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

NOTICE OF HEARING OF COMPLAINT

TO: SHEVIE ANN DABAO

A. JURISDICTION

1. At all times material to the charges hereinafter set out you were on the Register and were a member of the Saskatchewan Registered Nurses Association (SRNA);

2. At the time of the incidents contained in the charges, your license from the SRNA to practice registered nursing in Saskatchewan commenced August 19, 2016 and was in effect during the relevant times pertaining to these charges;

3. The Investigation Committee of the SRNA reviewed and investigated the complaints regarding your conduct and competence and, pursuant to paragraph 28(3)(a) of *The Registered Nurses Act, 1988*, hereby recommends that the Discipline Committee hear and determine a formal complaint regarding the charges set out below.

B. CHARGES

Charge Number 1 - Sepsis

4. 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

5. 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

6. 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.

C. RELEVANT LEGISLATION AND BYLAWS

7. The above alleged professional misconduct and professional incompetence are contrary to section 25 and subsections 26(1) and (2) of *The Registered Nurses Act, 1988:*

> ***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:*
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> *(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 of this Act.*
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> ***Professional misconduct***
> ***26****(1) For the purpose of this Act, professional misconduct is a question off act 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.*
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> *(2) Without restricting the generality of subsection (1), the discipline committee may find a nurse guilty of professional misconduct if the nurse has:*
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> *(e) wrongfully abandoned a client;*
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> *(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;*
>
> *(/) failed to comply with the code of ethics of the association;*
>
> *(q) contravened any provision of this Act or the bylaws.*

8. The above alleged professional misconduct and/or incompetence is contrary to the *Code of Ethics for Registered Nurses, 2017*. The following nursing values and ethical responsibilities are applicable in this case:

(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.

9. The above alleged professional misconduct and/or incompetence is contrary to the *Standards and Foundation Competencies for the Practice of Registered Nurses, 2013.* The following competencies are applicable in this case:

(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 III - Ethical Practice: 62, and 63;

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

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

D: PARTICULARS

10. The in Regina is part of the Saskatchewan Health Authority.

11. 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."

E: DAY, TIME AND PLACE OF HEARING

NOW THEREFORE TAKE NOTICE that the Discipline Committee will hear the charges and such evidence as may be tendered with respect to them starting at 9 o'clock in the forenoon on **the 17th day of February, 2021** at a location in Regina, Saskatchewan to be determined by the SRNA, and from day to day thereafter until the charges have been heard.

TAKE NOTICE THAT at the said time and place you have the right to be present with counsel and a support person.

TAKE NOTICE THAT, in default of you attending at the said time and place, the Discipline Committee may, on proof of service of this Notice on you and/or your legal counsel, proceed with the hearing of said charges, and the evidence with respect to them.

TAKE NOTICE THAT, if the Discipline Committee finds you guilty of professional misconduct, the Committee may order one or more of the following pursuant to section 31 of *The Registered Nurses Act, 1988*:

> *31(1) Where the discipline committee finds a nurse guilty of professional incompetence or professional misconduct, it may:*
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> *(a) order that the nurse be expelled from the association and that the nurse's name be struck from the register;*
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> *(b) order that the nurse be suspended from the association for a specified period;*
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> *(c) order that the nurse may continue to practise only under conditions specified in the order which may include, but are not restricted to, an order that the nurse:*
>
> *(i) not do specified types of work;*
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> *(ii) successfully complete specified classes or courses of instruction;*
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> *(iii) obtain treatment, counselling or both;*

(d) reprimand the nurse; or

(e) make any other order that to it seems just.

(2) In addition to any order made pursuant to subsection (1), the discipline committee may order:

(a) that the nurse pay to the association within a fixed period:

(i) a fine in a specified amount;

(ii) the costs of the inquiry and hearing into the nurse's conduct and related costs, including the expenses of the investigation committee and the discipline committee; or

(iii) both of the things mentioned in subclauses (i) and (ii); and

(b) where a nurse fails to make payment in accordance with an order pursuant to clause (a), that the nurse be suspended from the association.

(3) The discipline committee shall send a copy of an order made pursuant to subsection (1) or (2) to the nurse who is the subject of the report and to the person, if any, who made the report.

(4) Where a nurse is expelled or suspended from the association, the registrar shall strike the name of the nurse from the register or indicate the suspension on the register, as the case may be.

AND FURTHER TAKE NOTICE THAT, if you decide to enter a guilty plea, you and your legal counsel must contact legal counsel for the Investigation Committee of the SRNA at the earliest opportunity in order to implement the procedure to speak to penalty.

DATED at Regina, Saskatchewan, this 7th day of January 2021.

Cindy Smith, RN, MN, Executive Director
Saskatchewan Registered Nurses Association