

## Investigation Committee Notice of Section 52 decision

To: Angela Jenkins  
Trevor Waugh  
Council of the College of Registered Nurses and Midwives of PEI

This is to inform you that an Investigation Committee of the College of Registered Nurses and Midwives of Prince Edward Island (CRNMPEI) has considered the complaint dated May 14, 2024, made by Trevor Waugh against Angela Jenkins, NP registration number 005463, and the response from Angela Jenkins dated June 26, 2024.

The Investigation Committee received the Investigation Report, completed by Stefanie Blacker, on October 30, 2025, and has considered the report, as required by section 52 of the *Regulated Health Professional Act* ("RHPA"). Section 52 of the RHPA requires an Investigation Committee to consider one of four 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.
- (a.1) refer the complaint to a mediator for mediation if,
  - (i) the investigation committee is satisfied that the referral is appropriate in the circumstances and not contrary to the public interest, and
  - (ii) the complainant and the respondent agree to participate in mediation
- (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 were: Colleen Dunn (Chair), Laurie Thomas (Member) and Jim Ross (Public Representative).

The complaint submitted by Trevor Waugh described three incidents involving Angela Jenkins which the complainant says occurred at Colville Manor in March 2024, as follows:

1. The first allegation is failure to conduct appropriate physical examination on long-term care resident [REDACTED], on several occasions;
2. The second allegation is inappropriate delay in assessment and care of resident [REDACTED];  
and
3. The third allegation is inadequate documentation/charting for resident [REDACTED].

Following a comprehensive review of the information gathered by the investigator, the Investigation Committee has decided to dismiss the first and second allegations. The Committee determined that the available evidence is insufficient to substantiate the allegations that the member, Angela Jenkins, failed to complete an appropriate physical examination on resident [REDACTED] or contributed to any delay in resident [REDACTED]'s assessment. In reviewing these allegations, the committee noted that the accounts provided were inconsistent, and there was insufficient corroborating documentation to establish that an assessment did not occur and that any delay was attributable to Angela. Additionally, several witnesses were unable to clearly confirm when an assessment should have occurred or what would constitute a timely assessment in the circumstances. As a result, there is insufficient evidence to support that there was any act or omission on the part of Ms. Jenkins, as it relates to a failure to examine or a delay in assessment and care, that may constitute professional misconduct or incompetence as defined in section 57 of the RHPA. As a result, the first and second allegation are dismissed.

Regarding the third allegation, the Committee did find evidence of inadequate documentation by Angela Jenkins, which falls below standards expected of registrants with CRNMPEI. There was information from another NP that there was no documentation from Angela for an assessment that she had performed on N.M., but a staff nurse had documented that Angela had completed the assessment. The medical director for Colville Manor also had concerns regarding the lack of documented assessments. Angela herself admitted that she does not put certain assessments in Cerner, and that most of her assessments were documented in the paper chart. Finally, Angela also stated that she found it difficult to write chart entries that were comprehensive and reflective of observational data. It is the opinion of this committee that this evidence could reasonably support the finding of professional misconduct as outlined in section 57(1)(a) and 57(1)(a.1) of the RHPA, and by contravening:

1. CRNMPEI Practice Directive: Documentation Standards;
2. Principle 3.13 of The Code of Ethical Conduct for Registered Nurses and Nurse Practitioners; and
3. Standard 1: Professional Responsibility & Accountability from the Standards of Practice for Nurse Practitioners:

## **RHPA**

### 57. Professional misconduct

- (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;

### **Practice Directive: Documentation Standards**

The following are essential characteristics of nursing documentation:

- Factual, objective and client centered
- Accurate and relevant
- Complete
- Current
- Organized, logical and sequential
- Compliant with standards of practice and other legal requirements.

### **Code of Ethical Conduct**

Principle 3: Nurses provide safe, competent and ethical care.

In this principle, nurses work within the limits of their scope of practice, education, experience, knowledge, skill and judgment. To achieve this principle, nurses are expected to:

- 3.13 Maintain and keep clear, complete, accurate and timely documentation. Nurses do not document false or misleading information.

### **Standards for Nursing Practice**

Standard 1: Professional Responsibility & Accountability

6. Documents clinical data, assessment findings, diagnoses, plans of care, therapeutic interventions, client responses and clinical rationale in a timely and accurate manner.

Incomplete or missing nursing assessments breach the requirement to include all components of the nursing process including nursing actions and client responses and fail to ensure that documentation is current and complete. By not documenting assessments or clinical findings, a nurse's record lacks critical data that ensure continuity of care, legal defensibility, quality assurance, and professional accountability. The standards of practice, code of ethics, and practice direction all require that documentation clearly reflects the care given, decisions made, and client responses. Failing to document essential assessments can, therefore, be a breach of section 57(1)(a) of the RHPA. In addition, failure to document is conduct that is detrimental to patient safety and harmful to the best interest of a patient, and can, therefore, be a breach of section 57(1)(a.1) of the RHPA.

The Committee notes that Ms. Jenkins has acknowledged responsibility for these documentation deficiencies, therefore pursuant to section 52(1)(b), it is the Investigation Committee's decision to make an order under subsection 58(2) of the RHPA, provided the respondent agrees to the terms of the order.

The Investigation Committee makes the following order, **IF AND ONLY IF ANGELA JENKINS SIGNS THE BOTTOM OF THIS DOCUMENT ON OR BEFORE THE DATE INDICATED BELOW TO INDICATE CONSENT TO, AND AGREEMENT WITH, THE FOLLOWING:**

- (i) The member, Angela Jenkins, will undergo additional education and training related to documentation standards within 30 days of this order.
  - Angela will review the CRNMPEI Practice Directive: Documentation Standards
  - Angela will review the Standards for Nursing Practice: Nurse Practitioner according to CRNMPEI
  - Read the free book "Documentation in Nursing: 1<sup>st</sup> Canadian Edition" available from pressbooks at the following link <https://pressbooks.library.torontomu.ca/documentation/>
- (ii) Within 30 days of completing the required education, Angela will complete a written reflective practice assignment addressing:
  - What constitutes appropriate documentation under professional standards
  - How her documentation practices fell below expected standards in this case
  - Specific, actionable steps she will implement to prevent recurrence

- How she will integrate learning into daily practice
- (iii) Upon completion of the reflective practice assignment, Angela shall meet with the Coordinator of Professional Practice for CRNMPEI. The purpose of this meeting is to:
- Review and discuss Angela's reflective assignment
  - Confirm that Angela's learning demonstrates an understanding of the required documentation standards for Registered Nurses
  - Ensure that the reflective assignment is satisfactory and meets the expectations of the Coordinator of Professional Practice.

The Investigation Committee retains jurisdiction over the complaint if Angela Jenkins consents to the order but fails to comply with the terms set out above, in which case the matter will be returned to the Committee for further decision.

The member shall have 14 days to consent to this order by signing her 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. Failure to do this will mean that the complaint will be referred by the Committee to a hearing.

Dated this 20th day of January 2026, at Charlottetown, PEI



Colleen Dunn, Chair of the Investigation Committee

I, Angela Jenkins, consent to the order described above.

  
Angela Jenkins, Respondent  
Date