see separate EGK actions againt 5 other HCWs

File # 12-CRV-0104

2013 CanLII 35357 (ON HPARB)

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

PRESENT:

Thomas Kelly, Vice-Chair, Presiding
Kim Stanton, Board Member
Lydia Stewart Ferreira, Board Member

Review held on January 22, 2013 at Toronto, Ontario

IN THE MATTER OF A COMPLAINT REVIEW UNDER SECTION 29(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act*, *1991*, Statutes of Ontario, 1991, c.18, as amended

B E T W E E N:

E.G.J. W.

Applicant

and

K.A.W., RN

Respondent

Appearances:

The Applicant:	E.G.W., RN
For the Respondent:	Robert K. Stephenson, Counsel
For the College of Nurses of Ontario:	Anna Wyse and Jason Legault

DECISION AND REASONS

I. DECISION

1. It is the decision of the Health Professions Appeal and Review Board to confirm the decision of the Inquiries, Complaints and Reports Committee of the College of Nurses of Ontario to take no further action.

2. This decision arises from a request made to the Health Professions Appeal and Review Board (the Board) by E.W. (the Applicant) to review a decision of the Inquiries, Complaints and Reports Committee (the Committee) of the College of Nurses of Ontario (the College). The decision concerned a complaint regarding the conduct and actions of K.A.W., RN (the Respondent). The Committee investigated the complaint and decided to take no further action.

II. BACKGROUND

3. On November 9, 2007, D.D. (the patient) signed a Power of Attorney for Personal Care with the following specific instructions regarding life-prolonging treatment:

> If at any time I should have a terminal condition and my attending physician has determined that there can be no recovery from such a condition and my death imminent, where the application of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medications or the performance of' any other medical procedure deemed necessary to provide me with comfortable care or to alleviate pain.
>
> In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this Declaration shall be honored by my family and physician as a final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

4. On May 1, 2008, at 88 years of age, he was admitted to Lakeridge hospital where he was treated for a large pleural effusion, thought to be due to congestive heart failure. He had a past medical history significant for end-stage kidney disease (vasculopathy), coronary artery disease, atrial fibrillation, type II diabetes, peripheral vascular disease, bilateral toe gangrene and had been on maintenance dialysis since 2006.

5. The Applicant is a registered nurse and was the patient's daughter and Substitute Decision Maker (SDM).

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6. On July 29, 2008, the patient was transferred to Sunnybrook Health Centre (Sunnybrook) for more comprehensive care due to his increased vascular needs and dialysis requirements.

7. On August 28, 2008, a Do Not Resuscitate order ("DNR") was completed at a family meeting.

8. On September 9, 2008, a vascular screening was performed, which demonstrated critical ischemia, and a surgical consultation was arranged with a vascular surgeon and subsequently, with an orthopaedic surgeon.

9. On September 10, 2008, the orthopaedic surgeon determined, "bilateral amputation was warranted for the purposes of palliation, although his mortality from the procedure remained extremely high."

10. On September 17, 2008 the patient's status was changed to "Full Code" at the Applicant's request, because of her concern that her father's intra-operative and post-operative care might be compromised by his DNR. On that day, his legs were amputated above the knee and he was placed in the Intensive Care Unit (ICU) post-operatively.

11. On September 20, 2008, the patient was transferred from ICU to C4 Medical.

12. On September 22, 2008, Dr. Chapman, the critical care staff physician member of the Rapid Response team assessed the patient and recorded the following progress note in the chart:

> Impression: this gentleman is in the final phase of his life and the time he has remaining would seem short.
> Further aggressive therapy, e.g. CPR, ICU care, would almost certainly not provide any lasting benefit to his health, only increased suffering. Therefore this will not be offered as a therapeutic option. I have discussed this with Drs. Livingstone and Sinuff who concur and this is the consensus of our medical opinion.
> Do not attempt resuscitation in event of cardiac arrest.

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13. Dr. Livingstone added the following progress note: "agree — in this patient resuscitation represents a futile therapy without demonstrable benefit." In addition, Drs. Chapman and Livingstone co-signed the following orders in the chart: "do not attempt resuscitation in the event of cardiorespiratory event. No transfer to ICU."

14. The change in code status was made without input from the Applicant. Dr. Chapman called the Applicant and left a message.

15. That day, according to the chart records, the patient was showing signs of heart failure and fluid overload. The scheduled dialysis was cancelled. The Applicant came to the hospital that afternoon, unaware of the change in the patient's code status to a DNR, where she witnessed her father in respiratory distress. According to the chart records, no medical interventions were made to save the patient, despite the Applicant's pleading for help and her own efforts of placing an ampubag on the patient. She requested an urgent dialysis which was not done. Her father passed away later that day.

16. A subsequent autopsy revealed fluid overload and identified that the death was attributed to complications of congestive heart failure and renal failure.

17. On September 21 and 22, 2008, the Respondent was working on the Rapid Response Team whose responsibility is to routinely assess patients who have been discharged to ward care after being in the ICU.

18. She assessed the patient in the morning of September 21, 2008 and again on September 22, 2008. After her assessment on September 22, 2008, she asked Dr. Chapman to assess the patient, which led to the change in code status.

19. On September 22, 2008, later in the evening, she received a call that the patient had further deteriorated and attended at the patient's room where she encountered the Applicant in conversation with Dr. Chapman. She left shortly thereafter.

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The Complaint

20. The Applicant complained that the Respondent ignored the complainant's instructions to intubate the client and transfer him to the ICU. She complained that the Respondent should have questioned the physician and refused the DNR order because consent had not been obtained from the client or his Substitute Decision Maker.

The Committee's Investigation and Decision

21. The Committee investigated the complaint and decided to take no further action.

III. REQUEST FOR REVIEW

22. Dissatisfied with the decision of the Committee, in a letter dated February 1, 2012, the Applicant requested that the Board review the Committee's decision.

IV. POWERS OF THE BOARD

23. After conducting a review of a decision of the Committee, the Board may do one or more of the following:

a) confirm all or part of the Committee's decision;
b) make recommendations to the Committee;
c) require the Committee to exercise any of its powers other than to request a Registrar's investigation.

24. The Board cannot recommend or require the Committee to do things outside its jurisdiction, such as make a finding of misconduct or incompetence against the member, or require the referral of allegations to a discipline hearing that would not, if proved, constitute either professional misconduct or incompetence.

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V. ANALYSIS AND REASONS

25. Pursuant to section 33(1) of the *Health Professions Procedural Code* (the *Code*), being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider either the adequacy of the Committee's investigation, the reasonableness of its decision, or both.

26. The Board was assisted in its deliberations by submissions from the Applicant and the Respondent's Counsel and information provided by the College representatives.

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Adequacy of the Investigation

27. An adequate investigation does not need to be exhaustive. Rather, the Committee must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.

28. The Board has considered the submissions of the parties, examined the Record of Investigation (the Record), reviewed the Committee's decision, and determines that the Committee's investigation was adequate for the following reasons.

29. After reviewing the Record, the Board finds that the Committee's investigation covers the complaint and events in question and includes the relevant documentation required to review the care provided to the patient by the Respondent and the Respondent's actions. Specifically, the Board notes that the Committee's investigation included:

- the Applicant's letter of complaint and a summary of an interview with her;
- summary of interview with the Respondent;
- hospital records from Sunnybrook;
- Coroner's Investigation Statements;
- Decision of the Geriatric / Long-Term Care Review Committee; and
- the Respondent's letter of response, through Counsel.

30. The Applicant submitted that the investigation was inadequate because the Committee did not interview the Respondent concerning her knowledge of the events and of the circumstances surrounding the DNR order.

31. The Respondent's Counsel submitted that the investigation was adequate.

32. The Board concludes that it was not necessary for the Committee to interview the Respondent as her knowledge of the events was set out in her detailed response to the complaint. It is unlikely that a personal interview would have provided additional relevant information.

33. The Board concludes that the Committee collected and considered the relevant information to assess the complaint. There is no indication of further information that might reasonably be expected to have affected the decision, should the Committee have acquired it. Accordingly, the Board finds that the Committee's investigation was adequate

Reasonableness of the Decision

34. In considering the reasonableness of the Committee's decision, the question for the Board is not whether it would arrive at the same decision as the Committee, but whether the Committee's decision can reasonably be supported by the information before it and can withstand a somewhat probing examination. In doing so, the Board considers whether the decision falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

35. After considering the parties' submissions, examining the Record and reviewing the Committee's decision, the Board concludes for the following reasons that the decision is reasonable.

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36. The Board notes that the Committee reviewed in detail and reasonably relied on the information in the Record to support its conclusions regarding the reasonableness and appropriateness of the Respondent's conduct and actions.

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37. It is apparent to the Board that the permeating issue is the changing of the patient's code status to DNR without consultation with or communication to the Applicant. When the Applicant arrived at the hospital on the afternoon of September 22, 2008, she was unaware of the change in status and was operating on the presumption that her father was full code, whereas Dr. Chapman had made a DNR order earlier that day.

38. The Applicant complained that the Respondent should have questioned the physician and refused the DNR order because consent had not been obtained from the client or his Substitute Decision Maker.

39. The Committee noted that a DNR order was in place for some time before the Applicant had her father's status changed to full code. The Committee further noted that three physicians conferred about the patient's status and came to a consensus of medical opinion, concluding that further treatment would not provide any benefit to him but would simply prolong his suffering and that as a result, the status was changed back to DNR.

40. Moreover, the Committee noted that when there are conflicting views about a DNR order, it is the most responsible physician who facilitates discussion and who is ultimately responsible for writing the DNR order. Nursing staff are not involved in this process. They are however expected to follow physician's orders, including a DNR order in the health record.

41. The Board finds the Committee's conclusion in this regard to be reasonable as it is based upon the Committee's interpretation of the College's standards of practice and the Committee's expertise regarding DNR orders.

42. The Applicant complained that the Respondent ignored the complainant's instructions to intubate the client and transfer him to the ICU. The Respondent asserted that she was not instructed by the Applicant to intubate the client or transfer him to the ICU.

43. In her response, the Respondent noted the guidance provided by the College of Nurses in its practice guideline about end of life care, where it is noted that a nurse, in advocating for the client, should not initiate treatment when:

> … the attending physician has informed the client that the treatment will be of no benefit and is not part of the plan of treatment that the client has agreed to. In this situation, the nurse is not expected to perform life sustaining treatment (for example, resuscitation), even if the client or substitute decisionmaker requests it.

44. The Respondent further stated that she believed that it would have been wrong for her to have intubated the patient or transferred the patient to the ICU, in flagrant disregard of the clear direction given by the physician in circumstances in which that direction appeared to be clinically appropriate and in the patient's best interests. She summarized by stating that, in any event, intubation and transferring a patient to the ICU are not within her scope of practice.

45. The Committee concluded that, even if the Respondent had been so instructed by the Applicant, she could not have defied the physician's order, which explicitly stated that no attempts at resuscitation should be made and that there should be no transfer to the ICU.

46. The Board finds the Committee's conclusion in this regard to be reasonable as it is based on information in the Record and the Committee's own expertise in interpreting the College's standards of practice.

47. The Committee concluded that it did not believe there was sufficient information to support the allegation and considered it reasonable to take no action regarding the complaint.

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48. The Board finds the Committee's decision to take no action to be reasonable as it is a decision which falls within a range of possible, acceptable outcomes that are defensible in respect of the facts and the law.

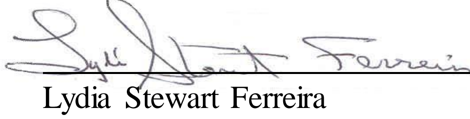
VI. DECISION

49. Pursuant to section 35(1) of the *Code*, the Board confirms the Committee's decision to take no action.

ISSUED June 12, 2013

Thomas Kelly

Kim Stanton



Lydia Stewart Ferreira

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