DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Heather Stevanka, RN	Member
Sherry Szucsko-Bedard, RN	Member
Devinder Walia	Public Member
Chuck Williams	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
KELLY REINHART	)	SOPHIA RUDDOCK for
Reg. No. 0453993	)	Kelly Reinhart
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 23, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on July 23, 2018 at the College of Nurses of Ontario (the "College") at Toronto.

Kelly Reinhart (the "Member") was present for the hearing and was represented by Counsel.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated May 17, 2018 are as follows.

IT IS ALLEGED THAT:

1. 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 Nurse at Lanark Heights Long Term Care ("the Facility") in Kitchener, Ontario,

you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, on or about March 22, 2015, with respect to:

(a) misappropriating from the Facility the narcotic, Dilaudid, intended for the client, [the Client], and/or

(b) making a false entry in the client's record for [the Client] indicating the narcotic had been administered to the client when, in fact, you had misappropriated the narcotic.

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(8) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Lanark Heights Long Term Care ("the Facility") in Kitchener, Ontario, you misappropriated property from a client or workplace with respect to misappropriating from the Facility the narcotic, Dilaudid, intended for the client, [the Client], on or about March 22, 2015.

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 subsection 1(14) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Lanark Heights Long Term Care in Kitchener, Ontario, you falsified a record relating to your practice with respect to making a false entry in the client's record for the client, [the Client], indicating that Dilaudid had been administered to the client when, in fact, you had misappropriated the narcotic, on or about March 22, 2015.

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(37) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Lanark Heights Long Term Care ("the Facility") in Kitchener, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, on or about March 22, 2015, with respect to:

(a) misappropriating from the Facility the narcotic, Dilaudid, intended for the client, [the Client], and/or

(b) making a false entry in the client's record for [the Client] indicating the narcotic had been administered to the client when, in fact, you had misappropriated the narcotic.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b), 2, 3, 4(a) and 4(b) 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

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

THE MEMBER

1. Kelly Reinhart (the "Member") obtained a diploma in nursing from Conestoga College in 2003.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on March 5, 2004. The Member resigned from the College on February 8, 2016.

3. The Member was employed at Lanark Heights Long Term Care (the "Facility") from July 31, 2014 to April 1, 2015, when she resigned her employment as part of a settlement with the Facility.

THE FACILITY

4. The Facility is located in Kitchener, Ontario. It is a long-term care home with five units, each with 32 beds. It is home to 160 residents.

5. The Member worked at the Facility as the RN Manager, which meant she was in charge of the entire facility when she was the RN on duty. She provided support to staff, processed medication changes, documented workplace injuries and communicated with families about any issues or concerns.

6. The Member primarily worked the day shift, from 0700 to 1500. She occasionally worked the evening shift, from 1500 to 2300, and the night shift, from 2300 to 0700.

7. On the day and evening shift, there were five Registered Practical Nurses ("RPN") on shift and one RN, usually the Member. On the night shift, there were two RPNs and one RN on shift.

8. RPNs were responsible for medication administration at the Facility.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incident at the Facility

9. On March 22, 2015, the Member worked the evening shift, from 1500 to 2300. She was not responsible for medication administration.

10. [Nurse #1], RPN, also worked the evening shift on March 22, 2015. She was responsible for medication administration on one of the five units.

11. Around 1630, the Member approached [Nurse #1] and offered to administer medication to [the Client] (the "Client"), who was palliative and receiving Dilaudid for pain.

12. [Nurse #1] told the Member she had already completed an assessment of the Client and would administer the medication shortly, but the Member insisted on doing it herself.

13. [Nurse #1] opened the narcotic bin for the Member. The narcotic bin was in the medication cart, which was in the medication room. [Nurse #1] watched the Member draw up a vial of Dilaudid into a syringe. The Member then walked down the hallway, towards the Client's room, looking back at [Nurse #1] as she walked.

14. [Nurse #1] moved so she had a clear view of the Client's room. She watched the Member enter and then come out of an empty room next to the Client's room. The Member told [Nurse #1] that she had mixed up the rooms.

15. The Member then entered the Client's room. [Nurse #1] followed her in. [Nurse #1] then observed that the syringe the Member had in her hand was empty. She watched the Member pretend to administer the Dilaudid to the Client.

16. The Member documented the administration of Dilaudid in the Client's Individual Narcotic and Controlled Drug Sheet as though it had been administered.

17. [Nurse #1] notified Facility management of the incident that evening.

Criminal Charges & Conviction

18. On April 27, 2015, the Member was charged, in relation to the incident above, with theft of a value not exceeding $5,000, contrary to section 334(b) of the *Criminal Code of Canada*, possession of property obtained by a crime of a value not exceeding $5,000, contrary to section 355(b) of the *Criminal Code of Canada*, and knowing a document to be forged, did use, deal or act on it as if it were genuine, contrary to section 368(1)(a) of the *Criminal Code of Canada*.

19. On June 5, 2015, the Member was also charged in relation to the incident with unlawfully, by deceit, falsehood or other fraudulent means, defraud a person of services, contrary to section 380(1) of the *Criminal Code of Canada.*

20. On August 30, 2016, following a trial, the Member was found guilty in relation to the incident of theft of a value not exceeding $5,000, contrary to section 334(b) of the *Criminal Code of Canada*, with respect to the Dilaudid she misappropriated from the Facility. The other charges were withdrawn or stayed, although the trial judge observed that the elements of those offences had also been made out on the evidence.

21. On December 6, 2016, the Member received a suspended sentence and two years' probation.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

22. The Member admits that she committed the acts of professional misconduct as described in paragraphs 9 to 17 above, in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as alleged in the Notice of Hearing, as follows:

- 1(a) in that she misappropriated Dilaudid from the Facility that was intended for the Client on March 22, 2015;

- 1(b) in that she made a false entry in the Client's record when she indicated that Dilaudid had been administered to the Client when, in fact, she had misappropriated the narcotic.

23. The Member admits that she committed the act of professional misconduct, as alleged in paragraph 2 of the Notice of Hearing, in that she misappropriated Dilaudid from the Facility that was intended for the Client on March 22, 2015.

24. The Member admits that she committed the act of professional misconduct, as alleged in paragraph 3 of the Notice of Hearing, in that she falsified a record relating to her practice when she made a false entry in the Client's record on March 22, 2015, indicating that Dilaudid had been administered to the Client when, in fact, she had misappropriated the narcotic.

25. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 4 (a) and (b) of the Notice of Hearing, and in particular, her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 9 to 17 above.

Decision

The College bears the onus of proving the allegations in the Notice of Hearing 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(a), 1(b), 2, and 3. The Panel finds that the Member engaged in conduct that would be reasonably considered by members to be disgraceful, dishonourable and unprofessional as alleged in paragraphs 4(a) and 4(b) of the Notice of Hearing.

Reasons for Decision

Allegation 1(a) and 1(b) in the Notice of Hearing is supported by paragraphs 9 to17 and 22 in the Agreed Statement of Facts. The facts document that the Member committed the act of professional misconduct in that the Member insisted that she would give the Client his Dilaudid even though [Nurse #1], an RPN, reported to the Member that she had already completed her assessment of the Client and would administer the medication shortly. [Nurse #1] watched the Member draw up the Dilaudid into a syringe. [Nurse #1] watched the Member enter an empty room next to the Client's room. [Nurse #1] observed that the syringe the Member had in her hand was empty. [Nurse #1] watched as the Member pretended to administer the Dilaudid to the Client. The Member then documented that she had administered the Dilaudid in the Client's Individual Narcotic and Controlled Drug Sheet when in fact the Member misappropriated the narcotic Dilaudid. The Member admits to this allegation as per the Agreed Statement of Facts.

Allegation 2 in the Notice of Hearing is supported by paragraphs 13 to 15 and 23 in the Agreed Statement of Facts. The facts document that the Member committed the act of professional misconduct

in that the Member had [Nurse #1] open the narcotic bin for her. [Nurse #1] watched the Member draw up a vial of Dilaudid into the syringe. [Nurse #1] observed the Member coming out of an empty room with an empty syringe. The Member then told [Nurse #1] she had gone into the wrong room. The Member pretended to administer the Dilaudid to the Client in front of [Nurse #1]. The Member admits to this allegation as per the Agreed Statement of Facts that she misappropriated the narcotic Dilaudid.

Allegation 3 in the Notice of Hearing is supported by paragraphs 16, 20, 22, and 24 in the Agreed Statement of Facts. The facts document that the Member committed the act of professional misconduct in that the Member falsified a record relating to her practice when she made a false entry into the Client's medication administration record. In fact, the Member documented that the Client did receive the Dilaudid on or about March 22, 2016. The Member admits to this allegation as per the Agreed Statement of Facts that she did enter into the Client medication record that she gave the Dilaudid. The Member failed to meet the Client's health care needs in that the Member allowed her personal interest to influence her professional judgement. The Member had no regard for what was in the best interest of the Client.

With respect to Allegation 4(a) and 4(b**)** in the Notice of Hearing, these allegations are supported by paragraphs 9-21 and 25 in the Agreed Statement of Facts. The facts document that the Member committed the act of professional misconduct when she misappropriated the narcotic Dilaudid from the facility**.** The Member made a false entry in the Client's Individual Narcotic and Controlled Drug Sheet record indicating the narcotic was administered to the Client when in fact the Member had misappropriated this medication for her own use.

The Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. Nurses are accountable for practising in accordance with the Professional Standards, practice expectations, legislation and regulations. The Member gave false and misleading information, which is dishonest and breaches the public's trust in the profession.

The Panel also finds that the Member's conduct was dishonourable. The Member demonstrated an element of dishonesty and deceit by approaching [Nurse #1] and offering to administer medication to the Client who was palliative and receiving Dilaudid for pain. The Member misappropriated the medication Dilaudid for her own use. The Member failed to meet the basic needs of the Client when she withheld the Client's medication, this act in its self is neglect and morally wrong. The Member was in a position of power over not only the Client but also [Nurse #1] who was an RPN working under the Member's direct supervision.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct of the Member resulted in her being criminally charged and convicted on August 30, 2016 in relation to the incident of theft of a value not exceeding $5,000, contrary to section 334(b) of the *Criminal Code of Canada* with respect to the Dilaudid she misappropriated from the Facility. Then Member was also charged with possession of property obtained by crime of a value not exceeding $5,000, contrary to section 355(b) of the *Criminal Code of Canada*, knowing a document to be forged, did use, deal or act on it as if it were genuine, contrary to section 368(1)(a) of the *Criminal Code of Canada*, and with unlawfully, by deceit, falsehood, or other fraudulent means defrauding the Client of services, contrary to section 380(1) of the *Criminal Code of*

Canada. The fact that the Member willingly withheld/misappropriated pain medication from a palliative Client casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects nursing professionals to meet. This Member demonstrated a lack of integrity, dishonesty, abuse of her power and disregard for the welfare and safety of the Client. The health profession will not tolerate this conduct. The Member's conduct has brought shame not only on herself but also on the profession as a whole.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for five months. This suspension shall take effect from date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense, and within six months from the date the Member obtains an active certificate of registration. 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 seven 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Therapeutic Nurse-Client Relationship*.

iv. At least seven 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 clients, 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 her 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 her 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 her 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 her 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. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
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

c) The Member shall not practise 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 the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

College Counsel and the Member's Counsel made submissions.

The Parties agreed that the mitigating factors in this case were:
The Member has co-operated with the College and has taken responsibility for her actions. The Member agreed with the Joint Submission on Order. The Member admitted she was dishonest and deceitful in her actions. The Member acknowledged she misappropriated the narcotic Dilaudid from the Client and that she falsified the Client Narcotic and Controlled Drug Sheet. The Member has had no prior history of workplace misconduct nor has she had any prior complaints with the College. The Member attended the hearing. The Member resigned from the College on February 8, 2016. The Member's Counsel advised the Panel that the Member had/is suffering from medical issues, but gave no indication what type of medical issues the Member is in fact having.

The aggravating factors in this case were:
The Member must have some element of moral turpitude in that her conduct was unjust and shameful, and it brings shame not only on the Member but also on the profession and causes the public to fear similar care at the hands of the nursing profession. The Member caused harm to the Client by failing to meet the Client's basic need by withholding the Client's pain medication Dilaudid. By definition, this is neglect. The Member also took advantage of a vulnerable Client. The Member should have known that withholding the Client's pain medication would cause the Client undue pain and suffering. The Member undermined the trust the Client had for her. The Member breached the trust of the Client and the profession. The Member abused her power as a Nurse Manager at Lanark Heights Long Term Care Facility ("the Facility") knowing she could gain full access to the Dilaudid because she was the only RN on shift, all the other nurses were RPNs which the Member had direct control over. Nurses should honour their commitment to the profession and do no harm. The Member knowingly and willingly falsified the Client's medical record when she misappropriated the narcotic Dilaudid.

The proposed penalty provides for general deterrence by sending a message to the profession as a whole that this type of conduct (i.e. misappropriating medication) will not be tolerated and those members can and will be prosecuted criminally if they engage in this type of conduct.

The proposed penalty provides for specific deterrence through the five-month suspension, and the terms, conditions and limitations. It sends a strong message to the nursing profession that breaches of the Practice Standards will not tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand, suspension, and terms, conditions and limitations including employer notification.

The proposed penalty provides for remediation and rehabilitation through two meetings with a nursing expert. This will provide the Member the opportunity to reflect back on her actions so that she will not repeat them in the future.

Overall, the public is protected because the Member will be required to notify her employer of this decision for a period of 18 months after the suspension ends. The proposed penalty also promotes public confidence in the ability of the nursing profession to regulate its members.

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

CNO v Visca (Discipline Committee 2017). This case involved a member who misappropriated two bottles of narcotics and $40.00 cash from Client A and misappropriated $20.00 to $30.00 dollars from Client B. The Panel gave this member a five-month suspension and similar terms, conditions and limitations on her certificate. The Panel ordered the member to appear before the panel for an oral reprimand within three months of the date on the order. The Panel ordered that the member would not be able to practise independently for a period of 18 months.

CNO v Genereaux (Discipline Committee 2018). This case involved the misappropriation of narcotics from a client on several occasions. This member was given a seven-month suspension and similar terms, conditions and limitations on her certificate. The member also had to meet with a nursing expert for two meetings. The Panel ordered that the member would not be able to practise independently for 18 months.

Independent Legal Counsel stated, “That the primary goals of an order are to ensure the protection of the public and to maintain confidence in nursing and self-regulation.” Independent Legal Counsel referenced the Joint Submission on Order and informed the Panel that we must accept the Joint Submission on Order unless we decide that the proposed penalty was so disproportionate to the offence that to accept it would not be in the public’s interest or would bring the administration of justice into disrepute.

Penalty Decision

The Panel accepts the Joint Submission as to Order and accordingly orders:

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

2. The Executive Director is directed to suspend the Member’s certificate of registration for five months. This suspension shall take effect from date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

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

    a. The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense, and within six months from the date the Member obtains an active certificate of registration. 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 seven 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Therapeutic Nurse-Client Relationship*.

        iv. At least seven 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 clients, 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 her 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 her 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 her 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 her 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. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

1. that they received a copy of the required documents, and
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

c. The Member shall not practise 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 the College, 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. Conduct by nurses that demonstrates a lack of integrity, dishonesty, abuse of power, access and authority, or disregard for the welfare and safety of members of the public is conduct that cannot be tolerated by the nursing profession.

I, Dawn Cutler, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.

_____ _____

Chairperson Date