DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	David Edwards, RPN	Chairperson
	Sylvia Douglas	Public Member
	Lalitha Poonasamy	Public Member
	George Rudanycz, RN	Member
	Sherry Szucsko-Bedard, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
ALVIN DAVIS	)	NO REPRESENTATION for
Registration No.: JE101775	)	Alvin Davis
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 23, 2020

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario ("the College") on July 23, 2020, via videoconference.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991, for an order preventing public disclosure and banning publication or broadcasting of the names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Alvin Davis.

The Panel considered the submissions of the parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Alvin Davis.

The Allegations

The allegations against Alvin Davis (the "Member") as stated in the Notice of Hearing dated July 6, 2020 are as follows:

IT IS ALLEGED THAT:

1. You committed an act of professional misconduct as provided by subsection 51(1)(a) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, in that you were found guilty of an offence that is relevant to your suitability to practice, and in particular, on December 19, 2017, you were found guilty of knowingly using a forged document, contrary to s. 368(1)(a) of the *Criminal Code of Canada*.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while employed as a Registered Practical Nurse at Extendicare – Peterborough, in Peterborough, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession as follows:

    a. on or about March 2, 2017, you provided inadequate care to [Patient A], including but not limited to the following:

        i. you failed to respond appropriately and/or in a timely manner when you were informed that [Patient A] was choking; and/or

        ii. you failed to appropriately document, report, and/or follow-up on [Patient A] choking on March 2, 2017;

    b. on or about March 13, 2017, you provided inadequate care to [Patient B], including but not limited to the following:

        i. you attempted to administer Ripserdal to [Patient B] in food, contrary to the Patient's order;

        ii. you failed to administer Risperdal to [Patient B] as ordered;

        iii. you documented that you had administered Risperdal to [Patient B] when you had not;

        iv. you failed to appropriately dispose of [Patient B]'s Risperdal; and/or

        v. you failed to appropriately document, report, follow-up on and/or investigate the Risperdal which was not administered to [Patient B] on March 13, 2017;

    c. on or about June 8, 2017, you provided inadequate care to [Patient C], including but not limited to the following:

        i. you failed to administer Metformin to [Patient C] as ordered;

        ii. you documented that you had administered Metformin to [Patient C] when you had not; and/or

iii. you failed to appropriately document, report, follow-up and/or investigate the Metformin which had not been administered to [Patient C] on June 8, 2017;

d. on or about June 7, 8, and 9, 2017, you provided inadequate care to [Patient D], including but not limited to the following:

i. you failed to administer Humalog in accordance with [Patient D]'s orders; and/or

ii. you failed to check [Patient D]'s blood sugar in accordance with [Patient D]'s orders.

3. You have committed an act of professional misconduct, as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in paragraph 1(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at the Facility, you failed to keep records as required, and in particular:

a. on or about March 13, 2017, you documented that you had administered Risperdal to [Patient B] when you had not; and/or

b. on or about June 8, 2017, you documented that you had administered Metformin to [Patient C] when you had not.

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93*, in that you contravened a term, condition or limitation on your certificate of registration, and in particular:

a. you failed to provide to the Executive Director of the College of Nurses of Ontario ("CNO") details of your finding of guilt on December 19, 2017, for knowingly using a forged document, contrary to s. 368(1)(a) of the *Criminal Code of Canada*, as required by s. 1.5(1)1.i of *Ontario Regulation 275/94*; and/or

b. you failed to provide to the Executive Director of CNO details of your charge on or around July 19, 2017 for knowingly using a forged document, contrary to s. 368(1)(a) of the *Criminal Code of Canada*, as required by s. 1.5(1)1.ii of *Ontario Regulation 275/94*.

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(19) of *Ontario Regulation 799/93*, in that you contravened a provision of the *Regulated Health Professions Act, 1991,* S.O. 1991, c. 18, and in particular, s. 85.6.1 of the *Health Professions Procedural Code*, in that you failed to report your finding of guilt on December 19, 2017, for knowingly using a forged document, contrary to s. 368(1)(a) of the *Criminal Code of Canada*, to the Executive Director of CNO.

6. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that you engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

a. on or about March 2, 2017, you provided inadequate care to [Patient A], including but not limited to the following:

    i. you failed to respond appropriately and/or in a timely manner when you were informed that [Patient A] was choking; and/or

    ii. you failed to appropriately document, report, and/or follow-up on [Patient A] choking on March 2, 2017;

b. on or about March 13, 2017, you provided inadequate care to [Patient B], including but not limited to the following:

    i. you attempted to administer Ripserdal to [Patient B] in food, contrary to the Patient's order;

    ii. you failed to administer Risperdal to [Patient B] as ordered;

    iii. you documented that you had administered Risperdal to [Patient B] when you had not;

    iv. you failed to appropriately dispose of [Patient B]'s Risperdal; and/or

    v. you failed to appropriately document, report, follow-up on and/or investigate the Risperdal which was not administered to [Patient B] on March 13, 2017;

c. on or about June 8, 2017, you provided inadequate care to [Patient C], including but not limited to the following:

    i. you failed to administer Metformin to [Patient C] as ordered;

    ii. you documented that you had administered Metformin to [Patient C] when you had not; and/or

    iii. you failed to appropriately document, report, follow-up and/or investigate the Metformin which had not been administered to [Patient C] on June 8, 2017;

d. on or about June 7, 8, and 9, 2017, you provided inadequate care to [Patient D], including but not limited to the following:

    i. you failed to administer Humalog in accordance with [Patient D]'s orders; and/or

    ii. you failed to check [Patient D]'s blood sugar in accordance with [Patient D]'s orders;

e. you failed to provide to the Executive Director of CNO details of your finding of guilt on December 19, 2017, for knowingly using a forged document, contrary to s. 368(1)(a) of the *Criminal Code of Canada*; and/or

f. you failed to provide to the Executive Director of CNO details of your charge for knowingly using a forged document on or around July 19, 2017, contrary to s. 368(1)(a) of the *Criminal Code of Canada*.

Member's Plea

The Member admitted the allegations set out in paragraphs 1, 2(a)(i), (ii), 2(b)(i),(ii), (iii), (iv), (v), 2(c)(i), (ii), (iii), 2(d)(i), (ii), 3(a), 3(b), 4(a), 4(b), 5, 6(a)(i), (ii), 6(b)(i), (ii), (iii), (iv), (v), 6(c)(i), (ii), (iii), 6(d)(i), (ii), 6(e) and 6(f) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

College Counsel and the Member advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which as amended reads, unedited, as follows:

THE MEMBER

1. Alvin Davis (the "Member") obtained a diploma in nursing from Fleming College in 2005.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on November 22, 2005.

3. The Member was employed at Extendicare – Peterborough (the "Facility") from August 2007 to June 12, 2017, when his employment was terminated following the incidents described below.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Practice Issues

[Patient A]

4. On March 2, 2017, a Personal Support Worker ("PSW"), [Colleague A], observed [Patient A] choking during dinner time. She immediately notified the Member that [Patient A] was choking. The Member was the only registered staff member in the vicinity at the time.

5. When [Colleague A] notified the Member that [Patient A] was choking, the Member acknowledged [Colleague A] by nodding his head at her, and he continued to observe another patient taking medication. In response to the fact that [Patient A] choking, the Member instructed another PSW, [Colleague B], to "get [Patient A] out of here".

6. The Member failed to attend to [Patient A], ensure [Patient A]'s airway was clear, take [Patient A]'s vital signs, document or complete an incident report with the Facility, or notify [Patient A]'s family, physician, and dietary staff of the incident. Instead, the Member continued clearing plates from the dining room, a task which was not his responsibility.

7. [Colleague A] and [Colleague B] removed [Patient A] from the dining room. A Registered Nurse ("RN"), [Colleague C], ultimately assisted [Colleague B] and [Colleague A] with [Patient A].

8. The Member admits and acknowledges that he failed to respond appropriately, document, report and follow-up on [Patient A] in a situation where [Patient A]'s safety was compromised, and his conduct was a breach of the standards of practice.

[Patient B]

9. [Patient B] had an order that her medication was not to be put in food. Contrary to the order, on March 13, 2017, the Member placed [Patient B]'s scheduled Risperdal (an antipsychotic) dose in a brownie.

10. During the evening shift on March 13, 2017, the brownie containing the Risperdal went missing, and the Member began asking PSWs on shift whether they had eaten or taken the brownie, or if they knew what had happened to it. The brownie containing the Risperdal was never found. The Member failed to report the incident to the Facility. It was a PSW who reported the incident to the Facility.

11. The Member completed a progress note for [Patient B] on March 13, 2017, which stated that [Patient B] refused to get up for dinner and refused her medications. In [Patient B]'s Medication Administration Record ("MAR"), the Member documented that the Risperdal had been administered to [Patient B], which was inaccurate.

12. There were no adverse effects to [Patient B] from the missed dose.

13. The Member admits and acknowledges that his attempt to administer Risperdal in food, his failure to administer the Risperdal, his inaccurate documentation, his failure to appropriately dispose of the Risperdal and his failure to appropriately report, follow-up and investigate the Risperdal was a breach of the standards of practice and that he failed to keep records as required when he inaccurately documented the administration of medication on [Patient B]'s MAR.

[Patient C]

14. On June 8, 2017, the Member documented in [Patient C]'s MAR that she received her scheduled Metformin.

15. The next morning, a RPN, [Colleague D], discovered that contrary to the Member's documentation, the Member had not administered the Metformin to [Patient C] on June 8, 2017.

16. There were no consequences to [Patient C] from the missed dose of Metformin; however, since the medication was necessary to regulate [Patient C]'s blood sugar, there was the possibility that she could have become hyper- or hypo-glycemic.

17. After discovering the error, [Colleague D] completed a Medication Incident Report. The Member did not subsequently amend [Patient C]'s MAR to indicate her Metformin had not been administered on June 8, 2017.

18. The Member was instructed by a RN, [Colleague E], to contact [Patient C]'s family and physician about the incident, but he did not do so.

19. The Member admits and acknowledges that his failure to administer the Metformin, inaccurate documentation and failure to report and follow-up was a breach of the standards of practice and that he failed to keep records as required when he inaccurately documented the administration of medication on [Patient C]'s MAR.

[Patient D]

20. [Patient D] had an order that his blood sugar be checked at 1630 daily and that he be administered Humalog at 1700, after he began eating. If [Patient D] was not eating dinner, his dose of Humalog was to be reduced.

21. On both June 7 and 8, 2017, the Member checked [Patient D]'s blood sugar after administering the Humalog and before dinner, contrary to the order. Specifically, the Member checked [Patient D]'s blood sugar at 1631 on June 7, 2017, and at 1622 on June 8, 2017, and administered Humalog at 1629 and 1618, respectively.

22. On June 8, 2017, at approximately 2100, [Colleague C] found that [Patient D]'s blood sugar was low and she could not rouse him or get his blood sugar up. She then arranged for [Patient D] to be transferred to hospital for assessment. [Colleague C] subsequently reinstructed the Member on the proper administration of insulin.

23. [Patient D] returned to the Facility from the hospital on the morning of June 9, 2017.

24. On June 9, 2017, the Member again failed to comply with [Patient D]'s order. The Member checked [Patient D]'s blood sugar one minute before administering the Humalog, rather than half an hour beforehand. He also administered the Humalog before [Patient D] began eating dinner, contrary to the order. Specifically, the Member checked [Patient D]'s blood sugar at 1634 and administered Humalog at 1635.

25. [Colleague C] and an RPN, [Colleague F], observed the manner in which the Member administered the Humalog to [Patient D], and that he had done so contrary to the order. [Colleague C] and [Colleague F] ensured [Patient D] received apple juice and a good meal to avoid any further adverse effects.

26. The Member admits and acknowledges that his failure to administer Humalog and to check [Patient D]'s blood sugar in accordance with the order was a breach of the standards of practice.

Criminal Charge and Finding of Guilt

27. On or around July 19, 2017, the Member was charged with knowingly using a forged document, to wit, a disability claim form as if it were genuine, contrary to s. 368(1)(a) of the *Criminal Code of Canada*.

28. The charge arose from a disability claim form which the Member submitted to his insurer. On the form, the Member forged the signature of a clerk at the Facility.

29. On December 19, 2017, the Member pled guilty and was found guilty of the charge.

30. The Member was required as a term, condition, or limitation on his certificate of registration, to report any charge to the Executive Director of CNO pursuant to section 1.5(1)1.ii of *Ontario Regulation 275/94*.

31. The Member was also required to report any findings of guilt to the Executive Director of CNO pursuant to:

- Section 1.5(1)1.i. of *Ontario Regulation 275/94* which required him to report the finding of guilt as a term, condition, or limitation on his certificate of registration; and

- Section 85.6.1 of the *Health Professions Procedural Code* which required him to report the finding of guilt to the Registrar of CNO.

32. The Member failed to report the charge or the finding of guilt to CNO.

33. The Member admits and acknowledges that the finding by the criminal court constitutes a finding of guilt for an offence that is relevant to the Member's suitability to practice within the meaning of s. 51(1)(a) of the *Health Professions Procedural Code*.

34. The Member admits and acknowledges that his failure to report the charge and finding of guilt amounts to professional misconduct. The Member further admits and acknowledges that the finding of guilt in relation to knowingly using a forged document is relevant to his suitability to practice, as it involves dishonesty, a lack of the integrity, and casts doubt on the Member's ability to discharge the higher obligations expected of professionals.

CNO STANDARDS

35. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of practice of the profession. A nurse demonstrates this standard by actions such as:

- Providing, facilitating, advocating and promoting the best possible care for [patients];

- Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;

- Seeking assistance appropriately and in a timely manner;

- Taking action in situations in which [patient] safety and well-being are compromised;

- Taking responsibility for errors when they occur and taking appropriate action to maintain [patient] safety; and

- Identifying and addressing practice-related issues.

36. CNO's *Medication* standard provides that three principles outline the expectations related to medication practices that promote public protection. These principles include authority, competence, and safety. With respect to safety, nurses promote safe care and contribute to a culture of safety within their practice environment, when involved in medication practices. The standard further provides that nurses:

    - take appropriate action to resolve or minimize the risk of harm to a [patient] from a medication error or adverse reaction; and

    - report medication errors, near misses or adverse reactions in a timely manner.

37. CNO's *Documentation* standard provides that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. The standard further clarifies that a nurse meets the standard by:

    - Ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;

    - Documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;

    - Indicating when an entry is late as defined by organizational policies; and

    - Ensuring that relevant [patient] care information is captured in a permanent record.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

38. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing in that he was found guilty of an offence that is relevant to his suitability to practice, as described in paragraphs 27 to 34 above.

39. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2(a) to (d) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as described in paragraphs 4 - 26 and 35 to 37 above.

40. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a) to (b) of the Notice of Hearing in that he failed to keep records as required, as described in paragraphs 9 - 19 and 37 above.

41. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 4 (a) to (b) of the Notice of Hearing in that he failed to provide details of his charge and finding of guilt to the Executive Director of CNO, as described in paragraphs 27 to 34 above.

42. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 5 of the Notice of Hearing in that he failed report his finding of guilt to the Executive Director of CNO, as described in paragraphs 27 to 34 above.

43. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 6 (a) to (f) of the Notice of Hearing, and in particular his conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 4 to 37 above.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1, 2(a)(i), (ii), 2(b)(i), (ii), (iii), (iv), (v), 2(c)(i), (ii), (iii), 2(d)(i), (ii), 3(a), 3(b), 4(a), 4(b) and 5 of the Notice of Hearing. As to allegation # 6(a)(i), (ii), 6(b)(i), (ii), (iii), (iv), (v), 6(c)(i), (ii), (iii), 6(d)(i), (ii), 6(e) and 6(f), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1 in the Notice of Hearing is supported by paragraphs 27-34 and 38 in the Agreed Statement of Facts, in that the Member was convicted of knowingly using a forged document, namely a disability claim form, contrary to s. 368(1)(a) of the *Criminal Code of Canada*. The Member forged a disability form and submitted it to his insurer. The Member admitted that he committed an act of professional misconduct as this conviction is relevant to his suitability to practice. The Panel finds that this conviction does relate to the Member's suitability to practice as this action involves dishonesty, a lack of integrity and casts doubt on the Member's ability to discharge the higher obligations expected of professionals.

Allegations #2(a)(i), (ii), 2(b)(i), (ii), (iii), (iv), (v), 2(c)(i), (ii), (iii), 2(d)(i) and (ii) in the Notice of Hearing are supported by paragraphs 4-26, 35-37 and 39 in the Agreed Statement of Facts. These facts demonstrate that the Member failed to meet the standard of practice with multiple patients in many ways including not taking action when informed a patient was choking; failing to check a patient's blood sugar; failing to document accurately and failing to report and follow up on a medication error. A nurse meets the College's *Professional Standards*, *Medication* and *Documentation* standards by actions such as providing, facilitating, advocating and promoting the best possible care for patients that includes taking appropriate action when medication errors occur and accurate documentation, which the Member failed to do.

Allegations #3(a) and (b) in the Notice of Hearing are supported by paragraphs 9-19, 37 and 40 in the Agreed Statement of Facts. The Member breached the College's *Documentation* standard when he falsely documented medication administration on more than one patient. This breach constitutes a failure to keep records as required.

Allegations #4(a) and (b) in the Notice of Hearing are supported by paragraphs 27-34 and 41 in the Agreed Statement of Facts. The Member committed an act of professional misconduct when he contravened a term, condition or limitation on his certificate of registration when he failed to report the charge of forgery or the finding of guilt of that same charge to the Executive Director of the College.

Allegation #5 in the Notice of Hearing is supported by paragraphs 27-34 and 42 in the Agreed Statement of Facts. The Member committed professional misconduct when he failed to report the finding of guilt for the forgery charge to the Executive Director of the College.

With respect to Allegations #6(a)(i), (ii), 6(b)(i), (ii), (iii), (iv), (v), 6(c)(i), (ii), (iii), 6(d)(i), (ii), 6(e) and 6(f), the Panel finds the Member's conduct would reasonably be regarded by members of the profession as unprofessional. By failing to take action in situations when patients' safety and well-being were compromised and by not taking appropriate action to resolve or minimize the risk of harm when a medication error occurred, this displayed a serious and persistent disregard for the Member's professional obligations.

The Panel also finds that the Member's conduct was dishonourable. The Member ought to have known that falsifying medication records was unacceptable and dishonest and that by doing so, demonstrated a level of apathy towards his patients that is unacceptable to this Panel and by members of the public. As such, the Member's conduct was unacceptable and fell well below the standards of a professional.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct of forging disability documents, failure to report to the College the charge and finding of guilt and the failure to meet care standards for multiple patients casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

Penalty

College Counsel and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 6 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practicing class.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires,

online learning modules, decision tools and online participation forms (where applicable):

1. *Professional Standards*,
2. *Medication,*
3. *Documentation,*
4. *Reporting Guide,* and
5. *Code of Conduct*;

iv. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into his behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his certificate of registration;

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide his employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

1. that they received a copy of the required documents,
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession, and
3. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director after each audit regarding the results of each audit:

    a. the first audit shall take place within 3 months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
    c. the third audit shall take place within 9 months from the date the Member begins or resumes employment with the employer,
    d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer;

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 5 patient records to ensure they meet both CNO and employer standards, and
2. discussing with the Member's Mentor (as defined below) whether any deficiencies have been noted in the Member's nursing practice.

c) For a period of at least 12 months from the date the Member returns to the practice of nursing, the Member must meet with a Registered Nurse who is employed at the same employer as the Member and who is pre-approved by the Director ("Mentor") to discuss his efforts to ensure that his care, medication administration and documentation are meeting the standards of practice of the profession. The Member must meet with the Mentor at such frequency as

determined by the Mentor, but at least monthly. In order for the Mentor to be pre-approved by the Director, the Member must:

i. Provide the proposed mentor with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

ii. Provide the Director with a copy of the proposed mentor's résumé and a report confirming the following:

1. that the proposed mentor has received a copy of the documents identified in 3(c)(i), and
2. that the proposed mentor agrees to notify the Director and the Member's employer immediately upon receipt of any information that the Member has breached the standards of practice of the profession.

d) After the 12 month period identified in 3(c) above, the Mentor will determine whether further meetings are required and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

e) The Member shall not practice independently in the community for a period of 18 months from the date the Member returns to the practice of nursing.

4. All documents delivered by the Member to CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member's conduct was serious and pertained to multiple patients over a short time frame;
- The Member showed a cavalier attitude in regards to patient safety;
- The Member was a poor role model for colleagues and did not listen when they tried to assist;
- The Member had a persistent disregard for patients or accountability to them;
- The Member was charged and criminally convicted for forging the signature of another staff member from his place of employment. This was fundamentally dishonest and casts doubt on the Member's ability to discharge his obligations;

- The Member failed to report the criminal charge and conviction, thereby impeding the College from discharging its responsibilities, and raises governability questions.

The mitigating factors in this case were:

- The Member had no prior discipline history with the College;
- The Member accepted responsibility for his actions and pleaded guilty;
- The Member participated in an uncontested hearing.

The proposed penalty provides for general deterrence through the oral reprimand and a 6-month suspension, sending a message to the profession that conduct of this nature will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and a 6-month suspension as it shows the Member that there are consequences for his behaviour.

The proposed penalty provides for remediation and rehabilitation through the terms, conditions and limitations placed on the Member's certificate of registration including two meetings with a Nursing Expert, an 18-month employer reporting with random audits to be completed, and a 12-month Mentor relationship.

Overall, the public is protected because:

- The Joint Submission on Order, in its totality, is geared toward public protection. The order sends a message to nurses that there are consequences for their behaviour, and to the public of the profession's ability to self-regulate.
- In particular, the 18-month employer notification will protect the public because of the increased employer awareness and understanding of the Member's past actions.

College Counsel submitted three cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO v. Russon (Discipline Committee, November 2018): The member was not in attendance. The member failed to meet the standards when she performed controlled acts without proper delegation; failed to document treatment provided and failed to ensure assessment completed by the physician or nurse practitioner. The member was given a penalty which included an oral reprimand, a four-month suspension, two meetings with the Nursing Expert and a twenty-four month employer notification.

CNO v. Simeone (Discipline Committee, March 2017): The member was self-represented. The member did not meet the standards of practice when she failed to attend to provide care; failed to document the telephone call with the wife of the patient; failed to complete a wound assessment and failed to complete a medication error report. This case involved many patients over a 2-year period. The member was given a penalty which included an oral reprimand, a five-month suspension, two meetings with the Nursing Expert, an eighteen-month employer notification, random audits and not being allowed to practice independently in the community.

CNO v. Scott (Discipline Committee, October 2017): The member was self-represented. The member was found guilty of an offence relevant to suitability to practice (i.e. was found to have operated a motor vehicle while impaired) and failed to report the charges and finding of guilt to the College. The

member was given a penalty which included an oral reprimand, a three-month suspension, one meeting with the Nursing Expert and a twelve-month employer notification.

The Member had no submissions.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 6 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practicing class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;
        ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Medication,*
            3. *Documentation,*
            4. *Reporting Guide,* and

5. *Code of Conduct*;

iv. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into his behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his certificate of registration;

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide his employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

1. that they received a copy of the required documents,
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession, and
3. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director after each audit regarding the results of each audit:

    a. the first audit shall take place within 3 months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
    c. the third audit shall take place within 9 months from the date the Member begins or resumes employment with the employer,
    d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer;

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 5 patient records to ensure they meet both CNO and employer standards, and
2. discussing with the Member's Mentor (as defined below) whether any deficiencies have been noted in the Member's nursing practice.

c) For a period of at least 12 months from the date the Member returns to the practice of nursing, the Member must meet with a Registered Nurse who is employed at the same employer as the Member and who is pre-approved by the Director ("Mentor") to discuss his efforts to ensure that his care, medication administration and documentation are meeting the standards of practice of the profession. The Member must meet with the Mentor at such frequency as determined by the Mentor, but at least monthly. In order for the Mentor to be pre-approved by the Director, the Member must:

i. Provide the proposed mentor with a copy of:

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. this Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

ii. Provide the Director with a copy of the proposed mentor's résumé and a report confirming the following:

1. that the proposed mentor has received a copy of the documents identified in 3(c)(i), and
2. that the proposed mentor agrees to notify the Director and the Member's employer immediately upon receipt of any information that the Member has breached the standards of practice of the profession.

d) After the 12 month period identified in 3(c) above, the Mentor will determine whether further meetings are required and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

e) The Member shall not practice independently in the community for a period of 18 months from the date the Member returns to the practice of nursing.

4. All documents delivered by the Member to CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. These objectives are reached by the Member being audited and not practicing independently in the community for 18 months, and by the remediation of the Member through the meetings with the Regulatory Expert. The six-month suspension and not being able to work independently will ensure public protection. The penalty sends a strong message to the Member and the membership as a whole that not maintaining accurate documentation and providing care below practice standards will not be tolerated.

The penalty is in line with what has been ordered in previous cases.

I, David Edwards, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.