ARNPEI Professional Conduct Review Committee
Formal Inquiry Panel Report
Complaint # PE-2013-002
Re: Cynthia "Cindy" MacDonald, Member Registration no. 005440

Introduction

The Formal Inquiry Panel of the Professional Conduct Review Committee of the Association of Registered Nurses of Prince Edward Island (now, the College of Registered Nurses of Prince Edward Island) conducted a formal inquiry hearing, in Charlottetown, P.E.I., in relation to a complaint filed on June 6, 2013 by Mary Harris, Marilyn MacDonald, and Eileen Larkin against Registered Nurse Cynthia MacDonald, registration number 005440. At the time of the complaint, Mary Harris was Acting Director of Nursing at the Queen Elizabeth Hospital (QEH), Marilyn MacDonald was Nurse Manager of Unit 2 at the QEH, and Eileen Larkin was Acting Nurse Manager at Unit 2 of the QEH.

The complaint was filed on June 6, 2013, but the formal inquiry did not begin until December 1, 2017, for a number of reasons. Once the hearing began, it was delayed on a number of occasions and continued over 10 hearing days, eventually concluding on January 27, 2020.

The incidents described in the complaint were all alleged to have occurred while the *Registered Nurses Act* was in force, and the hearing began when that was the case. Although the hearing did not conclude until after the *Registered Nurses Act* was repealed and replaced by the *Regulated Health Professions Act* ("RHPA"), the parties agreed that section 99 of the RHPA required the hearing to be concluded under the *Registered Nurses Act* as though the RHPA had not become law.

The purpose of this formal inquiry is explained in subsection 30(4) of the *Registered Nurses Act*, which states:

> 30(4) After considering the evidence presented at a hearing, the Review Committee shall determine whether
> (a) the complaint should be dismissed; or
> (b) the respondent suffered or suffers from incapacity or is guilty of professional misconduct, conduct unbecoming the profession, incompetence, incapability or lack of fitness to practice, as the case may be.

In the case of Cynthia MacDonald, as indicated in the Notice of Formal Hearing dated October 5, 2017, the following allegations were considered:

1) THAT on or about Thursday, January 24, 2013, while Ms. MacDonald was employed as a registered nurse on Unit Two of the Queen Elizabeth Hospital (the "QEH"), a thirty six bed medical-surgical unit located at 60 Riverside Drive in Charlottetown, Prince Edward Island, she failed to locate medication requested for a seizuring patient on an urgent basis;

2) THAT on or about Sunday, January 20, 2013, while Ms. MacDonald was employed as a registered nurse on Unit Two of the QEH, she inserted a catheter without appropriate use of a numbing agent, in circumstances where the patient was in apparent discomfort:

3) THAT between January 18, 2013 and March 7, 2013, while employed as a registered nurse on Unit Two of the QEH, Ms. MacDonald engaged in the following behaviors which reflected poor nursing practice:

   a) failure to properly administer medication, including:
      i) failure to administer medication safely or when required;
      ii) failure to assess patients for pain; and
      iii) failure to check allergy bands.
   b) failure to use proper nursing technique, including:
      i) failure to utilize proper IV technique;
      ii) failure to perform a general assessment of patients; and
      iii) failure to take appropriate steps to maintain hand hygiene or to avoid the transmission of infection.
   c) failure to report information in an accurate and timely fashion to colleagues.
   d) failure to complete required administrative tasks, including:
      i) failure to process physician orders;
      ii) failure to coordinate consults;
      iii) failure to order medication as required; and
      iv) failure to complete relevant documentation as required.

The Notice of Formal Hearing alleged that by doing these activities, Cindy MacDonald engaged in professional misconduct, incompetence, incapacity and/or lack of fitness to practice.

Members of the Professional Conduct Review Committee Formal Inquiry Panel (hereafter referred to as "the Panel") were: Robin Laird (chair), Elaine Blanchard (member), Jill MacKinnon (member), and Craig McDowell (public representative). The complainants were Mary Harris, RN, Eileen Larkin, RN and Marilyn MacDonald (who died before the hearing could be concluded). The respondent, Cynthia MacDonald, attended all hearing dates with the exception of November 27th, 2019. November 27th was not a date to officially resume the hearing, rather it was planned as a time for all parties to come together to select dates to resume the hearing. The panel was becoming increasingly concerned with the length of time it was taking for the judicial review and decided the hearing should resume. Ms MacDonald, nor her solicitor, attended that day. The panel selected the dates for the hearing to resume in their absence. During the time frame mentioned above, there have been three different solicitors for the respondent: Karen Campbell for the first two hearing days; Nicole Brown for the next seven hearing days, and Jordan Brown, who represented Ms. MacDonald at the final hearing day. Tom Keeler was the solicitor appointed to adduce evidence for the Association of Registered Nurses of Prince Edward Island (ARNPEI). Mr. Doug Drysdale was legal counsel and advisor for the Panel. Representatives from the Office of the Future (now, Island Confidential Associates Inc.) recorded the formal hearing audio at each of the hearing dates.

The Panel was brought together to determine whether Cynthia MacDonald is guilty of any matters alleged in the Notice of Formal Hearing, and if so, to determine an appropriate penalty, and to report the outcome to the Council of the College of Registered Nurses of Prince Edward Island, the complainants and the respondent. This document is our report to Council.

The Formal Inquiry hearing commenced on December 1, 2017, and an Agreed Statement of Facts was introduced by Mr. Keeler, and agreed to by Cindy MacDonald and her lawyer. The Panel chose to not accept this document due to lack of clear admissions of responsibility for the professional misconduct alleged in the Notice. The parties requested an opportunity to try again, and a revised Agreed Statement of Facts was presented to the Panel on February 7, 2019; however, it was also rejected by the Panel. The amount of information contained in the second Agreed Statement of Facts, particularly in light of Cindy MacDonald's admission to only a vague portion of one of the allegations, did not give the Panel confidence that it could determine an appropriate penalty.

Tom Keeler was directed to prepare the case for consideration by the Panel, with the attendance of relevant witnesses and documents, in compliance with the Professional Conduct Review Regulations, upon proper notice. The parties were advised that the hearing would begin again when they were ready.

The hearing resumed on July 10th, 2018 with lawyer Nicole Brown representing Cindy MacDonald. The first two days of the three days set aside were spent on a motion from the member for a stay/dismissal based on lengthy delay and stating that the delay had prejudiced the member because one of the complainants, Marilyn MacDonald, had recently died. The panel received affidavit evidence from Ms. Brown and from Mr. Keeler and decided not to dismiss the hearing for delay. The Panel gave its decision at that time, and acknowledged that there had been regrettable delay in this case, but the simple fact of delay did not mean necessarily that the complaint should be dismissed. There were a number of reasons for delay, some of which were attributable to the Association, some of which were attributable to the member or her lawyers, and some of which was simply due to scheduling problems. The Panel was not convinced that Marilyn MacDonald's evidence was vital to the member's case, although what that evidence might have been was not clearly explained. The Panel did note that if this witness had possessed relevant evidence, her absence from the hearing could have been detrimental to Mr. Keeler's case as well as to the member's case, because Marilyn MacDonald was, after all, one of the complainants.

The Panel decided that the delay was not unreasonable and did not prejudice the member's ability to defend herself. The purpose of professional conduct review proceedings is to hold nurses accountable for substandard conduct for the purpose of protecting the public. This purpose is not served if complaints are dismissed without a full hearing of the facts. While delay might in some cases warrant ending a hearing, the circumstances of the delay in this case did not call for that severe result.

The first witness was called to testify on July 12th, 2018. Witness testimony continued on August 24th and 27th, 2018 and on September 4, 2018. During these days of testimony, multiple exhibits were introduced and reviewed. The two complainants testified, as well as the

investigator for ARNPEI. Testimony was heard from an experienced clinical nurse who had assessed Ms. MacDonald's practice. On September 10, 2018, the hearing was adjourned by the Panel when Nicole Brown insisted that she be allowed to proceed to court to seek judicial review of the process which had been followed to date. [redacted]

This Panel was not directly involved in the judicial review process, although it was informed that a judicial review application had been filed in the Supreme Court of Prince Edward Island. More than a year passed, and the Panel decided to continue the hearing, even though the judicial review process had not been completed. The member had previously expressed significant concern about delay, and the panel felt that too much time had passed. The Panel wrote to the parties on October 3, 2019, and Tom Keeler responded that he had been contacted by Karen Campbell that Nicole Brown was no longer working for her law firm, and Ms. Campbell had indicated that the file would be reassigned, most likely to Ms. Campbell herself.

The panel booked the date of November 27th, 2019 for all parties to come together to select dates to resume the hearing. However, neither Cindy MacDonald nor Karen Campbell or any representative showed up (Ms. Campbell later apologized in writing for missing the meeting). The panel chose the dates of January 27, 28, and 29, 2020 to resume the hearing. The hearing resumed on January 27th at 0900hr with the same people present, except Jordan Brown, the lawyer now representing Ms. MacDonald, attended, rather than Ms. Campbell.

[redacted]

Agreed Statement of Facts

At the continuation of the hearing on January 27th, 2020, Tom Keeler presented a new Agreed Statement of Facts; in this, the member admitted to each of the allegations and admitted that she had engaged in the activities described in the Agreed Statement of Facts, and she acknowledged that her conduct was professional misconduct as that term was described in the *Registered Nurses Act*.

The panel recessed to review the Agreed Statement of Facts, and questioned why the member had only accepted responsibility for professional misconduct, when other types of misconduct (namely, incompetence, incapacity, and lack of fitness to practice) had also been alleged against her. The parties did not explain this, but the Panel has concluded that the definition of professional misconduct includes violations of the Code of Ethics and Standards of Practice which require competence and capacity and fitness to practice, and the Panel is satisfied that the member's acceptance of responsibility is sufficient as a result. The Panel accepted the Agreed

Statement of Facts as presented and noted that no further evidence would be required at the hearing.

Based on the Agreed Statement of Facts and the evidence already presented, the Panel found Cindy MacDonald guilty of professional misconduct in relation to each of the allegations set out in the Notice of Formal Hearing.

Each of the allegations taken individually and separately, constitute professional misconduct, but perhaps with employer education and training could have been addressed. The fact that Ms. MacDonald, while not an experienced nurse, had worked for well over a year post her preceptorship, combined with the number of allegations, posed a risk to patient safety and greatly concerned the panel. One would expect that a nurse working on the same unit would know the location of medications in an emergency and if not, would immediately be seeking assistance. As well, when options exist to minimize patient discomfort, they should be exercised. What the panel found to be most concerning was the volume of allegations and the fact that some constitute the most basic of nursing practice, such as proper hand hygiene and medication safety. Ms. MacDonald's failure to properly communicate lead to poor reporting and documentation, both of which pose a risk to patient safety.
The panel remains somewhat concerned that Ms. MacDonald does not have insight into these findings. There were two previous Agreed Statements of Facts that did not address most of the allegations and were rejected by the panel. The panel did not have an opportunity to hear evidence from Ms. MacDonald in regards to most of these allegations, so are uncertain whether she truly understands the risks her practice posed to patient safety. In light of that, the following Penalty is imposed.

Penalty

Mr. Keeler presented a Joint Recommendation on Penalty, which was submitted jointly with the member and her lawyer. He outlined the thinking behind the decisions and his reasoning. Mr. Brown was given the same opportunity. The Panel thanked those present and adjourned the hearing with a commitment to determine the penalty and notify the member in a timely manner.

The Joint Recommendation has been reviewed by the Panel, and the Panel feels that while some of the recommendations are acceptable, some require modification. The Panel is persuaded that the years which have passed since the complaint was made, during which Cindy MacDonald has practiced as a registered nurse without apparent incident (in a non-acute care setting) is strong evidence that she can practice safely, at least in that environment. However, in considering the evidence that was heard during the hearing and the Agreed Statement of Facts, the Panel remains concerned with Ms. MacDonald's ability to problem-solve in a stressful, fast-paced environment, her ability to team-lead and multitask, and her ability to translate theory into practice.

During the hearing, evidence presented by Tracy Hagan-O'Connor concerning lack of proper hand hygiene, lack of allergy checks, lack of pain assessments and failure to document relevant information, are examples of entry-level standards that Ms. MacDonald should have been meeting at the time the incidents occurred. A qualified registered nurse must not only know the standards, but must also practice them consistently.

In light of those concerns, the following penalty is imposed:

1) Ms. MacDonald will have the following conditions placed on her nursing registration effective the date this decision is delivered to her counsel:

    a) Within six months of the date of this decision, Cindy MacDonald shall complete a clinical practice assessment in the area of geriatric nursing care with a Nursing Expert ("Expert") acceptable to the Coordinator of Regulatory Services at CRNPEI, in the field of Geriatric Nursing, at her own expense. To comply, Ms. MacDonald is required to ensure that:

        i) the Expert has expertise in nursing practice standards for geriatric care and is approved by this panel to conduct this assessment;

        ii) the Expert has been provided with a copy of the complaint, notice of hearing, agreed statement of facts, and this report;

        iii) she has reviewed the CRNPEI *Standards of Practice* and the *Code of Ethics*, at least one week prior to meeting with the Expert for the first time and provide the expert with a written statement of at least 1000 words reflecting on the issues identified in the decision issued by this panel in relation to this matter;

        iv) the subject of the sessions with the Expert will include:

            (1) practice standards;
            (2) any acts or omissions committed by Ms. MacDonald as identified in the Decision, including any professional misconduct or violations of the CRNPEI *Standards of Practice* or the *Code of Ethics;*
            (3) the potential consequences of professional misconduct to Ms. MacDonald's clients, colleagues, profession and self;
            (4) strategies for preventing professional misconduct from recurring;
            (5) the development of a learning plan containing competencies in collaboration with the Expert, if necessary.

        v) Within thirty (30) days of the completion of the final session with the Expert, Ms. MacDonald shall require the Expert to forward a report to this Panel, in which the Expert will confirm:
            (1) the dates of completed sessions;
            (2) that Ms. MacDonald reviewed the practice standards for care of the elderly and verbalized understanding to the Expert;
            (3) that Ms. MacDonald reviewed the CRNPEI *Standards of Practice* and the *Code of Ethics* prior to meeting with the Expert;
            (4) that the Expert reviewed or confirmed appropriate review of the required documents and subjects with Ms. MacDonald;
            (5) the successful completion of any required learning plan; and

(6) the Expert's independent assessment of Ms. MacDonald's insight into her behavior.

vi) If Ms. MacDonald does not comply with any one or more of the requirements above, the Expert
   (i) may cancel any scheduled session, even if that cancellation results in a breach of a term, condition or limitation on Ms. MacDonald's certificate of registration; and
   (ii) shall notify the Panel, and the Panel will consider possible alternatives or additional penalties.

b) Cindy MacDonald shall provide a copy of this written decision to her current employer, and, for a period of five (5) years from the date of this decision, shall provide a copy of this decision to any employer who offers her employment as a registered nurse, and Ms. MacDonald shall provide written verification from any such employer to CRNPEI, within two (2) weeks of receiving any such offer.

c) Ms. MacDonald's registration with CRNPEI will be subject to the condition that she must obtain the approval of the Registrar of the College in the event that she chooses to practice outside of the care of the elderly, and the Registrar shall determine whether she has the necessary professional knowledge and skills to practice in the different area. The Registrar shall have discretion to approve the change in practice without requiring the member to obtain further education or training, and shall not withhold approval unreasonably, but may require Ms. MacDonald to be tested or to complete refresher training, depending on the circumstances at the time.

2) The conditions described in paragraph 1(a) above shall be removed once this Panel has reviewed the Expert's Report and accepted it as satisfactory.

3) Ms. MacDonald shall be required to pay a fine to CRNPEI in the amount of Four Thousand Dollars ($4,000.00), which fine shall be paid in Twenty Four (24) equal monthly installments of $166.67 by pre-authorized debit commencing on March 1, 2020, or such other accelerated payment terms as may be agreed to by Ms. MacDonald and CRNPEI;

4) Ms. MacDonald shall be required to pay CRNPEI the amount of Fifteen Thousand Dollars ($15,000.00) in respect of the expenses associated with the investigation and adjudication of this complaint. These expenses shall be paid in Seventy-Two (72) equal monthly installments of $208.33 by pre-authorized debit commencing no later than March 1, 2022, or such other accelerated payment terms as may be agreed to by Ms. MacDonald and CRNPEI;

5) Failure to comply with any of the above conditions, including the failure to pay any installment of the fine or the expenses, will render Cindy MacDonald ineligible to apply for registration with CRNPEI.

Summary Notes from the Panel

This has been a very difficult case for the panel. We believe there was a multitude of reasons for this and the panel felt it important to note a few factors that contributed.

- Delay. There was significant delay in this case and the Panel would like to acknowledge that a portion resided with the CRNPEI and a portion with the member. A significant challenge was in regards to scheduling. Trying to schedule 2-3 days in a row between 3 lawyers, 2 complainants, the member and 4 Panel members (who volunteer their time) is difficult. The Panel appreciated that everyone appeared to do their best to move things along in this regard. The Panel does not believe that the delay altered the outcome.
- Environment. Everyone on the Panel has participated in some capacity in the PCR process before this case. This was, without a doubt, the most hostile any of us have encountered and has left an impression on us. The actions and unnecessary aggression of Ms. Brown was unlike anything any of us have previously encountered in hearings and it created an atmosphere of hostility and stress in which nobody benefitted.
- Agreed Statement of Facts. It took three Agreed Statement of Facts before the Panel felt that the allegations were addressed. Sound reasoning must be applied in the development of these statements. One should consider that the majority of the panel is made up of RNs who understand the practice of nursing, so each allegation **has** to be addressed.
- Judicial Review. The panel felt that Ms. Brown used the mention of going to court as a strategic "ploy" on several occasions, and, on September 10, 2018, when Ms. Brown insisted that she be permitted to seek judicial review in court, the Panel agreed to adjourn the hearing, partially out of frustration, to allow her to address her concerns elsewhere. This caused some delay, but it did provide a "cooling off" period, and a time to reset the process. We encourage the member to apply herself in satisfying the registration conditions so that she may move on to have a successful nursing career.

Respectfully submitted this 4th day of March, 2020.

Robin Laird
Chair, Formal Inquiry Panel