DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	David Edwards, RPN	Chairperson
	Janet Adanty, RN	Member
	Sylvia Douglas	Public Member
	Donna May, RPN	Member
	Ian McKinnon	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	GLYNNIS HAWE for
	)	College of Nurses of Ontario
- and -	)	
	)	
OMAR SALAH	)	CARINA LENTSCH for
Registration No. AB826249	)	Omar Salah
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: May 30, 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") on May 30, 2022, via videoconference.

Publication Ban

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

The Panel considered the submissions of College Counsel and Member's Counsel and decided that there be an order preventing public disclosure and banning publication or broadcasting of the name(s) of the patient(s), or any information that could disclose the identity(ies) of the patient(s) referred to orally or in any documents presented in the Discipline hearing of Omar Salah.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(c)(iv), (v), 3(b)(iii), 4(c)(iv) and (v) in the Notice of Hearing dated April 22, 2022. The Panel granted this request. The remaining allegations against Omar Salah (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 Practical Nurse ("RPN"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that:

    a) On January 30, 2019, while working as the only registered staff on shift at Craigweil Gardens in Ailsa Craig, Ontario ("Facility A"), you left the facility without arranging for alternative or replacement services;

    b) On April 17, 2019, while working at Bobier Villa in Dutton, Ontario ("Facility B"), you revised Patient [1]'s medication reconciliation and physician order form with the wrong quantity of Risperidone; and/or

    c) On June 23, 2019, while working at Facility B, you:

        i. failed to document a physician's order discontinuing Lasix for Patient [2];

        ii. failed to document speaking with Patient [2]'s substitute decision-maker regarding their consent to commence palliative care;

        iii. advised Patient [2]'s physician that Patient [2] had palliative care orders in place, when he did not;

        iv. [*Withdrawn*]; and/or

        v. [*Withdrawn*];

2. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in paragraph 1(5) of Ontario Regulation 799/93, in that, while working as an RPN at Facility A on January 30, 2019, you discontinued professional services when you left the facility without arranging for alternative or replacement services;

3. You have committed an act or acts 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, you failed to keep records as required as follows:

a) on April 17, 2019, while working at Facility B, you revised Patient [1]'s medication reconciliation and physician order form with the wrong quantity of Risperidone; and/or

b) on June 23, 2019, while working at Facility B, you:

   i. failed to document a physician's order discontinuing Lasix for Patient [2];

   ii. failed to document speaking with Patient [2]'s substitute decision-maker regarding their consent to commence palliative care; and/or

   iii. [*Withdrawn*];

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of Ontario Regulation 799/93, in that while employed as an RPN, 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:

   a) on January 30, 2019, while working as the only registered staff on shift at Facility A, you left the facility without arranging for alternative or replacement services;

   b) on April 17, 2019, while working at Facility B, you revised Patient [1]'s medication reconciliation and physician order form with the wrong quantity of Risperidone; and/or

   c) on June 23, 2019, while working at Facility B, you:

      i. failed to document a physician's order discontinuing Lasix for Patient [2];

      ii. failed to document speaking with Patient [2]'s substitute decision-maker regarding their consent to commence palliative care;

      iii. advised Patient [2]'s physician that Patient [2] had palliative care orders in place, when he did not;

      iv. [*Withdrawn*]; and/or

      v. [*Withdrawn*].

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Omar Salah (the "Member") initially registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on March 8, 2012.

2. From July 22, 2016 until 2019, the Member was employed at Craigwiel Gardens, a long-term care home in Ailsa Craig, Ontario.

3. From March 13 to July 4, 2019, the Member was also employed at Bobier Villa, a long-term care home in Dutton, Ontario.

4. The Member has no history of discipline with CNO.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Craigwiel Gardens – January 30, 2019

5. At the time of the incident, Craigwiel Gardens housed 76 patients, some of whom had complex care needs.

6. On January 30, 2019, the Member worked the evening shift at Craigwiel Gardens, from 1400 - 2200 hrs. When the Registered Nurse ("RN") scheduled to work the night shift called in sick, the Member was asked to cover the night shift, from 2200 – 0600 hrs the following morning, as no other RN was available. As the Facility was short-staffed, the Member agreed to stay and work a double shift.

7. Although the night shift was typically staffed with an RN, on January 30 to 31, 2019, the shift was staffed by the Member and three Personal Support Workers ("PSWs") on site, and the Facility's Assistant Director of Care ("ADOC") as a back-up on-call RN.

8. At or around 2345 hrs, the Member left the Facility to get food from the nearest Tim Hortons location. The Member took with him a Facility master set of keys required to access the medication room and offices, which nurses were not permitted to take off site.

9. Before leaving the Facility, the Member put his cell phone number on a sticky note and told the PSWs that they could call him on his cell phone if anyone needed him.

The Member did not notify the on-call RN that he was leaving the Facility. After the Member left, a PSW called the on-call RN, who arrived at the Facility at or around 2400 hrs.

10. The on-call RN called the Member on his cell phone but he did not answer. The on-call RN left the Member a voicemail. If the Member were to testify, he would state that he did not receive the calls and voice message because the battery on his cell phone died on the way to the Tim Hortons.

11. The Member returned to the Facility at or around 00:15 hrs.

12. No patients were harmed as a result of the Member's absence; all patients were stable when the on-call RN arrived. However, the Member admits that in leaving the Facility, he placed the patients of the facility at an increased risk of harm.

13. The Member admits that in leaving the Facility without another registered staff member on site he discontinued professional services and failed to provide the Facility with a reasonable opportunity to arrange for replacement or alternative care services.

14. If the Member were to testify, he would state that he left the premises because he has Type 2 diabetes. He did not bring food with him for dinner because he had not anticipated working a double shift and filled in on short notice. He would also state that he checked on all patients before leaving the Facility and all were in stable condition.

15. The Member would also testify that he did not know that he was not permitted to leave the Facility for any reason. Had he known this, he would not have left. Nevertheless, the Member admits that it was poor judgment to leave the Facility and that he had an obligation to act in accordance with the standards of practice of the profession, which he did not.

16. The Member admitted to his mistake and took full responsibility for his actions.

Bobier Villa – April 17, 2019

17. On April 17, 2019, the Member worked a day shift at Bobier Villa and assisted with the admission of a new patient, [Patient 1].

18. [Patient 1] was prescribed Risperidone in two quantities: 0.25mg (am) and 0.125mg (pm).

19. Upon admission to the home, the Member was responsible for transcribing [Patient 1]'s prescription into a Medication Reconciliation & Physician Order Form and the

patient's electronic Medication Administration Record ("eMAR"), which he did correctly. He then scanned and sent the correct order to the pharmacy to be processed.

20. The pharmacy then processed the scanned order and uploaded the information to the patient's eMAR, incorrectly listing a dosage amount of 0.125mg for both morning and evening. The Member did not identify the pharmacy's error.

21. If the Member were to testify, he would state that when he viewed the information received from the pharmacy on the patient's eMAR, he assumed that the pharmacy had received an updated order from the physician. The Member then changed the Medication Reconciliation & Physician Order Form he had initially completed to state that 0.125mg had been ordered for [Patient 1] for both morning and evening dosages. He did so without first verifying his assumption by calling the pharmacy or the prescriber.

22. The oncoming nurse assigned to double-check medication orders from the pharmacy that day identified the documentation error. The documentation was then corrected, and no medication error occurred.

23. If the Member were to testify, he would state that the incident occurred at the end of his shift, and he asked the oncoming nurse to verify orders. However, he acknowledges that he ought to have verified the order information himself prior to making changes in [Patient 1]'s chart.

24. The patient was not harmed as a result of this incident.

Bobier Villa – June 23, 2019

25. On June 23, 2019, the Member worked the day shift at Bobier Villa, from 0600 – 1400 hrs.

26. Patient [2] was 88 years old and had been diagnosed with pulmonary fibrosis, congestive heart failure, and several other co-morbidities. He had recently injured his pelvis and was residing in a locked Dementia Unit.

27. Prior to 0800 hrs, [Patient 2] experienced a hypotensive episode during which he was non-responsive and required oxygen. The Member tended to [Patient 2] along with another RPN, who documented the incident in the patient's progress notes.

28. The Member called [Patient 2]'s substitute decision-maker ("SDM"), [Patient 2]'s wife, to update them about the patient's status and ascertain their wishes for the ongoing care for the patient. He asked the SDM if she wanted [Patient 2] sent to the

hospital following the hypotensive episode. [Patient 2]'s wife advised that she would return his call. The Member failed to document this conversation.

29. At 0800 hrs, the Member administered scheduled medication to [Patient 2], including a scheduled dose of furosemide (Lasix), and documented this on the patient's eMAR. Lasix is a diuretic used to reduce edema (water retention) caused by heart failure.

30. The Member then spoke with [Patient 2]'s physician via telephone to discuss the patient's plan of care. The physician gave the Member several verbal orders for [Patient 2], including a verbal order to discontinue [Patient 2]'s prescription for Lasix.

31. Following the conversation with the physician, the Member updated the patient's eMAR and recorded the verbal orders into a Physician's Order Form. In doing so, he failed to record the order to discontinue Lasix on the Physician's Order Form.

32. The Physician's Order Form was sent to the pharmacy for processing. The oncoming nurse responsible for double-checking [Patient 2]'s medication orders noticed and corrected the error. The patient did not experience any harm as a result.

33. During the Member's call with [Patient 2]'s physician, the Member informed the physician that he had spoken with [Patient 2]'s SDM, his wife, and [Patient 2]'s physician asked the Member to check the plan of care to see whether the patient had palliative orders in place. The Member incorrectly advised the physician or gave the physician the incorrect impression that [Patient 2] did, which was not accurate, as no palliative care orders had yet been written.

34. [Patient 2]'s physician then documented in the progress notes "to use the palliative care orders" when there were none. When the mistake was discovered by the oncoming nurse, the physician spoke with [Patient 2]'s SDM, who provided her consent for [Patient 2] to receive palliative care.

35. The Member admits that he failed to accurately document the orders communicated to him by [Patient 2]'s physician and his conversation with [Patient 2]'s SDM, and that he failed to accurately communicate information regarding [Patient 2]'s palliative care orders to his physician.

36. If the Member were to testify, he would state that it was a very busy day at the long-term care home and the documentation and communication errors he made were inadvertent. He acknowledges that this does not excuse his conduct and takes responsibility for his errors. The Member understands that nurses are required to be accurate in their documentation and medication practices.

CNO STANDARDS

37. CNO has published nursing standards and guidelines to set out the expectations for the practice of nursing. CNO's standards and guidelines inform nurses of their accountabilities and apply to all nurses regardless of their role, job description, or area of practice.

Professional Standards

38. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the standards of practice of the profession.

39. A nurse demonstrates the accountability standard by:

- Providing, facilitating, advocating and promoting the best possible care for patients;
- Advocating on behalf of patients;
- Seeking assistance appropriately and in a timely manner;
- Taking action in situations in which patient safety and well-being are compromised; and
- Taking responsibility for errors when they occur and taking appropriate action to maintain patient safety,

40. A nurse demonstrates the knowledge standard by:

- Assessing/describing the patient situation using a theory, framework or evidence-based tool; and
- Identifying/recognizing abnormal or unexpected patient responses and taking action appropriately.

Documentation Standard

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

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

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

- ensuring that relevant patient care information is captured in a permanent record.

Discontinuing Nursing Services

42. CNO's *Refusing Assignments and Discontinuing Nursing Services* Practice Guideline provides that nurses are accountable for providing safe, effective, and ethical care to their patients.

43. Nurses demonstrate regard for patient well-being and maintain their commitments to their patients and the profession by putting the needs and wishes of patients first and advocating for quality patient care.

44. Where a conflict arises between a nurse's personal needs and professional obligations, the nurse must resolve that conflict in a way that protects the public's right to safe care, that considers all aspects of the situation, and with an awareness of the relevant standards and legislation. When faced with a situation in which a nurse is considering discontinuing services, a nurse must be guided by the following principles:

    - The safety and well-being of the patient is of primary concern;

    - Nurses are accountable for their own actions and decisions and do not act solely on the direction of others; and

    - Nurses must critically appraise the factors in any situation as the foundation of clinical decision-making and professional judgment.

45. The Practice Guideline states that "abandonment" occurs when a nurse has accepted an assignment and discontinues care without the patient requesting the discontinuation, arranging a suitable alternative or replacement service, or allowing a reasonable opportunity for alternative or replacement services to be provided. The Practice Guideline states that a nurse who abandons an assignment could be found guilty of professional misconduct.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

46. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a), 1(b), and 1(c)(i), 1(c)(ii), and 1(c)(iii) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 5 to 45 above.

47. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, in that he discontinued professional services that were needed, as described in paragraphs 5 to 16 above.

48. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a), 3(b)(i) and 3(b)(ii) of the Notice of Hearing in that he failed to keep records as required, as described in paragraphs 17 to 41 above.

49. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 4(a), 4(b), and 4(c)(i), 4(c)(ii), and 4(c)(iii) of the Notice of Hearing, and in particular that his conduct was dishonourable and unprofessional, as described in paragraphs 5 to 45 above.

50. With leave of the Discipline Committee, CNO withdraws allegations 1(c)(iv), 1(c)(v), 3(b)(iii), 4(c)(iv), and 4(c)(v).

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), (b), (c)(i), (ii), (iii), 2, 3(a), (b)(i), (ii), 4(a), (b), (c)(i), (ii) and (iii) of the Notice of Hearing. As to allegations 4(a), (b), (c)(i), (ii) and (iii), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be dishonourable and unprofessional.

Reasons for Decision

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

Allegation #1(a) in the Notice of Hearing is supported by paragraphs 6-16, 38, 39, 42-45 and 46 in the Agreed Statement of Facts. While on shift at Craigwiel Gardens ("Facility A"), the Member left to get food and did not notify the on-call Registered Nurse ("RN") that he was leaving. The Member admitted that in leaving Facility A without another registered staff member on site he discontinued professional services.

The College's *Refusing Assignments and Discontinuing Nursing Services* Practice Guideline provides that nurses are accountable for providing safe, effective, and ethical care to their patients. The Member's actions are a serious breach of this guideline.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 17-23, 38, 39, 41 and 46 in the Agreed Statement of Facts. While on shift at Bobier Villa ("Facility B"), the Member sent the correct order to the pharmacy to be processed; the pharmacy then processed and uploaded the information to Patient [1]'s electronic Medication Administration Record ("eMAR"), incorrectly listing a dosage amount. The Member did not identify the pharmacy's error. The Member acknowledges that he ought to have verified the order information himself prior to making changes in Patient [1]'s chart.

The College's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the standards of practice of the profession. Among other things, a nurse demonstrates the accountability standard by taking action in situations in which patient safety and well-being are compromised; and taking responsibility for errors when they occur and taking appropriate action to maintain patient safety. The Member's conduct breached this standard.

Allegation #1(c)(i) in the Notice of Hearing is supported by paragraphs 30-32, 36, 38, 39, 41 and 46 in the Agreed Statement of Facts. The Member failed to document a physician's order to discontinue Lasix for Patient [2]. The College's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the standards of practice of the profession. In addition, the College's *Documentation Standard* provides that nurses are accountable for ensuring their documentation of patient care is "accurate, timely and complete." This includes ensuring that relevant patient care information is captured in a permanent record.

Allegation #1(c)(ii) in the Notice of Hearing is supported by paragraphs 28, 33-36, 38, 39, 41 and 46 in the Agreed Statement of Facts. The Member failed to document his conversation with Patient [2]'s substitute decision-maker ("SDM") regarding consent to commence palliative care and by so doing, breached the College's *Documentation Standard*, which provides that nurses are accountable for ensuring their documentation of patient care is "accurate, timely and complete." This includes ensuring that relevant patient care information is captured in a permanent record.

Allegation #1(c)(iii) in the Notice of Hearing is supported by paragraphs 33-36, 38-40 and 46 in the Agreed Statement of Facts. During the Member's call with Patient [2]'s physician, the Member informed the physician that he had spoken with Patient [2]'s SDM, his wife, and Patient [2]'s physician asked the Member to check the plan of care to see whether Patient [2] had palliative orders in place. The Member incorrectly advised the physician or gave the physician the incorrect impression that Patient [2] did, which was not accurate, as no palliative care orders had yet been written. The Member admitted that he failed to accurately

communicate information regarding Patient [2]'s palliative care orders to his physician. If the Member were to testify, he would state that he understands that nurses are required to be accurate in their documentation and medication practices. The Member breached the College's *Professional Standards* by failing to provide, facilitate, advocate and promote the best possible care for patients and failing to take appropriate action to maintain patient safety.

Allegation #2 in the Notice of Hearing is supported by paragraphs 6-16 and 47 in the Agreed Statement of Facts. The Member admitted that he committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, in that he discontinued professional services that were needed. The Member left the Facility to get food and took with him a Facility master set of keys, which nurses were not permitted to take off site. The Member did not notify the on-call RN that he was leaving the Facility. Based on the facts set out in the Agreed Statement of Facts and the Member's admission the Panel finds that in leaving the Facility without another registered staff member on site he discontinued professional services.

Allegation #3(a) in the Notice of Hearing is supported by paragraphs 17-23 and 48 in the Agreed Statement of Facts. While on shift at Bobier Villa ("Facility B"), the Member sent the correct order to the pharmacy to be processed; the pharmacy then processed and uploaded the information to Patient [1]'s electronic Medication Administration Record ("eMAR"), incorrectly listing a dosage amount. The Member did not identify the pharmacy's error. He assumed that the pharmacy had received an updated order from the physician. The Member then changed the Medication Reconciliation & Physician Order Form he had initially completed, without verifying his assumption by calling the pharmacy or the prescriber. The Member acknowledges that he ought to have verified the order information himself prior to making changes in Patient [1]'s chart.

Allegation #3(b)(i) in the Notice of Hearing is supported by paragraphs 30-32 and 48 in the Agreed Statement of Facts. The Member spoke with [Patient 2]'s physician via telephone to discuss the patient's plan of care. The physician gave the Member several verbal orders for [Patient 2], including a verbal order to discontinue [Patient 2]'s prescription for Lasix. The Member failed to record the order to discontinue Lasix on the Physician's Order Form. The oncoming nurse responsible for double-checking [Patient 2]'s medication orders noticed and corrected the error.

Allegation #3(b)(ii) in the Notice of Hearing is supported by paragraphs 28, 33-36 and 48 in the Agreed Statement of Facts. The Member called[Patient 2]'s SDM to update them about the patient's status and ascertain their wishes for the ongoing care for the patient. He asked the SDM if she wanted [Patient 2] sent to the hospital following the hypotensive episode. The SDM advised that she would return his call. The Member failed to document this conversation.

If the Member were to testify, he would state that he understands that nurses are required to be accurate in their documentation and medication practices.

CNO's *Documentation Standard* sets out the requirement that nurses' documentation of patient care is "accurate, timely and complete". The Member's documentation clearly did not meet this requirement. The Panel therefore finds that he committed the acts of professional misconduct as alleged in paragraphs #3(a), (b)(i) and (ii) of the Notice of Hearing, in that he failed to keep records as required.

With respect to allegations #4(a), (b), (c)(i), (ii) and (iii), the Panel finds that the Member's conduct in discontinuing professional services that were needed, and in failing to keep records as required, was unprofessional as it demonstrated a serious and persistent disregard of his professional obligations.

The Panel also finds that the Member's conduct was dishonourable as he knew or ought to have known that it was unacceptable and fell well below the standards of a professional. The Member's actions had the potential to jeopardize patient's safety, and so had an element of moral failing.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 2 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 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 that this Order becomes final. 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 that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by 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,
    3. the Agreed Statement of Facts,
    4. this Joint Submission on Order, and
    5. if available, a copy of the Panel's Decision and Reasons;

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

    1. *Code of Conduct,*
    2. *Professional Standards*, and
    3. *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 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 12 months from the date that this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e., not including the period during which the Member's certificate of registration is suspended), 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,
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 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.

c) For a period of at least 8 months and no longer than 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), the Member must meet with a Registered Nurse who is employed at the same employer as the Member and who is pre-approved by the Director ("Mentor") to discuss his efforts to ensure that his care, medication administration and documentation are meeting the standards of practice of the profession. The Member must meet with the Mentor at such frequency as determined by

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

i. Provide the proposed mentor with a copy of:

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

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

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

d) After the 8-month period identified in 3(c) above, the Mentor will determine whether additional meetings with the Member are required and will arrange those meetings as necessary during the 12-month period.

e) The Mentor will advise the Director in writing when the meetings have ended.

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were that the Member's misconduct in leaving the site was serious and posed a risk of harm, although no harm occurred; and that the misconduct involved multiple patients, demonstrating a lack of care repeated over time.

The mitigating factors in this case were that the Member has no disciplinary history with the College, has accepted responsibility, acknowledged his misconduct, and cooperated with the College by agreeing to an Agreed Statement of Facts and a Joint Submission on Order.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2-month suspension of the Member's certificate of registration, which will deter the Member from repeating the same behaviour going forward.

The proposed penalty provides for general deterrence through the 2-month suspension of the Member's certificate of registration, which will signal to other members of the profession that this conduct is unacceptable.

Rehabilitation and remediation are achieved through a minimum of 2 meetings with a Regulatory Expert, as well as the mentorship provisions.

Overall, the public is protected through the 12 months of employer notification which will ensure that the Member's employer is aware of the misconduct and will allow the employer to be diligent in monitoring the Member's practice on his return to the profession.

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

CNO v. Pedzinski (Discipline Committee, 2020): In this case, the member committed acts of misconduct including failing to assess a patient as needed, entering a progress note without documenting it as a late entry, and failing to arrange alternative or replacement services before leaving her shift. The penalty included an oral reprimand, a one-month suspension of the member's certificate of registration, two meetings with a Regulatory Expert and 12 months of employer notification.

CNO v. Simeone (Discipline Committee, 2017): In this case, the member failed to attend home visits and improperly delegated tasks to non-registered staff. The member failed to complete a medication error report form. The penalty included an oral reprimand, a five-month suspension of the member's certificate of registration, two meetings with a Nursing Expert, 18 months of employer notification, random spot audits of the member's practice and no independent practice for 18 months. In comparison to the case before this Panel, this case had more frequent acts of professional misconduct.

CNO v. Whyte (Discipline Committee, 2020): In this case, the member failed to assess the client when necessary, failed to accurately report the client's condition to co-workers and family, and failed to document vital signs assessed. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, a minimum of two meetings with a Regulatory Expert and 24 months of employer notification.

College Counsel submitted that the case before this Panel falls within the range of similar cases, and the proposed Joint Submission on Order is reasonable and in line with previous cases.

Submissions were made by the Member's Counsel.

The Member's Counsel submitted that the Member has been a registered member since 2012 with no discipline history and is working in Long Term Care. He has been cooperative and forthright and was so even before he had counsel. He admitted to his conduct, apologized and is deeply regretful. He was not terminated and continues to work for his employer. He wants to ensure his nursing is up to standard in the future.

The Member's Counsel submitted the following case for comparison:

CNO v. Craig (Discipline Committee, 2009): In this case, the member made medication errors for several patients and failed to attend some scheduled care visits. On several occasions, the member billed for visits that were not made. The penalty included a two-month suspension.

Penalty Decision

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

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

2. The Executive Director is directed to suspend the Member's certificate of registration for 2 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 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 that this Order becomes final. 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 that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by 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,
            3. the Agreed Statement of Facts,

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

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

1. *Code of Conduct,*
2. *Professional Standards*, and
3. *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 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 12 months from the date that this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is

suspended), 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,
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 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.

c) For a period of at least 8 months and no longer than 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), the Member must meet with a Registered Nurse who is employed at the same employer as the Member and who is pre-approved by the Director ("Mentor") to discuss his efforts to ensure that his care, medication administration and documentation are meeting the standards of practice of the profession. The Member must meet with the Mentor at such frequency as determined by the Mentor, but at least monthly. In order for the Mentor to be pre-approved by the Director, the Member must:

i. Provide the proposed mentor with a copy of:

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

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

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

d) After the 8-month period identified in 3(c) above, the Mentor will determine whether additional meetings with the Member are required and will arrange those meetings as necessary during the 12-month period.

e) The Mentor will advise the Director in writing when the meetings have ended.

4. All documents delivered by the Member to CNO, the Expert or the Mentor 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.

The penalty provides for specific deterrence though the oral reprimand and the 2-month suspension of the Member's certificate of registration, which will deter the Member from engaging in the same behaviour in the future. The penalty also provides for general deterrence through the employer notification provision and the 2-month suspension, which sends a clear message to the profession that this misconduct will not be tolerated.

The penalty provides for remediation and rehabilitation through the employer notification period, a minimum of two meetings with a Regulatory Expert, and the mentorship provisions. The public also is protected through the employer notification and mentoring provisions. The penalty is also in line with what has been ordered in previous cases in similar circumstances.

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