IN THE MATTER OF A HEARING BY
THE DISCIPLINE COMMITTEE OF THE BRITISH COLUMBIA COLLEGE OF NURSING PROFESSIONALS CONVENED PURSUANT TO THE PROVISIONS OF THE *HEALTH PROFESSIONS ACT* RSBC 1996, c.183

BETWEEN:

The British Columbia College of Nursing Professionals

(the "College" or "BCCNP")

AND:

Shannon Whieldon

(the "Respondent")

DETERMINATION OF THE DISCIPLINE COMMITTEE

Hearing Dates:	May 22 to June 1, 2019
Discipline Committee Panel:	Sheila Cessford, Chair Edna McLellan Dr. Thomas Ward
Counsel for the College:	Jennifer Groenewold and Jessica Abells
Counsel for the Respondent:	Preston Parsons

Introduction

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

2. For the reasons that are set out below, the Panel finds that allegations 1(a)(i)(ii)(iv), (c), (d), (f), (g)(i)(ii), (h)(i)(iii), and (j) of the Citation are proven to the requisite

standard. The Panel determines that Ms. Whieldon breached a standard imposed under the Act in relation to allegations 1(a)(i)(ii)(iv), (c), (d), (f), (g)(i)(ii), (h)(i)(iii), and (j); that she committed professional misconduct in relation to allegations 1(f); and that she has incompetently practiced the profession in relation to allegations 1(a)(i), (a)(ii), (c), (f), g(i), h(i) and (j). The Panel dismisses allegations 1(a)(iii), (b), (e) and (h)(ii) and h(iv).

Background

3. The particulars of the allegations against Ms. Whieldon are set out in the Citation dated April 16, 2019, as follows:

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

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

4. The College further alleged in the Citation as follows:

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.

5. During the course of the discipline hearing, the College confirmed that it would not be proceeding with allegations 1(i) and 1(k) in the Citation (and for that reason, those allegations are not set out above). The Panel will refer to the remaining allegations by their original numbering and lettering.

6. During the course of the hearing and in her written closing submissions, Ms. Whieldon made a number of admissions. The Panel will deal with those admissions in the course of its reasons.

7. The hearing took place at the College’s offices at suite 900 – 200 Granville Street, Vancouver, British Columbia.

8. The parties led evidence at the hearing with respect to the allegations at issue.

9. The Panel marked a Joint Book of Documents as Exhibit 1.

10. The College called the following witnesses:

a. Angela King;

b. Dacia Howard-Jovanovic;

c. Damaris Grunert;

d. Shalynne Smith;

e. Andrea Hull;

f. Sandy Hill;

g. Patient #5 (B.R.); and

h. Patient #4 (S.H.).

11. The Respondent testified, and called the following other witnesses:

a. Dr. Elaine Mah; and

b. Kayda Kurtz.

12. The parties both delivered written submissions.

13. The Panel's determination takes into account the evidence adduced at the hearing and the parties' written submissions.

Service

14. The College filed the Citation, along with proof of service, on the first day of the hearing. The Respondent agreed the Citation was properly served and proper notice of the hearing was given. The Panel finds service was properly effected.

Burden and standard of proof

15. The College acknowledged that it bears the burden of proof and must prove its case on a "balance of probabilities". The College cited several cases including the leading authority of *F.H. v. McDougall*, 2008 SCC 53, in which the Supreme Court of Canada stated that "evidence must always be sufficiently clear, convincing and cogent to satisfy the balance of probabilities test".

16. The Respondent also submitted that the College must prove its case on a balance of probabilities.

17. The Panel agrees with the parties with respect to the burden and standard of proof.

Registration

18. Ms. Whieldon practiced as a Registered Nurse from 1992 until January 4, 2017. She predominantly practiced in the perinatal unit at Langley Memorial Hospital ("LMH"), which is part of the Fraser Health Authority. She was suspended pending an investigation by the College. Ms. Whieldon agreed to voluntarily surrender her license. Ms. Whieldon underwent a Competency Assessment & Enhancement for Nurses ("CAEN") assessment through Kwantlen Polytechnic University, however, she failed that assessment. She questioned various aspects of the assessment and the result. In May 2018, Ms. Whieldon retired from nursing.

Relevant HPA Provisions, Bylaw Provisions and Professional and Practice Standards

HPA

19. Under section 39(1) of the HPA, the Discipline Committee may dismiss the matter, or determine that Ms. Whieldon:

> 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
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> (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.

20. The parties have put the following provisions at issue in this case: 39 (1) (b), (c), and (d).

College Bylaws

21. The relevant bylaw in force at the material times was bylaw 8.01 which stated "Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics".

22. That bylaw was enacted pursuant to section 19(1)(k) of the HPA.

Professional Standards

23. The College referred to Professional Standards 1, 2, 3, and 4, which confirm and codify both broad and more specific standards:

    a. Professional Standard 1, Professional Responsibility and Accountability ("Standard 1");

        i. Specifically, Standards 1, 2, 3, 4;

    b. Professional Standard 2, Knowledge-Based Practice ("Standard 2");

        i. Specifically, Standards 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 13;

    c. Professional Standards 3, Client-Focused Provision of Service ("Standard 3");

        i. Specifically, Standards 1, 2, 7;

    d. Professional Standard 4, Ethical Practice ("Standard 4"); and

        i. Specifically, Standards 1, 2, 3, 5, 6, 7, 11.

Practice Standards

24. The College referred to three Practice Standards:

    a. Medication Administration;

    b. Documentation; and

    c. Consent.

Citation paragraph 1(a)(i)

Evidence

25. The College presented expert evidence from Angela King, 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 a Registered Nurse, licensed to practice in Ontario, where she has worked in obstetrical nursing since 1993.

26. Ms. King provided an expert report dated May 7, 2019. Through her expert report and oral testimony, Ms. King gave evidence that:

    a. 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.

    b. When using Oxytocin, the pregnant woman 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.

    c. There is an increased risk of uterine rupture with the use of Oxytocin.

    d. There are two methods for assessing the fetal heart rate in labour: intermittent auscultation and external fetal monitoring. External fetal monitoring is the recommended method of monitoring when administering Oxytocin or assessing a high-risk pregnancy.

    e. External fetal monitoring is a continuous assessment of the fetal heart rate and uterine contractions. Transducers are applied to the patient's abdomen. One records the fetal heart rate and the other records the frequency and duration of uterine contractions. The monitoring provides a continuous tracing of the fetal heart rate and uterine contractions.

f. The continuous tracing is assessed, interpreted and documented by the nurse on the labour flow sheet. The frequency of assessment, interpretation and documentation is determined by the standard of care and the stage of labour. The physician is notified of abnormal findings.

g. Obstetrical nurses are required to be certified in Fetal Heart Surveillance (fetal heart monitoring).

27. Damaris Grunert was a Clinical Nurse Educator ("CNE") LMH. She gave evidence with respect to the Oxytocin Protocol; specifically:

a. The administration and management of Oxytocin and epidural analgesia are protocols at LMH.

b. The Oxytocin Protocol went through a significant change in 2012. This change introduced the Pre-Oxytocin Checklist and the Oxytocin Management Checklist. These standardized the initiation, administration and management of Oxytocin. Previously, dose adjustments had been left up to the nurse.

c. The Oxytocin Protocol went through a revision in 2015 where the definition of tachysystole was changed. Other minor modifications were also made.

d. Nurses cannot use independent clinical judgment and customize the Oxytocin Protocol. Any proposed deviations from the protocol need to be communicated to and authorized by the physician.

28. Both Ms. Grunert and Shalynne Smith, another CNE at LMH, gave evidence that new policies and procedures at LMH were rolled out with education for unit nurses.

29. The Pre-Oxytocin Checklist for Labour Induction or Augmentation (the "Pre-Oxytocin Checklist") states that the checklist should be completed before Oxytocin is initiated, and if the checklist cannot be completed, Oxytocin should not be initiated. The Pre-Oxytocin Checklist requires 20 minutes of electronic fetal monitoring tracing that is classified as normal before starting Oxytocin.

30. Once Oxytocin has been initiated, the Oxytocin Management Checklist must be completed every 30 minutes.

31. The Oxytocin Management Checklist states that:

    a. For an atypical fetal heart rate pattern, the following should be done:

        i. Initiate intrauterine resuscitation

        ii. Decrease Oxytocin dose by half until fetal heart pattern becomes normal

        iii. Change maternal position

        iv. If indicated, give IV bolus

        v. Perform vaginal exam if indicated

        vi. Conduct baby pause

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

        viii. Notify physician/midwife when Oxytocin has been decreased

32. Ms. King gave evidence that:

    a. On April 28, 2016, Ms. Whieldon 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 the Oxytocin at 10:00 am. She would have been expected to adjust the position of the patient and adjust the transducers to ensure an accurate tracing before increasing the rate of Oxytocin infusion.

    b. At 10:45 am, Ms. Whieldon increased the Oxytocin infusion rate. There were three consecutive uncomplicated variables. As a result, the tracing should have been interpreted as atypical. Ms. Whieldon 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, Ms. Whieldon 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, Ms. Whieldon increased the infusion rate. Ms. Whieldon 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, Ms. Whieldon maintained the Oxytocin infusion rate. With repetitive uncomplicated variables and two complicated variables, the fetal heart rate should have been interpreted as atypical. Ms. Whieldon 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, Ms. Whieldon increased the Oxytocin infusion rate. With repetitive uncomplicated variables, the fetal heart rate tracing should have been interpreted as atypical. 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, Ms. Whieldon 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 physicians' orders.

33. Ms. King was asked on cross-examination whether accelerations could cause the appearance of a rise in baseline where the baby is active. She agreed that it could

but that the baseline would not remain elevated for long. She testified that she was not aware that sugar could have a similar effect.

34. The Respondent called Dr. Elaine Mah. Dr. Mah was qualified as an expert in obstetrics and gynecology. Dr. Mah works at LMH.

35. 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).

36. 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 this hearing, including O.M.

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

38. Ms. Whieldon testified that:

    a. She took a leave of absence from October 30, 2015 until April 2016 to care for a critically ill child following a traumatic assault. Her first day back to the unit began on April 27, 2016. She testified that she received inadequate orientation on her return, and that the unit was chronically short staffed.

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

    c. 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. Ms. Whieldon also testified that the majority of the 30 minutes of the partogram was normal which is why she classified it as normal. She was not aware of the requirement to decreased Oxytocin by half at this time. That requirement was on the back of the checklist and was only brought to her attention in June 2016.

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

e. With respect to maintaining the Oxytocin infusion rate between 11:30 am to 12:15 pm, Ms. Whieldon testified that the baby was active and her interpretation was that it was normal. She admitted that on 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 was in the room and they reviewed the tracing strip together and agreed that it was normal.

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

g. With respect to the Oxytocin increase at 5:30 pm, Ms. Whieldon 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. Ms. Whieldon testified she opposed the increase. She stated that she was relieved for her break and left the room and Ms. Kurtz followed Dr. Mohtashami’s verbal order.

Analysis and Findings of Fact

39. 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.

40. The Panel finds significant changes were made to the Oxytocin Protocol in 2012 and minor changes were made in 2015. The Panel finds that there were no material changes in relation to the allegations at issue that were made during Ms. Whieldon's leave of absence from October 30, 2015 to late April 2016.

41. Ms. Whieldon submitted that her subjective interpretation at bedside should not be wholly discarded. Ms. Whieldon submitted that for all three patients where Oxytocin administration is concerned (including 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.

42. In relation to O.M., Ms. Whieldon 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.

43. With one exception described below, the Panel accepts Ms. King's expert evidence. She was consistent and unshaken in her cross-examination. Dr. Mah agreed with the first nine pages of her report and did not provide expert evidence with respect to any of the fetal heart rate monitor tracing at issue.

44. With respect to the infusion rates at 10:00 am, 10:45 am, 11:30 am, 11:30 am - 12:15 pm, and 2:00 pm, the Panel prefers the evidence of Ms. King over that of Ms. Whieldon. With respect to 10:00 am, the Panel finds that Ms. Whieldon was unable to appropriately assess the fetal heart rate and uterine contractions when

she increased the Oxytocin infusion rate. With respect to 10:45 am, 11:30 am, 11:30 am -12:15 pm, and 2:00 pm, the Panel finds Ms. Whieldon 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.

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

Breach of Standard Imposed under the Act

46. Ms. Whieldon submitted she adhered to BCCNP Professional Standards 1, 2 and 4.

47. Ms. Whieldon admitted that she erred with respect to aspects of her administration of Oxytocin. She agreed that she erred by not noting the requirement to initially decrease by half the Oxytocin when an atypical or abnormal strip presented. She testified that she became aware of this requirement in mid-June 2016 and thereafter, she did her best to adhere to that requirement.

48. Ms. Whieldon made the following admissions in her closing submissions:

> 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.

49. The Panel finds Ms. Whieldon 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.

50. These standards were established by the College's board pursuant to bylaw 8.01 that stated "Registrants must conduct themselves in accordance with the standards of practice and the standards of professional ethics". That bylaw was enacted pursuant to section 19(1)(k) of the HPA.

51. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(a)(ii)

Evidence

52. Ms. King provided evidence that between 10:30 am and 11:00 am there were multiple uncomplicated variable decelerations and her interpretation of the fetal heart rate tracing at that time was atypical.

53. She also provided evidence that between 11:00 am and 11:30 am, there were multiple uncomplicated variable decelerations and that her interpretation of the fetal heart tracing between 11:00 am and 11:30 am was atypical.

54. Ms. Whieldon gave evidence as to how she classified the fetal heart rate monitoring tracing at 10:00 am, 10:30 am and 11:00 am. She testified she classified them all to be normal. She explained that at the time she understood that in order to classify the fetal heart rate monitor strip, one would look to the majority of the segment. Because the majority of those segments were not atypical, she classified them as normal. She testified: "But our interpretation at that time was in that 30-minute window what was the majority of the -- like what was the majority of the interpretation."

Analysis and Findings of Fact

55. The College submitted that Ms. King's evidence should be accepted in its totality.

56. Ms. Whieldon submitted that she recognized the fetal heart monitor strip as atypical at 11:00 am and decreased the Oxytocin in response. She agreed that she should have classified the end of that 30-minute block as atypical.

57. Ms. Whieldon argued that the College did not lead evidence sufficient to establish that she erred in her interpretation of this patient's fetal heart monitoring. Rather, she submits there was a documentation error.

58. The Panel finds that Ms. Whieldon did not accurately interpret the fetal heart monitor strip at 11:00 am when she classified it as atypical. Ms. Whieldon's testimony about her understanding of how the tracing was to be interpreted and classified demonstrated a fundamental lack of understanding with respect to the interpretation and classification of fetal heart rate monitoring, and demonstrated that this was not simply a documentation error.

Breach of Standard Imposed under the Act

59. In failing to accurately interpret the fetal heart monitoring strip at 11:00 am, the Panel finds that Ms. Whieldon breached the following College Standard:

> **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.

60. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(a)(iii)

Evidence

61. Ms. King gave evidence that at 4:55 pm the epidural rate was decreased to 5 millilitres per hour. There was no documentation by Ms. Whieldon in regards to communication with the obstetrician or anaesthesiologist, or the patient, about the plan for pain control in the second stage of labour. She stated that there was no physician order to decrease the epidural rate or to stop the epidural infusion. In Ms. King's opinion, the failure to contact the anaesthesiologist in regards to the patient's pain management, the failure to contact the obstetrician in regards to the plan for the second stage of labour and the failure to not follow physician orders fell below the standard of care.

62. On cross-examination, Ms. King agreed that she did not review the nursing notes or section 12 of the partogram.

63. Ms. Whieldon testified that she was in the room with both Dr. Mohtashami and Ms. Kurtz and that Dr. Mohtashami gave a verbal order to decrease the epidural. She testified Ms. Kurtz decreased the epidural. Ms. Whieldon testified she did not know the codes for the epidural infusion pump as she had just returned from her leave of absence. Ms. Whieldon testified she charted the change in epidural rate.

64. Ms. Kurtz testified that she could not recall who decreased the epidural but typically anytime there are changes in epidural infusions those are double checked. Ms. Kurtz testified she was likely in the room at the time. She stated that if she changed the epidural rate, it would likely have been Ms. Whieldon who would have verified that.

Analysis and Findings of Fact

65. While Ms. Whieldon's documentation is unclear with respect to the decrease in epidural rate, the Panel notes that the clinical records contain references indicating that Dr. Mohtashami was in the room as of 4:55 pm, and there is an entry at 4:55 pm documenting a decrease in the epidural. While there is not a specific entry regarding Dr. Mohtashami's verbal order to decrease the epidural, in considering all of the testimony and the clinical records together, the Panel finds on a balance of probabilities that Dr. Mohtashami did issue a verbal order to decrease the epidural rate.

66. Accordingly, this allegation is dismissed

Citation paragraph 1(a)(iv)

67. In her closing submissions, Ms. Whieldon admits the entirety of this allegation:

> ***Allegation (a)(iv), (g)(ii) and h(iii): Documentation (Patients O.M., A-J. B, and B.G.M.)***
>
> 284. The College has alleged that Ms. Whieldon did not follow protocol in her documentation and narrative charting, and specifically that she:
> (a) Used judgmental statements;
> (b) Did not consistently use medical terminology;
> (c) Failed to consistently use approved abbreviations and graphics;
> (d) Incorrectly dated entries on the April 28 Partogram and in the nursing progress notes;
> (e) Documented in narrative "block" in the nursing progress notes;
> (f) Did not document assessment findings and clinical rationale(s) for the changes made to the epidural and/or Oxytocin infusion rates; and
> (g) Did not document every required assessment on the Oxytocin Management Checklist.
>
> …
>
> 287. Despite the foregoing, Ms. Whieldon admits that on the dates in question with respect to these Allegations, her practice fell below the standard of care regarding the Documentation Practice Standard.

68. The Panel agrees and finds Ms. Whieldon's documentation fell below the standard as alleged and admitted. Specifically, Ms. Whieldon's practice fell below the following provisions of the College's Documentation Practice Standard:

1. Nurses are responsible and accountable for documenting in the client record the care they personally provide to the client. Care provided by others should ordinarily be documented by those individuals, unless there are exceptional circumstances such as an emergency.

2. Nurses document a decision-making process (e.g., assessment, nursing diagnosis, planning, implementation and evaluation) to show the care they provided.

4. Nurses document in a clear, concise, factual, objective, timely, and legible manner.

5. Nurses document all relevant information about clients in chronological order in the client record.

6. Nurses document at the time they provide care or as soon as possible afterward. Nurses clearly mark any late entries, recording both the date and time of the late entry and of the actual event.

7. Nurses correct any documentation errors in a timely, honest, and forthright manner.

10. Nurses carry out more comprehensive, in-depth and frequent documentation when clients are acutely ill, high risk, or have complex health problems.

69. As a result, the Panel finds Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(b)

Evidence

70. Dacia Howard-Jovanovic is the Manager for Clinical Operations at LMH. She testified that:

a. She received a voicemail from a patient's partner with a complaint about Ms. Whieldon's care on April 28, 2016.

b. Ms. Howard-Jovanovic returned this individual's call. She had a conversation with the patient's partner to obtain information about the complaint.

c. Because he was not physically present during Ms. Whieldon's care of the patient, Ms. Howard-Jovanovic asked to speak with the patient. Ms. Howard-Jovanovic described the patient as being very upset and emotional about her experience. Ms. Howard-Jovanovic took notes of this telephone call.

d. The patient complained about a vaginal exam performed by Ms. Whieldon. The patient experienced it as very painful and described Ms. Whieldon as very detached from the care that she provided. She said that Ms. Whieldon's interactions and communications were directed to her colleague in the room. The patient did not identify Ms. Whieldon by name but described her by appearance.

e. Ms. Howard-Jovanovic made a note in the progress notes on April 29, 2016 which states "Client's spouse called writer. Spoke with client. Reports that she feels internal pain in the area of cervix. Cervical show is increased a mix of mucus and blood. …Writer encouraged client to contact MD and explain circumstances from last LMH visit and ask to be seen today for assessment. Client agrees to plan."

f. Ms. Howard-Jovanovic held an informal meeting with Ms. Whieldon. She shared the patient's experience of the care she received. They discussed trauma informed practice.

g. Ms. Whieldon stated that the patient was upset about Ms. Whieldon's findings that she did not meet admission criteria and had to be sent home.

71. Ms. Whieldon testified that:

a. The triage nurse that day, Gillian Loewen, asked her to perform a vaginal exam on this patient as she was having difficulty reaching the cervix.

b. Ms. Whieldon entered the room and introduced herself to the patient. She told the patient that she understood the patient's nurse, Ms. Loewen, would like her to perform a vaginal exam as she was unable to reach the cervix. Ms. Whieldon discussed that this type of exam can be painful. The patient indicated she understood and gave her consent to proceed with the examination.

c. Ms. Whieldon was seated at the end of the bed. She explained to the patient what she was doing as she was performing the examination. Ms. Loewen was at the side of the bed documenting the patient encounter.

d. Ms. Whieldon located the cervix and reported her findings verbally to the patient.

e. The patient showed no signs that she was experiencing pain during this exam.

f. After the examination, Ms. Whieldon spoke to the patient. She expressed empathy that the patient did not meet the criteria for admission at that time. She conveyed that she understood that was scary for the patient given that the patient had a history of precipitous labour and that she was afraid of not delivering the baby in the hospital. Ms. Whieldon wished her good luck and then initialled the charting that had been done by Ms. Loewen.

Analysis and Findings of Fact

72. The College submitted that while its evidence in relation to this allegation rests on hearsay (the patient's statements to Ms. Howard-Jovanovic), it has not been refuted and ought to be given weight.

73. The College submitted that the Panel should draw an adverse inference based upon the Respondent's failure to call Ms.Loewen, the triage nurse in the room during the examination, as she could have provided corroborative evidence.

74. The Respondent submitted that the College failed to call the patient. Further, she submitted that the Panel should prefer Ms. Whieldon's evidence over Ms. Howard-Jovanovic's hearsay evidence.

75. The Panel finds that it may accept hearsay evidence and has considered the evidence of Ms. Howard-Jovanovic.

76. The Panel finds, however, that Ms. Howard-Jovanovic's evidence is insufficient to prove this allegation in the Citation on balance of probabilities. The fact that this patient may have experienced pain during a vaginal examination is not, on its own, evidence of breach of a standard, the Act, or of professional misconduct. The Panel finds that the evidence that the patient experienced Ms. Whieldon as detached and that her interactions and communications were directed to Ms.

Loewen is insufficient to prove on a balance of probabilities that Ms. Whieldon did not communicate appropriately. The Panel finds based upon Ms. Whieldon's testimony and the clinical records, that she did adequately communicate the findings of her vaginal examination to the patient. For these reasons, the Panel dismisses this allegation.

Citation paragraph 1(c)

Evidence

77. Ms. Whieldon testified that:

    a. She was nursing the mother and present for the birth of this infant patient on May 5, 2016.

    b. It was a vacuum assisted birth because the baby had developed tacycardia. The baby was born limp and required resuscitation. The baby had an Apgar score of 1 at one minute of life, and by five minutes of life, the baby had an Apgar score of 9. Those circumstances put the baby at risk for hypoxia, hypoglycemia or a potential brain injury.

    c. The following day, Ms. Whieldon was the postpartum nurse assigned to care for the baby.

    d. On May 6, 2016, Ms. Whieldon gave the baby a bath and charted at 8:40 am that the baby was alert and active but exhibited "strange movements with hands, clenching, splaying fingers, gripping and internally rotating wrists - will need to observe. Two superficial dry closed scratches to scalp insider slightly raised slightly red vacuum ring on head. Parents shown and asked to advise most responsible physician ("MRP") about possible treatment and as well to observe".

78. Ms. King gave evidence that there are several reasons the birth history of this infant would raise concerns if strange movements were observed. Strange movements may be a sign of seizure activity. Fetal tachycardia during labour and birth, a vacuum assisted birth, and a one minute Apgar score of 1 may put a newborn at risk for hypoxia, hypoglycemia or potential brain injury.

79. Ms. King gave evidence that Ms. Whieldon would have been expected to assess the newborn's vital signs, including her oxygen saturation and assess her colour, her head for swelling and how long the strange movements lasted and whether it was symmetrical or one-sided. Ms. Whieldon would have been expected to notify the paediatrician immediately with assessment findings and bring the baby to the Neonatal Intensive Care Unit ("NICU") for further observation. In Ms. King's opinion, abnormal findings that are not further assessed or reported to the physician falls below the standard of care.

80. Sandra Hill, a registered nurse in the unit at LMH, testified that:

    a. She is often viewed as the "go to" among other nurses.

    b. She worked with Ms. Whieldon since 2002.

    c. At some point during the day on May 6, 2016, Ms. Whieldon came to the nursery and told Ms. Hill that she had a baby that was making different movements. Ms. Hill said Ms. Whieldon described the baby's movements as being clenched fists, with thumbs inside, and rotating.

    d. Ms. Hill asked Ms. Whieldon if she could stop the movement by touching the baby, because if it can be stopped, it may not be a seizure.

    e. She did not herself assess the baby.

81. Ms. Whieldon testified that:

    a. While she was bathing the baby, she checked the scratch on the baby's head. The baby exhibited a startle reflex. She stated "So while I'm doing the bath with this baby, I go down to check the scratch on the head. It's a reflex. It's called a startle reflex. So the babies start out with their hands clenched. And as you drop the baby it stimulates a reflex to open the hands. Then as I see this because I'm focusing on the head, I'm like what. And then I kind of adjusted my hand, so I tip the baby slightly it internally rotates the hand. And so I grab this baby's hand to see if this is in fact seizure activity or not, and the hand stops."

    b. The baby was content and breast-feeding well.

c. After the bath, she performed a full head to toe assessment, and she documented the bath, the baby's presentation, and the scratches on the baby's head. She spoke to the baby's parents.

d. She then spoke to Ms. Hill and explained to her what she observed with respect to the baby's movements. Ms. Whieldon was not concerned that the baby had had a seizure, as she believed it to be reflex activity, but she wanted to be overly cautious and ensure she had not missed anything in her assessment.

e. She monitored the baby frequently.

f. She charts by exception, meaning only abnormal findings are charted.

g. When Ms. Whieldon returned to work the night of May 7, 2016, she spoke with Ms. Hill and learned that this infant had had a seizure and had been transferred to BC Children's Hospital.

h. Ms. Hill asked Ms. Whieldon whether she had observed anything further with the baby on May 6, 2016. Ms. Whieldon replied she had seen the baby but she appeared normal. She had not done further charting as they chart by exception and there was nothing exceptional to chart. Ms. Hill told Ms. Whieldon she should chart and "cover her butt".

i. Ms. Whieldon made a late entry in the chart on May 7, 2016 stating:

> Nursery nurse advised writer baby transfer to BCCH for seizures. Asked if any further odd movements noticed after initial bath. Checked frequently throughout day yesterday. Alert and vigorous at breast. No strange movements with hand seen during these feeds. Last checked the at 19:25 May 6 just prior to getting off shift. Being held by uncle in rocking chair. Checked HR and temp N. Alert, not stiff. Tone good. No jitters noted, no strange movements with hands noted. Eyes were open and looked at uncle who was chatting. Parents reported baby had fed well at all feeds. Many family members in room. Had consulted with S. Hill after a.m. bath – asked if I had tried to stop jitters – yes hands stopped and all movements stopped and not stiff, but this is why writer went in and checked baby frequently through day and just prior to leaving despite being re-assigned to labor @18:30.

82. On cross-examination, Ms. Whieldon denied that she recognized the baby's movements as being a variance requiring her to chart. She testified she believed the movements to be reflex activity but because of the fact that the baby had had a vacuum assisted birth and a resuscitation, she made a chart entry in case anyone else later saw any unusual movements which they could assess for themselves to determine if they were reflex activity or something else.

83. Ms. Whieldon testified there was no need to escalate care as she had determined the baby was exhibiting reflex activity. She agreed that had she seen seizure activity, she would have had to escalate care.

84. In response to a question by the Panel, Ms. Whieldon agreed that with a startle reflex the baby moves their arms out and then back again. When asked to explain that the startle reflex doesn't include internal rotation of the wrists, Ms. Whieldon testified that the wrist rotation occurred when she tipped the baby.

85. Ms. Whieldon further explained to the Panel the fact that she charted what she described as normal movements because she wanted to highlight to staff that they should be assessing the baby more regularly. She felt the unit was short staffed and nurses were not meeting their standards. She testified that she wanted to raise some heightened awareness out of an abundance of caution and she wanted staff to check the baby through the night. She wanted to trigger other nurses to ask a question. Ms. Whieldon testified this was her way of communicating to her colleagues to trigger them to do further assessments.

Analysis and Findings of Fact

86. The Panel does not accept Ms. Whieldon's evidence that she thought the baby was exhibiting reflex activity for several reasons. First, she expressly characterized and charted the movements she observed as being "strange". If she thought she had seen normal reflex activity, there would be no reason to describe the movements as "strange". Second, Ms. Whieldon testified that she charts by exception. The Panel does not accept Ms. Whieldon's explanation that in this instance she charted a normal occurrence because she wanted to alert other care

providers to watch this patient more closely. Moreover, if that was the case, it is unclear why Ms. Whieldon did not chart the test where she applied her hand to the baby to see if the movements stopped. Third, the symptoms that Ms. Whieldon charted are classic seizure symptoms. They are not classic reflex symptoms. Fourth, immediately after charting the baby's movements, she writes "will need to observe". There would be no need to observe a baby in relation to normal reflex activity. Finally, the late entry by Ms. Whieldon in the chart uses the language of "jitters" as opposed to "strange movements with hands, clenching, splaying fingers, gripping and internally rotating wrists".

87. The Panel finds that this baby exhibited seizure signs, that Ms. Whieldon observed them to be seizure signs, and that she charted the baby's movements as seizure signs.

88. The Panel finds that Ms. Whieldon failed to escalate care of this baby after having identified signs of seizure.

Breach of Standard Imposed under the Act

89. The Panel is very concerned by Ms. Whieldon's failure to have escalated care in this instance. The Panel is also concerned by Ms. Whieldon's testimony that she continues to be of the belief that the signs she recorded were normal.

90. The Panel finds that Ms. Whieldon 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.
> 3. Assesses own practice and undertakes activities to improve practice and meet identified learning goals on an ongoing basis.
> 4. Takes action to promote the provision of safe, appropriate and ethical care to clients.
>
> **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.

Standard 3: Client-Focused Provision of Service

1. Communicates, collaborates and consults with clients and other members of the health care team about the client's care.
2. Coordinates client care in a way that facilitates continuity for the client.

91. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(d)

Evidence

92. The parties' evidence regarding this allegation, and the late entry at issue, is set out in the discussion above regarding allegation 1(c).

Analysis and Findings of Fact

93. The College submits that the content of the late entry is entirely inappropriate. The focus is not client centered, rather it contains a number of self-serving statements to provide a justification for Ms. Whieldon's failure to escalate care for the concerning clinical symptoms she encountered. The issue is not whether the "strange movements" were actually seizure activity, but that they could have been and the charge nurse ("CN"), patient care coordinate ("PCC"), and MRP were not informed.

94. Ms. Whieldon submits that the College's characterization is unsubstantiated by the evidence presented at the hearing, and false. Ms. Whieldon did not deny that she made a late entry, adding that it was not to avoid taking responsibility for her actions. She submits her evidence was consistent that her late entry was only in response to Ms. Hill's advice that she document further. Ms. Whieldon felt confident in her documentation from the day prior and only made this entry at the urging of Ms. Hill. Ms. Whieldon submits that this was not disputed by Ms. Hill in

her evidence in cross-examination, who admitted she may have told her to document to “cover her butt”. Ms. Whieldon submits that by characterizing the entry as a “late entry”, she has wholly accepted responsibility for this entry. She did not try and hide this entry within the patient’s chart; she clearly indicated that this entry was made after the fact and was clear in her evidence that these types of entries are only to be made on rare occasions.

95. The Panel finds that Ms. Whieldon made the late entry after she was told to “cover her butt” by Ms. Hill. The Panel finds the late entry to be self-focussed as opposed to patient-focussed. For example, she writes “this is why writer went in…despite…”. The Panel also noted the change in characterization of the baby’s movements from “strange movements” which detailed a number of physical signs, to labelling those same movements as “jitters”, which implies something less concerning. The Panel finds that Ms. Whieldon completed the late entry in an effort to provide a justification for not escalating care.

Breach of Standard Imposed under the Act

96. The Panel finds that Ms. Whieldon breached 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**
>
> 11. Documents timely and appropriate reports of assessments, decisions about client status, plans, interventions and client outcomes.

97. In addition, Ms. Whieldon has not complied with provisions 4, 5, and 6 of the Documentation Standard.

98. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(e)

Evidence

99. Patient #4 (S.H.) testified that:

a. She gave birth to her first child on April 18, 2016 at Surrey Memorial Hospital ("SMH"). Her daughter was born six weeks early.

b. Her daughter had to stay in NICU at SMH for approximately three weeks and was then transferred to LMH.

c. The reason for her daughter's stay at LMH was to "grow her".

d. A feeding plan was developed which changed over time. The goal was for her daughter's feeding to transition from tube to breast and bottle.

e. Her husband was involved in their daughter's care in hospital.

f. She experienced challenges breastfeeding her daughter, specifically with respect to milk supply.

g. Ms. Whieldon was assigned to care for Patient #4's infant daughter and her family on the night of May 7, 2016.

h. She described that night shift with Ms. Whieldon as "horrible".

i. Her first interaction with Ms. Whieldon was while she was using a nipple shield while breastfeeding her daughter. Ms. Whieldon said: "why are you still using that? It's not a good idea", or words to that effect. Patient #4 gave Ms. Whieldon "cues to back off", which she perceived Ms. Whieldon did not accept.

j. During the second interaction, Ms. Whieldon told her she was breast pumping incorrectly.

k. During the third encounter, Ms. Whieldon said to her "most moms want their children to go home", or words to that effect. Patient #4 testified she felt like she had been punched in the stomach. She said she was a nervous new mom and found the comments to be extreme and hurtful.

l. She then told her husband that she “is not going back to that woman, I will forget about the 2 o’clock feed and sleep through”. Patient #4 testified she was very upset that she had slept through the 5:30 am feed though she found out later that her husband had decided to let her sleep through the feed to let her “cool off”.

m. As the morning progressed, Patient #4 felt more and more upset, and her husband suggested that she call her father for reassurance that she was a good mother, which she did.

100. Ms. Whieldon testified that:

a. She had just been assigned to care for Patient #4 and that the physician had changed the feeding orders from scheduled feeds to feeding on demand. Ms. Whieldon was tasked to inform Patient #4 of this change. The nurse who had previously cared for Patient #4 anticipated Patient #4 would not be receptive to the change.

b. She may have inquired why Patient #4 was using the nipple shield due to the possibility that it can reduce milk production.

c. She had suggested to Patient #4 she could try to pump on one side and feed on the other side. Her intent was to make Patient #4 aware of the available options. At no time did she intend to cause her distress. Patient #4 tried that method briefly and found it was not something she liked and ceased immediately. Ms. Whieldon testified she tried to make Patient #4 feel good about that and told her not to worry that she did not want to pursue that method.

d. At no time was she aware that Patient #4 was angry or annoyed with her. She was a new mother and she was trying very hard to establish breastfeeding. She was very focused on her task of breastfeeding.

e. She did not recall saying words to the effect of “most mothers want their children to go home” and regretted if Patient #4 interpreted something she said in that manner.

f. With respect to the 5:30 a.m. feeding, Ms. Whieldon interacted with Patient #4's husband about waking her for the feed. The husband told Ms. Whieldon he would bottle feed the baby and said that it was fine for Patient #4 not to be woken.

Analysis and Findings of Fact

101. The College submits that Patient #4 was credible in her clear recollection of how her interactions with Ms. Whieldon affected her confidence in her ability to breastfeed. Patient #4 stated that she and her husband were in agreement over what they thought was best for their baby and the feeding plan. While Ms. Whieldon may have assigned Patient #4's "annoyance" to not being called for the 5:30 am feed, the College submits Patient #4's testimony was clear that she felt her husband protected her from another unpleasant and confidence eroding interaction with Ms. Whieldon by letting her sleep through this feed.

102. Ms. Whieldon submits that even if Patient #4's version of events is accepted as true by the Panel, the College has not demonstrated that anything said by Ms. Whieldon to Patient #4 constitutes a breach of her Professional Standards. Although Patient #4 may have taken offence to what was said or the tone with which Ms. Whieldon conveyed her comments, the evidence is clear that at all material times Ms. Whieldon was providing her with various methods by which she could properly care for her baby. Moreover, she submits that Patient #4 could not recall specific words said to her, indicating she may well have misinterpreted them. At all material times Ms. Whieldon's care for Patient #4 was client-centered and in accordance with her professional obligations.

103. The Panel accepts the evidence of both witnesses. The Panel accepts that Ms. Whieldon made comments to the effect of the ones described by Patient #4 and that they upset Patient #4. The Panel also accepts Ms. Whieldon's evidence that she was conveying information about breastfeeding options and did not intend to cause Patient #4 any distress.

104. While the Panel finds Ms. Whieldon's communications may be open to improvement, for example, with respect to the timing of the discussion in the

middle of the night, and an apparent lack of sensitivity around more challenging breastfeeding options, the Panel does not find that Ms. Whieldon failed to support Patient #4's breastfeeding plan by criticising her parental choices. The Panel also finds that the comments made do not rise to a breach of professional standards in these circumstances.

105. The Panel finds that Ms. Whieldon did not fail to wake up Patient #4 for the 5:30 am feed as Patient #4 chose to sleep through that feed and her husband told Ms. Whieldon not to wake his wife as he would be feeding his daughter.

106. For these reasons, this allegation is dismissed.

Citation paragraph 1(f)

Evidence

107. Patient #5 (B.R.) testified via video that:

a. Her son was born on June 7, 2016 in an uncomplicated delivery. He was a heathy boy and her third child. She requested an early discharge at 12 hours.

b. Ms. Whieldon was her post partum nurse. She found Ms. Whieldon to be friendly and their initial interactions to be positive.

c. She asked Ms. Whieldon whether her son had been given eye ointment or whether the standards of practice had changed. She recalled her two previous children had "goopy eyes" after having been given the medication.

d. Ms. Whieldon discussed the timeframe within which the medication should be given, told Patient #5 that it was too late for the medication to be given, and told Patient #5 she was low risk because she only had one partner and was therefore at low risk of infection and passing it on to her child.

e. She found that information unsettling and asked for a second opinion when the next nurse came on shift.

f. The next nurse, Andrea Hull, consulted a physician who gave the order for Erythromycin ointment despite being outside the window period.

g. Ms. Whieldon provided no information to Patient #5 about what she should watch out for if the medication was not given, the signs and symptoms of infection, or that she could change her mind at any time about whether her son should be given Erythromycin ointment.

h. She did not fill out a form indicating she refused to have Erythromycin ointment given to her son.

108. Ms. Whieldon's version of events were put to Patient #5 on cross-examination. Patient #5 did not recall Ms. Whieldon discussing the pros and cons of taking a second dose of Erythromycin ointment and she did not recall Ms. Whieldon advising she would call the night nurse to determine whether Erythromycin ointment had been given. She denied the word "refusal" ever having been part of their conversation. She denied there being a discussion about the fact that the unit did not have any Informed Refusal forms.

109. Andrea Hull testified that:

a. She was at the nursing station when Patient #5's husband requested early discharge. She was not assigned to be Patient #5's nurse but offered to do the early discharge education.

b. During the discharge education, Patient #5 told Ms. Hull that she had spoken to Ms. Whieldon about the fact that her son's eyes were not goopy and that Ms. Whieldon told her that it was too late to be given the eye ointment and that it was not needed.

c. Ms. Hull looked in the chart and asked Patient #5 if she had refused the Erythromycin ointment because she noted the Informed Refusal box had been selected. Patient #5 stated she did not refuse the medication and had it for her other children.

d. Ms. Hull spoke to a physician and received an order for the Erythromycin ointment to be given immediately, despite being late. She wrote the physician's order in the chart.

e. Ms. Hull gave the Erythromycin ointment to the baby, finished the discharge teaching and then the baby was discharged.

f. The forms for Informed Refusals were readily available at the nurse's station.

g. Her charting may have been late but accurately reflects the events.

110. On cross-examination, Ms. Hull was asked whether Ms. Whieldon told her the notation in the chart for "Informed Refusal" was in reference to a possible second dose. Ms. Hull's response was that she did not understand as they never give second doses of Erythromycin ointment and she has never heard any one speak of such a thing. Ms. Hull also did not recall being asked by Ms. Whieldon to call the night nurse to verify whether Erythromycin ointment was given.

111. Ms. Whieldon testified that

a. The unit was short-staffed this day.

b. She was assigned to Patient #5 as well as to a post partum load at the opposite end of the hospital and did not feel that was an appropriate assignment.

c. When she arrived to meet Patient #5, the previous nurse, Gillian Loewen, provided her with a report during handover and explained that "everything had been done for the baby" but that her vitals needed to be completed. Ms. Loewen did not hand Ms. Whieldon the package of Erythromycin.

d. Ms. Whieldon checked her vitals and told her that she also needed to check her fundus and flow. Patient #5 declined as she was on a Skype video conference call.

e. She spoke with Patient #5 about whether her son had been given Erythromycin ointment. Ms. Whieldon testified Patient #5 told her she

thought it had been given. They had a discussion about whether or not the presence or absence of goopy eyes indicated the medication had been given.

f. Ms. Whieldon testified that there were two empty packages sitting on the counter: Erythromycin and Vitamin K. Both medications had been removed from their packaging. She testified that if the medications had not been given the nurses were to physically hand the medication to the next nurse coming on to shift.

g. A discussion ensued between Ms. Whieldon and Patient #5 about what to do. Ms. Whieldon testified they discussed whether a second dose of Erythromycin ointment could be given and the pros and cons of administering a second dose. They discussed the risk factors and purpose of Erythromycin ointment, and that Patient #5 had been screened and was in a monogamous relationship. Ms. Whieldon asked Patient #5 whether she would like her son to be given Erythromycin ointment now believing it to be a second dose, or wait until Ms. Loewen woke up to verify Ms. Whieldon's impression that the dose had already been given.

h. Patient #5 refused the Erythromycin ointment. Ms. Whieldon could not locate any Informed Refusal forms in the unit. She had been attempting to obtain those forms from the PCC for over a week.

i. Later in the day, Ms. Whieldon interacted with Ms. Hull about the Patient #5's request for early discharge. During the course of that discussion, they spoke about the Erythromycin ointment. Referring to the chart entry, Ms. Whieldon told Ms. Hull that Patient #5 had not refused the Erythromycin ointment but had refused a second dose of the medication. It was believed that Ms. Loewen had given the medication. Ms. Whieldon asked Ms. Hull to contact Ms. Loewen at home to confirm whether the medication had been given as by that time she would now have been awake.

112. On cross-examination, Ms. Whieldon acknowledged it was the hospital policy and the law to administer Erythromycin ointment to all newborns within the first hour of life, and if a parent refuses, the Informed Refusal process must be followed. Ms. Whieldon testified that this was not the case of an Informed Refusal but confusion over whether Erythromycin ointment had been given. Ms. Whieldon denied that checking off "Informed Refusal" in the patient records was inappropriate. She testified she did that to remind herself for later, and as a point of reminder for others nurses to ask her about that if they saw it. She testified she should have charted the notation in the nurses' notes, however, she did not have time to do so because of the staffing on the unit that day which was preventing her from meeting the applicable standards. When asked about her attempts to contact Ms. Loewen to confirm whether Erythromycin ointment had been given, Ms. Whieldon said that it was not possible to reach her as she was asleep. Ms. Whieldon admitted that since the medication had to be given within one hour of life, that it would have been prudent to take steps to reach Ms. Loewen immediately and that she did not attempt to do so or tell the CN to do so. Ms. Whieldon acknowledged she did not contact Patient #5's physician to ask about the Erythromycin ointment.

Analysis and Findings of Fact

113. The College submits that Patient #5 and Ms. Hull were very forthcoming in their evidence about what they did and did not recollect from the events of this day. In contrast, the College submits that Ms. Whieldon's explanation of her nursing actions that day was bizarre. The College submits that in light of the confusion as to whether the medication was given, Ms. Whieldon ought to have contacted Ms. Loewen, advised her CN or the PCC to assist if necessary, and to contact the MRP. The College also submits that given the time sensitivity for giving the medication that Ms. Whieldon ought to have taken those steps immediately on being questioned by Patient #5 about whether the baby got the medication and not put off taking action until some later time in the shift.

114. Ms. Whieldon submits that believing that Erythromycin ointment had already been given, she did not have to fill out an Informed Refusal form. This was not a refusal

of Erythromycin ointment; it was a decision not to proceed with a potential second dose. As a result, Ms. Whieldon submits that the College has not led sufficient evidence to establish that she erred by failing to provide Erythromycin ointment and document that Erythromycin ointment was given to Patient #5's infant.

115. The Panel finds that the requirement to have administered a dose of Erythromycin ointment to all infants within the first hour of life unless parents provide an Informed Refusal was not in dispute. The Panel accepts this was the policy and law at the material times.

116. The Panel finds both Patient #5 and Ms. Hull to be credible witnesses. The Panel finds Patient #5's evidence to be clear and cogent. Her evidence was internally consistent, and was consistent with the evidence given by Ms. Hull. Patient #5 and Ms. Hull did not exaggerate and readily acknowledged points they could not recall.

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 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 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 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's son. The Panel finds that Ms. Whieldon did not conduct an Informed Refusal process with Patient #5 and did not obtain Patient #5'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.

Breach of Standard Imposed under the Act

120. In failing to administer Erythromycin ointment to Patient #5's son, and in entering "Informed Refusal" in the patient record where she had not conducted an Informed Refusal process or obtained the patient's Informed Refusal, the Panel finds that Ms. Whieldon 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 3: Client Focused Provisions of Service**
>
> 1. Communicates, collaborates and consults with clients and other members of the health care team about the client's care.
> 2. Coordinates client care in a way that facilitates continuity for the client.
>
> **Standard 4: Ethical Practice**
>
> 1. Makes the client the primary concern in providing nursing care..

3. Demonstrates honesty and integrity.

Scope of Practice Standard

11. Nurses may not change or cancel a client-specific order given by a listed health professional when the activity is outside of autonomous scope of practice or the nurse's individual competence.
12. Nurses follow legal and ethical obligations regarding client consent.

Consent Standard

8. Nurses do not use coercion, fraud or misrepresentation in the consent process. Nurses are sensitive to the difference in power between health professionals and clients and do not misuse that power to influence clients' decision making.

121. In addition, the Panel finds that Ms. Whieldon acted contrary to provision 4 of the Documentation Standard.

122. The Panel also notes the direction at page 26 of the Scope of Practice Standard which states: "If you have questions about a client-specific order or the order does not contain the required information for you to carry it out safely, seek further clarification from the person who gave the client-specific order or from others on the health care team or your team leader."

123. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(g)(i)

124. In her closing submissions, Ms. Whieldon admits the following 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), and 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 28th, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

125. Based upon the above passages, it is unclear whether Ms. Whieldon is offering a complete admission in relation to this allegation.

126. As a result, the Panel wishes to be clear that it accepts the evidence in the expert report of Ms. King in relation to this allegation, namely that Ms. Whieldon 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 infusion increases which occurred at 1:00 pm, 2:00 pm, 3:00 pm, 4:40 pm, and 6:30 pm. The Panel agrees with Ms. King's opinion that Ms. Whieldon fell below the standard of care and did not follow the Oxytocin Management Checklist in each of those instances.

127. Ms. Whieldon submits that she was not aware of the requirement for 20 to 30 minutes of normal EFM tracing immediately before increasing Oxytocin. She stated she only learned of this requirement during the course of the evidence offered in this hearing, and noted the 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. In addition, Ms. Whieldon also relied 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 start Oxytocin right away, that Oxytocin can be used to induce labour for the mother within a window of a couple of hours.

128. The Panel finds that neither of these points is an answer to Ms. Whieldon's failure to have adhered to applicable College standards and health authority policies and protocols relating to the administration and management of Oxytocin. As discussed above, the Oxytocin Protocol was intended to standardize the administration and management of the drug, and limit variability between health providers that results from the reliance on individual nurses' judgment in order to reduce risk and improve patient safety and outcomes. While Dr. Mah may adjust the Oxytocin Protocol as indicated, it is not within Ms. Whieldon's scope of practice to customize the Protocol.

129. The Panel finds that Ms. Whieldon breached the Oxytocin Protocol, and the Oxytocin Management Checklist.

130. Ms. Whieldon 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; however, it also finds Ms. Whieldon's conduct constitutes broader and more significant breaches than have been admitted. The Panel finds that Ms. Whieldon breached 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.

131. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(g)(ii)

132. In her closing submissions, Ms. Whieldon admits the entirety of this allegation:

> ***Allegation (a)(iv), (g)(ii) and h(iii): Documentation (Patients O.M., A-J. B, and B.G.M.)***
>
> 284. The College has alleged that Ms. Whieldon did not follow protocol in her documentation and narrative charting, and specifically that she:
> (a) Used judgmental statements;
> (b) Did not consistently use medical terminology;
> (c) Failed to consistently use approved abbreviations and graphics;
> (d) Incorrectly dated entries on the April 28 Partogram and in the nursing progress notes;
> (e) Documented in narrative “block” in the nursing progress notes;
> (f) Did not document assessment findings and clinical rationale(s) for the changes made to the epidural and/or Oxytocin infusion rates; and
> (g) Did not document every required assessment on the Oxytocin Management Checklist.
>
> …
>
> 287. Despite the foregoing, Ms. Whieldon admits that on the dates in question with respect to these Allegations, her practice fell below the standard of care regarding the Documentation Practice Standard.

133. The Panel agrees and finds Ms. Whieldon’s documentation fell below the standard as alleged and admitted. The Panel finds that Ms. Whieldon breached the following provisions in the College’s Documentation Standard: 1, 2, 4, 5, 6,7, and

10. As a result, the Panel finds Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(h)(i)

Evidence

134. In her closing submissions, Ms. Whieldon admits the following in relation to this allegation:

> ***Citation Allegation 1(a)(i), 1(g)(i), and 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 28th, August 28th, and September 16th, 2016, and constituted a breach of the Medication Administration Practice Standards.

135. Despite the admission above, Ms. Whieldon made the same submission as in allegation 1(g) (i), which is outlined above. That is, she was not aware that the requirement for 20 to 30 minutes of normal EFM tracing was to be immediately prior to an increase. The Panel's findings in that regard are set out above. For the same reasons as set out in relation to allegation 1(g)(i) above, the Panel does not accept Ms. Whieldon's submissions for her failure to have adhered to applicable College standards and health authority policies and protocols relating to the administration and management of Oxytocin.

136. In relation to the allegation that Ms. Whieldon decreased Oxytocin due to maternal pain with this patient, the College relies upon Ms. King's expert report and the patient records.

137. Ms. King's report states that maternal pain is not an indicator to decrease the rate of Oxytocin infusion, but rather an indicator to assess the uterine contractions, change position and assist with pain relief options if assessment is within normal limits. If a patient is not coping well with the pain from uterine contractions and the fetal heart rate and uterine contraction pattern are within normal limits, then the nurse is expected to assist the patient with coping methods, change position, massage or breathing techniques and offer pain medication if appropriate.

138. The progress notes on September 16, 2016 contain the following entry at 2:10 pm: “Oxytocin half’ed”…”as pt crying out of control”. The entry at 4:50 pm states Oxytocin was decreased as “5:10 cont & trouble coping”.

139. Ms. Whieldon 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.

Analysis and Findings of Fact

140. The College submits that the Registrant’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 two passages referenced above and which are found in the Joint Book of Documents, Vol 2, Tab 9, at page 51:

    q. 1410: Pain/Fear Oxytocin half’ed down to 9mu/min as pt crying out of control.

    r. 1650: Oxy Decreased from 12 to 10 mu as 5:10 cont & trouble coping.

141. Ms. Whieldon submits that she knew that maternal pain is not a reason to decrease Oxytocin, and she decreased the Oxytocin for other reasons.

142. The Panel finds that Ms. Whieldon decreased Oxytocin due to maternal pain. Ms. Whieldon’s chart notes are clear that maternal pain was a reason for her adjustment of Oxytocin infusion rates. All progress notes are preceded by a column titled “Focus”. Ms. Whieldon testified that the “Focus” column is intended to capture “what the focus of the entry is”. In this instance, Ms. Whieldon indicated that the “Focus” of the 2:10 pm chart entry is “Pain/Fear”. 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 Ms. Whieldon recorded that she reduced the Oxytocin by half because the patient was crying out of control.

143. In addition, the Panel does not accept Ms. Whieldon’s evidence that she reduced the rate of Oxytocin by half at 2:10 pm because of three uncomplicated variables.

That is inconsistent with her admitted failure to have reduced Oxytocin by half due to the presence of three uncomplicated variables in relation to allegation 1(a)(i) because she was not aware of the requirement to do so.

144. The Panel is mindful that Ms. Whieldon's admission in 1(a)(i) is that she erred by not noting the requirement to initially decrease by half the Oxytocin when an atypical or abnormal strip presented, but that she became aware of this requirement in mid-June 2016 and, thereafter, she did her best to adhere to that requirement. Given that this allegation pertains to an event on September 16, 2016, Ms. Whieldon's evidence is that she knew of the requirement to reduce Oxytocin by half by this time. However, the patient record for September 16, 2016 shows that Ms. Whieldon continued to make Oxytocin infusion adjustments with this patient and on this date, which did not in fact conform to the Oxytocin Protocol requirements. For example, 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.

Breach of Standard Imposed under the Act

145. The Panel finds that Ms. Whieldon breached the Oxytocin Protocol and the Oxytocin Management Checklist.

146. Ms. Whieldon 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; however, it also finds Ms. Whieldon's conduct constitutes broader and more significant breaches than have been admitted. The Panel finds that Ms. Whieldon 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.

147. As such, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1) of the HPA.

Citation paragraph 1(h)(ii)

Evidence

148. Ms. Whieldon testified that:

a. Dr. Erica Phelps wanted to be in control of the delivery.

b. Dr. Phelps was aware the patient had requested an epidural and wanted morphine administered first.

Analysis and Findings of Fact

149. The College submits that the epidural order set that forms part of the client record is the protocol that nurses are expected to follow. The order set is customized for the patient and a decision tree of what to do when faced with complications is detailed, including the instruction to call the anesthetist if necessary. These orders are to be read and followed. When orders are modified and/or changed, those new

directions received from a physician must also be documented. If a nurse takes a verbal order then she must ensure that it is properly recorded given she is the one who actioned it.

150. Ms. Whieldon submits that the College has not outlined what Ms. Whieldon did wrong with respect to how she responded in this situation. The submissions do not specify which aspect of either the Medication Administration or Documentation Practice Standard was breached. Ms. Whieldon submits that there are vague allusions that she ought to have notified the anesthetist about the doctor's orders regarding the epidural, but this was only brought to her attention after the fact and only in the course of the hearing.

151. The medical records show that Ms. Whieldon called for orders and was waiting for the epidural herself. As a result, the Panel dismisses this allegation.

Citation paragraph 1(h)(iii)

152. In her closing submissions, Ms. Whieldon admits the entirety of this allegation:

> ***Allegation (a)(iv), (g)(ii) and h(iii): Documentation (Patients O.M., A-J. B, and B.G.M.)***
>
> 284. The College has alleged that Ms. Whieldon did not follow protocol in her documentation and narrative charting, and specifically that she:
> (a) Used judgmental statements;
> (b) Did not consistently use medical terminology;
> (c) Failed to consistently use approved abbreviations and graphics;
> (d) Incorrectly dated entries on the April 28 Partogram and in the nursing progress notes;
> (e) Documented in narrative "block" in the nursing progress notes;
> (f) Did not document assessment findings and clinical rationale(s) for the changes made to the epidural and/or Oxytocin infusion rates; and
> (g) Did not document every required assessment on the Oxytocin Management Checklist.
>
> …
>
> 287. Despite the foregoing, Ms. Whieldon admits that on the dates in question with respect to these Allegations, her practice fell below the standard of care regarding the Documentation Practice Standard.

153. The Panel agrees and finds Ms. Whieldon's documentation fell below the standard as alleged and admitted. The Panel finds that Ms. Whieldon's conduct was

contrary to the following provisions of the College's Documentation Standard: 1, 2, 4, 5, 6, 7, and 10. As a result, the Panel finds Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1)(b) of the HPA.

Citation paragraph 1(h)(iv)

154. The College did not lead evidence that Ms. Whieldon failed to follow Fraser Health Authority's policy and procedure regarding baby pauses consistently. Accordingly, the Panel dismisses this allegation.

Citation paragraph 1(j)

Evidence

155. The College led evidence through Ms. Howard-Jovanovic that nurses working in the post partum area of the unit had a standard list of discharge processes prior to a family and baby leaving the unit. The decision with respect to if and when to discharge a patient rests with the MRP and not with the nurse. That was not at issue between the parties.

156. Dr. Mah gave evidence that most physicians do rounds in the mornings and will write down the discharge order; however, sometimes they get distracted and the order is not written but is communicated orally.

157. Ms. Kurtz gave testimony that a verbal or written order is necessary before discharging a patient. She stated the order must come from the physician.

158. The clinical records indicate that Ms. Whieldon signed out the hospital discharge. Ms. Whieldon made a notation that she was glad the family was home and not waiting for discharge.

159. Ms. Whieldon testified that:

    a. This patient was not in her care during the material times.

    b. She interacted with this patient and family when they were walking out of the door with their baby in a car seat. Ms. Whieldon performed a car seat check before the family left the hospital.

c. She asked if they had seen the baby's doctor and the obstetrical physician.

d. She confirmed that the PKU lab results had been completed.

e. The family then waved at Dr. Angela Busletta who was sitting at the nurses' station. Ms. Whieldon concluded that the patient must have been discharged by Dr. Busletta.

f. When Dr. Phelps arrived on the unit, she was upset that her patient had been discharged without an order.

Analysis and Findings of Fact

160. Ms. Whieldon submits that she did not discharge this patient without a discharge order because it was not her duty to care for that patient.

161. The Panel finds based upon the paperwork and interactions on the date in question, that Ms. Whieldon did discharge the patient without a physician's order.

Breach of Standard Imposed under the Act

162. As such, Ms. Whieldon 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.

163. As a result, the Panel finds that Ms. Whieldon has not complied with a standard imposed under the Act, contrary to section 39(1) of the HPA.

<u>Return to Work</u>

164. Both of the parties led evidence and made submissions in relation to Ms. Whieldon's return to work in April 2016 following her five month leave of absence, the adequacy of her orientation upon her return, her learning opportunities, as well as the staffing and safety levels on the unit.

165. Ms. Howard-Jovanovic testified that Ms. Whieldon was asked to identify whether she had any specific learning needs which she needed to be addressed on her return and that Ms. Whieldon did not identify any. Ms. Howard-Jovanovic testified she was not prepared to agree to Ms. Whieldon only working post partum shifts as that would have amounted to a “sweet-heart” deal. She cannot arrange for informal accommodation without medical support. Ms. Howard-Jovanovic testified that following receipt of complaints against Ms. Whieldon, she sent a letter to Ms. Whieldon dated June 7, 2016 in which some re-orientation shifts were contemplated. In addition, that letter provided for motivational interviewing, web-based learning courses, a trauma informed care in-service, and a learning plan. On cross-examination, Ms. Howard-Jovanovic acknowledged several of those supports were not conducted.

166. Ms. Whieldon testified that Tanya Jantzen was the CNE who conducted the first learning plan in June 2016. She conducted a chart audit and approved of how Ms. Whieldon managed Oxytocin. Ms. Whieldon testified that the June 2016 learning plan was never completed because Ms. Jantzen left LMH.

167. Ms. Smith and Ms. Whieldon testified about a chart audit which was conducted in September 2016. Shortly after Ms. Smith’s arrival at LMH in August 2016, she offered to conduct a chart audit for any interested nurses. Ms. Whieldon accepted the offer and submitted an Oxytocin chart for review. Ms. Smith delayed in either conducting or delivering the results of that chart review for several months.

168. Ms. Howard-Jovanovic testified that in addition, Sarah Kaufman, a Clinical Nurse Specialist, conducted a chart review after Ms. Whieldon made a Respectful Workplace complaint against Ms. Howard-Jovanovic. It was determined that review would be more appropriately done at arm’s length. In September 2016, Ms. Kaufman’s audit identified a number of issues relating to adherence to protocols, standards, Oxytocin administration and management, fetal health surveillance and fetal heart strip interpretation, as well as the failure to escalate care. The results of the audit were reviewed with Ms. Whieldon.

169. Ms. Grunert and Ms. Smith both testified about the second learning plan which was conducted in December 2016. They both testified that they wanted to assist Ms. Whieldon in successfully remediating her practice. They would have expected Ms. Whieldon to successfully complete the plans given her years of experience. Ultimately the second learning plan was not completed.

170. Ms. Whieldon testified several times as to her concerns about staffing and safety levels on the unit. She filed several PRFs and PSLSs in relation to those concerns.

171. Ms. Whieldon testified that her employer originally enrolled her for the wrong CAEN exam. She testified that the health authority failed to support her in the lead-up to the CAEN exam. Ultimately, Ms. Whieldon was unsuccessful in the CAEN assessment.

172. The Panel has considered all of the evidence and submissions from both parties in relation to Ms. Whieldon's return to work, her re-orientation, chart audits, learning plans, CAEN assessment, as well as Ms. Whieldon's complaints of staffing and safety levels. While the Panel appreciates the evidence is important context to many of the allegations at issue in this hearing, the Panel ultimately did not find this evidence established any of the College's allegations or provided Ms. Whieldon with a defence to any of the allegations which were proven.

Professional Misconduct

173. Section 39(1) (c) of the HPA provides that on completion of a hearing, the Discipline Committee may determine that the Respondent has committed professional misconduct or unprofessional conduct.

The College's Submissions

174. The College argued that Ms. Whieldon committed professional misconduct.

175. The College pointed out that section 26 of the HPA defines "unprofessional conduct" as including "professional misconduct". "Professional misconduct" is defined in section 26 of the HPA to include "sexual misconduct, unethical conduct, infamous conduct and conduct unbecoming a member of the health profession".

176. The College relied on the case of *Pearlman v. Manitoba Law Society Judicial Committee*, [1991] 2 SCR 869 in which the Supreme Court of Canada defined "professional misconduct" as "conduct which would be reasonably regarded as disgraceful, dishonorable, or unbecoming of a member of the profession by his well respected brethren in the group – persons of integrity and good reputation amongst the membership".

177. The College argued that, as emphasized in *Pearlman*, a professional's conduct should be measured against the judgment of other members of the profession who are competent and in good standing. In this case, Ms. Whieldon's conduct should be measured against the judgment of a competent registered nurse.

178. The College submits that the evidence supports multiple breaches of the standards and the failure of Ms. Whieldon to meet her standards represents serious professional misconduct. Further, the College argues that the behaviour, when taken together, represents a pattern of professional misconduct which is disgraceful, dishonorable and unbecoming of a member of the profession. The College submits that Ms. Whieldon failed to take responsibility for her actions and on multiple occasions attempted to divert blame onto other healthcare practitioners and her patients. Amongst others, the College pointed to Ms. Whieldon's:

    a. Failure to follow agency protocols, failure to follow medication administration protocols, and failure to follow College Standards;

    b. Failure to escalate care after witnessing an infant's strange movements, failure to act within her scope of practice by ruling out a seizure, and charting a late entry to avoid responsibility for her error, which were in breach of her College Standards;

    c. Documentation of an Informed Refusal for Erythromycin that never took place and by failure to provide a dose of Erythromycin to a newly born infant, which were in breach of College Standards; and

    d. Discharge of a patient without a physician's order which was in breach of her College Standards.

The Respondent's Submissions

179. Ms. Whieldon submits that the College has not proven its case in multiple instances, and where the alleged conduct is admitted, for example, in the case of medication administration in allegations 1(a)(i), 1(g)(i), and 1(h)(i), it does not rise to the level of seriousness required to find professional misconduct.

180. Ms. Whieldon disputes the College's assertion that there is a pattern of misconduct or bad behaviour. Ms. Whieldon argues that where she has admitted responsibility, those incidents were based upon insufficient knowledge for which Ms. Whieldon was prepared to improve and adapt. Moreover, in relation to documentation, Ms. Whieldon argues this was a general issue on the unit, and not only with her. She points out that several documentation errors were raised in respect of her colleagues during the hearing.

181. Ms. Whieldon denies that she failed to take responsibility for her actions. She submits she made several admissions and expressed a willingness to learn and improve and took courses to improve her skills. She submits her actions were not reckless or deliberate and she made steps to correct her behaviour. She submits she explained herself clearly with respect to her Oxytocin administration and why she adjusted the infusion rates as she did.

Analysis and Determination

182. The Panel disagrees with Ms. Whieldon that the breaches it has found are not serious. To the contrary, it finds the proven conduct to be very serious. Nevertheless, the threshold to characterize conduct as professional misconduct is high. The Panel accepts the definition set out in *Pearlman*.

183. In this case, the Panel has determined pursuant to section 39(1)(c) of the Act that Ms. Whieldon committed professional misconduct with respect to allegation 1 (f). Ms. Whieldon failed to administer Erythromycin ointment to an infant, advised the patient that it was too late for the ointment to be given to her son, failed to escalate the issue with her CN, PCC or the MRP, and falsified a patient record to indicate that an Informed Refusal had taken place, when she had not performed an

Informed Refusal process and did not obtain the patient's Informed Refusal. The Panel finds this conduct would be regarded as disgraceful by other members of her profession.

Incompetence

184. The parties also both made submissions as to whether the Panel should make a determination that Ms. Whieldon's constitutes incompetence pursuant to section 39(1)(d) of the Act.

College's Submissions

185. The College submits that Ms. Whieldon has demonstrated that she has incompetently practiced her designated health profession.

186. The College relies upon *Mason v. Registered Nurses Association of British Columbia*, 1979 Canlii 419, which defined incompetence as the "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". The College points out that case has been adopted in many professional disciplinary proceedings.

187. The College also references *Reddy v. Association of Professional Engineers and Geoscientists of British Columbia*, 2000 BCSC 88 for the principle that incompetence is typically a finding based upon a pattern of incompetent behaviour, rather than on a single instance of negligence.

188. The College submits that Ms. Whieldon has demonstrated consistently that she was either unable or unwilling to accept constructive feedback regarding her nursing practice despite numerous attempts to direct her to remediate her practise.

189. The College submits that Ms. Whieldon's pattern of conduct with respect to the administration and management of Oxytocin is particularly concerning. The College argues that it strains credulity that she was unaware of the changes to the Oxytocin Protocol in 2012. Irrespective, her failure to follow the Oxytocin Protocol was brought to her attention repeatedly throughout the relevant time period, including through her first learning plan, her chart audit process with Ms. Kaufman and Ms. Smith, and through her second learning plan.

190. The College points to three Ontario decisions where findings of incompetency were made by the relevant professional bodies: *College of Nurses of Ontario v. Kaastra*, 2011 CanLII 99853; *College of Nurses of Ontario v. Powell*, 2011 CanLII 100540, and *College of Physicians and Surgeons of Ontario v. James*, 2016 ONCPSD 6.

191. The College submits that Ms. Whieldon's position that she was practicing to the best of her abilities is not a defence.

The Respondent's Submissions

192. Ms. Whieldon submits that based on the evidence before the Panel, the College has not met the burden of proof to establish that the Registrant is incompetent to continue the practice of nursing.

193. Ms. Whieldon argues that she should not be held to a standard of perfection but to a reasonable standard based upon a competent fellow nurse. She points to evidence from the hearing in which:

    a. Ms. Hill and Ms. Kurtz indicated Ms. Whieldon was an experienced, knowledgeable, and capable nurse;

    b. Ms. Kurtz testified she never witnessed Ms. Whieldon do something she considered to be unsafe;

    c. Some of the witnesses liked Ms. Whieldon and found her to be friendly;

    d. All nurses have gaps;

    e. In many cases, Ms. Whieldon did not fail to provide care to her patients but made errors in the care she did provide;

    f. Ms. Whieldon raised consistent concerns with her practice and the level of care at LMH as was evidenced by her filing of PRFs, PSLs, and various grievances where she felt the standard of care was not met. This is not the practice of an incompetent nurse but of a nurse who is dedicated to improving her practice.

194. Ms. Whieldon referred to page 7 of the College's Professional Standards which provides that that employers have a responsibility to provide essential support systems which allow nurses to meet the Professional Standards.

195. Ms. Whieldon alleges that LMH failed to discharge this burden by lack of re-orientation following a leave of absence, understaffing the hospital, insufficient access to written policies and policy updates, a lack of computer training, inconsistent feedback on Ms. Whieldon's performance and documentation, lack of support during Ms. Whieldon's learning plan, and a failure to support Ms. Whieldon in the lead up to her CAEN assessment.

196. Ms. Whieldon distinguishes two of the College's Ontario cases on the basis that those registrants did not appear at their disciplinary hearings to defend the allegations made against them.

Analysis and Determination

197. The Panel finds Ms. Whieldon to have incompetently practiced her designated profession with respect to:

    a. The administration and management of Oxytocin; and

    b. Her failure to function within her own level of competency and escalate care.

198. The Panel's findings with respect to allegations 1(a)(i), a(ii), g(i) and h(i) reveal a want of ability with respect to the administration and management of Oxytocin. The Panel found there to be a pattern of incompetent behaviour as opposed to a single instance. Moreover, the Panel found that want of ability was not only historical but continued with Ms. Whieldon's testimony at the hearing and in her closing submissions. While the Panel found Ms. Whieldon to be an experienced RN who cared for her patients, she has nevertheless continued to assert that she is justified in departing from the Oxytocin Protocol based upon her personal observations and interactions with the patient in the room, and parameters that are not recognized in the Protocol.

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.

200. Moreover, in only pointing to the employer's responsibility for ensuring Professional Standards, she ignores the responsibility set out for individual nurses on the same page of the Professional Standard she cited:

> **Individual Nurses**, as self-regulating professionals, are responsible for acting professionally and being accountable for their own practice. All nurses are responsible for understanding the Professional Standards and applying them to their practice, regardless of their setting, role or area of practice. The policies of employers or other organizations cannot relieve individual nurses of accountability for their own actions or their primary obligation to meet these Professional Standards.

201. The Panel also finds that Ms. Whieldon's assertions of understaffing also fail to explain Ms. Whieldon's past and continued departure from the Oxytocin Protocol. The Panel did not find any evidence that staffing levels caused Ms. Whieldon's proven departures from the Oxytocin Protocol or the College Standards.

202. In respect of Ms. Whieldon's failure to escalate care, the Panel finds in respect of the conduct in allegations 1 (c), 1 (f) and 1(j), Ms. Whieldon demonstrated a want of ability to function within her own level of competence and escalate patient care. Ms. Whieldon's failure to have escalated the care of an infant displaying symptoms of seizure, her failure to have contacted the MRP in the case of a suspected missed dose of Erythromycin ointment, and the discharge of a patient without a physician's order, demonstrate this was not an isolated event but part of a larger pattern of behaviour. In each case, Ms. Whieldon's response was also to deflect blame on to either the patient, another nurse, or the overall operations of the

hospital. The Panel finds Ms. Whieldon demonstrated a deficiency to use her experience and abilities properly.

203. The Panel has determined that pursuant to section 39(1)(d) of the Act, Ms. Whieldon incompetently practiced her designated profession with respect to the administration and management of Oxytocin and her failure to have functioned within her own level of competence and escalate care, in respect of allegations 1(a)(i), (a)(ii), (c), (f), g(i), h(i) and (j).

Order

204. The Panel determines pursuant to section 39(1)(b), (c) and (d) of the Act that the Ms. Whieldon has:

    a. Breached a standard imposed under the Act in relation to allegations 1(a)(i)(ii)(iv), (c), (d), (f), (g)(i)(ii), (h)(i)(iii), and (j);

    b. Committed professional misconduct in relation to allegations 1(f); and

    c. Incompetently practiced the profession in relation to allegations 1(a)(i), (a)(ii), (c), (f), g(i), h(i), and (j).

205. The Panel dismisses allegations 1(a)(iii), (b), (e) and (h)(ii) and h(iv).

Schedule for Submissions on Penalty and Costs

206. The Panel requests that the parties provide written submissions regarding the appropriate penalty and costs.

207. The Panel requests that the parties provide the written submissions in accordance with the following schedule:

    a. Submissions must be delivered by counsel for the College to Ms. Whieldon and the Panel no later than October 10, 2019;

    b. Submissions must be delivered by Ms. Whieldon to counsel for the College and the Panel no later than November 11, 2019; and

    c. Reply submissions may be delivered by counsel for the College to Ms. Whieldon and the Panel no later than November 25, 2019.

208. Submissions for the Panel should be delivered to Susan Precious, counsel for the Panel and may be delivered electronically.

Notice of right to appeal

209. 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.

Date: September 11, 2019

Sheila Cessford, Chair

Dr. Thomas Ward

Edna McLellan