COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF TASNEEM ALI, R.N. REGISTRATION #**55,868**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA

11120 178 STREET

EDMONTON, ALBERTA

ON

DECEMBER 8, 2020

INTRODUCTION

A virtual hearing was held on December 8, 2020 by the College and Association of Registered Nurses of Alberta ("CARNA") to hear a complaint against Tasneem Ali, R.N. Registration #55,868.

Those present at the hearing were:

a. Hearing Tribunal Members:

Jason Anuik, Chairperson
Tracy Cowden
Terrie Tietz
David Rolfe, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Mary Marshall

c. CARNA Representative:

Vita Wensel, Conduct Counsel

d. Regulated Member Under Investigation:

Tasneem Ali (sometimes hereinafter referred to as "the Regulated Member")

e. Regulated Member's Legal Counsel:

Erin Runnalls

PRELIMINARY MATTERS

Conduct Counsel and the Legal Counsel for the Regulated Member 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. The Chairperson noted that members of the public were present and read the rules of behaviour for the public.

Conduct Counsel confirmed that 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 Dr. William Mather Professional Corp. Dental Office ("**WMPC**"), Edmonton, Alberta, the Regulated Member's practice fell below the standard expected of a RN when:

Allegation 1:

The Regulated Member failed to appropriately initiate and deliver Basic Life Support ("**BLS**") to [Patient 1], when she:

i. Failed to call 911, or direct someone to call 911, to activate the emergency response system, immediately when she found the patient to be unresponsive;

ii. Failed to call for an Automatic External Defibrillator ("**AED**") immediately when she found the patient to be unresponsive;

iii. Failed to correctly perform child cardiopulmonary resuscitation ("**CPR**"); and

iv. Failed to adequately document BLS activities during and after the resuscitation of the patient when she was the most responsible health care professional for the code.

Allegation 2:

The Regulated Member failed to provide appropriate nursing care to [Patient 1], when she:

i. Failed to appropriately monitor the patient during recovery from general anesthetic; and

ii. Failed to remain with the patient at all times during recovery from general anesthetic.

Allegation 3:

i. The Regulated Member knew, or ought to have known, that she would need to practice her BLS skills to maintain her BLS knowledge and skill and did not do so.

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:

NUMBER	DESCRIPTION	
Exhibit #1:	Notice to Attend a Hearing by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta dated December 1, 2020	
Exhibit #2:	Agreed Statement of Facts and Liability between Tasneem Ali, #55,868 and Vita Wensel, Conduct Counsel	
Exhibit #3:	Appendices (A through G) of the Agreed Statement of Facts	
	Appendix A	CARNA Complaint Details Document
	Appendix B	Notice to Attend a Hearing by the Hearing Tribunal of the College and Association of Registered Nurses of Alberta dated November 17, 2017

NUMBER	DESCRIPTION	
	Appendix C	CV of the Regulated Member
	Appendix D	Practice Standards for Regulated Members Effective April 2013, the 2017 Edition Code of Ethics for Registered Nurses, and the Documentation Standards for Regulated Members Effective January 2013
	Appendix E	[Patient 1]'s Emergency Service Records
	Appendix F	[Patient 1]'s Monitor Strip
	Appendix G	[Patient 1]'s Chart
Exhibit #4:	Joint Recommendations on Sanction	
Exhibit #5:	Book of Authorities	
	Tab 1	Excerpt from *Jaswal v. Newfoundland Medical Board*, (1996), 42 Admin L.R. (2d) 233, 1996 CanLII 11630 (NL SC) ("Jaswal")
	Tab 2	*College of Nurses of Ontario v Alleyne*, 2012 CanLII 100089 (ON CNO)
	Tab 3	*Adams v Law Society of Alberta*, 2000 ABCA 240
	Tab 4	*R v Anthony-Cook*, 2016 SCC 43
Exhibit #6:	2008 Edition of the Canadian Nurses Association Code of Ethics for Registered Nurses ("2008 Code of Ethics")	

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), (ii) and (xii) of the HPA.

Conduct Counsel noted that the following Practice Standards were applicable: Standards 1.2, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 3.4, 4.1, 4.2, 4.3, 5.5, 5.6 and 5.7. Conduct Counsel also noted that the following provisions from the 2008 Code of Ethics applied: A1, A5 and A6; B1 and B3; G1 and G3. Conduct Counsel also noted that the following provisions in the Documentation Standards for Regulated Members applied: 1.1, 1.2, 1.3, 1.4, 1.14 and 1.15. Conduct Counsel noted there may be other applicable provisions, but that in her view, these were applicable. Conduct Counsel reviewed the Agreed Statement of Facts and Liability (Exhibit #2).

Submissions by the Legal Counsel for the Regulated Member:

The Regulated Member's Legal Counsel submitted that the parties had come to an agreement and that the agreement was in the public interest.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal adjourned to consider the materials and 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;
>
> (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 that the Regulated Member breached the following provisions of the Practice Standards: **1.2, 1.4, 2.1, 2.2, 2.3, 2.4, 2.5, 2.7, 3.4, 4.1, 4.2, 4.3, 5.5, 5.6 and 5.7**, 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.

1.4 The nurse practices competently.

Standard Two: Knowledge-Based Practice

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

Indicators

2.1 The nurse supports decisions with evidence-based rationale.

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

2.3 The nurse uses critical inquiry in collecting and interpreting data, planning, implementing and evaluating all aspects of their nursing practice.

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.

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

Standard Three: Ethical Practice

The nurse complies with the Code of Ethics adopted by the Council in accordance with Section 133 of HPA and CARNA bylaws (CARNA, 2012).

Indicators

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

4.1 The nurse coordinates client care activities to promote continuity of ***health services***.

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.

4.3 The nurse effectively assigns care or nursing service and supervises others when appropriate or required to enhance client outcomes.

Standard Five: Self-Regulation

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

Indicators

5.5 The nurse practices within their own level of ***competence***.

5.6 The nurse regularly assesses their practice and takes the necessary steps to improve personal competence.

5.7 The nurse engages in and supports others in the continuing competence process.

The Hearing Tribunal finds that the Regulated Member breached the following provisions of the 2008 Code of Ethics: **A1, A5 and A6; B1 and B3; G1 and G3,** 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 as well as with families, communities, groups, populations and other members of the **health-care team**.

5. Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms. See Appendix D.

6. When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care, families and employers informed about potential and actual changes to delivery of care. They inform employers about potential threats to safety.

B. Promoting Health and Well-Being

Nurses work with people to enable them to attain their highest possible level of health and well-being.

Ethical responsibilities:

1. Nurses provide care directed first and foremost toward the health and well-being of the person, family or community in their care.

3. Nurses collaborate with other health-care providers and other interested parties to maximize health benefits to persons receiving care and those with health-care needs, recognizing and respecting the knowledge, skills and perspectives of all.

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, practise according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice.

3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, seek help from their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

The Hearing Tribunal finds that the Regulated Member breached the following provisions of the Documentation Standards for Regulated Members: **1.1, 1.2, 1.3, 1.4, 1.14 and 1.15,** as follows:

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

Criteria:

The nurse must:

1.1 Record a complete account of nursing assessment of the client's needs, including:

- **a.** identified issues and concerns
- **b.** assessment findings
- **c.** diagnosis
- **d.** plan of care
- **e.** intervention(s) provided
- **f.** evaluation of the client care outcomes

1.2 Document the following aspects of care:

- **a.** relevant objective information related to client care
- **b.** the time when assessments and interventions were completed
- **c.** follow-up of client assessments, observations or interventions that have been completed
- **d.** the administration of medications after administration
- **e.** formal and informal educational/teaching activity provided to the client and family
- **f.** any adverse event or ***adverse outcome***

1.3 Ensure all entries made in the client care record (whether in person or by phone, by means of dictation/transcription) are authenticated and dated (CHIA, 2008).

1.4 Record:

- **a.** legibly, in English, using clear and established terminology
- **b.** accurately, completely and objectively
- **c.** only information relating to own encounter with the client
- **d.** chronologically, the client ***encounter*** with the health system
- **e.** ***contemporaneously***
- **f.** late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy
- **g.** in permanent ink on paper records
- **h.** using only own password/personal access code on electronic entries
- **i.** the date and time that nursing care was provided
- **j.** communication with other care providers, including name and outcomes of discussion

k. communication with clients following discharge from care according to employer policy

1.14 When clarifying (or altering) information after the fact in the client care record, identify the person making the alteration, the date and time; the original entry must also be included in the client care record.

1.15 In a paper client care record:

a. sign all documentation by using first initial, full legal surname and regulatory title on the client care record

b. ensure there are no empty lines or spaces in the documentation

c. correct own documentation by striking out the documentation error, adding the correct information, the date and time of the new entry, and initialing the amendment so that the author can be clearly identified

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. Further, the Regulated Member displayed a lack of knowledge of or lack of skill or judgment in the provision of professional services pursuant to section 1(1)(pp)(i) of the HPA. Patients and co-workers relied on the Regulated Member as a registered nurse to provide safe and competent care.

On or about September 7, 2016, the Regulated Member failed to call 911, or direct someone to call 911, to activate the emergency response system, immediately when she found [Patient 1] to be unresponsive. The Regulated Member failed to correctly perform child cardiopulmonary resuscitation ("CPR") and performed CPR with her fingers rather than her palm. The Regulated Member was responsible as the RN on duty to monitor [Patient 1]'s recovery from general anesthetic. The Regulated Member failed to appropriately monitor the patient during recovery from general anesthetic, and did not take or record [Patient 1]'s vitals while she was in recovery beyond observing the O2 sats and pulse on the O2 Sats Monitor; removed [Patient 1]'s blood pressure cuff in advance of the recovery period being complete; and removed [Patient 1]'s IV in advance of the recovery period being complete. The Regulated Member failed to remain with the patient at all times during recovery from general anesthetic, and left the operatory room and left [Patient 1] alone for a few seconds. She failed to adequately document Basic Life Support activities during and after the resuscitation of the patient when she was the most responsible health care professional for the code.

The Regulated Member knew, or ought to have known, that she would need to practise her Basic Life Support skills to maintain her knowledge and skill and did not do so. The Regulated Member received her Pediatric Advanced Life Support Certification ("**PALS**") and her Advanced Cardiovascular Life Support Certification ("**ACLS**") from an organization that is not recognized by the Heart & Stroke Foundation, nor was it recognized in Canada. She was not aware at the time that these methods of online certification were not recognized in Canada but acknowledges that as a registered nurse she had an obligation to follow all current and relevant legislation and regulations relevant to the profession and all standards, guidelines and position statements from CARNA relevant to the profession.

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). In brief, the proposed sanctions are a reprimand, and a permanent undertaking never to practise again. The Regulated Member is not practising and no longer intends to practise. Her permit is not currently active, and she will never be able to apply to be a Registered Nurse again. This is an individualized process and the public protection dimension is critical.

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: These are very serious allegations and the proposed sanction speaks to this. The violation of documentation standards and leaving a room while the patient is recovering are grave allegations. Patients may have complex needs immediately after surgery and changes in a patient's condition may create an emergent situation. The Regulated Member made grave errors while the patient was recovering and when an emergency arose, she made further errors with her response. The late documentation was wholly deficient and not properly completed. Taken together, the nature and gravity of the proven allegations are very serious.

2. The age and experience of the member: The Regulated Member registered in 1988, and was [age redacted] years old at the time of the incident. She was a very experienced nurse who had worked in many different settings. The Regulated Member has not been entitled to practise since 2017.

3. The previous character of the member: The Regulated Member had no previous interactions with CARNA and no discipline history.

*4. The age and mental condition of the offended patient: [*Patient 1] was an unconscious child in the care of the Regulated Member without her parents present. The patient was exceptionally vulnerable.

5. The number of times the offence was proven to have occurred: This was a single incident.

6. The role of the registered nurse in acknowledging what occurred: The Regulated Member cooperated with the investigation, and agreed to the facts and a consent hearing.

7. Whether the member has already suffered other serious financial or other penalties: The Regulated Member has been under an undertaking not to practise since 2017.

8. The impact on the offended patient: The patient suffered very serious health consequences and they are set out in further detail in [Patient 1]'s Emergency Service Records (Exhibit #3, Appendix E).

9. The presence or absence of any mitigating factors:

10. The need to promote specific and general deterrence: Both aspects of deterrence are required and met by the proposed sanctions. These are unacceptable behaviours that should not be repeated. Further, the profession will know from these sanctions that the behaviour is unacceptable and that safe nursing practice is a requirement.

11. The need to maintain public confidence: Public confidence in the nursing profession is essential and the proposed sanction accomplishes this objective.

12. Degree to which offensive conduct is outside the range of permitted conduct: The Regulated Member's conduct falls far outside the permissible range, and needs to be marked as unacceptable.

Submissions by Counsel for the Regulated Member:

Counsel for the Regulated Member noted that joint recommendations on sanction benefit the administration of justice. The Regulated Member is a mother and grandmother, and this was a devastating isolated incident in a 29-year career. The way that the dental office was set up created an unsafe situation for nursing practice. The Regulated Member has accepted her responsibility for this incident, and agreed to retire from nursing in 2017 before she wanted to end her career. This joint submission is a continuation of the 2017 undertaking not to practise.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal has carefully considered the joint submissions on sanction and the submissions of the parties. The Hearing Tribunal has considered the factors noted in *Jaswal v. Newfoundland Medical Board.* The Hearing Tribunal accepts the joint recommended sanction. The joint recommendations take into account the nature of the findings of the Hearing Tribunal. They also address the issues that brought this Regulated Member before the Hearing Tribunal. The Hearing Tribunal finds that this recommended sanction appropriately considers the factors in *Jaswal.* The Hearing Tribunal finds that the recommended sanction protects the public interest and is reasonable.

The Regulated Member should take the comments in the written decision as well as the concerns expressed by the Hearing Tribunal with respect to her conduct as her reprimand. In addition, the Member should consider her experiences in dealing with this complaint before this Hearing Tribunal and CARNA, as well as the joint submissions on sanction as a reminder of how important it is to practise in accordance with the Practice Standards and Code of Ethics. The Hearing Tribunal recognizes the very serious and tragic outcome on a young and vulnerable patient and her family. The impact of the Regulated Member's conduct will have a serious and long-lasting impact. The public puts their trust in the nursing profession to provide safe and competent care, and the Regulated Member's behaviour erodes this trust.

The Hearing Tribunal understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Hearing Tribunal also considered the penalty in light of the principle that joint submissions should not be interfered with lightly. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Hearing Tribunal finds that the penalty satisfies the principles of specific and general deterrence, and public protection. As the Member has given a permanent and irrevocable undertaking not to practise, it was unnecessary for the order to address rehabilitation and remediation. Members of the profession will be reminded of the importance of client-centered care. Public protection is achieved as the Member will never practise nursing in any capacity in the future.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

SANCTION:

1. The Regulated Member, TASNEEM ALI, #55,868 (the "**Regulated Member**"), shall receive a reprimand for unprofessional conduct.

2. The Regulated Member has confirmed that she has retired from her practice as a Registered Nurse ("**RN**")**.** As a result, the Regulated Member is not currently employed as a RN and no longer intends to be.

3. The Hearing Tribunal accepts the Regulated Member's Permanent and Irrevocable Undertaking Not to Practice as a Registered Nurse ever again, whereby:

    a. The Regulated Member gives her solemn promise and permanent and irrevocable undertaking to CARNA that the Regulated Member will not:

        i. work or practice as a regulated member of CARNA (Registered Nurse, Nurse Practitioner, Temporary Permit Holder), whether as a paid or unpaid employee, a volunteer, a contractor or a student in a clinical setting;

        ii. use the title RN or Registered Nurse, or in any way hold out to be, or make representation of being, an RN; and

        iii. apply to be reinstated as a regulated member of CARNA, or RN, ever again.

    (the "**Undertaking**").

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. Should the 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*.

6. 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.

II. CONDITIONS:

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

    a. ***Permanent and Irrevocable Undertaking not to Practice as a RN.***

8. Effective on December 8, 2020**,** 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 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).

9. For clarity, as soon as this Order of the Hearing Tribunal takes effect, the previous conditions on the Regulated Member's practice permit shall be expired as follows:

    a. ***Permanent and Irrevocable Undertaking not to Practice as a RN***, from an undertaking signed on December 5, 2017.

10. This Order takes effect, on the date of the Hearing, December 8, 2020, 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,

_____
Jason Anuik, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: December 8, 2020