

College of Registered Nurses of PEI (CRNPEI)

Hearing Committee Decision

Complaint # 2017-06

Re: Melissa Butler, Member Registration # **005207**

A Hearing Committee of the College of Registered Nurses of Prince Edward Island (the "Committee") conducted a hearing in Charlottetown, PE on February 15, 2019, to consider a complaint dated June 13, 2017 against Registered Nurse Melissa Butler, registration number **005207**.

It should be noted that on July 4, 2018, the *Registered Nurses Act* and the Professional Conduct Review Regulations were repealed and replaced by the *Regulated Health Professions Act* (the "RHPA"). This committee has received legal advice that sections 32 and 33 of the Prince Edward Island Interpretation Act and section 99 of the RHPA require this Committee to follow the process in the RHPA, but to assess the nurse member's conduct according to the law as it was at the time of the incidents alleged against her; that is, the *Registered Nurses Act* and its PCR Regulations. We agree and heed this advice, and observe that this is fair to member, Melissa Butler.

Members of the Committee in attendance at the hearing were: Melanie Bruce (chair); Chelsea Chessman (member), Jim Ross (public representative). Also in attendance were: Complainant, Susanne LaPierre (Matthews), accompanied by Isabelle Keeler and Laura Killam; Respondent, Melissa Butler and Matthew Walters, Legal Counsel for the Respondent; Adducer, Tom Keeler; Legal Counsel and Advisor for the Committee, Doug Drysdale; and Christine MacDougall from Island Confidential Associates.

The purpose of the hearing on February 15, 2019, was to determine whether Melissa Butler engaged in activities that constituted professional misconduct as that phrase is defined or used in the now-repealed PCR Regulations. The allegations that were considered related to a number of medication administration errors which were documented as Patient Safety Incident Reports ("PSIR"), and which occurred during a period of time while the respondent was employed as a Registered Nurse (RN) at Community Hospitals West ("CHW") in Alberton and O'Leary, PE between November 13, 2015 and May 19, 2017.

1. In summary, Allegation 1 states that the member engaged in professional misconduct in that she failed to administer medication as required to patients on the following dates:

- a. November 13, 2015: PSIR # 42987
 - b. January 23, 2016: PSIR # 47052; PSIR # 47053; PSIR # 47054
 - c. February 25, 2016: PSIR # 47995
 - d. March 11, 2016: PSIR # 48375
 - e. May 25, 2016: PSIR 50278;
 - f. August 10, 2016: PSIR # 52426; PSIR # 52428
 - g. September 18, 2016: PSIR # 53481; and
 - h. December 2, 2016: PSIR # 55856; PSIR # 55858
2. Allegation 2 states that the member engaged in professional misconduct in that she incorrectly administered medication to the wrong patient on the following dates:
- a. March 9, 2016: PSIR # 48294;
 - b. May 18, 2017: PSIR # 61692 and PSIR # 61704

At the beginning of the hearing, Chair Melanie Bruce confirmed that the Notice of Formal Hearing had been received by all parties.

The Chair asked if there were any objections to the inclusion of any of the Committee Members on the Hearing Committee. There were no objections.

Tom Keeler, adducer of evidence, provided a Book of Documents (Exhibit 1) and indicated that he and Matthew Walters had prepared an Agreed Statement of Facts (Exhibit 2) for the Committee's consideration. The document was circulated for review to all present and Tom Keeler summarized the Agreed Statement of Facts. Following this, the Committee recessed to consider it. The Agreed Statement of Facts was signed by Tom Keeler, Matthew Walters and Melissa Butler dated February 15th, 2019.

At the resumption of the hearing, Chair Melanie Bruce stated that the Committee accepted the Agreed Statement of Facts and agreed that no further presentation of evidence would be necessary. As noted in the Agreed Statement of Facts, Melissa Butler admitted that her conduct constituted two counts of Professional Misconduct contrary to subsection 30(4) of the Act. She acknowledged that she would be subject to penalties as a consequence of the foregoing facts.

In accepting the Agreed Statement of Facts, the Committee found Melissa Butler to be guilty of two charges of Professional Misconduct in relation to the allegations in the Notice of Formal Hearing. The allegations outlined in the Agreed Statement of Facts indicate 12 instances where Ms. Butler failed to administer medications as required to patient and two instances where she incorrectly administered

medication to the wrong patients. It is evident throughout the Agreed Statement of Facts and upon review of the PSIRs provided in the Book of Documents that Ms. Butler must improve her medication administration, organization and documentation skills. Obviously, care is required when administering medication, and repeated errors are very concerning. A summary of the omissions and errors made by Ms. Butler as outlined in the Agreed Statement of Facts is below. The Committee felt this is appropriate to disclose to deter Ms. Butler and other RNs of similar conduct in the future.

Allegation 1(a) relates to an incident where Ms. Butler incorrectly reported to a colleague that an antibiotic medication had been ordered by the attending physician to be discontinued. However, in fact the relevant Order was for the antibiotic to be continued at a reduced amount. As a result of this, the patient missed a scheduled dose of antibiotic medication.

Allegation 1(b) relates to three incidents:

- a. It was observed that two patient medications were still located in the patient's medication strip, and that they had not been signed as given by Ms. Butler during her shift.
- b. It was observed that one patient medication was still located in the patient's medication strip, despite the fact that it had been signed as given by Ms. Butler.
- c. It was observed that medication was not recorded as having been administered to a patient in the electronic health record, notwithstanding that this medication was no longer located in the patient's strip of medication. Ms. Butler was contacted at home, and confirmed that she had given this medication, but had failed to accurately record it as having been administered.

Allegation 1(c) relates to an incident where it was observed at 1800hrs that a patient's morning medication strip was sitting on top of the medication cart, despite having been signed as administered in the medication administration record. Ms. Butler's evidence with respect to this incident was that she had incorrectly administered the patient's evening medications, as they had been located in the strip. As a result of this error, the patient received an incorrect dose of a medication.

Allegation 1(d) relates to an incident where Ms. Butler failed to administer a medication to a patient as ordered, due to the fact that the patient was not present on the unit at the time the

patient was scheduled to receive the medication. However, Ms. Butler failed to administer this medication upon the patient's return.

Allegation 1(e) relates to an incident where Ms. Butler failed to administer a dose of medication, despite recording that it had been administered.

Allegation 1(f) relates to two incidents:

- a. Ms. Butler reported at shift change that she had administered a suppository to a patient with no results. It was subsequently observed that the suppository had fallen to the floor at the Nurse's Station, and Ms. Butler had not recorded the medication as being given in the Medication Administration Record. Upon follow up, the patient confirmed that the suppository had not been administered.
- b. Ms. Butler failed to administer a medication to a patient, despite recording the medication as having been administered.

Allegation 1(g) relates to an incident where a colleague found a full medication cup next to a patient's bedside. The medication was left at the patient's bedside the previous evening, and was not directly administered to the patient, despite having been charted by Ms. Butler as being administered.

Allegation 1(h) relates to two incidents:

- a. It was observed that antibiotics had not been administered two days in a row by Ms. Butler, as the antibiotic medication was still located in the patient's medication strip.
- b. It was noted that Ms. Butler failed to administer a medication to a patient as ordered. The medication was again found in the patient's medication drawer.

Allegation 2(a) relates to an incident where Ms. Butler incorrectly administered medication to the wrong patient, which she attributed in her report to the fact that she had not kept her medication cart and computer with her at the bedside to confirm that the medication was being administered to the right patient.

Allegation 2(b) relates to an incident where Ms. Butler incorrectly administered a Morphine Sulfate Immediate Release (MSIR) pill to a patient in place of a Dilaudid pill which the patient

had been ordered to receive. The discrepancy arose in the MSIR pill count, and Ms. Butler initially believed she had inadvertently administered two MSIR pills to another patient, before it was discovered that there was one extra Dilaudid pill, due to the fact that Dilaudid had not been administered.

Tom Keeler then presented a Joint Recommendation on Penalty (Exhibit 3) to the Committee, which was signed by Tom Keeler, Matthew Walters and Melissa Butler, and dated February 15th, 2019. Mr. Keeler explained why he felt the penalty described in the document was appropriate for the circumstances in the case.

Matthew Walters, legal counsel for the Respondent, then was given an opportunity to explain his client's perspective on the recommendations of penalty. Mr. Walters spoke to crafting a penalty that is proportional, in that it provides deterrence to Melissa Butler as well as other Registered Nurses and allows for rehabilitation and return to gainful employment for Melissa Butler. Mr. Walters reviewed the Respondent's [REDACTED]. He referred to two letters in the Book of Documents from her family doctor [REDACTED]. Mr. Matthews indicated that the Respondent recognized and accepted the seriousness of this matter and has cooperated throughout this process.

The Complainant, Susanne LaPierre (Matthews), spoke that she hoped the Respondent will be able to work again as a Registered Nurse. She expressed concern about the Respondent working in a position where medication administration is a requirement, given the sheer number of incidents.

At this point, Mr. Keeler, Mr. Walters, the Respondent and the Complainant were dismissed from the hearing and the hearing was adjourned to allow the Panel to reach its final decision with respect to an appropriate penalty.

Following adjournment of the hearing, the Committee met to review and consider submissions for penalty.

The Committee noted the admissions outlined in the Agreed Statement of Facts. The Respondent, Melissa Butler, has accepted responsibility for professional misconduct. The Committee recognized that some of the incidents presented in this hearing individually may not appear serious but the volume of incidents and potential for serious repercussions for patients in Ms. Butler's care could not be ignored. The Committee decided to accept most of the Joint Recommendation on Penalty, but felt some changes

were necessary and appropriate. The following penalty shall be issued to the Respondent, Melissa Butler:

1. Melissa M. Butler shall be issued a formal reprimand from the College of Registered Nurses of Prince Edward Island ("CRNPEI"), and a copy shall be kept in her discipline file at CRNPEI;
2. Melissa M. Butler shall have the following conditions placed on her nursing registration, effective the date this decision is delivered to Ms. Butler or her counsel:
 - a. Melissa M. Butler shall comply with two (2) continuing competency audits coordinated by the Coordinator of Regulatory Services at CRNPEI, one to be completed in October 2019 and another in October 2020, which shall include, but are not limited to, a detailed assessment of Ms. Butler's medication administration and documentation skills. These continuing competency audits are independent of and in addition to any continuing competency requirements imposed by the *Regulated Health Professions Act*, or otherwise.
 - b. Within six months of the date of this decision issued by the hearing Committee, Melissa M. Butler shall complete refresher training with a Nursing Expert ("Expert"), at her own expense. To comply, Ms. Butler is required to ensure that:
 - i. the Expert has expertise in nursing regulation and the type of practice area Melissa Butler was in at the time the incidents occurred, and has been approved by the CRNPEI Coordinator of Regulatory Services to provide refresher training;
 - ii. the Expert has been provided with a copy of:
 1. the Complaint;
 2. the Notice of Hearing;
 3. the Agreed Statement of Facts; and
 4. this decision.
 - iii. she has reviewed the CRNPEI *Standards of Practice* and the CNA *Code of Ethics* (2017), and at least seven days before meeting with the Expert has provided 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 Hearing Committee in relation to this matter;

- iv. the subject of the sessions with the Expert will include:
 - 1. any acts or omissions committed by Ms. Butler as identified in the Agreed Statement of Facts, including any misconduct or violations of the *CRNPEI Standards of Practice* or the *Code of Ethics (2017)*;
 - 2. the potential consequences of the misconduct to Ms. Butler's clients, colleagues, profession and self;
 - 3. strategies for preventing the misconduct from recurring;
 - 4. refresher training, as required by the Expert; and
 - 5. the development of a learning plan in collaboration with the Expert.
- v. within thirty (30) days of the completion of the final session with the Expert, Ms. Butler shall confirm that the Expert has forwarded a written report to the CRNPEI Coordinator of Regulatory Services, in which the Expert has confirmed:
 - 1. the dates of all completed sessions;
 - 2. that Ms. Butler reviewed the *CRNPEI Standards of Practice* and the *Code of Ethics (2017)* prior to meeting with the Expert;
 - 3. that the Expert reviewed or confirmed appropriate review of the required documents and subjects with Ms. Butler;
 - 4. the successful completion of any required learning plan; and
 - 5. the Expert's independent assessment of Ms. Butler's insight into her behaviour.

if Ms. Butler does not comply with any one or more of the requirements above, the Expert may cancel any future scheduled session, even if that results in a breach of a term, condition or limitation on Ms. Butler's certificate of registration.

- c. Upon completion of conditions 2(a) and 2(b) in a form satisfactory to CRNPEI, Ms. Butler may apply for removal of all conditions from her registration; and submit a letter from her health care provider stating her current mental and physical fitness to practice within the profession of nursing.
- d. Ms. Butler shall disclose that her registration is subject to these conditions to all employers or potential employers, until such time that the conditions have been

removed.

3. Ms. Butler shall be required to pay a fine to CRNPEI in the amount of One Thousand, Two Hundred and Fifty Dollars (\$1,250.00). This fine may be paid in monthly installments of no less than One Hundred Dollars (\$100.00), payable on the first of each month and beginning in the first full month after Ms. Butler successfully obtains employment as a Registered Nurse, provided that Ms. Butler pays the full amount no later than December 1, 2020, regardless of when she obtains employment.
4. Ms. Butler shall be required to pay CRNPEI the amount of One Thousand, Two Hundred and Fifty Dollars (\$1,250.00) in partial payment of the expenses associated with the investigation and adjudication of this complaint. These expenses may be paid in monthly installments of no less than One Hundred Dollars (\$100.00), payable on the first of each month and beginning in the first full month after Ms. Butler successfully obtains employment as a Registered Nurse, provided that Ms. Butler pays the full amount no later than December 1, 2020, regardless of when she obtains employment.
5. Ms. Butler shall provide a copy of this decision to any current employer, or any employer who offers her employment as a Registered Nurse, and shall provide written verification to CRNPEI from the employer that the employer has received this decision. This obligation will continue until terminated by CRNPEI or the removal of all conditions from her registration.
6. Failure to comply with any of the above conditions will result in inability to apply for registration with CRNPEI.

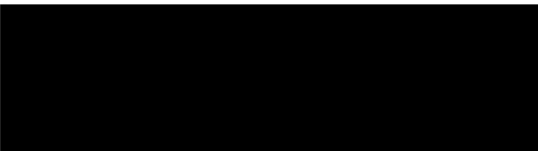
The Committee concluded that the penalty is reasonable and in best interest of the public. It is to be noted that Ms. Butler cooperated with the College and, by agreeing to the facts and the proposed penalty, has accepted responsibility. The Committee felt the fines and penalty were meant to recoup some of the financial loss sustained by CRNPEI related to this investigation and to deter Ms. Butler and other members from performing in a way that demonstrates professional misconduct. The fine and

penalty are comparable to other fines and penalties issued by the College. The Committee also wishes to highlight that the intent of this decision is to allow Ms. Butler to improve and succeed within the nursing profession. It should be noted that Ms. Butler has taken significant steps to gain insight into [REDACTED] [REDACTED], which she noted during the hearing were factors contributing to the errors which resulted in her professional misconduct. This should serve as a reminder to the membership at large to ensure all members are caring for their own mental and physical health to ensure they are competent, responsible and accountable practitioners when providing care to others, using the Standards for Nursing Practice and the Canadian Nurses Association Code of Ethics to guide them. We encourage Ms. Butler and all other RNs to take measures to ensure that your own mental and physical health is a priority and further encourage the ongoing maintenance of this through appropriate supports.

As noted above, this decision has been made as if relevant parts of the Registered Nurses Act and the Professional Conduct Review Regulations were still in force, while at the same time following the process in the Regulated Health Professions Act. Accordingly, the respondent member, Melissa Butler, has the right to appeal this decision within 30 days after being served with this decision, under the authority of section 59(2) of the Regulated Health Professions Act.

Also, the former Registered Nurses Act did not require penalties to be "ordered", but since the process we are following is under the Regulated Health Professions Act rather than the Registered Nurses Act, the Committee orders Melissa Butler to comply with the penalties written above (paragraphs 1 through 6) – see section 58, RHPA.

Respectfully submitted at Charlottetown, Prince Edwards Island this 12th day of March, 2019.



Melanie Bruce, Chair of the Hearing Committee

