THE COLLEGE OF REGISTERED PSYCHIATRIC NURSES OF MANITOBA

IN THE MATTER OF:	***The Regulated Health Professions Act,* CCSM, c. R117**
AND IN THE MATTER OF:	**KARA TRUELOVE, a registered psychiatric nurse registered with the College of Registered Psychiatric Nurses of Manitoba**

DECISION AND REASONS OF THE INQUIRY COMMITTEE PANEL HEARING DATE: February 23, 2024

College of
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of Manitoba

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AND IN THE MATTER OF:	**KARA TRUELOVE, a registered psychiatric nurse registered with the College of Registered Psychiatric Nurses of Manitoba**

DECISION AND REASONS

Inquiry Committee Panel Members:	Alexandria Taylor, RPN-Chair Sara Wikstrom, RPN Patrick Desrochers – Public Representative
Counsel to the Complaints Investigation Committee ("CIC"):	Jeff Hirsch, K.C. and Chimwemwe Undi Thompson Dorfman Sweatman LLP
Member:	Kara Truelove
Counsel to the Member:	Saul B. Simmonds, K.C. Simmonds & Associates
Counsel to the Panel:	William G. Haight Phillips Aiello

Introduction

1. On Friday, February 23, 2024, an Inquiry Committee Panel of the College of Registered Psychiatric Nurses of Manitoba (respectively, the "Panel" and the "College") held a hearing into charges against the member, Kara Truelove (the "Member"). The Member appeared at the hearing with her counsel, Saul Simmonds, K.C.

2. The charges against the Member are found on a copy of a Notice of Hearing dated August 8, 2023, which was marked as **Exhibit "1"** at the hearing and is attached to these reasons as **Appendix "A"**.

3. At the outset of the hearing, it was established that the Notice of Hearing had been properly served and that the jurisdictional requirements set out in subsections 102(3), 116(2), 116(3), 116(4) and 120(1) of *The Regulated Health Professions Act* (the "RHPA") have been satisfied.

4. No objections were raised regarding the composition of the Panel and the Panel proceeded with the hearing.

5. Through her legal counsel, the Member waived reading of the allegations in the Notice of Hearing and entered pleas of guilty to all charges contained within the Notice.

6. The Member also admitted that the conduct, confirmed by her pleas of guilty, constitutes professional misconduct, conduct unbecoming a member and/or has contravened the RHPA, and/or the College's General Regulation, Man. Reg. NR 60/2002 (the "Regulation"), the Standards of Psychiatric Nursing Practice 2019 (the "Standards") and the College's Code of Ethics 2017 (the "Code").

7. The parties agreed that the identity of the patient, the care for whom by the Member resulted in the charges set out in the Notice of Hearing, should not be disclosed and the Panel agreed with this position.

8. The Panel heard submissions from counsel for the CIC and the Member. The parties made a joint recommendation as to the disposition of all charges recommending the Panel impose the following:

   (a) a reprimand;
   (b) a fine of $2,500.00;
   (c) contribution to the costs of the investigation and the hearing in the amount of $5,000.00;
   (d) the Member will have a condition placed on her Certificate of Practice requiring that:
      i. for a period of 1,800 hours of practice, her employer must submit reports after 450 hours of practice, which reports, at a minimum, are to include an

assessment of the Member's ability to apply the nursing process in her practice, her understanding and implementation of policies and assessment tools, her clinical decision making and reasoning, her therapeutic engagement with clients, and, her ability to prioritize her workload and identify when assistance is required;

ii. the Member is responsible for informing her employer about these conditions; and

(e) the Panel's decision will be made available to the public.

9. After hearing submissions, the Panel adjourned to consider the joint recommendation, but requested the parties remain at the hearing location. Upon concluding its consideration of the joint recommendation, the Panel called the parties back into the hearing and advised it was prepared to accept the joint recommendation with written reasons to follow. These are those reasons.

Facts

10. A Statement of Agreed Facts was tendered as **Exhibit #2(a)** at the hearing. **Exhibit #2(b)** contained a series of documents referenced in the Statement of Agreed Facts. Both the CIC and the Member relied upon the facts and documents contained in **Exhibits #2(a) and #2(b)**. As a result, there is no dispute regarding the facts.

11. The Member graduated with a Bachelor of Science in Psychiatric Nursing in 2020. She has been a Registered Psychiatric Nurse ("RPN") since April of 2021. Between June of 2020 and December 2022, the Member was employed in the mental health program of a tertiary care centre in the City of Winnipeg . The conduct to which the Member has pled guilty occurred on December 2, 2022.

12. Prior to the Member's plea of guilty on February 23, 2024, the Member had no disciplinary history with the College.

13. On December 20, 2022, the College received a mandatory employer report about the Member's practice, which resulted in an investigation, the Notice of Hearing attached as **Appendix "A"** and the pleas entered by the Member. The investigation found, and the Member has acknowledged, the facts set out in paragraphs 14 to 27 hereof.

Counts 1 a)-d)

14. Contrary to subsections 4.2(3), 4.2(5) and 4.3(1) of the Regulation, statements 7 to 9 of standard 1 of the Standards, statements 1, 2, 3, 5 and 12 of standard 2 of the Standards, statement 4 of standard 4 of the Standards and statement 10 of the safe, competent and ethical practice provisions of the Code, the Member did not exercise critical thinking and clinical judgment by failing to engage with or assess a patient "T.K." and develop a plan of care, and in particular:

(a) failed to conduct a mental status assessment or suicide risk assessment or either of them;
(b) failed to enter the patient's room and/or properly observe and assess the patient;
(c) failed to conduct a comprehensive psychiatric nursing assessment, including a physical health assessment and failed to monitor vital signs as ordered; and
(d) failed to establish a plan of care and implement any psychiatric nursing interventions for the patient.

15. On December 1, 2022, T.K. presented at the emergency room of the health care facility in which the Member was employed following an intentional opioid overdose. The patient was admitted to an acute in-patient psychiatric unit. The admitting nurse's general orders directed that T.K.'s vital signs be checked twice a day and that staff maintain a frequent 15-minute observation level with patient checks to be conducted every 15 minutes. This was due to T.K.'s assessed suicidal ideation. The initial nursing assessment noted that T.K.

reported ongoing thoughts of suicide and a plan for the manner in which suicide would be attempted again.

16. The Member reported for the December 2, 2022 shift at 07:30 and ended her shift at 15:45.

17. On December 2, 2022, after the Member had worked and completed her shift, an RPN who worked the evening shift went into T.K.'s room and became concerned regarding the patient's shallow breathing. A code blue was called and attempts were made to resuscitate the patient.

18. T.K. was pronounced deceased at 21:04 on December 2, 2022. Counsel for CIC informed the Panel that the Member's misconduct was not the cause of T.K.'s death. The Panel was informed there were system-wide failings which have resulted in revisions to policy at the subject health care facility.

19. The employer conducted a preliminary review of the documentation recording the care that T.K. had received. A mandatory employer report was made to the College expressing concerns with the Member's clinical assessment and nursing practice.

20. During the course of the investigation, the Member acknowledged:

    (a) She did not exercise critical thinking and clinical judgment by failing to engage with or assess patient T.K. and develop a plan of care.

    (b) She failed to conduct a mental status assessment or suicide risk assessment.

    (c) She had read T.K.'s patient chart, the orders and the initial nursing assessment and understood that T.K. was assessed as having suicidal ideation with a plan for attempting suicide, and a history of suicide attempts and overdoses.

    (d) She acknowledged that she failed to enter the patient's room and/or properly observe and assess the patient. The Member advised she had checked on T.K. twice during the December 2, 2022 shift, but these checks were comprised of standing in the doorway and looking at the patient. She did not enter the room or attempt to

rouse the patient in any manner. The Member acknowledges that she should have attempted to awaken T.K.

(e) She failed to conduct a comprehensive psychiatric nursing assessment, including a physical health assessment and vital signs as ordered.

(f) She did not provide appropriate registered psychiatric nursing care to T.K.

21. Subsection 4.2(5) of the Regulation requires an RPN engaging in the practice of registered psychiatric nursing in a clinical practice setting to provide nursing care which includes an assessment to determine the needs and circumstances of the client.

22. The Member advised that she asked the attending psychiatrist, to assess the client with her, and that the psychiatrist had deferred the assessment to let the patient sleep. The Member indicated that she had an "off day" and felt overwhelmed by the patient load on December 2, 2022. She was assigned charge nurse duties on that shift and 60% to 70% of that shift was consumed by an eating-disorder patient.

Count 2

23. Contrary to subsections 4.3(2) of the Regulation, statements 7 and 9 of standard 1 of the Standards, statements 1, 3, 7 and 8 of standard 2 of the Standards, statement 10 of the safe, competent and ethical practice provisions of the Code, the Member failed to document or properly document her observations and/or assessment of the patient, or her discussions and interactions with the attending psychiatrist, nursing assistants and colleagues who were treating the patient.

24. The Member acknowledges she observed the patient twice during her shift, once at 11:00 and again at 13:30. The Member acknowledges that she did not document these observations.

25. During the December 2, 2022 shift, the Member updated the integrated progress note for T.K. with only one entry at 14:45 in which she wrote:

> "Nursing Note: [T.K.] has been sleeping all shift. No interactions with the writer or team… No meds to give. Continue F15 for SI."

26. As a result of the conduct acknowledged by the Member, her employment was terminated. The Member has grieved the termination and the Panel does not know of the results of the Member's grievance of this termination.

27. Subsequent to the tragic outcome referenced in these reasons, the Member has, on her own volition, taken a number of remedial courses. Details of these remedial steps were tendered before the Panel by the Member's counsel and were marked as **Exhibit #3**. This exhibit also contained positive letters of reference from colleagues who currently work with the Member.

Analysis and Decision

28. The Panel considered the legal principles applicable to penalties imposed in professional regulatory matters, including the principles relevant to appropriate sanction enunciated in *Jaswal v. The Medical Board* (Nfld.). In particular, the Panel's application of the *Jaswal* factors included:

- The misconduct acknowledged by the Member is serious, demonstrated poor judgment and included conduct inconsistent with the standards of psychiatric nursing practice.

- The Member has been a registered psychiatric nurse since April of 2021. Her relative inexperience at the time of the December 2, 2022 shift is a mitigating circumstance.

- The Member has no discipline history with the College prior to her entering the pleas of guilty on February 23, 2024.

- The Member pled guilty to the charges, acknowledging her conduct did not meet the standards of the profession, thereby saving the College and others the time and expense involved with a contested hearing.

- The Member has been subjected to conditions which prevented her from working as the only nurse on a unit and from being charge nurse or assuming charge nurse responsibilities.

- The principles of specific and general deterrence.

- The Member's conduct must be addressed in order to reassure the public that unacceptable conduct will not be tolerated and to maintain the public's confidence in the College's ability to regulate the profession. The Member's conduct fell well below the standards of psychiatric nursing practice and adversely affected a vulnerable patient with a very recent history of substance abuse and suicidality.

- The Member, on her own volition, enrolled in and completed substantial remedial courses.

29. The Panel considered the law regarding joint recommendations as pronounced by the Supreme Court of Canada in *R. v. Anthony-Cook*. In particular, the Panel took note of the "undeniably high threshold" for rejecting a joint recommendation. At paragraph 34 of the *Anthony-Cook* decision, the Supreme Court noted:

> "[A] joint submission should not be rejected lightly… Rejection denotes a submission so unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down."
>
> *R. v. Anthony-Cook,* 2016 SCC 43 at para 34

30. The Panel accepts that the reasoning applied by the Supreme Court in *R. v. Anthony-Cook* is applicable to proceedings under the RHPA.

31. The Panel is satisfied that the joint recommendation properly addresses and protects the public interest, and it reassures the public that the College is working to maintain standards and ensure continued trust in registered psychiatric nurses.

32. The Panel is mindful of the College's obligation to protect and serve the public interest through quality registered psychiatric nursing regulation. In order for the public to have confidence in the profession, the College must regulate the conduct of its members appropriately and consistently and, where appropriate, inquiry panels must impose sanction to deter serious misconduct.

33. The Panel believes that the joint recommendation adequately addresses all applicable obligations of the College and therefore makes the following Order:

(a) The Member will be reprimanded;

(b) The Member will pay a fine of $2,500.00;

(c) The Member will pay a contribution to the costs of the investigation and the hearing in the amount of $5,000.00;

(d) The Member will have a condition placed on her Certificate of Practice requiring that:

i. for a period of 1,800 hours of practice, her employer must submit reports after 450 hours of practice, which reports, at a minimum, are to include an assessment of the Member's ability to apply the nursing process in her practice, her understanding and implementation of policies and assessment tools, her clinical decision making and reasoning, her therapeutic engagement with clients, and, her ability to prioritize her workload and identify when assistance is required;

ii. the Member is responsible for informing her employer about these conditions; and

(e) The Panel's decision will be made available to the public.

34. These reasons will be signed in counterpart by the Panel members and an electronic copy of this signature shall be provided to the parties.

DATED at Winnipeg, Manitoba, the 15th day of March 2024.

ALEXANDRIA TAYLOR, RPN-Chair

SARA WIKSTROM, RPN – Public Representative

PATRICK DESROCHERS – Public Representative

APPENDIX "A"

THE COLLEGE OF REGISTERED PSYCHIATRIC NURSES OF MANITOBA

In the matter of:	***The Regulated Health Professions Act,* CCSM, c R117**
And in the matter of:	**Kara Truelove, a registered psychiatric nurse registered with the College of Registered Psychiatric Nurses of Manitoba**

NOTICE OF HEARING

Take notice that a hearing will be conducted by a panel of the Inquiry Committee of the College of Registered Psychiatric Nurses of Manitoba (the "College") at 1854 Portage Avenue, Winnipeg, Manitoba, on Monday, September 25, 2023 at 9:30 a.m., with respect to charges formulated by the Complaints Investigation Committee of the College alleging that you, being a member of the College under the provisions of *The Regulated Health Professions Act,* CCSM, c R117 (the "Act"), are guilty of professional misconduct, conduct unbecoming a member, having demonstrated an unfitness to practise psychiatric nursing, having displayed a lack of knowledge, skill, or judgment in the practice of psychiatric nursing, or having contravened the Act, and/or the *College of Registered Psychiatric Nurses General Regulation* Man Reg 60/2002 (the "Regulation"), and/or the *Standards of Psychiatric Nursing Practice 2019* (the "Standards"), and/or the College's *Code of Ethics 2017* (the "Code"), or any of the above, in that:

1. contrary to subsections 4.2(3), 4.2(5), and 4.3(1) of the Regulation, or any of them, statements 7 and 9 of standard 1 of the Standards, statements 1, 2, 3, 5, and 12 of standard 2 of the Standards, statement 4 of standard 4 of the Standards, and statement 10 of the Safe, competent, and ethical practice provisions of the Code, or any of them, you did not exercise critical thinking and clinical judgment by failing to engage with or assess patient "TK" and develop a plan of care, in particular:

   (a) you failed to conduct a mental status assessment or a suicide risk assessment, or either of them;
   (b) you failed to enter the patient's room and/or properly observe and assess the patient;
   (c) you failed to conduct a comprehensive psychiatric nursing assessment, including a physical health assessment and vital signs as ordered; and,
   (d) you failed to establish a plan of care and implement any psychiatric nursing interventions for the patient.

2. contrary to subsection 4.3(2) of the Regulation, statements 7 and 9 of standard 1 of the Standards, statements 1, 3, 7, and 8 of standard 2 of the Standards, and statement 10 of the Safe, competent, and ethical practice provisions of the Code or any of them, you did not document, or properly document your observations and/or assessment of the patient, or your discussions and interactions with the physician, nursing assistants and colleagues who were treating the patient.

And further take notice that you are required to personally attend at the time and place set for the hearing and that you have the right to be represented by legal counsel of your choice. At the hearing, you may adduce evidence, examine and cross-examine witnesses appearing at the hearing, and make such representations as may be material to these charges. Should you fail to attend at the time and place appointed for the hearing, the Inquiry Committee may proceed with the hearing in your absence without further notice to you and may take such action as it deems fit pursuant to the Act.

And further take notice that if the Inquiry Committee finds you to be guilty of professional misconduct, or conduct unbecoming a member, or having demonstrated an unfitness to practise psychiatric nursing, or having contravened the Act, the Regulation, the Standards, the Code, or any of the above, as alleged or at all, you may be liable to sanction in accordance with sections 126 and 127 of the Act, including reprimand, fine, suspension or cancellation of your registration or certificate of practice.

DATED at Winnipeg, Manitoba this 8th day of August, 2023.

THE COLLEGE OF REGISTERED PSYCHIATRIC NURSES OF MANITOBA

Per: 

Christine Prociuk, RPN, BA
Chair, CRPNM Complaints Investigation Committee

TO: Kara Truelove
[redacted]