

## **Investigation Committee Order**

Dear Nurse MacMillan:

This is to inform you that an Investigation Committee of the College of Registered Nurses of Prince Edward Island has considered the complaint dated June 5, 2020 made by Eva Mol against Emily Kate MacMillan, RN registration number 005546, and the response from Emily Kate MacMillan, dated July 9, 2020, as required by section 52 of the *Regulated Health Professions Act (RHPA)*.

Section 52 requires the Investigation Committee to consider the investigation report, dated November 24, 2020, and to choose one of three options:

- (a) dismiss the complaint, if in the opinion of the investigation committee
  - (i) the allegations are frivolous, vexatious or without merit, or
  - (ii) there is insufficient evidence to support the allegations;
- (b) make any order that the hearing committee is authorized to make under subsection 58(2), if the respondent consents to the order; or
- (c) request that the person or persons who appointed the investigation committee appoint a hearing committee and refer the complaint to the hearing committee.

Members of the Committee are: Carol Walker (Chair), Pamela Condon (Member) and Robert Clow (Public Representative).

### **Decision**

The complaint submitted by Eva Mol described 2 incidents involving Emily Kate MacMillan which the complainant says occurred in the homes of two Queens County Home Care clients on March 31, 2020 and April 29, 2020, as follows:

1. The first allegation is that Emily Kate MacMillan reinserted a Gastrostomy tube (G-Tube) on a client in the client's home on or about March 31, 2020, which was outside of her scope of practice.
2. The second allegation is that Emily Kate MacMillan removed a Peripherally Inserted Central Catheter (PICC) line from a client in the client's home on or about April 29, 2020 without a physician's order.

This Committee decided on September 9, 2020 to refer the complaint to an investigator for investigation, and the investigation by Rosemary White has been completed. We have reviewed the Investigation Report dated November 24, 2020. In our decision on September 9, we asked the investigator to consult with Ms. MacMillan's health care provider before interviewing her. The investigator has confirmed that she did that and that the provider felt that Ms. MacMillan was able to participate in the discipline process. We also asked the investigator to determine whether the complainant intended to include a third allegation in her complaint, and the investigator has reported that she did not, meaning there are only two allegations against the member.

The Committee also asked the investigator in our September 9 decision to answer a number of questions, and we are satisfied that she has done so in the Investigation Report.

The Investigation Report includes an interesting comment from the Investigator's interview with Ms. MacMillan (she was accompanied by her father). The Report states: "She [Nurse MacMillan] said that she was very interested in a possible consent agreement with the Investigation Committee."

In her interview with the Investigator, Emily Kate MacMillan admitted to doing the things alleged in the two allegations contained in the complaint, with some explanation. She also indicated that she was very busy at the time, was not sleeping well and was hypomanic, and sought medical assistance around the time of the events, and that she has been feeling better as a result of getting help.

These facts, together with the member's stated interest in a consent agreement, have caused the Investigation Committee to decide to make an order under section 52(1)(b) of the Regulated Health Professions Act. The member respondent Emily Kate MacMillan has indicated a willingness to accept responsibility for the events described in the complaint. It appears to this committee that the facts could support a finding of professional misconduct and incompetence. "Professional misconduct" and "incompetence" are both defined in section 57 of the RHPA:

57.(1) The conduct of a respondent may be found to constitute professional misconduct if

(a) the respondent contravenes this Act, the regulations, the bylaws, standards of practice, code of ethics or practice directions in a manner that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practise a regulated health profession;

- (a.1) in the opinion of the investigation committee or the hearing committee, the conduct is harmful to the best interests of a client or other person, or to the integrity of the profession;
  - (b) the respondent has been found guilty of an offence that, in the opinion of the investigation committee or the hearing committee, relates to the respondent's suitability to practise a regulated health profession;
  - (c) the respondent refuses or fails to cooperate fully in respect of the investigation or hearing of a complaint;
  - (d) the respondent contravenes an order made under this Act; or
  - (e) the conduct of the respondent constitutes professional misconduct as set out in the regulations.
- (2) The conduct of a respondent may be found to constitute incompetence where
- (a) an act or omission of the respondent
    - (i) demonstrates a lack of knowledge, skill or judgment,
    - (ii) demonstrates disregard for the safety or welfare of a client, or
    - (iii) constitutes incompetence as set out in the regulations; or
  - (b) the respondent is unable to practise a regulated health profession in accordance with accepted professional standards for any reason, including that the respondent is impaired by illness, addiction or other incapacity.

We make the observation that the facts could support a finding of professional misconduct or incompetence on the basis of the Investigation Report and the Complaint and the member's written Response and without hearing evidence, as section 52 allows this, and it is our view that the member needs some rehabilitation now, rather than waiting months for a hearing to occur. We note also that the member told the Investigator that she would "never ever remove a PICC line or insert a G-tube again", which tells us that she understands the seriousness of her actions.

It is the Committee's decision that the respondent Emily Kate MacMillan should be given an order as permitted by section 58(2) of the RHPA because the facts outlined in the Investigation Report could well lead to a finding that she has committed professional misconduct due to contraventions of the Standards for Practice and the Code of Ethics, or having engaged in conduct that was harmful to the integrity of the nursing profession. As well, she might have been incompetent as that word is defined, because if the evidence described in the Investigation Report is proved, she showed a lack of knowledge, skill or judgment, and perhaps disregarded the safety or welfare of one or both clients. The explanation of this decision is as follows:

1. Standard 1.1 of the Standards for Nursing Practice states that each nurse has appropriate theoretical and skills as needed in his/her area of practice. In

both incidents, the removal of a PICC line and the reinsertion of a G-tube require advanced skill training which the respondent did not have.

2. Standard 2.7 states that each nurse performs planned interventions in accordance with appropriate policies, procedures and service standards. There is a specific policy noted in the Investigation Report stating who may remove PICC lines and what training is required. The respondent does not meet these training requirements.
3. Incompetency was shown in both allegations by the lack of judgement under the Code of Ethics Part I.A. Provide safe, compassionate, competent and ethical care (6) Nurses practise "within their own level of competence and seek (appropriate) direction and guidance... when aspects of the care required are beyond their individual competence". The committee feels the respondent went beyond her scope of practice in both allegations. The resources were available for her to refer her clients to them - the Nurse Specialized Wound, Ostomy and Continence (NSWOC) consultant and Ambulatory Care were available for PICC removal.

In deciding to issue an order at this stage of proceedings, the Committee considered a number of factors. The Committee recognizes that Emily Kate MacMillan has indicated a willingness to accept responsibility for her actions, and she will accept that responsibility if she agrees with the terms of the Order set out below. The respondent also has sought out help for her personal health issues.

On the other hand, it was noted that her employer had tried on several past occasions to address with the respondent several concerns including crossing professional boundaries.

The Committee has decided that the following orders will be issued if the member consents:

1. The Respondent will be issued a formal reprimand from the College of Registered Nurses of Prince Edward Island (CRNPEI). The reprimand shall be prepared by the Coordinator of Regulatory Services, for review and approval by the Chair, and will be sent to the Respondent, and a copy will be kept in the Respondent's file at CRNPEI.
2. The Respondent will take refresher training with a Nursing Expert, to be completed within 6 months from the date that a copy of this decision with the member's signature indicating consent is returned to the Committee. Within 1 month of the decision being returned to the Committee, the Respondent, in consultation with a Nursing Expert of her own choosing and at her own expense shall submit a plan for refresher training to the CRNPEI Coordinator of Regulatory Services for the approval. To comply, the Respondent is required to ensure that:

- i. The Expert has been provided with a copy of the complaint; notice of formal hearing; the respondent's written response to the complaint; and this decision.
  - ii. Before the first meeting with the Expert, the Respondent shall review the following CRNPEI publications:
    1. CNA Code of Ethics
    2. Standards for Nursing Practiceand provide the Expert with a short, written statement of at least five hundred (500) words reflecting on the issues identified in the decision issued by the Committee in relation to this matter.
  - iii. The Subject of the sessions with the Expert will include:
    1. The acts or omissions for which the Respondent has accepted responsibility, as described in the Investigation Report;
    2. The potential consequences of the misconduct and/or incompetence to the Respondent's patients, colleagues, profession, and self;
    3. Strategies for preventing the misconduct and incompetence from recurring;
    4. The development of a learning plan in collaboration with the Expert; and
    5. Review of Removal of PICC Line Policy
  - iv. Within 30 days after the Respondent has completed her last session, the Respondent will make sure that the Expert forwards his/her report to the CRNPEI Coordinator of Regulatory Services, in which the Expert will confirm
    1. The dates the member attended the sessions;
    2. That the Expert received the required documents from the Respondent;
    3. That the Expert reviewed the required documents and subjects with the Respondent; and
    4. The Expert's assessment of the Respondent insight into her behavior.
  - v. The CRNPEI Coordinator of Regulatory Services will provide the Expert's report to the Committee, and the Committee will review the report and will decide whether any additional order is required based on its content.
3. The respondent will participate in regularly scheduled visits with the health care provider who spoke to the investigator about this matter or his replacement, if any, for 1 year. The Committee requests the health care provider to submit two brief written status reports to the Committee with

respect to the respondent's health condition and its impact on her ability to practice nursing, the first within six months from the date this decision is returned to the Committee, and the second at the one-year anniversary.

4. The respondent will participate with her direct supervisor/designate in monthly professional performance appraisals and develop a plan of learning for 1 year. The Committee requests the direct supervisor/designate to submit written reports to the Committee every three months during the year.

The Committee feels the employer could have done more to help avoid these incidents from occurring. The employer did initially have a performance improvement plan, but documentation on the follow-up was unclear. The Committee feels the employer should also improve the education to staff on where/how to access policies for Health PEI and their Home Care site-specific policies. We recommend that Council of the College provide a copy of this decision to Health PEI Home Care for their review.

Nurse MacMillan, if you are prepared to consent to the orders described above, you have 15 working days (excluding holidays) to consent to this order by signing your name and dating the bottom of a copy of this document and returning it to the CRNPEI office, to the attention of the Chair named below. If you do this, the order will become effective, and you will be required to do what it says. If you are not prepared to consent, or if you do not return a copy of this document to the CRNPEI office as required, the complaint will be referred by the Committee to a hearing, under section 52(1)(c) of the RHPA.

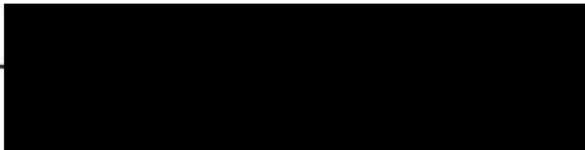
Dated this 21st day of December 2020, at Charlottetown, PEI.



Carol Walker, Chair of the Investigation Committee

I, Emily Kate MacMillan, Respondent Member consent to the order described above.

Signature:



Date: January 8<sup>th</sup> / 2021