COLLEGE OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **KIMBERLY THOMPSON**, N.P. REGISTRATION #**66,364**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

11120 178 STREET

EDMONTON, ALBERTA

ON

MAY 1, 2024

INTRODUCTION

A hearing was held on **May 1, 2024,** via Microsoft Teams videoconferencing by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**") to hear a complaint against Kimberly Thompson, N.P. registration #66,364.

Those present at the hearing were:

a. Hearing Tribunal Members:

Bonnie Bazlik, RN Chairperson
Claire Mills, RN
Don Wilson, Public Representative
Sarita Dighe-Bramwell, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Julie Gagnon

c. CRNA Counsel:

James Hart, Conduct Counsel

d. Registrant Under Investigation:

Kimberly Thompson (sometimes hereinafter referred to as the **"Registrant**")

e. Registrant's Labour Relations Officer:

Lesley Lapierre

f. CRNA Staff:

Lisa Legaspi, Hearings Coordinator as Clerk supporting Chair of the Tribunal in procedural management of virtual proceeding technology.

PRELIMINARY MATTERS

Conduct Counsel and the Labour Relations Officer for the Registrant confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing. No preliminary applications were made.

The Chairperson noted that pursuant to section 78 of the *Health Professions Act*, RSA 2000, c. H-7 ("**HPA**"), the hearing was open to the public. No application was made to close the hearing.

Conduct Counsel confirmed that the matter was proceeding by way of Agreed Statement of Facts and Liability and a joint submission on sanction.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend are as follows:

1. Between March 31, 2022 and April 13, 2022, the Registrant failed to adequately and/or accurately document Patient 1's medical assistance in dying ("**MAID**") procedure when they did one or more of the following:
    a. The Registrant failed to accurately document Patient 1's assessment on March 31, 2022, including:
        i. Erroneously checking in the affirmative and checking "N/A" in section 4;
        ii. Erroneously checking in the affirmative in section 4(b) despite Patient 1's death being reasonably foreseeable.
    b. The Registrant failed to adequately document and/or ensure that Patient 1's MAID procedure on April 13, 2022, was adequately documented, specifically the Consent to Treatment Plan or Procedure (Side A).
2. Between March 31, 2022 and April 13, 2022, the Registrant failed to preserve a copy and/or failed to ensure that there was preservation of a copy of their assessment for MAID of Patient 1 completed on March 31, 2022 in the Patient's chart.

It is further alleged that the Registrant's conduct constitutes "unprofessional conduct", as defined in section 1(1)(pp)(i),(ii), and/or (xii) of the HPA, including:

The conduct underlying Allegations 1 and 2 contravenes one (1) or more of the following: the CNACE; the CPSRM; and the CDSRM.

The Registrant has admitted to the conduct in the allegations in the Agreed Statement of Fact and Liability (Exhibit #2).

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend a Hearing;

Exhibit #2 – Agreed Statement of Fact and Liability dated March 27, 2024;

Exhibit #3 – Joint Recommendations on Sanction;

Exhibit #4 – Course Catalogue;

Exhibit #5 – Excerpt from *Jaswal* v. *Newfoundland Medical Board.*

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. Conduct Counsel noted that the allegations relate to the Registrant's failure to adequately or accurately document the MAID procedure and the failure to preserve or ensure preservation of a copy of an assessment for MAID. He noted that MAID documentation must be done accurately and retained properly in order to comply with both the *Criminal Code* of Canada and the AHS Medical Assistance in Dying Policy. Conduct Counsel briefly reviewed the Agreed Statement of Fact and Liability. Conduct Counsel submitted that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i) and (ii) of the HPA.

Conduct Counsel noted that the following Practice Standards were applicable: Standards 1.2, 2.2, 2.4, 2.5 and 5.2; Code of Ethics: A1, D6 and G1; Documentation Standard: 1.4.

Submissions by the Labour Relations Officer for the Registrant:

The Registrant's Labour Relations Officer confirmed that the Registrant had reviewed and agreed to the Agreed Statement of Fact and Liability.

Questions from the Hearing Tribunal:

The Hearing Tribunal requested additional information regarding Allegation 1(b), in terms of what was not adequately documented on the Consent to Treatment Plan or Procedure (Side A). Conduct Counsel noted that the issue was that the time under the "Witness Statement" portion was not included. The Hearing Tribunal asked whether the "Most Responsible Person" section needed to be filled out. Conduct Counsel noted that was not an issue in this case. The Labour Relations Officer had no submissions on the Hearing Tribunal's question.

The Hearing Tribunal also requested additional information regarding Allegation 2 and how the Registrant failed to preserve a copy or failed to ensure that there was preservation of a copy of the MAID assessment completed on March 31, 2022 in the patient chart. Conduct Counsel noted that the Registrant did not preserve a copy of the assessment in the patient chart, nor did she ensure that a copy was kept in the nurse manager's office, which was required to be kept in an envelope, separate from the patient chart. The Labour Relations Officer noted that the MAID assessment did exist in the MAID chart, but confirmed it was not in the facility chart.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal has reviewed the exhibits and considered the submissions made by the parties.

The Hearing Tribunal considered the definition of unprofessional conduct under section (1)(1)(pp) of the HPA. The Hearing Tribunal finds that the Allegations are proven and that the Registrant's conduct constitutes unprofessional conduct under section (1)(1)(pp) of the HPA, as follows:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;

(ii) contravention of this Act, a code of ethics or standards of practice;

(xii) conduct that harms the integrity of the regulated profession.

The Hearing Tribunal finds the following facts to be proven, as agreed to in the Agreed Statement of Fact and Liability.

Background

On May 12, 2022, the Complaints Director received a written complaint from a physician. The complaint alleged concerns regarding the Registrant's care provided to Patient 1 (the "**Patient**") while the Patient was undergoing MAID.

Agreed Facts

The Registrant was aware of the following policy and materials:

Nurse Practitioner ("**NP**") Job Description
AHS Medical Assistance in Dying Policy
AHS MAID Planning Tips for RDRHC

The Registrant was bound by the AHS Medical Assistance in Dying Policy. The AHS Medical Assistance in Dying Policy contains the following relevant clauses:

> 8.6 Health care providers shall ensure documentation in the patient's health record is in accordance with AHS policies and legislative requirements.
>
> 9.10 Physicians and Nurse Practitioners shall ensure documentation in the patient's health record is in accordance with AHS policies and legislative requirements. This documentation shall include, but is not limited to, capacity assessment, mandatory requirements, goals of care designation, completed consent forms, and record of medication administration.

The *Criminal Code*, RSC 1985, c C-46 has legislative requirements for MAID. Section 241.2 (7) delineates that: Medical assistance in dying must be provided with reasonable knowledge, care and skill and in accordance with any applicable provincial laws, rules or standards. The Registrant was bound by the *Criminal Code*.

The Registrant completed the MAID training program on May 10, 2018. The course was a full day session that included topics such as the introduction to MAID, legal requirements, NP specific information and review of a case study. In addition, the Registrant observed a MAID procedure in person.

On March 31, 2022, a licensed practical nurse in house at the facility told the Registrant that a patient wanted to speak to her. The Patient knew the Registrant was involved with MAID and asked staff if the Registrant could assist her. The Patient was suffering from macular degeneration, was going blind, was diabetic and had tremors. The Registrant did the MAID assessment while speaking to the Patient on March 31, 2022 and the Patient formally requested MAID on that date. The Patient's death was determined to be reasonably foreseeable. The Registrant then told the Patient that she would refer her to the MAID coordinating team and inform

them that she had done the assessment, which she did. A second assessment was still required and was completed on April 6, 2022. The Patient told the Registrant not to tell anyone about her request for MAID, including staff or her doctor. The Registrant informed the Patient that she would have to tell the nurse on the MAID coordinating team and the Patient agreed. The Registrant started to make arrangements for the MAID procedure to take place. Ultimately, the MAID procedure was carried out on April 13, 2022.

There are two documentation requirements for a MAID procedure. There is a form titled Part A- Assessor and Part B- Provider. Both need to be filled out properly in order to ensure compliance with the *Criminal Code* and any applicable provincial laws, rules or standards. The Registrant completed the applicable sections of Part B. Documentation errors were made under Part B.

The Registrant did not preserve a copy of her assessment in the Patient's chart nor did the Registrant ensure a copy was kept in the nurse manager's office.

Admission

The Registrant admits that her practice fell below the standard expected of a RN when:

1. Between March 31, 2022 and April 13, 2022, the Registrant failed to adequately and/or accurately document the Patient's MAID procedure when they did one or more of the following:

    a. The Registrant failed to accurately document the Patient's assessment on March 31, 2022, including:

        i. Erroneously checking in the affirmative and checking "N/A" in section 4;
        ii. Erroneously checking in the affirmative in section 4(b) despite the Patient's death being reasonably foreseeable.

    b. The Registrant failed to adequately document and/or ensure that the Patient's MAID procedure on April 13, 2022, was adequately documented, specifically the Consent to Treatment Plan or Procedure (Side A).

2. Between March 31, 2022 and April 13, 2022, the Registrant failed to preserve a copy and/or failed to ensure that there was preservation of a copy of their assessment for MAID of the Patient completed on March 31, 2022 in the Patient's chart.

The Registrant checked a box on the assessment form that "if the patient had difficulty communicating", the Registrant "took all necessary measures to provide a reliable means by which the patient may understand the information that is provided to him or her and communicate his or her decision." The Registrant also checked the box for "not applicable" for the same section. Both items cannot be checked. The section could not be both not applicable and answered in the affirmative, as was done in this case.

The assessment form is both inaccurate and inadequate. In addition, the Patient's death was reasonably foreseeable, but the Registrant filled out a section of the assessment form (section 4(b)) that is applicable if a patient's death is not reasonably foreseeable. Again this was not adequate nor accurate.

The Registrant also failed to ensure that the time of the witness signature was noted on the Consent to Treatment Plan or Procedure. This again constituted inadequate documentation.

Finally, the Registrant failed to ensure that a copy of the assessment for MAID was kept in the patient chart in the facility and in the nurse manager's office.

The Hearing Tribunal finds that the Registrant's conduct in Allegations 1 and 2 demonstrated a lack of knowledge in the provision of professional services. The Registrant demonstrated a lack of knowledge or a lack of skill in how to properly fill out the MAID forms and how to preserve the copies of required forms. It is imperative that MAID documentation be properly filled out and preserved, to ensure compliance with the *Criminal Code* and provincial requirements. The conduct is sufficiently serious to constitute unprofessional conduct under section 1(1)(pp)(i) of the HPA.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards:

Standard 1: Responsibility and Accountability

The nurse is personally responsible and accountable for their nursing practice and conduct.

Indicators

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

Standard 2: Knowledge-Based Practice

The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

Indicators

2.2 The nurse uses appropriate information and resources that enhance client care and the achievement of desired client outcomes.

2.4 The nurse exercises reasonable judgment and sets justifiable priorities in practice.

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

Standard 5: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

Indicators

5.2 The nurse follows all current and relevant legislation and regulations.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Code of Ethics:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the **health-care team**.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Documentation Standards:

Standard 1

Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

Criteria:

The nurse must:

1.4 Record:

…

b. accurately, completely and objectively

…

j. communication with other care providers, including name and outcomes of discussion

The Registrant failed to follow the requirements for MAID documentation in accordance with the required employer policies. The conduct breached the AHS Medical Assistance in Dying Policy and AHS MAID Planning Tips for RDRHC. Breaches of MAID documentation may engage provisions of the Criminal Code and thus documentation must be carefully prepared and preserved for MAID procedures. Registered Nurses must abide by legislation and policies and ensure compliance with documentation requirements. A failure to properly document information on a patient record can lead to serious and adverse outcomes in patient care. The breaches of the Practice Standards, Code of Ethics and Documentation Standards are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

The Hearing Tribunal finds that the conduct at issue is serious. MAID is a sensitive issue and is highly regulated. Registered nurses providing MAID services must ensure the careful compliance with all legislation and requirements. There is a public expectation that a MAID procedure will be undertaken with very careful compliance with all requirements. Failure to follow MAID policies and procedures undermines the integrity of the profession and the conduct in this case constitutes unprofessional conduct under section 1(1)(pp)(xii) of the HPA.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations on Sanction (Exhibit #3).

Conduct Counsel noted that the proposed sanction was designed to protect the public and maintain confidence in the profession. The proposed sanction sends the appropriate message to members of the regulated profession. Denunciation and deterrence are legitimate factors in setting a sanction, but the ultimate sanction must be measured, proportionate and reasonable.

Conduct Counsel reviewed a number of factors in the decision of *Jaswal* v. *Newfoundland Medical Board* and how those factors applied to the present case.

1. The nature and gravity of the proven allegations: the conduct is serious in that MAID documentation needs to be completed properly in order to ensure compliance with the *Criminal Code* and in order to ensure an accurate record of the MAID procedures in place.

2. The age and experience of the member: The Registrants has been registered since 1996 with the College and has been registered as a NP since October 2008. The Registrant should be aware of her responsibilities, ethical and otherwise, with respect to her nursing practice.

3. The previous character of the member: The Registrant has a prior disciplinary history with the College.

4. The age and mental condition of the offended patient: The Patient was 80 years old at the time and the Patient's mental condition was not abnormal.

5. The number of times the offence was proven to have occurred: The conduct occurred between March 31, 2022 and April 13, 2022.

6. The role of the registered nurse in acknowledging what occurred: The Registrant has accepted responsibility for the conduct. This is a significant mitigating factor.

7. Whether the member has already suffered other serious financial or other penalties: Conduct Counsel noted he was not aware of any serious financial or other penalties.

8. The impact on the offended patient: There is no direct evidence of impact on the Patient arising from the conduct.

9. The presence or absence of any mitigating factors: Conduct Counsel noted he was not aware of any additional mitigating factors.

10. The need to promote specific and general deterrence: General deterrence is paramount. Ensuring that other registered nurses are aware of the proper MAID procedure is important. Specific deterrence is achieved in this case through the reprimand.

11. The need to maintain public confidence: Maintaining confidence in the profession is critical. The proposed sanction achieves that purpose.

12. Degree to which offensive conduct is outside the range of permitted conduct: Conduct counsel noted that the conduct was clearly unacceptable.

Conduct Counsel noted the deference owed to a joint submission on sanction as recognized by the Supreme Court of Canada decision in *R v Anthony Cook*. The proposed sanction balances rehabilitation and deterrence and is a reasonable sanction. It does not bring the administration of justice into disrepute and is not contrary to the public interest.

Submissions by the Labour Relations Officer for the Registrant:

The Labour Relations Officer noted that there has been agreement by the parties and that the Registrant has completed most of the requirements of the proposed sanction. It was submitted that this speaks to the Registrant's professionalism.

Questions from the Hearing Tribunal:

The Hearing Tribunal requested submissions from the parties on a proposal to add the designation of "NP" to the proposed order in paragraph 10(b). Conduct Counsel and the Labour Relations Officer each noted that they had no concerns with this proposed revision to the Orders.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal carefully considered the Joint Recommendations on Sanction and the submissions of the parties. The Hearing Tribunal also noted the high level of deference owed to a joint recommendation on sanction.

The Hearing Tribunal considered the *Jaswal* factors outlined by Conduct Counsel. The Hearing Tribunal placed no weight on the fact that the Registrant has a prior disciplinary history, as no information was provided regarding the prior matter. It was not known whether the conduct in the prior matter was recent or whether it involved conduct related to the issues in this case, which might be factors that would be relevant to the Hearing Tribunal's consideration.

The Hearing Tribunal noted that the proposed sanction is reasonable. The reprimand is appropriate. The course work is aimed at documentation and is related to the issues identified in the hearing. The review of standards is also reasonable and appropriate to respond to the issues raised in the hearing. The Behavior Improvement Plan provides specific and clear direction and will allow the Registrant the opportunity to outline specific practice changes and improvements going forward. The timelines proposed for the course work, review of standards and Behavior Improvement Plan are reasonable. These requirements are robust and serve a remedial function, to assist the Registrant to improve her practice. This, in turn, helps ensure the protection of patients and the public.

Finally, the Practice Setting Letter is appropriate. This will ensure that the Registrant's supervisor is aware of the issues. The Practice Setting Letter serves to further protect patients and the public.

The Hearing Tribunal has considered the joint recommendation on sanction and finds that it is reasonable and protects the public interest. The joint recommendation on sanction balances the need for deterrence and denunciation while still providing a sanction that is measured, proportionate and reasonable. The Hearing Tribunal accepts the joint recommendation on sanction, with the addition of "NP" to paragraph 10(b) as noted by the Hearing Tribunal during the hearing.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By **September 1, 2024**, the Registrant shall provide a certificate of completion, satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities**:**

    a. Documentation (CRNA eLearning on College Connect).

3. By **September 1, 2024**, the Registrant shall provide a written declaration to the Complaints Director, in the form attached as "Schedule A" to this Agreement, confirming that they have read and reviewed:

    a. the Canadian Nurses Association Code of Ethics for Registered Nurses (2017);

    b. the Documentation Standards (2022);

    c. the Practice Standards for Registrants (2023);

    d. the Entry-Level Competencies for Nurse Practitioners in Canada (2016); and

e. the Medical Assistance in Dying Standards of Practice for Nurse Practitioners (2016).

4. By **September 1, 2024**, the Registrant shall provide to the Complaints Director a self-improvement plan on documentation of the MAID process ("**Behavior Improvement Plan**") and the Behavior Improvement Plan must be satisfactory to the Complaints Director and must:

    a. Be typed and comply with professional formatting guidelines (American Psychological Association style);

    b. Be at least one thousand (1000) words in length;

    c. Include a list of five (5) goals of self-improvement relating to documentation, specifically:

        i. Describe how the Registrant will improve their practice, including strategies, plans and supports or resources that may assist their improvement;

        ii. Detailing the process of documentation for medical assistance in dying ("**MAID**") as a NP including the importance of clear documentation; and

        iii. Cite at least six (6) applicable standards and responsibilities from the following:

            1) the *Documentation Standards;*

            2) the *Practice Standards;*

            3) *Medical Assistance in Dying Standards of Practice for Nurse Practitioners;* and

            4) the *Code of Ethics.*

5. Within **fifteen (15) days** of the Hearing Order being issued in writing by the Tribunal, the Registrant shall provide a letter ("**Practice Setting Letter"**) to the Complaints Director from the Registrant's Registered Nurse ("**RN**") or Nurse Practitioner ("**NP**") Supervisor (the "**Supervisor"**) at their current place of employment ("**Practice Setting"**), confirming:

    a. The Supervisor's name and contact information;

    b. The Practice Setting;

    c. The Registrant's role of employment;

    d. That the Supervisor has reviewed the Hearing Tribunal's Decision, including the findings and Order;

    (the "**Condition(s)**")

COMPLIANCE

6. Compliance with this Order shall be determined by the Complaints Director of the College. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

7. The Registrant will provide proof of completion of the above-noted Conditions to the Complaints Director via e-mail to procond@nurses.ab.ca or via fax at 780-453-0546.

8. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of HPA.

9. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated non-compliance and any request for an extension.

CONDITIONS

10. The Registrant understands and acknowledges:

    a. pursuant to section 119 of the HPA, and section 33(1) of the *Registered Nurses Profession Regulation*, Alta Reg 232/2005, it is the Registrant's professional obligation to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment; and

    b. employment is defined in section 57(3) of the HPA as being engaged to provide professional services as a RN or NP on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer.

11. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is self-employed, under an undertaking to not work, is on sick leave or disability leave, or if the Registrant had not been called to do shifts, but could be called:

Employer Name	**Employer Address & Phone Number**
Alberta Health Services	[An Alberta Health Centre]

12. The Registrar of the College will be requested to put the following conditions against the Registrant's practice permit (current and/or future) and shall remain until the conditions are satisfied:

    a. ***Course work required – Arising from Disciplinary Matter***;

    b. ***Behavior Improvement Plan required – Arising from Disciplinary Matter;***

c. ***Confirmation of Practice Settings(s) required – Arising from Disciplinary Matter***.

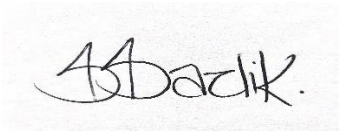
13. Effective on the date of the Hearing, which is to be determined, or the date of this Order if different from the date of the Hearing, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

14. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

15. This Order takes effect on the date of the Hearing, which is to be determined, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,



Bonnie Bazlik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: May 1, 2024