INVESTIGATION COMMITTEE
of the
SASKATCHEWAN REGISTERED NURSES ASSOCIATION

-and-

Jessica J. V. McCulloch

DECISION

of the

DISCIPLINE COMMITTEE

of the

SASKATCHEWAN REGISTERED NURSES ASSOCIATION

Legal Counsel for the Investigation Committee:	Roger Lepage and Titli Datta
Legal Counsel for Jessica McCulloch:	Brandi Rintoul
Legal Counsel for the Discipline Committee:	Darcia Schirr, Q.C.
Chairperson for the Discipline Committee:	Chris Etcheverry

Date of Hearing:	September 21 through September 25, 2020 October 19 through October 23, 2020 February 8 through February 11, 2021
Submissions Heard:	April 14, 2021
Location:	In person at the Ramada Hotel, Regina, SK And by video conference
Date of Decision:	October 25, 2021

I. INTRODUCTION

1. The Discipline Committee of the Saskatchewan Registered Nurses Association (SRNA) convened to hear and determine complaints of professional misconduct and professional incompetence against Registered Nurse #0039641. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act,* 1988 (the Act).

2. The allegations against Ms. McCulloch were outlined in a Notice of Hearing of Complaint dated January 28, 2020, charging her with professional incompetence and/or professional misconduct contrary to sections 25(a) and (b) and 26(1), (2)(f), (i), (l), (n) and (q) of the Act. The Notice also alleged a breach of numerous provisions of the *Code of Ethics for Registered Nurses*, 2008 and the *Standards and Foundations Competencies for the Practice of Registered Nurses*, 2013. The provisions of the *Code* and *Standards* are set out at Appendix A to this decision.

3. The Notice of Hearing sets out the following charges:

Charge Number 1

> You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988*, regarding events that occurred on or about March 13, 2015. You completed a medication return form on which there were two entries for acetaminophen with Codeine 30 mg tablets (Tylenol #3). One entry listed five tabs while the other listed 49 tabs for a total of 54 tabs. The 54 tabs of Tylenol #3 were not received by the pharmacy. You could not provide an explanation as to the disappearance of the Tylenol #3. The missing narcotics were never recovered. You failed in your obligation to properly secure and return the narcotics as required by the standards of the SRNA.

Charge Number 2

> You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on October 4 and 5, 2015. You were the RN on shift when 40 acetaminophen with codeine 30 mg tabs belonging to a Churchill Unit patient went missing. On October 4, 2015 at 2210 hours, you documented on the Narcotic Administration Record "wasted rack fell, meds stepped on" and you proceeded to change the documented count from 40 to 0. You did not sign the Narcotic Administration Record nor did you have another RN co-sign that the narcotics had been wasted.

You failed to follow the proper procedure to account for drug wastage. You changed your explanation during the investigation. You failed to honestly account for the missing drugs. There was no evidence that the drugs had been wasted as you stated. You failed in your obligation to properly secure and account for the drugs under your control. You failed to properly account for the drugs and the missing medication card.

Charge Number 3

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on or about January 20, 2016. You received a card from an inmate stating, "Sorry I pissed you off this morning. I was only joking and didn't realize that you were stressed out. "My bad!" If you aren't getting anything good, just steal a few days worth of mine. (It should make you feel better!) I think you're an awesome nurse and don't want to add to any stressors." You failed to establish and maintain appropriate professional boundaries with patients, including the distinction between social interaction and therapeutic relationship. You shared private and personal details about yourself with inmates. Your conduct put you and your coworkers and patients at risk of harm.

Charge Number 4

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on or about January 21, 2016. An Autopak roll consisting of nine 150 mg tablets of Wellbutrin prescribed to a patient recently admitted were found in the front foyer of the Bow Unit. You were asked how this medication ended up in the front foyer and you stated, "I have no idea, but those are the medications I just put in the return bin this morning." Later that day, you told your nursing supervisor that "I realize what happened. They must have been stuck to my butt. You know the Velcro on the back of the CPR masks. It must have stuck to that on my belt and fallen off in the foyer when I went for my break." A witness viewed video footage that confirmed that you had been in the foyer where the medications were located, four minutes before the medication had been found. You failed to properly secure and account for drugs as required by the SRNA standards.

Charge Number 5

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on February 26, 2016. You falsely documented the administration and wastage of narcotics and then wrote the name of a correctional officer as a witness to the wastage. You failed to follow the appropriate standards in relation to the administration of narcotics as well as to account for narcotics and/or wastage. You falsely documented on the Narcotic Administration Record the name of a person who did not witness the alleged wastage of a narcotic. You administered double the dose that had been prescribed. Your actions have potentially contributed to the underground economy of the drug trade among the inmate population at RPG. This can increase the propensity for violence and unrest by creating and sustaining the black market currency in the institution.

Charge Number 6

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred between the dates of March 13, 2015 and April 4, 2016. You failed to recognize that you were unfit to practice nursing, to remove yourself from working as an RN and, contrary to the Code of Ethics, to advise your employer that you were unfit to practice nursing.

CHARGES WHILE EMPLOYED BY SASKATCHEWAN HEALTH AUTHORITY, SASKATCHEWAN HOSPITAL, NORTH BATTLEFORD

Charge Number 7

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred on April 29, 2016. You failed to advise your potential employer that you were suffering from a longstanding mental health diagnosis that may impact your fitness to practice as an RN.

Charge Number 8

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred between the dates of January 1, 2019 and April 25, 2019, as follows:

(a) You carried on your person and consumed personal medication in front of patients;

(b) You brought contraband items such as Q-tips® and newspapers for specific patients onto the corrections unit;

(c) You brought inappropriate movies rated 18A/R for patients without approval of the health care team and employer;

(d) You consumed patient canteen products contrary to the training provided by your employer;

(e) You completed a patient's puzzle in his absence knowing that it would be upsetting to the patient and stated that you were doing it just to "piss him off';

(f) You would make and leave sticky notes with confidential patient information in an area shared with non-medical staff who did not have the right to know about this confidential patient information; and

(g) You failed to maintain a proper therapeutic patient relationship with patients by making inappropriate jokes with patients regarding conducting cavity searches.

Your behavior put you, the patients and other staff at risk by compromising the safety of the unit.

Charge Number 9

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred between the dates of April 9 and 10, 2019. You failed to meet the SRNA Standards and Foundation Competencies and the Standards and Policies and Procedures of your employer, the Saskatchewan Health Authority as follows:

(a) You provided canteen privileges to patients who had lost their privileges;

(b) You provided a patient with his canteen privileges in a cup hidden by a rubber glove and allowed the patient to proceed to his room;

(c) You failed to be truthful with your work colleagues about providing the canteen privileges to two patients;

(d) You untruthfully charted the events surrounding the provision of canteen privileges to these two patients by altering the time stamp on the chart and falsifying the chart; and

(e) Your interaction with these two patients violated your obligation to maintain a therapeutic relationship with patients.

Charge Number 10

You, JESSICA J.V. McCULLOCH, are alleged to be guilty of professional misconduct and/or professional incompetence contrary to sections 25 and 26 of *The Registered Nurses Act, 1988* regarding events that occurred between the dates of January 1, 2019 to April 29, 2019. You failed to recognize that you were unfit to practice nursing, to remove yourself from working as an RN and, contrary to the Code of Ethics, to advise your employer that you were unfit to practice nursing.

4. The Notice contained detailed and lengthy particulars and those are set out at Appendix B to this decision.

II. RELEVANT LEGISLATION

5. The Notice relies on the following definitions of professional misconduct and professional incompetence in the Act:

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:

(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.

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:**
>
> **(f) misappropriated drugs;**
>
> **(i) falsified a record with respect to the observation, rehabilitation or treatment of a client;**
>
> **(I) failed to comply with the code of ethics of the association;**
>
> **(n) an addiction to the excessive or habitual use of intoxicating liquor, opiates, narcotics or other habit forming substances;**
>
> **(q) contravened any provision of this Act or the bylaws.**

III. HEARING

6. Ms. McCulloch contested all of the charges.

7. Over the course of three weeks, the Discipline Committee heard from a total of 42 witnesses. The Investigation Committee called 27 witnesses. Ms. McCulloch called 15 witnesses, including herself. For the first week, the hearing was conducted in person. For the weeks of October 19, 2020 and February 8, 2021, the hearing proceeded by video conference.

8. Both the Investigation Committee and Ms. McCulloch filed extensive documentary evidence. After the evidence was concluded, the hearing stood down until April 14, 2021 when the hearing reconvened to hear submissions. In advance of April 14, 2021, both the Investigation Committee and Ms. McCulloch filed lengthy briefs of law.

A. Background to the ten charges:

9. The Notice of Hearing sets out ten charges arising out of Ms. McCulloch's employment at two different workplaces – the Regional Psychiatric Centre (RPC) in Saskatoon and the Saskatchewan Hospital (Sask Hospital) in North Battleford.

10. These are the key undisputed facts regarding Ms. McCulloch's nursing background and

her employment record at RPC and Sask Hospital:

(a) Jessica McCulloch was born on [redacted]. She completed her nursing program in April 2009 and was granted a practicing membership with the SRNA on July 24, 2009. She was continuously registered with the SRNA after that date. (Exhibit P2)

(b) On September 28, 2009, Ms. McCulloch began her employment at RPC.

(c) On June 19, 2011, Ms. McCulloch was involved in a hostage taking at RPC. After this incident, Ms. McCulloch was on leave from June 20 until September 8, 2011. Upon her return to work, she was the subject of a number of return to work plans, periods of leave and accommodations. Those are documented in Exhibit P10.

(d) On April 4, 2016, Ms. McCulloch was placed on indefinite leave. She never returned to RPC. Ms. McCulloch's employment at RPC was terminated effective January 20, 2017. The termination letter was copied to the SRNA. An investigation by the SRNA Investigation Committee has resulted in charges 1 through 6 inclusive.

(e) On April 26, 2016, Ms. McCulloch began employment at the Sask Hospital. A new facility was constructed and it opened in November 2018. Ms. McCulloch was part of the staff component that moved from the old Sask Hospital to the new facility.

(f) On April 25, 2019, Ms. McCulloch was suspended by the Sask Hospital pending an investigation regarding allegations and events as set out in charge 9. The investigation concluded with a four-day unpaid suspension. (P3-Tab 2)

(g) Ms. McCulloch has not worked a shift at Sask Hospital since April 9, 2019. She has not practiced nursing since that date. [redacted], nursing unit manager at Sask Hospital, submitted a letter of complaint to the SRNA dated May 3, 2019. An investigation by the SRNA Investigation Committee has resulted in charges 7 through 10 inclusive.

(h) Ms. McCulloch has signed a Voluntary Non-Practice Agreement with the Investigation Committee. By the terms of that Agreement, Ms. McCulloch agreed to

voluntarily surrender her registered nursing license effective midnight on March 18, 2020.

Regional Psychiatric Centre:

11. The RPC in Saskatoon is the regional Corrections Canada treatment centre for the prairie region which consists of Alberta, Saskatchewan and Manitoba. It opened in 1978 and it currently houses 178 offenders with all three levels of security (minimum, medium and maximum). RPC is the only "stand alone" facility in that all other similar facilities are attached or connected to a prison. RPC is also an accredited teaching hospital. It is located on the grounds of the University of Saskatchewan.

12. There is an agreement with the Province of Saskatchewan which allows the Province to use up to 31 beds for those that are remanded in the provincial justice system and those individuals who are deemed not criminally responsible in the provincial justice system. Most of the RPC patients are individuals serving more than a two-year sentence. Many patients are serving indeterminate sentences. The population includes some high-profile offenders.

13. RPC is a forensic mental health facility. RPC has two mandates (1) to provide essential health services to patients and (2) to help the patients move through their correctional plan by way of programming. Overall, the RPC mandate is to evaluate, assess and treat. Patients may be at the facility for only a brief period of time in order to stabilize or on a long-term basis which can mean many years or even decades. There are many older patients who may be too fragile to be in a regular jail, patients who are in the acute stages of psychosis, others who are stable and some with substance abuse disorders. The population was described as "dynamic".

14. There is a large interdisciplinary team at RPC consisting of psychiatrists, nurses and social workers. At present, there are 58.5 nursing staff positions and these are registered nurses and registered psychiatric nurses.

15. Because it is a correctional facility, there is a large staff component of correctional officers.

16. It is a highly secure facility. At the main entrance, staff and the public must enter through a metal detector. All staff carry a personal alarm which is a panic button with a GPS. All common

areas are on close circuit TV 24 hours a day, 365 days a year. The doors are controlled and monitored by correctional officers.

17. The patients are housed in 5 units and these are called Assiniboia, Churchill, MacKenzie, Clearwater and Bow. Female patients are in the Assiniboia Unit. The Assiniboia Unit is not material to the charges.

18. The Bow Unit is the largest one as it can house 100 male offenders. It is also the busiest unit as it is the source of many security incidents. Witnesses for both Ms. McCulloch and the Investigation Committee described this unit by various terms including tough and hectic with demanding and difficult offenders.

19. A nurse starting employment at RPC has orientation of 12 "buddy" shifts. The first six shifts would be on the "buddy" nurse's home unit and for the next six shifts, the new nurse would have orientation through the other units.

20. All nurses work 12 hour shifts and those shifts are described by letters and time period: A-0645 to 1945; B – 0915 to 2250; C – 1900 to 0700.

21. The smaller units would have one A nurse and one B nurse. The larger units such as Bow would have two A nurses and two B nurses during the day and at night, one nurse only. Nursing staff is available at all times in the facility and all of the nurses carry radios.

22. Both nursing and correctional staff must undergo a one-week orientation. Part of that orientation includes a presentation called "Anatomy of a Set Up and the Importance of Dynamic Security". This orientation impresses upon staff that these patients can be manipulative as they watch staff closely and test limits and boundaries. It is important for staff to maintain therapeutic relationships with the patients at all times.

23. Given the nature of the patients, there is a considerable amount of narcotics and controlled drugs dispensed. Medication is administered from each unit, as each unit has a "control post" or "bubble" which consists of a room with plexiglass all around. The bubble is monitored and the doors are controlled. Patients line up for their medication. A correctional officer remains in this bubble when the nurse dispenses the medication.

24. RPC does not have a pharmacy on site. There is a Corrections Canada regional pharmacy in Saskatoon which serves the prairie region including RPC.

25. At RPC, medication is packaged in a "bubble card" and the bottom portion of the card contains the patient information. Occasionally, patients are transferred to RPC from other facilities and these transferring patients arrive with their medication. Other facilities package medication differently than RPC. A transferring patient's medication would be re-packaged using the RPC bubble card system.

26. Occasionally and for a variety of reasons, medication may be returned by RPC to the regional pharmacy. Each unit has a medication room which is supposed to be locked and accessible by a key. All nurses have access to the medication key and to use the words of one of the nurses who testified , "the key is passed around" between the nurses. Within the medication room, there is a vault or a safe which should also be locked and secure. The vault or safe (the term was used interchangeably through the hearing) is accessible by a password or a dial depending on the unit. The medication rooms have a return tote (which was also described as a bin). The staff put medication in the return tote when medications are be returned to the regional pharmacy. The procedure is that the tote is locked by the night shift nurse who is responsible to take the tote out to the gate house for pick up. The night nurse does this on Sunday and Wednesday at midnights. The regional pharmacy retrieves the locked return tote from the gate house on Monday and Thursday. While it appears the return totes are supposed to be locked, the evidence shows that more often than not, the return totes were only locked when they were full.

Saskatchewan Hospital:

27. In November 2018, the Saskatchewan government opened a new Sask Hospital, replacing an old facility North Battleford that had been built in the early 1900's.

28. The old facility contained 156 beds. The new Sask Hospital has a total of 293 beds which includes an integrated corrections unit.

29. Correctional officers were not employed at the old facility and correctional officers were only introduced in the new Sask Hospital. The new Sask Hospital contains an integrated correctional unit which houses individuals from the provincial correctional system meaning these

are patients who have been sentenced to two years less a day or they are on remand and sent for a psychiatric assessment. The old facility contained a forensic unit which was staffed by health professionals. The integrated corrections unit at the new Sask Hospital is staffed by health professionals and correctional officers.

30. Ms. McCulloch began working at the old facility in May 2016. Ms. McCulloch was part of the staff from the old facility that moved to the new Sask Hospital in October 2018. In December 2018, the new Sask Hospital began admitting patients to one particular unit called East Prairie View A.

31. Charges 8 through 10 relate to East Prairie View A at Sask Hospital. At the material time, the unit housed male inmates only and there were a total of 11 male inmates at East Prairie View A.

32. Nurses at the new Sask Hospital receive 11 days of an induction training program which is delivered by correctional staff. Part of that training includes a display of items that were made by inmates from seemingly innocent objects that could be made into a weapon. For example, Q-tips are not provided on the unit as they could be made into a weapon or used to plug a lock. Inmates do not have access to newspapers because the newspaper may describe court proceedings and identify witness names. As a general statement, anything that was brought in from the outside was characterized as contraband.

33. All staff who are employed at the new Sask Hospital also received training called "Anatomy of a Set Up". This is described at Exhibit P3-Tab 5. The purpose of the training is to provide participants with an understanding of how manipulation by offenders can occur, to give participants the ability to recognize situations where manipulation may occur and to provide staff with tools to minimize their risk of falling victim to a set up.

34. The new Sask Hospital has a canteen program for patients. Patients earn money from jobs at the facility and they are able to spend the money by purchasing items from the canteen. Those items would be things like soft drinks, potato chips and candy. Patients order canteen products and the canteen products were distributed by nursing staff in conjunction with the medication pass. Canteen was distributed on Wednesday, Friday and Sunday. A work standard dated April 25, 2019

was tendered into evidence (P3-Tab 6) which set out the operation of the canteen program.

35. Canteen was seen as a privilege which could be suspended. Suspension was a decision made by the charge nurse and the team and any suspension and the reasons for it would be documented in electronic charting. The electronic charting system is called the Mental Health Addictions Information System (MHAIS).

36. The transition from the old hospital to the new Sask Hospital was not without challenges. Many policies and procedures did not apply to the new Sask Hospital or the policies and procedures had to be redrafted. When East Prairie View A opened, staff were not provided with a handbook or a package of policies. Staff was encouraged to bring issues, suggestions and concerns to supervisors or managers either individually or at staff meetings.

B. Jessica McCulloch's Mental Health:

37. The Discipline Committee was presented with considerable evidence regarding Ms. McCulloch's mental health and that evidence was given through documentation and testimony from witnesses.

38. On June 19, 2011, Ms. McCulloch was one of three nurses involved in a hostage taking at RPC. Ms. McCulloch testified about that incident as did another nurse named . Jessica McCulloch, and another registered nurse were in the unit office of the Bow Unit, having just completed the medication pass. All three were in the unit office doing charting. The door slammed and an inmate had entered the office. The inmate was agitated and angry. He barricaded the door and was holding something that was later determined to be a toilet bowl cleaner brush that had been made into a shank. The office was small and was stocked with a number of tables and chairs.

39. The inmate ordered the three nurses to lay on the floor. While Ms. McCulloch was on the floor, the inmate came behind and straddled her, placed his arm around her neck, and held the shank to her neck. Nurse and the other nurse were able to run out of the office but Ms. McCulloch remained trapped with the inmate on top of her. testified that saw Ms. McCulloch trying to fight off the inmate. Eventually the correctional officers were able to gain

entry to the office and wrestled the inmate off Ms. McCulloch. The incident took about 3 minutes but for Ms. McCulloch and , it seemed much longer than that.

40. Exhibit D4 contains written statements given by Ms. McCulloch and two of the correctional officers involved. Based on those statements and the testimony given, the Discipline Committee fully accepts that this was a traumatic incident for all concerned and particularly for Jessica McCulloch. The day after the incident, the story was in the media and that is when Ms. McCulloch knew what the inmate was holding against her neck. Ms. McCulloch suffered some physical injuries as her neck had been cut and her finger injured. Ms. McCulloch applied for Workers' Compensation benefits and she was on medical leave from June 20, 2011 to September 8, 2011 (P10).

41. After the hostage taking incident, Jessica McCulloch was the subject of three mental health assessments directed by Workers' Compensation Board:

(a) August 18, 2011 – , Registered Doctoral Psychologist – D5
(b) April 5, 2013 – , Registered Doctoral Psychologist – D4-Tab 23
(c) May 16 and May 25, 2017 – , Registered Doctoral Psychologist – D1-Tab11

42. In the 2011 report, made a DSM-IV diagnosis of , acute (in partial remission). In the 2013 report, concluded "Ms. Pittner meets all of the criteria for a diagnosis of ". In the May 2017 report, made three diagnoses:

43. The Discipline Committee heard testimony from who is a psychologist

practicing in Saskatoon. began treating Jessica McCulloch in 2013. explained that a diagnosis is based on an individual's history, clinical presentation and objective testing. stated that for Jessica McCulloch, her "umbrella" diagnosis is and the diagnoses of are secondary. has been a consistent diagnosis for Ms. McCulloch. called the 2011 hostage taking the "index event" or "core event of trauma" for Ms. McCulloch. In response to questions from the Discipline Committee, stated that an index or core event means a central event that is "causative" and at the root of symptoms.

44. At the request of the Investigation Committee, Ms. McCulloch agreed to attend in Edmonton to undergo an examination by who is a clinical psychologist and neuropsychologist. Over the course of two days in August 2020, administered a variety of tests and conducted a detailed interview. In advance of the examination, was also provided with Ms. McCulloch's chart – although for reasons that were not clear or stated, did not receive report of August 2011. August 2011 was the first report made by a psychologist diagnosing .

45. report was tendered into evidence and also testified. made a number of conclusions with the primary one being Ms. McCulloch likely never met the full criteria for . concluded the more appropriate diagnosis under the DSM would be "".

46. Both and testified that trauma is cumulative and symptoms can ebb and flow. admitted that the DSM diagnosis of "" is a new diagnosis under the DSM. also testified that the criteria for has changed since Ms. McCulloch's initial diagnosis.

47. While not directly critical of stated that a mental health professional cannot project back to understand what was going on nine years earlier. Put another way, it is one thing to review records but another to make direct observations at the material time. opinion makes sense to the Discipline Committee. The Discipline Committee accepts the evidence set out in the reports of and from 2011, 2013 and 2017. In each of those reports, the diagnosis of is made. is a mental health disorder and a disability.

48. In *The Law of Professional Regulation* by Bryan Salte, a concise summary is given about disciplining members with a disability. At page 441:

> **11.4 Disciplining Members with a Disability**
>
> **There are several ways that the obligation not to discriminate and the obligation to provide accommodation can have an impact on how a regulatory body will deal with possible professional misconduct by a member.**
>
> 1. **They can have an impact on the penalty that will be imposed for proved unprofessional conduct (*Wright*, *Fossum, Law Society of Upper Canada v Kelly*)**
> 2. **They may have an impact on the wording of charges and the agreements reached with individuals whose ability to practice a profession is affected by a disability (*Fossum, Duvall*)**
> 3. **They may have an impact on whether the matter is dealt with through formal discipline or by some other method.**
> 4. **In an extreme situation, a member's disability that resulted in an inability to meet the expectations of the profession may result in a conclusion that the member's conduct was not unprofessional (*Vader*).**

49. In argument, Ms. McCulloch's legal counsel suggested that Ms. McCulloch's mental health was a complete defence and an explanation for the conduct in charges 5, 6 and 10. Counsel referred to one case and that is *The Law Society of Upper Canada v Vader*, 2013 ONLSHP 8. In that case, paralegal Vader faced a number of charges for failure to respond to the Law Society and failure to cooperate with a Law Society investigation. Based on the evidence presented, the hearing panel determined that Vader had established a nexus between her mental illness and her failure to comply with her obligations to the Law Society. The hearing panel referred to other cases which stated that the threshold for a licensee to rely on a defence of mental health is very high:

> **[28] In 2008, in *Law Society of Upper Canada v Thomas John Simpson*, 2008 ONLSHP 62, in the context of a lawyer experiencing episodes of amnesia and black-out, resulting in a lack of recollection of what had occurred, the panel decided at paragraph 16 that:**
>
> > **The sole issue to determine in these proceedings is whether Mr.**

> **Simpson's health issues are a complete defence to the allegations against him. We find that they are. We are cognizant that it is *a rare case* in which stress, anxiety, and mental illness will furnish a complete defence to allegations of processional misconduct. However, this is a most unusual case in which detailed expert evidence proved that Mr. Simpson's mental abilities were seriously compromised due to medical illness, surgical complications, substantial side-effects from prescribed medications, and psychiatric illness. This is a judgment that turns entirely on its facts. We are satisfied that Mr. Simpson has satisfied the legal standard set out in [the Cox decision].**

50. In direct evidence, [redacted] was asked whether Ms. McCulloch's [redacted] may have contributed to the ten charges she was facing before the Discipline Committee. In response, [redacted] asked himself a rhetorical question - whether it was probable that her [redacted] diagnosis affected her general performance as a nurse and to that question, he said yes. However, that is not the issue as the issue or question for the Discipline Committee is whether there is a causal connection between the disability and the acts and omissions that are the subject of the charges.

51. The Discipline Committee concludes that Ms. McCulloch has not established a nexus or connection between her acts and omissions and her mental health disability. Charges 1 through 5 inclusive allege acts and/or omissions for specific dates in March and October 2015 and January and February 2016 – four years and more after the June 2011 hostage taking. As [redacted] stated, one would have expected Ms. McCulloch's trauma related symptoms to be at the worst within three or four years after the hostage taking. Based on the evidence presented, there was no evidence that there were reports of cognitive issues or concerns affecting Ms. McCulloch's nursing performance within the three or four year period after the hostage taking.

52. This is not to say that Ms. McCulloch's mental health struggles are not material or relevant. However and based on all of the evidence presented, the Discipline Committee cannot conclude that her mental health affords her a complete defence and explanation to the charges suggested by her legal counsel or to any of the charges. At the material time and at present, Ms. McCulloch's mental health may undoubtedly be a factor for the Discipline Committee to consider when addressing sanction.

C. Nature of the Charges:

53. In Canada, there are three types of offences: (1) *mens rea* offences (2) strict liability offences and (3) absolute liability offences. The difference between the three lies in the element of fault that must be proven.

54. In law, there is a presumption that regulatory offences are strict liability offences. In the text *The Law of Professional Regulation* at page 137:

> **Strict liability offences are offences in which, once the conduct in the charges is proved to have occurred, the onus shifts to the person charged to prove that he or she exercised due diligence to prevent the conduct from occurring.**

55. In Saskatchewan, the courts have addressed the nature of charges in professional discipline hearings in three cases. Those cases are *Merchant v The Law Society of Saskatchewan*, 2009 SKCA 33; *Merchant v The Law Society of Saskatchewan*, 2014 SKCA 56 and *Phillips v The Law Society of Saskatchewan*, 2021 SKCA 16. At paragraph 59 of the *Phillips* decision:

> **.. The touchstone of such analysis is whether there is inserted into the charge *any words* that would indicate the conduct unbecoming hinged on a finding of intention. In *Merchant 2014*, this Court clarified that "the absence of such words [denoting intention] is not determinative if the nature of the charge and the circumstances as a whole nevertheless lead to the conclusion *mens rea* is required" (at para 70).**

56. The Investigation Committee argues that all ten charges are strict liability offences although it concedes that elements of charges 2, 5 and 9 require a finding of moral culpability and intention. Ms. McCulloch submits that charges 1, 2, 4, 6, are *mens rea* offences.

57. Considering the "nature of the charge(s) and the circumstances as a whole" of each charge and the evidence heard, the Discipline Committee concludes that charges 2, 5 and 9 are *mens rea* offences. All others are strict liability.

IV. CHARGES

Charge 1:

58. On March 13, 2015, Ms. McCulloch was working the day shift on Bow Unit along with registered nurse [redacted]. One of their tasks that day was to package up and return a number of narcotics to the regional pharmacy. Ms. McCulloch completed a form called "Narcotic, Controlled Drugs, Benzodiazepines, Other Targeted Substances and Methadone Return Form". (Exhibit P5-Tab 3). Ms. McCulloch signed her name next to a line that stated "name of nurse preparing narcotics for transfer". [redacted] witnessed her signature. Preparing drugs for transfer to the regional pharmacy is a two person exercise as both nurses are counting the narcotics, one person completes the form and both sign the form. The narcotics to be returned are placed in canvass bags and the canvass bags are then placed in a return tote. The tote is left in the medication room. It was the night nurse's duty to take the return tote to the gate house. The completed form is faxed to the pharmacy and a copy is also included with the narcotics in the return tote.

59. 54 tablets of Tylenol #3 were not received by the pharmacy nor were they ever recovered or found.

60. Ms. McCulloch testified that she did not work the following day being March 14, 2015. The next time she did return to work, her supervisor [redacted] told her about the missing narcotics and asked her to check the narcotic bags in the vault in the medication room. She did that, found nothing and reported this to [redacted].

61. Ms. McCulloch testified that she did not know what became of the narcotics after she and [redacted] had completed the form and prepared them for transport. Similarly, [redacted] testified that he had no explanation as to how these 54 tablets did not end up at the pharmacy other than to say "at some point, the tablets got taken out but I did not take them out".

62. [redacted] was the acting manager of Mental Health Nursing. She testified that there was no formal investigation as to how or why the Tylenol #3 tablets did not arrive at the pharmacy. RPC also did not file a loss report with Health Canada or report the matter to the police.

63. is a labour relations advisor with Correctional Services Canada. Her responsibilities included managing disciplinary files. Regarding the facts of charge 1, testified fairly that management determined it could not prove on a balance of probabilities that Ms. McCulloch was responsible for the disappearance of the narcotics. She stated "there was no way to verify who it was and there was really no way that they could determine what happened to the medication". As there was no investigation involving anyone, no disciplinary action was taken.

64. The charge states:

> **You could not provide an explanation as to the disappearance of the Tylenol #3. The missing narcotics were never recovered. You failed in your obligation to properly secure and return the narcotics as required by the standards of the SRNA.**

65. There were two nurses involved on March 13, 2015. Neither Ms. McCulloch or could provide an explanation as to what had happened between their handling of the narcotics and the receipt of the return tote by the regional pharmacy. March 13, 2015 was a Friday. Returned narcotics are taken by the night nurse to the gate house at midnight on Sunday. On Monday the regional pharmacy would retrieve the medication. Between Friday and Sunday midnight, many nurses were in and out of the medication room. While the return totes were in the medication room, the totes were usually unlocked. All nurses had access to the key for the medication room. The Discipline Committee was not presented with any evidence as to who was in and out of the gate house and who may have had access to the totes. It is reasonable to assume that there were individuals in and out of the gate house from Sunday midnight until Monday when the pharmacy retrieved the medication.

66. In its brief dated March 5, 2021, the Investigation Committee states:

> **165. It is correct that if taken in isolation, there is no concrete proof that Jessica was indeed responsible for the Tylenol #3s going missing as per Charge #1. However, if the testimony of other witnesses is to be considered, and the Charge is to be analyzed and investigated in the context of and along the lines of the subsequent Charges against Jessica, a clear pattern of missing medicines, falsification of records, and destruction of evidence arises.**

67. In its reply brief, dated April 5, 2021, the Investigation Committee further argues:

> **47. If treated as an isolated incident, it is true that the incident referred to in Charge #1 may not give rise to a reasonable inference as to Jessica's responsibility for the missing narcotics. However, if Charges #1, #2, #4, and #5 are taken together, the DC now has the benefit of observing a pattern of behaviour upon which to weigh each of the occurrences noted in the aforesaid Charges, including Charge #1.**

68. The Investigation Committee appears to argue that the Discipline Committee can consider and apply evidence from other charges to make a finding that the facts alleged in charge 1 have been proven. In submissions, counsel for the Investigation Committee characterized the argument as the application of the principles of circumstantial evidence. Circumstantial evidence is also known as direct evidence.

69. In the *Canadian Encyclopedic Digest*, circumstantial evidence is described as follows:

> **[30].. circumstantial evidence is evidence that tends to prove a factual matter by proving other events or circumstances from which, either alone or in combination with other evidence, <u>the occurrence of the matter in issue</u> can be reasonably inferred. [emphasis added]**

70. "The occurrence of the matter in issue" is whether Ms. McCulloch failed to properly secure and return the narcotics. The principle of circumstantial evidence does not mean that evidence lead on other charges can be used to prove the charge at issue. The Discipline Committee has to assess the evidence lead on each particular charge separately and independently. No witness testified to seeing Ms. McCulloch remove narcotics out of the return tote. There was no evidence that Ms. McCulloch made admissions that she had removed the narcotics or as the charge states, that she had failed to properly secure them. Given all of the evidence presented, the Discipline Committee cannot conclude, on a balance of probabilities, that Ms. McCulloch failed to properly secure the narcotics.

71. Charge 1 is unsubstantiated and the Discipline Committee finds Ms. McCulloch not guilty.

Charge 2:

72. On October 4, 2015, Ms. McCulloch was working the B shift on the Churchill Unit. She and her colleague [redacted] were in the medication room conducting the narcotic count. The protocol or routine is that one nurse counts the medication, the other nurse documents the count and then both nurses are to co-sign the Narcotic Administration Record.

73. [redacted] testified as one of Ms. McCulloch's witnesses. She testified that this routine occurred on the morning of October 4, 2015 and [redacted] documented 40 T3's on hand.

74. Ms. McCulloch testified that [redacted] left before the count was completed. During her absence, Ms. McCulloch claimed that she knocked down a medication card containing T3's, it fell to the floor and she stepped on the card. She got on her hands and knees to "scoop up" the crushed pills, putting the contents in the sink. She documented what had happened by writing the word "waste" on the Narcotic Administration Record and she drew a line through the number 40 and over top of that, she wrote a zero. She maintained she tried to reach [redacted] but she could not reach her. She admitted she did not sign the Narcotic Administration Record nor was this alleged wastage witnessed by anyone.

75. In an interview with [redacted] a few days later, Ms. McCulloch stated that she put the wastage in the sharps container when she earlier explained that she had put the contents in the sink.

76. In cross examination, Ms. McCulloch admitted that she knew the policies and procedures for drug wastage and drug wastage documentation. She admitted that she did not follow those policies and procedures. In an interview with [redacted] and another supervisor named [redacted] within a day or two after the incident, Ms. McCulloch admitted that she made "a lot of errors in judgment" in dealing with the medication (P5-Tab 5).

77. Failure to follow appropriate procedure regarding wastage of narcotics and the documentation of wastage is a serious matter. However, there is more to the charge than that as

the charge also states "You failed to honestly account for the missing drugs. There was no evidence that the drugs had been wasted as you stated." Ms. McCulloch's version of events is suspect on a number of fronts. When Ms. McCulloch met with [redacted] a few days after the incident, she gave inconsistent explanations for what had occurred and what she had done. [redacted] testified that narcotics would be in the vault and not hanging on a rack as Ms. McCulloch claimed. Further, Ms. McCulloch testified that she stepped on the medication card once and that crushed the bubble card with the result that a number of the narcotics fell out. Many witnesses including the RPC pharmacist [redacted] testified that this was quite unlikely. Ms. McCulloch's explanation and version of events simply does not ring true. Further and even if the Discipline Committee accepts Ms. McCulloch's testimony that she was unable to reach [redacted], there were other nurses available on other units to attend and witness the wastage and ensure proper documentation was completed.

78. The Discipline Committee finds that this charge has been substantiated and that the proven facts amount to professional misconduct and professional incompetence. Ms. McCulloch is found guilty.

Charge 3:

79. On January 20, 2016, Jessica McCulloch and another nurse were administering medications to the patients on the Bow Unit. Ms. McCulloch testified that many of the patients were rude, "rowdy" and demanding. The other nurse became overwhelmed and began to cry. Ms. McCulloch told the patients to settle down. Ms. McCulloch testified that in the course of the medication pass, one of the patients handed her an envelope, that she did not open it and that she forgot about it.

80. Based on a document entitled "Statement Observation Report" dated June 22, 2016 (P5-Tab 15), an envelope was found on January 22, 2016 on a counter in an office on the Bow Unit. The envelope was addressed to "Jessica" and it contained a greeting card. The front of the card had a photograph of a monkey sitting on a dog with the words "Get Well Soon". The inside of the card had the printed statement "Meanwhile, enjoy the things you see on medication" followed by

handwriting. As there was no other Jessica working, RPC concluded the card was intended for Jessica McCulloch. [redacted], the labour relations advisor, testified that the card was added to Ms. McCulloch's file for consideration "and it became part of her history". When the greeting card was found, no one with RPC management discussed the card, its contents or how it ended up on the table with Ms. McCulloch.

81. The charge sets out verbatim the contents of the card and then makes the statement: "You failed to establish and maintain appropriate professional boundaries with patients, including the distinction between social interaction and therapeutic relationship.". An unsolicited greeting card which Ms. McCulloch never opened is not evidence of the failure to establish and maintain appropriate professional boundaries.

82. The charge also states: "You shared private and personal details about yourself with inmates." There is nothing in the greeting card or in its contents that makes out that statement. If the statement is intended to extend beyond the greeting card, the Discipline Committee was presented with no evidence by any witness that Ms. McCulloch shared private and personal details about herself with inmates or patients. While [redacted] characterized the card as "concerning on many levels", she also agreed in cross examination that patients frequently gave cards and drawings to staff including nursing staff. [redacted] admitted that RPC took no action because of the greeting card specifically or more generally because of any concern with boundaries.

83. The Discipline Committee finds Ms. McCulloch not guilty of charge 3.

Charge 4:

84. On Thursday, January 21, 2016, an RPC employee named [redacted] found a packet of prescription medication called Wellbutrin on the foyer floor. She left this packet (which witnesses called an autopak) with an administrative assistant who was working in a psychiatrist's office just off the foyer. From there, the packet was given to nurse supervisor [redacted] who went to the medication room on Bow Unit. Ms. McCulloch and another nurse named [redacted] were in the medication room. Both Ms. McCulloch and [redacted] indicated they had no idea how this prescription medication may have ended up on the foyer floor. Ms. McCulloch

testified that the three of them were "brain storming" about how this may have occurred. In her testimony, [redacted] admitted they were all "baffled" about this. In the course of this brainstorming, Ms. McCulloch offered an unusual explanation - that the autopak may have stuck to the Velcro on her duty belt and it may have fallen off in the foyer while she was leaving for her break.

85. Ms. McCulloch asked her nursing supervisor [redacted] whether an incident report was necessary. [redacted] responded that such a report was not necessary. The Discipline Committee finds this troubling as one would have expected an incident report would be prepared by someone documenting the discovery of this medication. The failure to complete an incident report is reflective of inadequate security systems for medications at RPC.

86. The medication belonged to a patient who had been transferred from another institution to RPC. RPC does not use an autopak system of packaging medication. There was no evidence presented as to when the autopak arrived at RPC. Further, there was no evidence presented about any formal tracking system of drugs and narcotics that came in with a transferring patient.

87. The essence of the charge is that Ms. McCulloch failed to secure and account for the drugs.

88. A number of witnesses testified that the medication room in the Bow Unit was often left unlocked. There is a return bin or tote in the medication room and this is for medications to be returned to the regional pharmacy. Medications would be returned for any number of reasons including the need for different packaging. At midnight on Sunday and at midnight on Wednesday, the night nurse secures the return tote and takes it to the front gate house. Until this is done, the return bin remains unlocked in the medication room.

89. In cross examination, nurse [redacted] testified that the autopak may have been taken out by another patient during the evening or night shift the day before. The comment illustrates the poor narcotic security systems in place at the material time.

90. Jessica McCulloch was not the only nurse working the day shift on January 21, 2016. Jessica McCulloch is no more or less accountable for the security of drugs on that day. The onus

of proof is on the Investigation Committee to establish the charge. The Discipline Committee concludes that this charge has not been established on a balance of probabilities. Ms. McCulloch is found not guilty of charge 4.

91. Although not necessary given the Discipline Committee's finding for this charge, the Discipline Committee will comment on the argument made by Ms. McCulloch's counsel that the video tape that apparently existed of the foyer on that day was intentionally destroyed. Counsel refers to the "law of spoliation".

92. Another term for spoliation is "lost evidence". The Investigation Committee is under a "first party" disclosure obligation to disclose and produce all documents and information in its possession whether or not such documents and information will be tendered into evidence and whether or not the evidence is either inculpatory or exculpatory. If a video tape existed of the front foyer, the Discipline Committee is satisfied that the Investigation Committee never had access to or possession of the video. The video tape was in the possession of RPC and the Investigation Committee could not control what RPC may have done with the video tape especially years after the fact. Spoilation does not apply.

Charge 5:

93. Ms. McCulloch had agreed to take an overtime shift on February 26, 2016. She testified she tried to cancel this shift as a friend had passed away and her funeral was on February 26. As the unit was short staffed, she agreed she would come in after the funeral. She was assigned to the Mackenzie Unit. She attended to the Mackenzie Unit and went to the medication bubble. There were two nurses on the unit but their shifts were ending. Ms. McCulloch testified that there was one patient in the unit who had "heavy needs" as he needed assistance with bathing and feeding and he was being weaned off Gabapentin.

94. [redacted] is a corrections officer and he was also working on the Mackenzie Unit that day. Ms. McCulloch testified about an alleged conversation she had with [redacted] shortly after starting her shift. According to Ms. McCulloch, [redacted] advised her about a situation where a patient was found on the top of a dryer so that he could enter the ceiling with plans to

escape or take a hostage. Ms. McCulloch testified that upon hearing this information, she felt anxious and she wanted to leave. She tried to reach another nurse to take her place but was unsuccessful. She stated "I felt I was stuck there. I couldn't leave so I proceeded the best I could."

95. testified for the Investigation Committee. In direct evidence, stated he did not recall saying anything to Ms. McCulloch about a patient who had apparent plans to escape or take a hostage. In cross examination, he was not asked any questions about this alleged conversation. The Discipline Committee does not accept Ms. McCulloch's testimony about the alleged discussion with .

96. Ms. McCulloch prepared to administer medications from the bubble as the patients lined up at the medication window. was also in the medication bubble and according to Ms. McCulloch, he was at the computer terminal looking at pictures of snowmobiles. Ms. McCulloch could see that one patient appeared to be getting frustrated and she recognized this as the patient who had "heavy needs". She was watching this patient and at the same time, another patient R.W. came to the window. Narcotics had to be administered to R.W. in apple sauce. According to Ms. McCulloch, R.W. reached in to get the narcotic cup and when he did so, he spilled the apple sauce contents at the window counter. The contents contained Dilaudid. Ms. McCulloch described taking a paper towel and "swooshing up" the contents in a paper towel and discarding the paper towel in the secure shredding bin.

97. testified he never saw any spillage of R.W.'s Dilaudid. He further testified Ms. McCulloch never advised him about the incident. Further and even if he did witness the wastage, , as a correctional officer, was not entitled to sign the Narcotic Administration Record as a witness to the wastage.

98. The events underlying charge 5 were the subject of an internal investigation at RPC. Registered nurse worked the day shift on Mackenzie Unit on February 27, 2016. was interviewed on March 17, 2016 as part of the internal investigation and the report entitled "Disciplinary Investigation Report" was tendered into evidence (P5-Tab 26). In his testimony before the Discipline Committee, adopted and confirmed the accuracy of the information he gave to the internal investigation panel. At P5-Tab 26, pages 15 and 16:

RN identified that the 17:30 entry on the Narcotic Administration Record where patient ** received four, 1 mg Dilaudid pills at 17:30, not two 1 mg pills which was double the dose. The running total went from 139 to 135 which reflected the four 1 mg pills dispensed to patient **** which were recorded as "PT dropped cup." The "Dose" section has the number 2 scribbled out and the number 4 printed.**

RN reported patient ** was required to receive two 3 mg extended release Dilaudid capsules at 17:30. The running total went from 62 to 60 which reflected two 3mg capsules were dispensed to patient **** at 17:30 and recorded as "PT dropped cup." RN explained the 3 mg extended release Dilaudid capsules are not dissolved in apple sauce. The capsule is placed in a plastic cup and the patient is observed swallowing the medication.**

RN then identified the next Narcotic Administration Record entry at 17:30 for patient **. In the "Dose" section, there is an entry of 6mg/4mg and Nurse Signature initials " ". The running total of 1 mg went from 135 to 131 which reflected four 1 mg pills dispensed. The running total of 3 mg capsules went from 60 to 58 which reflected two capsules were dispensed. The 21:30 shift count was correct.**

RN explained that the procedure to follow when a narcotic is wasted by a patient or Registered Nurse is that the Registered Nurse contacts the Nurse Supervisor. If a Nurse Supervisor is not available or at the institution, a second Registered Nurse is contacted to attend the area, witness the narcotic waste and sign the Narcotic Administration Record. At no time would a correctional Officer sign as the witness on the Narcotic Administration Record.

…

RN reviewed the Medication Administration Record for patient ** RN explained patient **** medication order had been changed on February 24, 2016 and the Medication Administration Record reflected this date going forward to February 29, 2016. The February 24, 2016 Doctor Order was Hydropmorpime [sic] ER 6mg po bid x 2/52. Hydromorphine 1-2 mg qid pm x 2/52. There were two entries of Hydromorphine; 1-2 mg PRN and ER 6mg (0800, 1730). The PRN is an as needed prescription where the one or two 1 mg pills are dissolved in apple sauce prior to the patient receiving it. The ER 6mg is an extended release capsule, each capsule is 3 mg and is not dissolved in apple sauce.**

99. In her testimony, Ms. McCulloch admitted that she wrote name on the

Narcotic Administration Record but she did not intend this to be his signature to witnessing wastage. Her purpose in entering [redacted] name on the Narcotic Administration Record was not clear. In cross examination, Ms. McCulloch admitted that she did not reference this incident at shift report, she did not prepare an incident report and she did not advise anyone about the alleged wastage of the Dilaudid. To the extent she had an explanation for her actions, she stated she was "not in a good frame of mind" as she was left alone doing the work of two nurses and she was upset and anxious. She claimed that she called other units to find a witness to the wastage but she could not reach anyone. The Discipline Committee does not accept her explanation that she tried to contact another registered nurse given the evidence about the nurse coverage in the facility.

100. Charge 5 contains four key elements:

a. Ms. McCulloch falsely documented the administration and wastage of narcotics and then wrote the name of a correctional officer as a witness to the wastage;
b. Ms. McCulloch failed to follow the appropriate standards in relation to the administration of narcotics as well as to account for narcotics and/or wastage;
c. Ms. McCulloch falsely documented on the Narcotic Administration Record the name of a person who did not witness the alleged wastage of a narcotic;
d. Ms. McCulloch administered double the dose that was prescribed.

101. Each of those elements have been proven by the Investigation Committee and in fact, Ms. McCulloch essentially admitted to each and every one of those allegations. The Discipline Committee has no hesitation in finding that those elements of charge 5 have been proven and Ms. McCulloch is found guilty.

102. Charge 5 also contains these comments:

> **Your actions have potentially contributed to the underground economy of the drug trade among the inmate population at RPC. This can increase the propensity for violence and unrest by creating and sustain the black market currency in the institution.**

103. Those matters should not be the subject of a charge as they amount to argument and speculation. In any event, no evidence was led to substantiate those statements.

104. There is one further point to be made regarding this charge. In the course of her direct evidence, [redacted] testified that she looked at video footage of the medication window on that date. Counsel for the Investigation Committee advised the Discipline Committee that this was the first he had heard about a video tape. Investigation Committee counsel advised he would take steps to obtain the video and share it with Ms. McCulloch's counsel. However, the Investigation Committee advised that it would close its case without tendering the video tape and made that determination without seeing the video tape.

105. The Investigation Committee argued that an adverse inference should be drawn against Ms. McCulloch because she did not tender the video tape as part of her case. In its brief, the Investigation Committee argued "… they [Ms. McCulloch and her counsel] have effectively barred the IC from presenting the Video as evidence."

106. The Investigation Committee chose not to bring an application to the Discipline Committee to reopen its case to tender the video tape. The disposition of such an application would be up to the Discipline Committee – not Ms. McCulloch or her counsel.

107. If the video tape was inculpatory, Ms. McCulloch is not expected to tender incriminating evidence against herself. The Discipline Committee draws no adverse inference against Ms. McCulloch regarding the video tape. In any event, the issue is moot given the Discipline Committee's finding based on the facts.

Charge 6:

108. This charge alleges that between March 13, 2015 and April 4, 2016, Ms. McCulloch failed to recognize that she was unfit to practice nursing, that she failed to remove herself from working as an RN and that she failed to advise her employer that she was unfit. The date of March 13, 2015 relates to the events of charge 1. April 4, 2016 was the date Ms. McCulloch was placed on an unpaid leave of absence.

109. RPC was well aware of Ms. McCulloch's mental health challenges after the June 2011

hostage taking incident. After the hostage taking incident and right through to the termination of her employment on January 20, 2017, Ms. McCulloch was on four periods of leave, three return to work plans and two accommodation periods (P10). There was no evidence that Ms. McCulloch did not cooperate with those return to work plans and accommodation periods. For the period March 21, 2016 until May 10, 2016, she was not working at RPC at all but instead, she was working at regional headquarters in Saskatoon doing administrative work and not practicing nursing.

110. In order to find that Ms. McCulloch failed to recognize she was unfit to practice nursing, the core question is whether the Discipline Committee was presented with evidence that, through the time period in the charge, Ms. McCulloch was in fact unfit to practice. Through the time period alleged in the charge, Ms. McCulloch was under the scrutiny of RPC by way of return to work plans and accommodations. Further and for much of the time period, she was not practicing nursing but instead was doing administrative work.

111. As indicated, the events underlying charge 4 and 5 were the subject of an internal investigation. Ms. McCulloch was interviewed along with numerous other witnesses. Had the internal investigators had any concerns about Ms. McCulloch's fitness to practice, it is expected that would have been documented in the report.

112. The Discipline Committee finds Ms. McCulloch not guilty of charge 6.

Charge 7:

113. The charge alleges that Ms. McCulloch is guilty of professional misconduct and/or professional incompetence "regarding events that occurred on April 29, 2016".

114. On April 29, 2016, Ms. McCulloch completed a document entitled "Representative Workforce – Self Identification Form". The document was tendered as part of P3 at Tab 30. It consists of statements and questions including the following:

4. Persons with a Disability: are those individuals whose prospects of

> **securing employment, receiving training, and advancing in suitable employment may be substantially reduced as a result of any physical or mental impairment to perform an activity to the manner or within the range considered normal for a human being. (Source: Office of Disability Issues).**
>
> **Do you consider yourself to be a person with a disability? ___ Yes**
>
> **Comment: ____**

115. In submissions, the Investigation Committee conceded that the only "event" that occurred on April 29, 2016 was Ms. McCulloch's completion of the form. It is argued that by not checking "yes" to the question, Ms. McCulloch failed to disclose to the Sask Hospital that she suffered from a mental health problem that may impact her ability to practice safely as a registered nurse. It is further argued that in not answering the question, Ms. McCulloch is guilty of professional misconduct.

116. In cross examination, Ms. McCulloch testified that she completed this form truthfully. At that time, she did not consider herself as suffering from a mental health disability. She also characterized the form as voluntary. [redacted] also described the form as voluntary. Ms. McCulloch saw the purpose of the form as the collection of demographic information.

117. Ms. McCulloch testified that when she was interviewed for a position at the Sask Hospital, she met with [redacted]. She further testified that she told [redacted] "everything that had happened to her at RPC". She stated that she advised [redacted] that she was on leave RPC and that she had been diagnosed with [redacted] as a result of a hostage taking at RPC. When Ms. McCulloch began work at the Sask Hospital, the WCB claim that she had brought at RPC because of the hostage taking incident followed her there. While at Sask Hospital, she was on a return to work program. The manager of that program was [redacted]. [redacted] testified on behalf of the Investigation Committee. He described "weekly check ins" with Ms. McCulloch in which the two of them would complete a form. He was aware that the WCB injury was a mental health problem. [redacted] received reports from [redacted], Ms. McCulloch's treating psychologist.

118. Neither [redacted] nor [redacted] was asked by the Investigation Committee what the employer would have done if Ms. McCulloch had answered "yes" to question 4 on the self

identification form. Had such a question been asked, it is reasonable to conclude that the answer would have been that the employer would work with and accommodate Ms. McCulloch through her employment - which is what Sask Hospital did over the course of her employment there.

119. [redacted] was the nursing unit manager at the times material to the charges. She had no role in hiring Ms. McCulloch and she confirmed that [redacted] would have been the individual involved in the interview. [redacted] was not called as a witness by either the Investigation Committee or Ms. McCulloch. The Investigation Committee argues that the Discipline Committee should draw an adverse inference against Ms. McCulloch given that fact.

120. The Discipline Committee is not prepared to draw an adverse inference. The Investigation Committee has maintained that the "event" that occurred on April 29, 2016 was the completion of the form and not alleged misrepresentations Ms. McCulloch may have made in an interview.

121. Charge 7 is not sustained and Ms. McCulloch is found not guilty.

Charge 8:

122. Charge 8 alleges seven specific and separate allegations of professional misconduct and/or professional incompetence.

123. Standing alone, some of these allegations might, at face value, appear trivial. However, the charges have to be assessed in context. Sask Hospital is a psychiatric hospital which includes an integrated correctional unit with a forensic unit that houses individuals involved with the criminal justice system. There is a reason that nursing staff at Sask Hospital received unique training about contraband items which, viewed from the outside, may involve simple and innocuous items. Given the environment, there is also a reason that nursing and correction staff received training regarding manipulative behavior by patients at Sask Hospital.

124. There are other contextual factors to consider. Based on the evidence the Discipline Committee heard, there were growing pains with the opening of the new Sask Hospital. [redacted] conceded that there were challenges as nursing staff did not receive any kind of handbook

when the new unit was opened and all of the policies had to be reworked because of the incorporation of "the corrections piece". Nursing and corrections staff attended meetings where they were encouraged to identify issues and bring forward suggestions for improvement. In an email dated June 8, 2019, [redacted], manager of correctional operations, stated (D1 page 631):

> **We are about six months in since the opening of our unit. There has been and continues to be a learning process for all of us. And with learning processes, like everything else, there are growing pains…**

125. Exhibit D1 contains a number of emails sent from management to staff with reminders and guidelines about DVD ratings, the security of personal medication and staff eating patient's canteen products (see for example D1 pages 635, 636 and 667). The emails are reflective of the "growing pains" of operational matters at Sask Hospital.

126. The definition of professional misconduct in section 26 of *The Registered Nurses Act*, 1988 is a broad one and has previously been set out. In a brief dated March 24, 2021, Ms. McCulloch's counsel refers to a British Columbia Law Society case called *Re Lyons* 2008 LSBC 9. The case contains a number of helpful comments and principles regarding professional misconduct:

> **[32] A breach of the Rules does not, in itself, constitute professional misconduct. A breach of the Act or the Rules that constitutes a "Rules breach", rather than professional misconduct, is one where the conduct, while not resulting in any loss to a client or done with any dishonest intent, is not an insignificant breach of the Rules and arises from the respondent paying little attention to the administrative side of practice. (*Law Society of BC v Smith*, 2004 LSBC 29)**
>
> **[33] … Whether conduct deserves discipline is a factual question to be decided by the member's professional peers. "What may, in each particular circumstance, constitute professional misconduct ought not to be unduly restricted." *Stevens v. Law Society (Upper Canada)* (1979), 55.O.R. (2d) 405 (Div. Ct.) at 410.**
>
> **[34] It is no longer a requirement that the conduct proven be disgraceful in itself or dishonorable. The overall test for professional misconduct is set out in Martin (supra) at para. [171] where the Panel reviewed the law and concluded that the test for misconduct is "whether the facts, as made**

> **out, disclose a marked departure from the conduct the Law Society expects of its members; if so, it is professional misconduct."**
>
> **[35] In determining whether a particular set of facts constitutes professional misconduct or, alternatively, a breach of the *Act* or the Rules, panels must give weight to a number of factors, including the gravity of the misconduct, its duration, the number of breaches, the presence or absence of *mala fides*, and the harm caused by the respondent's conduct.**

127. The Investigation Committee has to prove, on a balance of probabilities that the factual allegations have been made out. The Investigation Committee then needs to satisfy the Discipline Committee that the proven facts amount to professional misconduct and/or professional incompetence.

128. Ms. McCulloch had seven years experience at RPC before taking her job at the Sask Hospital. She was an experienced nurse working in a unique and specialized environment given the nature of the patients. She would know the purpose of a broad prohibition against contraband whether such a prohibition was set out in writing or not. She admitted that she brought Q-tips on to the unit and that she used them to clean the medication cart and she made them available to patients. Her rationale appeared to be that the unit was short of supplies. If that was the case, it appeared management at the Sask Hospital welcomed ideas and suggestions for supplies. Ms. McCulloch simply could have made a suggestion instead of bringing in her own supplies and particularly, something that has security connotations. The Discipline Committee finds that charge 8(b) and its reference to contraband Q-tips has been substantiated. The charge also refers to contraband newspapers. There was no evidence that Ms. McCulloch brought newspapers to the units.

129. Regarding charge 8(e), the Discipline Committee heard testimony from [redacted], a registered nurse. She testified that patients were encouraged to work on puzzles and that many of them took pride in completing something like a puzzle independently. [redacted] recalled seeing Ms. McCulloch completing a puzzle that patient A.F. had been doing and [redacted] asked her why she was completing A.F.'s puzzle. According to [redacted], Jessica McCulloch responded "I am doing it just to piss him off." [redacted] stated that she was concerned enough about what she saw and what she heard Ms. McCulloch say that she brought it up in report at shift

change. Ms. McCulloch was not asked about this incident in her direct examination. The Discipline Committee accepts the evidence of .

130. Regarding the allegations set out in charges 8(a) through (c) inclusive and 8(f) and (g), the evidence was either lacking or insufficient to amount to findings of professional misconduct and/or professional incompetence. Even if there was evidence substantiating charges, 8(a) through (c), Ms. McCulloch's conduct is not "a marked departure". Considering the factors set out in *Re Lyons*, the allegations set out in charges 8(a), (c) and (d) do not rise to the level of professional misconduct.

131. The Discipline Committee finds that the facts set out in charges 8(b) (the reference to Q-tips only) and (e) have been proven and that those proven facts amount to professional misconduct. The other charges are dismissed.

Charge 9:

132. This charge relates to events that occurred on April 9 and April 10, 2019 involving patient A.F. and to a lesser extent, patient A.W. The charge is broken down into five components.

133. As already described in the decision, Sask Hospital had a structure for the ordering and delivery of canteen products to patients. Canteen products are items such as soft drinks, chips and candy. Canteen is seen as a privilege which can be earned by patients but such privileges can also be suspended or forfeited. If canteen privileges were suspended or forfeited, this fact would be documented in the electronic charting. Both the nursing and correctional staff were educated on how the canteen functioned.

134. On April 9, 2019, Jessica McCulloch was working the day shift on East Prairie View A. A.F. and A.W. were both patients on that unit. On April 7, there was a confrontation between A.F. and A.W. – with the result that the canteen privileges for both A.F. and A.W. were suspended. A registered psychiatric nurse named documented that fact in the progress notes for A.F. The progress note entry is at P3-Tab 20. In that entry, documented what had happened between these two patients. As a result of A.F.'s conduct, he was confined to his room

and placed on close observation at 15 minute intervals. Near the end of charting is the statement "canteen withheld". The entire chart entry is type written.

135. made a corresponding entry in the progress notes for patient A.W. His entry is shorter than that made for A.F. Nurse made the following entry at 2019-04-08 at 01:02 (P3-Tab 26):

> **Patient involved in altercation with co-pt (A.F.), confined to room for timeout due to same. Patient agreeable, returned to room with no concerns. As evening progressed patient displaying bizarre behavior, laughing to self and yelling "I did some rails". Patient reported he was "snorting" sugar packets. Patient redirected from same and confined to room for remainder of night. Canteen withheld due to same. Received PRN Haldol 5mg @ 2020, same effective. Patient currently sleeping …**

136. also worked the day shift on East Prairie View A on April 9. is a corrections worker. She testified that at shift report that morning, the staff was advised that both A.F. and A.W. had lost their canteen privileges. She testified she did not have the details about the incident but she just knew that the privileges were suspended for both of them. All nurses are expected to attend shift report. Her recollection was that Ms. McCulloch was at shift report.

137. testified that she overheard A.F. asking staff including Ms. McCulloch where his canteen was. She did not hear all of the conversation between A.F. and Ms. McCulloch but she overheard comments he made about making a container or using a puzzle bag or glove "so no one would know" that he had the canteen product. saw A.F. stretch out a glove and when she asked him what he was doing, he said "nothing". Ms. McCulloch intervened in that discussion, stating that she gave A.F. a blue glove as a joke, stating that A.F. probably wanted to do cavity searches for a fork that had gone missing on the unit.

138. is a corrections officer at Sask Hospital. She was also working the day shift on April 9 with Jessica McCulloch and . She testified that near the end of the shift, she and Jessica McCulloch were sitting at the nursing desk. She could see a patient causing trouble in the TV room so she directed a camera to this patient to watch him. As she was trying to watch the camera screen, she noticed that A.F. was hovering around the desk and she heard Ms. McCulloch say something like "put it in a glove .. nobody will see". testified that

she saw Ms. McCulloch hand a blue glove to A.F. and it appeared there was something in it. A.F. took the glove and walked down the hall to his room. She told [redacted] what she had seen. [redacted] walked down the hallway to A.F.'s room and she noticed Ms. McCulloch was coming up behind her. [redacted] asked A.F. what Ms. McCulloch had given him and he responded again "nothing".

139. At this time, [redacted] was the nurse manager of the Sask Hospital. She was working on April 9. She received a call from [redacted], the manager of the corrections workers. She and [redacted] went to East Prairie View A to speak with Jessica McCulloch after she had completed giving shift report at the end of her shift. She and [redacted] met with Ms. McCulloch privately, advising that they had information she gave canteen to both A.F. and A.W. when their privileges had been removed. In the meeting, Ms. McCulloch admitted she had given canteen to A.F. When asked why she had done that as his privileges had been suspended, she had no response. [redacted] testified that through the interview, Ms. McCulloch said "yup" to most questions.

140. [redacted] also testified. She is a corrections officer. She was aware that Ms. McCulloch was having a meeting with [redacted] and [redacted]. [redacted] was in the staff room when Ms. McCulloch entered the staff room and she allegedly said "they don't know fucking anything, I gave both of them their canteen. They are so fucking stupid".

141. On April 9, [redacted] was working the night shift. She is a corrections officer. She testified that when she came on shift, she could see there was a problem or a situation with A.F. She approached his room and she saw him pacing, crying and making threats of self-harm. [redacted] testified that she had a good rapport with A.F. and spoke with him for about 20 to 25 minutes after which he calmed down. When she spoke with A.F., it appeared that the source of his behavioral outbreak was the fact that he had to return his canteen items back when they had been given to him by Ms. McCulloch. A.F.'s mental condition was such that he was placed on close observation every 15 minutes and he was given a sedative.

142. On April 10, 2019, [redacted] worked another night shift (7:00 p.m. to 7:00 a.m.). Shortly after her shift began, she had a conversation with A.F. who stated to her that he hoped Ms. McCulloch did not get into trouble. She responded to A.F. that he should not be concerned by

that and this was a new day. However, A.F. did not let the matter go as he stated he understood Ms. McCulloch had sent an email taking full responsibility. [redacted] found A.F.'s comments odd. Later in her shift, she reviewed an entry made on A.F.'s chart. At P3-Tab15, Ms. McCulloch made the following entry:

> **Authored By: McCulloch, Jessica, R.N.**
>
> **Category: Inpatient**
>
> **Effective Date: 2019-04-09 18:00**
>
> **Late entry for April 09, 2019 at approximately 1920hrs.**
>
> **Writer asked to speak to MCO and FIN after shift change. MCO questioned writer on giving patient his canteen items which were in the back nursing office. Writer reported that writer did give patient his canteen. Writer accepting of MCO and FIN's comments as they voiced concerns over the same. Writer however unable to explain reasoning why as MCO educating writing on his concerns.**
>
> **Writer unable to report that writer noted two bags of canteen in the back office and assumed that it was brought to the unit as on numerous occasions patients have not received their canteen. Writer was asked by co patient A.W. for an item from his canteen which has been kept in the dispensary, when checked and same not there writer noted co patient A.W. and patients canteen was in the back office. Writer gave both patients their canteen items under assumption of it being missed in the previous nights canteen order. Writer made this assumption as the canteen items were not placed in the outgoing mail with direction return to the canteen.**
>
> **Writer accepts full responsibility re: same. Writer was under the assumption of being in charge, writer could made the decision to give patients their canteen. As there was no indication of patients having same taken away.**

143. Supervisory nursing staff had a number of concerns with this entry in the patient's chart. Registered nurse [redacted] saw the entry and concluded that if anything, such information should be in an incident report not in a patient's health chart. Further, the suspension of canteen privileges for A.F. and A.W. had clearly been documented in the charts of both of those patients and was the subject of comment at shift report. Ms. McCulloch's entry "there was no indication of patients having same taken away" was clearly false.

144. The Discipline Committee accepts the evidence presented by the Investigation Committee. The Discipline Committee does not accept Ms. McCulloch's testimony that she was unaware of the suspension of the privileges. If she was unaware, that was a product of her own negligence as the information was there to be seen. Ms. McCulloch's actions in providing a glove to A.F. and her conduct with him illustrates an intention to hide what was going on.

145. Charge 9(d) is as follows:

> **(d) You untruthfully charted the events surrounding the provision of canteen privileges to these two patients by altering the time stamp on the chart and falsifying the chart**

146. P3 Tab-25 are the electronic progress notes for A.W. Ms. McCulloch made the following entry:

2019-04-09 18:00	Complete	Inpatient	Late entry for April 09, 2019 at approximately 1920hrs. Patient requested for one of his "halls" none noted in the dispensary, however writer noted patient has a bag of canteen in the back nursing office. Patient walked away from desk as writer was to give him one of his "halls". Writer placed patients halls in the dispensary under the assumption of it being missed in the previous nights canteen order. Writer made the assumption as the canteen items were not placed in the outgoing…	2019-04-10-18:58	McCulloch, Jessica, R.N.	Nurse

147. The Discipline Committee was presented with no evidence regarding the time entries and more particularly, there was no evidence to substantiate the allegation that Ms. McCulloch had altered any time stamp. As a result, the Discipline Committee finds that charge 9(d) has not been substantiated.

148. The Discipline Committee finds that charge 9(a) through (c) and (e) have been proven and those proven charges amount to professional misconduct.

Charge 10:

149. This charge is similar to charge 6. Charge 10 alleges that Ms. McCulloch is guilty of professional misconduct and/or professional incompetence regarding "events that occurred between the dates of January 1, 2019 to April 29, 2019". Like charge 6, it goes on to state that Ms. McCulloch failed to recognize she was unfit to practise nursing, she failed to remove herself from working as a registered nurse and she failed to advise her employer that she was unfit to practise nursing.

150. The parameters for "fitness to practice" are set out in Part G of *The Code of Ethics for Registered Nurses*, 2008 under the heading "Being Accountable". The Notice of Hearing references G(4):

> **4.Nurses maintain their fitness to practice. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self -employed, arranging that someone else attend to their clients' health-care needs. Nurses then that the necessary steps to regain their fitness to practise.**

151. The date range in charge 10 is broadly the same as charge 8. There was no evidence or suggestion by the Investigation Committee that the allegations in charge 8 were the product of Ms. McCulloch's "unfitness".

152. In terms of the allegation that Ms. McCulloch failed to advise her employer that she was unfit to practise, this too is not substantiated by the evidence. Similar to her employment at RPC, throughout Ms. McCulloch's employment at Sask Hospital Ms. McCulloch was on return to work programs. She worked with , the return to work manager, and work plans were based on reports from her practitioners including . described Ms. McCulloch as genuine. There was no suggestion in the evidence that Ms. McCulloch did not cooperate with her employer or that she was dishonest.

153. The Discipline Committee finds that charge 10 is unsubstantiated.

V. CONCLUSION

154. In the end result, the Discipline Committee finds that charges 2, 5, 8(b) and (e) and 9(a) through (c) inclusive and 9(e) have been substantiated. All other charges are dismissed.

155. The Discipline Committee will reconvene to hear submissions regarding sanctions pursuant to section 31 of the Act. The hearing will be scheduled at a date convenient to legal counsel and the Discipline Committee.

Dated this 25th day of October, 2021.

Chris Etcheverry, RN Chairperson
On behalf of Members of the Discipline Committee:
Russ Marchuk, Public Representative
Stella Swertz, RN
Janna Balkwill, RN

Appendix A

***The Code of Ethics for Registered Nurses,* 2008**

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

4. Nurses question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care to those to whom they are providing care, and they support those who do the same. See Appendix D.
6. When resources are not available to provide ideal care, nurses collaborate with others to adjust priorities and minimize harm. Nurses keep persons receiving care, families and employers informed about potential and actual changes to delivery of care. They inform employers about potential threats to safety.
10. Nurses work to prevent and minimize all forms of violence by anticipating and assessing risk of violent situations and by collaborating with others to establish preventative measures. When violence cannot be anticipated or prevented, nurses take action to minimize risk to protect others and themselves.

D. Preserving Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

7. Nurses maintain appropriate professional boundaries and ensure their relationships are always for the benefit of the persons they serve. They recognize the potential vulnerability of persons and do not exploit their trust and dependency in a way that might compromise the therapeutic relationship. They do not abuse their relationship for personal or financial gain, and do not enter into personal relationships (romantic, sexual or other) with persons in their care.

F. Promoting Justice

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

Ethical responsibilities:

2. Nurses do not engage in any form of lying, punishment or torture or any form of unusual treatment or action that is inhumane or degrading. They refuse to be complicit in such behaviours. They intervene, and they report such behaviours.

G. Being Accountable

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

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the *Code of Ethics for Registered Nurses* and in keeping with the professional standards, laws and regulations supporting ethical practice.

2. Nurses are honest and practice with integrity in all of their professional interactions.
3. Nurses practice within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, seek help from 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.
4. Nurses maintain their fitness to practice. If they are aware that they do not have the necessary physical, mental or emotional capacity to practise safely and competently, they withdraw from the provision of care after consulting with their employer or, if they are self -employed, arranging that someone else attend to their clients' health-care needs. Nurses then that the necessary steps to regain their fitness to practise.

***The Standards and Foundation Competencies for the Practice of Registered Nurses,* 2013**

Standard 1 – Professional Responsibility 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.

Foundation Competencies
The registered nurse:

1. Is accountable and accepts responsibility for own actions and decisions.
2. Articulates and enacts the role and responsibilities of a registered nurse as a member of the health care team.
3. Recognizes the registered nurse scope of practice and individual competence limitations within the practice setting and seeks guidance as necessary.
7. Advocates for clear and consistent roles and responsibilities within the health care team.
8. Demonstrates effective collaborative problem solving strategies, including conflict resolution.
11. Promotes current evidence-informed best practices.
16. Identifies, reports, and takes action on actual and potential unsafe practices or situations that have risk to clients, health care team members and/or others.
17. Challenges and takes action on unclear or questionable orders, decisions, or actions, made by other health care team members.
18. 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 takes action to stop and minimize harm.
19. Utilizes a systems approach to patient safety, participates with others in the prevention of near misses, errors and adverse events

21. Exercises professional judgment when using agency policies and procedures, or when practicing in the absence of agency policies and procedures.

Standard II – Knowledge-Based Practice

This standard has two sections: Specialized Body of Knowledge and Competent Application of Knowledge.

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.

Foundation Competencies

The registered nurse:

26. Applies a knowledge base from nursing and other disciplines in the practice of registered nursing.
29. Applies knowledge from nursing and other disciplines concerning current and emerging health care issues.
31. Demonstrates knowledge of the role of primary health care in health delivery systems and its significance for population health.

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.

Foundation Competencies

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.
64. Establishes and maintains appropriate professional boundaries with clients and other health care team members, including the distinction between social interaction and therapeutic relationships.

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.

Foundation Competencies

The registered nurse:

72. Articulates the authority and scope of practice of the registered nurse.

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.

Foundation Competencies

The registered nurse:

84. Demonstrates knowledge of the registered nursing profession as self-regulating, autonomous, and mandated by provincial legislation.
85. Practises within the scope of registered nursing practice as defined in *The Registered Nurses Act*, 1988.

Appendix B - Particulars

The Regional Psychiatric Centre in Saskatoon is a multi-level security institution for male and female offenders established by Correctional Services Canada. Particulars of the alleged professional incompetence and/or misconduct while employed at the Regional Psychiatric Centre in Saskatoon are as follows:

(a) (Charge #1) A lot of medications are administered and RPC has written procedures and policies regarding medication returns being placed in locked totes which you failed to implement;

(b) (Charge #2) Regarding the incident of October 4 and 5, 2015, you received from your employer a written reprimand for medication mismanagement on February 10, 2016;

(c) (Charge #3) Regarding the card of January 20, 2016 received from an inmate, it was found on January 23, 2016 on the counter in the middle office on Bow Unit.The card was intended for you since there is no other nursing staff named Jessica;

(d) (Charge #3) Regarding the incident of January 20, 2016, you struggle with boundary issues with patients and you appear to be targeted and sought out by patients with borderline personality disorders. A patient on Bow Unit reported you were supplying and providing medications to patients on Bow Unit without an order from a physician or psychiatrist and without proper authorization;

(e) (Charge #4) The incident of January 21, 2016 resulted in employer disciplinary investigation. The roll of Wellbutrin (9 x 150 mg tabs) had been found in the front foyer and you had admitted being in possession of those drugs earlier that day;

(f) (Charge #5) On February 26, 2016, you made two entries to the Narcotic Administration Record for a patient on the McKenzie Unit. Both entries were on the same patient and for the same controlled substance. The entries were consecutive and for different doses of the controlled narcotic hydromorphone (Dilaudid). The patient was to receive 6 mg of Dilaudid Extended Release (ER) and 4 mg of Dilaudid Immediate Release (IR). The Narcotic Administration Record shows that you removed this initial dose of both ER and IR Dilaudid. On both entry lines of the Narcotic Administration Record, you falsely wrote "patient dropped med cup" and that the narcotics had been wasted by you

in the presence of a correctional officer. The patient denied having dropped or wasted any medication. You falsified the Narcotic Administration Record by stating that the medication had_ been wasted and you inappropriately documented that .the wastage had been co-signed by the correctional officer, D.R. You either removed the medication from the institution on your person or consumed the medication yourself. You did not advise the correctional officer that you had written his name as a co-signor on the Narcotic Administration Record. You minimized your actions and discounted the seriousness of the incident by saying, "I feel like I practically have to strip every time I leave the institution." As a result, you were placed on administrative leave;

(g) (Charges #4 and #5) Regarding the events of January 21, 2016 and February 26, 2016, your failure to follow standards regarding medication management and the boundary issues with the patient population contribute to the underground economy of the drug trade among the inmate population. This increases the propensity for violence and unrest by creating and sustaining the black market currency in the institution. Your failure to follow medication administration standards compromised the safety of yourself, patients and staff at the Regional Psychiatric Centre. The employer believed you were compromised in your continued presence at the Regional Psychiatric Centre. It placed you and others in a position of risk or harm since it is believed that you had provided medications to patients without proper authorization and may have abused narcotics by taking and mismanaging the narcotics and controlled substances throughout the institution. Your integrity, honesty and professionalism were compromised by your disregard for standards;

(h) (Charges #4 and #5) On July 14, 2016, a letter of complaint was received by the Investigation Committee of the SRNA from Correctional Service Canada advising that following investigation you had been found to have been negligent in the performance of your duties on January 21 , 2016 in relation to medication found in the front foyer of the Regional Psychiatric Centre, that you failed to follow policy and procedures regarding proper disposal of wasted medication on February 26, 2016 and that you have falsified information in regards to the performance of your duties on February 26, 2016. On February 3, 2017, the SRNA was advised by Correctional Service of Canada that you had been terminated effective January 31 , 2017 because the employer disciplinary investigation concluded that there were significant findings of misconduct;

(i) The employer determined that you could not be trusted to be

in the presence of inmates or have responsibility for the custody and care of inmates while managing their medications. The employer determined that you could not be trusted to adequately supervise, monitor or interact with the patient population.

The Saskatchewan Hospital in North Battleford ("SHNB") is an integrated correctional facility for inmates serving two years less a day. Inmates are referred to SHNB by psychiatrists who consider the inmate to be experiencing a treatable mental illness. Particulars of the alleged professional incompetence and/or misconduct while employed with the Saskatchewan Health Authority at SHNB are as follows:

(a) (Charge #7) On April 29, 2016, you completed an employment application form entitled "Representative Workforce - Self Identification Form”. Question 4 asked as follows: "Persons with a Disability: are those individuals whose prospects of securing employment, receiving training, and advancing in suitable employment may be substantially reduced as a result of any physical or mental impairment to perform an activity in the manner or within the range considered normal for a human being (Source: Office of Disability Issues). Do you consider yourself to be a person with a disability? _ Yes; Comment:_". You failed to disclose to the potential employer that you did suffer from a mental health issue that may impact upon your ability to practice safety as a registered nurse;

(b) (Charges #8 and #9) On October 4, 2018, as part of your orientation to the new hospital setting, you followed a course called "Anatomy of a Set Up" to understand the goals and reasons for manipulative behavior, the ability to accurately identify manipulative behaviors and situations and the ability to respond to manipulative behaviour using appropriate techniques;

(c) (Charges #9) On April 7, 2019, two patients had their canteen privileges revoked for fighting and the revocation of canteen privileges was recorded on their file. As charge nurse, you ignored the revocation of privileges and surreptitiously gave the canteen products to the two patients;

(d) (Charges #8, #9 and #10) You were the registered nurse in charge when the events took place between January 1, 2019 and April 25, 2019;

(e) (Charges #8, #9 and #10) On April 25, 2019, as a result of an employer investigation, you were advised that the employer concluded that the complaints made against you were true and your conduct and actions were unprofessional and inappropriate.

Your conduct breached the trust that an employer must have in an RN. You were issued a four-day unpaid suspension. Because you had been suspended pending investigation, the employer considered that you had served your suspension on April 13, 14, 18 and 19, 2019. You were also required to comply with a Work Plan that you signed on April 25, 2019. You were advised that your employer would be filing a complaint with the SRNA;

(f) (Charges #8, #9 and #10) On May 3, 2019, your employer provided you with a letter regarding its conclusions of the investigation and its expectations. On May 3, 2019, the Saskatchewan Health Authority filed a complaint with the Investigation Committee of the SRNA. Since the employer/employee meeting of April 25, 2019, you have not returned to work. You are on medical leave and cannot return to work until you obtain medical clearance.