

**DISCIPLINE COMMITTEE OF THE  
NURSES ASSOCIATION OF NEW BRUNSWICK**

**BETWEEN:**

**NURSES ASSOCIATION OF NEW BRUNSWICK**

**And**

**CYNTHIA DONOVAN  
Registration number 017802**

**NOTICE OF HEARING**

**THE COMPLAINTS COMMITTEE** of the Nurses Association of New Brunswick (“NANB”) has referred the complaint against you to the Discipline Committee of NANB. The complaint was referred in accordance with paragraph 29(9)(b) of the *Nurses Act*. The allegations relating to the complaint are outlined in this Notice of Hearing. A panel of the Discipline Committee (the “**Panel**”) will hold a hearing under the authority of section 30 of the *Nurses Act* for the purposes of deciding whether the allegations are true and whether you committed acts of professional misconduct.

**ALLEGATIONS**

**IT IS ALLEGED THAT:**

1. In or about April, May, and June, 2021, you committed acts of professional misconduct as defined in subsection 2(1) of the *Nurses Act* in that, while working as a Registered Nurse at Loch Lomond Villa (the “**Facility**”), you digressed from established or recognized professional standards or rules of practice of the profession, including but not limited to the NANB *Standards of Practice for Registered Nurses* and the NANB *Standards for the Nurse-Client Relationship*, as follows:
  - a. On or about April 27, 2021, you sent a notice to the family of an 83-year-old resident with dementia and confusion (the “**Resident**”) that the Resident would be discharged from the Facility without having first employed any alternatives to discharge with the Resident’s best interest in mind, and without providing a written warning to the Resident’s family that the Resident may be discharged from the Facility. By discharging the Resident without employing alternate measures, you failed to ensure that all professional behaviours and actions met the needs of the Resident, and/or you failed to practice using a client-centered practice as required by standard 1 of the NANB *Standards for the Nurse-Client Relationship* and standard 3.5 of the NANB *Standards of Practice for Registered Nurses*.

- b. On or about April 22, 2021, you asked the Resident's family by email if they wished to take the Resident home for 30 or more days to care for her in the community, and you stated that if this option was not feasible, the Facility would facilitate the Resident's transfer to another nursing home. Although the Resident's family replied by email dated April 22, 2021 to say they were seeking clarification regarding your suggested accommodation options for the Resident, you sent the above-noted notice of discharge on April 27, 2021, which provided insufficient time for the Resident's family to assess their ability to care for the Resident and/or to make inquiries with other nursing homes about accepting the Resident into their care.
  - i. By discharging the Resident without employing alternate measures, you failed to ensure that all professional behaviours and actions met the needs of the Resident, and/or you failed to practice using a client-centered practice as required by standard 1 of the NANB ***Standards for the Nurse-Client Relationship*** and standard 3.5 of the NANB ***Standards of Practice for Registered Nurses***.
  - ii. By failing to provide sufficient time for the Resident's family to consider and respond to your offer, you failed to communicate effectively with the Resident's family to promote continuity and the delivery of safe, competent, compassionate and ethical care to the Resident; and/or you failed to maintain and terminate the nurse-client relationship; and/or you failed to support the Resident and her family by providing information, resources and referrals for them to make informed decisions and access appropriate health care services for the Resident as required by standards 3.2 and 3.6 of the NANB ***Standards of Practice for Registered Nurses*** and standard 3 of the NANB ***Standards for the Nurse-Client Relationship***.
- c. Following the notice of discharge letter dated April 27, 2021, you sent a second notice of discharge letter to the Resident's family on or about May 7, 2021. Other than these two letters, you failed to communicate with the Resident's family about the Resident's discharge and her transfer to another institution. Facility staff members contacted the Resident's family the day before her discharge and on May 22, 2021 as the Resident was being discharged. In this regard, you failed to communicate effectively with the Resident's family to promote continuity and the delivery of safe, competent, compassionate and ethical care to the Resident as required by standard 3.2 of the NANB ***Standards of Practice for Registered Nurses***.
- d. Following the Resident's discharge from the Facility, you sent a letter dated June 30, 2021 to all Facility families about the Resident's discharge. Although your letter did not include the Resident's name, the letter included information which could be utilized, either alone or with other information, to identify the Resident and her family. In this regard, you failed to uphold and protect the Resident's and her family's privacy and confidentiality in all forms of communication as required by standard 3.4 of the NANB ***Standards of Practice for Registered Nurses***.

2. In or about April and May, 2021, you contravened Part I, section C 10 of the Canadian Nurses Association's ***Code of Ethics for Registered Nurses*** in that you failed to consider and respect, along with substitute decision-makers, the best interests of the person receiving care, as follows:
  - a. On or about April 27, 2021, you sent a notice to the Resident's family that the Resident would be discharged from the Facility without having first employed any alternatives to discharge with the Resident's best interest in mind, and without providing a written warning to the Resident's family that the Resident may be discharged from the Facility.
  - b. On or about April 22, 2021, you asked the Resident's family by email if they wished to take the Resident home for 30 or more days to care for her in the community, and you stated that if this option was not feasible, the Facility would facilitate the Resident's transfer to another nursing home. Although the Resident's family replied by email dated April 22, 2021 to say they were seeking clarification regarding your suggested accommodation options for the Resident, you sent the above-noted notice of discharge on April 27, 2021, which provided insufficient time for the Resident's family to assess their ability to care for the Resident and/or to make inquiries with other nursing homes about accepting the Resident into their care.
3. On or about June 30, 2021, you contravened Part I, sections E, 3, 4, and 5 of the Canadian Nurses Association's ***Code of Ethics for Registered Nurses*** in that you failed to safeguard personal and family information obtained in the context of your professional relationship, in that following the Resident's discharge from the Facility, you sent a letter dated June 20, 2021 to all Facility families about the Resident's discharge. Although your letter did not include the Resident's name, the letter included information which could be utilized, either alone or with other information, to identify the Resident and her family.

The allegations respecting professional misconduct on your part will be heard by the Panel pursuant to subsection 30(6)(a) of the ***Nurses Act*** on a date to be set by the Registrar, via electronic hearing by way of videoconference, pursuant to Rule 4.03(1) of the Discipline Committee Rules of Procedure. The details for participating in the hearing will be provided to you in advance of the hearing. The hearing will be conducted in English.

At least 48 hours before the hearing is scheduled to commence, you must provide NANB with the email address where you can be reached for the hearing.

**IF YOU DO NOT ATTEND AT THE HEARING IN ACCORDANCE WITH THE PRECEDING PARAGRAPHS, THE PANEL MAY PROCEED IN YOUR ABSENCE PURSUANT TO PARAGRAPH 11.17(D) OF THE NANB BYLAWS AND YOU WILL NOT BE ENTITLED TO ANY FURTHER NOTICE IN THE PROCEEDINGS.**

**PURSUANT TO SUBSECTION 30(8) OF THE *NURSES ACT***, if the Panel finds that you have committed one or more acts of professional misconduct, it may make an Order of any one or more of the following:

1. Revoking your registration;
2. Suspending your registration for a specific period of time;
3. Suspending your registration pending completion of such conditions as may be ordered by the Panel;
4. Ordering that conditions or restrictions be imposed on your registration;
5. Issuing a reprimand;
6. Imposing a fine not exceeding \$1,000; and/or
7. Making such other order as it deems just.

**PURSUANT TO SUBSECTION 41(1)(a) OF THE *NURSES ACT***, if the Panel finds that you have committed one or more acts of professional misconduct, it may make an Order requiring you to pay all or part of the following costs and expenses:

1. NANB's legal costs and expenses;
2. NANB's costs and expenses incurred in investigating the Complaint; and
3. NANB's costs and expenses incurred in conducting the hearing.

**YOU ARE ENTITLED** to disclosure of the evidence against you in accordance with Rules 7.01(2) and (3) of the Discipline and Fitness to Practice Committee Rules of Procedure. You, or your representative, may contact the lawyer for NANB. Their name and contact information is:

**Melissa M. Everett Withers  
Director of Complaints & General Counsel  
Nurses Association of New Brunswick  
165 Regent Street  
Fredericton, NB E3B 7B4**

**YOU ALSO HAVE** disclosure obligations under Rules 7.01(2) and (3) of NANB's Discipline and Fitness to Practice Committee Rules of Procedure which provide, in part, that each party shall deliver to every other party, in advance of the hearing, copies of all documents and things upon which the party intends to rely at the hearing. At least 45 days before the scheduled hearing date, you are required to disclose to NANB any document or thing upon which you intend to rely at the hearing.

Date: \_\_\_\_\_

\_\_\_\_\_  
(original to be signed by)  
Kate Sheppard, RN, MN  
Interim CEO & Registrar  
Nurses Association of New Brunswick

TO: CYNTHIA DONOVAN

**APPENDIX A**

1. The documents to be tendered in evidence at the hearing have been sent separately.
2. Take notice that documents that have been or will later be disclosed to you will be tendered as business documents pursuant to section 49 of the *Evidence Act*, RSNB 1973, c. E-11.
3. All documents that are disclosed to you in this matter are disclosed on the basis that they are to be used solely for the purpose of this proceeding and for no other purpose.