DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Susan Roger, RN	Chairperson
	Carly Gilchrist, RPN	Member
	Sandra Larmour	Public Member
	Donna Marie May, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
CHIDIEBERE ANYAEGBUNAM	)	NO REPRESENTATION for
Registration No. AF167292	)	Chidiebere Anyaegbunam
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: April 12, 13, 19, 26 and July 7, 2022

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") commencing on April 12, 2022, via videoconference.

As Chidiebere Anyaegbunam (the "Member") was not present, the hearing recessed for 15 minutes to allow time for the Member to appear. Upon reconvening the Panel noted that the Member was still not in attendance.

College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing on March 8, 2022 by way of an affidavit from [ ], Prosecutions Clerk, dated March 9, 2022, confirming that [the Prosecutions Clerk] sent correspondence, which included the Notice of Hearing, on March 8, 2022 to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if he did not participate in the hearing, it may proceed

without his participation. Accordingly, the Panel decided to proceed with the hearing in the Member's absence.

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 the publication or broadcasting of the names of the patients, or any information that could disclose the patients' identities, referred to orally or in any documents presented at the Discipline hearing of Chidiebere Anyaegbunam.

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

The Allegations

The allegations against the Member as stated in the amended Notice of Hearing dated March 8, 2022 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 Practical Nurse ("RPN") at the Markham Stouffville Hospital in Markham, Ontario ("Hospital"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, with respect to the following incidents:

    (a) on or about October 20-21, 2018, you attempted to administer crushed medication via a syringe to the patient, [Patient A], who had a decreased level of consciousness, contrary to the direction given to you by your RPN preceptor, [Preceptor A];

    (b) on or about October 28, 2018, you confirmed to your RPN preceptor, [Preceptor B], that the patient, [Patient B], was clean and ready for bed when the patient was soaked in urine;

    (c) on or about October 28, 2018, you documented that the patient, [Patient C], who was blind, weak and had suffered falls, was "within defined limits" when she was not;

(d) on or about October 28, 2018, you attempted to administer medications to the patient, [Patient C],

i. by pouring the medications with juice down the patient's throat, without explanation, despite a language barrier, the patient being blind, and contrary to the direction given to you by your RPN preceptor, [Preceptor B], and/or,

ii. when the patient choked on the juice and medications, you pushed the patient forward and banged on her back without warning to her, causing her to become agitated and/or incontinent of urine;

(e) on or about November 2, 2018, you made inappropriate comments regarding other nursing staff at a meeting with management, stating that you knew women, that gossiping was "a woman thing" and that such gossip should not affect the staff's opinion of your work, or words to that effect;

(f) on or about November 2, 2018, following your meeting with management,

i. you asked [Preceptor A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her uncomfortable since the quality of your work was an issue to be addressed by management; and/or

ii. you asked [Nurse A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her feel uncomfortable since the quality of your work was an issue to be addressed by management, and you also expressed anger that other nurses should not be criticizing your work, you did not need to be "babysat", and that you did not need to take direction from "these girls", or words to that effect;

(g) on or about November 9, 2018,

i. you failed to waste properly a vial of midazolam, a controlled substance, after some of the medication had been administered to a patient, and,

ii. you spoke angrily and/or in an agitated manner to the pharmacy technician, [ ], when she called you to advise you that either you had to waste the medication properly or she would have to do it and prepare an incident report.

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(13) of *Ontario Regulation 799/93*, in that, while employed as an RPN at the Hospital, you failed to keep records as required on or about October 28, 2018 when you documented that the patient, [Patient C], who was blind, weak and had suffered falls, was "within defined limits" when she was not.

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(37) of *Ontario Regulation 799/93*, in that, while employed as an RPN at the Hospital, 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 with respect to the following incidents:

    (a) on or about October 20-21, 2018, you attempted to administer crushed medication via a syringe to the patient, [Patient A]., who had a decreased level of consciousness, contrary to the direction given to you by your RPN preceptor, [Preceptor A];

    (b) on or about October 28, 2018, you confirmed to your RPN preceptor, [Preceptor B], that the patient, [Patient B], was clean and ready for bed when the patient was soaked in urine;

    (c) on or about October 28, 2018, you documented that the patient, [Patient C]., who was blind, weak and had suffered falls, was "within defined limits" when she was not;

    (d) on or about October 28, 2018, you attempted to administer medications to the patient, [Patient C],

        i. by pouring the medications with juice down the patient's throat, without explanation, despite a language barrier, the patient being blind, and contrary to the direction given to you by your RPN preceptor, [Preceptor B], and/or,

        ii. when the patient choked on the juice and medications, you pushed the patient forward and banged on her back without warning to her, causing her to become agitated and/or incontinent of urine;

    (e) on or about November 2, 2018, you made inappropriate comments regarding other nursing staff at a meeting with management, stating that you knew women, that gossiping was "a woman thing" and that such gossip should not affect the staff's opinion of your work, or words to that effect;

(f) on or about November 2, 2018, following your meeting with management,

i. you asked [Preceptor A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her uncomfortable since the quality of your work was an issue to be addressed by management; and/or

ii. you asked [Nurse A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her feel uncomfortable since the quality of your work was an issue to be addressed by management, and you also expressed anger that other nurses should not be criticizing your work, you did not need to be "babysat", and that you did not need to take direction from "these girls", or words to that effect;

(g) on or about November 9, 2018,

i. you failed to waste properly a vial of midazolam, a controlled substance, after some of the medication had been administered to a patient, and,

ii. you spoke angrily and/or in an agitated manner to the pharmacy technician, A.L., when she called you to advise you that either you had to waste the medication properly or she would have to do it and prepare an incident report.

Member's Plea

Given that the Member was not present nor represented, he was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member first registered with the College on August 23, 2016 as a Registered Practical Nurse ("RPN"). The Member was hired on a part-time basis at One Centre, Markham Stouffville Hospital Oak Valley Health Centre in October 2018. One Centre (the "Unit") provided care for palliative patients as well as patients requiring complex continuing care. The incidents occurred while he was training with a preceptor on the Unit. Due to allegations as described in the Notice of Hearing, the Member was terminated from his position in November 2018. The Member resigned his certificate of registration with the College in April 2022.

The issues at the hearing were as follows:

1) Did the Member fail to meet the standards of practice of the profession?

2) Did the Member fail to keep accurate records? and

3) Would the Member's conduct reasonably be considered by other members of the profession as disgraceful, dishonourable and unprofessional?

The Panel heard evidence from nine witnesses and received forty-six exhibits to consider. The Panel found that the Member committed professional misconduct by failing to meet the standards of practice, failing to keep accurate records and engaged in conduct that would be regarded by members of the profession to be dishonourable and unprofessional.

The Evidence

The Panel heard testimony from nine witnesses, one of whom the Panel accepted as a Nursing Expert. Documentary evidence included e-mail exchanges and written notes between the Member and witnesses, relevant documentation, the health records of patients involved as well as the relevant College Practice Standards.

Witness [A] – [ ] ("[ ]")

[Witness A] reviewed her post-secondary education with the Panel. [Witness A] initially graduated from Seneca College and has been registered with the College since 1991. In 1999, she graduated from Ryerson University with a BScN degree. [Witness A] has been employed with Markham Stouffville Oak Valley Health Centre since 2015. Her roles within the organization have involved acting as a clinical manager, patient flow coordinator and discharge planner. [Witness A]'s role on the Unit involves overseeing the Unit, hiring individuals for positions on the Unit, completing performance appraisals and attendance management, reviewing staff schedules and liaising with patients and families if concerns arise.

[Witness A] provided an overview to the Panel of the client population of the Unit, staffing ratios, general routine of the Unit including documentation expected of the nurses. College Counsel inquired about the Unit's medication administration cart. [Witness A] testified that medication bins are usually locked. An Automatic Dispensing Unit ("ADU") is kept in the medication room which contains narcotics. Medication bins contain patients' routine scheduled medication and narcotics are not stored in these bins. Nurses are responsible for taking their medication bins for exchange from the medication cart to the medication room where there is a bin exchange of the day's medication. The pharmacy routinely completes the exchange between 1400-1500 hours daily.

[Witness A] reviewed for the Panel the electronic documentation system on the Unit, which is Meditech. She also reviewed orientation practices for new staff, which involves a week-long mandatory orientation session facilitated by the professional practice lead which reviews documentation, skills lab/SIM lab and where to locate policies and procedures.

[Witness A] reviewed and testified to the Panel about Exhibits #7-#12. These included the Member's orientation schedule and name of his preceptor, [ ] ("[Preceptor A]"). There was a brief

e-mail exchange between the Member and [Witness A] indicating that he would only be able to work on weekends. [Witness A] testified that she had concerns with this as it is generally not her practice to schedule an orientation shift to begin on the weekend as there is less staff and support (i.e., professional practice leaders) available. [Witness A] reviewed the Unit's Patient Assignment Sheets from October/November 2018 confirming that the Member was assigned to be trained with [Preceptor A]. In regards to Exhibit #12, [Witness A] reviewed the handwritten notes that she had completed during an exchange with [Preceptor A]. [Preceptor A] provided feedback to [Witness A] about the Member. The notes indicate that [Preceptor A] reported that the Member wanted to complete tasks "his way", that he "wasn't listening" and "moving too slowly" and requiring more education and orientation time. [Preceptor A] reported that the Member "did not want to take her advice" while she was providing education on a CAAD pump. [Preceptor A] had reported to [Witness A] that the Member had, further, given oral medications to a patient that [Preceptor A] had assessed to be "too sedated". The Member's assessment was contrary to that of [Preceptor A] and he administered the medication. [Witness A] testified to the amount of orientation shifts expected of a new employee, which usually consisted of 4–6-day shifts and 2-night shifts. [Witness A] reviewed the expectations of the orientation were initially just shadowing the preceptor and working up to a full patient load. [Witness A] testified that she touches base with each preceptor to evaluate how the orientee is progressing, reviewing the need for further orientation and whether specific skills i.e., wounds, CADD pump etc. have been reviewed. [Witness A]'s usual practice is to meet with the employee if he/she is unable to complete a full workload assignment, assessing their learning needs, providing support and allowing for more scheduled orientation days, if required.

College Counsel discussed general policies with [Witness A]. [Witness A] testified that these are found under the internal intranet and that staff can access those policies on the intranet on an as needed basis. [Witness A] reinforced to the Panel that general education is to be completed annually depending on the discipline and competency checklist.

College Counsel reviewed with the Panel and [Witness A] the Narcotic and Controlled Drugs Substances Management Policy dated September 4, 2018. [Witness A] described that it is a policy in compliance with legislation and organizational practices for administering narcotics as well as proper storage, documentation and wastage of narcotics. [Witness A] confirmed that this policy is one that nurses are expected to follow on the Unit. [Witness A] testified that narcotics are stored in locked drawers or cupboards at all times which are located in a locked medication room.

[Witness A] testified to the organization's Inpatient Standards of Care and Assessment dated September 20, 2018. [Witness A] confirmed to the Panel that this document provides expectations of care at Markham Stouffville Oak Valley Health Centre and in particular the Unit. College Counsel directed [Witness A] and the Panel to page 3 which involves assessment standards. [Witness A] testified that parameters of Within Defined Limits ("WDL") are defined as current findings that are within normal limits. [Witness A] provided an example to the Panel of a normal range of a heart rate which is 60-100 beats per minute, anything below or above this value would not be considered WDL. If the nurse's assessments were considered not WDL a nurse must explain in

detail in the “drop down box”. [Witness A] confirmed to the Panel that assessments are to be completed immediately upon interaction with the patient.

College Counsel reviewed with [Witness A] and the Panel multiple exhibits that were confirmed to be handwritten and typed notes from a meeting with another preceptor of the Member, [ ] (“[Preceptor B]”). [Witness A] testified that [Preceptor B] had waited for [Witness A] after the preceptor's night shift to speak with her about her orientation shifts with the Member. [Preceptor B] voiced concern over the Member’s orientation progression and reported that she felt like the Member was “not listening” and not completing tasks that were previously shown to him in the orientation such as chart checks. According to these handwritten notes, [Preceptor B] reported concerns regarding the Member’s documentation and not meeting expected standards. [Preceptor B] also reported to [Witness A] that she felt that the Member was “not being truthful”. [Preceptor B] provided an example of when the Member needed to assess a patient’s vital signs in order to administer a medication called Metoprolol, the Member did not do so before administering the medication. [Preceptor B] also described an incident of inaccurate documentation when the Member documented that the patient’s genitourinary assessment was WDL, but the patient was incontinent of urine requiring care. [Preceptor B] voiced concerns over the Member’s ability to prioritize.

College Counsel reviewed with [Witness A] and the Panel an email exchange between herself and the Member. [Witness A] testified that the Member had completed two 12-hour day shifts and four 12-hour night shifts. [Witness A] testified that the Member had indicated that he had felt that he had covered all aspects of his orientation. On November 2, 2018, [Witness A] and [ ] (“[Witness E]”) met with the Member. The details of the meeting were described to the Panel. The Member reported that he felt like he was “doing quite well”. [Witness A] discussed with the Member that there were concerns brought to her attention about potential learning gaps of the Member and inquired whether the Member required any further support. [Witness A] indicated to the Panel that she felt like the Member lacked insight into his practice as he reported that he felt like he was doing a “pretty good” job. [Witness A] did note that the Member was very eager and willing to fulfil his educational requirements for the Unit. [Witness A] reviewed with the Panel that the Member was required to have additional orientation shifts, review policies and procedure, and complete learning packages. The Member was also required to attend a hospital orientation, in particular, skills day and SIM lab. [Witness A] testified to the Panel that the Member did not feel that it was necessary for him to attend and he was unable to do so. [Witness A] testified that during the meeting the Member did raise a concern about his previous preceptors and that these were “women issues”. [Witness A] testified to the Panel that she interpreted this as that the Member had felt that his preceptors were not being fair to him. [Witness A] testified that it was evident by the end of the meeting that the Member was upset. [Witness A] had asked the Member to complete his documentation and ‘report off’ to his preceptor, advising the Member that he would be paid for his entire shift and for him to leave the Unit. [Witness A] testified that she felt that the Member “was not in the right frame of mind” to care for patients. [Witness A] testified that the Member did not follow her directions. At approximately 1800 hours that same day [Witness A] testified that his preceptor had reported to her that the Member was in the medication room with another nurse, [ ] (“[Nurse A]”). [Witness A] testified that she went to the

medication room and found the Member there with [Nurse A]. She inquired why the Member had not followed her directions. [Witness A] testified that the Member explained that he and [Nurse A] were wasting a medication. [Witness A] testified that she asked the Member to leave the Unit again.

[Witness A] testified to the Panel that she spoke with [Nurse A] and that [Nurse A] reported that the Member was asking her about how his orientation was progressing. [Witness A] confirmed that [Nurse A] was never his preceptor. [Witness A] testified that [Nurse A] stated that she felt "uncomfortable" and that the Member had "cornered her" in the medication room.

A copy of an email from [Witness A] to the Member dated November 7, 2018 was submitted into evidence. [Witness A] testified that the intent of the email was to summarize the content of the meeting which included the Member's next steps of learning.

[Witness A] testified that she was approached on November 8, 2018 by another of the Member's preceptors, [ ] ("[Witness F]") about his practice. [Witness A] testified that [Witness F] had concerns about the Member's assessments. [Witness A] testified that she was provided the following examples of concerns: 1) The Member's assessments were not accurate; and 2) The Member told a patient who had a significant wound that it was healing and in fact the patient told the Member "this is not going to heal, this isn't part of the healing process".

[Witness A] testified about two separate incidents where the Member did not complete care of a patient who was waiting for her husband to visit and an incident where a narcotic was sent down to the pharmacy in the medication bin. [Witness A] testified that the pharmacy technician, [ ] ("[Witness G]") contacted the Unit to have the Member go to the pharmacy and sign the wastage. [Witness A] testified that the Member became "very loud" with the pharmacy technician on the phone.

In light of the feedback from the Member's preceptors, [Witness A] testified that it was ultimately determined to terminate the Member's employment on November 14, 2018.

Witness 2 – [ ] ("[Witness B]")

[Witness B] obtained a Bachelor Honours Degree in Psychology as well as her Registered Nurse license in England between 1988-1989. She has been registered with the College since 1991. [Witness B] testified that her first job in Canada was at Sunnybrook Hospital in Toronto working in a Psycho-Geriatric Long Term Care Veteran's wing for three years. [Witness B] then transferred to an Acute Psychiatry Unit for 3-4 years within the same organization. [Witness B] testified that between 2001-2002 she moved to Markham Stouffville Oak Valley Health Centre to an Inpatient Mental Health Unit working as a full-time Registered Nurse for 5 years. She then transferred into the position of Professional Practice Lead which initially was temporary. In this role, [Witness B] would support an Inpatient Mental Health Unit, 2 Centre (Alternative Level of Care), Reactive Care Unit and the Unit. [Witness B] testified that she retired in February 2022.

[Witness B] testified that her role as Professional Practice Lead involved working with all nursing staff on her assigned units. She would help orientate new staff, provide support in educational programs, and teach Crisis Intervention. Her work also involved policy development and best practices review within the organization. [Witness B] testified that there is a 'high level' generic orientation to the organization involving review of codes, ceiling lifts, workplace safety, and WHMIS. [Witness B] testified that she had direct interaction with the Member when he completed his orientation for his other position as an RPN on an Inpatient Mental Health Unit. During this orientation the Member received education on documentation, Meditech, IV pumps, medications, how to access an ADU, infection control practices, glucometer training, simulation training and that the Member was paired with a preceptor and supported through his orientation on the Unit.

[Witness B] was presented with several exhibits and testified that these documents were sign in log sheets for skills labs which involved how to use a glucometer, a simulation lab about how to manage patients with fluctuating clinical presentations, and education on infection prevention and control. There was also education on Electronic Medication Administration Record ("eMar"), use of an ADU, and how to administer medication with the Meditech system. [Witness B] reviewed with the Panel an Orientation Manual which outlined the orientation, expectations of the unit as well as resources available to the employee. [Witness B] testified that the Member would have received this manual as a standard practice.

[Witness B] testified that a preceptor was one who had experience on the Unit and enjoyed working with new staff. The preceptor would have to demonstrate an appropriate level of skill and further testified that the preceptor would work and follow the orientee for 5 shifts and with the goal of the orientee taking on more responsibility with the preceptor's support over the orientation period.

Exhibit #25 was the Nursing Orientation Mental Health Competency Checklist and Exhibit #26 were the Member's Learning Goals while he was employed on the Mental Health Unit. [Witness B] testified that the orientation checklist for the Mental Health Unit contains various competencies that are expected of new staff. The orientee would complete a self-assessment, including how confident they would feel about the task. [Witness B] testified that she would meet with the orientee during their orientation and see how the orientee was managing a full case load independently. [Witness B] testified that she recalled the Member's orientation to the Unit was challenging and that he required more support than most staff. [Witness B] then reviewed with the Panel the Member's learning goals. [Witness B] testified that the Member was oriented with "one of the stronger nurses" as the unit manager felt like the Member required extra support. [Witness B] testified that there were several concerns with the Member's practice, but in particular she recalled his lack of documentation. [Witness B] testified that the Member did not always use appropriate mental health terminology and the terminology he used was not always specific and objective.

[Witness B] testified to an incident with the use of restraints. [Witness B] testified that when the Member came to the Unit, he reported that he was very confident in using Pinel restraints, however, when [Witness B] reviewed the use of Pinels with the Member she noted that he had no

idea that Pinels operated on a magnetic lock and key. [Witness B] was not able to provide any further details about the incident. [Witness B] testified that while the Member was employed with the Unit, she had direct contact with the Member and assisted him with his training.

[Witness B] testified that the Member would have received training from a preceptor on the Unit. [Witness B] also testified that the Member attended hospital wide training, however, was unable to recall the sessions the Member attended. [Witness B] testified that she did spend time with the Member reviewing Alaris Pumps.

[Witness B] testified that the Member had sent an email to her because his glucometer access had expired. He also inquired about his PIN number for medication administration, as well as questioned [Witness B] about whether he needed certification for IV insertion. [Witness B] testified that her reply was more focused on support. [Witness B] testified that she had concerns about the Member stating that he was able to apply a restraint when he was unable to do so. [Witness B] testified that she wanted to make it very clear to the Member that he should ask questions and if he did not ask questions it was assumed by others that he already knew the answer. [Witness B] testified that she wanted the Member to know how to get his glucometer access. [Witness B] testified that she felt that the Member was not skilled enough on the Unit to complete IV initiation.

[Witness B] testified to the Panel about the extensive competency checklists and learning goals that each orientee is required to fill out during orientation. [Witness B] testified that the orientee is responsible for reviewing each item on the checklist and completing a self-assessment. The preceptor then co-signs to support that the orientee has completed those competencies. [Witness B] testified that based on those checklists the orientee would complete a learning goal. The Member's goals included becoming more proficient and/or knowledgeable about Meditech, the use of a CADD pump and VAC dressings. [Witness B] testified that she had thought the Member had requested more information about a CADD pump, which is a device used to deliver medication for palliative patients. [Witness B] also testified that she reviewed the Alaris Pump with the Member. [Witness B] testified that she also remembers speaking with the Member about IV access and how he was unable to wait. [Witness B] testified that she felt that the Member was not ready to learn the skill and that he had other priorities.

In response to a Panel member's inquiry as to whether the Member had a language barrier, [Witness B] testified "no not at all, he was very verbally eloquent". College Counsel did not have any questions to make on the Panel member's question.

Witness 3 - [Preceptor A]

[Preceptor A] initially went to college and took General Arts and Science, obtained a diploma in Esthetics. She graduated in 2018 from Seneca College as a Registered Practical Nurse. College Counsel confirmed with [Preceptor A] that she is registered with the College. [Preceptor A] testified that her current employer is Markham Stouffville Oak Valley Health Centre. She initially obtained a part-time temporary position in 2018 on One Centre Palliative/Continuing Complex Care Unit. She eventually obtained a permanent position and is currently working on a temporary

full-time line basis. [Preceptor A] testified that an RPN must follow their scope of practice, A nurse takes transfer of accountability ("TOA"), completes assessments, vitals, administers medication, charting and provides direct patient care. [Preceptor A] testified that there is an element of teamwork in the Unit. Nurses need to communicate with one another. [Preceptor A] testified that on a day shift RPNs are usually assigned 5 patients and on nights up to 7. [Preceptor A] testified that the patient population involves palliative patients generally over the age of 18. [Preceptor A] testified that the Unit cares for elderly patients and that the majority of the patients are over 60 years of age. In regard to the continuing complex care patients, [Preceptor A] testified that their ages range and their needs depend on the individual patient. [Preceptor A] testified that the care needs of a continuing complex care patient often differ from a palliative patient. [Preceptor A] testified that a continuing complex care patient often times has tracheostomy, feeding tubes and may require the use of a mechanical lift.

College Counsel inquired whether [Preceptor A] had ever acted as a preceptor. [Preceptor A] confirmed to the Panel that she had and discussed the roles and responsibilities of a preceptor. She provided details for the Panel regarding her responsibilities to orientate the new hire to the Unit. [Preceptor A] testified that she would show the orientee where the medication is kept, how to use the computer, where the charts are and guide the orientee on how to care for a palliative patient. [Preceptor A] testified that "it's more orientating to the unit, they should already have the skills".

College Counsel confirmed with [Preceptor A] that she was assigned to orientate the Member. [Preceptor A] testified that she generally expects an orientee to shadow her for the first shift. If the orientee feels comfortable they can participate in tasks and if they feel competent then the orientee can assist in care. [Preceptor A] testified that a new orientee can provide patient care, administer medication and that she would be there to support the orientee. [Preceptor A] testified that the Member was always eager, "always 3-4 steps ahead a me, trying to do tasks before he was ready". [Preceptor A] recalled an incident for the Panel regarding an Alaris Pump. [Preceptor A] testified that the Member indicated that he knew how to work the pump, but was unable to work the pump, testifying that "he was trying to show me before I was ready to explain it to him". [Preceptor A] reinforced to the Panel that the Member had prior mental health experience and his pump experience could have been limited.

<u>Patient [A]</u>

[Preceptor A] reviewed with the Panel the reason Patient [A] was admitted onto the Unit and that she was receiving palliative sedation to help cope with distressing end of life symptoms. [Preceptor A] was familiar with Patient [A]'s health record, providing knowledge to the Panel about her condition, physician notes, prescriptions and eMAR. College Counsel reviewed the medical record of Patient [A] with [Preceptor A] and the Panel dated October 20, 2018 at 0814 hours. [Preceptor A] confirmed that the Member did not administer the medication with the rationale that Patient [A] was sleeping. College Counsel questioned [Preceptor A] if she recalled if the Member attempted to administer these medications. [Preceptor A] confirmed to the Panel that the Member attempted to administer this medication. [Preceptor A] testified that Patient [A]

was a palliative patient and that Patient [A] had an altered level of consciousness. At times Patient [A] was unrousable. [Preceptor A] testified that she stated to the Member that he would not be able to administer the medication to Patient [A] because Patient [A] would be at risk for aspiration testifying that Patient [A] was not always alert enough to swallow. [Preceptor A] testified that the Member stated to her that he would "show her how he would give the medication to the patient". [Preceptor A] testified that the Member proceeded to crush the medication and deliver it to Patient [A]. [Preceptor A] testified that once the Member was in Patient [A]'s room, he realized that Patient [A] was not responding and was unable to swallow the medication. [Preceptor A] testified that the Member came out into the hallway and stated "he couldn't give it". College Counsel inquired whether the Member told [Preceptor A] how he planned on administering the medication. [Preceptor A] testified that the Member crushed the medication. [Preceptor A] testified that the Member was not open to guidance or support and that the Member was going to "show her" how to administer the medication. [Preceptor A] testified that it was possible that if the Member were to have administered the mediation to Patient [A] she could have aspirated. [Preceptor A] testified that if the medication were to have been aspirated it would have caused Patient [A] more pain, and that it could be detrimental to Patient [A]. [Preceptor A] testified that she provided feedback to her manager. She recalled the conversation with her manager, but not the actual meeting.

[Preceptor A] testified that medication bins are kept locked in a locked room, and that the pharmacy changes the medication bins in the afternoon. Staff are to go into a locked room in the afternoon and retrieve new bins. [Preceptor A] testified that staff have a cart with a computer on it and drive around the Unit. Medication bins are locked up in the care area and staff have a password for each drawer. College Counsel inquired what type of medications are in the bins. [Preceptor A] testified all medications but narcotics. Narcotics are kept in the ADU which requires a fingerprint and a password to release the medication. [Preceptor A] testified that she would have reviewed with the Member the process to retrieve individual medication bins, putting them into the cart and then back in the afternoon. [Preceptor A] also confirmed that she would have reviewed narcotic administration, the retrieval and wastage of the medication and the need for a double signature with the Member. [Preceptor A] testified that nurses who work in palliative care administer narcotic medication on a regular basis.

[Preceptor A] testified to an incident involving the Member on the day that he was terminated from his employment. [Preceptor A] testified that the Member approached her and asked her to meet with him in the locked medication room. While in the room [Preceptor A] testified that the Member started asking her questions about his practice. [Preceptor A] testified that the Member appeared upset and was irritable. [Preceptor A] testified that the Member wanted her to let him know if she had thought that he had done anything wrong. [Preceptor A] testified that it appeared that the Member was "looking for someone to blame". [Preceptor A] further testified that she "did not want to get into anything with him" and that she tried to encourage the Member to never give up on his dreams. [Preceptor A] testified that she felt uncomfortable and "really wanted to get out of the room". [Preceptor A] testified that it made her uncomfortable "being in a room with a man that I did not know, he was grilling me about what happened." [Preceptor A] testified that after this incident the Member had contacted her through Facebook. College Counsel entered a

Facebook message as evidence. [Preceptor A] testified that it made her uncomfortable. [Preceptor A] testified that she did not have a personal relationship with the Member, "I worked two shifts with him... he is reaching out after being let go, I don't know for what purpose."

Witness 4 - [Preceptor B]

[Preceptor B] attended Georgian College for Pre-Health Sciences. She then attended Fleming College from 2012-2014 studying in the Practical Nurse Program. [Preceptor B] initially registered under a temporary license with the College, then obtained her permanent license. [Preceptor B] worked in a Retirement Home in Bobcaygeon as an RPN from 2014-2016, she then briefly worked at Belleville General Hospital before obtaining her current position with Markham Stouffville Oak Valley Health Centre on a permanent part-time basis on One Centre: Palliative and Complex Continuing Care. [Preceptor B] worked part-time until 2018 when she obtained full-time employment on the Unit. Although the Unit has been allocated a variety of names [Preceptor B] has always worked in palliative and complex continuing care. [Preceptor B] testified to the roles and responsibilities of an RPN on the Unit. She testified that the RPN was responsible for the completion of activities of daily living ("ADL") and that the patient population could include acute medicine and palliative or end of life patients. [Preceptor B] described to the Panel that RPNs were responsible for documentation, medication administration, including IV medication, and wound care. [Preceptor B] testified to the general practices of the night shift. [Preceptor B] testified that the RPN would receive TOA, assess their patients, complete medication administration and assist patients with completion of ADLs. If a patient was incontinent, care would be provided on an as needed basis. Patients that suffered from limited range of motion were repositioned throughout the night. [Preceptor B] testified that she acted as a preceptor for the Member (Exhibit #11). [Preceptor B] testified that her role included showing the Member how the Unit flows, where equipment and supplies were and what was expected of the Member on the Unit. As well as his role as part of the health care team, how to document appropriately, medication administration, review of medications that are administered regularly, including narcotics, and care for the palliative patient. [Preceptor B] testified that palliative patients required more attention. College Counsel inquired regarding how [Preceptor B] would provide feedback on the new orientee to the manager. [Preceptor B] testified that she would speak with the manager and charge nurse directly. Contents of these discussions would include how the orientee is managing and if they required any extra training or education.

[Preceptor B] testified that her first shift as the Member's preceptor was "good". [Preceptor B] testified to the Panel that the Member was interested in the Unit and demonstrated excitement. [Preceptor B] testified that during the second shift there seemed to be a disconnect with the Member. [Preceptor B] testified that she had to repeat herself a lot to the Member, showing the Member skills or tasks that had already been demonstrated. [Preceptor B] gave an example to the Panel related to the Member's completion of the ADL assessment. [Preceptor B] reviewed with the Member how to complete the assessment and document it in an appropriate manner. [Preceptor B] would then review the Member's documentation to ensure it was accurate. [Preceptor B] testified that there seemed to be a disconnect on how the Member would document. For example, the Member would document that an assessment was not WDL and not

provide a rationale. [Preceptor B] testified that she would provide education to the Member reminding him to provide a rationale for abnormal findings. [Preceptor B] testified that in response to this education the Member would state “okay, I understand”, however, he would not adjust his documentation.

College Counsel inquired about the Member’s response to advice or recommendations in regard to patient care. [Preceptor B] testified that, at first, the Member responded well to advice. The Member demonstrated understanding and was accepting of [Preceptor B’s] suggestions. [Preceptor B] testified that the Member got upset with her one evening; she was unsure whether it was because she had to repeat herself or if it was due to the Member’s non acceptance of her suggestions.

Patient [B]

[Preceptor B] was able to identify, for the Panel, Patient [B]’s chart (Exhibit #31), a dictated note from her most responsible physician, Patient [B]’s history and the reason for admission and the date of her death.

College Counsel reviewed reduced oral intake with [Preceptor B]. [Preceptor B] testified that Patient [B] had either stopped eating or was eating very little. [Preceptor B] discussed the Member’s involvement with Patient [B] and testified that the Member would complete Patient [B]’s care independently or with assistance from her. [Preceptor B] testified to an incident where she asked the Member if he had gone in to assess if Patient [B] was incontinent or needed to be changed. The Member stated to [Preceptor B] “she was fine”. [Preceptor B] was unable to recall if the Member did change Patient [B]’s brief, but the Member did indicate to her that Patient [B] was “dry”. [Preceptor B] testified that she went to double check the Member’s care and found Patient [B] “saturated” in urine. Her gown was wet, and “she had voided an extreme amount”. [Preceptor B] was unable to recall the length of time between the Member reporting that the care was completed and her actual assessment. However, she stated that “it wasn’t long... under an hour, probably under half an hour”. College Counsel inquired as to what [Preceptor B’s] conclusions were because she found Patient [B] in this manner. [Preceptor B] testified that the Member had not completed the care or had not checked to see if Patient [B] was incontinent. She stated “he was not being honest with me”. [Preceptor B] further testified that the Member did not complete care “because of the amount of urine in/on the patient brief and in the bed, it was everywhere, the patient would not have been that wet”.

Patient [C]

[Preceptor B] was able to identify, for the Panel, Patient [C]’s chart (Exhibit #32), a dictated note from her most responsible physician, Patient [C]’s history and reason for admission, course of treatment and discharge date. [Preceptor B] testified to the Panel that Patient [C] was a young female, diagnosed with nasopharyngeal cancer with metastases to her bones, lungs and brain. Patient [C] was blind and was at risk of falling. Patient [C] had a language barrier.

College Counsel directed the Panel and [Preceptor B] to Patient [C]'s order sheet. College Counsel reviewed a telephone order from Dr. [ ] and their recommendations for Patient [C]. In particular a special diet to prevent choking or aspiration. College Counsel directed the Panel and [Preceptor B] to the bottom of page 6 of Exhibit #32 where it was noted with an asterisk "Medication Administration: as tolerated". College Counsel inquired what [Preceptor B's] interpretation was of this notation. [Preceptor B] testified that a nurse would have to use their discretion when administering medication and nurses would have to assess how the patient was tolerating her medication, for example whole or crushed.

[Preceptor B] reviewed with the Panel notes from a fall experienced by Patient [C] on October 26, 2018. [Preceptor B] described to the Panel the documentation required when a patient falls. This includes how and when the patient fell, whether there were any injuries sustained, who was notified of the fall, was any follow up required and if there were any preventative measures initiated.

College Counsel directed the Panel and [Preceptor B] to page 172 of Exhibit #32 dated October 28, 2018. [Preceptor B] reviewed the note with the Panel. [Preceptor B] testified that it was a note made by the Member that Patient [C] could not take her medication by mouth safely. Patient [C] was coughing and took a sip of juice. [Preceptor B] testified that she recalled this medication administration. [Preceptor B] testified that it occurred at night time. The Member was administering the medication (whole in a medication cup). [Preceptor B] recalled the Member taking the medication cup putting it to Patient [C]'s lips and pouring it into her mouth. The Member then gave Patient [C] water. Patient [C] started to cough and the Member gave her more water, then gave her juice. Patient [C] continued to cough "a great deal" and Patient [C] was incontinent of urine. The Member proceeded to push Patient [C] forward and started banging on her back roughly. [Preceptor B] testified that she had to intervene and that the Member did not stop. College Counsel questioned [Preceptor B] as to whether the Member had a discussion with Patient [C] prior to the medication administration. [Preceptor B] was unable to recall this. She testified that "it happened all very quickly... it was here's your medication". [Preceptor B] testified that Patient [C] had a language barrier and that she was blind. [Preceptor B] testified to the Panel that she felt like Patient [C] did not understand. With further questioning from College Counsel [Preceptor B] testified that Patient [C] became incontinent because she was coughing. "He [the Member] did not need to bang on her back". [Preceptor B] was unable to recall if the incontinence occurred during, in the middle or at the end of the Member banging on Patient [C]'s back. "It happened very, very quickly".

College Counsel reviewed with the Panel and [Preceptor B] documents (Exhibit #32) of a head-to-toe assessment of Patient [C] completed by the Member. These included genitourinary, musculoskeletal and neurological assessments. [Preceptor B] testified that a genitourinary assessment is related to urinary function which involves continence or incontinence, dysuria, frequency, burning sensation, urinary colour and bladder distension. College Counsel provided evidence that the Member documented incontinence as WDL. [Preceptor B] testified that incontinence is a significant finding and that the Member should have documented that it was not WDL. [Preceptor B] testified that under no circumstances should the Member have documented

that urinary incontinence was WDL, even if Patient [C] was incontinent at her baseline. In regard to the gastrointestinal assessment, the Member documented that his clinical findings had included symptoms of vomiting. [Preceptor B] testified that she subsequently completed her own documentation on Patient [C], correcting that there was no vomiting at this time. [Preceptor B] testified that she wanted to ensure that the flowsheet accurately reflected the clinical picture. College Counsel reviewed with the Panel and [Preceptor B] documentation on the musculoskeletal assessment. The Member documented that Patient [C] was WDL, whereas [Preceptor B] documented that Patient [C] was not WDL. [Preceptor B] testified that she had a conversation with the Member, in particular about his musculoskeletal assessment, reviewing that Patient [C] had previously experienced a fall and that Patient [C] presented with weakness in her legs. [Preceptor B] testified to the Panel that there seemed to be a "disconnect" with the Member's documentation and the correct findings. [Preceptor B] testified that the Member "raised" his voice regarding Patient [C] and his documentation. [Preceptor B] testified that the Member disagreed with her and stated that Patient [C] could be left alone and care for herself. [Preceptor B] testified that she disagreed with the Member stating that Patient [C] had a previous fall and that she had weak legs and required documentation to reflect this. College Counsel reviewed with [Preceptor B] and the Panel the Member's neurological assessment of Patient [C]. The Member documented that Patient [C]'s presentation appeared WDL. Subsequently, [Preceptor B] altered the documentation and gave her rationale. [Preceptor B] testified that she knew that Patient [C] was forgetful, that Patient [C] had mild weakness in her legs and that Patient [C] had recently suffered a fall.

Panel Questions

A Panel member directed [Preceptor B] to page 312 of Exhibit #32 and inquired as to who the first individuals were that documented WDL. The Panel member then reviewed three other individuals who documented WDL as well. [Preceptor B] was able to provide the Panel with the names of nurses who documented WDL, however, she clarified with the Panel that one of these nurses documented that Patient [C] had "mild weakness".

Another Panel member requested clarification of [Preceptor B's] testimony that the Member had responded well to the feedback that was provided to him. [Preceptor B] indicated that she was professional, testifying that she did not want to make someone feel bad. [Preceptor B] then testified that the Member became upset with her. A Panel member asked [Preceptor B] to tell the Panel what "being upset" means to her. [Preceptor B] testified that she recalled sitting in the nursing station discussing the Member's charting, WDL and the need to explain specifics about the "how and why". [Preceptor B] testified that the Member stated that he could not chart that Patient [C]'s musculoskeletal assessment was not WDL because he felt that it was. [Preceptor B] testified that she explained her view to the Member and that Patient [C] was weak and had experienced a fall. [Preceptor B] testified that the Member became quite argumentative and loud. [Preceptor B] testified that she stated to the Member that she was not going to argue with him and that the Member stated he was going to do his documentation "his way" and that she could do it "her way".

College Counsel's Response to the Panel's Questions

College Counsel reviewed the neurological assessments with the Panel and [Preceptor B]. College Counsel inquired as to whether [Preceptor B] was able to comment on an assessment finding when [Preceptor B] was not on shift. [Preceptor B] testified that she could only document what she observed on her shift.

Witness 5 – [Witness E]

[Witness E] attended Queen's University initially for a Bachelor of Science Degree, however, she transferred to Western University and completed her degree in Bachelor of Science in Physical Therapy in 1998. She started working as a Physiotherapist and obtained a Master's Degree in Science, Aging and Health in 2018. [Witness E] is employed at Markham Stouffville Oak Valley Health Centre, she initially obtained a casual position in 2000, however, began her full-time employment as a Physiotherapist in 2002. [Witness E] has worked in most areas of the Hospital but more specifically the Medicine, Intensive Care Unit, and Rehabilitation. In 2015, [Witness E] applied to work as a Professional Practice Lead which is a part-time position, and the other portion of the week she works as a physiotherapist. In 2018, [Witness E]'s Professional Practice Lead position covered specific units of the hospital including One Centre: Palliative and Complex Continuing Care. [Witness E] testified that she was familiar with the Member and her first interaction with the Member was in his previous employment. [Witness E] testified that she provided the Member with orientation on the mechanical lift system. [Witness E] confirmed to the Panel that she had met the Member once during his orientation and once when the meeting occurred with [Witness A]. [Witness E] confirmed that the Member, [Witness A] and herself were in attendance at the meeting on November 1, 2018. [Witness E] elaborated to the Panel that [Witness B] had been more involved with the Member's orientation, however, she was unable to attend the meeting. [Witness E] testified that she thought [Witness A] wanted her to attend the meeting because it was anticipated that it was going to be an important meeting. [Witness E] noted that there were concerns raised about the Member's orientation and his performance. [Witness A] wanted an individual present as a witness and to record minutes. [Witness E] testified that [Witness B] had provided her with background information on the Member. [Witness E] testified that the Member was someone who was orientating on the Unit and was having difficulty meeting the targets of orientation. [Witness E] testified that it was an impromptu meeting and that she took informal notes.

[Witness E] reviewed the contents of the notes with the Panel. It was reviewed that [Preceptor B] had reported concerns about the Member, such as his listening skills, incomplete documentation, his TOA reports and work list management. Other concerns raised were that the Member was not following the standards of care policy, failing to document on a deteriorating patient, failing to recognize and treat a deteriorating patient, incomplete TOA, and not adjusting documentation to reflect an accurate clinical picture. [Witness E] testified to the Panel that [Preceptor B's] perspective was that the Member required education on acute medicine skills, head-to-toe assessment and Meditech Training.

The Panel and [Witness E] were directed to the notes of the meeting with the Member on November 1, 2018. [Witness E] took the notes on her laptop. [Witness E] testified that [Witness A] opened the meeting by discussing with the Member that he was still on his orientation period and that she and [Witness E] wanted to support his success in the hospital. [Witness A] gave the Member an opportunity to discuss how he felt his orientation was going. The Member responded that "everything was going really well", and that he was positive about his knowledge in all areas and felt that he was managing his workload on the Unit. [Witness E] specifically mentioned to the Panel that she recalled the Member mentioning that he was doing so well and that he was getting his tasks done and was able to offer assistance to other staff members. The Member did not identify any issues. [Witness A] discussed the Member's orientation by reviewing the feedback that she was provided by his preceptors. [Witness A] outlined that the Member had a full complement of orientation shifts and that there were concerns raised about his documentation, time management, completion of worklists and completion of mandatory assessments. There were also concerns about assessment skills that the Member had completed when he had not yet completed education certification on such as initiation of intravenous therapy and assessing blood glucose. [Witness E] testified that the Member tried to explain that these concerns were all situational. The Member was also unsure where these concerns had risen from stating "who is saying this? Why aren't they telling me this... people should tell me directly". [Witness A] responded to the Member by advising him that she had spoken to his preceptors and more than one of them had raised concerns about his practice. [Witness E] testified that the Member did not appear "reflective" and that he did not seem to "hear" what was being communicated to him. [Witness E] testified that the Member was more concerned about "why people are talking about me, they should come directly to me" and then at one point [Witness E] testified that the Member indicated that the concerns raised were inappropriate in nature and that he did not see any problems with his practice. [Witness E] testified that [Witness A] offered to pair the Member with another preceptor and the Member stated "I know women, they like to gossip, if you pair me with someone else it won't matter, they are going to talk about me". [Witness E] testified that the meeting was one to two hours in length and that she did not get a sense that the Member was understanding the concerns raised and the challenges with his practice.

[Witness E] reviewed her meeting notes with the Panel and testified that based on her perspective, throughout the meeting there was enough evidence provided to the Member of specific details from his practice that he needed to improve upon. [Witness E] testified that she did not get the sense that the Member was accepting of the feedback stating "his bottom line at the end was whatever I have to do tell me, I will fix it". [Witness E] testified that she felt that at the end of the meeting they were "not that much further ahead". The Member was provided educational learning materials to complete as well as assigned more orientation shifts with different preceptors. College Counsel questioned [Witness E] as to whether there were any instructions provided to the Member at the end of the meeting. [Witness E] testified that she recalled [Witness A] asking the Member to complete his documentation and provide TOA to the rest of the team who would cover his patients. College Counsel inquired about the Member's demeanour throughout the meeting. [Witness E] testified that the Member was "okay". [Witness E] testified that she felt that the Member was not agreeing with his reported behaviours. [Witness

E] testified that the Member was willing to do anything to improve his performance and that following this meeting she did not have any further interaction with him.

Witness 6 – [Witness F]

[Witness F] obtained her Practical Nurse Diploma in 1991 from Centennial College. She worked on a Medicine Unit for 16 years at Scarborough General Hospital. She, then, worked part-time concurrently in nursing homes then obtained a job at Markham Stouffville Oak Valley Health Centre in 1999 first on a part-time basis then a full-time basis. [Witness F] has worked on the Unit for approximately 20 years.

College Counsel asked [Witness F] to review the process on the Unit for medication bins to be refilled by the pharmacy. [Witness F] testified that at 2pm the pharmacy restocks the medication bins and drawers. The porter usually brings a whole new cart to the Unit and removes the previous bins and restocks them for the afternoon, night and the following day shift. This occurs seven days a week. [Witness F] testified that narcotics are not to be stored in patient bins. She testified that narcotics are stored in the ADU. [Witness F] testified that the process is separate from the medication bin exchange.

[Witness F] confirmed that she has acted as a preceptor "several times". [Witness F] testified that she was the Member's preceptor on one occasion.

College Counsel reviewed the Unit assignment sheets with the Panel confirming that [Witness F] was the Member's preceptor on November 9, 2018. [Witness F] testified as to her role as the Member's preceptor and that she was to shadow the Member and if there were any concerns or questions, she would provide guidance to him.

[Witness F] testified that her biggest concern with the Member, was the "pharmacy incident". [Witness F] testified in detail about how the Member had left a Midazolam vial in the medication bin and it was transferred, inadvertently, to the pharmacy. [Witness F] testified that the pharmacy had contacted the Unit to speak to the Member advising him that the medication had been left in the drawer. [Witness F] testified that the pharmacy wanted the Member to go to the pharmacy and waste the narcotic medication. [Witness F] testified that it is policy and procedure for a narcotic or any controlled substance to be wasted in the ADU machine or from a computer at the bedside. [Witness F] testified that she instructed the Member to go to the pharmacy and waste the Midazolam. The Member had made a phone call to the pharmacy. [Witness F] testified that the Member spoke "quite loudly and aggressively" towards the pharmacy technician and indicated that he was not coming to the pharmacy, that the pharmacy technician needed to bring the medication to him and he would waste the medication on the Unit. [Witness F] testified that this exchange was loud enough "for everyone to notice", and that the Member was very loud and boisterous. [Witness F] testified that there were patients and families present and she went to the pharmacy as it was an unusual event. [Witness F] testified that she wanted to rectify the situation as she felt partially responsible. [Witness F] testified that she was only able to hear part of the conversation.

College Counsel asked [Witness F] to clearly describe the tone in which the Member communicated his message to the pharmacy team member. [Witness F] testified that the Member was "very angry, yelling at the nursing station," describing the Member as "very aggressive", his tone was "very loud, disruptive". [Witness F] testified that it was loud enough that people were taking notice of his yelling in the nursing station.

College Counsel inquired as to why this event was so unusual. [Witness F] testified that it was because the Member was yelling so loudly and aggressively. [Witness F] testified that this "is not how anybody speaks in the nursing station".

[Witness F], testified to the Panel that "you do not put narcotics in the medication drawer, there is no purpose for it to sit in the medication drawer". [Witness F] testified to the interaction that occurred when she went to the pharmacy. [Witness F] testified that she spoke with a pharmacy technician and that the pharmacy technician was upset enough that it caught the attention of the pharmacy manager. [Witness F] testified that the pharmacy manager was updated on the incident and that she was going to speak with [Witness A]. [Witness F] described the pharmacy technician as "upset and tearful". [Witness F] recalled being apologetic and having to console the pharmacy technician. [Witness F] testified to the Panel that she was unable to recall who wasted the narcotic and when [Witness F] returned to the Unit after the incident, she did not address the incident with the Member. [Witness F] testified that the call from the pharmacy was witnessed by three other staff members.

College Counsel inquired as to whether [Witness F] took notes during the Member's orientation. [Witness F] testified that she was taking notes of the general flow of the day and things that she thought the Member needed to improve upon. [Witness F] testified that she would have provided her notes to [Witness A] and the Professional Practice Lead.

Witness 7 – [Witness G]

[Witness G] graduated from Centennial College in 2011 with a diploma in Pharmacy Technician. [Witness G] is registered as a Pharmacy Technician with the Ontario College of Pharmacists. [Witness G] started to work at Markham Stouffville Oak Valley Health Centre in 2017, and this is her current employer.

[Witness G] testified to her roles and responsibilities as a pharmacy technician and that technicians support the pharmacist with daily inpatient pharmacy activities, such as sending new medication orders to the units, completing the next 24-hour review, pre-packaging medication as well as preparing intravenous medication.

College Counsel questioned [Witness G] about the processes that pharmacy technicians follow when they refill medication carts for the Unit. [Witness G] testified that there were two parts in the process 1) The pharmacy technician refilled the medication cassette; and 2) The pharmacy technician refills ward stock medication and high frequency medication from the ADU machine.

[Witness G] testified that the ADU is refilled twice a day and that narcotics and controlled substances are kept in the ADU.

[Witness G] testified that every day between 2-3pm the porter would collect the patient medication bins that were sent out to the nursing unit and the previous bins were returned. [Witness G] testified that the previous medication bin could contain discontinued medication and PRN medication that are to be returned to the pharmacy. [Witness G] testified that narcotics would not go into the medication bins and that there was a locked area that nurses could return the medication to. [Witness G] testified that every Tuesday the pharmacy would empty the secure bin and that if a nurse were to use a partial vial of medication, they would not need to return it to the pharmacy. However, they needed to waste it right away with a second nurse present.

College Counsel directed the Panel and [Witness G] to a medication incident report from November 9, 2018. [Witness G] identified this document to the Panel and confirmed that she completed the document. [Witness G] testified that when the pharmacy finds a medication stored in an unsecure area or improper way, the pharmacy has to fill out a Quality Assurance Report for the pharmacy.

College Counsel inquired whether [Witness G] could recall anything from the incident on November 9, 2018. [Witness G] testified that when she initially found the Midazolam vial, she contacted the Unit advising them that the pharmacy had received a medication that was returned in an improper manner. [Witness G] testified that she reached out to the Member and was advised that he could not come to the pharmacy to pick up the medication. [Witness G] testified that the Member stated he was too busy with patient activity and did not have the time. [Witness G] testified that she notified the Member that this was not usual procedure and the Member was offered a time to come down to the pharmacy. [Witness G] testified that if a nurse was unable to come to the pharmacy, two technicians would waste the medication, an incident report would be completed and management would investigate. [Witness G] wasted the medication with another pharmacy technician and an incident report was filled out. College Counsel inquired whether any other nurse came to the pharmacy to waste the medication. [Witness G] testified that another nurse came to the pharmacy but was unable to recall the conversation details nor was she able to recall the tone of the Member's voice during their interaction.

Witness 8 - [Nurse A]

[Nurse A] graduated in 2008 from Durham College with a diploma in Practical Nursing. Her registration is current with the College. [Nurse A] has been employed with Markham Stouffville Oak Valley Health Centre since December 2015 and she works as an RPN on the Unit. [Nurse A] confirmed with the Panel that she was familiar with the Member while he completed his orientation on the Unit. [Nurse A] testified that she had had few interactions with the Member and clarified for the Panel that she did not act as the Member's preceptor at any time during the Member's orientation.

College Counsel questioned [Nurse A] about her first most significant interaction with the Member. [Nurse A] testified that initially she had a student assigned to her during the Member's orientation and therefore did not spend a lot of time with the Member. [Nurse A] testified that while she was documenting in the nursing station, the Member asked to shake her hand. [Nurse A] testified that the Member stated to her "I just want to thank you for being so nice to me". [Nurse A] testified that the Member had requested she follow him into the medication room and she did so. [Nurse A] was able to describe the medication room to the Panel and that the door was closed during the interaction. College Counsel asked [Nurse A] to tell the Panel what was discussed during this interaction. [Nurse A] testified that the Member was visibly upset and that he was speaking in a much louder tone than usual. [Nurse A] testified that the Member reported to her that he was "tired of all the girls telling him what to do and telling him how to do his job". [Nurse A] testified that she attempted to redirect and calm the Member down by words of encouragement such as "staff are coming from a place of wanting him to do well" and reporting to the Member that the staff were trying to help him succeed. [Nurse A] testified that the Member told her that "a lot of his anger was because of his charting and that people are trying to tell him that his charting was incorrect". The Member further reported that his "charting was his opinion". [Nurse A] testified that she tried to explain to the Member that it was best to chart based on "fact" versus "what we think". [Nurse A] testified that the Member described a situation where if he were to tell his daughter to do something and she did it a different way, but the job still got done then "it's okay". [Nurse A] testified that she attempted to reassure the Member that staff were trying to help him. The Member began speaking about his culture and explaining that he is from Nigeria and that his culture may have something to do with the difficulties with perceptions of him "not doing well". [Nurse A] testified that she listened to the Member and attempted to reassure him that his culture had nothing to do with his practice and perceptions of him. [Nurse A] testified that the Member began to become more aggressive with his words and was getting louder. The Member was standing between [Nurse A] and the door, however, [Nurse A] testified that she felt that she could leave the medication room if she wanted to. [Nurse A] testified shortly after this interaction [Witness A] entered the medication room and that the Member quickly switched topics of conversation indicating that he had a medication requiring a wastage. [Nurse A] testified that the Member put his fingerprint on the scanner of the ADU and it immediately stated "no waste found".

College Counsel focused the Panel's attention to a comment made by the Member "I don't need to take direction from these girls". College Counsel inquired as to who [Nurse A] thought the Member was referring to. [Nurse A] testified that she thought the Member was referring to the all-female nurses who were precepting him. [Nurse A] testified that the Member had reported to her that he had a nursing degree from another country, as well as a Psychology background, and that the Member did not think he needed to listen to their advice or direction. [Nurse A] testified that she felt "taken back" during this conversation. [Nurse A] reiterated to the Panel that she did not have much interaction with the Member other than typical greetings in the nursing station. [Nurse A] testified that "it was a lot of heated information at one time, I felt a bit strange that he would pull me in there [medication room] and divulge this". [Nurse A] testified that initially [Witness A] had followed the Member out of the medication room and that the Member was not on the Unit after this interaction. [Nurse A] testified that eventually [Witness A] inquired as to why

[Nurse A] was in the medication room with the Member. [Nurse A] explained to [Witness A] that the Member had asked her into the medication room to talk to him. [Nurse A] sent [Witness A] an email about the conversation between her and the Member testifying to the Panel that it was "very strange that I was involved when I did not need to be involved".

College Counsel inquired as to whether [Nurse A] was involved in any other interaction with the Member. [Nurse A] testified that she was involved in one more incident with the Member's practice. [Nurse A] testified that she was sitting in the nursing station charting and that the phone had rung. [Nurse A] testified that the ward clerk had answered the call, inquiring who was looking after a specific room and that the pharmacy was on the phone. [Nurse A] testified that [Witness F] had initially taken the phone call but left to go get the Member. [Nurse A] testified that she was unsure what was said on the other end of the phone call. [Nurse A] testified that the Member picked up the phone and got "very loud, everyone stopped what they were doing to look in his direction". [Nurse A] further testified "the way he was speaking on the phone was not typically how we would talk or interact at the nursing station". [Nurse A] testified that the Member kept saying "that's not his job and that he is very busy looking after patients and that they can bring it up to him". [Witness F] had asked [Nurse A] to go to the pharmacy with her and dispose of the medication in question. [Nurse A] testified that typically pharmacy would dispose of the medication themselves and complete an incident report.

College Counsel confirmed with [Nurse A] that she went with [Witness F] to the pharmacy. Both of them inquired as to who was looking after the Unit's medication bins. [Nurse A] testified that once the woman, [Witness G], was identified, she was noted to be "visibly upset and shaking". [Nurse A] testified that [Witness G] explained to her that she had "never been spoken to like that" and "could not believe that she would be spoken to like that in the workplace". [Nurse A] testified that it was not usual practice for two nurses to go to the pharmacy and waste any medication. However, the pharmacy manager advised [Witness F] and [Nurse A] that the pharmacy would waste the medication. [Nurse A] did not have any further interaction with the Member.

Witness 9 Barbara Flynn ("Ms. Flynn")

Ms. Flynn obtained a Bachelor's Degree in Nursing at York University in 2006 and completed continuing education from 2010-2012 in critical care nursing from Durham College. Ms. Flynn testified that this was a Post Graduate certificate specializing in the needs of the critically ill patient population. In 2019, Ms. Flynn completed an online education course from the De Souza Institute specializing in the foundations of oncology. In 2020, Ms. Flynn commenced a Master's Degree in Nursing from York University. Ms. Flynn testified that her first nursing position was at Lakeridge Health, and she worked on the continuing complex care ward and that her roles included medication administration, assessments, completion of patient ADL's and documentation. In 2007, Ms. Flynn transferred to an internal medicine unit and continued in that role for three years until her current position in critical care. Ms. Flynn also testified that she is working for Durham Region Public Health focusing on health promotion and prevention in terms of COVID-19. In regards to clinical teaching experience, Ms. Flynn testified that she had worked a few sessions at Durham College with the Practical Nursing Program. Her main focuses were

educating the students on accurate clinical assessments, medication administration documentation and completion of ADL's. More recently, Ms. Flynn testified that she was working at Ontario Tech University in the Bachelor of Nursing Program. Ms. Flynn described her role to the Panel which included teaching the foundations of nursing practice.

The Panel reviewed Ms. Flynn's resume and qualified her, in this matter, as a Nursing Expert on the standards of practice of the profession as they relate to the standards of care for patients in palliative and complex care situations.

Ms. Flynn acknowledged to the Panel that she would provide evidence that was fair, objective and nonpartisan and only related to her areas of expertise. Ms. Flynn testified that she received a retainer letter with numerous enclosures including four standards of practice, a hypothetical, inpatient standard of care and assessment form, narcotic and controlled substance management policy and a MAR record for Patient [A] from Markham Stouffville Oak Valley Health Centre and that she had reviewed each of these documents.

Ms. Flynn testified that the purpose of the *Professional Standards* is to have a clear outline of the expectations of all Registered Nurses and Registered Practical Nurses in the province, in order to standardize care. Ms. Flynn testified that each standard is specific to all areas and all settings that nurses provide care in regardless of their years of service.

Ms. Flynn testified that the *Documentation* Standard communicates to other staff members about what is going on with the patient, where they are at in terms of assessments, care that the patient may require and the care that was delivered. Ms. Flynn further testified that it is a legal document to prove what has occurred during the patient's stay in the hospital. College Counsel questioned Ms. Flynn about what the expectations are of nurses with regard to documentation. Ms. Flynn testified that nurses are expected to document what has occurred with accuracy and objectivity. It is not subjective; it is not a nurse's opinion.

College Counsel inquired what the purpose of the *Medication* Standard was and what it communicates to nurses. Ms. Flynn testified that, in summary, the *Medication* Standard clearly states the responsibility of the nurse when administering medication, to do so safely. Ms. Flynn testified that the *Medication* Standard discusses authority, competence and safety. Ms. Flynn testified that the College requires a member to have the knowledge, skill and judgment to administer medication safely.

College Counsel directed Ms. Flynn and the Panel to the Conflict Management and Prevention Guideline at Exhibit #44. Ms. Flynn testified that this guideline is more of a fluid document, versus a standard, as relationships are quite dynamic. Ms. Flynn testified that this guideline reviews professional relationships with colleagues and clients in the workplace. Ms. Flynn testified that this document discusses the rationale of having a good relationship or healthy communication between all of the stakeholders, in order to provide the best possible care to the patient.

Based on her review, Ms. Flynn was asked to describe the patient population described in the hypothetical provided to her. Ms. Flynn testified that these patients were quite vulnerable and required care in a facility for a variety of reasons such as palliative end of life care, having an illness that was terminal and that patients were at the point of no longer being able to be cared for in the community.

Patient [A]

Ms. Flynn testified that she had experience with patients with a CADD pump. Ms. Flynn testified that palliative sedation is given for symptoms that are very uncomfortable for patients. For example, respiratory ailments including respiratory distress. The role of a continuous sedation pump is not to sedate the patient but provide treatment for symptoms.

College Counsel asked Ms. Flynn whether, in her opinion, having reviewed the facts related to Patient [A], she was able to say whether the Member contravened the standards of practice or failed to meet the standards of practice when he attempted to administer medication to Patient [A] given her level of consciousness. Ms. Flynn testified that the Member did not demonstrate the knowledge, skill or judgment required to care for a patient with this conscious status. Ms. Flynn testified that it would not be safe to administer medication orally to patients with a decreased level of consciousness. Ms. Flynn testified that she had reviewed Patient [A]'s medication record and indicated to the Panel that there was not one oral medication that would have been appropriate for Patient [A] to have received. Ms. Flynn testified that there was no sublingual medication prescribed for Patient [A]. Ms. Flynn testified that the Member did not follow the *Medication* Standard of practice, specifically referring to the competence and safety aspects.

Ms. Flynn testified that the Member's conduct was questionable from a safety and competence perspective. Ms. Flynn testified that the Member should have looked at the physician's order, assessed Patient [A] and understood that it was not an appropriate order for Patient [A]. Ms. Flynn testified that Patient [A] could not follow any commands, would not have been aware of the medication in her mouth and that she would not have been able to swallow the medication. Ms. Flynn testified that the danger would have involved the medication being aspirated and causing an aspiration type event or harm.

College Counsel referred Ms. Flynn to the hypothetical where it discussed the verbal direction the Member was receiving from his preceptor on this medication administration. Ms. Flynn testified that taking into consideration that the Member was orientating with a preceptor, it was important to note that the Member was warned about what the consequences would be if the nurse attempted to administer the medication. Ms. Flynn testified that the rationale provided to the Member was that Patient [A] would "choke". Ms. Flynn testified that the rationale was clear in reviewing the possible harm arising to Patient [A]. A concerning aspect in the hypothetical was the Member acting in a dismissive manner when he proceeded to try and administer the medication, despite education and instruction.

Patient [B]

College Counsel reviewed with the Panel and Ms. Flynn, the testimony from [Preceptor B] that she had assessed Patient [B] somewhere between 30-60 minutes after the Member. College Counsel questioned Ms. Flynn whether in her opinion, it was possible for Patient [B] to have been dry when the Member assessed Patient [B] and then for Patient [B] to be "saturated" in urine when [Preceptor B] assessed Patient [B] 30-60 minutes later. Ms. Flynn testified that briefs are highly absorbent and for urine to have leaked out onto Patient [B]'s clothing indicated to Ms. Flynn that the urine amount was quite large. Ms. Flynn testified that based on her experience and Patient [B]'s scenario with having a reduced oral intake this would be highly unlikely to occur within 30-60 minutes. Ms. Flynn hypothesized that a patient's urine output would improve if the patient was receiving intravenous therapy. Ms. Flynn reinforced to the Panel that it was unlikely that the Member had assessed Patient [B] accurately.

Ms. Flynn directed the Panel to the *Professional Standards*. Ms. Flynn testified that the Member's conduct in this scenario did not ethically meet the standard of practice as he did not provide ideal care for Patient [B]. Ms. Flynn also testified that the Member did not meet the accountability aspect of care. Ms. Flynn testified that the Member needed to be accountable and when he said that he had checked and assessed Patient [B] for incontinence, it was highly unlikely that he had done so. Ms. Flynn testified that the Member breached the standard of practice in regard to Patient [B].

Ms. Flynn testified that she was familiar with the term "Within Defined Limits" ("WDL") and that WDL were parameters set out by the facility in terms of documentation, and anything going outside those parameters would be considered an abnormal finding. Ms. Flynn testified that if a nurse were to complete their assessments of a patient and have normal findings, a nurse would document WDL and if anything was found during their assessments to be outside those limits, a nurse was expected to document a significant finding and document in detail about this finding. Ms. Flynn testified that the Member breached the standard of practice when he documented that Patient [B] was WDL when Patient [B] had been incontinent during the Member's shift. Ms. Flynn directed the Panel to the *Documentation* Standard referring to communication. The Member did not meet the standard in terms of communicating the urinary incontinence of Patient [B] to other members of the team. Ms. Flynn testified that in terms of knowledge, the Member had a preceptor who pointed out and educated the Member that he had inaccurately documented Patient [B]'s incontinence. Ms. Flynn testified that the Member did not meet the standard because it was documented that he was informed what the correct manner of documentation should be.

<u>Patient [C]</u>

Ms. Flynn testified that the Member failed to meet the standard of practice when he attempted to administer medication to Patient [C] by pouring juice down her throat without any explanation in advance. Ms. Flynn testified that there were multiple issues with the Member's conduct. Ms. Flynn testified that in the hypothetical, the patient was blind and also had a language barrier. Patient [C] previously required support of a translator. Ms. Flynn pointed out to the Panel the importance of introduction to the patient, providing an explanation and having consent given, prior to initiating

any care. Ms. Flynn testified that the *Professional Standards* included an indicator of accountability. Ms. Flynn testified that a nurse demonstrates this standard by identifying him or herself and explaining his or her role. Ms. Flynn testified that she did not believe that the Member had done this with Patient [C] as there was visual impairment and a language barrier.

Ms. Flynn testified to the Panel that the Member did not meet the standard of practice when he pushed Patient [C] forward when she began coughing during his medication administration and when he banged on her back without warning. Ms. Flynn testified that this approach to medication administration started a "domino effect" of unfortunate events. Ms. Flynn testified that according to the hypothetical it appeared that the Member pushed Patient [C] forward and "thumped on her back in a rough manner". Ms. Flynn testified that it appeared that the Member's conduct was a reactionary event and that she "could only imagine how it would be felt by Patient [C]". Ms. Flynn testified that she did not believe that the actions of the Member would meet the expectations of the College and that his conduct breached the standards of practice. In regards to Patient [C]'s incontinence, Ms. Flynn testified that it was probably very upsetting to Patient [C] as this was not her baseline behaviour and it was due to outside causes for example by the initiation of medication administration.

College Counsel inquired as to whether Ms. Flynn had any views on the Member not responding to his preceptor's directions. Ms. Flynn testified that the preceptor had known Patient [C] prior and had additional experience and insight into the needs of Patient [C]. Ms. Flynn testified that it was concerning that the Member disregarded his preceptor when he was asked to stop pounding on Patient [C]'s back.

Inappropriate Comments to Staff

College Counsel brought to Ms. Flynn's attention the comments made by the Member to staff.

College Counsel inquired what Ms. Flynn's opinion would be concerning when the Member made comments such as "he knows women, gossiping is a women's thing" to [Witness A] and [Witness E], and in particular did those comments breach the standards of practice. Ms. Flynn testified that in her opinion the Member's comments were a breach of the standard. Ms. Flynn was not able to direct the Panel to a particular standard but testified that the comments were discriminatory and used stereotypes. College Counsel directed the Panel and Ms. Flynn to page 12 of the *Professional Standards*. Ms. Flynn testified that the Member did not demonstrate knowledge and respect for each other's roles on the interdisciplinary team.

In regards to bringing a colleague into the medication room and making comments such as" he doesn't need to take direction from these girls". Ms. Flynn testified that the Member's conduct and comments were a breach of the standards of practice. Ms. Flynn testified that there were a few concerning breaches. The Member was asked to leave after his meeting with [Witness A] and [Witness E], and instead he found a colleague and met with her in a locked medication room. Ms. Flynn testified that this behaviour was not acceptable and that it is an intimidating type of behaviour. Ms. Flynn testified that in the Conflict Resolution Guideline, horizontal violence, and

interpersonal conflict between colleagues includes antagonist behaviours such as gossiping, criticism, intimidation and passive aggression. Ms. Flynn testified that this type of behaviour would be considered unseemly by the College.

College Counsel questioned Ms. Flynn on her opinion as to whether the Member breached a standard of practice when he left a partial vial of Midazolam in the medication bin after administration. Ms. Flynn directed the Panel to the *Medication* Standard (Exhibit #43). Ms. Flynn testified that it is a federal requirement to store substances (narcotics, benzodiazepines) in a safe manner and it is up to the facility on how they will follow these federal guidelines. Ms. Flynn testified that the *Medication* Standard describes a nurse's accountability when engaging in medication practices, such as administration, dispensing, medication storage, inventory management and disposal of a medication. Ms. Flynn testified that there is a safety component to the Member's conduct and that the porter would not have had the education to transport or store this medication safely and that the Member's conduct breached this standard.

Lastly, College Counsel brought to Ms. Flynn's attention the Member's conduct when he spoke to the pharmacy technician in an "angry or agitated manner". Ms. Flynn testified that in her opinion, the Member did not meet the *Professional Standards* of practice. In terms of professional relationships Ms. Flynn testified that in her opinion, the Member did not demonstrate respect for other members roles on the interdisciplinary team and that when he raised his voice, he did not demonstrate effective conflict resolution skills.

Panel Questions

A Panel member inquired as to whether a syringe is ever an appropriate method when administering medication with juice in a patient's mouth? Ms. Flynn testified that there are oral syringes available for medication that are less than 5 ml and require accurate dosing.

Another Panel member had a question about the scenario with Patient [A], when the Member was told that there could be a serious issue when administering medication to Patient [A] and the Member ignored this direction. The Panel member asked Ms. Flynn what the responsibility of a preceptor was to ensure that he did not proceed? Ms. Flynn testified that she thought the responsibility would be to prevent the administration of the medication even though the Member was working under his own license.

In response to the Panel's questions, College Counsel questioned Ms. Flynn about whether a syringe was for a crushed-up pill to be administered or for liquid medication? Ms. Flynn testified that it would be for an elixir or liquid medication, for measurement.

Final Submissions

College Counsel submitted that the Panel had heard from 8 fact witnesses and 1 expert witness about the alleged breaches of standards, failure to keep records and disgraceful, dishonourable and unprofessional conduct of the Member towards a number of patients and colleagues. College

Counsel asked the Panel to make findings that the Member's conduct did constitute professional misconduct in that it was a breach of the standards of practice, in particular the College's *Professional Standards*, *Medication* Standard, and *Documentation* Standard, that the Member's conduct amounted to failing to keep records as required, and that his conduct was disgraceful, dishonourable and unprofessional.

Burden of Proof

College Counsel submitted that 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. The Member did not participate in the hearing and had been deemed to have denied the allegations against him. College Counsel submitted that it was the Panel's job to assess and weigh the evidence and determine if it is more likely than not that the Member engaged in professional misconduct as alleged in the Notice of Hearing. College Counsel submitted that the Panel needed to assess the credibility and the reliability of the witnesses that the Panel had heard.

In assessing witness evidence, College Counsel submitted that the Panel should remember that there may be a discrepancy in a witness's testimony or their testimony and that of other witnesses and that does not necessarily or automatically mean that the evidence should be discredited. The Panel is entitled to accept some, none or all of a witness's evidence. The Panel is entitled to conclude that a witness misremembers certain details but is still credible on key points.

College Counsel submitted that the Panel received consistent, cogent, clear and convincing evidence from the witnesses. College Counsel submitted that all witnesses were forthright and sincere with their evidence.

College Counsel reviewed with the Panel each allegation and the evidence relevant to each allegation as set out in the Notice of Hearing.

With respect to allegation #1, College Counsel submitted that the Member breached the *Medication* Standard when he attempted to administer crushed medication via a syringe to Patient [A] who had a decreased level of consciousness and contrary to the direction he received from his preceptor. College Counsel submitted that the Member breached the *Documentation* Standard when he documented that Patient [C] was WDL when she was not. College Counsel submitted that the Member breached the *Medication* Standard relating to another medication administration for Patient [C] who was blind and had a language barrier. The Member poured medication down Patient [C]'s throat without explanation and contrary to his preceptor's direction and when she choked, the Member pushed her forward pounding on her back without explanation. College Counsel submitted that the Member breached the *Professional Standards* when the Member made inappropriate comments to his colleagues and in particular sexist comments. College Counsel submitted that the Member breached the *Professional Standards* when he met with one of his colleagues alone in a medication room, expressed anger and a sexist undertone to the colleague about criticism he was receiving from his colleagues and stated that he "didn't need to be babysat" or take direction from "these girls". College Counsel submitted that

the final breach of the standard relates to medication administration when the Member failed to properly waste a vial of a narcotic and then spoke angrily to the pharmacy technician. More specifically:

Allegation #1(a)

With respect to this allegation, College Counsel submitted that the Panel heard direct evidence from [Preceptor A], who was the Member's preceptor on that particular shift. [Preceptor A] testified that Patient [A] was a palliative patient at end of life and she was receiving palliative sedation to help manage her symptoms. College Counsel submitted that the CADD pump medication made Patient [A] "groggy" and difficult to rouse. [Preceptor A] testified that during the shift Patient [A] did have an order for oral medication and that the Member wanted to administer the medication despite Patient [A]'s decrease in level of consciousness and difficulty with rousing. [Preceptor A] testified that she told the Member that it was not appropriate to administer the medication, that Patient [A] was not conscious enough to swallow the medication properly, and administering the medication could be dangerous and that Patient [A] could "choke". [Preceptor A] testified that the Member disagreed with her and proceeded to crush the medication and try to administer it to Patient [A] through a syringe. [Preceptor A] testified to the Panel that the Member quickly realized that he was not able to administer the medication as she had previously indicated to the Member. College Counsel submitted that this was the fact evidence that the Panel heard.

College Counsel also reminded the Panel of the expert evidence of Ms. Flynn. Ms. Flynn testified to the Panel that she had felt that the Member's conduct in this regard showed a lack of knowledge, skill and judgment as it was not safe to administer medication to Patient [A] in light of her decrease level of consciousness. College Counsel submitted that Ms. Flynn testified to the Panel that Patient [A] could aspirate and breathe the medication into her lungs. Ms. Flynn testified that the Member's conduct was a breach of the *Medication* Standard in that the Member failed to assess the appropriateness of the medication in light of the assessment of Patient [A]. College Counsel reviewed with the Panel page 3 of the *Medication* Standard, under competence "Nurses: assess the appropriateness of the medication practice by considering the client, the medication and the environment; know the limits of their own knowledge, skill and judgment, and get help as needed". College Counsel submitted that in this situation the Member did not have that knowledge or education. College Counsel submitted that the Member was provided with the knowledge by his preceptor who told him that it was not appropriate to administer this medication and nevertheless the Member disregarded the information and proceeded to attempt to administer the medication. College Counsel submitted to the Panel that there is sufficient evidence before the Panel to make a finding that the Member engaged in professional misconduct and failed to meet the standards of practice by his attempt to administer medication to Patient [A] and in doing so, he breached the *Medication* Standard.

Allegation #1(b)

College Counsel submitted that for this allegation, the Panel heard evidence from [Preceptor B] who was the Member's preceptor on the shift in question. College Counsel submitted that

[Preceptor B] testified to the Panel that she asked for a report from the Member on the status of Patient [B] and the Member's report was that Patient [B] was "good to go" and "ready for bed" and dry. College Counsel submitted that [Preceptor B] being a diligent nurse testified to the Panel that she went to assess all her patients before bed and when she checked on Patient [B] in particular, she found her to be saturated in urine both through and into the bottom sheet and the gown. [Preceptor B] testified that she believed that she checked on Patient [B] between 30-60 minutes certainly no more than 60 minutes after receiving the report from the Member and in [Preceptor B]'s experience working on the floor, she did not feel that it was possible for Patient [B] to be dry when the Member checked on her and then be completely saturated in urine within an hour or less. College Counsel submitted that Ms. Flynn testified and confirmed before the Panel, her opinion given the absorbency of the briefs as well as Patient [B]'s diagnosis of reduced oral intake, it was highly improbable that Patient [B] could have been dry when the Member checked on her and then be soaked with urine within the hour. College Counsel submitted that Ms. Flynn concluded that the Member breached the standard of practice in that he was not truthful with the preceptor when providing that report and testified to the ethical component of the *Professional Standards*.

College Counsel referred the Panel to page 6 of Exhibit #41: *Ethics*. The introduction says "Ethical nursing care means promoting the values of client well-being, respecting client choice, assuring privacy and confidentiality, respecting the sanctity and quality of life, maintaining commitments, respecting truthfulness and ensuring fairness". College Counsel submitted that this allegation goes to truthfulness as well as quality of life aspect of this standard. College Counsel submitted if Patient [B] was sitting and soaked in urine there is a question about what level of care this Member was providing to Patient [B]. In College Counsel's submission, the Panel has sufficient evidence before it to establish that the Member breached the standards of practice with respect to this incident and in particular breached the *Professional Standards*.

<u>Allegation #1(c)</u>

College Counsel submitted that the Panel heard evidence from two witnesses, [Witness A] and [Preceptor B] on the definition of WDL at Markham Stouffville Oak Valley Health Centre. College Counsel submitted that these witnesses testified to the Panel that the assessments done by the nurses cover all different areas and functions of the body and that a nurse is to document those assessments as WDL if what the nurse finds is an expected normal result. Conversely, if it is not WDL that means that there is an unexpected or abnormal result and that it must be documented with an explanation.

College Counsel provided the Panel with an example to remind the Panel of the evidence provided. College Counsel asked the Panel to review Patient [C]'s health record, at page 245 of Exhibit #32: genitourinary assessment which is the assessment concerning bladder function and provides a definition with examples on what WDL includes. College Counsel submitted that the Panel received evidence of the Member's documentation which provided that Patient [C]'s genitourinary function was WDL even though she was incontinent. [Preceptor B] testified that the Member's documentation was incorrect. [Preceptor B] testified to another example for the Panel

in regards to musculoskeletal assessment where the Member documented that Patient [C] was WDL, however, in [Preceptor B's] testimony Patient [C] had weakness and experienced a fall and therefore was not WDL. [Preceptor B] testified that she had completed her own documentation as a result of this disagreement with the Member. College Counsel submitted to the Panel that Ms. Flynn provided an explanation about what the meaning of WDL means and that incontinence is not typically understood to be a normal finding. College Counsel submitted that the documentation itself proves that it was not WDL. College Counsel submitted that the Member's documentation was inaccurate and as a result, was a breach of the *Documentation* Standard. College Counsel submitted to the Panel that there is sufficient evidence to establish that the Member breached the standard of practice with respect to the *Documentation* Standard.

College Counsel submitted to the Panel that the Member's documentation was also a breach of the *Professional Standards* because his preceptor tried to provide the Member with education around his documentation and the Member did not seem open to the suggested feedback or education. College Counsel submitted that this demonstrates the Member was not being aware of his own limits and did not get help when needed. College Counsel submitted that this is an expectation of all nurses to know what their own limits are particularly from the knowledge perspective. College Counsel directed the Panel to page 7 of Exhibit #40, the *Professional Standards* knowledge section indicating that a nurse is supposed to know "where/how to access learning resources when necessary". College Counsel submitted that this is a situation where a nurse has a preceptor providing knowledge and that the Member is not open to receiving it.

<u>Allegations #1(d)(i) and #1(d)(ii)</u>

College Counsel submitted to the Panel that [Preceptor B] provided direct evidence to the Panel that she acted as the Member's preceptor and testified that she saw the Member go in rather quickly with the medication whole to Patient [C]'s room. [Preceptor B] testified that it happened "all very quickly" and that the Member did not explain in any way what he was doing before doing this administration and as a result Patient [C] started to cough. [Preceptor B] testified that she recalled the Member pushing Patient [C] forward when she started to cough and roughly "banging and pounded" on Patient [C]'s back. [Preceptor B] testified that she was disturbed by what she had witnessed. College Counsel submitted that she thought [Preceptor B] used the word "jarring" and that the Member's conduct was aggressive. College Counsel submitted that [Preceptor B] tried to stop the Member but he "was not listening". [Preceptor B] testified that it did happen very quickly.

College Counsel submitted that the Panel heard evidence from Ms. Flynn and that her opinion was that the Member's conduct was a breach of the *Professional Standards* in a number of ways. College Counsel submitted that Ms. Flynn commented on how the Member failed to introduce himself and failed to explain what he was doing and that was contrary to the accountability standard in the *Professional Standards*. College Counsel reviewed with the Panel that in this document it is the very first thing a nurse must do in explaining his/her role to the patient. College Counsel submitted that Ms. Flynn testified to the manner in which the Member poured the medication down Patient [C]'s throat. Ms. Flynn testified that it was an indication of a lack of

knowledge on the Member's part on how to properly communicate with a patient as well as the Member's lack of knowledge with respect to this particular patient care plan as Patient [C] had significant swallowing issues and the Member's behaviour was contrary to Patient [C]'s care plan. College Counsel submitted that Ms. Flynn testified on the manner in which the Member responded when Patient [C] started to cough and that the "banging" on Patient [C]'s back was not supported by any nursing education or scientific basis, it was more "reactionary" than clinical. College Counsel submitted to the Panel that Ms. Flynn also testified to the fact that Patient [C] was incontinent and that it was not normal for Patient [C], given her opinion indicating that it was a sign of distress. College Counsel submitted that as with the other allegations this is another instance when the Member's preceptor was trying to stop him and educate him. The Member disregarded this education and continued with his conduct. College Counsel submitted that there is sufficient evidence that the Member breached the standard of practice both with respect to the manner in which he administered the medication and how he responded when Patient [C] started to cough.

Allegation #1(e)

College Counsel submitted that with respect to this allegation, the Panel heard from two fact witnesses, [Witness A] and [Witness E]. College Counsel submitted that [Witness E] took detailed notes during the meeting of November 1, 2018 and that these notes are in evidence and make reference to the Member's comments about "he knew women, and gossiping was a women thing and that should not affect staff opinion of his practice and performance". College Counsel submitted that both witnesses testified remembering that the Member made these comments. [Witness E] testified that the comment was made in response to a suggestion of a different preceptor. [Witness E] testified that the Member said "it wouldn't make a different because they are all gossiping about me anyway".

College Counsel submitted to the Panel that it received testimony from Ms. Flynn about these types of comments from the Member. Ms. Flynn testified that the Member contravened the *Professional Standards* and that any kind of blanket statement about gender is not appropriate, unprofessional, disrespectful and shows an unwillingness to establish and maintain collegial relationships which are required under the *Professional Standards*. College Counsel submitted that there is a professional relationship component on page 12 of the *Professional Standards* which deals with professional relationships which are supposed to be based on trust and respect which results in improved client care. College Counsel submitted that the Member's sexist, gender-based comments made during his meeting with management are a breach of the standards of practice in particular the *Professional Standards*.

Allegations #1(f)(i) and #1(f)(ii)

College Counsel submitted to the Panel that it had heard testimony from two witnesses [Preceptor A] and [Nurse A]. [Preceptor A] testified that the Member had asked her to come into the medication room and asked her if she had any concerns with his practice or if any of the other nurses had told her that. [Preceptor A] testified feeling uncomfortable during the discussion, that the Member was asking her about his practice and that she tried to give words of encouragement

in response. College Counsel submitted that [Nurse A] testified that the Member also approached her and asked her to come into the medication room. College Counsel submitted that [Nurse A] had never acted as his preceptor before and this request was "out of nowhere". The Member asked [Nurse A] about his practice, expressing frustration about taking direction "from these girls", reporting that he did not need any direction and that the Member already knew everything given his experience prior to being on the Unit. [Nurse A] testified that although she did not feel physically threatened by the Member and could have left the room at any time, it was an intimidating and uncomfortable experience. [Nurse A] testified that [Witness A] came into the medication room and found them there. College Counsel submitted that subsequently [Nurse A] sent an email to [Witness A].

College Counsel submitted that the Panel heard testimony from Ms. Flynn about what her expert opinion was with respect to those exchanges between the Member and his colleagues. Ms. Flynn testified that she felt that his conduct was unprofessional and a breach of a standard of practice in two ways. 1) The Member was asked to leave the Unit after the meeting with management; and 2) The Member brought colleagues into the medication room which was a locked room. The Member interrogated them about his performance and the fact that the witnesses reported feeling uncomfortable demonstrated to Ms. Flynn that the manner in which the Member was speaking to them was not professional and did not foster collegial relationships.

<u>Allegations #1(g)(i) and 1(g)(ii)</u>

College Counsel submitted that the Panel was provided with a number of witnesses concerning the medication storage process at the hospital and on the Unit. [Witness A] testified about this to the Panel as well as a number of the "on the floor" nurses. College Counsel submitted that essentially each afternoon sometime between 2-3 pm, a porter comes to the Unit, goes to the medication room, collects the medication bins which the nurses would then place in the room in advance. The porter takes those empty bins to the pharmacy and the bins get refilled by the pharmacy for the next 24 hours and brought back up to the Unit. College Counsel submitted that this occurred for all regular medications. For narcotics and controlled substances, College Counsel submitted that the Panel heard testimony that they are not kept in bins but instead kept in the ADU which is in the medication room. College Counsel submitted that the Panel was provided evidence of the hospital's policy in regards to narcotics and controlled substances which has set out how narcotics are to be stored and wasted. College Counsel submitted that the medication order was for a partial dose of medication to be administered to the patient and that the policy would have dictated that the medication would have to be wasted immediately after administration into the ADU. College Counsel submitted that the Panel also heard from a number of the witnesses about the medication restocking system on the Unit which was done every day, seven days a week and by November 9, 2018, the Member had 3 prior day shifts on the Unit. College Counsel submitted that the Member would have seen this process and would have been taught this process by his preceptors and should have known how this process worked.

College Counsel further submitted that the Panel heard evidence that the pharmacy technician, [Witness G] found the partial vial of Midazolam on November 9, 2018 in one of the Member's

patient's bins and testified that it was against hospital protocol for a narcotic to be in patient bins. [Witness G] decided to call the Unit and speak with the Member, raised this concern with him and asked him to come and collect the medication and waste it properly. College Counsel submitted to the Panel that there were two witnesses that testified that they overheard the conversation with [Witness G]. College Counsel submitted that those two witnesses were [Witness F] and [Nurse A]. [Witness F] was the Member's preceptor that shift and she recalled the incident. [Nurse A] recalled the Member coming to the phone to speak with [Witness G] and that the Member was very loud and angry when speaking with [Witness G]. College Counsel submitted that [Nurse A] described the Member yelling to the point where everyone on the Unit stopped and listened because it was so out of character. [Witness F] testified that it was so out of character that she went down to the pharmacy to actually speak with someone to find out what was going on and to make sure everything was okay. College Counsel submitted that [Witness F]'s recollection was that when she went down to the pharmacy [Witness G] was visibly upset as a result of the way the Member had spoken to her. College Counsel submitted that the Panel also heard from [Nurse A] about this incident. College Counsel submitted that [Nurse A] recalled overhearing the conversation in the nursing station and the volume and tone of the Member's voice was loud and angry. [Witness F] testified that this conduct was odd and unusual enough that [Nurse A] decided to accompany [Witness F] to the pharmacy. College Counsel submitted that [Nurse A] also remembered that [Witness G] was upset and shaking. College Counsel submitted to the Panel that [Nurse A] also testified that she remembered the Member saying "I don't have time to come down, you bring it up". [Witness G] testified that she explained to the Member that this was not how it was going to work and that [Witness G] was not bringing the medication to him and that the Member could come and get it. College Counsel submitted that [Witness G] could not recall the Member's tone of voice when he was communicating this to her. [Witness G] did not have a good recollection about how this interaction made her feel and her recollection was not as clear as [Nurse A]'s or [Witness F]'s recollection. College Counsel submitted that witnesses are not expected to have perfect memories. The Panel is entitled to accept [Nurse A]'s or [Witness F]'s recollection of the Member's tone of voice, even though [Witness G] was on the other end of the phone, but does not recall what his tone of voice was like. College Counsel submitted that the Panel has clear evidence about the Member's medication error which is supported by all of the witnesses' evidence about the protocols on the Unit as well as what [Witness G] found when reviewing the patient bin and the medication incident report that [Witness G] had completed on that day. College Counsel submitted that the Panel has clear evidence about what [Nurse A] and [Witness F] heard while sitting in the nursing station and that it was "so out of the norm that they went to the pharmacy to speak with the individual".

College Counsel submitted to the Panel that Ms. Flynn also provided her opinion about this matter. With respect to leaving the narcotic in the bin, Ms. Flynn gave her opinion that it was contrary to the hospital's policy and that all narcotics or controlled substances should be locked and stored safely and as a result of the Member's failure to comply with the policy it was a breach of both the *Professional Standards* and the *Medication* Standard. Ms. Flynn testified that the Member was not applying proper knowledge and safe medication administration under the *Medication* Standard. College Counsel referred the Panel to the *Medication* Standard submitting it discusses engaging in medication practices such as administration, dispensing, storage, inventory,

disposal that are competent and safe and failing to comply with the hospital's policy and leaving a narcotic out of a safe locked cabinet in possession of non-registered staff is not safe practice and is a breach of the standard. With respect to the manner in which the Member spoke to [Witness G], College Counsel submitted that Ms. Flynn provided her opinion that it was a breach of the standard, in particular the *Professional Standards* in that the Member failed to establish or maintain a collegial relationship with a member of the health care team.

Allegation #2

College Counsel submitted to the Panel that the same evidence under allegation #1 is sufficient evidence to prove that the Member failed to keep records as required.

In that regard, College Counsel submitted that allegation #2 is a failure to keep records as required with respect to documenting that Patient [C] was WDL when she was not.

Allegations #3(a), #3(b), #3(c), #3(d)(i), #3(d)(ii), #3(e), #(3)(f)(i), #3(f)(ii), #3(g)(i) and #3(g)(ii)

College Counsel submitted to the Panel that when considering an allegation, the Panel has to first satisfy itself that the conduct in question is relevant to the practice of nursing. College Counsel submitted that once the Panel passes this initial threshold, the Panel then proceeds to determine whether the Member's conduct amounts to disgraceful, dishonourable and unprofessional conduct by considering how the conduct would be viewed by other reasonable members of the profession. College Counsel submitted that the Member's conduct in this case when taken cumulatively is all three of disgraceful, dishonourable and unprofessional.

Unprofessional conduct is to be considered as a serious and persistent disregard for professional obligations. Dishonourable conduct is slightly more serious than unprofessional, and usually involves an element of moral failing or dishonesty. Disgraceful conduct is very similar to dishonourable, but slightly more serious in that it usually involves bringing shame on the member and by extension the profession at large.

College Counsel submitted that when the Panel is thinking about the particular allegations at issue here, that it was important for the Panel to recognize that all the issues occurred over a very short period of time during a handful of shifts when the Member was training and orientating to the new unit. The Panel was asked to consider that the Member was being guided by a preceptor on each of these shifts and at each of the instances when provided with educational opportunities from his preceptor, manager and professional practice lead, the Member was not receptive to the feedback and often his responses were dismissive and rude. College Counsel submitted that the Member made derogatory comments about his female colleagues and objected to take direction from "women or girls". College Counsel submitted that in some instances the Member's refusal to take direction from his colleagues resulted in direct negative consequences for patients. College Counsel submitted that in at least one instance the Member was dishonest with a colleague about the care that he provided to Patient [B]. College Counsel submitted that in another instance he caused Patient [C] to be incontinent and handled her "roughly". College Counsel submitted that the Member expressed his anger to his colleagues and other health care members and placed

them in uncomfortable situations. College Counsel submitted that the Member failed to waste a narcotic medication properly and then yelled at the pharmacy technician who was trying to give him some education and an opportunity to correct the mistake as opposed to having to fill out an incident report.

College Counsel submitted to the Panel that when taken together, the Member demonstrated a serious and persistent disregard for his professional obligations. The Member's conduct had an element of moral failing as there was dishonesty involved and his failure to follow direction from those with more experience than him. The Member's refusal to follow direction resulted in patient harm and brought shame on the Member and the profession at large. College Counsel submitted that the Member's conduct falls far below the standards of practice and casts serious doubt on his moral fitness and his inherent ability to discharge the high obligations of the profession nor did it meet the public's expectations of nurses.

Prior Cases

College Counsel submitted the following cases to the Panel, which did not include the full complement of the conduct at issue before the Panel:

CNO v. Simeone (Discipline Committee, 2017): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. College Counsel submitted that this case involved a home care setting as opposed to a hospital setting. The Panel was instructed to review the allegations as they relate to a failure to provide adequate care for patients and a failure to document. College Counsel directed the Panel to review the decision particularly as the member failed to meet the standard of practice with multiple clients including improper delegation, failing to provide proper care including failure to document. In this case, the panel found that the conduct at issue was unprofessional and dishonourable as it had an element of dishonesty and deceit.

CNO v. Varga (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the incidents occurred in an Inpatient Mental Health Unit. College Counsel submitted that some of the allegations are of a similar theme to the case before this Panel. The member failed to follow a care plan specifically on de-escalation techniques and then did not listen to direction from the Charge Nurses or any other nurse that had more experience with this patient. The member's conduct was found to contribute to the patient's escalation. Finally, the member fed the patient while he was lying on his back in four-point restraints which led to the patient being a choking risk and failed to meet the swallowing guidelines for this patient while he was restrained. College Counsel submitted that while it was a different practice setting, the member's conduct was similar behaviour in that a member was not following a care plan, not following the direction of colleagues who had more experience with the patient and the member engaged in behaviour that was dangerous for the patient. The panel found that the member's conduct amounted to a breach of the *Professional Standards* when she did not comply with the patient care plan and went against the advice of her colleagues which caused harm to the patient and put the patient at risk for choking. The panel found that the member's conduct was unprofessional, dishonourable and disgraceful. The member's conduct in

this case caused the patient to escalate further and engage in self harm. College Counsel submitted that this case is similar to the case before this Panel in that the Member did not listen and did not follow the care plan ultimately causing harm to Patient [B] and Patient [C].

CNO v. Bruce (Discipline Committee, 2019): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. College Counsel submitted to the Panel that she provided this case as it has relevant findings with respect to the manner in which the Member spoke to some of his colleagues. College Counsel submitted to the Panel that in this case, allegations #1(a), (b) and (f) relate to the manner in which the member spoke with a colleague in a raised voice and an unprofessional manner. Page 11 of the *Professional Standards* states that each nurse must establish and maintain respectful, collaborative, therapeutic and professional relationships. The panel accepted the admissions of professional misconduct and found that the member breached the standard of practice when she engaged in unprofessional communication with her colleagues including using a loud and unprofessional tone and a confrontational manner. The panel found that the member's conduct did not meet the threshold of disgraceful and was only found to be unprofessional and dishonourable conduct.

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(a), 1(c), 1(d)(i), 1(d)(ii), 1(e), 1(f)(ii) (only with respect to "… you also expressed anger that other nurses should not be criticizing your work, you did not need to be "babysat", and that you did not need to take direction from "these girls", or words to that effect"), 1(g)(i), 1(g)(ii), 2, 3(a), 3(c), 3(d)(i), 3(d)(ii), 3(e), 3(f)(ii) (only with respect to "… you also expressed anger that other nurses should not be criticizing your work, you did not need to be "babysat", and that you did not need to take direction from "these girls", or words to that effect"), 3(g)(i) and 3(g)(ii). With respect to allegations #3(a), 3(c), 3(d)(i), 3(d)(ii), 3(e), 3(f)(ii), 3(g)(i) and 3(g)(ii), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be unprofessional and dishonourable.

The Panel is unable to find that there is clear, cogent and convincing evidence establishing on the balance of probabilities that the Member has committed acts of professional misconduct as alleged in paragraphs 1(b) 1(f)(i), 3(b) and 3(f)(i). With respect to allegations #1(f)(ii) and #3(f)(ii), the Panel finds that there was not enough evidence to support the allegation that the Member "asked [Nurse A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her feel uncomfortable since the quality of your work was an issue to be addressed by management."

Reasons for Decision

The Panel was provided with a significant number of documentary exhibits and evidence from nine witnesses. The Panel was also provided with the testimony of one expert witness.

The Panel assessed credibility and reliability of witnesses using the criteria set out in *Pitts v Ontario (Ministry of Community and Social Services, Director of Family Benefit Branch)* and found the evidence of the witnesses to be forthright, credible and consistent with documentary evidence.

Allegation #1(a)

The testimony of [Preceptor A] was reviewed and accepted by the Panel. The Panel found her ability to recall specific events appropriate given the length of time between when the events occurred and the discipline hearing of the Member. [Preceptor A] was the Member's preceptor and had direct knowledge of Patient [A]. [Preceptor A] was able to testify in a consistent and confident manner about the incident involving Patient [A] when she witnessed the Member attempting to administer medication to Patient [A]. As noted earlier, the Panel accepted Ms. Flynn as a Nursing Expert. Her testimony included her expert opinion and a review of the standards of practice. The Panel reviewed the *Medication* Standard and in particular, that the Member needed to "assess the appropriateness of the medication practice by considering the client, the medication and the environment" as well as "know the limits of their own knowledge, skill and judgment, and get help as needed".

The Panel has concluded that despite [Preceptor A]'s instructions the Member wanted to administer medication to Patient [A] even though she had decreased level of consciousness. The Panel accepted Ms. Flynn's evidence and concluded that the Member breached the *Medication* Standard by not assessing his appropriate medication practice and not recognizing his limits of personal knowledge of this matter.

Accordingly, the Panel finds that the Member has committed an act of professional misconduct as alleged.

Allegation #1(b)

The testimony of [Preceptor B] was reviewed and accepted by the Panel. [Preceptor B] testified that she had asked the Member about the status of Patient [B] and that he confirmed care had been provided by the Member. The Member reported to [Preceptor B] that Patient [B] was "dry". [Preceptor B] testified that on assessment of Patient [B] 30-60 minutes later, she was found incontinent in her brief, bed linen and hospital gown. The Panel considered the question that given how Patient [B] was found did the Member actually assess her and complete care as needed. The Panel carefully reviewed the testimony and deliberated on the matter. The Panel reviewed the *Professional Standards* (Exhibit #41) in particular, that "Ethical nursing care means … respecting truthfulness … acting with integrity, honesty and professionalism …". The Panel accepted [Preceptor B's] testimony as truthful, however, it found that [Preceptor B] was unable to provide an accurate and specific timeline on her assessment of Patient [B]. Given this testimony,

the Panel concluded that the Member could have completed care on Patient [B] even though 30 – 60 minutes later she was incontinent of urine.

As a result, the Panel finds that there is insufficient evidence to prove that the Member committed this act of professional misconduct as alleged.

Allegation #1(c)

The Panel was provided sufficient testimony and evidence as to what WDL means at Markham Stouffville Health Centre and in particular on the Unit.

The Panel accepted testimony from [Preceptor B]. [Preceptor B] provided strong evidence about documentation and the definition of WDL. [Preceptor B] was able to recall Patient [C]'s medical history and treatment in an appropriate manner given the length of time between the incident and the discipline hearing of the Member. [Preceptor B] testified about Patient [C]'s medical history and why certain assessments would be not WDL. The Panel was provided and reviewed page 245 of Exhibit #32, which included findings documented by the Member and documentation from [Preceptor B] demonstrating a discrepancy.

The Panel referred to the *Documentation* Standard specifically that "Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete". [Preceptor B] testified that she spoke to the Member about his documentation and that he was not receptive to education from his preceptor.

The Panel also reviewed evidence from Ms. Flynn. Ms. Flynn testified that she was familiar with the term WDL. She confidently provided examples to the Panel that would demonstrate WDL. Ms. Flynn directed the Panel to the communication section in the *Documentation* standard. Ms. Flynn testified that the Member did not meet this standard in terms of communicating the episode of incontinence to other members of the team. The Panel reviewed Ms. Flynn's testimony and the practice standard indicating that there was enough evidence to support that the Member breached the standard.

The Panel finds that the Member has committed this act of professional misconduct as alleged.

Allegations #1(d)(i) and #1(d)(ii)

The testimony of [Preceptor B] was reviewed and accepted by the Panel. The Panel found her ability to recall specific events appropriate given the length of time between when the events occurred and the discipline hearing of the Member. [Preceptor B] was the Member's preceptor and had direct knowledge of Patient [C]. [Preceptor B] was able to testify in a consistent and confident manner about the incident involving Patient [C] when the Member administered medication by pouring it down Patient [C]'s throat contrary to [Preceptor B's] direction. The Panel also received and accepted evidence that the Member administered the medication whole to Patient [C], provided her with water, and that when she began to cough, he provided her with

more fluid, causing her to cough again and that Patient [C] was then incontinent. The Member also pushed Patient [C] forward "banging" her on the back.

As noted earlier, the Panel accepted Ms. Flynn as a Nursing Expert. Her testimony included her expert opinion on the Member's "reactionary" response to Patient [C] choking. Ms. Flynn testified that the Member breached the standard of practice by administering medication in this manner as he lacked knowledge on how to properly care for Patient [C] and in particular with her swallowing care plan.

The Panel accepted and relied upon Ms. Flynn's evidence and accordingly finds that the Member has committed an act of professional misconduct as alleged.

Allegation #1(e)

The Panel reviewed evidence from [Witness A] and [Witness E]. The Panel found both [Witness A]'s and [Witness E]'s testimony was forthright and credible. Evidence was provided to the Panel from the typed notes of the meeting between the Member, [Witness A] and [Witness E]. Exhibit #34 was reviewed closely by the Panel which indicated that the Member made inappropriate comments regarding nursing staff in a meeting with [Witness A] and [Witness E]. In particular the Panel found that the Member alluded to knowing he "knows women" and gossiping as a "woman thing".

Ms. Flynn testified that any blanket statement about gender is not appropriate. It is unprofessional, disrespectful and shows an unwillingness to establish and maintain collegial relationships which are required under the *Professional Standards*. The Panel reviewed the *Professional Standards*. Ms. Flynn testified that in this standard, personal relationships are supposed to be based on trust and respect and that the Member breached this standard. The Panel accepts Ms. Flynn's evidence and finds that the Member has committed an act of professional misconduct as alleged.

Allegations #1(f)(i) and #1(f)(ii)

The Panel closely reviewed evidence from [Preceptor A] and [Nurse A].

[Preceptor A] confirmed that she met with the Member in the medication room to discuss his practice. [Preceptor A] testified that the Member was upset and that she was uncomfortable with the interaction. [Preceptor A] further testified that she was uncomfortable "being in a room with a man that I did not know". [Preceptor A] believed the Member's questions regarding his practice were appropriate however confirmed that it was the environment that made her feel uncomfortable.

[Nurse A] confirmed with the Panel that she met the Member in the medication room. [Nurse A] testified that the Member was visibly upset expressing to her that he was "tired of all these girls telling him what to do". [Nurse A] testified that she provided redirection with hopes to calm the

Member down. Exhibit #18 was reviewed by the Panel. This document is an email exchange between [Nurse A] and [Witness A]. The email is a description about the incident. The email did not indicate that at any time [Nurse A] felt uncomfortable with the Member.

The Panel accepted testimony from Ms. Flynn who was of the opinion that the Member's conduct was unprofessional and a breach of the standards. The Member spoke to his colleagues in a locked room and spoke to them in an unprofessional manner which did not foster collegial relationships.

As a result, in regards to allegation #1(f)(i), the Panel finds that there is insufficient evidence to prove that [Preceptor A] felt uncomfortable in her interaction with the Member and that he committed an act of professional misconduct as alleged.

In regards to allegation #1(f)(ii), the Panel accepts Ms. Flynn's evidence and finds that the Member has committed an act of professional misconduct when the Member made comments about not taking directions "from these girls" or words to the effect.

<u>Allegations #1g(i) and #1(g)(ii)</u>

The Panel reviewed evidence from [Witness F], [Witness G] and [Nurse A]. The Panel felt that the witnesses were credible and truthful.

[Witness G] testified that she found the Midazolam vial in a patient medication bin and that she contacted the Unit to speak with the Member, to discuss the appropriate measures of disposing of a controlled substance and asked the Member to go to the pharmacy to dispose of the medication. [Witness G] testified that she was unable to recall the tone of voice the Member utilized during the conversation. The Panel reviewed an incident report from [Witness G] confirming that an incorrect storage of a narcotic substance report was completed.

[Witness F] and [Nurse A] testified to the Panel that they overheard the Member speaking with [Witness G] on the telephone. [Witness F] and [Nurse A] testified that the Member was "very angry" and was "loud". [Nurse A] testified that the Member said "that it's not his job and that he is very busy looking after patients and that they can bring it up to him". Both witnesses testified to the Panel that as a result of this, they went to the pharmacy because it was an "out of character" incident. [Nurse A] testified that [Witness G] was upset and visibly shaking.

The Panel accepted testimony from Ms. Flynn. Ms. Flynn testified that because the Member did not follow hospital policy in wasting a medication in a proper manner, the Member breached both the *Professional Standards* and the *Medication* Standard. The Member failed to dispose of a medication in a safe and competent manner. By speaking to [Witness G] in an unprofessional manner, the Member failed to establish or maintain a collegial relationship with a member of the healthcare team.

The Panel finds that the Member has committed this act of professional misconduct as alleged.

Allegation #2

The Panel was provided sufficient testimony and evidence regarding the meaning of WDL at Markham Stouffville Health Centre and in particular on the Unit.

The Panel accepted testimony from [Preceptor B]. [Preceptor B] provided strong evidence about documentation and the definition of WDL. [Preceptor B] was able to recall Patient [C] medical history and treatment in an appropriate manner given the length of time between the incident and the discipline hearing of the Member. [Preceptor B] testified to the Panel about Patient [C]'s medical history and why certain assessments would not be considered WDL. The Panel was provided and reviewed Exhibit #32 which included documentation findings of the Member for Patient [C]'s genitourinary function. The Member documented it as WDL when Patient [C] was incontinent of urine. The Panel reviewed the Member's documentation for the musculoskeletal assessment. The Member documented that Patient [C] was WDL, however, Patient [C] suffered from weakness and had recently experienced a fall. The Panel was also provided with [Preceptor B's] documentation noting the discrepancies which it accepted.

Accordingly, the Panel was satisfied that Patient [C] was not WDL and finds that the Member has committed an act of professional misconduct as alleged when he documented that she was and as a result, failed to keep records as required.

Allegations #3(a), #3(c), #3(d)(i), #3(d)(ii), #3(e), #3(f)(ii), #3(g)(i) and #3(g)(ii)

The Panel finds that the Member's conduct was unprofessional and dishonourable. The Panel finds that the Member's conduct was unprofessional as it involved a serious and persistent disregard of his professional obligations. The Member breached the *Professional Standards*, the *Documentation* Standard, the *Medication* Standard and the *Conflict Prevention and Management Practice Guidelines*.

The Panel also finds that the Member's conduct was dishonorable, he demonstrated an element of moral failing and the Member's conduct falls well below the conduct expected of a nursing professional. There were elements of deceit or deception, but this behaviour goes to the very core of nursing. Even though the Member was orientating with a preceptor the Member's conduct demonstrated persistent disregard with his ongoing breaches. The Member ought to have known that administering medication in an unsafe and improper manner is unacceptable. Even after the Member was provided education on documentation, he refused to change his practice. The Member was also noted on more than two separate occasions to make inappropriate comments towards his colleagues. The Member should have demonstrated self-awareness that this type of conduct is unacceptable in the nursing profession. The Member also knew or ought to have known that his conduct was unacceptable and fell well below the standards of a professional.

Having considered the evidence and the onus and standard of proof, the Panel is unable to find that there is clear, cogent and convincing evidence established on the balance of probabilities that the Member has committed acts of professional misconduct as alleged in paragraphs 3(b) and

3(f)(i). In regards to allegation 3(b), the Panel closely reviewed testimony from [Preceptor B]. While the Panel did accept [Preceptor B's] testimony in that she asked the Member to complete care of patient [B] and that she went to assess the patient "under an hour, probably half an hour", the Panel concluded that it is plausible for the Member to have completed care of patient K.H and that the patient could have been incontinent with in that time frame. With respect to allegation #3(f)(ii) the Panel found that there was not enough evidence to support the allegation that the Member "asked [Preceptor A], RPN, to meet with you alone in the medication room to inquire if she had any concerns regarding your work, which made her feel uncomfortable" as the witness came to the medication room willingly and further stated that she was uncomfortable with the line of the Member's questioning, in that she believed his questions should be addressed by management, and not herself. In regards to disgraceful conduct, the Panel considered his findings of professional misconduct as a whole. While his professional misconduct demonstrated an element of moral failing and fell well below the standards of practice, the Member's conduct demonstrated did not rise to the level of disgraceful misconduct in that it did not cast serious doubt on the Member's ability to discharge the higher obligations of the profession.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should 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 5 months. This suspension shall take effect from the date that the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date the Member's suspension ends. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO 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 the Member's suspension ends. To comply, the Member is required to ensure that:

i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

    1. the Panel's Order,
    2. the Notice of Hearing, and
    3. 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 and decision tools (where applicable):

    1. *Code of Conduct,*
    2. *Professional Standards*,
    3. *Practice Guideline re Conflict Prevention and Management*, and
    4. *Documentation*;

iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

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 their report to CNO, 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 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 12 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 CNO 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, and
3. 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 CNO, in which it will confirm:

1. that they received a copy of the required documents, and
2. that they agree to notify CNO immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

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.

5. Requiring the Member to pay CNO a portion of its legal costs and expenses incurred in the course of the prosecution in the amount of $2,000 within six months of the date of this Order.

College Counsel submitted that when the Panel is at the stage of considering what the appropriate penalty is for the Member, there are a number of interests that the Panel must consider: 1) Protection of the public which is the primary duty of the College; 2) The College must maintain the public's confidence in its ability to self-regulate its members; 3) Consideration of the Member must be made in regards to his own personal circumstances. College Counsel submitted that to satisfy these various interests, penalties must achieve: 1) General deterrence for the profession as

a whole; 2) Specific deterrence for the Member; and 3) Rehabilitation and remediation of the Member. College Counsel submitted that panels are expected to consider both the aggravating and mitigating circumstances when fashioning the appropriate penalty.

The aggravating factors in this case were:

- The conduct at issue is quite serious in that the Member failed to follow direction from his preceptors while he was in training on multiple occasions and in some of those incidents, his failure to follow direction caused harm to patients and had adverse outcomes;
- The Member's conduct was repeated, this was not a one-time incident, there were multiple patients involved over multiple incidents even after attempts were made to educate the Member and provide him with feedback the conduct continued; and
- The Member's conduct and actions showed a serious disregard for his obligations to his patients and to the profession.

In terms of the mitigating factors, College Counsel submitted that because the Member did not attend the hearing, the Panel has very little information to consider. However, College Counsel submitted that:

- The Member does not have a prior discipline history with the College.

College Counsel submitted that in light of all these factors, the appropriate penalty in this case calls for a significant period of suspension and tailored remedial training as well as employer notification.

College Counsel submitted that although a term of the order sought is for the Member to receive a 5-month suspension of his certificate of registration. College Counsel submitted that the Member's certificate of registration is currently resigned but the suspension would occur if the Member were to return to the practice of nursing. College Counsel submitted that one of the terms, conditions and limitations on the Member's certificate of registration should be that the Member would attend a minimum of 2 meetings with a Regulatory Expert. College Counsel submitted that this would be required once his suspension is completed. College Counsel submitted that the final component of the proposed penalty would be 12 months of employer notification once he returns to the practice of nursing.

College Counsel submitted that the proposed penalty meets the interests of the public, the profession and the Member in the following ways:

1. It is in the public interest to ensure that there are serious consequences when a member breaches the *Professional Standards*, fails to keep records as required and engages in conduct that is both unprofessional and dishonourable.

2. The 5-month suspension of the Member's certificate of registration, the 2 meetings with the Regulatory Expert and the employer notification all act to protect the public by ensuring that the Member is closely monitored should he chose to return to the practice of nursing.

3. The proposed penalty provides for general deterrence through the 5-month suspension of the Member's certificate of registration as it sends a message to the profession that members cannot engage in this type of conduct without impunity and that a breach of the standards and failure to keep records will not be tolerated and hopefully other members of the profession will learn from the Member's mistakes.

4. The proposed penalty provides for specific deterrence through the oral reprimand and the 5-month suspension of the Member's certificate of registration which will clearly communicate to the Member that engaging in this conduct has severe consequences.

5. To proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert, which will allow the Member to learn and improve his practice if he returns to the profession.

Prior Cases:

College Counsel submitted the following cases to the Panel to demonstrate that the proposed penalty fell within a reasonable range of similar cases from this Discipline Committee:

CNO v. Varga (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the incidents occurred in an Inpatient Mental Health Unit. College Counsel submitted that some of the allegations are of a similar theme to the case before this Panel. The member failed to follow a care plan specifically on de-escalation techniques and then did not listen to direction from the Charge Nurses or any other nurse that had more experience with this patient. The member's conduct was found to contribute to the patient's escalation. Finally, the member fed the patient while he was lying on his back in four-point restraints which led to the patient being a choking risk and failed to meet the swallowing guidelines for this patient. College Counsel submitted that while it was a different practice setting, the member's conduct was similar in that a member was not following a care plan, not following the direction of colleagues who had more experience with the patient and the member engaged in behaviour that was dangerous for the patient. The panel found that the member's conduct amounted to a breach of the *Professional Standards* when she did not comply with the patient care plan and went against the advice of her professional colleagues which caused harm to the patient and put the patient at risk for choking. The panel found that the member's conduct was unprofessional, dishonourable and disgraceful. The member's conduct in this case caused the patient to escalate further and engage in self harm. The penalty included an oral reprimand, a 4-month suspension of the member's certificate of registration, a minimum of 2 meetings with a Regulatory Expert and 12 months of employer notification. College Counsel submitted that this case is similar to the case before this Panel in that the Member did not listen and did not follow the care plan ultimately causing harm to Patient [B] and Patient [C]. College Counsel submitted

that the most significant distinguishing feature in this case was that it proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The panel had the mitigating factor that the member showed remorse and had taken accountability for her conduct. College Counsel submitted that this mitigation is not demonstrated with the case before this Panel. College Counsel submitted that the member's conduct in this case occurred over one day versus the Member's conduct in the case before this Panel was over multiple days warranting a lengthier suspension.

CNO v. Bruce (Discipline Committee, 2019): This case proceeded by an Agreed Statement of Facts and a Joint Submission on Order. College Counsel submitted to the Panel that there were a number of allegations in this case largely regarding failure to properly triage patients and concerns with documentation. College Counsel submitted to the Panel that allegations #1(a), (b) and (f) relate to the manner in which the member spoke with a colleague in a raised voice and an unprofessional manner. The panel found that the member breached the standard of practice and demonstrated a failure to document or keep records. The penalty included an oral reprimand, a 4-month suspension of the member's certificate of registration, a minimum of 2 meetings with a Regulatory Expert, 24 months of employer notification and 24 months of no independent practice. In this case, College Counsel submitted that the documentation failures were much more significant than in the case before this Panel. College Counsel submitted that the member completely failed to document that the patient was present in the Emergency Room as well as made inappropriate comments to patients and their family members. College Counsel submitted that a distinguishing feature in this case was that it proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order and that the panel had the mitigating factor that the member showed remorse and took accountability for her conduct.

CNO v. Simeone (Discipline Committee, 2017): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. College Counsel submitted that this case involved home care and a number of incidents related to a failure to provide adequate care and failure to document findings in an accurate manner. The panel found that the member engaged in a breach of the standards, a failure to keep records as well as dishonourable or unprofessional conduct. The penalty included an oral reprimand, a 5-month suspension of the member's certificate of registration, 2 meetings with a Nursing Expert, 18 months of employer notification, random spot audits of the member's practice and 18 months of no independent practice. College Counsel submitted that while the suspension is the same as in the case before this Panel College Counsel is proposing the other terms of employer notification and no independent practice are longer as this member's conduct was more serious as it occurred over two years and involved a number of different incidents. College Counsel submitted that even though the member had the mitigating factor of an Agreed Statement of Facts and a Joint Submission of Order and took accountability for her actions the conduct required lengthier employer notification and no independent practice period. College Counsel submitted that the member's conduct was more serious warranting a lengthier suspension as it involved a breach of trust and conduct that would be considered disgraceful, dishonourable and unprofessional.

Costs

College Counsel requested $2,000.00 in costs to partially cover the protracted pre-hearing phase and a total of six pre-hearings required. The Member was reluctant to set dates for this hearing and had to be ordered to do so by the Discipline Committee Chairperson.

It is important to note that costs are not part of a penalty, however, they may be ordered by a Panel of the Discipline Committee.

College Counsel submitted that pursuant to Section 53.1 of the *Health Professions Procedural Code*, in an appropriate case, a panel may make an order requiring a member who the panel finds, has committed an act of professional misconduct or finds to be incompetent, to pay all or part of the following costs and expenses:

1. The College's legal costs and expenses;

2. The College's cost and expenses occurred in investigating the matter; and

3. The College's cost and expenses occurred in conducting the hearing.

College Counsel submitted that the language of the provision provides for a two-step analysis in awarding costs: a) The Panel must first consider whether this was an appropriate case for awarding costs; and b) If the Panel determines that it would be appropriate to order costs, it must then determine what is a fair and reasonable amount of costs to order.

College Counsel submitted that in determining the first step, there are a few factors that the Panel must consider:

1. Did the College successfully prove some or all of the allegations? College Counsel submitted that in this case the College proved not all, but the majority of the allegations

2. The nature and seriousness of the conduct, the length and complexity of the case; and

3. If the Member's defense or refusal to admit wrong doing complicated or lengthened the proceedings in any way?

College Counsel submitted that if the Panel determined that costs were appropriate, the second stage of the analysis was the amount of award and that there were a number of considerations that the Panel needed to review.

- Did the Member take steps to shorten the process?

- Were the resources expended reasonable?

- Is there any evidence of financial hardship to the Member?

College Counsel submitted that it is important to understand that costs are not meant to be punitive. Rather, the idea of awarding costs is that while a member has the right to defend

themselves against allegations, the membership at large should not be solely responsible for paying the fees or the costs of a discipline process. College Counsel submitted that costs are appropriate under the first step given the College's overall success in proving a majority of the allegations and secondly the Member's conduct in complicating the proceedings. College Counsel submitted the most notable steps that the Member took in this case that complicated the proceedings from the College's perspective is that the parties in this case attended six pre-hearing conferences. College Counsel submitted that this is highly unusual. College Counsel submitted that at the first pre-hearing conference, the Member was not represented and he did not provide a form 1A. At the first pre-hearing conference the Member made a number of disclosure requests and a further pre-hearing conference was scheduled for approximately 5 weeks later. The Member was then represented at the second pre-hearing conference and the same counsel represented him throughout the remainder of the pre-hearing conferences. College Counsel submitted that the Member made further disclosure requests, but did not submit a form 1A until after the last pre-hearing conference and until the Chair of the pre-hearing made an order for him to complete one. College Counsel submitted that often Member's counsel would attend the pre-hearing conference having not reviewed the disclosure and therefore the pre-hearings were not productive. College Counsel submitted that throughout this period the Member continued to adamantly deny the allegations and advised that he was going to vigorously defend them at the hearing. College Counsel submitted that the College continued to try and reach a resolution with the Member or to narrow the issues. College Counsel submitted that less than two weeks before the hearing, the Member resigned his certificate of registration and advised that he would no longer be participating in the hearing. In light of this unexpected news, College Counsel advised the Member's Counsel that the College would likely seek costs at the hearing and continued to make final attempts to resolve the case. College Counsel submitted that it was the night before the hearing that the Member's position remained the same and that he would not plead guilty to the allegations or participate in the hearing. College Counsel submitted that because of the Member's conduct and need for so many unproductive pre-hearings, the College was seeking costs against the Member. College Counsel provided the Panel with the College's bill of costs. College Counsel submitted to the Panel that the bill of costs only related to the fees charged by College Counsel's firm and did not relate to the College's costs of investigation, expert fees or other processes. College Counsel submitted that this matter was first assigned to another Counsel who attended the first three pre-hearing conferences. College Counsel submitted that the bill of costs has been broken down into the preparation for pre-hearing conferences, attendance at pre-hearing conference and hearing preparation and attendance. The bill of costs included the actual rate of fees that the College paid the firm and 50% of that cost. College Counsel submitted that the College is only seeking $2,000.00 in costs for the total cost of the pre-hearing for preparation and attendance.

College Counsel submitted that there is a range of appropriate costs. College Counsel provided the following caselaw to the Panel:

CNO v. Rojas Leal (Discipline Committee, 2019): College Counsel submitted that this was a much more complicated case. There were a number of pre-hearing motions that were complicated and costly for the College. College Counsel submitted that in this case the College sought a much

higher cost award of $135,000.00 against the member which was two-thirds of the College's costs. College Counsel submitted that there was an affidavit provided reviewing the preliminary steps, motions and various correspondence with the member and Counsel. College Counsel submitted that this is appropriate given the very costs being sought and all of the conduct that was at issue. College Counsel reviewed with the Panel the appropriateness of costs in this case and made reference to the Divisional Court case of *Venneri v. College of Chiropractors of Ontario*, 2010, and the quantum of costs referred to in other Divisional Court cases from other health regulatory discipline committees. College Counsel submitted that this is a similarity here based on the College's success and that the Member's conduct complicated and lengthened the proceedings.

CPSO v. Shamess (2019): College Counsel provided the Panel with the penalty decision in this case. The parties submitted a Joint Submission on Penalty but not on costs. College Counsel reviewed prior decisions and order for costs, evidence and submissions on cost. College Counsel submitted that what was notable in that case was that the CPSO was not successful in all the allegations against the member. The most serious allegations were not made out. College Counsel submitted that the case sets out what the discretion of the committee on costs and what the issues to be considered are when doing so as provided by the Code. College Counsel submitted that, the CPSO sought $10,000.00 in costs which were for one full day of the hearing but ultimately the decision of the panel considered all the components of the costs and prior decisions. The panel found that although the most serious allegations were not found against the doctor, the misconduct that was found against the doctor was not incidental or minor. The panel accepted that the doctor was responsible for a portion of the hearing and ordered $5,000.00 in costs.

CPO v. Lum (2017): College Counsel submitted that this case is helpful as the member did not appear. The case proceeded on a contested basis in his absence. The CPO was able to prove its case through a single witness. In that case, the CPO sought and was awarded 50% of its actual costs which amounted to $4,500.00.

CTCMPAO v. Turevski (2018): College Counsel submitted that this is another example of the member not attending the hearing and having been deemed to have denied the allegations. College Counsel submitted that the allegations were proven by the *CTCMPAO* and there was an element of dishonesty, fraud and theft. The *CTCMPAO* was awarded 60% of its costs in an amount of $10,000.00.

CP v. Bannis (2021): College Counsel submitted that this case proceeded by way of an Agreed Statement of Facts, however, at the last opportunity the member did admit to the allegations. College Counsel submitted that there was a lot of preparation for this hearing as initially it was supposed to be a contested hearing, and significant costs were awarded because of the member's late decision. The cost award was $107,000.00 which was two-thirds of the costs.

Penalty Decision

The Panel makes the following order as to penalty:

1. The Member is directed 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 4 months. This suspension shall take effect from the date that the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date the Member's suspension ends. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO 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 the Member's suspension ends. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. 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 and decision tools (where applicable):

            1. *Code of Conduct,*
            2. *Professional Standards*,
            3. *Practice Guideline re Conflict Prevention and Management*, and
            4. *Documentation*;

        iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

        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 their report to CNO, 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 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 CNO 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, and
    3. 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 CNO, in which it will confirm:

    1. that they received a copy of the required documents, and
    2. that they agree to notify CNO immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

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.

Costs Order

The Panel makes the following order as to costs

1. The Member is required to pay CNO a portion of its legal costs and expenses incurred in the course of the prosecution in the amount of $4,800.00 within six months of the date of this Order.

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.

As the Member has resigned his certificate of registration, he will need to meet re-entry requirements before obtaining his certificate of registration, at which time this penalty will take effect. The order provides for specific deterrence through the oral reprimand and a 4-month suspension of the Member's certificate of registration. General deterrence is achieved by the 4-month suspension of the Member's certificate of registration. In reviewing the case law presented by College Counsel, it was determined by the Panel that the Member's misconduct did not require a lengthier suspension of 5 months as sought by the College. The Panel was convinced that a penalty more closely matching *CNO v. Varga* was warranted. The Panel concluded that based on the Member's findings of professional misconduct he required further remediation and rehabilitation components which included closer observation by his employer. The Panel ordered a lengthier employer notification period of 18 months rather than the 12 months sought by College Counsel thereby extending his supervision period and further allowing for remediation and rehabilitation. This should reassure the public and future patients that employers have been notified of the Member's misconduct and his practice will be closely monitored.

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

Reasons for Cost Order

In regard to costs, the Panel reviewed the submissions of College Counsel, the advice of ILC and prior decisions in awarding costs. The Panel understands that awarding costs is not punitive in nature as every member has a right to defend allegations of professional misconduct in a contested hearing. Based on the submissions made by College Counsel, the Panel felt that the Member was provided more than one opportunity to defend his misconduct. This fact in concert with six pre-hearing conferences led the Panel to determine that a cost order to address the additional costs associated with the protracted pre-hearing phase was warranted. The Member

and his Counsel did not complete the appropriate paperwork required for a pre-hearing until ordered to do so by the pre-hearing Chair. The Panel determined that the Member took unnecessary steps to delay the discipline hearing and accordingly orders him to pay costs in the amount of $4,800.00, being approximately 50% of the pre-hearing costs. The Panel was not convinced that $2,000 was sufficient based on the work and effort expended to ensure that the Member was given every opportunity to defend his position and therefore made additional award totaling $4,800.

I, Susan Roger, 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.