DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **MARIO TREMBLAY**, R.N. REGISTRATION #**66,564**

AS A RESULT OF A VIRTUAL HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

June 9, 2021

INTRODUCTION

A hearing was held on June 9, 2021 at the College and Association of Registered Nurses of Alberta ("CARNA") by the Hearing Tribunal of CARNA to hear a complaint against Mario Tremblay R.N. registration #66,564.

Those present at the hearing were:

a. Hearing Tribunal Members:

Grace Brittain, Chairperson
Lynn Headley, RN
Douglas Dawson, Public Representative
Jim Lees, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Heidi Besuijen

c. CARNA Representative:

Vita Wensel, Conduct Counsel

d. Regulated Member Under Investigation:

Mario Tremblay (sometimes hereinafter referred to as "the Regulated Member")

e. Regulated Member's Legal Counsel:

Laura Mensch

PRELIMINARY MATTERS

Conduct Counsel and Legal Counsel for the Regulated Member confirmed 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.

No application was made to close the hearing.

Conduct Counsel confirmed the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

The allegations in the Notice to Attend are as follows:

While employed as a Registered Nurse ("RN") at [an Edmonton AB hospital]:

1. On or about December 21, 2018, the Regulated Member failed to communicate effectively with [Patient 1's] family member, after [Patient 1] suffered an injury, contrary to the *CNACE* and the *CPSRM.*

2. Between January 18, 2019 and May 31, 2019, the Regulated Member failed to be accountable and failed to demonstrate reasonable judgment when they did not reply to a Patient Relations request for information about [Patient 1's] injury and care, contrary to the *CNACE* and the *CPSRM.*

3. On or about January 8, 2020, the Regulated Member failed to adequately explain nursing care to [Patient 1's] family, specifically when they were unprepared while participating in a Patient Relations meeting and failed to advise [Patient 1's] family that they had not been given notice of the meeting and had therefore not had opportunity to prepare, contrary to the *CNACE* and the *CPSRM.*

The Regulated Member has admitted to the conduct in the allegations in the Agreed Statement of Facts and Liability (Exhibit #2).

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Notice to Attend a Hearing by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta;

Exhibit #2 – Agreed Statement of Facts and Liability between Mario Tremblay, #66,564 and Vita Wensel, Conduct Counsel;

Exhibit #3 – Appendices to the Agreed Statement of Facts and Liability:

A. Complaint Documents;

B. Resume of the Regulated Member;

C. Ongoing education for the Regulated Member;

D. CARNA Practice Standards for Regulated Members ("Practice Standards") and 2017 Edition of the Canadian Nurses Association Code of Ethics for Registered Nurses ("Code of Ethics");

E. Policy on Recognizing and Responding to Hazards, Close Calls and Clinical Adverse Events Policy and the Code of Conduct;

F. [an Edmotnon AB hospital] Job Allocation Card - Patient Care Management Jobs;

G. Position Description - Patient Care Manager;

H. [an Edmotnon AB hospital] PCM and UM Role Statements / RACI Matrix;

I. [Patient 1's] redacted chart and the [unit redacted] charting abbreviations;

J. Email from Regulated Member dated December 21, 2018;

K. Emails from Patient Relations to the Regulated Member dated January 18, 2019, April 9, 2019 and May 30, 2019; and

L. Email from Regulated Member dated January 25, 2019.

Exhibit #4 – Joint Recommendations on Sanction; and

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

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions. 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, 2.7, 3.1, 3.4, 4.2, 4.4, 4.5, and 4.6. Conduct Counsel also noted that the following provisions from the Code of Ethics applied: a.1, a.2, a.5, b.4, g.1, g.2. Conduct Counsel noted there may be other applicable provisions, but that in her view, these were applicable. Conduct Counsel reviewed the Agreement (Exhibit #2).

Submissions by the Labour Relations Officer/Legal Counsel for the Regulated Member:

The Regulated Member's Legal Counsel advised she did not disagree with Conduct Counsel's submissions but emphasized that the conduct at issue related to failures to respond and communicate effectively.

Questions from the Hearing Tribunal:

The Hearing Tribunal had no questions arising from the submissions of Conduct Counsel and Counsel for the Regulated Member.

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 Regulated Member's conduct constitutes unprofessional conduct under section (1)(1)(pp) of the Health Professions Act, 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; and
>
> (ii) contravention of this Act, a code of ethics or standards of practice

The Hearing Tribunal accepts the facts as admitted to in the Agreement Statement of Facts and Liability (Exhibit #2).

The Hearing Tribunal finds that the following facts, to which the Regulated Member admitted, have been proven.

The Regulated Member is the Patient Care Manager of [unit redacted] at [an Edmonton AB hospital].

In his position, the Regulated Member manages patient care issues and ensures patient safety standards and protocols are applied in all patient care delivery. The Regulated Members duties include: managing “formal” or post-discharge patient and family concerns or complaints; leading investigations related to patient and family concerns, safety issues and safety incidents; and facilitating effective patient care related communication and collaboration between units and integrated services.

On December 21, 2018, [Patient 1], a minor, attended the [an Edmonton AB hospital] for surgery. She underwent surgery in the operating room, under general anesthesia, and was transferred to the [unit redacted] to recover from anesthesia at 0927 hours. [Patient 1] was transferred to the [unit redacted] at 1104 hours for further recovery. While at the [unit redacted], [Patient 1’s] mother pulled back [Patient 1’s] blankets and discovered a lump on [Patient 1’s] [body part]. Physicians later determined [Patient 1’s] [body part] was [injured]. [Patient 1] underwent surgery for her [body part] at 1555 hours and was transferred to the [unit redacted] to recover at 1625 hours. She later returned to the [unit redacted] at 1715 hours and was discharged at 2000 hours.

The Regulated Member was not assigned nor provided direct patient care to [Patient 1] between her admission and discharge.

At 1515 hours, an RN on the [unit redacted] advised the Regulated Member by telephone about [Patient 1’s] [body part injury]. The Regulated Member went to the [unit redacted] while [Physician 1] was speaking with [Patient 1’s] parents. Shortly after arriving, the Regulated Member approached [Patient 1’s] father to discuss [Patient 1]. The conversation lasted approximately two minutes.

During the conversation with [Patient 1’s] father, the Regulated Member made a comment to the effect that it may never be known what happened, in reference to [Patient 1’s] [body part injury]. The Regulated Member’s comment upset [Patient 1’s] father who was in shock about what had happened to [Patient 1].

The Regulated Member advised the matter would be investigated and he would follow up to see how quickly [Patient 1] could be returned to the operating room. The Regulated Member reported back to [Patient 1’s] family regarding when [Patient 1] would return to the operating room, and arranged for [Patient 1’s] mother to be with [Patient 1] in [unit redacted] after the surgery but otherwise did not provide any further updates, speak with, or visit [Patient 1] or [Patient 1’s] parents on December 21, 2018.

After speaking to [Patient 1’s] father, the Regulated Member asked for a copy of [Patient 1’s] chart and called the Executive Director (“ED”) and the Site Patient Care Manager. He also followed up with an email which he copied to the Unit Manager. He spoke with the [unit redacted] RN and Charge RN. He also spoke to the on-call ED and the on-call PCM to advise

them of what occurred. However, the Regulated Member did not speak to the responsible RN in the [unit redacted], [co-worker 1], or the assisting LPN, [co-worker 2], nor request written statements from [co-worker 1] or [co-worker 2] on December 21, 2018.

The Regulated Member did not personally follow up with any members of the healthcare team about [Patient 1's] care after her surgery on December 21, 2018. By the time the surgery was completed, the Regulated Member's shift was over, and he had gone home. Before leaving for the day he ensured the [unit redacted] Charge RN on the evening shift was briefed. He also confirmed that the patient relations contact information would be provided to the family.

The Regulated Member did not fully review [Patient 1's] chart on December 21, 2018 but did so on December 24, 2018. [Patient 1's] parents made a Patient Relations complaint on December 23, 2018.

During the first week of January 2019, the Regulated Member spoke to the Manager of the [unit redacted] and [unit redacted] and requested that she speak to certain individuals. The Regulated Member received a report from the [unit redacted] Manager soon after and observed that her report was consistent with the patient chart. The first written statement of [co-worker 1], and other relevant health care providers, was obtained by the [unit redacted] Manager on January 22, 2020.

On January 18, 2019, a Patient Relations Consultant, contacted the Regulated Member by email seeking further information. [Patient Relations Consultant] requested follow up on April 9, 2019 and May 30, 2019. The Regulated Member did not respond to the request for information until May 31, 2019 and provided his substantive response on June 4, 2019. The Regulated Member believed the Regional Director ("RD") was addressing the matter and had communications with the Executive Director ("ED") about that. Nonetheless, the Regulated Member did not provide a direct response which might have been a factor in any delay in the Patient Relations investigation.

Even though the Regulated Member did not respond directly to [Patient Relations Consultant], he did correspond and respond to requests from the ED and other members of the healthcare team about this incident. The Regulated Member recommended to the ED that a Quality Assurance Review ("QAR") be completed and continued to communicate with the ED on this point until the QAR Committee decided that a QAR would not be done.

On January 25, 2019, the Regulated Member did provide a timeline, based on his chart review, to the ED and the Senior Operating Officer ("SOO").

On January 8, 2020, [Patient 1's] parents met with numerous people to discuss their concerns. During the meeting, when asked about [Patient 1's] nursing care, the Regulated Member failed to provide adequate reasons about his investigation, the nursing care and quality improvement activities initiated because he was not prepared for the meeting. The Regulated Member was not advised about the meeting until shortly before it occurred and was not able to prepare for it. However, he did not explain to [Patient 1's] family of this and so his responses and the appearance of not being prepared caused further distress to [Patient 1's] parents.

The Hearing Tribunal finds that the conduct by the Regulated Member displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services. The ability to communicate appropriately and effectively with a patient (or their family) is at the core of delivering patient care.

The Hearing Tribunal also finds the Regulated Member breached the following provisions of the Practice Standards: 1.2, 2.2, 2.4, 2.7, 3.1, 3.4, 4.2, 4.4, 4.5, and 4.6, as follows:

Standard One: 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 Two: 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.

2.7 The nurse applies nursing knowledge and skill in providing safe, competent, ethical care and service.

Standard Three: Ethical Practice

The registered nurse complies with the *Code of Ethics* adopted by the Council in accordance with Section 133 of *Health Professions Act* and CARNA bylaws (CARNA, 2012).

Indicators

3.1 The nurse practices with honesty, integrity and respect.

3.4 The nurse communicates effectively and respectfully with clients, significant others and other members of the health care team to enhance client care and safety outcomes.

Standard Four: Service to the Public

The nurse has a duty to provide safe, competent and ethical nursing care and service in the best interest of the public.

Indicators

4.2 The nurse collaborates with the client, significant others and other members of the health-care team regarding activities of care planning, implementation and evaluation.

4.4 The nurse explains nursing care to clients and significant others.

4.5 The nurse articulates nursing's contribution to the delivery of health care services.

4.6 The nurse participates in quality improvement activities.

The Hearing Tribunal finds the Regulated Member breached the following provisions of the Code of Ethics: a.1, a.2, a.5, b.4, g.1, g.2**,** as follows:

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.

2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

5. Nurses are honest and take all necessary actions to prevent or minimize patient safety incidents. They learn from near misses and work with others to reduce the potential for future risks and preventable harms.

B. Promoting Health and Well-Being

Nurses work with persons who have healthcare needs or are receiving care to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with healthcare needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.

G. Being Accountable

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

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

2. Nurses are honest and practise with integrity in all of their professional interactions. Nurses represent themselves clearly with respect to name, title and role.

The breaches of the Practice Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

The Regulated Member's conduct showed poor judgment in how he communicated, or failed to communicate, with [Patient 1's] family and they showed a lack of empathy and consideration for the distress they must have been experiencing as a result of what happened to [Patient 1]. He did not show respect to [Patient 1] or her family and did not communicate effectively which is a keystone element of delivering patient care. Finally, the Regulated Member's interactions to [Patient 1's] family had the effect of escalating, rather than deescalating, the distress they were feeling.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations (Exhibit # 4).

Conduct Counsel reviewed the 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: Conduct Counsel identified that in terms of how serious this conduct was that it was on the lower end of the spectrum resulting from a lack of diligence rather than something more troubling.

2. The age and experience of the member: The Regulated Member is [age] years old and has been registered with CARNA since 1996.

3. The previous character of the member: Conduct Counsel suggested the Regulated Member's long career which was wholly absent of concern was a significantly mitigating factor.

4. The age and mental condition of the offended patient: [Patient 1] is a child; however, Conduct Counsel noted the issues in this hearing relate to communications rather than patient care but this factor still must be considered.

5. The number of times the offence was proven to have occurred: This conduct occurred over a period of months and on more than one occasion.

6. The role of the registered nurse in acknowledging what occurred: Conduct Counsel noted the Regulated Member had acknowledged his conduct and that this was a significant mitigating factor.

7. Whether the member has already suffered other serious financial or other penalties: The Conduct Counsel noted the Regulated Member had participated in a lengthy investigation in regard of these matters.

8. The impact on the offended patient: The probable impact of this conduct on [Patient 1] and her parents was a general mistrust in medical professions.

9. The presence or absence of any mitigating factors: No specific mitigating factors were presented other than those previously noted.

10. The need to promote specific and general deterrence: The education component of the proposed sanction would offer specific deterrence to the Regulated Member and offer general deterrence in demonstrating the importance of patient communications.

11. The need to maintain public confidence: Conduct Counsel suggested the proposed sanction showed the Regulated Member was being held accountable, his admissions showed he recognized his errors and demonstrated that CARNA was meeting its mandate to govern its members and protect the public.

12. Degree to which offensive conduct is outside the range of permitted conduct: Conduct Counsel did not offer specific comments with regard to this factor.

Submissions by the Legal Counsel for the Regulated Member:

Counsel for the Regulated Member confirmed the agreement to the proposed sanction. She noted it was clear from the Regulated Member's resumé that he had a strong career over many years of practice. Further, she advised the Hearing Tribunal the Regulated Member had deeply considered his conduct. While he believed he was taking the right steps in addressing the concerns relating to [Patient 1], that he recognized the gap in those steps in failing to keep the family apprised in these very serious circumstances. She advised that he has taken to heart the concerns about his conduct and was taking forward what he had learned and incorporating it into his practice.

Statement by the Regulated Member:

The Regulated Member read to the Hearing Tribunal a statement which he had prepared. He advised that he had thought a lot about what occurred and would work to ensure clarity going forward. He addressed [Patient 1] and her family expressing that he was sorry for what had occurred, that it must have been very traumatic and that [Patient 1] would continue to suffer the consequences.

He recognized his failure and talked about how he did not properly and professionally communicate in the circumstances. He confirmed that when he is dealing with difficult events in the future that he would use what he had learned in working with patients and families. Finally, he addressed looking to engage in his profession in a compassionate manner.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal carefully considered the exhibits provided and submissions made. In the result, the Hearing Tribunal finds that the proposed sanction is reasonable in all of these circumstances and appropriately protects the public interest. The education and writing components of the sanction will provide the Regulated Member with an opportunity to reflect on his conduct and his practise going forward.

The Regulated Member has a long track record of engaging in his profession without issue. The Hearing Tribunal was left with the clear impression, from the Regulated Member's cooperation in

the investigation and acknowledgement of his conduct as well as his comments during the hearing, that he has already begun to consider his actions and develop an understanding of the impact of his conduct as well as an appreciation for how to learn and grow from this experience.

The Hearing Tribunal is satisfied the objectives of specific and general deterrence are met with these proposed orders and the public's confidence will also be maintained. Accordingly, the Hearing Tribunal accepts the proposed sanction as presented.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

1. The Regulated Member shall pay a fine in the sum of **$200.00**, whereby such fine may be effected via payment to MyCARNA by **December 3, 2021**, and noting the following term may apply:

    a. Pursuant to Section 82(3)(c) of the *HPA,* the Regulated Member may be automatically suspended for any non-payment.

2. The Regulated Member shall provide proof satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities, no later than **December 3, 2021**:

    a. ***Responsible Nursing (NURS0170 from MacEwan University)***.

3. The Regulated Member shall write and submit to the Complaints Director, a paper which must be deemed satisfactory to the Complaints Director, by no later than **December 3, 2021**. The paper shall:

    a. be titled "The Importance of Patient Family Communication: What it Means to My Practice as a RN";

    b. be at least **1,000** words in length;

    c. be typed and comply with professional formatting guidelines (e.g. APA);

    d. demonstrate an understanding of the importance of patient family communication;

    e. Include a specific analysis of the how failures to communicate compassionately, professionally, effectively, and respectfully with patient family members are harmful to:

i. the public (patients, families and communities);

ii. the reputation of the profession of nursing; and

iii. the Regulated Member's own career.

f. demonstrate insight into why the conduct of the Regulated Member, as outlined in this Agreement, were unacceptable, citing specific CARNA *Nursing Practice Standards* and the CARNA *Code of Ethics*; and

g. have a bibliography of at least **five (5)** references (no older than ten years old), one of which must be the CARNA *Nursing Practice Standards* and *Code of Ethics* and others of which must be from academic journals or textbooks.

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

I. COMPLIANCE

4. Compliance with this Order shall be determined by the Complaints Director of CARNA. All decisions with respect to the Regulated Member's compliance with this Order will be in the sole discretion of the Complaints Director.

5. The Regulated Member 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.

6. Should the Regulated Member 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.

7. The responsibility lies with the Regulated Member to comply with this Order. It is the responsibility of the Regulated Member to initiate communication with CARNA for any anticipated non-compliance and any request for an extension.

III. CONDITIONS

8. The Regulated Member confirmed the following list sets out all the Regulated Member's employers and includes all employers even if the Regulated Member is under an undertaking to not work, is on sick leave or disability leave, or if the Regulated Member has not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer. The Regulated Member confirmed the following employment**:**

Employer Name	**Employer Address & Phone Number**
[an Edmonton AB hospital]	[an Edmonton AB hospital contact information redacted]

9. The Regulated Member understood and acknowledged that it is the Regulated Member's professional responsibility to immediately inform CARNA of any changes to the Regulated Member's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

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

    a. ***Shall pay fine***;

    b. ***Course work required***; and

    c. ***Essay required***.

11. 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 Regulated Member's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Regulated Member is also registered (if any).

12. Once the Regulated Member 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.

13. 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,

Grace Brittain, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: June 9, 2021