College of Registered Nurses of PEI (CRNPEI)

Hearing Committee Decision

Complaint # 2017-008

Re: Kelly Campbell, Member Registration #005947

A Hearing Committee of the College of Registered Nurses of Prince Edward Island (the "Committee") conducted a hearing in Charlottetown, PE on November 30, 2018, to consider a complaint dated July 21, 2017 against Registered Nurse Kelly Campbell, registration number 005947. The Hearing followed a meeting of the Investigation Panel of the former Professional Conduct Review Committee which resulted in a written decision from that Panel dated July 30, 2018 to proceed to a formal inquiry. That decision states that the Panel met on July 3, 2018, to make its decision.

The next day, July 4, 2018, the *Registered Nurses Act* and the Professional Conduct Review Regulations were repealed and replaced by the *Regulated Health Professions Act* (the "RHPA"). This Committee has received legal advice that sections 32 and 33 of the Prince Edward Island *Interpretation Act* and section 99 of the RHPA require this Committee to follow the process in the RHPA, but to assess the nurse member's conduct according to the law as it was at the time of the incidents alleged against her; that is, the *Registered Nurses Act* and its PCR Regulations. We agree with this advice, and observe that this is fair to the member, Kelly Campbell.

Members of the panel in attendance at this hearing were: Tara Roche (chair); Sandra MacKay (member); and Shirley Urquhart (public representative). Also in attendance were: Complainant, Kim Wood; Respondent, Kelly Campbell; Adducer, Tom Keeler; Legal Counsel for the Respondent, Christopher Montigny; and Legal Counsel and Advisor for the Committee, Doug Drysdale. A representative from Island Confidential Associates audio recorded the formal hearing. Kelly Campbell's father was also in attendance as her support.

The purpose of the hearing on November 30, 2018, was to determine whether Kelly Campbell engaged in activities that were either or both professional misconduct and/or incompetence, as those terms are defined or used in the PCR Regulations, between approximately May 2017 and June 2017. The conduct to be reviewed occurred during approximately two months of working on Unit 8 at the Queen Elizabeth Hospital, Charlottetown, PE. Two allegations were presented.

1. In summary, Allegation 1 involved a patient (referred to hereafter as "Patient A") that was admitted to QEH with a suspected infectious process on May 28, 2017. At the time of admission Patient A was identified as having "Full Code" status, meaning that if this patient was discovered unresponsive, with no pulse or breath sounds, Health Care staff are obligated to call a Code Blue and initiate life-saving procedures. On May 30, 2017, when Kelly Campbell observed that Patient A was unresponsive, with no pulse or discernible respiratory function, MS. Campbell left Patient A's room and asked for assistance related to pronouncing Patient A dead, rather than initiating

life-saving procedures. Following the declaration of death it was noted that Patient A was "Full Code" and the Code Blue was then initiated, which lead to a delay in life-saving procedures with the end result being death of Patient A. Further, Kelly Campbell incorrectly documented in Patient A's chart related to time of assessments and times of initiation of life-saving procedures. Detailed descriptions of allegations related to Patient A are outlined in The Joint Book of Documents (Exhibit 3).

2. In summary, Allegation 2 involved a patient (referred to hereafter as "Patient B") that was transferred to ICU on June 3, 2017 and was mechanically ventilated for 7 days following care on Unit 8 at QEH, which was assigned to RN Kelly Campbell. Kelly Campbell received order suggestions from a surgeon who assessed Patient B on June 2, 2017 at approximately 2000h. Kelly Campbell inquired about the suggested orders with the surgeon who directed her to contact the admitting physician for Patient B to confirm whether the orders should be applied. Kelly Campbell did not contact the admitting physician until Patient B was very ill approximately 7 hours later (0300h). Patient B was subsequently transferred to ICU. Other Health Care Providers had concerns that were communicated to Kelly Campbell that Patient B's health was declining during these 7 hours. Kelly Campbell's documentation relating to Patient B's care on her shift was found to be inaccurate and incomplete.

The Panel also had the task of deciding an appropriate penalty, if warranted. A Notice of Formal Hearing dated September 7, 2018, and an Amended Notice of Formal Hearing dated November 27, 2018, contained the allegations against the member, Kelly Campbell, and these documents were the basis of the hearing. The Notices incorrectly referred to a hearing date of Friday, October 5, 2018, but all participants attended on November 30, 2018, except Mary Harris, one of the complainants, and the correct hearing date was noted for the record, with no objections to proceeding with the hearing on November 30. The Amended Notice of Formal Hearing alleged:

1. On or about May 30, 2017, while employed as a Registered Nurse on Unit 8 of the Queen Elizabeth Hospital, you engaged in conduct in relation to the treatment of Patient A which violated the provisions of the Act, as follows:
    a. you failed to recognize the code status of Patient A, and as a result failed to take required steps to respond to Patient A's status;
    b. you failed to demonstrate knowledge of the applicable emergency procedure in relation to the treatment of Patient A;
    c. you provided false or incorrect information to other health team members relating to the delay in reporting the code status of Patient A;
    d. you completed false or incorrect medical records, which includes documenting interventions and assessments as having been performed with respect to Patient A when they were not, and documenting false or incorrect information regarding the time at which code status was requested with respect to Patient A; and

e. you failed to demonstrate accountability for your practice by failing to report the full extent of an error with respect to the treatment of Patient A, contrary to applicable policies and procedures.

2. On or about June 2nd and 3rd, 2017, while employed as a Registered Nurse on Unit 8 of the Queen Elizabeth Hospital, you engaged in conduct relating to the treatment of Patient B which violated the provisions of the Act, as follows:
    a. you failed to appropriately communicate with a physician or supervisor in relation to the health status of Patient B;
    b. you failed to respond in a timely manner to the health status of Patient B;
    c. you failed to appropriately assess or document assessments performed in relation to Patient B, and did not appropriately respond to the expressed concerns of other health team members in relation to the health status of Patient B.

At the beginning of the hearing, Chair Tara Roche read the Amended Notice of Formal Hearing, and confirmed that written notice of this Hearing had been received by all parties.

The Chair asked if there were any objections to the inclusion of any of the Committee Members on the Hearing Committee. There were no objections. Chris Montigny, lawyer for Kelly Campbell, said that Ms. Campbell had no concerns about procedure, as she was willing to accept responsibility for her actions, and did not require a full hearing.

Tom Keeler, adducer of evidence, provided a Joint Book of Documents (Exhibit 3), and indicated he and Christopher Montigny had prepared an Agreed Statement of Facts (Exhibit 4) for the Committee's consideration. This document was circulated and Tom Keeler read through the Agreed Statement of Facts. Following this, the Committee recessed to consider it. The Agreed Statements of Facts was signed by Tom Keeler, Chris Montigny and Kelly Campbell and dated November 30th, 2018. At the resumption of the hearing, Chair Tara Roche stated that the panel accepted the Agreed Statement of Facts and agreed that no further presentation of evidence would be necessary.

In the Agreed Statement of Facts, Kelly Campbell admits that her conduct constituted both professional misconduct and incompetence contrary to subsection 30(4) of the Act. Specifically, Ms. Campbell admits that the facts stated in the document support the conclusion that she:

a. failed to recognize the code status of Patient A, and as a result failed to take required steps to respond to Patient A's status;
b. failed to demonstrate knowledge of the applicable emergency procedure in relation to the treatment of Patient A;
c. provided incorrect information to other health team members relating to the delay in reporting the code status of Patient A;
d. completed incorrect medical records, which includes documenting interventions and assessment as having been performed with respect to Patient A when they were not, and documenting incorrect information regarding the time at which code status was requested with respect to Patient A;

e. failed to demonstrate accountability for her practice by failing to report the full extent of an error with respect to the treatment of Patient A, contrary to applicable policies and procedures.

With respect to Patient B, Ms. Campbell admitted in the Agreed Statement that her conduct comprised both professional misconduct and incompetence contrary to subsection 30(4) of the Act. Specifically, Ms. Campbell admitted that the facts in the Agreed Statement support the conclusion that she:

a. failed to appropriately communicate with a physician or supervisor in relation to the health status of Patient B;
b. failed to respond in a timely manner to the health status of Patient B and;
failed to appropriately assess or document assessments performed in relation to Patient B, and did not appropriately respond to the expressed concerns of other health team members in relation to the health status of Patient B.

In accepting the Agreed Statement of Facts, the panel found Kelly Campbell to be guilty of professional misconduct and incompetence in relation to both of the allegations in the Amended Notice of Formal Hearing.

Tom Keeler then presented a Joint Recommendation on Penalty (Exhibit 5) to the Committee, which was signed by Tom Keeler and Chris Montigny, and dated November 30th, 2018. Mr. Keeler explained why he felt the penalty described in the document was appropriate in the circumstances of this case.

Chris Montigny, legal counsel for the Respondent, then was given an opportunity to explain his client's perspective on the recommendations for penalty. Mr. Montigny spoke to crafting a penalty that is proportional, in that it provides deterrence to Kelly Campbell as well as to other Registered Nurses (RN) and allows for rehabilitation of Kelly Campbell. Mr. Montigny listed factors for the Committee to consider when deciding on penalty. He also gave the Committee a Book of Authorities (Exhibit 6) which included recent decisions across Canada of similar situations related to discipline of Registered Nurses. Mr. Montigny also shared a letter from Ms. Campbell's current employer (Exhibit 7) for the panel's consideration. Mr. Montigny noted that the Respondent has acknowledged the seriousness of this matter and has cooperated throughout this process. The Respondent has agreed with the Statement of Facts and accepts responsibility for her actions.

The Complainant, Kim Wood, spoke to the seriousness of this matter and that the families of these patients have been seeking answers with respect to what happened and why. She indicated that she has not been able to give the family answers. She asked the Committee to consider the seriousness of the incidents and the impact on the families.

At this point, Mr. Keeler, Mr. Montigny, the Respondent and the Complainant were dismissed from the hearing and the hearing was adjourned to allow the Panel to reach its final decision.

Following the adjournment of the hearing, the Committee met to review and consider the submissions on penalty.

The Committee noted the mitigating factors outlined in the Agreed Statement of Facts. The Respondent, Kelly Campbell, has accepted responsibility for professional misconduct and incompetence. The Committee recognized the allegations presented in this review were serious and non-professional and considered the nature and gravity of the allegations and the impact of the incidents on individuals (patients, patient's families, employer, co-workers) and agrees that a registration suspension is warranted. Also, some improvement in Ms. Campbell's practice abilities is needed. The Committee decided to accept most of the Joint Recommendation on Penalty, but felt that some changes were necessary and appropriate. The following penalty shall be issued to the Respondent, Kelly Campbell:

1. Kelly Campbell's registration to practice nursing shall be suspended for a period of two (2) months following the date this Decision is signed and delivered to her or her lawyer.
2. Kelly Campbell shall have the following conditions place on her nursing registration, effective the date this document is delivered to the member or her lawyer:
    a. Kelly Campbell shall comply with three (3) annual continuing competency audits coordinated by the Coordinator of Regulatory Services of CRNPEI, which shall begin in 2019, and shall include assessment of continuing competence related to Standards 1, 2, 3, 4 and 6 of the CRNPEI Standards of Practice and the provisions of CNA Code of Ethics, as well as assessments of interdisciplinary communication, physical assessments and critical thinking skills. These continuing competency audits will happen in October of each year;
    b. Within six months of the date of this decision, Kelly Campbell shall complete refresher training with a Nursing Expert ("Expert"), at her own expense. To comply, Ms. Campbell is required to ensure that:
        i. The Expert has expertise in nursing regulation and has been approved by the CRNPEI Coordinator of Regulatory Services to provide refresher training;
        ii. The Expert has been provided with a copy of:
            1. The Complaint;
            2. The Amended Notice of Formal Hearing;
            3. The Agreed Statement of Facts; and
            4. This decision.
        iii. Ms. Campbell has reviewed the CRNPEI Standards of Practice and the CNA Code of Ethics (2017), and at least seven days before meeting with the Expert has provided the Expert with a written statement of at least five hundred (500) words reflecting on the issues identified in this decision in order to demonstrate insight into what went wrong in the events described in the Agreed Statement of Facts;
        iv. The subject of the sessions with the Expert will include:
            1. Any acts or omissions committed by Ms. Campbell as identified in this decision, including any misconduct or violations of the CRNPEI Standards of Practice and/or the Code of Ethics (2017);
            2. The potential consequences of the misconduct to Ms. Campbell's clients, clients' families, colleagues, profession and self;

3. Strategies for preventing the misconduct from recurring;
4. Refresher training, as identified by the Expert; and
5. The development of a learning plan in collaboration with the Expert.

v. Within thirty (30) days of the completion of the final session with the Expert, Ms. Campbell shall confirm that the Expert has forwarded a report to the CRNPEI Coordinator of Regulatory Services, in which the Expert has confirmed:
   1. The dates of the completed sessions;
   2. That Ms. Campbell reviewed the CRNPEI Standards of Practice and the Code of Ethics (2017) prior to meeting with the Expert;
   3. That the Expert reviewed or confirmed appropriate review of the required documents and subjects with Ms. Campbell;
   4. The successful completion of a written plan and initiation of the required learning plan in practice; and
   5. The Expert's independent assessment of Ms. Campbell's insight into her behavior.

vi. If Ms. Campbell does not comply with any one or more of the requirements above, the Expert may cancel any scheduled session, even if that results in a breach of a term, condition or limitation on Ms. Campbell's certificate of registration.

c. Upon completion of conditions 2(a) and 2(b) in a form satisfactory to CRNPEI, Ms. Campbell may apply to this Committee for the removal of all conditions from her registration; and
d. Ms. Campbell shall disclose that her registration is subject to these conditions to all employers or potential employers, until such time that the conditions have been removed.

3. Ms. Campbell shall be required to pay a fine to CRNPEI in the amount of One Thousand, Two Hundred and Fifty Dollars ($1,250.00) by June 30, 2019;
4. Ms. Campbell shall be required to pay CRNPEI the amount of One Thousand, Two Hundred and Fifty Dollars ($1,250.00) in respect of the expenses associated with the investigation and adjudication of this complain by June 30, 2019;
5. Ms. Campbell shall provide a copy of this decision to any current or future employer who offers her employment as a Registered Nurse and shall provide written verification to CRNPEI from the employer that the employer has received this report. This obligation will continue until terminated by CRNPEI or the removal of all conditions on her registration;
6. Failure to comply with any of the above conditions will result in inability to apply for registration with CRNPEI.

The panel concluded that the penalty is reasonable and in the public interest. Ms. Campbell has cooperated with the College and, by agreeing to the facts and the proposed penalty, has accepted responsibility. Chris Montigny's Book of Authorities (Exhibit 6), provided the Committee with Hearings

of similar nature, held in Ontario, including their respective penalties. The penalties issued in Ontario were suspension of license ranging from one month to two months. The Committee felt that comparative penalties were reasonable to issue in Kelly Campbell's case. The fine and penalty were meant to recuperate some of the financial loss to CRNPEI related to this investigation and to deter other members from performing in a way that demonstrates misconduct and incompetence. The fine and penalty are comparative to other fines and penalties issued by the College.

Respectfully submitted at Charlottetown, Prince Edward Island this 4th day of January, 2019.

Tara Roche, Chair of the Hearing Committee