Respondent testified that:

    a. The Respondent’s first day back to the Unit after the 2015 to 2016 Leave was April 27, 2016. She testified that she received inadequate orientation on her return, and that the Unit was chronically short staffed.

    b. The Respondent testified about O.M’s labour and delivery, including that she moved the mother’s positioning for there to be a vaginal delivery. She testified about her interpretation of the fetal heart monitoring strip and the patient’s clinical status. The Respondent testified that the baby has mild IUGR, about the positive group B strep status of the patient, the rupture of membranes and the pressure to move the delivery along efficiently.

    c. While there was a loss of contact of the fetal heart rate monitoring at 10:00 am, she said she could still hear the heart rate in the room, she could see and feel the patient’s contraction pattern with her hand, and she observed a good baseline with good variability and accelerations and an active baby. She was moving the patient. The Respondent admitted that there was a loss of contact of the heart rate tracing, but she felt she had all the information she required to increase the Oxytocin.

d. With respect to the increase of Oxytocin at 10:45 am, she had only seen two uncomplicated variables, not three, and she was moving the patient from side-to-side. The third uncomplicated variable appeared at 10:45 am, simultaneously with the infusion increase. After that, she recognized it as atypical by 11:00 am and decreased the Oxytocin. The Respondent also testified that most of the 30 minutes of the partogram was normal which is why she classified it as normal. She testified “Now the piece that comes into play here is confusion [sic]. It's the majority of the time and when you classify and what you classify.” On cross-examination, the Respondent testified, “Because the way that we had been ruled out [sic] to us to interpret was the majority of the time in that 30 minutes. And that's not my impression of the interpretation now. It's [sic] one incident of atypical occurs, it doesn't matter if that lasts 6 minutes or 9 minutes, you put the whole block as atypical. So that's new knowledge that I have now.”

e. The Respondent admitted that she did not decrease the Oxytocin by half. She testified that she was not aware of the requirement to decrease Oxytocin by half at this time. The Respondent testified that she was “not aware of the brackets” and that the requirement “had not been brought to [her] attention”. The Respondent testified that the requirement to decrease Oxytocin by half was brought to her attention by her union steward in June 2016.

f. With respect to the increase of Oxytocin at 11:30 am, the Respondent testified that the baseline had not changed, and both the mother and baby were active; there was good variability and accelerations. The Respondent had given the mother juice to clear up her ketones.

g. With respect to maintaining the Oxytocin infusion rate between 11:30 am to 12:15 pm, the Respondent testified that the baby was active, and her interpretation was that it was normal. She admitted that upon review, from 11:50 am to 12:00 pm, three uncomplicated variables were present, and she should have classified this part of the tracing as atypical. She also

testified that from 12:30 pm to 1:00 pm, Kayda Kurtz, a registered nurse, was in the room and they reviewed the tracing strip together and agreed that it was normal. The Respondent was then on break at 1:00 pm.

h. With respect to the Oxytocin increase at 2 pm, the Respondent testified that this is questionable in terms of interpretation as it is arguable whether there were early decelerations with good variability followed by a normal baseline. The Respondent testified that she decreased the Oxytocin at 1:30 pm as she had discussed this with Dr. Fariba Mohtashami at 1:20 pm. The Respondent acknowledged that her documentation of that conversation could have been clearer.

i. The Respondent testified on direct examination that one of her reasons for decreasing Oxytocin was to give herself additional time to insert a Foley catheter:

> So what we're believing happened, we don't know ever until after the outcome, if there's some cord involvement, it's around the neck, it's pinched between the head and that or it's around the hand or leg. But there's cord involvement here. And the head is not well placed and I need to continually use mother's positioning to get this baby moved if I want to have a vaginal delivery.
>
> And so then if you go back to my documentation, so that would be page 55, one page before. You can see at 1300 I have the oxytocin at 20. Then at 1330 I have decreased it to 15.
>
> So my interpretation from -- is that we're to use from the doctor's order and oxytocin management sheet, that we're to use the minimum oxytocin possible to get the desired rate.
>
> As well I am continually taking care of this patient and managing them for these uncomplicated variable decels with almost every contraction. And especially if I'm putting the patient on the side where I need her to be on, to move this baby.
>
> So I'm decreasing the oxytocin because of two reasons. In the protocol it says that the patients retain the fluid with the hydro oxytocin at 20 milliunits. And there's much greater risk of postpartum hemorrhage with these high doses.
>
> So based on the two areas in that oxytocin policy I'm wanting to use the minimum dose and the doctor's order is to use the minimum dose.
>
> I'm decreasing the oxytocin at this time since we've hit 20 milliunits. And also I need to put in the Foley catheter. And so I want some time, I want myself to get these extra 30 seconds of time dealing the

> contractions while I'm doing this procedure, which is sterile procedure that I need to set up to put in this Foley catheter.
>
> And by getting the catheter in, it's going to drain the bladder and allow the head to be better applied to the cervix. So this is why I've decreased the oxytocin.

j. The Respondent testified that at 2:40 pm, Dr. Mohtashami documented the tracing as normal and indicated that the patient should continue Oxytocin.

k. With respect to the Oxytocin increase at 5:30 pm, the Respondent testified that Dr. Mohtashami was in the room and gave a verbal order to increase the Oxytocin despite the atypical tracing. She referred to the entries in the patient record in support of this evidence. The Respondent testified that she opposed the increase. She stated that she was relieved for her break and left the room and Nurse Kurtz followed Dr. Mohtashami's verbal order.

123. The Respondent submitted that her subjective interpretation at bedside should not be wholly discarded. The Respondent submitted that for all three patients where Oxytocin administration is concerned (including relating to this allegation), there is no evidence of physician concerns, that the patients were unsafe or that the babies were not delivered in a healthy and successful manner.

124. In relation to O.M., the Respondent submitted that her decision to change the Oxytocin infusion rates was based on the patient's clinical presentation and on her accurate interpretation of the fetal heart rate tracing, except for a couple of instances where she admitted that she should have interpreted the tracing differently. She said that her decisions were based upon what was in the patient's best interests.

125. Further, as noted above, the Respondent made the following admissions in relation to this allegation:

> **Citation Allegation 1(a)(i), 1(g)(i), an 1(h)(i): Oxytocin administration and Management (Patients O.M., A-J.B. and A.L.); FHS interpretation for 1(a)(i)**
>
> 275. Despite the foregoing, Ms. Whieldon concedes that her practice fell below the standard of care on April 28 h, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

126. As also outlined above, the Respondent admits that she did not completely agree with the totality of the allegations made under each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), but agreed that she had erred under each – in particular ways at particular times – thereby establishing breaches of a standard for each Oxytocin Allegation. With respect to allegation 1(a)(i), the Respondent admits that she erred in relation to 2 of the 6 points in Ms. King's evidence. The Respondent admits that the College has established a breach of the Medication Administration Standards in relation to Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i).

127. The Panel accepts Ms. King's expert evidence. The Panel finds that Ms. King's expert evidence outlined above was consistent, detailed, thorough, systematic, cogent, clear, and unshaken on cross-examination. The Panel accepts Ms. King's expert evidence. Dr. Mah agreed with the first nine pages of Ms. King's report. Dr. Mah did not provide expert evidence with respect to any of the fetal heart rate monitor tracing at issue.

128. The Panel finds that the Respondent's testimony lacked credibility. The Respondent's tracing interpretations were, for the most part, not inherently believable. The tracings are clearer than the Respondent suggested in her testimony. There is insufficient evidence that juice or sugar caused an elevation of this patient's baseline at the material times. The Respondent's testimony was inconsistent with the expert testimony of Ms. King. The Panel found Ms. King's evidence to be more reasonable and more likely. With one exception described below, where the evidence of Ms. King and the Respondent depart, the Panel prefers and accepts the evidence of Ms. King.

129. With respect to the infusion rates at 10:00 am, 10:45 am, 11:30 am, 11:30 am to 12:15 pm, and 2:00 pm, the Panel prefers the evidence of Ms. King over that of the Respondent.

130. With respect to 10:00 am, the Panel finds that the Respondent was unable to appropriately assess the fetal heart rate and uterine contractions when she increased the Oxytocin infusion rate.

131. With respect to 10:45 am, 11:30 am, 11:30 am to 12:15 pm, and 2:00 pm, the Panel finds the Respondent failed to interpret the fetal heart rate tracings correctly, failed to follow the Oxytocin Management Checklist interventions, and failed to notify the physician where the heart rates were atypical.

132. The Panel finds that the Respondent slowed the rate of infusion of Oxytocin in order to slow the patient's contraction period to give the Respondent additional time to place the Foley catheter. This is not a relevant parameter of the Oxytocin Management Checklist. The Respondent made infusion rate changes that were not based upon the Oxytocin Protocol.

133. The Panel accepts the Respondent's evidence with respect to Dr. Mohtashami's verbal order at 5:30 pm to increase the Oxytocin infusion rate and finds that the Respondent's evidence is consistent with entries in the clinical records. Ms. King did not review those clinical records. Accordingly, the Panel prefers the Respondent's evidence to that of Ms. King on this point.

134. The Panel does not accept the Respondent's argument about the absence of evidence of physician concerns, that the patients were unsafe or that the babies were not delivered in a healthy and successful manner. Health authority protocols and College standards exist in order to protect the public from potential harm. The absence of any evidence that actual harm materialized is irrelevant to the issues before the Panel. Moreover, there is no way for this Panel to know whether any harm did or did not materialize, whether it was recognized or whether it was reported.

135. Based upon the totality of the evidence in front of it, the Panel finds that the evidence establishes on a balance of probabilities that while the Respondent was employed as a perinatal nurse at LMH, on or about April 28, 2016, while caring for Patient O.M., the Respondent did not follow the applicable College nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. The Panel finds that the evidence also establishes on a balance of probabilities that the Respondent made infusion rate changes that were not based on the patient's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the

Oxytocin management checklist, or physician's orders. Accordingly, the College has proved this allegation on a balance of probabilities.

Standards Imposed under the Act

136. As noted above, the Respondent admits that the College has established a breach of the Medication Administration Standard in relation to allegation 1(a)(i) of the Citation. In her reconsideration submissions, the Respondent acknowledges:

> The breaches to which the Registrant readily admitted responsibility in relation to the Oxytocin Allegations—namely, her breaches of the Medication Administration Practice Standard resulting from her inadvertent breaches of the Oxytocin Protocol at material times—were based on admitted mistakes and insufficient knowledge, which the Registrant regretted and was prepared to improve and adapt.

137. The Respondent acknowledges a breach of the College's Medication Administration Standard amounts to a breach of the College's Professional Standards:

> The Registrant again submits that, if the Panel properly weighs the evidence in accordance with Justice Masuhara's directions and the SKCA's sage guidance in Strom, supra, the Panel cannot properly find that there was a breach of professional standards in relation to the Oxytocin Allegations (beyond the breaches of the Medication Administration Practice Standard admitted by the Registrant in the course of these proceedings). Nor can the Panel determine that the Registrant engaged in professional misconduct or incompetence relating to the Oxytocin Allegations.
>
> [emphasis added]

138. The Panel agrees and finds that the Respondent's proven conduct also breached the following College Standards:

> **Professional Standards for Registered Nurses and Nurse Practitioners**
>
> **Standard 1: Professional Responsibility and Accountability**
>
> 1. Is accountable and takes responsibility for own nursing actions and professional conduct.
>
> **Standard 2 Knowledge-Based Practice**
>
> 2. Knows how and where to access information to support the provision of safe, competent and ethical client care.
>
> 3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.
>
> 5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.

> 9. Uses decision support tools appropriately to assess and make decisions about client status and plan care.
>
> **Medication Administration**
>
> **Principles**
>
> 3. Nurses adhere to “seven rights” of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.
>
> 6. Nurses act upon pre-printed orders when the authorized health professional has made those orders client-specific by reviewing them, adding the client’s name, customizing them, signing, and dating them.
>
> **Applying the Principles**
>
> 1. Read BCCNP’s Scope of Practice for Registered Nurses: Standards, Limits and Conditions to ensure you understand the standards, limits and conditions under which nurses administer medications.

139. As these standards were established by the College’s board pursuant to Bylaw 8.01, which was enacted pursuant to section 19(1)(k) of the HPA, the Panel finds that the Respondent has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Incompetence

140. The Respondent submits that her conduct does not rise to professional misconduct or incompetence. The College is not seeking a determination for professional misconduct in relation to the Oxytocin Allegations, but it seeks a determination of incompetence.

141. The College argues that a determination of incompetence is appropriate for several reasons.

142. The College submits that the Respondent did not just make an occasional mistake with Oxytocin. There was a pattern of incompetent practice.

143. The College argues that the “context” the Respondent suggests exists is largely not supported by the evidence (short staffing claims, “chaos” claims, lack of training claims, employer fault for lack of training etc.).

144. The College argues that the Respondent had ample resources and opportunities open to her. The fact that the Respondent appeared not to take advantage of any of

the opportunities open to her (asking clinical nurse educators questions, asking a physician or senior colleague, contacting the pharmacy, reviewing policies and procedures online or the paper copies provided to her by Ms. Jantzen), cannot be said to have “fallen through the cracks” but rather is indicative of her view that she was not responsible for her own nursing competence or currency.

145. The College also argues that the Respondent demonstrated that she was either unable or unwilling to accept feedback regarding her nursing practice despite several attempts to remediate her practice during work meetings and up to and including two learning plans with the CNEs.

146. The College further submits that during her testimony at the Discipline Hearing, the Respondent often displayed a passive attitude regarding adherence to the Oxytocin Protocol whereby she waited to be told she was not adhering to protocols and policies and from then onwards, she would try to do better. As the College submits, there was evidence from the CNEs that the Respondent often did not accept feedback or improve after it was provided.

147. The College further notes that the Respondent did not complete the learning plans or successfully complete the CAEN assessment.

148. The Respondent submits that her conduct does not rise to professional misconduct or incompetence. The Respondent argues that a determination of incompetence is not appropriate in this case for several reasons.

149. The Respondent submits that Nurse Hill described her as a dedicated, smart, knowledgeable and well experienced nurse; Nurse Kurtz testified she never witnessed the Respondent doing something she considered to be unsafe; and some of the witnesses liked the Respondent.

150. The Respondent argues that many nurses have gaps or areas for improvement.

151. The Respondent argues that she did not fail to provide care for her patients but made errors due to knowledge gaps at a stressful time in her life.

152. The Respondent says that she demonstrated a consistent concern with her practice and care, and the Conduct Decision made a finding that the Respondent is an experienced nurse who cares for her patients.

153. The Respondent further argues that a determination of incompetence is not appropriate because LMH did not discharge its responsibility under the College's Professional Standards to provide essential support systems, including human and material resources, which allow nurses to meet the Professional Standards. In that regard, the Respondent says LMH:

    a. failed to re-orient the Respondent after the 2011 to 2013 Leave;

    b. failed to train the Respondent on the 2012 Oxytocin Protocol despite her absence;

    c. scheduled the Respondent in the nursery without her having been on the nursery in years;

    d. understaffed the hospital on material dates;

    e. provided insufficient access to written policies and policy updates;

    f. had a lack of computer training and gaps of CNEs on the Unit;

    g. provided inconsistent feedback to the Respondent;

    h. failed to adequately consider the Respondent's safety concerns;

    i. showed a lack of support for the Respondent's learning plan; and

    j. failed to support the Respondent in the lead up to her CAEN assessment.

154. The Respondent submits that the evidence demonstrates that the Respondent did all she could to keep up to date on changing protocols and was responsive to any concerns raised about her nursing practice.

155. The Respondent denies that she exhibited a passive approach to the nursing process and that she would continue to backslide to unsafe practices after receiving feedback. The Respondent argues instead that:

a. she expressly requested a need for re-orientation and the hospital did not schedule it for her (even after it was agreed on June 7, 2016 in an e-mail from her manager that she would get two reorientation shifts);

b. she expressed various reservations in 2016 about her return which were not addressed in her schedule;

c. the June learning plan went well; she completed all the course work she was instructed to take and updated her manager on her progress, but her manager did not schedule her for the remaining education;

d. once she was made aware of the requirement to decrease Oxytocin by half there is no evidence she made any further such administration errors;

e. she volunteered for an Oxytocin chart audit with Nurse Smith in late August 2016 to get additional feedback on another Oxytocin chart and was not provided feedback until late November 25, 2016;

f. she was provided with only an oral summary of the chart audit findings of Nurse Kaufman and was not given copies of the charts to see, a written summary of the findings, or a chance to meet;

g. she was unfairly scored on her December learning plan (i.e., “not met” or “in progress” instead of “not applicable”); and

h. she was subsequently found to have met the requirements relating to Oxytocin administration on the one Oxytocin assignment provided to her during the December Learning Plan, and requested more Oxytocin days, but did not receive any.

156. The College submits that the Respondent did not just make an occasional mistake with Oxytocin. She had ample resources and opportunities open to her. The “context” the Respondent argues exists is largely not supported by the evidence (short staffing claims, “chaos” claims, lack of training claims, employer fault for lack of training etc.). The fact that the Respondent appeared not to take advantage of any of the opportunities open to her (asking clinical nurse educators questions, asking a physician or senior colleague, contacting the pharmacy, reviewing policies

and procedures online or the paper copies provided to her by Ms. Jantzen), cannot be said to have “fallen through the cracks” but rather is indicative of her view that she was not responsible for her own nursing competence or currency.

157. The College submits that the Respondent demonstrated that she was either unable or unwilling to accept feedback regarding her nursing practice despite several attempts to remediate her practice during work meetings and up to and including two learning plans with the CNEs. The College also submits that in her testimony at the hearing, the Respondent often displayed a passive attitude regarding adherence to the Oxytocin Protocol whereby she waited to be told she was not adhering to protocols and policies and from then onwards, she would try to do better. As the College submits, there was evidence from the CNEs that the Respondent often did not accept feedback or improve after it was provided. The Respondent did not complete the learning plans or successfully complete the CAEN assessment.

158. The Panel has determined that the Respondent has incompetently practised the profession contrary to section 39(1)(d) of the HPA. The Panel finds that the Respondent displayed a want of ability suitable to the administration of Oxytocin. The Respondent repeatedly failed to adhere to the Oxytocin Protocol. As noted above, the Panel has found that the Respondent increased the Oxytocin infusion rate when the fetal heart rate tracing was not interpretable due to loss of contact, she inappropriately assessed the fetal heart rate and uterine contractions, multiple times she failed to interpret tracing as atypical and inappropriately increased the Oxytocin infusion rate when she should have decreased the Oxytocin infusion rate, she maintained the patient's Oxytocin rate when it should have been decreased, she decreased Oxytocin to give herself additional time to insert a Foley catheter, and she failed to notify the physician where the heart rates were atypical. While the Respondent is an experienced and qualified nurse, her conduct demonstrates a concerning pattern of incompetent practice. The proper administration of medication in accordance with the Oxytocin Protocol is extremely important to ensure the safety of a pregnant patient and their baby. The Respondent’s conduct did not involve inadvertence, an isolated incident or a lapse in judgment. The Respondent displayed this pattern of incompetent practice with respect to multiple instances of proven

conduct involving Patient O.M. within this allegation. There also exists a broader pattern of incompetent practice within the Oxytocin Allegations.

159. The Panel agrees with the College that many of the Respondent's assertions were not established in the evidence. With respect to the training on the 2012 Oxytocin Protocol changes, just as the College has not established that the Respondent participated in the rollout meetings or received the rollout updates, the Respondent has not established that she did not receive those updates or participate in those meetings. There was an absence of specific evidence on that point. This will be discussed in further detail below as relates to the 2011 to 2013 Leave.

160. With respect to computer training, the Panel does not find that there was any material lack of training for the Respondent. The Panel finds that the witnesses' evidence establishes that the computer systems were straightforward. The Respondent acknowledged her responsibility to adapt her practice to changes, including to computer systems. The Panel finds that members of staff at LMH assisted the Respondent by demonstrating how certain aspects of the computer systems functioned, and by printing off materials which were on the intranet but not available at home.

161. Similarly, the Respondent asserts that there was chaos and chronic understaffing on the Perinatal Unit, however the Panel finds the evidence does not establish this to have been the case. The Panel found Ms. Howard-Jovanovic offered more specific and compelling testimony that the Respondent's testimony on this point. She acknowledged that there were quite a few maternity leaves, however, she testified that those were all filled and that when Ms. Howard-Jovanovic arrived there were no vacant lines on the Unit. The Panel considers that Ms. Howard-Jovanovic would have more intimate familiarity with any staffing issues and the Panel preferred her evidence.

162. The Panel is not satisfied that there was sufficient evidence in support of the Respondent's assertion that LMH did not take her safety concerns seriously. She knew the processes to engage and filed multiple complaints and reports which appear to have been processed in the ordinary course.

163. The Panel also finds that there is inadequate evidence of a lack of support for the Respondent's learning plan and lack of support in the lead up to the Respondent's CAEN assessment. While the Respondent disagrees with how those were administered and how she was evaluated, the Panel finds that two separate learning plans supported by three Clinical Nurse Educators, an audit of the Registrant's practice by an arms-length clinician, and the funding of a perinatal CAEN assessment to assess her safety to practice. The CAEN assessment is typically used to assess entry to practice competence.

164. The Panel agrees with the Respondent that additional orientation and supports were promised but not provided to her. However, the Respondent minimizes the many learning opportunities and supports that were extended to her, and the resources that were readily available to her on a daily basis.

165. Many of the Respondent's arguments about deficient and inconsistent feedback are in essence that the Respondent did not receive feedback in the form that she preferred, not that no feedback was delivered to her at all. Nurse Smith's feedback was late, Nurse Kauffman's feedback was delivered orally rather than in writing, and the CNEs feedback used the wrong terms. The Panel is not persuaded by these arguments. The Panel does not consider, for example, there to be a significant difference between the terms "not met" or "in progress" contained in the learning plan as opposed to "not applicable".

166. Moreover, as will be discussed in more detail below, the Panel agrees that LMH did not re-orient the Respondent upon her return in 2013; however, the Respondent undertook her own re-orientation by reviewing the material changes that occurred during her 2011 to 2013 Leave. In addition, the Respondent had numerous resources available to her that included seeking support from her colleagues, the CNEs on the Unit, and her manager, as well as utilizing written and computer resources available on the Unit and in the individual patient rooms. The Panel finds that the Respondent deflects and minimizes her conduct by attributing her deficits to a knowledge gap.

167. Similarly, the Panel does not accept the Respondent's arguments about scheduling deficiencies. As will be detailed below, the Respondent did not request an orientation prior to her return in April 2016 and she did not indicate that she needed any orientation or supports at that time. It was therefore neither necessary nor appropriate to refrain from scheduling her in the nursery.

168. The Panel finds the Respondent's arguments that she was well liked and that other nurses have gaps to be irrelevant to a determination of incompetence. Other nurses' conduct is not before this Panel. The fact that Nurse Hill found the Respondent to be dedicated, smart and experienced does not preclude a determination of incompetence with respect to the proven conduct.

169. While it is not necessary to establish incompetence, the Panel finds that the Respondent failed to respond to feedback regarding her practice. The Panel finds that while the Respondent did take some positive steps to enhance her learning (for example, by re-orienting herself, reviewing the binders to update herself on changes during her absence, completing coursework on Oxytocin Protocol, and volunteering for an Oxytocin chart audit), she was inconsistent with her engagement and also displayed issues with accepting and implementing feedback with respect to the learning plan.

170. The Panel accepts Nurse Grunert's evidence that "It was hard giving feedback at times because a lot of the time when you gave feedback she would have a lot of rationale of why things were the way they were." The Panel finds that there were instances in which Respondent was indicated to have followed the Oxytocin Protocol, at the same time, there were instances in which she did not. For example, it was noted that the Respondent did not follow the baby pause which incorporates a review of the EFM and Oxytocin dosage at handoff.

171. Further, the Panel does not accept the Respondent's arguments that she sometimes met the Oxytocin Protocol requirements. The Panel finds that the Respondent's adherence to the Oxytocin Protocol and engagement with feedback was inconsistent and partial. The partial adherence that took place does not excuse the serious non-compliance that occurred.

172. Moreover, the Respondent's understanding of the Oxytocin Protocol continues to raise concerns given, for example, her view that the Oxytocin Management Checklist does not contain an express requirement for a minimum of 20 to 30 minutes of normal EFM tracing before increasing Oxytocin, which will be discussed in greater detail below.

173. The Panel also observed the inconsistency in the Respondent's improvement or slipping back noted by the CNEs during the Respondent's testimony during the Discipline Hearing. The cross-examination questioning on the decrease by half requirement demonstrates this issue. The Respondent started the exchange by stating that she did not know about the requirement until it was brought to her attention by her union steward. The Respondent then ended that portion of the questioning by asking counsel for the College about where the Oxytocin Protocol contains the requirement to decrease by half: "Where does it say on here to decrease it by half?". This undermines the Respondent's argument that once she was made aware of the decrease by half requirement, she improved in relation to that parameter of the Oxytocin Protocol.

174. Below, the Panel further elaborates on the issues raised in the Judgment Reasons.

The Respondent's 2011 to 2013 Leave

175. As noted above, the Court found that the Panel failed to consider the petitioner's absence from 2011 to 2013.

176. In the Conduct Decision, the Panel found that the Respondent's leave of absence from the Perinatal Unit did not excuse her conduct:

> 199. The Panel accepts Ms. Whieldon's submission that her re-orientation following a 5-month absence due to a traumatic family event could have been improved. Ms. Whieldon requested additional orientation, and was promised certain supports which were not provided. Having said that, as discussed above, the Panel does not find this to be a defence in the circumstances. The changes made to the Oxytocin Protocol were released several years before Ms. Whieldon took her leave of absence, those changes were rolled out to staff, and the key documents were readily available to her in hard copies and electronically. Moreover, Ms. Whieldon did participate in numerous learning opportunities offered through LMH in respect of Oxytocin.

177. The Panel focussed on the 2015 to 2016 Leave instead of the 2011 to 2013 Leave in the Conduct Decision for several reasons. First, it was this leave (and return) and not the 2011 to 2013 Leave which was most emphasized in the evidence during the proceedings and the parties' submissions to the Panel. Second, the Citation related to conduct that occurred from April 2016 to January 2017. The 2015 to 2016 Leave was the most closely connected in time to the conduct at issue before the Panel. Third, the Respondent had returned to the Perinatal Unit from her 2011 to 2013 Leave and had been practising as a nurse on that Unit for several years before her 2015 to 2016 Leave, her subsequent return, and the events that are alleged in the Citation.

178. Nevertheless, the Panel elaborated upon its reasoning regarding the Respondent's time away from the Unit in general and expressly referenced the 2011 to 2013 Leave in the Penalty Decision given the further emphasis that the Respondent placed on the 2011 to 2013 Leave in her penalty and costs submissions. The Panel's reasoning in the Penalty Decision accepted that the Respondent was indeed absent from the Perinatal Unit while she was practising in IV Therapy from 2011 to 2013 but held that this did not excuse her conduct:

> 35. The Panel agrees with the College's submission that the Respondent continues to deflect and minimize her conduct by attributing her deficits to a knowledge gap. As the Panel found in its Verdict Decision, the changes made to the Oxytocin Protocol were released several years before the Respondent took her leave of absence, those changes were rolled out to staff, and the key documents were readily available to her in hard copies and electronically. Moreover, the Respondent did participate in numerous learning opportunities offered through LMH in respect of oxytocin. The Respondent argues that the Oxytocin Protocol changes were made while she was practicing in IV therapy. The Panel does not accept this explanation for her conduct. As the Panel found in the Verdict Decision, the key documents (the Oxytocin Pre-Printed Order Set and Oxytocin Management Checklist) were readily available to the Respondent during the relevant period when she was practicing as a neonatal nurse.
>
> [emphasis added]

179. Accordingly, the Respondent's submission to the Court, which the Court reproduced (but did not accept or reject) at paragraph 67 of the Judgment Reasons, "that the Panel either found or inferred that the petitioner was not on leave during this time and that she had received this training, even though her leave is firmly established

by the evidence" is neither what the Panel held nor inferred. The Panel accepted that the Respondent was absent during that period but was not persuaded by the Respondent's argument in relation to the significance of that leave to the allegations in this case given the totality of the evidence.

180. The Panel takes the opportunity on reconsideration to further explain why the Respondent's 2011 to 2013 Leave does not change the Panel's determination.

181. The Respondent argues that she was not present when the changes occurred to the Oxytocin Protocol in 2012 and she was not trained on the 2012 changes to the Oxytocin Protocol. The Respondent submits that she "was not working in the Perinatal Unit at that time, there is no evidence that she received any updates or participated in any meetings about the changes to the Oxytocin Protocol that occurred while she was working in IV Therapy." The Respondent submits that although some general evidence was tendered at the Discipline Hearing from witnesses that there were updates from the manager and educators at the staff meetings, and sometimes discussions of new equipment or policies, the College did not call specific evidence that any of the protocols at issue in the Citation were discussed during staff meetings the Respondent attended while she was on leave.

182. The Panel largely agrees with this submission. The Panel finds that significant changes were made to the Oxytocin Protocol in 2012 and minor changes were made to the protocol in 2015. The Panel finds that the Respondent was absent from the Perinatal Unit when she worked in IV Therapy from November 2011 to August 2013. The Panel finds that the Respondent was not working in the Perinatal Unit when the 2012 changes were made to the Oxytocin Protocol. The Panel finds that there were no material changes to the Oxytocin Protocol in relation to the allegations at issue that were made while the Respondent worked in the Perinatal Unit from 2013 to 2015, or during the Respondent's 2015 to 2016 Leave.

183. The Panel also accepts the evidence of Nurse Grunert and Nurse Smith as to the rollout of the 2012 Oxytocin Protocol that took place on the Unit. The Panel finds Nurse Grunert and Nurse Smith to be credible witnesses. They were clear and consistent. Nurse Grunert's evidence was fair and nuanced. Nurse Smith readily

acknowledged if she could not recollect something. The Panel finds that the Oxytocin Protocol rollout took place on the Perinatal Unit in the manners described by Nurse Grunert and Nurse Smith.

184. The Panel agrees, however, with the Respondent's submission that there is no evidence that the Respondent herself received any of those updates or participated in any of the meetings about the changes to the Oxytocin Protocol that occurred while she was working in IV Therapy.

185. The Panel also accepts the Respondent's evidence that she did not receive any orientation shifts on her immediate return to the Perinatal Unit in 2013. Her testimony on that point was not challenged on cross-examination.

186. The Panel further finds, however, that on her return in 2013, the Respondent worked in the nursery during her initial shifts and took active steps to re-orient herself with the changes that took place during her absence. The Respondent testified:

> Q You mentioned that you took a leave from the perinatal unit in 2011 to 2013 and returned in August 2013 to the perinatal unit at Langley Memorial. When you returned, do you recall receiving any orientation shifts at that time?
>
> A I did not receive any orientation shift coming back. It was quite a time of influx and chaos, and especially with the renovations and the changing managers. So my first few shifts back I worked in the nursery and tried as best as I could to orientate myself to anything that had changed.
>
> One of the benefits of working in the nursery is at times when you're between feeds of an infant, then you could access the computer and try to update yourself.
>
> As well, we had that black binder. And everything that was changed was put in the black binder. And what you would do is you initial. So you would initial when you had read a change of policy, everything was there. So you would know since the last time I was here, here's my last initial. And you can literally start forward.
>
> And then as you read everything and made sure that you were updated on what was the changes, you could see it right there in this black binder, which you could take into the patient care room for -- available for you.

187. The Respondent also testified on cross-examination that it is a nurse's obligation to keep current with changes and adapt their practice in accordance with those changes. The Respondent volunteered that, in that regard, there was a black binder containing the current policies which was accessible to her:

> Q Would you agree with me that in order to practice safely for over two decades of a nursing career that nurses need to adapt their practice to those changes?
>
> A Absolutely.
>
> Q In fact, it's part of an RN's obligation to keep current, correct?
>
> A Correct. And the current policies were there available for us to access by that black binder.

188. Accordingly, in consulting the computer and the black binder in 2013 to re-orient herself with the changes that occurred during her absence, the Respondent accessed the 2012 Oxytocin Protocol changes. Thus, while the Respondent did not receive training in the changes to the Oxytocin Protocol, she undertook her own re-orientation to review the changes that occurred during her absence which included the 2012 Oxytocin Protocol changes, as she admitted was her professional obligation to do.

189. Further, the Panel finds that the rollout of the Oxytocin Protocol to staff on the Perinatal Unit is also relevant because the new protocol had been implemented on the Perinatal Unit and was in place during the years that the Respondent did work on the Unit from 2013 to 2015, which were prior to the conduct alleged in the Citation.

190. Accordingly, by the time of the conduct in the Oxytocin Allegations, the Respondent had been working with the Oxytocin Protocol – which included the 2012 changes that occurred during her absence – for several years. The black binder was kept on the Perinatal Unit, the red binders were in every maternity room, the relevant documents were available on the intranet (Maternity Central), the Oxytocin Management Checklists were completed for the patients in paper form and kept in every maternity room, and the charge nurse was available to answer questions or print off documents for the Respondent.

191. While the Respondent argues that at one point the black binder “went missing”, that she was not clear how to access the protocols on the intranet, and that the intranet was not available at home, there was no evidence that the binder was missing during any of the material times or that she experienced issues accessing the protocols on the intranet in relation to any of the allegations in this case. Even if that were the case, the overwhelming evidence is that the relevant Oxytocin Protocol documents

were accessible to the Respondent in some form (if not, in many forms) at all material times.

The Respondent's 2015 to 2016 Leave

192. The Respondent also argues that no training or re-orientation occurred for her after her 2015 to 2016 Leave.

193. In this regard, the Panel prefers the evidence of Ms. Howard-Jovanovic over that of the Respondent with respect to whether the Respondent requested orientation at the April 20, 2016 meeting.

194. The Panel accepts Ms. Howard-Jovanovic's evidence that the Respondent had been attending many of the team meetings during her 2015 to 2016 Leave and the Respondent did not request any re-orientation for her April 2016 return. The Panel accepts Ms. Howard-Jovanovic's evidence that no re-orientation was arranged for the Respondent because the Respondent did not feel as though she needed it. This evidence is consistent with the general chronology of events and the documentary record.

195. The Panel notes in particular the late March 2016 emails between the Respondent and Ms. Howard-Jovanovic leading up to their April 20, 2016 meeting. Ms. Howard-Jovanovic's email to the Respondent summarizing their March 23, 2016 meeting shows that the Respondent was not requesting orientation at that time but, to the contrary, voicing an interest in becoming a charge nurse on her return – a role with more, not less, responsibilities. Ms. Howard-Jovanovic's response was to encourage the Respondent to focus instead on her return to the team at that time.

196. As already noted, the relevant Oxytocin Protocol documents were accessible to the Respondent in some form (if not, in many forms) at all material times on return.

197. The Panel also finds that the Respondent was kept apprised of Unit matters during this time through other channels. The Respondent attended some staff meetings during her 2015 to 2016 Leave.

198. In addition, the CNE, Nurse Janzen, printed off the following Fraser Health policies and protocols for the Respondent and put them in a pink binder for the Respondent

to review at home: acute care standards antepartum, acute care standards triage, acute care standards intrapartum, acute care standards postpartum, the acute care standards related to neonatal level 1A, 1B.

The Respondent's November 2016 Leave

199. The Respondent argues that instead of reasonably inquiring with the Respondent to ensure that she was okay and recovering from the trauma that led to her three leaves, and providing her with supports, training, and re-orientation, the health authority investigated her for raising safety issues through the respectful workplace complaint process. Following her stress leave in November 2016, the health authority immediately issued her a disciplinary letter and suspended her for two days.

200. The Panel's findings with respect to the Respondent's arguments about an absence of supports, training and re-orientation following her November 2016 Leave are the same as with respect to her two previous leaves set out above. The Respondent had already re-oriented herself with respect to the Oxytocin Protocol by this time and the relevant Oxytocin Protocol documents were accessible to the Respondent in some form (if not, in many forms) at all material times on return. Thus, while the Panel accepts that the Respondent's circumstances during the first two leaves were very difficult and in November 2016, the Respondent's leave was due to stress, the Panel does not find that this explains or excuses the proven conduct.

201. The Panel finds that the letter dated December 9, 2016 (following the November 29, 2016 meeting) which issued the two-day suspension fairly identified several serious practice concerns, one of which was the administration of Oxytocin on September 16, 2016.

202. In that letter Ms. Howard-Jovanovic explained the supports that had been extended to the Respondent, confirmed the training and education that the Respondent had undertaken, and identified that the Respondent had not provided any information to demonstrate that she is unable to perform in the role of an RN on the Unit:

> Shannon, I am very concerned that in each of these patient care scenarios, the validity of your clinical documentation and decision making is in question. While we have been working to support your practice, specifically documentation, and you have previously indicated you completed the CRNBC documentation module and other relevant educational sessions, there continues to be inaccuracies in the documentation and patient charts.
>
> Of significant concern is that in all of the events that were discussed, you have not acknowledged any professional responsibility or accountability for the care you provided, or insight on what steps you may need to take in order to improve your practice. When asked in our meeting to reflect on your practice and consider what you would do going forward, you responded "*I guess what you are saying is that I cannot trust my patients*". The provision of safe and appropriate patient care is your responsibility, not the patient's, and it is concerning that you would draw this inference.
>
> In light of the above, and given you have not provided any information to demonstrate you are unable to perform in the role of RN on this unit, you are being issued a two day suspension. The suspension will be served on December 17th and 18th, 2016 for your pre-booked 1930-0730 night shifts. Please be advised that further incidents of misconduct will result in discipline up to and including termination of employment.

Is there an express requirement for 20 to 30 minutes of EFM tracing prior to increasing Oxytocin?

203. Part of the Respondent's argument regarding her leaves of absences is that her absence meant she was neither aware of nor trained in what she terms the "Invisible Requirement". The Respondent submits that there exists an "Invisible Requirement" in the Oxytocin Management Checklist requiring a minimum of 20 to 30 minutes of normal EFM tracing before increasing an already flowing dose of Oxytocin.

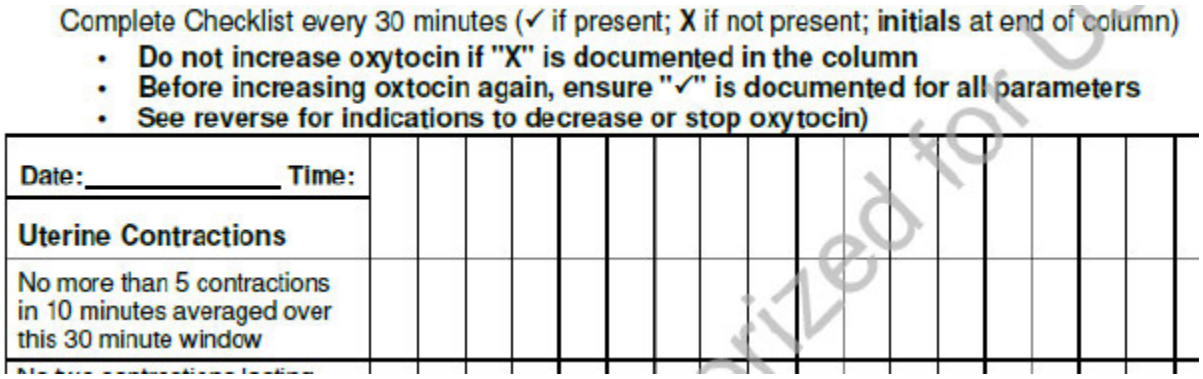
204. The College strongly denies that there is any such "Invisible Requirement" and argues that the requirement exists in plain sight. The College submits that the Oxytocin Protocol by its very nature is simple and easy to follow. It consists of the Physician's Order Set, the Pre-Oxytocin Checklist and the Oxytocin Management Checklist. The very purpose of a protocol is to be simple and remove individual discretion. The College argues that it is clear on its face that a nurse must use EFM in order to assess the parameters set out in the Checklist which mandates continuous monitoring with EFM for a minimum of 20 to 30 minutes prior to making any adjustment in the infusion rate.

205. The Panel does not accept the Respondent's argument. The Panel finds that the Oxytocin Protocol is straightforward, relatively brief, written in simple language, and clearly standardizes the administration of Oxytocin. There is no "Invisible

Requirement". The requirement for 20 to 30 minutes of EFM tracing before adjusting Oxytocin is not invisible at all. It is a clear requirement that is set out in writing.

206. The Oxytocin Protocol states at page 4: "Electronic fetal monitoring/nonstress test is classified as normal (minimum 20 minute tracing prior to starting oxytocin)." The Oxytocin Protocol states at page 6: "For women without risk factors and requiring induction of labour for conditions such as postdates, term ruptured membranes, or maternal age greater than 40 years, continuous electronic fetal monitoring is required whenever the oxytocin dose is changed and for 30 minutes following a change."

207. The Oxytocin Management Checklist expressly indicates that 30 minutes of EFM tracing is required before increasing Oxytocin:


Complete Checklist every 30 minutes (✓ if present; **X** if not present; **initials** at end of column)

- **Do not increase oxytocin if "X" is documented in the column**
- **Before increasing oxtocin again, ensure "✓" is documented for all parameters**
- **See reverse for indications to decrease or stop oxytocin)**

Date:_____ Time:																			
Uterine Contractions																			
No more than 5 contractions in 10 minutes averaged over this 30 minute window																			

208. A nurse may only administer Oxytocin within the parameters of the Oxytocin Management Checklist and physician orders. All the parameters of the Oxytocin Management Checklist must be met in order for Oxytocin to be increased. To meet all the parameters of the Oxytocin Management Checklist, an assessment of the EFM for the past 30 minutes is required.

209. The Pre-Oxytocin Checklist also expressly and clearly states that the Oxytocin Management Checklist requires 30 minutes of EFM tracing is required before increasing Oxytocin:

- Complete **Oxytocin Management Checklist** every 30 minutes
  - Do not increase **oxytocin** if the Checklist cannot be completed (see **protocol**)
  - Stop **oxytocin** if fetal health surveillance is abnormal
  - If **oxytocin** is stopped, review **Pre-Oxytocin Checklist** prior to restarting

210. This is consistent with the expert evidence regarding the amount of tracing that is required prior to adjusting Oxytocin.

211. The Respondent submits that "During cross-examination on the Oxytocin Management Checklist and Oxytocin Protocol, one of the College's witnesses – Shalynn Smith, a Clinical Nurse Educator – was asked to explain where in the protocol this requirement was, and she could not. She referred to the other requirement in the Pre-Oxytocin Checklist."

212. The Panel does not agree with the Respondent's characterization of Nurse Smith's testimony. A review of her testimony establishes that she was confused by several things that occurred during that portion of her questioning, including that she was first brought to the wrong document. Later, when the Oxytocin Management Checklist was placed in front of Nurse Smith, the question was not repeated; i.e., she was not asked to point to the requirement in the Oxytocin Management Checklist for 20 to 30 minutes of EFM prior to increasing Oxytocin.

The Decrease by Half Requirement

213. Part of the Respondent's argument regarding her leaves of absences is that her absence meant she was neither aware of nor trained in the requirement to decrease Oxytocin by half with an atypical strip.

214. The Respondent testified that she was not aware of the requirement to decrease Oxytocin by half with an atypical strip until it was brought to her attention by her union steward in 2016. In her direct examination, the Respondent testified:

> A… So you can see here that some bolded words really stick out to you.
>
> Management of atypical, decrease oxytocin, management abnormal, stop oxytocin. Those stick out quite a bit.

I apologize that in this for atypical after the decrease, decrease oxytocin dose until fetal health pattern becomes normal. That's the end of that sentence. And then in brackets it has: Initially decrease by half.

So I was not aware of this brackets. And I apologize that I did miss this and [sic] had not been brought to my attention.

Q When was that brought to your attention?

A That was brought to my attention by the union rep during some discussion. And then I went back and looked at it and saw that. So not when I had even had the meeting with Tanya.

Q Sorry, the timeframe on that? Was that in 2016?

A Yes, in 2016.

Q Do you recall when in 2016?

A It would be after -- I don't recall when, sorry, but it was when the union person who had mentioned this.

Q So you started back in April 2016. Would it have been at that time or later in your timeframe back?

A So it was not when I started that, it was later. I followed that policy as soon as it was pointed out to me. Of course I absolutely want to follow every policy that I can.

215. In cross-examination, the Respondent testified:

Q You gave evidence you were not aware that when the checklist could not be completed because the strip was atypical that you were to decrease the oxytocin by half?

A Correct, I did not see that decrease by half in the bracket on the back page of that sheet.

Q Well, in fact in your evidence you said you didn't realize that until your union steward pointed it out in 2016; isn't that right?

A Correct, it was brought to my attention by the union steward about this decrease by half.

Q So the union steward was able to read the oxytocin checklist and immediately was able to realize that that was the direction contained therein?

A I'm not aware of my union steward reading that. I'm aware of my union steward bringing information to me that the union steward had a discussion around with the manager. I'm not aware of the steward reading that protocol. So she didn't bring that protocol to me and show me or tell me.

Q Okay. Could we turn, just so we can all look at the same thing while we talk about oxytocin some more, to tab 24 of volume 3.

> Just for clarity, you gave evidence that you were aware of a big oxytocin change in 2012. Now I understand from your direct evidence that you returned to perinatal nursing again at Langley Memorial Hospital at or around 2013, right?
>
> A Correct.
>
> Q So from 2013 to mid 2015 you did not follow the protocol. When faced with atypical strips, you would not decrease the oxytocin as prescribed?
> A Where does it say on here to decrease it by half?

216. The College submits that the Respondent's evidence that "she did not even read the entire Oxytocin Protocol" from 2013 until 2016 should cause serious alarm. The Panel does not entirely agree with this characterization of the Respondent's evidence. The Respondent's evidence was that she did endeavour to read the whole protocol but did not notice "that one little line". On cross-examination, she testified that she tried her best to read "all of these documents":

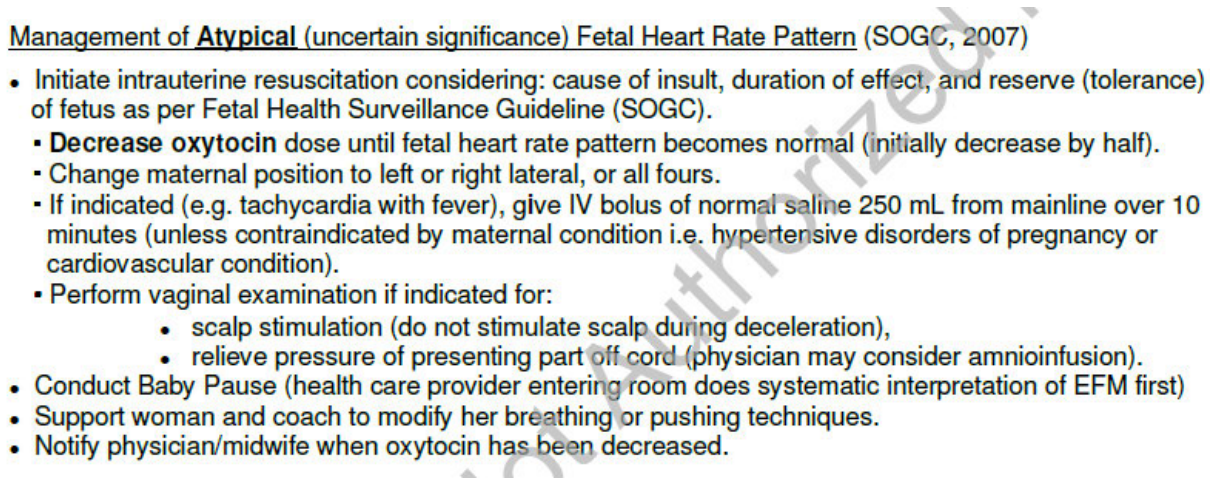
> A Correct. As I testified, I did not notice that bracket piece at the end, so I was not aware of that.
>
> Q So your evidence was that you didn't read the protocol completely before managing oxytocin with your patients?
>
> A I agree, my evidence was that I tried my best to read all of these documents and I did not notice that one little line in the protocol. So I do agree with that.
>
> [emphasis added]

217. This evidence is consistent with the Panel's finding that the Respondent did re-orient herself to the 2012 Oxytocin Protocol changes upon her return in 2013.

218. It is also consistent with the Respondent's other evidence that she has engaged in continuing education work in perinatal nursing, that included the Oxytocin Protocol. In a letter dated September 22, 2016 to Ms. Howard-Jovanovic, the Respondent set out the continuing education courses that she had completed since returning to work on April 27, 2016. Many courses are listed. For example, "FH Acute Care Standards Nursing – Maternity Intrapartum (Online)" is listed. This course covers the Oxytocin Protocol. The FHA ACUTE CARE STANDARD: Nursing - Maternity Intrapartum notes that assessments and interventions are to be implemented in accordance with Clinical Decision Support Tools (CDSTs). The Oxytocin Protocol is one of the

CDSTs. The Panel finds that the Respondent completed that coursework which included instruction on the Oxytocin Protocol.

219. The Panel disagrees with the Respondent's characterization of the requirement to decrease Oxytocin by half as being "one little line" in the Oxytocin Protocol. It is a central feature of the management of an atypical fetal heart rate pattern. It is the step identified immediately following the commencement of intrauterine resuscitation. The first two words of that line ("Decrease oxytocin") are prominent because they are bolded:



Management of **Atypical** (uncertain significance) Fetal Heart Rate Pattern (SOGC, 2007)

- Initiate intrauterine resuscitation considering: cause of insult, duration of effect, and reserve (tolerance) of fetus as per Fetal Health Surveillance Guideline (SOGC).
  - **Decrease oxytocin** dose until fetal heart rate pattern becomes normal (initially decrease by half).
  - Change maternal position to left or right lateral, or all fours.
  - If indicated (e.g. tachycardia with fever), give IV bolus of normal saline 250 mL from mainline over 10 minutes (unless contraindicated by maternal condition i.e. hypertensive disorders of pregnancy or cardiovascular condition).
  - Perform vaginal examination if indicated for:
    - scalp stimulation (do not stimulate scalp during deceleration),
    - relieve pressure of presenting part off cord (physician may consider amnioinfusion).
- Conduct Baby Pause (health care provider entering room does systematic interpretation of EFM first)
- Support woman and coach to modify her breathing or pushing techniques.
- Notify physician/midwife when oxytocin has been decreased.

220. Dr. Mah testified that the protocol clearly sets out the requirement to decrease Oxytocin by half and her expectation that a registered nurse would follow that requirement:

> Q This protocol clearly sets out what the nurse ought to do if normal uterine activity has not returned to normal after 10 minutes. And that is to decrease the oxytocin rate by at least half?
>
> A Right.
>
> Q That's correct?
>
> A Yes.
>
> Q And that would be your expectation for what a registered nurse should do working with a laboring mother who experienced tachysystole that didn't resolve after 10 minutes?
>
> A That's correct.

221. The Panel agrees with Dr. Mah that the requirement to decrease Oxytocin by half is clear. The wording is simple, straightforward, in plain sight, and the words “Decrease oxytocin” are bolded which draws further attention to this requirement.

222. The College submits that the Respondent’s argument amounts to a submission that the Respondent tried her best and practiced to her knowledge level and in accordance with her interpretation of the Oxytocin Protocol. The College urges the Panel to reject this argument as it amounts to establishing a subjective standard for acceptable nursing practice dependent upon what a nurse knows at a given time and on what they are willing to learn. The College submits that each registrant has a positive obligation to ensure that they understand how to give medication ordered for their patients. The Panel agrees that there is no subjective standard and that there are professional duties on nurses to, amongst others, take responsibility for their own actions, remain current, ensure they understand the limits and conditions under which they administer medications, to correctly use the appropriate decision-making tools and protocols, to act upon preprinted orders, and to administer the right medication to the right client in the right dose using the right route for the right reason with the right documentation.

223. The College submits that the Respondent was an experienced nurse with nearly 15 years of nursing experience when she returned to the Perinatal Unit and was faced with a new Oxytocin Protocol involving a different order set and a brand-new Oxytocin Management Checklist. The College submits that a prudent nurse would have immediately realized the need for training on the new protocol, would have reviewed the full protocol, enlisted the assistance of the clinical nurse educator(s), consulted peers, and sought feedback to make sure that they understood what the Oxytocin Protocol entailed. The College submits that the Respondent did not give any evidence that she took any positive steps to ensure that she understood how to use the Oxytocin Protocol when she returned to the Unit. The College argues that this failure is further aggravated by the fact that the Respondent did not take steps to remedy her knowledge gap despite the many opportunities to do so during the intervening years between her return to the Perinatal Unit and at the material times in the Citation.

224. The Panel largely accepts these submissions. The Respondent has held a perinatal speciality since 1998 which is enhanced education in this area of nursing. The Panel finds that the Respondent would be aware that perinatal nursing is an evolving and dynamic area of practice with many potential changes requiring nurses in that area to keep themselves apprised of such changes. As noted above, the Respondent was also clear in her understanding of her obligation to remain current, and she described the re-orientation and continuing education steps that she did undertook with respect to the Oxytocin Protocol.

225. The Panel finds it unlikely that the Respondent was not aware of the requirement to decrease Oxytocin by half until this was brought to her attention by her union steward. The Respondent was a senior nurse, she had worked on the Unit for close to twenty years, was aware of the significant changes made to the Oxytocin Protocol in 2012 to standardize the administration of Oxytocin, she took the initiative to re-orient herself with the protocol upon her return in 2013, she knew that she could ask her colleagues and nurse educators about the protocol, and she worked on the Unit with the Oxytocin Protocol – a straightforward and simple document – on her return in 2013 for several years. The rollout and use of the Oxytocin Protocol on the Unit was well established by 2013. It was in every delivery room and accessible via binders and on the hospital's intranet. It is not plausible that the Respondent was able to work with the Oxytocin Protocol for such a lengthy period having refamiliarized herself and not know about the clear and important metric of decreasing the Oxytocin by half – something which was bolded. The requirement to decrease Oxytocin by half is prominent in terms of being the second step identified in the management of an atypical fetal heart rate pattern and because it contains some bold font. It is not plausible or likely that the Respondent was unaware of the requirement.

226. The College submits that the Respondent was not credible when she stated that she was concerned about a rare complication of higher dose Oxytocin infusions, which she read about in the Oxytocin Protocol, but was at the same time was unaware of the "decrease by half" requirement or that the titration of Oxytocin depended on whether the parameter of the Oxytocin Management Checklist was met. The Panel

agrees and accepts this submission. The Respondent seems to suggest she carefully read those sections of the Oxytocin Protocol which assist her in relation to these allegations but did not carefully read the sections of the Oxytocin Protocol which do not assist her.

227. In any event, the Panel does not accept that the fact that the requirement is on the back, or the mere presence of brackets would explain any oversight. There is an obligation to read all of the text contained in the Oxytocin Protocol including the second page of the document and any text in brackets.

228. The College also submits that reading drug orders, which is what the Oxytocin Protocol is, is basic nursing task. All nurses must read the complete order to ensure that they understand how, when and to whom the drug is to be administered. The Panel agrees with this submission as well.

Departing from the Oxytocin Protocol – does incompetence require wilful or deliberate conduct?

229. Another argument by the Respondent is that the Panel erred in its incompetence analysis in the Conduct Decision by finding that the Respondent engaged in "wilful disregard" of the Oxytocin Protocol. In her reconsideration submissions, the Respondent argues that there is no evidence capable of establishing that her Oxytocin errors were intentional.

230. At paragraph 78 of the Judgment Reasons, the Court stated:

> The Panel's determination that the petitioner practiced her profession incompetently is in part premised upon the statement that she "continued to assert that she [was] justified in departing from the Oxytocin Protocol". It is unclear to me whether this statement amounts to a finding that the petitioner deliberately contravened established professional standards. That ambiguity is problematic given the role of this statement in the Panel's reasoning regarding incompetence, the significant professional impacts of a finding of incompetence, and the prejudice associated with a finding of deliberate departure from professional standards.
>
> [79]…. I would hope that these points of confusion might be clarified by the Panel on remittal of these findings.

231. The Panel did not make a finding that the Respondent engaged in "wilful" or "deliberate" conduct. The word "wilful" does not appear in the Conduct Decision. The

word “deliberate” appears only once in the decision when the Panel summarized the Respondent’s submissions. It is important to note that it is the Respondent herself who placed the notions of “wilful” and “deliberate” conduct at issue in her original submissions, in the appeal (as quoted by the Court) and again in her reconsideration submissions. Those were not the findings of the Panel in the Conduct Decision and are not the findings of the Panel on this reconsideration.

232. The reason that the Panel did not use those terms is because it is not necessary for the Panel to find that the Respondent’s conduct was wilful or deliberate in order to find incompetence.

233. The HPA does not require a mental element for a determination of incompetence. There are good reasons for the absence of a mental element. The public is protected by registrants acting competently. The public would not be adequately protected if incompetence could be overlooked because of good intentions.

234. As the Panel set out above, incompetence assesses whether there is a “want of ability suitable to the task, either as regards natural qualities or experience, or deficiency of disposition to use one’s abilities and experience properly.” Whether a registrant’s conduct constitutes incompetence is not dependent upon the intent of the registrant but on the facts of the case. As noted above, in this case, the Panel finds that the facts establish incompetence. The duration, scope and repetition of the Respondent’s incompetence is serious. There is a clear pattern of multiple different kinds of errors relating to the Respondent’s adherence to the Oxytocin Protocol. This was not mere inadvertence, an isolated incident or a lapse in judgment.

235. The Panel finds it more likely than not that there were instances during which the Respondent continued to titrate Oxytocin as she had done earlier in her nursing career rather than in accordance with the Oxytocin Protocol, which was designed to remove individual decision-making and standardize the administration of Oxytocin.

236. The Respondent referenced the titration approach from her training as follows:

> So it may or may not have any bearing at all. It's just in my training back in '96, '97 and in the training that I followed up, which is the same BCIT course afterwards, we are advised to titrate that oxytocin to more mimic what nature does so that the body will constantly be responding to that change.

237. This is consistent with the Respondent's evidence that she titrated Oxytocin for a 4 in 10 contraction pattern and that a 5 in 10 pattern does not provide her with any "leeway".

238. This is consistent with the Respondent's evidence that she made the decision to slow the rate of infusion of the Oxytocin to slow the patient's contraction period in order to provide herself with extra time to insert a Foley Catheter – something which is not a relevant parameter in the Oxytocin Protocol.

239. This is also consistent with the Respondent's evidence regarding her choice to use a "V" to indicate a "variance" in her documentation, despite that not being a legitimate abbreviation in the Oxytocin Checklist because she perceives that she is communicating "as best as [she] can" to her colleagues:

> So yes, I have made a documentation error in completing this checklist. I should have been putting Xs for this. So I'm not really up to speed with this. I'm trying to fill it out so that I'm communicating as best as I can so that everyone who read this would understand what I'm trying to communicate, that there's a variance to these decels and that no there's a variance to the heart rate.

240. Even if the Respondent did not know about the requirement to decrease Oxytocin by half, the Panel's decision would be the same. The Panel agrees with the College's submission that all nurses are responsible for identifying their learning needs and seeking out appropriate supports. The Respondent had numerous resources she was aware of available to her that included seeking support from her colleagues, the CNEs on the Unit, and her manager, as well as utilizing written and computer resources available on the Unit and in the individual patient rooms. The Respondent had a professional responsibility to carefully read and follow the entire Oxytocin Protocol. The Panel agrees with the College's submission that if she did not read and follow the instruction to reduce the Oxytocin infusion by half when faced with an atypical EFM strip, this also amounts to incompetence in this case. The Panel finds that level and scope of carelessness and inattention would also constitute a "want

of ability suitable to the task, either as regards natural qualities or experience, or a deficiency of disposition to use one's ability and experience properly."

Allegation 1(g)(i)

> g) on or about August 28, 2016, while caring for Patient #6 (A-J. B), who was admitted to hospital overdue after Cervidil induction and in the early period of the first stage of labour:
>
> > i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically you made infusion rate changes that were not based on Patient #6's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders; and

241. As noted above, the Respondent made the following admissions in relation to this allegation:

> **Patient #6 – A-J.B.**
>
> **Administration of Oxytocin**
>
> 179. Ms. Whieldon stated at the Hearing that she completed the Oxytocin Management Checklist and understood from that that she needed to have "Moderate Variability for 10 of the past 30 minutes" in order to increase it, which she did generally (except in two instances for A-J.B. at 15:00 and 16:40 which she admitted were in error). This is what the Oxytocin Management Checklist says. She also said that she now understands from the evidence given during the Hearing from different witnesses that prior to increasing Oxytocin there must also be 20-30 minutes of normal EFM immediately prior to the increase, despite this not being expressly stated on the Oxytocin Management Checklist or in the Oxytocin Protocol.
>
> . . . .
>
> **Citation Allegation 1(a)(i), 1(g)(i), an 1(h)(i): Oxytocin administration and Management (Patients O.M., A-J.B. and A.L.); FHS interpretation for 1(a)(i)**
>
> 275. Despite the foregoing, Ms. Whieldon concedes that her practice fell below the standard of care on April 28 h, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

242. As also outlined above, the Respondent admits that she did not completely agree with the totality of the allegations made under each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), but agreed that she had erred under each – in particular ways at

particular times – thereby establishing breaches of a standard for each Oxytocin Allegation. The Respondent admits that the College has established a breach of the Medication Administration Standards in relation to Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i).

243. Ms. King gave further expert evidence that this patient was admitted to the Perinatal Unit on August 28, 2016 for induction of labour due to post dates (past expected due date). Ms. King notes that the patient had received a dose of Cervidil (cervical ripening agent) on August 26, 2016 and a second dose on August 27, 2016. She had a Caesarean delivery on August 29, 2016. The Respondent provided care to her on August 28, 2016.

244. Ms. King gave evidence that the Respondent failed to assess the fetal heart rate and uterine contractions prior to increasing the Oxytocin infusion rate being administered to this patient, and inappropriately increased the Oxytocin infusion rate without the essential assessment of the fetal heart rate and uterine contractions. Ms. King particularized the initiation of Oxytocin and infusion increases which occurred at 1:00 pm, 2:00 pm, 3:00 pm, 4:40 pm, and 6:30 pm.

245. The College submits that Ms. King's testimony should be accepted in its entirety.

246. The College also argues that the Respondent's failure to assess fetal wellbeing immediately prior to the initiation of Oxytocin was reckless given that the patient underwent an artificial rupture of membranes approximately two hours previously. It was incumbent on a reasonably prudent nurse to ensure the fetal wellbeing after this intervention and prior to adding a stressor to the uterine environment (the Oxytocin infusion). In other words, a significant change had happened in the uterine environment – the amniotic sac had been ruptured which could have changed the fetus' status. The Respondent could not have known if that fetus was already stressed by the artificial rupture of membranes prior to starting Oxytocin – a drug that "stresses" the uterine environment by stimulating contractions or making uterine contractions stronger.

247. The College refers to Dr. Mah's testimony that when there have been several hours between the non-stress test and the initiation of Oxytocin, the non stress test should

be repeated to ensure the status of the fetus. The College argues that in this case, a significant change occurred, the rupture of membranes, meant to start labour by allowing the fetus' head to descend and apply to the cervix. This change should have prompted a prudent perinatal nurse to reassess the fetus and pregnant person to ensure their wellbeing prior to starting the Oxytocin.

248. As noted above, the Respondent submits that she was not aware of the requirement for 20 to 30 minutes of normal EFM tracing immediately before increasing Oxytocin. and argues that there is an absence of any words in the Oxytocin Management Checklist or Oxytocin Protocol which suggest that the 20 to 30 minutes of tracing must be immediately before any Oxytocin increase.

249. The Respondent also relies upon Dr. Mah's testimony that if a normal non-stress test of 20 to 30 minutes EFM monitoring has taken place with a mother not yet in labour and there is no staff available to initiate Oxytocin right away, that Oxytocin can be initiated within a window of a couple of hours.

250. The Panel agrees with and accepts Ms. King's evidence and finds that the Respondent fell below the standard expected of her and did not follow the Oxytocin Management Checklist in each of the instances she outlined. During each of the instances outlined by Ms. King on August 28, 2016, the Respondent failed to assess the fetal heart rate and uterine contractions for the requisite time prior to initiating and increasing the Oxytocin infusion rate for this patient.

251. The Panel finds that the Pre-Oxytocin Checklist must be completed prior to initiating an Oxytocin infusion and that a minimum of 20 minutes of tracing is required prior to initiating Oxytocin:

> ☐ Electronic fetal monitoring/ nonstress test is classified normal (minimum 20 minute tracing prior to starting oxytocin)

252. The Respondent acknowledges that this requirement exists in the Pre-Oxytocin Checklist.

253. Dr. Mah’s testimony is of limited assistance in relation to this allegation. She did not provide an opinion about the initiation of Oxytocin or increase of Oxytocin infusion rates in relation to this particular patient.

254. Dr. Mah was also not asked about the required length of time prior to increasing Oxytocin under the Oxytocin Protocol.

255. Dr. Mah was asked whether there is an acceptable window of time for the completion of a non stress test and the initiation of Oxytocin. Dr. Mah’s response was more nuanced than has been suggested: “The non-stress test is done. And if you're not able to start the oxytocin immediately, the non-stress test is still valid for starting the oxytocin later on. It could be an hour later or maybe a couple of hours later. If it's been more than a couple of hours, I would actually do another non-stress test to be assured that there has been no changes in the baby's status.”

256. Dr. Mah did not testify that the Respondent’s initiation of Oxytocin infusion on August 28, 2016 fell within the general circumstances she outlined above or that the Respondent adhered to the Protocol. Dr. Mah was not asked to comment on whether another non-stress test should have been administered given the particular changes in this particular patient.

257. Accordingly, the Panel prefers Dr. King’s expert testimony, in relation to the care of this particular patient, that the Respondent would have been expected to ensure a normal fetal heart rate tracing for 20 to 30 minutes prior to initiating Oxytocin and that her failure to assess the fetal status and uterine contraction pattern in this case prior to starting Oxytocin fell below the standard of care. This failure to properly assess the fetal status and uterine contraction pattern was contrary to the Pre-Oxytocin Checklist.

258. The Panel has addressed the Respondent’s argument about the absence of any express requirement for 20 to 30 minutes of tracing in the Oxytocin Protocol prior to increasing Oxytocin in its reasoning above with respect to allegation 1(a)(i) of the Citation. The Panel finds that this requirement is indeed contained in the Oxytocin Management Checklist.

259. The Panel finds that the Respondent failed to assess the fetal heart rate and uterine contractions prior to increasing Oxytocin contrary to the Oxytocin Management Checklist. The Panel finds that the Respondent breached the Oxytocin Protocol.

260. Based upon the totality of the evidence in front of it, the Panel finds that the evidence establishes on a balance of probabilities that while the Respondent was employed as a perinatal nurse at LMH, on or about August 28, 2016, while caring for Patient A.-J.B, who was admitted to hospital overdue after Cervidil induction and in the early period of labour, the Respondent did not follow the applicable College nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. The Panel finds that the evidence also establishes on a balance of probabilities that the Respondent made infusion rate changes that were not based on the patient's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders. Accordingly, the College has proved this allegation on a balance of probabilities.

Standards under the Act

261. The Respondent admits that where her practice fell below the standard of care in relation to this allegation, it constituted a breach of the Medication Administration Practice Standard. The Panel agrees. The Panel finds that the Respondent's proven conduct is also contrary to the following College Standards:

> **Standard 1: Professional Responsibility and Accountability**
> 1. Is accountable and takes responsibility for own nursing actions and professional conduct.
>
> **Standard 2 Knowledge-Based Practice**
> 2. Knows how and where to access information to support the provision of safe, competent and ethical client care.
>
> 3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.
>
> 5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.
>
> 9. Uses decision support tools appropriately to assess and make decisions about client status and plan care.

> **Medication Administration**
> **Principles**
> 3. Nurses adhere to “seven rights” of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.
>
> 6. Nurses act upon pre-printed orders when the authorized health professional has made those orders client-specific by reviewing them, adding the client’s name, customizing them, signing, and dating them.
>
> **Applying the Principles**
> 1. Read CRNBC’s Scope of Practice for Registered Nurses: Standards, Limits and Conditions to ensure you understand the standards, limits and conditions under which nurses administer medications.

262. Accordingly, the Panel has determined that the Respondent has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Incompetence

263. The Panel also finds that the Respondent has incompetently practised the profession contrary to section 39(1)(d) of the HPA. The Panel finds that the Respondent displayed a want of ability suitable to the administration of Oxytocin. The Respondent repeatedly failed to adhere to the Oxytocin Protocol. As explained above, there were multiple instances in which the Respondent initiated Oxytocin and increased the Oxytocin infusion rate without assessing the fetal heart rate or uterine contractions for the requisite period of time. While the Respondent is an experienced and qualified nurse, her conduct demonstrates a concerning pattern of incompetent practise. The proper administration of medication in accordance with the Oxytocin Protocol is extremely important to ensure the safety of a pregnant patient and their baby. The Respondent displayed this pattern of incompetent practise with respect to multiple instances of proven conduct involving Patient A.J.-B. within this allegation. There also exists a broader pattern within the Oxytocin Allegations.

264. The Panel’s findings with respect to the Respondent inconsistency in engagement, accepting feedback and implementing improvements is set out in allegation 1(a) and applies equally in relation to this allegation.

Allegation 1(h)(i)

> h) on or about September 16, 2016, you were caring for Patient #7 (A.L.) who had elevated blood pressure in pregnancy. The obstetrician ordered the administration of an infusion of Oxytocin for induction of labour. During the course of Patient #7's labour:
>
> > i. you did not follow the applicable BCCNP nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. Specifically, you made infusion rate changes that were not based on the appropriate parameters of Patient #7's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders;

265. As noted above, the Respondent made the following admissions in relation to this allegation:

> **Citation Allegation 1(a)(i), 1(g)(i), an 1(h)(i): Oxytocin administration and Management (Patients O.M., A-J.B. and A.L.); FHS interpretation for 1(a)(i)**
>
> 275. Despite the foregoing, Ms. Whieldon concedes that her practice fell below the standard of care on April 28 h, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

266. As also outlined above, the Respondent admits that she did not completely agree with the totality of the allegations made under each of Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i), but agreed that she had erred under each – in particular ways at particular times – thereby establishing breaches of a standard for each Oxytocin Allegation. The Respondent admits that the College has established a breach of the Medication Administration Standards in relation to Citation allegations 1(a)(i), 1(g)(i), and 1(h)(i).

267. Ms. King gave further evidence that this patient was admitted to the Perinatal Unit on September 15, 2016 for induction of labour due to hypertension in pregnancy.

268. Ms. King also gave expert evidence that the Respondent failed to assess the fetal heart rate and uterine contractions prior to increasing the Oxytocin infusion rate being administered to this patient, and inappropriately increased the Oxytocin infusion rate without the requisite assessment of the fetal heart rate and uterine contractions. Ms. King particularized the infusion increases which occurred at 11:25 am and 1:00 pm. Ms. King also opined that the Respondent decreased the patient’s

Oxytocin infusion rate at 2:10 pm due to the patient's pain. Ms. King expressed the opinion that pain is not normally a reason to decrease Oxytocin if the fetal heart rate is normal and the uterine contraction pattern is within normal limits. Rather, coaching, positioning and pain relief are options to be discussed with the patient.

269. The Respondent further testified that Oxytocin is not managed due to pain; it is managed in relation to contraction pattern. Her evidence was that she decreased the Oxytocin by half at 2:10 pm due to the presence of three uncomplicated variables and not due to the presence of pain.

270. The patient's clinical records contain a note that the obstetrician ordered the administration of an infusion of Oxytocin for induction of labour.

271. The College submits that Ms. King's evidence should be adopted in its entirety. The College also argues that the Respondent's narrative charting indicates that she manipulated the Oxytocin rate infusion to deal with maternal pain during labour. The College points in particular to the following two passages from the September 16, 2016 progress notes:

> 1410: Pain/Fear Oxytocin half'ed down to 9mu/min as pt crying out of control.
>
> 1650: Oxy Decreased from 12 to 10 mu as 5:10 cont & trouble coping.

272. The Respondent submits that she knew that maternal pain is not a reason to decrease Oxytocin, and she decreased the Oxytocin for other reasons.

Was Dr. King's expert evidence impeached?

273. One of the issues raised by the Respondent on appeal with respect to the Conduct Decision and referenced in the Judgment Reasons is whether Dr. King's evidence was impeached with respect to this allegation.

274. The Respondent submits that Ms. King's evidence was impeached as follows:

> 66. The College alleged that the Registrant "decreased oxytocin by ½" at 2:10pm due to "maternal pain". This was based on unclear charting by the Registrant and Ms. King's written report that the heart rate was "normal" instead of "atypical" at that time. The Registrant denied decreasing it due to maternal pain and clarified that her charting was unclear during her oral evidence. She said that "three

> uncomplicated variables" presented at 2:10pm on September 16, 2016 and she deceased oxytocin by ½ in response, because she knew this was required since June 2016. This is entirely consistent with her evidence that she did her best after June 2016 to adhere to this requirement.
>
> 67. As stated, Ms. King's written opinion said the heart rate was "normal" at 2:10pm. This was challenged under cross-examination. After reviewing the heart tracings in detail, she admitted an interpretation of the heart rate being "three uncomplicated variables" at 2:10pm, was possible:
>
> > Q Could that be interpreted as three uncomplicated variables?
> >
> > A It could be, yes.
> >
> > Q So if it was interpreted as three uncomplicated variables, that would be atypical?
> >
> > A That would be, yes.
> >
> > May 22nd Transcript: p. 95 lines 2-7
>
> 68. This is not a hypothetical. Ms. King admitted that the 2:10pm heart rate could be interpreted as three uncomplicated variables, and thus be interpreted as atypical, contrary to her own written report where she said it was "normal" at 2:10pm. Her written evidence on that point was thus, impeached.
>
> 69. Ms. King also agreed that if the 2:10pm heart rate was interpreted as three uncomplicated variables, then it would be atypical. If the heart rate was atypical, oxytocin would need to be decreased by ½. The Registrant testified that her interpretation at the bedside at 2:10pm was that three uncomplicated variables occurred, so she decreased by 1/2 and charted that. She agreed that her charting unfortunately was unclear as she also charted about maternal pain, during a difficult moment in the delivery, but disagreed that the reason she decreased by ½ was due to maternal pain. The two things happened contemporaneously, but one did not cause the other.

275. The College argues that the Respondent tested Ms. King's evidence on cross-examination, but that the exchange referenced by the Respondent was not an impeachment of her evidence. Rather, Ms. King was asked a hypothetical question: "**if** a section of the strip that could not be interpreted was a third deceleration, would that make the strip atypical?" The College argues that Ms. King's opinion was unshaken on cross examination and ought to be accepted in its totality with respect to her interpretation of fetal heart strips and appropriate interventions as well as the administration of Oxytocin for the Oxytocin Allegations.

276. The Panel does not agree with the Respondent that Ms. King's evidence was impeached on cross-examination. The full exchange is as follows:

Q So I want to ask you a few questions with respect to this tracing here.

In the 10 minutes or so before the oxytocin decrease, can you describe the tracing here?

A So right before the oxytocin?

Q The deceleration pattern here. Can you describe those?

A They're variables.

Q How many of them are there?

A Well, one with each contraction.

Q So is that three?

A Well, considering before the oxytocin is turned up -- or turned down, rather, so right before it's turned down **I only see two and a half contractions.**

So the strip with the very first, it looks like a contraction is ending. So I don't -- can't interpret what's right before that.

Q Sorry, so I can make sure I understand where you're at. That's the two bigger mountains and then a peak?

A Yes.

Q That's kind of the half?

A No. The half is right at the beginning of the page.

Q Yeah.

A That's a half of a contraction. So I can't see what the fetal heart rate is doing there because I don't have the other half from the previous sheet.

Q So --

A So I'm judging by the two contractions that I see after that, there are variables with each those.

Q Directly above?

A That's right.

Q So there's the first drop, the second decel?

A Yes.

Q And then there's a third to the right of that?

A It's hard to see what's going on there. It looks like the monitor has been moved or the patient has moved position so that I can't interpret exactly what that is.

Q Could that be interpreted as three uncomplicated variables?

A It could be, yes.

Q So **if it was interpreted** as three uncomplicated variables, that would be atypical?

A That would be, yes.

[emphasis added]

277. Ms. King did not change her expert evidence as to the interpretation of the relevant tracing strip as a result of the Respondent's cross-examination. The Panel does not find that her expert opinion was impeached. She agreed that *if* a section of the strip hypothetically contained a third deceleration, that strip could be interpreted as atypical. Ms. King did not agree that the relevant section of the strip at issue did in fact contain a third deceleration. To the contrary, Ms. King firmly resisted that proposition when she was asked how many variables she interpreted in the relevant section of the strip. Ms. King was asked: *"Q So is that three?*". Ms. King disagreed, responding: "*I only see two and a half contractions*." The Panel has considered Ms. King's expert testimony and has examined the strip and does not find that the relevant section of the strip contains a third deceleration. The Panel finds that the relevant portion of the tracing was normal not atypical.

278. Accordingly, the Panel accepts the evidence of Ms. King and finds that the Respondent failed to assess the fetal heart rate and uterine contractions prior to increasing the Oxytocin infusion rate being administered to this patient, and inappropriately increased the Oxytocin infusion rate without the requisite assessment of the fetal heart rate and uterine contractions at 11:25 am and 1:00 pm.

279. The Panel further finds that the Respondent decreased Oxytocin at 2:10 pm due to maternal pain. The Panel does not accept that the Respondent's chart notes are unclear. The notes are clear that maternal pain was a reason for the Respondent's adjustment of Oxytocin infusion rates. All progress notes are preceded by a column titled "Focus". The Respondent testified that the "Focus" column is intended to capture "what the focus of the entry is". In this instance, the Respondent indicated that the "Focus" of the 2:10 pm chart entry is "Pain/Fear". The word "pain" is expressly mentioned at the material time. The more detailed narrative in the corresponding "progress notes" column then records that Oxytocin was "half'ed to 9mu/min as pt crying out of control". The Panel finds the presence of the conjunction "as" to be significant. It also finds the presence of the words "pt crying out of control" to be significant. The Panel finds it more likely that the Respondent recorded that

she reduced the Oxytocin by half because the patient was crying out of control than that she reduced the rate of Oxytocin by half at 2:10 pm because of three uncomplicated variables.

Is there an inconsistency in the Respondent's evidence about the Decrease by Half Requirement in relation to allegations 1(a) and 1(h)?

280. Another issue raised by the Respondent on appeal with respect to the Conduct Decision and referenced in the Judgment Reasons is whether there is an inconsistency in the Respondent's evidence about the Decrease by Half Requirement in relation to allegations 1(a) and 1(h).

281. In this regard, the Court suggested in the Judgment Reasons that the Panel keep the following in mind with respect to allegation 1(h):

> • The Panel's analysis of allegation 1(h)(i) seems to suggest that Ms. Whieldon's testimony that she was unaware of the "Decrease by ½ Requirement" at the time of the events in allegation 1(a)(i) is inconsistent with her statement that she was aware of the requirement at the time of the events in allegation 1(h)(i), even though she explicitly stated (in testimony that is noted in the Decision) that she learned of the requirement between those two events.

282. The Panel expressly noted in paragraph 144 of the Conduct Decision that it was aware that the Respondent testified that she learned of the "Decrease by Half" requirement during the period between allegations 1(a)(i) and 1(h)(i).

283. As will be explained in further detail below, the Panel was making a different point than what the Respondent has attributed to it, however, on reconsideration, the Panel has decided this evidence is not relevant to its decision. The Panel makes no finding of inconsistency with respect to the evidence outlined by the Court in the passage above.

The 4:50 pm infusion: is it further evidence of the Respondent's departure from the Decrease by Half Requirement?'

284. Another issue raised by the Respondent on appeal with respect to the Conduct Decision and referenced in the Judgment Reasons is whether the 4:50 pm Oxytocin

infusion is further evidence of the Respondent's departure from the Decrease by Half Requirement.

285. The Respondent argues that the Panel erred in the Conduct Decision relating to the 4:50 pm infusion rate:

> 70. The Registrant submits that the Panel's original finding that the Registrant clearly had not learned the Decrease by ½ Requirement by September 16, 2016 *based on the 4:50pm example* (bolded at para 144 of the Liability Decision quoted above) was a palpable and overriding error of fact. What the Registrant did at 4:50pm *had nothing to do* with her admission, as she was not dealing with a situation to which the Decrease by ½ Requirement applied.

286. In this regard, the Court suggested in the Judgment Reasons that the Panel keep the following in mind with respect to allegation 1(h):

> • The Panel's decision regarding allegation 1(h)(i) is in part premised upon a finding that a decrease in oxytocin two hours after a failure to properly apply the "Decrease by ½ Requirement" provided *further* evidence of the petitioner's departure from *that* requirement without explaining the significance of this seemingly unrelated decrease to their determination.
>
> [emphasis added]

287. The Court was referencing the Respondent's argument that the Panel found the Respondent's Oxytocin infusion rate at 4:50 pm to be further evidence of a failure to apply the "Decrease by ½ Requirement" in the Oxytocin Management Checklist.

288. The Panel, however, did not use those words or make that finding. The Panel did not find that the 4:50 pm infusion was "further evidence" of the Respondent's departure from "*that* requirement" – "that requirement" being the requirement to decrease Oxytocin by half where there is an atypical tracing pattern.

289. Rather, the Panel expressly referred to the Respondent's failure to follow the Oxytocin Protocol under circumstances where the tracing pattern was normal: "at 4:50 pm, Ms. Whieldon reduced the Oxytocin from 12 to 10 mu, although the contractions and fetal heat rate was within normal limits."

290. In the Conduct Decision, the Panel found that the Respondent's 4:50 pm infusion rate was further evidence of the Respondent's continued failure to adhere to the

parameters set out in the Oxytocin Protocol in general, despite the fact that by September 16, 2016 she had been corrected on issues with her adherence to the Oxytocin Protocol.

291. It was concerning to the Panel that the Respondent continued to depart from the parameters of the Oxytocin Protocol by September 2016. The fact that she did continue to make multiple different types of departures from the Oxytocin Protocol undermined the Respondent's credibility about the extent of her general adherence to the Protocol by that time.

292. Nevertheless, on reconsideration, the Panel need not rely upon or make any findings with respect to the infusion rate at 4:50 pm. It is not necessary for the Panel to do so as the College has proved the allegation based on other evidence.

The Titrating Requirement

293. Related to the infusion at 4:50 pm is another issue raised by the Respondent on appeal and referenced in the Judgment Reasons regarding what the Respondent terms the "Titrating Requirement."

294. The Court states in the Judgement Reasons that the Respondent argues that the Panel "irrelevantly consider[ed] the "Titrating Requirement" when evaluating the petitioner's adherence to the "Decrease by ½ Requirement"". The Court does not evaluate this ground of appeal noting, "I cannot properly evaluate their reasoning on these issues in the face of this uncertainty, nor do I think that I should given that the Panel will be afforded an opportunity to consider the impact of the relevant absence on their determinations upon remittal" (paragraph 77).

295. Despite arguing it is an irrelevant consideration, the Respondent has made further submissions about a "Titrating Requirement" in her reconsideration submissions. The College responded to the points raised by the Respondent about the "Titrating Requirement".

296. The Respondent argues the Oxytocin Protocol contains a "Titrating Requirement" which she defines as "an express requirement for a nurse to titrate (a.k.a. "adjust")

oxytocin to the minimum dose required." The Respondent points to the following provisions:

> Perinatal nurses are responsible for titrating oxytocin for labour induction or augmentation.
>
> …
>
> Continue oxytocin at the minimum level required to achieve an adequate contraction pattern and progressive cervical dilation.

297. The Respondent submits that this framework explains her Oxytocin titration at 4:50 pm as "she was merely titrating oxytocin to the minimum dose required at 4:50 pm, as she understood she was to do from her historical practice and the Titrating Requirement."

298. The College argues that there is no routine ability of nurses to titrate Oxytocin outside of the parameters of the Oxytocin Protocol. A nurse may only titrate Oxytocin within the parameters of the Oxytocin Management Checklist and physician orders.

299. The Panel has considered the plain meaning of the words, read harmoniously with the Protocol, in light of the Protocol's standardization of the administration of Oxytocin. The references to nurses being responsible for "titrating oxytocin" and instructions to "continue oxytocin at the minimum level" do not mean that nurses possess the discretion to customize the Oxytocin infusion rate. It means that they manually adjust Oxytocin in accordance with the Oxytocin Protocol's parameters, the set orders and physician orders. The overwhelming evidence at the hearing by the experts and the CNEs, which the Panel accepts, was that the Protocol standardized the initialization, administration and management of Oxytocin, and that nurses cannot customize the Protocol.

300. The Panel wishes to be clear that in addressing this point, it is doing so because of the above passages in the Judgment Reasons and the parties' reconsideration submissions on this point but should not be taken to have irrelevantly considered this same point in arriving at its decision. As is set out above in these reasons, the Panel makes no finding as to the Respondent's infusion at 4:50 pm and finds that allegation is established through other evidence.

301. Based upon the totality of the evidence in front of it, the Panel finds that the evidence establishes on a balance of probabilities that while the Respondent was employed as a perinatal nurse at LMH, on or about September 16, 2016, while caring for Patient A.L, who had elevated blood pressure in pregnancy, the obstetrician ordered the administration of an infusion of Oxytocin for induction of labour, during the course of this patient's labour, the Respondent did not follow the applicable College nursing standards and Fraser Health Policy regarding the administration and management of Oxytocin. The Panel finds that the evidence also establishes on a balance of probabilities that the Respondent made infusion rate changes that were not based on the patient's clinical presentation, the fetal heart monitor record, the Oxytocin Protocol including the Oxytocin management checklist, or physician's orders. Accordingly, the College has proved this allegation on a balance of probabilities.

Standards imposed under the Act

302. The Panel finds that the Respondent breached the Oxytocin Protocol and the Oxytocin Management Checklist. The Respondent admits that where her practice fell below the standard of care in relation to this allegation, it constituted a breach of the Medication Administration Practice Standard. The Panel finds the Respondent's conduct has breached the following College Standards:

> **Standard 1: Professional Responsibility and Accountability**
> 1. Is accountable and takes responsibility for own nursing actions and professional conduct.
>
> 2. Functions within own level of competence, within the legally recognized scope of practice and within all relevant legislation.
>
> **Standard 2 Knowledge-Based Practice**
> 2. Knows how and where to access information to support the provision of safe, competent and ethical client care.
>
> 3. Uses critical thinking when collecting and interpreting data, planning, implementing and evaluating nursing care.
>
> 5. Identifies, analyzes and uses relevant and valid information when making decisions about client status.
>
> 9. Uses decision support tools appropriately to assess and make decisions about client status and plan care.

> **Medication Administration**
> **Principles**
> 3. Nurses adhere to “seven rights” of medication administration: right medication, right client, right dose, right time, right route, right reason and right documentation.
>
> 6. Nurses act upon pre-printed orders when the authorized health professional has made those orders client-specific by reviewing them, adding the client’s name, customizing them, signing, and dating them.
>
> **Applying the Principles**
> 1. Read CRNBC’s Scope of Practice for Registered Nurses: Standards, Limits and Conditions to ensure you understand the standards, limits and conditions under which nurses administer medications.

303. The Panel has determined that the Respondent has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Incompetence

304. The Panel has also determined that the Respondent has incompetently practised the profession contrary to section 39(1)(d) of the HPA. The Panel finds that the Respondent displayed a want of ability suitable to the administration of Oxytocin. The Respondent repeatedly failed to adhere to the Oxytocin Protocol. The Panel found multiple instances in which the Respondent increased the Oxytocin infusion without assessing the fetal heart rate or uterine contractions for the requisite period of time, and the Respondent decreased Oxytocin due to maternal pain. While the Respondent is an experienced and qualified nurse, her conduct demonstrates a concerning pattern of incompetent practise. The proper administration of medication in accordance with the Oxytocin Protocol is extremely important to ensure the safety of a pregnant patient and their baby. The Respondent displayed this pattern of incompetent practise with respect to the multiple instances of proven conduct involving Patient A.L. within this allegation. There also exists a broader pattern within the Oxytocin Allegations.

305. The Panel’s findings with respect to the Respondent inconsistency in engagement, accepting feedback and implementing improvements is set out in allegation 1(a) and applies equally in relation to this allegation.

H. PENALTY AND COSTS

306. The Respondent submits that the reversal of allegation 1(c) and the remittal of the Oxytocin Allegations to the Panel for reconsideration require that the Panel also reconsider the Penalty Decision. The Respondent submits that regardless of how the Panel determines the Oxytocin Allegations in this reconsideration, the Conduct Decision has already been drastically altered by the reversal of the Panel's findings in relation to allegation 1(c).

307. The Respondent submits that had the Panel properly determined allegation 1(c) at first instance and held the relevant context in mind when making findings about her credibility and evidence as a whole, the Panel may have made different findings with respect to other allegations against the Respondent. The Respondent argues the Panel's assessment of the Respondent's credibility and truthfulness on other charges may have changed. While those findings are not under appeal, the Respondent argues that the Panel must consider how their finding on allegation 1(c) and misapprehension of evidence on the Oxytocin Allegations may have affected their view of the Respondent and thus, their determinations as a whole.

308. The Respondent argues that a failure to address the necessary impact of the reversal of allegation 1(c) and the reconsideration of the Oxytocin Allegations on the Penalty Decision would not only be procedurally unfair, but an affront to the "high standard of justice" required from the Panel. It would result in a penalties and costs decision so clearly wrong as to amount to an injustice, and directly call into question the legitimacy of and the public's confidence in the College's disciplinary process.

309. The Respondent argues that the Penalty Decision makes multiple references to allegation 1(c). The Respondent submits that it is incumbent upon the Panel to examine the extent to which its findings on allegation 1(c) influenced its view overall of each factor in the *Dent* analysis and in the entire Penalty Decision. The Respondent argues that the length of the suspension ordered relies heavily on the Panel's erroneous determination that she breached professional standards by willfully disregarding protocol and that she was incompetent relating to the Oxytocin Allegations (as well as allegation 1(c)).

310. Ultimately, the Respondent suggests that it would be appropriate for the Panel to remove the 12-month suspension and ban on perinatal nursing. Alternatively, based upon the caselaw originally argued at the penalty stage, she suggests a six-month suspension would be appropriate. The Respondent argues that she has now been non-practising since she voluntarily surrendered her license at the outset of these proceedings and maintaining that non-practising status during the lengthy discipline, statutory appeal, and reconsideration process. She argues this period would be shorter had the Panel not made the findings which were revisited on appeal.

311. The Respondent argues that the costs awarded against her must be reduced in light of the reversal of allegation 1(c) and the reconsideration of the Oxytocin Allegations as those factored into the calculation of the costs award.

312. The College argues that the Panel does not have jurisdiction to reconsider its order with respect to penalty and costs. Had the Respondent wanted to preserve her right of appeal, she ought to have appealed the penalty and costs decision. She did not, which was remarked upon by the Court. The College relies upon *British Columbia (Workers' Compensation Board) v. Figliola*, 2011 SCC 52 and *Law Society of Alberta v. Virk,* 2021 ABLS 28 to argue that the Panel's Penalty Decision is final and as the limitation period for an appeal has passed, the Panel is *funtus officio* with respect to that decision. The College also relies upon *Alberta College of Physical Therapists v Fitzpatrick*, 2015 ABCA 95 and *The Owners, Strata Plan K855 v. Big White Mountain Mart Ltd.*, 2017 BCCA 438.

313. The College submits that the Discipline Committee, which does not have inherent jurisdiction, only has authority to reconsider the issue that has been specifically remitted to it pursuant to s. 40(9)(b) of the HPA and *Big White Mountain*. It is *functus officio* with respect to any other issues. Section 40(9)(b) provides:

> 40…
>
> (9) On the hearing of an appeal under this section, the court may
> (a) confirm, vary or reverse the decision of the discipline committee,
> (b) refer the matter back to the discipline committee, with or without directions, or
> (c) make any other order it considers appropriate in the circumstances.

314. The College submits that section 40(9) must be read together with section 40(1) which provides:

> 40 (1)A college, a respondent described in section 38 (2) or a registrant described in section 39.1 (1), aggrieved or adversely affected by an order of the discipline committee under section 39 or 39.1 (1), may appeal the order to the Supreme Court.

315. The College submits that the Respondent appealed the Conduct Decision that determined that she had breached the standards of the HPA, committed professional misconduct, and practiced incompetently. She did not appeal the Penalty Decision, which was released after the Conduct Decision. Accordingly, the only issues that were before the Court on appeal were the conduct findings. The Court ordered that one finding was reversed and that three other findings were quashed and remitted for reconsideration. He did not address the issue of penalty, as it was not before him, and he could therefore not refer the matter of penalty back to the Discipline Committee.

316. The College submits that the penalty decision, not having been appealed was a final decision following *Figliola*. None of the recognized exceptions to *functus officio* discussed in *Virk* apply in the circumstances. The Panel therefore does not have any jurisdiction to reconsider penalty.

317. The College submits that in any event, the most serious findings of the Panel were not disturbed on appeal and were not appealed. Moreover, even if the Panel determined that the Respondent's failures were limited to repeated breaches of the Medication Administration Standard on reconsideration, the penalty order remains proportionate, appropriate, and falls within the range of reasonable outcomes when considering the charges of the Citation that were proved and therefore leaving the penalty undisturbed would not "violate principles of natural justice".

318. The College argues that the Panel found that the Respondent committed professional misconduct in relation to allegation 1(f) of the Citation and said the following regarding the Respondent's explanation for her failure to adhere to nursing standards:

117. The Panel does not accept Ms. Whieldon's version of events. Her evidence is not plausible. The Panel does not accept that Ms. Whieldon's discussions with [Patient #5 (B.R.)] were in relation to a possible second dose of Erythromycin ointment. If Ms. Whieldon thought there was confusion about whether Ms. Loewen gave the medication within the first hour, it is not plausible she would ask Ms. Hull to call Ms. Loewen when she woke up, possibly several hours later, when Ms. Whieldon knew the urgency of the window within which to give the medication.

118. The Panel does not accept that Ms. Whieldon checked "Informed Refusal" on the patient record to remind herself about the possible second dose later and to prompt other nurses to approach her with questions. The Panel does not accept that there were no Informed Refusal forms available on the unit and prefers Ms. Hull's evidence that they were readily available. In any event, the Panel finds it inconsistent that Ms. Whieldon pointed to the lack of Informed Refusal forms as justification for not having completed an Informed Refusal in relation to a second dose, and at the same time, asserts a belief that Ms. Loewen administered the Erythromycin ointment, in which case an Informed Refusal would be unnecessary, whether for a first or second dose. The Panel also accepts Ms. Hull's testimony that a second dose of Erythromycin ointment is simply not done, and finds that if this had occurred, it would be more likely that Ms. Hull would have recalled a discussion with Ms. Whieldon about a second dose and how unusual that would have been.

119. The Panel finds that [Patient #5 (B.R.)] inquired with Ms. Whieldon about whether Erythromycin ointment had been given to her son, Ms. Whieldon told her that it was too late to give the medication, and that [Patient #5 (B.R.)] was low risk. The Panel finds that Ms. Whieldon failed to escalate the issue to her CN, PCC or the MRP, when by all accounts there was either a missed dose or contemplation of administering a second dose of Erythromycin ointment to [Patient #5 (B.R.)]'s son. The Panel finds that Ms. Whieldon did not conduct an Informed Refusal process with [Patient #5 (B.R.)] and did not obtain [Patient #5 (B.R.)]'s Informed Refusal for Erythromycin ointment. The Panel finds that Ms. Whieldon's entry in the patient record that an Informed Refusal had occurred was false.

319. The College notes that in addition to finding that the Respondent breached the Professional Responsibility and Accountability, Client Focused Provision of Service, Scope of Practice Professional Standards, the Panel found that the Respondent breached the Ethical Practice Standard by failing to make the client the primary concern in providing nursing care and by failing to demonstrate honestly and integrity.

320. The College argues that the penalty is fitting for a nurse who lied to a patient about care required by law for their newborn, who created false and misleading and/or confusing documentation in that infant's clinical record to bolster her lie, and then

continued to lie to the Panel about what happened when she swore on oath to tell the truth at her discipline hearing. The College submits that this lack of integrity and honesty, coupled with this Registrant's incompetence with respect to basic skills integral to peri-natal nursing – like interpreting external electronic fetal heart monitoring strips; discharging patients with an order, and knowing how to escalate concerns appropriately like when it was unclear the baby received their erythromycin - make the ordered limits and conditions reasonable in the circumstances even if the Panel changes its findings on reconsideration with respect to the Oxytocin Allegations.

321. The Respondent requested leave to make sur reply submissions, which the Panel permitted. The Respondent argues that *functus officio* does not apply in this case as the Penalty Decision was not a final decision. The Respondent argues in the alternative, that this matter falls within an exception to the *functus officio* doctrine because the Conduct Decision upon which the Penalty Decision was based violated principles of natural justice and rules of procedural fairness, as found by the Court.

322. The Respondent relies upon *Ontario English Catholic Teachers' Association v. Toronto Catholic District School Board*, 2020 ONSC 5953, which held that it is appropriate for a tribunal to reconsider or re-open a matter where (a) its statute authorizes it to do so; (b) the tribunal still has jurisdiction or has retained jurisdiction to dispose of an issue it has not yet disposed of; and (c) the tribunal "has been permitted to reconsider the matter afresh and render a valid decision".

323. The Respondent points out that a stay of the Penalty Decision order was negotiated by the parties and ordered by the Panel pursuant to its statutory authority. The Respondent submits this means that the Panel possesses an implied power to reconsider that which was stayed.

324. The Respondent argues that the stay terms expressly contemplate the Panel retaining its jurisdiction with respect to the Penalty Decision Order, pending the outcome of the appeal of the Conduct Decision: "Whether the Panel's Order on Penalty and Costs takes effect at the end of the Stay Period occasioned by the issuance of the Court's Reasons for Decision on the Appeal depends on whether

the Court's decision alters the Liability Decision underlying the Order on Penalty and Costs. If the Appeal is dismissed, the Panel's Order on Penalty and Costs would take effect immediately."

325. The Respondent also argues that the *Fitzpatrick* decision referred to by the College is distinguishable from the facts of this case.

326. The Panel declines to reconsider or alter its Penalty Decision for the following reasons. First, the Court expressly noted that the Penalty Decision had been issued, it set out the penalties and costs that were ordered, it remarked that the Conduct Decision was appealed pursuant to section 40 of the HPA, and it confirmed that no appeal of the Penalty Decision had been filed.

327. The Court issued no directions to the Panel to reconsider penalty and costs in this matter.

328. Second, sections 39(1), 39(2) and 40(1) of the HPA afforded the Respondent the right to appeal both the Conduct Decision and the Penalty Decision. The Penalty Decision expressly advised the Respondent of her right to appeal that decision and the time limitation within which to do so. It is not disputed between the parties, and it was a finding of fact by the Court, that the Respondent did not appeal the Penalty Decision. The Respondent has not provided any cases in support of her position involving a professional regulation tribunal that reconsidered its penalty decision where an appeal right exists but was not exercised, and only the conduct decision was appealed and remitted for reconsideration.

329. Third, in seeking to entirely eliminate the Respondent's suspension, the limit that the Respondent is not permitted to work in perinatal nursing, and all legal costs and disbursements, the Respondent is effectively seeking to reverse the core of the Penalty Decision without having exercised her statutory appeal. In support of that position, the Respondent argues that the appeal has prolonged her period of non-practising status; however, the Respondent voluntarily stepped away from the practice of nursing before any of the Panel's orders and took the position in her written submissions on penalty and costs to the Panel that "[she] will agree not to return to her nursing career, in perinatal nursing or otherwise".

330. Fourth, the Panel's Penalty Decision is a final decision. The general rule is that once a decision-maker has rendered its final decision, it is *functus officio*.

331. There are only limited circumstances in which a decision-maker such as this Panel may re-open its own proceedings to reconsider a decision it has already rendered. It can only do so where it is authorized by statute or if there has been a non-substantive slip or error. The Panel finds that these exceptions set out in *Chandler v. Alberta Association of Architects*, 1989 CanLII 41 (SCC) (cited in *Virk*) do not apply in this case. It can only do so where it is authorized by statute or if there has been a non-substantive slip or error. There is no express statutory authority in the HPA for the Panel to reconsider or re-open its decisions, and there has been no such slip or error. Even if one were to consider that an error that renders its decision a nullity such as a denial of natural justice constitutes an exception, that too is not engaged here. There has been no breach of natural justice in relation to the Penalty Decision. The Judgment Reasons made no such finding, and it is not open to the Respondent to extrapolate and expand the findings from the Conduct Decision to the Penalty Decision which were neither appealed nor before the Court.

332. Even if the Panel is not *functus officio*, the Panel would still decline the Respondent's request. The Panel does not accept with the Respondent's submission that the Conduct Decision has drastically been altered by the reversal of the Panel's findings in relation to allegation 1(c). The majority of the proven allegations in the Conduct Decision were not appealed and remain intact. Specifically, the five allegations in paragraphs 1(a)(ii)(iv), (c), (d), (f), (g)(ii), (h)(iii), and (j) were undisturbed. The Panel has reconsidered the Oxytocin Allegations, and those three allegations were proved on a balance of probabilities. Accordingly, only one allegation has been quashed by the Court and eight allegations have been proved against the Respondent. The proven conduct is very serious. The Panel agrees with the College's submissions outlined above which it will not reproduce again here about the severity of the Respondent's conduct and the proportionality and reasonableness of the penalty.

333. The Respondent's characterization of the Panel's references to allegation 1(c) in the Penalty Decision omits the Panel's other important findings, such as at paragraph 33 where the Panel held:

> [33] The Panel finds that the nature and gravity of the proven conduct is very serious. In the Verdict Decision, the Panel found the Respondent to have breached multiple standards imposed under the Act, including professional responsibility and accountability standards, knowledge-based practice standards, and medication administration standards. The Panel found the Respondent to have committed professional misconduct, and to have incompetently practiced the profession. The proven conduct involved multiple instances, of multiple different forms of problematic conduct, over the course of multiple months.

334. Because of the extent, scope, severity and volume of the Respondent's remaining conduct, these findings by the Panel in the Penalty Decision remain well founded despite the removal of allegation 1(c). Likewise, the costs remain proportionate and reasonable in the circumstances. The majority of the Citation allegations were proven and the allegations that took the most time and resources to advance were proven by the College. The hearing would have been the same number of days without allegation 1(c) and any reduction in documents and size in the expert report would have been negligible.

335. For these reasons, the Panel also finds that it would not be unfair to not adjust the orders for penalty and costs in the Penalty Decision.

I. ORDER

336. In summary, the Panel finds that the College has proven the allegations in paragraphs 1(a)(i), 1(g)(i), and 1(h)(i) of the Citation to the requisite standard.

337. Pursuant to section 39(1) of the HPA, the Panel has determined that the Respondent:

    a. Has not complied with a standard imposed under the Act and has incompetently practised the profession in relation to the allegation at paragraph 1(a)(i) of the Citation;

b. Has not complied with a standard imposed under the Act and has incompetently practised the profession in relation to the allegation at paragraph 1(g)(i) of the Citation; and

c. Has not complied with a standard imposed under the Act and has incompetently practised the profession in relation to the allegation at paragraph 1(h)(i) of the Citation.

Delivery and Public Notification

338. The Panel reminds the College of the requirements in section 39(3)(c) of the HPA.

339. The Panel directs that pursuant to sections 39.3(1)(d) of the Act, the Registrar notify the public of the determination made herein.

340. The Panel directs pursuant to section 39.3(3)(a) of the Act, the Registrar withhold part of the information otherwise required to be included in the public notification under this section as the Panel considers it necessary to protect the interests of the complainants and other persons affected by the matter. This includes patient names and identifying information.

Notice of Right to Appeal

341. The Respondent is advised that under section 40(1) of the Act, a respondent aggrieved or adversely affected by an order of the Discipline Committee under section 39 of the Act may appeal the decision to the Supreme Court. Under section 40(2), an appeal must be commenced within 30 days after the date on which this order is delivered.

Dated: October 27, 2023

Sheila Cessford, Chair

Edna McLellan, Non-Practising RN