INVESTIGATION COMMITTEE
of the
SASKATCHEWAN REGISTERED NURSES ASSOCATION

-and-

Shevie Ann Dabao
Saskatchewan RN/GN #0044681
REGINA, SASKATCHEWAN

DECISION

of the

DISCIPLINE COMMITTEE

of the

SASKATCHEWAN REGISTERED NURSES ASSOCIATION

Legal Counsel for the Investigation Committee:	Roger Lepage
Legal Counsel for Shevie Ann Dabao:	Ronni A. Nordal, Q.C.
Legal Counsel for the Discipline Committee:	Brittnee J. Holliday
Chairperson for the Discipline Committee:	Michell Jesse, RN

Date of Hearing:	February 17, 2021
Location:	*Via Videoconference* Saskatchewan Registered Nurses Association 2066 Retallack Street Regina, Saskatchewan S4T 7X5
Date of Decision:	March 25, 2021

I. INTRODUCTION

1. The Discipline Committee of the Saskatchewan Registered Nurses Association (SRNA) convened to hear and determine a complaint of professional misconduct and/or professional competence against Registered Nurse #0044681, Shevie Ann Dabao, on February 17, 2021. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act, 1988 (*the "*Act").*

2. The charges against Ms. Dabao are outlined in a Notice of Hearing of Complaint dated January 7, 2021. There are three charges of professional misconduct and/or professional competence and those charges are as follows:

Charge Number 1 - Sepsis

You, SHEVIE ANN DABAO, are alleged to be guilty of professional misconduct and/or professional incompetence as defined in sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on or about **June 26, 2018**. You were the day charge nurse on . At 1120 hours, you were notified by an LPN that a 54-year-old female resident's condition had changed and that her temperature and heart rate were elevated. You failed in your obligation to maintain the practice standards established by the SRNA as follows:

(a) You failed to recognize the significant risk for patient harm, to properly assess the patient's vital signs and do follow-up care, to appropriately document the information regarding this patient, to recognize the signs and symptoms of sepsis and to act on the assessment findings and to meet the expectations of a charge nurse;

(b) You did not call the physician to communicate that the resident was unwell when the LPN notified you of the problem. You only called the physician at 1400 hours for a Warfarin order; and

(c) You failed to initiate the early sepsis screening tool and protocol. On June 27, 2018, another nurse notified the physician regarding the events of June 26, 2018. Sepsis protocols were initiated, and the patient diagnosed with sepsis.

Charge Number 2 - Hemodialysis

You, SHEVIE ANN DABAO, are alleged to be guilty of professional misconduct and/or professional incompetence as defined in sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on **June 29, 2018**. You were the evening charge nurse from 1445 hours to 2315 hours for . A 73-year-old male resident on had recently returned from hemodialysis and the family who was present said the resident was experiencing

respiratory distress. At 1900 hours you were notified of the patient's condition and the family's observations. You were on at the time and had not yet assessed the residents on since the beginning of your shift. You failed in your obligation to maintain the practice standards established by the SRNA as follows:

(a) You failed to assess the patient early in your shift.

(b) When you attended to the patient, you engaged in a confrontation with the family and left the resident's room.

(c) You failed to do a timely comprehensive assessment of the patient and the patient's reported respiratory distress. You only did a visual assessment and deemed him not to be in respiratory distress. One hour after being notified, you conducted an assessment and documented it.

(d) You demonstrated lack of critical thinking and organization.

(e) You failed to recognize this patient as a priority.

(f) You demonstrated lack of understanding surrounding potential complication post- hemodialysis.

(g) You eventually contacted the physician and requested medication orders without accurate assessment findings.

(h) You called an ambulance only at the family's urging. The resident was admitted to hospital, required emergency hemodialysis, and was hospitalized for one week.

Charge Number 3 - Chronic Pain

You, SHEVIE ANN DABAO, are alleged to be guilty of professional misconduct and/or professional incompetence as defined in sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on **July 3, 2018**. You were the charge nurse on . A 75-year-old cognitively impaired female resident was suffering from chronic pain issues. She began yelling and using profane language towards staff. After hearing the patient's outburst, the manager spoke to you and then investigated and concluded that the patient was experiencing severe pain. The patient had been requesting analgesic relief and had become very upset. You and the manager each completed a separate Incident Investigation form regarding this occurrence. You failed in your obligation to maintain the practice standards established by the SRNA as follows:

(a) You failed to properly and thoroughly investigate the incident;

(b) You made assumptions regarding the root cause of the outburst as being "behavioural issues" rather than chronic pain issues; and

(c) The Incident Investigation form that you completed was inaccurate and your credibility is called into question due to the varying accounts of the events that you provided to your employer and the SRNA.

3. The Notice also sets out particulars for each charge and it is helpful to set out those particulars:

> The in Regina is part of the Saskatchewan Health Authority.
>
> Particulars of the alleged professional incompetence and misconduct while employed at the in Regina are as follows:
>
> (a) (Charge #1 - sepsis) The interdisciplinary progress notes for June 26, 2018 at 1120 state that the patient's temperature was 38.2 (AX) with a heart pulse of 125. The patient was complaining of painful ankles. At 1125 it was charted that the patient's right hand was shaking somewhat. It is charted that you, as the RN, were informed of this elevated temperature and heart rate. At 1750 it was charted that the resident's temperature was still elevated.
>
> (b) (Charge #1 - sepsis) The interdisciplinary progress notes show that on June 27, 2018 the oncoming nurse carried out the sepsis protocol and a diagnosis of sepsis was made.
>
> (c) (Charge #2 - hemodialysis) The Charge Nurse Evening Shift Guidelines for 1445 to 2315 hours provides that at 1445 hours the charge nurse must have discussions with LPN and any staff members related to resident conditions and events for the evening. At 1500 hours the charge nurse is to do a complete round of all residents and assess for any issues.
>
> (d) (Charge #2 - hemodialysis) A family member of resident reported coming into the patient's room on Friday, June 29, 2018 at 1900 hours and found him in respiratory distress. The nurse, Shevie Ann Dabao, stated "well there is nothing in my book that says he wasn't doing well all day". The family member replied, "Don't you check in on him?" The family member stated that she did not see Shevie Ann Dabao assessing the patient. Shevie Ann Dabao replied, "If you are going to talk to me that way, I don't have to talk to you" and then walked out of the room. Ms. Dabao did not return to the room until a family member went to get her where she was sitting in the charting room, looking at a book. She still did not return to the room. A family member went back a second time to where Shevie Ann Dabao was sitting and she came to the room this time. The family member asked that she immediately call an ambulance. At that point Shevie Ann Dabao asked the family member which hospital to send the patient.

(e) (Charge #2 - hemodialysis) The Interdisciplinary Progress Note shows a late entry for June 29, 2018 at 1934 hours, "made aware of resident's condition ordered...". The entry for 2000 hours is as follows: "Resident's chest was auscultated. Crackles noted on other lobes, diminished breath sounds noted on lower lobes, wife requesting resident to be sent to hospital for further assessment and made aware of same."

(f) (Charge #2 - hemodialysis) The 73-year-old male patient was admitted to the Regina General Hospital on June 29, 2018. He was treated with urgent dialysis to remove excess fluid. He received several treatments of dialysis, regular chest physio and spirometry. On July 8, 2018 at 1600 hours, the patient was returned to for ongoing care. The potential pulmonary infection, likely due from aspiration, was treated with intravenous antibiotics.

(g) (Charge #3 - chronic pain) On July 3, 2018, , RN Unit Manager, was approached by Continuing Care Staff to report the incident of a 75-year-old cognitively impaired female who was in pain and exhibiting behavioural issues. approached Shevie Ann Dabao and asked her if she had gone to speak with the resident. Shevie Ann Dabao told her that she had not. As a result, went to speak with the resident to handle the incident. Thereafter, she prepared an Incident Investigation form. While was handling this situation, she observed that Shevie Ann Dabao was in the charting room on the computer doing e-quizzes.

(h) (Charge #3 - chronic pain) Shevie Ann Dabao completed an Incident Investigation form and stated, "Resident had a verbal outburst due to miscommunication." She reported that the root cause of the outburst was "wrong assumption, behavioural issues". Shevie Ann Dabao wrote the following corrective action: "Manager spoke with resident and clarified concerns, educated resident on patient's rights and as well as harassment policy of SHA". Shevie Ann Dabao noted the long-term corrective action as follows: "Care plan will be reviewed with resident, stating on what are the goals of care and the doable assistance that will be or can be provided." “Timing will be set according to the needs of the unit." "Resident will be reminded on policies regarding being verbally abusive to staff."

(i) (Charge #3 - chronic pain) , RN Unit Manager, also completed an Incident Investigation form and noted the causal factor as "resident upset and swearing at staff'. She noted the root causes as follows: "Resident having pain++ and feels like getting different answers from everyone - feels like being blamed. Resident does not remember plan made with OT previously and having increased memory problems.” The immediate corrective action was charted as follows: "I went to speak with resident about concerns and to de-escalate situation. Reviewed plan for managing care and discussed working together to find solutions. Discussed using appropriate language and respectful communication with staff and our responsibility to do the same." She documented the following long-term corrective action. "Investigate memory

problems. Manage OT to assess and make recommendations to assist in wound healing. Develop a plan to best manage incontinence and promote wound healing. Review care plan and have a consistent plan. Reviewed with staff. A process to follow for consistency when resident swearing."

(j) (Charge #3 - chronic pain) The Interdisciplinary Progress Notes confirm that in July 2018 the patient was on medication for pain management. Charting confirms that the patient was on morphine and that she was still experiencing pain. Scheduled analgesics could only be given every four hours, but breakthrough medications could have been administered and were not.

(k) (Charge #3 - chronic pain) Shevie Ann Dabao instructed the staff she was supervising as follows: "if the resident calls you names, just leave her room." She did not document her interaction with the patient and admits, "I am really bad at documenting."

4. The Notice alleges that Shevie Ann Dabao is guilty of professional misconduct and professional incompetence contrary to section 25 and subsections 26(1) and (2) of the *Act.* The relevant provisions are as follows:

Professional incompetence
25 For the purposes of this Act, professional incompetence is a question of fact, but the display by a nurse in the professional care of a client of a lack of knowledge, skill or judgment or a disregard for the welfare of a client of a nature or to an extent that demonstrates that the nurse is unfit:

to continue in the practice of registered nursing; or

to provide one or more services ordinarily provided as part of the practice of registered nursing.

is professional incompetence within the meaning of this Act.

Professional misconduct
26(1) For the purpose of this Act, professional misconduct is a question of fact but any matter, conduct or thing, whether or not disgraceful or dishonourable, that is contrary to the best interests of the public or nurses or tends to harm the standing of the profession of nursing is professional misconduct within the meaning of this Act.

(2) Without restricting the generality of subsection (1) the discipline committee may find a nurse guilty of professional misconduct if the nurse has:

(e) wrongfully abandoned a client.

(j) failed to inform an employer of the nurse of the nurse's inability to accept specific responsibility in areas where special training is required or where the nurse does not feel competent to function without supervision;

(l) failed to comply with the code of ethics of the association;

(q) contravened any provision of this Act or the bylaws.

5. The Notice of Hearing also alleges that the following provisions of the *Code of Ethics for Registered Nurses, 2017* have been breached and are attached as Appendix "A" to this Decision:

   (a) A. Providing Safe, Compassionate, Competent and Ethical Care: A2, A3, A6, and A12;

   (b) B. Promoting Health and Well-Being: B1;

   (c) C. Promoting and Respecting Informed Decision-Making: C1;

   (d) D. Honouring Dignity: D6; and

   (e) G. Being Accountable: G1, G3, and G4.

6. Further, it is alleged that the following provisions of the *Standards and Foundation Competencies for the Practice of Registered Nurses, 2013* are applicable and are attached as Appendix "B" to this Decision:

   (a) Standard I – Professional Responsibility and Accountability: 1, 3, 4, 6, 8, 9, 14, 23, and 25(e);

   (b) Standard II - Knowledge-Based Practice: 26, 33, 36, 41, 45, and 52;

   (c) Standard Ill - Ethical Practice: 62, and 63;

   (d) Standard IV – Service to the Public: 80; and

   (e) Standard V - Self-Regulation: 85.

7. On February 16, 2021, prior to commencement of the Hearing, counsel for Ms. Dabao provided written materials to the Discipline Committee alleging that the Discipline

Committee did not have jurisdiction to hear and determine the Complaint on the basis that section 28 and 30 of the *Act* had not been complied with.

8. In the normal course, the Discipline Committee understands that any jurisdictional challenge would have been heard and determined prior to convening to hear and determine the Complaint. While the Discipline Committee noted this most unusual way of bringing a jurisdictional objection forward, it nonetheless determined, after hearing the consent of counsel, that it would hear the jurisdictional challenge and reserve its Decision.

9. Counsel for Ms. Dabao and the Investigation Committee were also in agreement that the Discipline Committee should proceed with hearing the evidence and submissions on the Complaint itself on February 17, 2021, with counsel for Ms. Dabao noting that a decision on the Complaint would not be required if the jurisdiction challenge was successful.

10. Written materials were filed in support of Ms. Dabao's jurisdictional challenge, including:
    - Documents to be relied upon by Shevie Ann Dabao ("Dabao Documents").
    - Written Submissions on Jurisdiction of the Discipline Committee; and,
    - Affidavit of , Investigator, filed in QBG No. 716 of 2020.

11. Counsel for the Investigation Committee also filed a Written Response to the Written Submissions on Jurisdiction of the Discipline Committee.

12. The following were also filed on agreement of both counsel:
    - Agreed Statement of Facts and Book of Exhibits of the Investigation Committee (marked as Exhibit "P1").
    - Notice of Guilty Pleas (marked as Exhibit "P2").
    - Joint Proposal for Discipline (marked as Exhibit "P3")

II. PRELIMINARY OBJECTION

13. Ms. Dabao relies on sections 28, 29 and 30 of the *Act* to support her preliminary objection on jurisdiction. The full text of these sections is attached as Appendix "C" to this Decision. The Discipline Committee derives its jurisdiction from sections 29 and 30 of the *Act*.

14. A brief history is required in order to understand the jurisdictional objection that has been raised by Ms. Dabao:

(a) Ms. Dabao brought an application for Judicial Review before the Court of Queen's Bench of Saskatchewan, seeking an order quashing a decision made by the Investigation Committee of the SRNA on January 9, 2020 to recommend the matter proceed to Discipline following Ms. Dabao's failure to execute a Consensual Complaint Resolution Agreement (CCRA) by January 2, 2020.

(b) The history of the Investigation and CCRA are set out in Justice McMurtry's Judgment dated September 25, 2020.[1]

(c) The application to quash the January 9, 2020 decision of the Investigation Committee to proceed to Discipline was dismissed with taxable costs ordered to the SRNA.

(d) As a part of the materials filed on the Judicial Review application, the Investigation Committee filed a document titled "Written Report of the Investigation Committee pursuant to Section 28(3) and 28(6) of *The Registered Nurses Act, 1988*"[2]. For ease of reference, this report will be referenced to as the "First Written Report".

(e) On January 7, 2021, Ms. Dabao and her counsel received an email from , Program Assistant, Complaints & Investigation – SRNA with attachment.[3] The email states:

> Attached please find the Written Report of the Investigation Committee pursuant to Section 28(3) & 28(6) of The Registered Nurses Act, 1988. This report is distributed to the member, the report writer(s), members of the Discipline Committee and SRNA Council.

The attachment was a document titled "Written Report of the Investigation Committee pursuant to Section 28(3) & 28(6) of *The Registered Nurses Act, 1988*". For ease of reference, this report will be referenced as the "Second Written Report." The Second Written Report is identical to the First Written Report except for the addition of the following on page 2:

[1] *Dabao v Investigation Committee of the Saskatchewan Registered Nurses' Association*, 2020 SKQB 242
[2] Tab 2 of Dabao Documents and Tab 10 of Exhibit P1
[3] Tab 3 of Dabao Documents

> The member failed to sign the CCRA by the extended deadline. On January 9, 2020, the Investigation Committee motioned to move to discipline.

The Second Written Report concludes the same as the First Written Report:

> A copy of this report pursuant to section 28(3) recommending no further action has been provided to the Discipline Committee, the Council of the SRNA, the report writer(s) and the member who was the subject of the report.

(f) On January 7, 2021, counsel for Ms. Dabao emailed counsel for the Investigation Committee forwarding email with the Second Written Report inquiring if there had been an error in having it sent to her and Ms. Dabao.[4]

(g) The Notice of Hearing of Complaint dated January 7, 2021 was served on counsel for Ms. Dabao on January 8, 2021.[5]

(h) On January 12, 2021, counsel for the Investigation Committee forwarded a response from confirming the Second Written Report had been sent to Ms. Dabao and her counsel based on section 28 of the *Act* and that "[i]t is our understanding that the member (and legal council [*sic*]) are entitled to a copy of the IC's decision regarding their case. This is why it was sent. It was not an error."[6]

(i) On February 3, 2021, counsel for the Investigation Committee emailed legal counsel for Ms. Dabao advising: "Attached is the second written report of the IC. I trust this resolves the issue of jurisdiction. …"[7] The attachment is a document titled "January 9, 2020 Written Report of the Investigation Committee pursuant to Section 28(3) and 28(6) of *The Registered Nurses Act, 1988*."[8] For ease of reference, this report will be referenced as the "Third Written Report."

(j) The Third Written Report is wholly different from the First Written Report and Second Written Report and sets out the January 9, 2020 motion to move the matter to discipline due to the failure of Ms. Dabao to execute the CCRA before the January 2, 2020 deadline, despite a number of extensions of time, and outlines in

[4] Dabao Documents, Tab 4
[5] Exhibit P1, Tab 1
[6] Dabao Documents, Tab 5
[7] Dabao Documents, Tab 6
[8] Dabao Documents, Tab 6 and Exhibit P1, Tab 10

detail the reasons for this determination along with its recommended penalty and costs.

Submissions on behalf of Ms. Dabao

15. Counsel for Ms. Dabao has argued that it is not open to the Investigation Committee or the Discipline Committee to follow a process that is not in line with the statutory requirements, that a failure to follow the statutorily mandated requirements will render the proceedings invalid, and that strict compliance with legislation governing professional discipline is required. Ms. Dabao relies on the following cases in support of these arguments: *Persaud v Society of Management Accountants (Ontario)* (1997) O.J. NO. 884, 144 D.L.R. (4th) 375, *Henderson v College of Physicians and Surgeons of Ontario*, 2002 CarswellOnt 209 (Ont. C.A.), *Nanson v. College of Psychologists (Saskatchewan)*, 2009 CarswellSask 166 (Sask. Q.B.), and *Parlee v. College of Psychologists of New Brunswick*, 2004 CarswellNB 228 (N.B. C.A.).

16. The statutorily mandated requirements that Ms. Dabao submits were not followed pertain to sections 28(3), 28(6), and 30(1) of the *Act*. Ms. Dabao submits that pursuant to section 28(3), the Investigation Committee must issue a written report recommending that either:

    (a) the discipline committee hear and determine the complaint set out in the written report; or
    (b) no further action be taken with respect to the matter under investigation.

17. Ms. Dabao also asserts that it is only where the written report issued pursuant to section 28(3) recommends no further action that it must be provided to the council, the person who made the report, and the nurse who is subject to the complaint. Ms. Dabao points to the Second Written Report provided on January 7, 2021 which states:

> A copy of this report pursuant to section 28(3) recommending no further action has been provided to the Discipline Committee, the Council of the SRNA, the report writer(s) and the member who was the subject of the report.

Ms. Dabao asserts that there was no report of the Investigation Committee issued requesting that the Discipline Committee hear and determine a complaint until the Third Written Report was circulated on February 3, 2021. Further, it is argued that it is not open to the Investigation Committee to issue multiple reports, and even if the report was issued in error, Ms. Dabao argues that there is no ability under the legislation for the Investigation

Committee to issue revised or additional written reports as the legislation is clear that there is “a written report”.

18. Ms. Dabao states that notice of the February 17, 2021 hearing was not provided by the executive director and could not have been provided pursuant to section 30(1) as there was no written report of the Investigation Committee that recommended that the Discipline Committee hear and determine a complaint

19. Ms. Dabao did not assert that she was not aware of the February 17, 2021 hearing date. Ms. Dabao also did not assert that she was not aware that the Investigation Committee was proceeding with a Notice of Hearing. Ms. Dabao submits that jurisdiction of the Discipline Committee to hear and determine the Complaint was lost by a failure to comply with sections 28 and 30 of the *Act*.

20. Ms. Dabao submits this issuance of multiple reports and inability to comply with section 30(1) invalidates the proceedings and is not a situation where an error can be corrected or remedied by starting over.

Submissions on behalf of the Investigation Committee

21. The Investigation Committee submits the Discipline Committee does have jurisdiction to hear the Complaint and that sections 28 and 30 of the *Act* have been strictly complied with by the SRNA. The Investigation Committee agreed that the Discipline Committee draws its jurisdiction from sections 28 and 30 of the *Act* but stated that the statutory requirements had been strictly complied with.

22. The Investigation Committee argued that the First Written Report was not an official report but was prepared as a working draft and for the purposes of consulting with Ms. Dabao on the CCRA. The Investigation Committee states that it was filed with the Court for informational purposes and was not meant to be the Investigation Committee’s decisive report. The Investigation Committee argued that it was not obligated to send the report to Ms. Dabao or her counsel as it relied solely on the signing of the CCRA by Ms. Dabao, which did not happen.

23. The Investigation Committee argued that the Second Written Report was the only report containing the Investigation Committee's conclusive recommendation on the matter, that as "the member failed to sign the CCRA by the extended deadline. On January 9, 2020 the Investigation Committee motioned to move to discipline."[9] The Investigation Committee further argued that the Investigation Committee was not obligated to send a copy of this report to Ms. Dabao, that the same was done as a gesture of courtesy, and that pursuant to section 28(3)(a) of the *Act*, once the Investigation Committee has made the decision to move the matter to Discipline, it is only required to send a copy of its written report to the Discipline Committee.

24. The Investigation Committee submitted that the Second Written Report contained some technical errors due to references from the First Written Report being retained in the Second Written Report but states this is a minor technical issue and akin to a typographical error. Further, these "errors", have no adverse impact on the recommendation that the matter be brought before the Discipline Committee due to the failure of Ms. Dabao to execute the CCRA. The Investigation Committee submits that these technical errors were rectified by revising the erroneous portions of the Second Written Report and issuing the Third Written Report on February 3, 2021.

25. The Investigation Committee argued that oversight on the part of the Investigation Committee in terms of the technical errors in the Second Written Report does not result in a loss of jurisdiction for the Discipline Committee as the Second Written Report very clearly set out what the decision of the Investigation Committee was, that the Complaint should "move to discipline." The Investigation Committee relied on case law to suggest that mere technicalities, or technical errors, cannot result in the removal of jurisdiction from an administrative board or tribunal: *Re Narain* (1983), 1983 BC SC 403 and *Hawrish v Law Society of Saskatchewan*, 1998 SK CA 12350.

26. The Investigation Committee further argued that section 30 of the *Act* was also followed as Ms. Dabao was provided with the Notice of Hearing of Complaint on January 8, 2021 and

[9] Exhibit P1, page 2 of 8

that Notice of Hearing contained a true and accurate excerpt of the written report, containing the full text of the Complaint, which is required by Section 30(1)(a) of the *Act*.

Analysis

27. The Discipline Committee has considered the written and oral submissions from both counsel on this matter and has determined that the Discipline Committee has jurisdiction to hear and determine the Complaint pursuant to section 30 of the *Act*.

28. The Discipline Committee is aware that statutory compliance and procedural fairness in professional regulatory matters are of the utmost importance. The Discipline Committee has determined that the SRNA did comply with sections 28 and 30 of the *Act*, albeit with some confusion. The relevant portions of these sections are:

> 28(3) The investigation committee shall make a written report to the discipline committee recommending that:
>
> (a) the discipline committee hear and determine the complaint set out in the written report; or
>
> (b) no further action be taken with respect to the matter under investigation.
>
> …
>
> 28(6) A copy of a written report pursuant to subsection (3) recommending no further action shall be provided to:
>
> (a) the council;
>
> (b) the person, if any, who made the report mentioned in subsection (1); and
>
> (c) the nurse who is the subject of the report mentioned in subsection (1).
>
> …
>
> 30(1) Where a report of the investigation committee recommends pursuant to section 28 that the discipline committee hear and determine a complaint, the executive director shall, at least 30 days prior to the date the discipline committee is to sit:
>
> (a) send a copy of the complaint contained in a written report prepared pursuant to subsection 28(3) to the nurse who is the subject of the complaint; and
>
> (b) notify the nurse mentioned in clause (a) of the date, time and place of the hearing.

29. The legislation is clear that the Investigation Committee "shall" prepare a written report to the discipline committee recommending that the Discipline Committee hear and determine the complaint or that no further action be taken with respect to the matter under investigation.

In the situation where the Investigation Committee has recommended no further action, the report must be provided to Council, the person who made the complaint, and the nurse who is subject to the complaint. Where the Investigation Committee has recommended the matter proceed to Discipline, there is no requirement for the report to be forwarded to anyone other than the Discipline Committee at that time.

30. The existence of multiple written reports certainly caused confusion; however, the Discipline Committee concludes that confusion and technical errors would not invalidate its jurisdiction altogether.

31. The Discipline Committee recognizes the confusion caused by the provision of the Second Written Report which, in its text and the accompanying email to counsel for Ms. Dabao, included reference to section 28(3) and 28(6), along with the concluding paragraph of the Second Written Report which states:

> A copy of this report pursuant to section 28(3) recommending no further action has been provided to the Discipline Committee, the Council of the SRNA, the report writer(s) and the member who was the subject of the report.

32. There is no question that Ms. Dabao was aware that the Investigation Committee had determined the matter would proceed to Discipline. This decision was the crux of the Judicial Review Application, was argued extensively before the Saskatchewan Court of Queen's Bench, and upheld. There is also no question that Ms. Dabao was also provided with the Notice of Hearing of the Complaint within the 30 day timeline stipulated in section 30 of the *Act*.[10]

33. The Discipline Committee concludes that the Second Written Report contained enough information for the Executive Director to cause a Notice of Hearing of Complaint to be prepared and served on Ms. Dabao in accordance with section 30 of the *Act*. The Second Written Report, while confusing, had been edited to include the Investigation Committee's conclusion that "[t]he member failed to sign the CCRA by the extended deadline. On January 9, 2020 the Investigation Committee motioned to move to discipline."

[10] Exhibit P1, Notice of Hearing of Complaint and Acknowledgment of Service

34. The Discipline Committee concludes that the technical errors in the Second Written Report do not result in a loss of jurisdiction and agrees with the reasoning in *Narain*[11] and *Hawrish*[12] in concluding that it would not be reasonable or just to invalidate an administrative proceeding for a mere technical error. The Discipline Committee notes that there was no authority provided for the proposition that any procedural irregularity would invalidate an administrative proceeding entirely.

35. As the Discipline Committee has determined that it has jurisdiction to hear and determine the Complaint, it will now turn to its determination of the Notice of Hearing of Complaint.

III. HEARING – Phase 1

36. Counsel for the Investigation Committee tendered proof of service of the Notice of Hearing showing that Ms. Dabao was served, through counsel, on January 8, 2021.[13]

Summary of Evidence

37. Counsel for the Investigation Committee filed Book of Exhibits and Agreed Statement of Facts (Exhibit P1), a "Notice of Guilty Plea" dated February 16, 2021 (Exhibit P2), signed on behalf of Ms. Dabao by her counsel, and a "Joint Proposal for Discipline" also dated February 16, 2021 (Exhibit P3).

38. Ms. Dabao's counsel advised the Notice of Guilty Plea was signed by her on the instruction and understanding of Ms. Dabao. Ms. Dabao was present for the Hearing.

39. The key points of the Agreed Statement of Facts and Notice of Guilty Plea are that Ms. Dabao has agreed to the facts and plead guilty to the three charges of professional misconduct and professional incompetence in the Notice of Hearing of Complaint dated January 7, 2021, except for Charge #2, paragraph 5(b), which was the subject of evidence called at the Hearing.

[11] *Re Narain* (1983), 1983 BC SC 403
[12] *Hawrish v Law Society of Saskatchewan*, 1998 SKCA 12350
[13] Exhibit P1

Witness Testimony

40. The Investigation Committee called one witness, to provide evidence in relation to the dispute Charge #2, paragraph 5(b), which states: "When you attended to the patient, you engaged in a confrontation with the family and left the resident's room." The following is a summary of her evidence:

(a) was the longtime spouse of the patient. She had been a frequent visitor to the care facility and attuned to changes in his condition. On June 29, 2018, noted that her spouse was having increasing difficulty breathing following his return from dialysis. She became increasingly alarmed and reported it to the care staff, who indicated they would notify the RN in charge.

(b) Ms. Dabao was delayed in attending and did not do a physical assessment on the patient when she attended. Ms. Dabao referred to the fact that she had checked the patient's book and there was nothing indicating the patient required further treatment.

(c) admitted to being scared and stressed. She stated her spouse was gasping for air and she felt he was "dying in front of [her] face". was candid in admitting that given the circumstances, she raised her voice to Ms. Dabao.

(d) After raised her voice, Ms. Dabao stated: "I don't have to talk to you if you are going to talk to me like that" and Ms. Dabao left the room.

(e) asked other care staff to have Ms. Dabao come back, as her spouse was breathing heavy, gasping, and appeared to be getting worse. Ms. Dabao eventually returned. Upon Ms. Dabao's return, the patient advised that he wished to go to the hospital. was unsure of the exact time between her requests for Ms. Dabao to come and return to the room as she explained she was very upset.

(f) Ms. Dabao only performed vital signs once the patient asked to go to hospital. Eventually an ambulance was called, and the patient was transferred to the hospital. He remained hospitalized for 8 days and then returned to the care facility. He later passed away on August 5, 2018, in hospital.

(g) brought a complaint to the Administrator of the care facility because she felt Ms. Dabao was not interested in her and that because she had raised her voice she "was a nobody."

(h) stated that in all her years she had never encountered anything like this, referring to the way Ms. Dabao treated her.

41. Counsel for Ms. Dabao did not call any witnesses.

Analysis

42. The Discipline Committee accepts the evidence found in the Agreed Statement of Facts and Book of Exhibits (Exhibit P1). The extent of the Agreed Statement of Facts was to reference the Notice of Hearing of Complaint and the Book of Exhibits. There were no narrative facts set out in the Agreed Statement of Facts, despite its title.

43. Narrative facts are contained within the Notice of Hearing. Ms. Dabao has provided a Guilty Plea to all of the Charges except Charge #2, paragraph 5(b).

44. In reviewing the evidence presented, the Discipline Committee accepts Ms. Dabao's guilty plea and finds the evidence before it proves the Charges. Ms. Dabao did not follow the appropriate nursing procedures and did not provide safe and compassionate care. The evidence presented supports that the lack of relational skills, knowledge, timely assessment, critical thinking, organization, prioritization, follow up, and documentation of care put patients at risk.

45. The Discipline Committee also finds Ms. Dabao guilty of Charge #2, paragraph 5(b). 's evidence was unequivocal in Ms. Dabao's mannerism, Ms. Dabao's handling of the patient, and 's concerns expressed to her. 's testimony was clear and credible. While she had some difficulties remembering the specifics in relation to time, her memory of the interactions she had with Ms. Dabao was remarkable and unwavering, particularly after the passage of time.

46. The Discipline Committee agrees with counsel for Ms. Dabao that nurses should not be subject to abuse in their work, however, the Discipline Committee also accepts 's uncontroverted evidence of her interactions with Ms. Dabao on June 29, 2018. was candid in advising that she raised her voice to Ms. Dabao and explained that she had done so due to Ms. Dabao's lack of a physical assessment of the patient and reliance on the patient's book to suggest there was nothing indicating he needed any further treatment.

47. The Discipline Committee finds that Ms. Dabao's reaction to the concerns raised and 's raised voice, that is to state that she did not have to speak to and leaving the room without performing a proper assessment, amounted to engaging in a confrontation and leaving. This portion of the Charge is sustained based on the evidence. The Discipline Committee notes that chart documentation was absent by Ms. Dabao with respect to interactions with the family, and therefore, could not be considered.

48. The Discipline Committee finds that each of the Charges have been proven based on the evidence and that the facts underlying each Charge constitutes professional misconduct and/or professional incompetence.

IV. HEARING – Phase 2

49. Having found Ms. Dabao guilty of all three Charges, the next issue is the imposition of a sanction. Section 31 of the *Act* set out the range of Sanctions available to the Discipline Committee.

50. The material presented to the Discipline Committee included a Joint Proposal for Discipline in which the Investigation Committee and Ms. Dabao had agreed to all aspects of sanctions except for costs.

51. The Joint Proposal for Discipline is lengthy and is included as Appendix "D".

52. The Discipline Committee is aware of the legal principles of joint submissions. In *Rault v Law Society of Saskatchewan, 2009 SKCA 81*, our Court of Appeal stated that discipline committees have a " duty to consider" joint submissions and to accept a joint submission if it is within a range of reasonable outcomes, fit and consistent with the public interest. In *R v Druken, 2006 NLCA 67*, the Newfoundland Court of Appeal indicated that a sentence is contrary to the public interest when it is "markedly out of line with the expectations of reasonable persons aware of the circumstances of the case".

53. After considering the evidence and the submissions of counsel, the Discipline Committee accepts the Joint Proposal for Discipline on the basis that it is reasonable, fit, and consistent

with the public interest. The Joint Proposal for Discipline includes a number of conditions to Ms. Dabao's continued practice, including written performance reviews to be completed by her employers, review of the *Standards and Foundation Competencies for the Practice of Registered Nurses (2013), Canadian Nurses Association Code of Ethics for Registered Nurses (2017), Documentation: Guidelines for Registered Nurses (2011)* with completion of reflective essays, completion of a number of courses, and that Ms. Dabao not engage in independent or autonomous nursing practice until the completion of 480 working hours of registered nursing practice following issuance of the Order. The Discipline Committee notes that the guiding documents referenced above have been updated and the Discipline Committee will direct, as set out in its Order below, that Ms. Dabao review the current versions of these documents.

54. The Joint Proposal for Discipline does not include a joint recommendation on costs but suggests that costs should be paid no later than February 17, 2023. As such, there are two aspects of the Joint Proposal that must be addressed and decided: the amount of costs to be ordered and the timing of those costs.

Submissions of Counsel for the Investigation Committee on the issue of Costs

55. Counsel for the Investigation Committee properly advised that the Investigation Committee would not be seek costs in relation to the Judicial Review Application as costs had been dealt with in the Court of Queen's Bench decision.

56. Counsel for the Investigation Committee filed an Affidavit of , legal assistant, setting out the anticipated costs of the Investigation and Hearing in the amount of $67,302.00. In his oral submissions, counsel for the Investigation Committee advised that he estimated $30,000.00 of the costs related to the Judicial Review Application. Counsel added that due to the jurisdictional challenge and the requirement to call evidence on Charge #2, paragraph 5(b), the costs of the Investigation Committee and Discipline Committee would have been increased in the amount of more than $10,000.00. He then estimated that overall costs of the Investigation and Discipline proceedings was approximately $80,000.00, reduced by $30,000.00 for the Judicial Review Application, to $50,000.00 total.

57. Counsel for the Investigation Committee advised that normally the Investigation Committee would seek 50% of the costs, however, due to the requirement to call evidence and respond to the jurisdictional challenge that the Investigation Committee is seeking $30,000.00 in costs, with a requisite amount of time to provide full payment.

58. Counsel for the Investigation Committee further submitted that it would not seek the costs award from the Court of Queen's Bench separately and that the same was included in the request for $30,000.00 in costs.

Submissions of Counsel for Ms. Dabao on the issue of Costs

59. Counsel for Ms. Dabao submitted that based on the information provided in the Affidavit of that roughly $40,000 of the total Investigation costs were attributable to the Judicial Review application. Counsel for Ms. Dabao submitted that Ms. Dabao's actions throughout the Investigation and Discipline process have been reasonable and appropriate and denied the suggestion that Ms. Dabao had caused unnecessary costs, noting that she had cooperated and tried to make the process as straightforward as possible.

60. Counsel for Ms. Dabao submitted that a member subject to investigation and discipline is entitled to take alternate positions and ask questions and Ms. Dabao should not be penalized for raising legitimate concerns, particularly concerning the jurisdictional objection due to the confusion, errors, and unique circumstances.

61. Counsel for Ms. Dabao went on to state that Ms. Dabao has taken responsibility, is accountable, acknowledges that she made mistakes, and has done everything she can to improve. Counsel for Ms. Dabao also notes that the Charges arise out of incidents on June 26, June 29, and July 3, 2018 and there is no suggestion of like circumstances in the intervening time period.

62. Counsel for Ms. Dabao also reviewed Ms. Dabao's personal circumstances, including fiscal pressures and her educational background.

63. Counsel for Ms. Dabao further argued that costs should not be punitive or prohibitive, that it would be disingenuous to put all of the blame for delays on Ms. Dabao, and that costs

should not be used as a tactic by the Investigation Committee when a member raises legitimate questions and brings applications in good faith.

64. Counsel further pointed to a number of previous decisions of the Discipline Committee in proposing that counsel for the Investigation Committee's overall estimate of costs should be reduced to $20,000.00 based on the Judicial Review Application and additional arguments, leaving costs of approximately $20,000. Counsel for Ms. Dabao suggested that half of this amount, $10,000.00, would be a reasonable costs order, with appropriate time to pay the amount in full.

Analysis on Costs and Timeline for Payment

65. The Discipline Committee understands the purpose of cost orders. The membership as a whole should not completely fund the cost of discipline proceedings where one member steps over the line. However, costs must also be reasonable and not punitive.

66. The Discipline Committee has considered the arguments of counsel, the approximation of costs to date as presented by the Investigation Committee, along with the increased costs of the jurisdictional challenge brought forward. The Discipline Committee is cognizant of the amount of costs to be borne by the membership, that costs orders should not be punitive or unduly prevent a member from being able to answering to charges and has considered Ms. Dabao's social and financial circumstances.

67. In considering all of the circumstances, including Ms. Dabao's guilty plea to the majority of the Charges, the Discipline Committee has set costs at $15,000.00 to be paid by April 5, 2025.

V. ORDER

68. The Discipline Committee therefore orders the following:

(a) Pursuant to Section 31(1)(c) of *The Registered* Nurses *Act, 1988,* Ms. Dabao may continue to practice only under conditions specified in this Order:

i. Ms. Dabao's employers will provide three written performance reviews noting the member's ability to demonstrate professional competence and professional conduct regarding nursing knowledge, skills and judgment and meet the SRNA *Standards and Foundation Competency for the Practice of Registered Nurses* (2019) and work within the *Canadian Nurses Association Code of Ethics for Registered Nurses* (2017). The performance reviews shall be submitted to the Registrar in the format provided by the registrar, signed by Ms. Dabao and the employer and sent directly by the employer to the SRNA. Unfavorable reviews will be reported by the Registrar to the Investigation Committee for further action. The first performance review shall be provided within thirty days of the date of this Order and thereafter upon having completed 240 actual work hours of RN practice after the Order and lastly after having completed 480 actual work hours of RN practice after the Order.

ii. Ms. Dabao shall review the *Standards and Foundation Competencies for the Practice of Registered Nurses* (2019). Within two months of this Order, Ms. Dabao shall provide a succinct, reflective essay to the Registrar of the SRNA referencing the relevant competencies related to the concerns identified in the three charges in the Notice of Hearing of Complaint. This essay shall identify how the RN Practice Standard and RN Entry Level Competencies documents will guide her current and future nursing practice.

iii. Ms. Dabao shall review the *Canadian Nurses Association Code of Ethics for Registered Nurses (2017).* Within two months of this Order, Ms. Dabao shall provide a thorough, reflective essay to the Registrar of the SRNA that references the relevant ethical values and responsibilities arising from the three charges in the Notice of Hearing of Complaint. The essay shall identify how the *Code of Ethics* will guide her current and future nursing practice.

iv. Ms. Dabao shall complete the *Canadian Nurses Association Code of Ethics for Registered Nurses* Learning Modules and within two months of this Order, Ms. Dabao shall provide the completion certificates to all 10 modules

to the Registrar of the SRNA. The cost of these modules is the responsibility of the member.

v. Ms. Dabao shall complete the online course *NCSBN Sharpening Critical Thinking Skills.* Within four months of this Order, the member shall provide the assignment booklet and the post-test with a minimum score of 75% to the Registrar of the SRNA. Ms. Dabao is responsible for the expenses incurred in completing this requirement.

vi. Ms. Dabao shall review *Documentation: Guidelines for Registered Nurses* (2021). Within three months of this Order, Ms. Dabao shall provide a self-reflective essay to the SRNA that identifies the areas that are related to the concerns identified in the three charges in the Notice of Hearing of Complaint. The essay shall identify how this document will guide her current and future nursing practice.

vii. Ms. Dabao shall complete the course *Patient Safety* (NRSG-252CE) provided through Saskatchewan Polytechnic. Within six months of this Order, Ms. Dabao shall provide to the Registrar of the SRNA an official transcript as proof of completion of this course. Ms. Dabao is responsible for the expenses incurred in completing the course.

viii. Ms. Dabao shall complete the course *Conflict Management* provided by the ACHIEVE Center for Leadership and Workplace Performance. Within four months of this Order, Ms. Dabao shall provide a certificate of completion of the said course. Ms. Dabao is responsible for the expense incurred in completingthe course.

ix. Ms. Dabao shall not engage in independent or autonomous nursing practice until the satisfactory completion of 480 actual worked hours of RN practice following the issuance of this Order. Independent or autonomous nursing practice includes areas of nursing practice where Ms. Dabao would be the sole nursing provider and enacting the entire nursing process independently (examples, but

not limited to: self-employed practice, public health, home care, chronic disease management, occupational health and areas directed by RN specialty practices).

x. Until the satisfactory completion of all the previously mentioned requirements Ms. Dabao shall:

- disclose to the Registrar of the SRNA, all past and present regulatory bodies with which she has been or is currently licensed;
- when practicing as a registered nurse, keep the Registrar verbally informed on a monthly basis of her progress in meeting the above requirements, conditions and restrictions;
- immediately advise the Registrar in writing if she applies for registration with any other regulatory body;
- hereby grant permission to the Registrar to discuss this Order with the member's present and future employers and relevant regulatory bodies;

xi. notify the Registrar of any change in registered nursing employment including any leave of absence greater than one month; and

xii. provide to the Registrar any updated and current telephone number, address and email information.

xiii. The member shall send to the Registrar of the SRNA all documents and information required by this Order to the Registrar directly from source marked "Personal and Confidential", SRNA, 2066 Retallack Street, Regina , SK S4T 7X5.

xiv. In the event the member fails to provide the documents and information within the timelines provided for in this Order, the member shall stand suspended from the Association until such time as the said documents and information are provided.

(b) Pursuant to paragraph 31(2)(a)(ii), Ms. Dabao shall pay costs of the inquiry and hearing which costs shall be fixed in the amount of $15,000.00.

(c) Pursuant to paragraph 31(2)(b), if Ms. Dabao fails to make payment of the said costs no later than April 5, 2025. Ms. Dabao shall be suspended from the Association until such time as the costs are paid in full.

April 27, 2021

Michell Jesse, RN, Chairperson
On behalf of Members of the Discipline Committee
Christine Barlow, RN, Writer
Frank Suchorab, RN
Ruth Black, RN
Sophie Grahame, Public Representative

Pursuant to section 31(2)(a)(ii) of the *Act*, a copy of this decision shall be sent to Shevie Ann Dabao and the complainant.

A copy of this decision shall be forwarded to:

(i) The editor of the SRNA news bulletin and the administrator for the SRNA website;
(ii) All Canadian Registrars of registered nurses;
(iii) Saskatchewan Association of Licensed Practical Nurses;
(iv) Registered Psychiatric Nurses Association of Saskatchewan;
(v) The College of Physicians and Surgeons of Saskatchewan;
(vi) Any other jurisdictions or other stakeholders as may be seen as appropriate by the Registrar.

Right of Appeal

Pursuant to section 34(1) of *The Registered Nurses Act, 1988,* a nurse who has been found guilty by the discipline committee or who has been expelled pursuant to section 33 may appeal the decision or any order of the discipline committee within 30 days of the decision or order to:

(a) the council by serving the executive director with a copy of the notice of appeal; or

(b) a judge of the court by serving the executive director with a copy of the notice of appeal and filing it with a local registrar of the court.

Appendix A

The relevant provisions of the *Code of Ethics* (Canadian Nurses Association, 2017) are as follows:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

A2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

A3. Nurses build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a **conscious** effort. Such relationships are critical to understanding people's needs and concerns.

A6. 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" (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island, & Prince Edward Island Health Sector Council, 2014, p. 3).

A12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).

B. Promoting Health and Well-Being

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

Ethical responsibilities:

B1. Nurses provide care directed first and foremost toward the health and well-being of persons receiving care, recognizing and using the values and principles of **primary health care.**

C. Promoting and Respecting Informed Decision-Making

Nurses recognize, respect and promote a person's right to be informed and make decisions.

Ethical Responsibilities:

C1. Nurses provide persons receiving care with the information they need to make informed and autonomous decisions related to their health and well-being. They also work to ensure that health information is given to those persons in an open, accurate, understandable and transparent manner.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical Responsibilities:

D6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

G. Being Accountable

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

Ethical responsibilities:

G1. 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.

G3. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to 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.

G4. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

Appendix B

The relevant provisions of the *Standards and Foundation Competencies for the Practice of Registered Nurses, 2013* are summarized as follows:

STANDARD 1 – PROFESSIONAL REPONSIBILITY AND ACCOUNTABILITY

The registered nurse consistently demonstrates professional conduct and competence while practicing in accordance with the SRNA standards for registered nursing practice and CNA's *Code of Ethics for Registered Nurses*. Further, the registered nurse demonstrates that the primary duty is to the client to ensure safe, competent, ethical registered nursing care.

The registered nurse:

1. Is accountable and accepts responsibility for own actions and decisions.

3. Recognizes the registered nurse scope of practice and individual competence limitations within the practice setting and seeks guidance as necessary.

4. Demonstrates professional presence and models professional behavior.

6. Displays initiative, confidence, self-awareness, and encourages collaborative interactions within the nursing and health care team, with the client as the centre of the health care team.

8. Demonstrates effective collaborative problem solving strategies, including conflict resolution.

9. Advocates and intervenes, as needed, to ensure client safety.

14. Advocates and intervenes in the client's best interest.

23. Organizes workload and develops time-management skills for meeting responsibilities.

25. Demonstrates professional leadership by:

    e. balancing competing values and priorities.

STANDARD II – KNOWLEDGE-BASED PRACTICE

II.1 Specialized Body of Knowledge

Specialized Body of Knowledge: The registered nurse draws on diverse sources of knowledge and ways of knowing, which includes the integration of nursing knowledge from the sciences, humanities, research, ethics, spirituality, relational practice, critical inquiry and the principles of primary health care.

The registered nurse:

26. Applies a knowledge base from nursing and other disciplines in the practice of registered nursing.

II. 2 Competent Application of Knowledge

Competent Application of Knowledge: The registered nurse demonstrates competence in the provision of registered nursing care. The competency statements in this section apply to the four components of registered nursing care; Assessment, Health Care Planning, Providing Care, and Evaluation. The provision of registered nursing care is an iterative process of critical inquiry and is not linear in nature.

Area i) Ongoing holistic assessment.

The registered nurse incorporates critical inquiry and therapeutic interpersonal skills to conduct an organized and comprehensive assessment that emphasizes client input and the determinants of health.

The registered nurse:

33. Uses appropriate assessment tools and techniques in consultation with clients and other health care team members.

36. Collects information on client status using assessment skills such as observation, interview, history taking, interpretation of data, and in direct care environments, physical assessment including inspection, palpation, auscultation and percussion.

Area ii) Collaborates with clients and families to develop plans of care.

The registered nurse plans registered nursing care appropriate for clients which integrates knowledge from nursing, health sciences and other related disciplines as well as knowledge from practice experiences; clients' knowledge and preferences; and factors within the health care setting.

The registered nurse:

41. Uses a critical inquiry process to support professional judgment and decision-making to develop plans of care.

45. Anticipates potential health problems or issues for clients and their consequences and initiates appropriate planning.

Area iii) Provides registered nursing care.

The registered nurse provides holistic individualized registered nursing care for clients and

families across the lifespan along the continuum of care.

The registered nurse:

52. Coordinates and provides timely registered nursing care for clients with co-morbidities, complex and rapidly changing health status.

STANDARD III – ETHICAL PRACTICE

The registered nurse demonstrates competence in professional judgment and practice decisions by applying the principles in the current CNA *Code of Ethics for Registered Nurses*. The registered nurse engages in critical inquiry to inform clinical decision-making, establishes therapeutic, caring, and culturally safe relationships with clients and the health care team.

The registered nurse:

62. Practises in accordance with the current CNA *Code of Ethics for Registered Nurses* and the accompanying responsibility statements.

63. Identifies the effect of own values, beliefs and experiences in relationships with clients, recognizes potential conflicts and ensures culturally safe client care.

STANDARD IV – SERVICE TO THE PUBLIC

The registered nurse protects the public by providing and improving health care services in collaboration with clients, other members of the health care team, stakeholders, and policy makers.

The registered nurse:

80. Manages resources to provide effective and efficient care.

STANDARD V – SELF-REGULATION

The registered nurse demonstrates an understanding of professional self-regulation by advocating in the public interest, developing and enhancing own competence, and ensuring safe practice.

The registered nurse:

85. Practises within the scope of registered nursing practice as defined in *The Registered Nurses Act, 1988*.

Appendix C

The relevant sections of *The Registered Nurses Act, 1988* are as follows:

Investigation
28(1) On the report, in writing, of any person alleging that a nurse is guilty of professional incompetence or professional misconduct, the investigation committee shall review the report for the purpose of deciding whether the discipline committee should hear and determine a complaint with respect to the matter disclosed in the report.

(2) The investigation committee may investigate the report by taking any steps it considers necessary.

(3) The investigation committee shall make a written report to the discipline committee recommending that:

(a) the discipline committee hear and determine the complaint set out in the written report; or

(b) no further action be taken with respect to the matter under investigation.

(4) A complaint set out in a written report made pursuant to clause (3)(a) may relate to any matter disclosed in the report mentioned in subsection (1) or in the investigation conducted by the investigation committee pursuant to subsection (2).

(5) A decision of the majority of the investigation committee is a decision of the committee.

(6) A copy of a written report pursuant to subsection (3) recommending no further action shall be provided to:

(a) the council;

(b) the person, if any who made the report mentioned in subsection (1); and

(c) the nurse who is the subject of the report mentioned in subsection (1).

(7) Subject to clause 38(6)(c), no statement or evidence given by the nurse whose conduct is the subject of the report to the investigation committee is to be used in evidence in any proceeding other than the investigation by that committee, except at the instance of the nurse who is the subject of the proceeding.

Discipline committee
29(1) The discipline committee is established consisting of at least three persons appointed by the council, a majority of whom shall be registered nurses.

(2) No member of council and no member of the investigation committee is eligible to be appointed as a member of the discipline committee.
(3) No member of the discipline committee who was a member of the investigation committee which investigated a complaint against a nurse shall participate in a hearing of that complaint by the discipline committee.

(4) A majority of the discipline committee constitutes a quorum.

Discipline hearing
30(1) Where a report of the investigation committee recommends pursuant to section 28 that the discipline committee hear and determine a complaint, the executive director shall, at least 30 days prior to the date the discipline committee is to sit:

(a) send a copy of the complaint contained in a written report prepared pursuant to subsection 28(3) to the nurse who is the subject of the complaint; and

(b) notify the nurse mentioned in clause (a) of the date, time and place of the hearing.

(2) The investigation committee shall submit to the discipline committee evidence respecting the complaint, but its members shall not participate in any other manner in the hearing of the complaint, except as witnesses when required.

(3) The discipline committee shall hear the complaint and shall decide whether or not the nurse is guilty of professional incompetence or professional misconduct, and the discipline committee need not refer any matter to a court for adjudication.

(4) The discipline committee may accept any evidence that it considers appropriate and is not bound by rules of law concerning evidence.

(5) The discipline committee may employ, at the expense of the association, any legal or other assistance that it considers necessary, and the nurse who is the subject of the complaint may at that nurse's own expense be represented by counsel or an agent.

(6) The testimony of witnesses is to be under oath administered by the chairperson of the committee.

(7) At a hearing by the discipline committee, there is to be full right to examine, cross-examine and re-examine all witnesses and full right to adduce evidence in defence and reply.

(8) On the application of the nurse who is the subject of the complaint or a member of the discipline committee, the local registrar of the court at any judicial centre shall, on payment of the appropriate fees, issue writs of subpoena and, where that writ is disobeyed, the proceedings and penalties are those applicable in civil cases in the court.

(9) Where the nurse who is the subject of the complaint fails to attend the hearing, the discipline committee may, on proof of service of the notice mentioned in subsection (1), proceed with the hearing in the absence of the nurse.

(10) The discipline committee may, either in the absence of the nurse who is the subject of the complaint or with the nurse's consent, accept evidence on affidavit.

(11) A decision of the majority of the discipline committee is a decision of the committee.

(12) If, during the course of a hearing, the evidence shows that the nurse who is the subject of the complaint may be guilty of a charge different from or in addition to any charge specified in the complaint, the discipline committee shall:

(a) notify the nurse of that fact; and

(b) if the discipline committee proposes to amend, add to or substitute the charge in the complaint and unless the nurse otherwise consents, adjourn the hearing for any period that the discipline committee considers sufficient to give the nurse an opportunity to prepare a defence to the amended complaint.

Appendix D

IN THE MATTER OF: *The Registered Nurses Act, 1988,* and SHEVIE ANN DABAO, RN #44681

BETWEEN:

INVESTIGATION COMMITTEE OF THE
SASKATCHEWAN REGISTERED NURSES ASSOCIATION

-and-

SHEVIE ANN DABAO

JOINT PROPOSAL FOR DISCIPLINE PURSUANT
TO SECTION 31 OF *THE REGISTERED NURSES ACT,* 1988

The Investigation Committee and Shevie Ann Dabao jointly submit to the Discipline Committee the following proposed discipline:

1. Pursuant to Section 31(1)(c) of *The Registered* Nurses *Act, 1988,* the member may continue to practice only under conditions specified in this Order:

    1.1 The member's employers will provide three written performance reviews noting the member's ability to demonstrate professional competence and professional conduct regarding nursing knowledge, skills and judgment and meet the SRNA *Standards and Foundation Competency for the Practice of Registered Nurses* (2013) and work within the *Code of Ethics for Registered Nurses* (2017). The performance reviews shall be submitted to the Registrar in the format provided by the registrar, signed by the member and the employer and sent directly by the employer to the SRNA. Unfavorable reviews will be reported by the Registrar to the Investigation Committee for further action. The first performance review shall be provided within thirty days of the date of this Order and thereafter upon having completed 240 actual work hours of RN practice after the Order and lastly after having completed 480 actual work hours of RN practice after the Order.

    1.2 The member shall review the *Standards and Foundation Competencies for the Practice of Registered Nurses* (2013). Within two months of this Order, the member shall provide a succinct, reflective essay to the Registrar of the SRNA referencing the relevant competencies related to the concerns identified in the three charges in the Notice of Hearing of Complaint. This essay shall identify

how the standards and foundation competencies document will guide the member's current and future nursing practice.

1.3 The member shall review the *Canadian Nurses Association Code of Ethics for Registered Nurses (2017).* Within two months of this Order the member shall provide a thorough, reflective essay to the Registrar of the SRNA that references the relevant ethical values and responsibilities arising from the three charges in the Notice of Hearing of Complaint. The essay shall identify how the *Code of Ethics* will guide the member's current and future nursing practice.

1.4 The member shall complete the *Canadian Nurses Association Code of Ethics* Learning Modules and within two months of this Order, the member shall provide the completion certificates to all modules to the Registrar of the SRNA.

1.5 The member shall complete the online course *NCSBN Sharpening Critical Thinking Skills.* Within four months of this Order, the member shall provide the assignment booklet and the post-test with a minimum score of 75% to the Registrar of the SRNA. The member is responsible for the expenses incurred in completing this requirement.

1.6 The member shall review *Documentation: Guidelines for Registered Nurses* (2011). Within three months of this Order, the member shall provide a self-reflective essay to the SRNA that identifies the areas that are related to the concerns identified in the three charges in the Notice of Hearing of Complaint. The essay shall identify how this document will guide the member's current and future nursing practice.

1.7 The member shall complete the course *Patient Safety* (NRSG-252CE) provided through Saskatchewan Polytechnic. Within six months of this Order, the member shall provide to the Registrar of the SRNA an official transcript as proof of completion of this course. The member is responsible for the expenses incurred in completing the course.

1.8 The member shall complete the course *Conflict Management* provided by the ACHIEVE Center for Leadership and Workplace Performance. Within four months of this Order, the member shall provide a certificate of completion of the

said course. The member is responsible for the expense incurred in completing the course.

1.9 The member shall not engage in independent or autonomous nursing practice until the satisfactory completion of 480 actual worked hours of RN practice following the issuance of this Order. Independent or autonomous nursing practice includes areas of nursing practice where the member would be the sole nursing provider and enacting the entire nursing process independently (examples, but not limited to: self-employed practice, public health, home care, chronic disease management, occupational health and areas directed by RN specialty practices).

1.10 Until the satisfactory completion of all the previously mentioned requirements the member shall:

1.11 disclose to the Registrar of the SRNA, all past and present regulatory bodies with which she has been or is currently licensed;

1.12 when practicing as a registered nurse, keep the Registrar verbally informed on a monthly basis of her progress in meeting the above requirements, conditions and restrictions;

1.13 immediately advise the Registrar in writing if she applies for registration with any other regulatory body;

1.14 hereby grant permission to the Registrar to discuss this Order with the member's present and future employers and relevant regulatory bodies;

1.15 notify the Registrar of any change in registered nursing employment including any leave of absence greater than one month; and

1.16 provide to the Registrar any updated and current telephone number, address and email information.

1.17 The member shall send to the Registrar of the SRNA all documents and information required by this Order to the Registrar directly from source marked "Personal and Confidential", SRNA, 2066 Retallack Street, Regina , SK S4T 7X5.

1.18 In the event the member fails to provide the documents and information within the timelines provided for in this Order, the member shall stand suspended from the Association until such time as the said documents and information are provided.

2. Pursuant to paragraph 31(2)(a)(ii), the member shall pay $_____ costs of the inquiry and hearing into the member's conduct and related costs including the expenses of the Investigation Committee and the Discipline Committee.

3. Pursuant to paragraph 31(2)(b), if the member fails to make payment of the said costs no later than February 17, 2023, the nurse shall be suspended from the Association until such time as the costs are paid in full.

4. The Investigation Committee and Shevie Ann Dabao are aware that the Supreme Court of Canada, the Saskatchewan Court of Appeal, and the Saskatchewan Court of Queen's Bench have ruled that, while a Joint Submission on Penalty is not binding on the decision-maker, the decision-maker can only depart from the Joint Proposal for Discipline if the decision-maker considers the recommendation is inappropriate, not within the range of sentences, unfit or unreasonable and/or contrary to the public interest.

Dated at Regina, Saskatchewan this 16th day of February, 2021.

Ronalda A. Nordal, QC
Legal Counsel for Shevie Ann Dabao

Dated at Regina, Saskatchewan this 16th day of February, 2021.

Roger J.F. Lepage
Legal Counsel for the Investigation
Committee of the SRNA