

**DISCIPLINE COMMITTEE  
OF THE COLLEGE OF NURSES OF ONTARIO**

**PANEL:**

Michael Hogard, RPN	Chairperson
Susan Roger, RN	Member
Margaret Tuomi	Public Member
Devinder Walia	Public Member

**BETWEEN:**

COLLEGE OF NURSES OF ONTARIO	)	<u>EMILY LAWRENCE</u> for
	)	College of Nurses of Ontario
- and -	)	
	)	
KATARZYNA TRZOP	)	<u>NADIA LIVA</u> for
Reg. No. JD87546	)	Katarzyna Trzop
	)	
	)	<u>LUISA RITACCA</u>
	)	Independent Legal Counsel
	)	
	)	Heard: May 17, 2017, May 18, 2017,
	)	June 19, 2017 and April 27, 2018

**DECISION AND REASONS**

This matter came on for hearing before a panel of the Discipline Committee (the “Panel”) on May 17, 2017 at the College of Nurses of Ontario (“the College”) at Toronto.

**Preliminary Matter**

At the attendance on April 27, 2018, the College advised that it would be seeking to withdraw a number of allegations as set out in the Notice of Hearing #1, as defined below, and that it would be seeking to introduce Notice of Hearing #2 (defined below) and asking the Panel to hear both matters together. In seeking this relief, the College advised that both matters related to the same facts and that both matters would be dealt with by way of an agreed statement of facts.

Upon being advised that Katarzyna Trzop (the “Member”) consented to the withdrawal of allegations in Notice of Hearing #1, to the introduction of Notice of Hearing #2 and to having the matters heard together, the Panel granted the College’s requests.

This matter proceeded on the basis of both Notice of Hearing #1 and #2.

## **Publication Ban**

At the request of the College and on being advised that the Member did not oppose the request, the Panel made an order banning the publication and broadcasting of the identity of the Client, and any information that could disclose the Client's identity, including any reference to the Client's name contained in the allegations in the Notices of Hearing and in any exhibit filed in the course of the hearing, pursuant to s.45(3) of the *Health Professions Procedural Code of the Nursing Act, 1991*.

## **The Allegations**

As set out above, the College advised the Panel that it was requesting leave to withdraw the allegations set out in paragraphs 1(b), 1(c), 1(d), 2, 3(b), 3(c) and 3(d) of the Notice of Hearing dated January 30, 2017 ("Notice of Hearing #1"). The Member consented to this request and therefore 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 employed as a Registered Practical Nurse at ParaMed, 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. you failed to maintain the boundaries of the therapeutic nurse-client relationship in respect to family members of your client [the Client], including
    - i. bringing your children to [the Client's] home when you were scheduled to provide care to [the Client] and at other times, in or about December 2013 to April 2014;
    - ii. engaging in a personal and sexual relationship with [the Client's] grandson in or about January 2014 to February 2015;
    - iii. residing in [the Client's] home from in or about March 2014 to November 2014; and/or
    - iv. engaging in a financial relationship with [the Client's] daughter by agreeing to pay rent to her in or about March 2014 to November 2014;
  - b. [withdrawn];
  - c. [withdrawn];
  - d. [withdrawn].
2. [withdrawn]
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 Practical Nurse at ParaMed, 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 of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

- a. you failed to maintain the boundaries of the therapeutic nurse-client relationship in respect to family members of your client, [the Client], including
  - i. bringing your children to [the Client's] home when you were scheduled to provide care to [the Client] and at other times, in or about December 2013 to April 2014;
  - ii. engaging in a personal and sexual relationship with [the Client's] grandson in or about January 2014 to February 2015;
  - iii. residing in [the Client's] home from in or about March 2014 to November 2014; and/or
  - iv. engaging in a financial relationship with [the Client's] daughter by agreeing to pay rent to her in or about March 2014 to November 2014;
- b. [withdrawn];
- c. [withdrawn]; and/or
- d. [withdrawn].

The allegations against the Member as stated in the Notice of Hearing dated April 3, 2018 ("Notice of Hearing #2") 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 at ParaMed, 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) you failed to maintain the boundaries of the therapeutic nurse-client relationship in respect to family members of your client, [the Client], including:
    - (i) you drank alcoholic beverages with [the Client's] adult grandson, [the Grandson] in [the Client's] and [the Grandson's] residence, when not on shift, in January and February 2014;

- (b) in or about late February or early March 2014, you offered to obtain a controlled substance, for [the Daughter], [the Client's] daughter; and/or
  - (c) you gave [the Daughter] 2-3 tablets of a controlled substance which were not prescribed to [the Daughter] on or about March 1, 2014; 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(37) of *Ontario Regulation 799/93*, in that while employed as a Registered Practical Nurse at ParaMed, 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 of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:
  - (a) you failed to maintain the boundaries of the therapeutic nurse-client relationship in respect to family members of your client, [the Client], including
    - (i) you drank alcoholic beverages with [the Client's] adult grandson, [the Grandson] in [the Client's] and [the Grandson's] residence, when not on shift, in January and February 2014;
  - (b) in or about late February or early March 2014, you offered to obtain a controlled substance, for [the Daughter], [the Client's] daughter; and/or
  - (c) you gave [the Daughter] 2-3 tablets of a controlled substance which were not prescribed to [the Daughter] on or about March 1, 2014.

### **Member's Plea**

The Member admitted the allegations set out in paragraphs 1(a)(i)-(iv) and 3(a)(i)-(iv) in the Notice of Hearing #1. The Member also admitted the allegations set out in paragraphs 1(a)(i), 1(b), 1(c) and 2(a)(i), 2(b), 2(c) in the Notice of Hearing #2.

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. Katarzyna Trzop (the "Member") obtained a diploma in nursing from Algonquin College in 2004.
2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") on October 28, 2004.

3. The Member has been employed as a full-time nurse at a homecare agency (the “Agency”) since November 2010. At all times during the incidents described below, the Member was scheduled to provide care to Agency clients, in their homes.
4. The Member has no prior disciplinary findings with the College.

## **THE CLIENT**

5. The Client was in her late 90s at the time of the incidents.
6. Between December 2013 and the end of March 2014, the Member provided almost daily palliative home care to the Client. Her duties did not include administering pain medication to the Client, which was undertaken by members of the Client’s family.
7. Both the Member and the Client spoke Polish and communicated with each other in Polish.
8. The Client lived with her daughter [the Daughter] and her son-in-law [the Son-In-Law], as well as her grandson [the Grandson], who was in his 40s, and her great grandson, who was in his 20s.
9. The Client died in January 2015.

## **THE INCIDENTS**

### **Personal Relationship with the Client’s Family Members**

10. Starting in or around January 2014, the Member would, on occasion, bring her daughter to the Client’s home when she was scheduled to provide nursing care to clients. On January 4, 2014, [the Grandson’s] dog gave birth to puppies. The Member asked if her teen-aged daughter could come over to the Client’s residence to play with the puppies, and possibly, take ownership of one of the puppies. The Member’s daughter first came to the Client’s home in and around January 7, 2014 to meet the puppies.
11. The Client’s family invited the Member to bring her daughter over to play with the puppies any time. Thereafter, the Member’s daughter regularly attended at the Client’s residence, both with the Member and without the Member, when the Member was visiting other clients.
12. In or around February 2014, the Member commenced a personal relationship with [the Grandson], which became sexual in mid-February 2014. The Member was aware at that time that it would be unprofessional for her to engage in a personal and sexual relationship with [the Grandson], and advised [the Grandson] of her view that her conduct was not professional.
13. On occasion, the Member drank alcoholic beverages with [the Grandson] in the Client’s residence when not on shift, including in January and February 2014.
14. In approximately late March 2014, the Member learned she was pregnant with [the Grandson’s] baby. The baby was born in late November 2014.

15. The Member withdrew herself from assignment to provide care to the Client when she decided to move into the Client's residence. The Member and her daughter and her daughter's friend moved in to the Client's residence in late March 2014. The Member slept in the same bedroom as [the Grandson] and her daughter and daughter's friend slept in the basement recreation room.
16. The Member began paying \$1000 in rent to the Client's daughter in April 2014.
17. The Member was paid for home care visits to the Client until April 14, 2014.
18. The Member and [the Grandson] lived together in the Client's home until approximately November 2014, and then moved into their own apartment.
19. In February 2015, [the Grandson] and the Member ended their personal relationship. On February 27, 2015, [the Daughter], the Client's daughter and the paternal grandmother of the baby, submitted a complaint to the College. If the Member were to testify, she would indicate that at the time of the complaint, [the Grandson] had been charged criminally with domestic assault and the parties have been embroiled in ongoing family law proceedings. The Member would testify that she was recently given sole custody of the child.

#### **Provision of Prescribed Medication to Client's Family Member**

20. The Client was prescribed 1mg morphine tablets, on an as needed basis. The Client told [the Daughter] and [the Grandson] that the Member gave her "the good pills". If the Member were to testify she would say that she did not administer medication to the Client.
21. In or about late February or early March 2014, the Member offered to obtain pain medication for [the Daughter], the Client's daughter, at [the Daughter's] request.
22. The Member exchanged text messages with [the Grandson] on March 1, 2014 regarding pain medication. She asked [the Grandson] to advise his mother that she "had stronger than oxy for now".
23. On or about March 1, 2014, the Member gave [the Daughter] two or three oxycodone tablets. If [the Daughter] were to testify, she would say that she purchased these tablets for \$20. [The Daughter] did not tell the Member for whom she was purchasing the pain medication. [The Daughter] gave her husband the pain medication. If the Member were to testify she would say that she (the Member) obtained these tablets from a family member at no cost.

#### **Expert Evidence on Standards**

24. The College retained an expert in the standards of practice and in particular, therapeutic boundaries. The expert's opinion is that the Member's conduct at paragraphs 10 to 23 breached the standards of practice in respect of appropriate therapeutic boundaries between the Member and the Client's immediate family who resided with the Client.

25. The Member acknowledges that she breached the standards of practice when she:
- a. brought her daughter to the Client's home;
  - b. engaged in a personal and sexual relationship with [the Grandson] while she was assigned to the Client;
  - c. after she terminated the therapeutic relationship with the Client, including when she drank alcohol with [the Grandson];
  - d. resided in the Client's home; and
  - e. engaged in a financial relationship with [the Daughter] by paying her rent.
26. The Member also admits that it is a breach of the standards of practice to obtain, and sell or give narcotic pain medication to individuals who are not prescribed the narcotic. She specifically admits that giving narcotics to [the Daughter] or [the Grandson] (which were not prescribed to [the Daughter], [the Grandson], or anyone else in the Client's family) was a breach of the standards of practice.

### **ADMISSIONS OF PROFESSIONAL MISCONDUCT**

27. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a)(i)-(iv) of the Notice of Hearing, dated January 30, 2017, as described in paragraphs 10 to 23 and 25 and 26 above, in that she breached the standards of practice.
28. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a)(i)-(iv) of the Notice of Hearing, dated January 30, 2017, and in particular, her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 10 to 23 and 25 and 26 above.

### **Decision**

The Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i)-(iv) in the Notice of Hearing #1 and as alleged in paragraphs 1(a)(i), 1(b), 1(c) of the Notice of Hearing #2. As to allegation 3(a)(i)-(iv) in the Notice of Hearing #1 and 2(a)(i), 2(b), 2(c) in the Notice of Hearing #2 the Panel finds that the Member engaged in conduct that would reasonably be regarded by members to be disgraceful, dishonourable, and unprofessional.

### **Reasons for Decision**

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

#### **Notice of Hearing, January 30, 2017 (#1)**

Allegation #1 in the Notice of Hearing is supported by paragraphs 10,11,12,14,15 and 16 in the Agreed Statement of Facts.

The Member's admitted that she had contravened a standard of practice related to ensuring appropriate boundaries with a client and the client's immediate family. The Panel considered that admission plus evidence identified in the Agreed Statement of Facts that described the Member's personal relationships with the client's family members, specifically bringing her daughter to the client's home during scheduled care appointments, commencing a personal and intimate relationship with the client's grandson and eventually moving into the client's home and paying rent to the client's daughter. While the Member withdrew herself from the client's care, the relationships were already in progress. Subsequently, the Panel finds that the Member committed an act of professional misconduct.

#### Notice of Hearing, April 3, 2018 (#2)

Allegation #1 in the Notice of Hearing is supported by paragraphs 13,20,21,22,23 and 26 in the Agreed Statement of Facts.

With respect to Allegation #3 (Notice of Hearing, January 30, 2017) and #2 (Notice of Hearing, April 3, 2018), the Panel finds that the Member's conduct in that she demonstrated a serious disregard for maintaining appropriate therapeutic boundaries with a client and her family and, subsequently, it was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through the dangerous and reckless manner that she conducted herself related to medication practices and by providing medications that may have fallen into the hands of someone not requiring them.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The Member engaged in an ongoing and intertwined relationship with members of a client's family. This casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

#### **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 12 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 her 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. *Therapeutic Nurse-Client Relationship*
- iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;
- v. The subject of the sessions with the Expert will include:
  1. the acts or omissions for which the Member was found to have committed professional misconduct,
  2. the potential consequences of the misconduct to the Member’s clients, colleagues, profession and self,
  3. strategies for preventing the misconduct from recurring,
  4. the publications, questionnaires and modules set out above, and
  5. the development of a learning plan in collaboration with the Expert;
- vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:
  1. the dates the Member attended the sessions,
  2. that the Expert received the required documents from the Member,
  3. that the Expert reviewed the required documents and subjects with the Member, and
  4. the Expert’s assessment of the Member’s insight into her behaviour;
- vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

4. Requiring the Member to pay the College its legal costs and expenses in the amount of \$1,500.00 within twelve months of the date of this Order.
5. 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 she agreed with those submissions.

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

- The Member had no prior history of discipline;
- The Member has cooperated with the College; and,
- The Member has taken responsibility for her conduct through admission of the allegations.

The aggravating factors in this case were:

- The Member's pattern of conduct over a short period of time displayed a series of poor decisions, specifically her decision to commence a romantic and personal relationship with a client's family member;

- Intertwined personal and financial relationships with members of a client's family; and
- Reckless medication security.

The proposed penalty provides for general and specific deterrence through a reprimand and a lengthy suspension to meet the goals of penalty and protect the public.

The proposed penalty provides for remediation and rehabilitation through meetings with a nursing expert and subsequent required learning plans and employer notification upon the Member's return to work.

A cost component has been included in the Joint Submission on Order however it is not intended to be punitive and therefore the College submitted that the Panel should consider it separate from the provisions for public protection.

Overall, the public is protected through the elements of specific deterrence and rehabilitation for the Member herself and elements of suspension proposed as general deterrence to the membership at large.

Counsel did not submit cases to support the proposed penalty explaining that there simply was not a case that matched the circumstances here.

### **Penalty Decision**

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

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.
2. The Executive Director is directed to suspend the Member's certificate of registration for 12 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 her 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. *Therapeutic Nurse-Client Relationship*
- iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;
- v. The subject of the sessions with the Expert will include:
  1. the acts or omissions for which the Member was found to have committed professional misconduct,
  2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
  3. strategies for preventing the misconduct from recurring,
  4. the publications, questionnaires and modules set out above, and
  5. the development of a learning plan in collaboration with the Expert;
- vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:
  1. the dates the Member attended the sessions,
  2. that the Expert received the required documents from the Member,
  3. that the Expert reviewed the required documents and subjects with the Member, and
  4. the Expert's assessment of the Member's insight into her behaviour;
- vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;
- b. For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
  - i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
  - ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
  2. the Notice of Hearing,
  3. the Agreed Statement of Facts,
  4. this Joint Submission on Order, and
  5. a copy of the Panel's Decision and Reasons, once available;
- iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
1. that they received a copy of the required documents, and
  2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
4. Requiring the Member to pay the College its legal costs and expenses in the amount of \$1,500.00 within twelve months of the date of this Order.
5. 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. The Panel is satisfied that the Member understands the seriousness of her conduct. While this hearing commenced as a contested hearing, the Member eventually took steps to take responsibility for her actions. The Member became embroiled with a client's family. She should not have done so. She has paid dearly for doing so. The Panel is convinced that the Member will not engage in such conduct again.

I, Michael Hogard, 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.

---

Chairperson

---

Date