INVESTIGATION COMMITTEE
of the
COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

-and-

Sheldon Mitchell
Saskatchewan RN #0043489
[redacted], SASKATCHEWAN

DECISION

of the

DISCIPLINE COMMITTEE

of the

COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

Legal Counsel for the Investigation Committee:	Christa Weber
Legal Counsel for Sheldon Mitchell	Marcus Davies
Legal Counsel for the Discipline Committee:	Brittnee Holliday
Chairperson for the Discipline Committee:	Christine Barlow, RN

Date of Hearing:	**October 21, 2024**
Location:	*Via Videoconference* College of Registered Nurses of Saskatchewan 1-3710 Eastgate Drive Regina, Saskatchewan S4Z 1A5
Date of Decision:	**January 10, 2025**

I. INTRODUCTION

1. The Discipline Committee of the College of Registered Nurses of Saskatchewan ("CRNS") convened to hear and determine a complaint of professional misconduct against Registered Nurse #0043489, Sheldon Mitchell, on October 21, 2024. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act,* 1988 (the "Act").

2. The charges against Sheldon Mitchell are outlined in a Notice of Hearing dated September 5, 2024. There is one Charge of professional incompetence, and that charge is as follows:

1. You committed an act of professional incompetence per section 25 of *The Registered Nurses Act, 1988,* in that, on July 14, 2023, between 0200 hours and 0530 hrs, when you were working in the triage nurse role at the [redacted], you displayed a lack of judgment in your professional care of a patient, or a disregard for the welfare of a patient, who was brought in by ambulance to the department at approximately 0200 hours.

<u>Particulars</u>

a. You failed to provide basic nursing care and the required assessments when you:

i. failed to conduct a thorough initial triage nursing assessment including obtaining a complete set of vitals from the patient and accurately assessing the chief complaint of the patient;

ii. failed to conduct proper reassessments as required based on the patient's triage assessment of CTAS 2;

iii. became aware that the patient was repeatedly on the floor calling out pain and discomfort, and directly witnessing the patient fall;

iv. failed to initiate timely chest compressions on the patient;

b. You failed to complete adequate documentation or charting relating to the patient; and,

c. You failed to advocate for the patient when you did not prioritize the patient and utilize department resources to ensure patient safety, comfort, and dignity.

II. LEGISLATION

3. The Notice of Hearing alleges that Mr. Mitchell is guilty of professional incompetence contrary to section 25 (a) and (b) of the Act:

> **Professional incompetence**
>
> **25 For the purpose 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:**
>
> **(a) to continue in the practice of registered nursing; or**
> **(b) to provide one or more services ordinarily provided as part of the practice of registered nursing;**
>
> **is professional incompetence within the meaning to this Act.**

4. The provisions of the Code of Ethics for Registered Nurses (2017), SRNA Registered Nurse Practice Standards (2019), and SRNA Nurse Entry-Level Competencies (2019), alleged in the Notice of Hearing to have been contravened are set out in Appendix A.

III. HEARING

5. When the Discipline Hearing began on October 21, 2024, neither counsel for the Investigation Committee nor counsel for Mr. Mitchell raised any objection regarding the composition of the Discipline Committee.

6. At the outset of the hearing, counsel for the Investigation Committee tendered a binder described as "Document Package for Filing with Discipline Committee". The binder consisted of an Agreed Statement of Facts and Evidence, Joint Submission Regarding Proposed Penalty, and a Costs Breakdown. The following were marked as Exhibits:

Exhibit P1: Agreed Statement of Facts and Evidence, including 10 tabs and 1 USB
Exhibit P2: Joint Submission as to Penalty and Costs
Exhibit P3: Costs Breakdown

7. Paragraph 73 of the Agreed Statement of Facts states:

> **Mr. Mitchell admits to the conduct (the charge and particulars) as stated in the Notice of Hearing Appendix A, dated September 5, 2024, and further admits that this conduct constitutes professional incompetence as defined in section 25 of the *Registered Nurses Act, 1988*, and contravenes the provisions of the Code of Ethics for Registered Nurses, SRNA Registered Nurse Practice Standards, and Registered Nurse Entry-Level Competencies as outlined in Appendix A of the Notice of Hearing.**

8. Sheldon Mitchell's legal counsel confirmed his guilty plea to the Charge set out in the Notice of Hearing.

IV. FACTS

9. Sheldon Mitchell, of [redacted] Saskatchewan, is a Registered Nurse ("RN") and practicing member of the CRNS.

10. Prior to becoming a RN, Mr. Mitchell worked as a primary care paramedic and was licensed as such from 2009 to 2019.

11. Mr. Mitchell completed his nursing education program at the University of Regina on April 25, 2015. He was registered on May 13, 2015, with the SRNA (now CRNS) as a practicing graduate nurse and has been a practicing RN with the CRNS since July 14, 2015.

12. Mr. Mitchell has no prior history of complaints or investigations with the CRNS.

13. On August 14, 2023, the CRNS Professional Conduct Committee received a written complaint from [redacted], alleging professional incompetence and misconduct on the part of Mr. Mitchell, specifically that on July 14, 2023, between 0200 and 0515 hours at the [redacted], while Mr. Mitchell was the triage nurse on shift, he failed to provide appropriate care and response to a Patient, including when the Patient experienced multiple falls to the floor and calls for help which were not attended to or acknowledged.

14. At approximately 0200 hours on July 14, 2023, a [redacted] Patient ("the Patient") was brought into the waiting room in a wheelchair by Emergency Medical Services (EMS). As the triage nurse, Mr. Mitchell was the primary nurse for the Patient until he assigned the Patient to a bed in the department.

15. On that night, there were treatment spaces available and an adequate compliment of staff.

16. EMS reported 8/10 severe mid-back pain as the Patient's chief complaint, including medical history of daily fentanyl use and chronic pain, as well as, difficulty walking without assistance.

17. Upon the Patient's arrival to the [redacted], Mr. Mitchell did not take a complete set of vitals, nor did he follow the Saskatchewan Health Authority ("SHA") "Access to Care in the ED" Work Standard that all staff were required to follow to ensure the safety of patients who appear vulnerable. Rather than documenting the chief complaint as back pain, Mr. Mitchell documented the chief complaint as substance misuse and withdrawal.

18. Mr. Mitchell assessed the Patient's Canadian Triage and Acuity Scale ("CTAS") score to be CTAS 2. A score of CTAS 2 requires reassessment of the patient every 15 minutes for the first hour, and every 15-30 minutes after until the patient is deemed to be stable by the nurse.

19. Mr. Mitchell did not reassess the Patient as per CTAS 2 requirements, or at any point during the Patient's time in the waiting room. The Patient was in the waiting room for just over three hours, from 0200 to 0515 hours, until a Code Blue was initiated. During this period, Mr. Mitchell was, at times, reading a book, on his cell phone at the triage desk, and conversing with the charge nurse and other employees.

20. Mr. Mitchell also did not follow the SHA policy regarding falls. The Patient was on the floor on seven different occasions, five of which Mr. Mitchell either witnessed himself or was advised of by the charge nurse or security. Mr. Mitchell did not do a fall risk assessment

and deemed the Patient being on the floor as 'behavioral' and by choice. He did not follow the "Falls Prevention in the Emergency Department" Work Standard.

21. Finally, when the Patient became still, Mr. Mitchell did not begin chest compressions as would have been appropriate, but rather, attempted to place the Patient into a sitting position, and therefore, did not provide basic nursing care.

22. Mr. Mitchell also did not complete adequate documentation. From the time of the initial triage nursing assessment at 0211 hours until after the Code Blue was called, Mr. Mitchell did not document anything on the Patient's chart; he did not document any changes in the Patient's condition, the Patient's falls, and/or the Patient's repeated lying on the floor and calling out for help. He also did not document offering the Patient Tylenol for the pain, her refusal of the Tylenol, or any of his conversations with the Patient.

23. Mr. Mitchell did not advocate for the Patient, nor did he ensure patient safety, comfort, and dignity. Despite open treatment spaces, and adequate time, he did not provide the Patient with a safe, comfortable, or dignified environment.

24. The Discipline Committee finds that the Agreed Statement of Facts and supporting documentation substantiates the Charge and the Discipline Committee accepts Mr. Mitchell's guilty plea to the Charge.

V. PROPOSED SANCTION

25. Having found that the Charge is sustained, and the guilty plea is accepted, the next task for the Discipline Committee is the imposition of an appropriate sanction pursuant to section 31 of the Act.

26. The Discipline Committee was presented with a Joint Submission as to Penalty and Costs ("Joint Submission"), Exhibit P2, which broadly consisted of the following:

(a) Continued practice, provided Mr. Mitchell completes an educational course and a research/reflective essay with an accompanying meeting with the Registrar or designate to discuss the issues explored in the essay; and,

(b) Payment of costs of the investigation and hearing in the amount of $5,000.00 within two years of the effective date of the Order.

27. Exhibit P3 outlines the total approximate costs to the CRNS in this professional disciplinary proceeding as $22,077.71. Although this is the total actual and anticipated costs, the Joint Submission provides that Mr. Mitchell would pay $5,000.00 of that amount or 22.6%.

28. Several factors are considered when determining an appropriate sanction for a professional. While the list is not intended to be exhaustive, a frequently cited list of factors established by case law can be found in the decision of *Jaswal v Medical Board (Newfoundland)*, 1996 CanLII 11630 (NL SC), 138 Nfld & PEIR 181 ["*Jaswal*"], at paragraph 35:

> **1. the nature and gravity of the proven allegations**
> **2. the age and experience of the offending physician**
> **3. the previous character of the physician and in particular the presence or absence of any prior complaints or convictions**
> **4. the age and mental condition of the offended patient**
> **5. the number of times the offence was proven to have occurred**
> **6. the role of the physician in acknowledging what had occurred**
> **7. whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made**
> **8. the impact of the incident on the offended patient**
> **9. the presence or absence of any mitigating circumstances**
> **10. the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine**
> **11. the need to maintain the public's confidence in the integrity of the medical profession**
> **12. the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct**
> **13. the range of sentence in other similar cases**

29. In *Camgoz v College of Physicians and Surgeons (Sask.)*, 1993 CanLLI 8952, 114 Sask R 161, the Court of Queen's Bench, as it then was, also outlined the *Jaswal* factors as

factors to consider when determining penalty. The Court specifically noted that the list is not exhaustive and does not mean that each specified factor will be relevant in every instance. As such, the factors need to be considered in relation to the specific facts of each case.

30. The findings of fact are serious. Mr. Mitchell neglected to provide basic nursing care, did not follow policy/protocol, did not appropriately document the medical record, and did not ensure the dignity of the Patient. The Discipline Committee notes the Patient was vulnerable.

31. Mr. Mitchell has been registered with CRNS since July 2015 and was licensed as a paramedic from 2009 to 2019. As such, he was aware of the importance of following policy/protocol and the ethical obligations to care.

32. There was a tragic outcome for this Patient that must be recognized, however, there is no suggestion that Mr. Mitchell's conduct was malicious or intentional or was motivated by personal gain. The Discipline Committee concludes that it is the conduct, being a serious lack of judgment or disregard for the Patient, and not the ultimate consequence that must be considered in determining penalty. There is no suggestion that Mr. Mitchell caused the tragic outcome.

33. Mr. Mitchell does not have prior disciplinary history and, while there were multiple instances of failing to provide basic nursing care, lack of documentation, and failure to advocate for the Patient, there is no suggestion or finding that this was a repeated pattern of behaviour. The conduct occurred in one evening, over a three-hour time period.

34. Mr. Mitchell acknowledged a lack of judgment on several fronts, took immediate responsibility for his conduct, expressed sincere remorse, and fully cooperated in these proceedings. Further, Mr. Mitchell has already experienced and will continue to experience financial and other consequences. Mr. Mitchell was terminated from the SHA and was unemployed for approximately four months, resulting in a substantial loss of income. In addition, this decision will be published and will remain as a part of Mr. Mitchell's discipline history with the CRNS.

35. Mr. Mitchell was regarded by the Discipline Committee as open, honest, and remorseful during the hearing and answered questions asked of him thoughtfully. Mr. Mitchell demonstrated insight regarding compassion fatigue and moral distress following the COVID-19 pandemic, exacerbated by his EMS experience and a previous assault. He noted not feeling 'a lot of support' and 'suffering in silence' at the time these events occurred. Mr. Mitchell advised that he had focussed on care of his mental health since the time of the incident and stated an understanding of the importance of wellness to nursing practice.

36. The Discipline Committee finds that the conduct was unacceptable and is regarded by consensus as inappropriate. Mr. Mitchell has taken initiative to undertake significant remediation, completing several educational courses, including those with a focus on substance use, reconciliation, and direct practice.

37. The Discipline Committee accepts the submissions of counsel for the Investigation Committee that case law on incompetence is factually specific and relates to what is required to meet the public interest. The incompetence here is a lack of appropriate judgment and how and when to employ it and does not relate to Mr. Mitchell's competence in terms of his skills or abilities as a nurse. The Discipline Committee agrees that a focus on remediation to ensure safe, competent nursing care, as opposed to punishment, should be emphasized.

38. The Discipline Committee finds the proposed sanction, focused on remediation, properly addresses the requirements of specific and general deterrence, improved competence, and maintaining public confidence and the integrity of the profession.

39. The Discipline Committee has considered the legal principles regarding joint submissions on penalty and concludes that the Joint Submission is fit, reasonable, and consistent with the public interest mandate of the CRNS.

VI. ORDER

40. The Discipline Committee makes the following Order pursuant to section 31 of the *Act*:

1. Pursuant to section 31(1)(c) of the Act, Mr. Mitchell shall successfully complete the John Collins Consulting Inc. Critical Thinking in Nursing Course (CTNRNO1) within six months of the effective date of this Order, the full cost to be borne by him. Mr. Mitchell must also provide proof of completion to the Registrar or designate.

2. Pursuant to section 31(1)(e) of the Act, within three months of the effective date of this Order, Mr. Mitchell shall submit a research/reflective essay to the Registrar or designate exploring nursing unit/team culture, how it can impact patient care and staff relationships, the risks at play when culture goes against policy or best practice, strategies to navigate unit culture issues, and what has been learned from this specific situation. The essay shall be between eight to ten pages with a minimum of three references cited appropriately.

3. Pursuant to section 31(1)(e) of the Act, within one month of the submission of Mr. Mitchells' research/reflective essay, he will have a discussion with the Registrar, designate, or practice advisor regarding the issues explored in his essay.

4. Pursuant to section 31(1)(e) of the Act, all documents and information requested in the Discipline Order must be sent to the CRNS **directly from source,** marked "Personal and Confidential" to the attention of the Registrar, c/o Assistant to the Registrar, CRNS, 1-3710 Eastgate Drive, Regina, Saskatchewan, S4Z 1A5.

5. Pursuant to section 31(1)(e) of the Act, Mr. Mitchell shall ensure that the Registrar is provided with updated and current telephone, address and email information and on an ongoing basis for so long as he is subject to any continuing conditions or restrictions of the Discipline Order.

6. Pursuant to section 31(2)(a)(ii) of the Act, Mr. Mitchell shall pay costs of the investigation and hearing process fixed in the amount of $5,000.00.

7. The costs shall be paid within two years of the effective date of this Order. Pursuant to section 31(2)(b) of the Act, failure to pay the costs within two years from the date of this Order, shall result in the immediate suspension of Mr. Mitchell's license until payment is made in full.

41. Pursuant to section 31(3) of the Act, a copy of this decision shall be sent to Mr. Mitchell and [redacted].

[DATE]

Christine Barlow, RN, Chairperson
On behalf of Members of the Discipline Committee
Anne KoKesch, RN
Leah Clement, RN
Jodi Romanow, RN
Sophie Grahame, Public Representative

Pursuant to section 31(1)(e) of the Act, a copy of this decision shall be forwarded to:

(a) The editor of the CRNS news bulletin and the administrator for the CRNS website;
(b) All Canadian Registrars of registered nurses;
(c) College of Licensed Practical Nurses of Saskatchewan;
(d) College of Psychiatric Nurses of Saskatchewan;
(e) The College of Physicians and Surgeons of Saskatchewan;
(f) 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

LEGISLATION, BYLAWS, CODE OF ETHICS, PRACTICE STANDARDS & COMPETENCIES CONTRAVENED:

The Registered Nurses Act, 1988

25 For the purpose 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:

(a) to continue in the practice of registered nursing; or

(b) to provide one or more services ordinarily provided as part of the practice of registered nursing;

is professional incompetence within the meaning to this Act.

Code of Ethics for Registered Nurses (2017)

A. **Providing Safe, Compassionate, Competent and Ethical Care**

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

7. When resources are not available to provide appropriate or safe care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care informed about potential and actual plans regarding the delivery of care. They inform employers about potential threats to the safety and quality of health care.

D. **Honouring Dignity**

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

2. Nurses support persons receiving care in maintaining their dignity and integrity.
8. In all practice settings where nurses are present, they work to relieve pain and suffering, including appropriate and effective symptom management, to allow persons receiving care to live and die with dignity.

F. Promoting Justice

Nurses uphold principles of justice by safeguarding human rights, equity and fairness and by promoting the public good.

Ethical responsibilities:

3. Nurses refrain from judging, labelling, stigmatizing and humiliating behaviours toward persons receiving care or toward other health-care providers, students and each other.

SRNA Registered Nurse Practice Standards (2019)

Standard 1: Professional Responsibility and Accountability

The registered nurse is responsible for practicing safely, competently and ethically, and is accountable to
the client, public, employer and profession.

The registered nurse upholds this standard by:

6. Advocating, intervening and participating with others, as needed, to ensure client safety.

7. Advocating and intervening in the client's best interest, and acting to protect client, self and others from actual or perceived harm.
9. Practicing in accordance with agency policy and legislation, and in a timely manner, recognizes and reports near misses and errors (own and others), adverse events and critical incidents, and taking action to stop and minimize harm.

Standard 2. Knowledge-Based Practice
The registered nurse practices using evidence-informed knowledge, skills and judgment from diverse sources of knowledge and ways of knowing.

The registered nurse upholds this standard by:
17. Anticipating potential health problems or issues for clients, the possible consequences and responding appropriately.
20. Evaluating the effectiveness of nursing interventions at the point of care to modify and individualize client care.

Standard 3: Ethical Practice
The registered nurse applies the principles in the current CNA Code of Ethics for Registered Nurses when making practice decisions and using professional judgment. The registered nurse engages in critical inquiry to inform clinical decision-making and establishes therapeutic caring and culturally-safe relationships with clients and the health care team.

The registered nurse upholds this standard by:
27. Identifying the effect of own values, beliefs and experiences in relationships with clients, recognizing and addressing potential conflicts.

Standard 4: Service to the Public
The registered nurse demonstrates leadership in quality and ethical nursing practice, delivery of health care services and establishing professional relationships.

The registered nurse upholds this standard by:
36. Listening respectfully to the expressed needs of clients, families and others.
43. Managing resources to provide safe, effective and efficient care.

SRNA Registered Nurse Entry-Level Competencies (2019)
1. Clinician
Registered nurses are clinicians who provide safe, competent, ethical, compassionate and evidence-informed care across the lifespan in response to client needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.
1.1 Provides safe, ethical, competent, compassionate, client-centred and evidence informed nursing care across the lifespan in response to client needs.
1.2 Conducts a holistic nursing assessment to collect comprehensive information on client health status.
1.4 Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.
1.6 Evaluates effectiveness of plan of care and modifies accordingly.

1.7 Anticipates actual and potential health risks and possible unintended outcomes.
1.8 Recognizes and responds immediately when client safety is affected.
1.9 Recognizes and responds immediately when client's condition is deteriorating.
1.12 Implements evidence-informed practices of pain prevention, manages client's pain and provides comfort through pharmacological and non-pharmacological interventions.
1.13 Implements therapeutic nursing interventions that contribute to the care and needs of the client.

2. Professional
Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession. Registered nurses demonstrate accountability, accepts responsibility and seeks assistance as necessary for decisions and actions within the legislated scope of practice.
2.5 Identifies the influence of personal values, beliefs and positional power on clients and the health care team and acts to reduce bias and influences.

3. **Communicator**
Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information and foster therapeutic environments.
3.2 Engages in active listening to understand and respond to the client's experience, preferences and health goals.
3.7 Communicates effectively in complex and rapidly-changing situations.
3.8 Documents and reports clearly, concisely, accurately and in a timely manner.

5. **Coordinator**
Registered nurses coordinate point-of-care health service delivery with clients, the health care team, and other sectors to ensure continuous, safe care.
5.1 Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.
5.2 Monitors client care to help ensure needed services happen at the right time and in the correct sequence.

6. **Leader**
Registered nurses are leaders who influence and inspire others to achieve optimal health outcomes for all.
6.5 Recognizes the impact of organizational culture and acts to enhance the quality of a professional and safe practice environment.

7. **Advocate**
Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.
7.1 Recognizes and takes action in situations where client safety is actually or potentially compromised.