DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Mary MacMillan-Gilkinson	Public Member
Linda Marie Pacheco, RN	Member
Tania Perlin	Public Member
George Rudanycz, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
CORBETT HOARE	)	ROBERT STEPHENSON for
Reg. No. 9721093	)	Corbett Hoare
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: October 23, 2018

DECISION AND REASONS

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

At the request of College Counsel and Counsel for Corbett Hoare (the "Member"), the Panel made an order pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991 banning the disclosure, including the publication and broadcasting, of the identity of the client referred to in the Discipline Hearing of Corbett Hoare or any information that could disclose the client's identity, including any reference to the client's name contained in the allegations in the Notice of Hearing and in any exhibits filed with the Panel.

The Allegations

Counsel for the College advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(a) iii and 3(a) iii of the Notice of Hearing dated August 9, 2018. The Panel granted this request. The remaining allegations against the Member 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 working as a Registered Nurse at St. Mary's General Hospital (the "Hospital"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that on or about March 9, 2016:

    a. you failed to ensure that your client, [the Client], received prompt medical treatment, including but not limited to the following:

        i. you failed to triage [the Client] as a Canadian E.D. Triage and Acuity Scale Level 2 (Emergent) case;

        ii. you failed to appropriately consider the electrocardiogram test(s) obtained by the EMS paramedic with respect to [the Client] when assessing and triaging [the Client];

        iii. [withdrawn];

        iv. you failed to initiate the appropriate medical directive for chest pain or instruct a colleague to initiate the directive, when [the Client's] presenting symptoms warranted doing so; and/or

        v. you failed to inform your colleagues that [the Client] had not been assessed by a physician and was in the waiting room during and/or at the conclusion of your shift; and/or

    b. you discarded an electrocardiogram test completed by the emergency medical services paramedic on [the Client]; and/or

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 a Registered Nurse at the Hospital, you failed to keep records, and in particular, you discarded an electrocardiogram test completed by the emergency medical services paramedic on [the Client]; and/or

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 a Registered Nurse 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 in that on or about March 9, 2016:

    a. you failed to ensure that your client, [the Client], received prompt medical treatment, including but not limited to the following:

i. you failed to triage [the Client] as a Canadian E.D. Triage and Acuity Scale Level 2 (Emergent) case;

ii. you failed to appropriately consider the electrocardiogram test(s) obtained by the EMS paramedic with respect to [the Client] when assessing and triaging [the Client];

iii. [withdrawn];

iv. you failed to initiate the appropriate medical directive for chest pain or instruct a colleague to initiate the directive, when [the Client's] presenting symptoms warranted doing so; and/or

v. you failed to inform your colleagues that [the Client] had not been assessed by a physician and was in the waiting room during and/or at the conclusion of your shift; and/or

b. you discarded an electrocardiogram test completed by the emergency medical services paramedic on [the Client]; and/or

c. you referred to the electrocardiogram test completed by the emergency medical services using unprofessional and unsuitable language.

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Corbett Hoare (the "Member") obtained a diploma in nursing from Conestoga College in 1997.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on July 11, 1997.

3. The Member was employed at St. Mary's General Hospital (the "Hospital") from 2000 to April 15, 2016, when his employment was terminated as a result of the incident below.

THE HOSPITAL

4. The Hospital is an acute care hospital with 150 care beds.

5. The Member worked in the Hospital's Emergency Department (the "Unit") as a part-time staff nurse – he frequently worked as the charge nurse on shift.

6. At the time of the incident, the Unit employed 29 part-time and 30 full-time nurses.

7. Nurses on the Unit worked 12 hour shifts – the day shift was from 0730 to 1930 and the night shift was from 1930 to 0730. There were also three swing shifts: 0900 to 2100, 0400 to 1600 and 1100 to 2100.

8. The Unit consisted of three areas: acute care, which had nine single rooms, separated by curtains and a nursing station; sub-acute care, which was across the hall and had 12 rooms, and ambulatory treatment, which had four rooms and was the minor treatment area. The Unit also had a waiting room. Nurses were staffed in each of the areas. The Emergency Room triage nurse was assigned to the waiting room. The charge nurse did not have an assignment to a specific area.

9. The Hospital practice was for the charge nurse to triage patients who arrived at the Hospital through emergency medical services ("EMS") paramedics, while the triage nurse triaged patients who walked in to the Emergency Department.

HOSPITAL POLICIES

10. The Hospital's Emergency Department Comprehensive Triage Protocol sets out the procedure by which the triage nurse will provide clients arriving at the Emergency Department with a nursing assessment. The Hospital adopted the triage protocol following the five Level Canadian E.D. Triage and Acuity Scale ("CTAS"). The following two levels from the Triage and Acuity Scale are relevant to this case:

> **Level II Emergent Time to Nursing assessment — Immediate**
>
> Time to Physician assessment— 15 minutes
>
> Conditions are a potential threat to life, limb or function and require immediate nursing intervention and rapid medical intervention or performance of delegated controlled acts by an authorized health professional.
>
> **Level Ill Urgent Time to Nursing assessment — 30 minutes**
>
> Time to Physician assessment — 30 minutes
>
> Conditions could potentially progress to a serious problem requiring emergency intervention; may be associated with significant discomfort or affect ability to function at work or affect activities of daily living.

11. The Hospital established a Procedure/Process for Emergency Visits. That document sets out the Hospital's expectation that the Emergency Department triage nurse will triage all patients within 10-15 minutes of arrival in the Emergency Department according to the CTAS, and that a nursing

assessment will be performed by a primary care nurse while the patient is in his or her assigned treatment area.

12. The Hospital has a Medical Directive/Delegation "Chest Pain: Tests & Interventions in the ED" for patients who present with chest pain in the Emergency Department. The Directive instructs a nurse to initiate a number of diagnostics and treatments immediately, and in any event prior to the physician's assessment of the client, if a client meets specified clinical criteria. To initiate this medical directive, the assigned nurse would complete the paperwork for bloodwork and conduct an ECG.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Background to Triage of [the Client]

13. On March 8-9, 2016, the Member worked from 1930 to 0730. He was the charge nurse on shift in the Emergency Department. As the charge nurse, he was responsible for triaging all clients arriving in the Emergency Department by ambulance. The Unit was busy and short-staffed on the night in question.

14. [The Client] (the "Client") was 59-years old at the time of the incident. He was brought to the Hospital by EMS at 0528 on March 9, 2016. EMS found the Client on the toilet at home, ashen, short of breath and complaining of chest pain. He had a history of cardiac issues. EMS performed one ECG in the Client's home at 0505 and administered 160 mg of Aspirin and oxygen. Before arriving at the Hospital, the EMS paramedics performed a second 12 lead ECG at 0515 and administered nitrolingual spray at 0519 and 0524. If the paramedic were to testify, she would state that she then performed a third ECG at 0526. The Client reported decreased chest pain after both administrations of the spray. The EMS paramedic classified the Client as CTAS Level 2 (Emergent).

The Member's Triage and Interactions with EMS

15. The Client arrived at the Hospital at 0529. The Member received the Client from EMS. He triaged the Client in the Hospital's electronic triage system commencing at 0529 and finishing at 0535.

16. During the Member's triage, he recorded the EMS paramedic's report, CTAS classification, and the EMS paramedic's interventions and monitor interpretations. He also noted that the Client's past medical history included atrial fibrillation, congestive heart failure, hypertension, and high cholesterol in the Hospital's electronic system.

17. During triage and transfer of care, the EMS paramedic showed the Member ECGs she had taken in the ambulance before arriving at the Hospital. The Member said he would take the "prettier one" or the "pretty one". If the Member were to testify, he would say that he perceived at least one ECG to be illegible and his comment was referring to the ECG that was legible and of diagnostic value, in his view. If the paramedic were to testify, she would say she observed the Member crumple up one or more ECGs and placed them in the garbage. If the Member were to testify, the Member would state that his practice for disposing of documents was to do so in a confidential manner, but does not recall how he discarded the illegible ECG.

18. The Hospital's policy was that nurses would mount EMS-administered ECGs for scanning into the Hospital's electronic system, which the Member acknowledges. If the Member were to testify, he would state that he did mount the ECG. Nurses were not responsible for scanning the mounted ECG into the electric system. When the Hospital investigated the incident, no EMS-administered ECGs had been scanned into the system for the Client. The Hospital obtained copies from the paramedic service.

19. The Member acknowledges that he should have kept and mounted all of the EMS-administered ECGs that were provided to him, even those that may have not been diagnostically useful. He further acknowledges that his failure to retain all of the EMS-administered ECGs was a failure to keep records, a breach of Hospital policy, and a breach of the standards of practice regarding documentation. He further acknowledges that his use of language regarding the ECG was a poor choice of words.

20. The Member assessed the Client as CTAS Level 3 (Urgent) and decided to send him to the waiting room. The EMS paramedic advised the Member that she disagreed with the Member's assessment of the Client's acuity. The Member maintained his assessment of the Client's acuity as Level 3. The EMS discharged the Client into the care of the Hospital at 0535. The EMS placed him in the waiting room.

21. If the Member were to testify, he would state that the Client was stable and pain-free when the Member assessed him, and the Member used his judgment to conclude that the Client was not at an acuity level that required priority and urgent physician intervention.

22. If the College's expert were to testify, she would state that the Client's clinical history (past medical history and medication list), and his presentation with an episode of chest pain with features that suggested acute coronary syndrome, warranted a CTAS Level 2 identification. She would further state that the Member should have considered all of the objective and subjective information (including the paramedic's ECG(s) and assessment, and the Client's report of his symptoms), and that the Member under-assessed the Client.

23. In hindsight, the Member acknowledges and admits that a CTAS Level 2 would have been appropriate for the Client, given his presenting symptoms and past history. The Member admits that his failure to assess the Client as CTAS Level 2 was a breach of the standards of practice.

24. The Member correctly determined that the Client's presentation triggered the Hospital's Medical Directive/Delegation "Chest Pain: Tests & Interventions in the ED". As part of the triage process, the Hospital's electronic triage system specifically asks a user if a patient is appropriate for a Diagnostic Medical Directive. The Member selected "yes" for the Client, when prompted. Selecting "yes" does not trigger the initiation of a Medical Directive; a nurse must then complete the requirements of the Medical Directive.

25. The Member did not initiate any medical directives with respect to the Client at any time. Specifically, the Member did not initiate the Hospital's Chest Pain Medical Directive which required obtaining blood samples and administering a 12 lead ECG. If the Member were to testify, he would state that he intended to initiate the Medical Directive or to delegate to the triage nurse

to do so. If the Member were to testify, he would state that he forgot to do so because the Unit was short-staffed and the shift was busy.

26. The Member admits that his failure to initiate and complete (or delegate) the tasks required by the Medical Directive was a breach of the standards of practice. The Member acknowledges that the completion of the Chest Pain Medical Directive was a necessary diagnostic tool for the health care team and should have been prioritized to be completed immediately after his triage of the Client.

Client's Death

27. After triaging the Client, the Member sent him to the waiting room at approximately 0535, along with the Client's son. Both the Member and the EMS paramedic told the Client to come and get assistance if his symptoms worsened. Thereafter, the Client's basic information (name, age and chief complaint) was listed on the waiting room's tracking board and was in view of the triage nurse. The Member could have added additional comments for view on the tracking board but did not do so. If required, additional information on the Client's condition was available by accessing various links on the tracking board. Neither the Client nor his son reported any change in the Client's status until after the change in shift. If the Member were to testify, he would state that he intended to complete the Chest Pain Medical Directive and he was confident the triage nurse would reassess the Client in accordance with the CTAS protocol.

28. The Member did not inform the triage nurse that the Client was in the waiting room. If he were to testify, he would state that he did not because the Client's information was on the tracking board. The Member did not ask her to complete the tasks required by the Chest Pain Medical Directive or report to her that the Client was subject to a medical directive or that he had not been seen yet by a physician.

29. The triage nurse did not assess the Client at any time in spite of her obligation to do so every 30 minutes as required by the CTAS protocol. If the triage nurse or the Hospital representative were to testify, they would state it is often difficult in a busy waiting room to achieve 30 minute checks on CTAS Level 3 clients in the waiting room.

30. If a representative from the Hospital were to testify, she would state that there were beds available in the acute area between 0535 and 0730, and that at least one client assessed as CTAS 3, who presented in the Unit after the Client, was moved from the waiting room and assessed between 0624 and 0745. The Member acknowledges that he did not take positive steps to ensure that the Client was seen by a physician promptly because he had under-assessed the Client's acuity.

31. The Member's shift ended at 0730. If the oncoming nurse were to testify, she would state that the Member did not give her a report about any specific patient, nor did he tell her that the Chest Pain Medical Directive had not been completed for the Client. If the Member were to testify, he would say he told the oncoming day shift nurse that the Client was in waiting room. The Member acknowledges that he did not specifically inform the oncoming day shift nurse that the Client had not yet been seen by a physician.

32. At approximately 0745, shortly after the Member's shift ended, the Client's son, who was waiting with the Client in the waiting room, approached a clerk to advise that his father was experiencing

chest pain. At this point, the Client had been in the Hospital since 0535 without being seen by a physician, reassessed by the Member or assessed by any another nurse, including the triage nurse, nor had any of the tasks required by the Medical Directive been completed.

33. After being advised by the Client's son that the Client was experiencing chest pains, the clerk called the day charge nurse, who performed a 12-lead ECG lead, and immediately reported the Client to the Emergency Room doctor. The Client worsened quickly, and became unresponsive and without a pulse at 0749. A nurse initiated CPR, and ventricular fibrillation. The ER staff were ultimately unable to resuscitate the Client, and he died shortly after.

34. The Member acknowledges that he did not ensure that the Client received prompt medical attention when he failed to complete the Chest Pain Medical Directive (which would have provided diagnostic information for a physician), when he failed to ensure that the Client was placed in priority to see a physician, and when he failed to report the status of the Client, and in particular, that the Medical Directive was not completed and he had not seen a physician, to his colleagues at the end of his shift.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

35. The Member admits that he committed the acts of professional misconduct as described in paragraphs 4-34 above, and as alleged in the following paragraphs of the Notice of Hearing. In particular, he admits that he breached the standards of practice in the following ways:

    - 1(a)(i) in that he failed to triage the Client as a Canadian E.D. Triage and Acuity Scale Level 2 (Emergent) case;

    - 1(a)(ii) in that he failed to appropriately consider the ECG obtained by the EMS paramedic with respect to the Client, when assessing and triaging the Client;

    - 1(a)(iv) in that he failed to initiate the appropriate medical directive for chest pain or instruct a colleague to initiate the directive, when the Client's symptoms warranted the directive;

    - 1(a)(v) in that he failed to inform his colleagues that the Client had not been assessed by a physician either during or at the conclusion of his shift, and;

    - 1(b) in that he discarded an ECG test completed by the EMS paramedic on the Client.

36. The Member admits that he committed the act of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, in that he failed to keep records as required, when he discarded an ECG test completed by the EMS paramedic on the Client.

37. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a) (i), (ii), (iv) and (v), (3(b) and 3(c) of the Notice of Hearing, and in particular, his conduct was unprofessional, as described in paragraphs 4-34 above.

38. With leave of the Discipline Committee, the College withdraws the following allegations in the Notice of Hearing:

- 1(a)(iii)
- 3(a)(iii)

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) i, ii, iv, v, 1(b) and 2 of the Notice of Hearing. As to allegations 3(a) i, ii, iv, v, 3(b) and 3(c) in the Notice of Hearing, the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be unprofessional.

Reasons for Decision

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

Allegation 1 in the Notice of Hearing is supported by paragraphs 4-35 in the Agreed Statement of Facts. The Client had a history of cardiac issues. He arrived at the Hospital by EMS at approximately 0528. EMS paramedics reported performing three ECGs on the Client. EMS paramedics classified the Client as CTAS Level 2 which indicated that there was a potential threat to life and that he required assessments every 15 minutes. The Member acknowledged that he did not fully consider EMS's ECG assessments. In fact, the Member admitted discarding at least one ECG that he believed was illegible. The Member, using his professional judgement, disregarded the paramedic's concerns regarding the Client and changed the Client's designation to CTAS Level 3. This classification deemed the Client a lower priority requiring checks every 30 minutes. The Client was sent to the waiting room. Although the Member acknowledged that a Medical Directive was needed, he did not complete the necessary paperwork for bloodwork and conduct an ECG. In addition, the Member did not delegate a colleague to complete the directive when the Member's shift ended at 0730, and acknowledged the he did not tell the oncoming nurse that the Client had not yet been seen by a physician. The Client died shortly after at 0749.

Allegation 2 in the Notice of Hearing is supported by paragraphs 15, 16, 17, 18, 19 and 36 in the Agreed Statement of Facts. The Member acknowledges receiving ECGs from the EMS paramedic when the Client arrived at the Hospital. The Member acknowledged that he discarded one ECG which he considered illegible. If the Member were to testify, he would say that, although it is his practice to dispose of documents in a confidential manner, he does not recall how he discarded the illegible ECG. If the EMS paramedic were to testify, she would say that the Member crumpled up one or more ECGs and put them in the garbage saying that he would take the "prettier one". The Member admits that his failure to retain all of the EMS administered ECGs was a failure to keep records.

With respect to Allegations 3(a) i, ii, iv, v, 3(b) and 3(c), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations.

The Member showed a lack of good judgement when he failed to acknowledge the seriousness of the Client's condition even after an EMS paramedic provided him with several ECGs and gave her opinion

that the Client was a CTAS Level 2. His unprofessional use of language when he told the EMS paramedic that he would choose the ECG that was "prettier" or "pretty" demonstrated a lack of respect for the seriousness of the situation and a disregard for the information contained within the ECG. He continued to show a persistent and serious disregard for his professional obligations when he did not complete the medical directive for the Client or ensure that a colleague completed the paperwork for bloodwork and an ECG. The results of those assessments would have provided additional information regarding the Client's condition and might have expedited his treatment.

Penalty

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

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

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

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at his own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

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

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

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

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

            1. *Professional Standards*,
            2. *Documentation*,

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

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

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

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

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

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

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

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

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

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

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

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

2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

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

Penalty Submissions

Submissions were made by College Counsel. The Member's Counsel indicated that he agreed with those submissions.

The parties agreed that the mitigating factors in this case were:

- The Member has taken responsibility for his actions and has avoided a long contested hearing.
- He has had a lengthy professional practice and has had no prior disciplinary issues with the College.
- He has negotiated with the College and has accepted the Agreed Statement of Facts.

The aggravating factor in this case was the fact that, because of the Member's conduct, the Client did not receive prompt assessment and treatment by a physician. The Client's death demonstrates that there can be serious consequences when a nurse's professional obligations and standards are not met.

The proposed penalty provides for general deterrence through the three month suspension. It sends a clear message to the membership that this conduct will not be tolerated.

The proposed penalty provides for specific deterrence through a suspension of three months. During this time, the Member will be guided through a process whereby he will gain increased knowledge and will have time to reflect on the serious consequences of not following his professional obligations. The oral reprimand will assist the Member in gaining a greater understanding of the impact of his conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert. The Member will review the College's publications relating to *Professional Standards* and *Documentation*.

Overall, the public is protected because the Member's three month suspension will provide him with the opportunity to reflect and improve on his practice. The 18 month employer notification will ensure that once he returns to work, the Member's employer will be aware of this decision and will continue to provide supervision.

Counsel for the College provided two cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee. She stated that, although the cases are not directly analogous to this case, they do involve nurses who failed to monitor their patients while working within a team of other health providers. In hindsight, their patients had been in distress. Ultimately, the members' failure to follow their professional standards met with serious consequences.

The College provided the Panel with the case of *CNO v. Gail Alleyne* (Discipline Committee, 2012). In this case, the member was responsible for monitoring a client in a recovery room after she had received liposuction. In addition to the member, there were other health care providers present at the clinic including a physician, an anesthesiologist, an RN and an assistant. The member admitted to not documenting any assessments of the client including her vital signs as well as any other care that she provided to her. As the client's blood pressure continued to drop, the member did not take any action, nor did any of her colleagues, until the client's condition became grave. The client was transferred to a nearby hospital where she was pronounced dead. The member was given a three month suspension and was required to take a course on assessment, nursing interventions and documentation. The member was also given 18 months of employer notification.

The College also provided the Panel with the case of *CNO v. Lancelot E. Williams* (Discipline Committee, 2014). In this case, the member worked in a mental health facility. The client had a long history of recurrent psychosis, self-injurious behaviour, disruptive behaviour and extreme episodic anxiety attacks. A physician's order required that the client receive constant monitoring when he was agitated. Even though the client became very disruptive, the member did not provide 1:1 monitoring. The member found the client with vital signs absent but did not act quickly to resuscitate him. Instead he sought out the RN who, together with their other colleagues, discussed what they should do next. The member failed to immediately initiate a Code Blue. The client died; no anatomical reason was found. The member was given a two month suspension and a 24 month employer notification requirement.

Penalty Decision

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

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

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

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at his own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

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

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

            1. the Panel's Order,
            2. the Notice of Hearing,

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

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

1. *Professional Standards*,
2. *Documentation*,

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

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

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

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

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

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

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

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

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

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

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

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

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. Members of the profession will be reminded that there can be serious consequences when professional standards are not followed. The penalty is in line with what has been ordered in previous cases.

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

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Chairperson Date