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

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| **PANEL:** | Terry Holland, RPN | Chairperson |
| | Andrea Arkell | Public Member |
| | Neil Hillier, RPN | Member |
| | Carolyn Kargiannakis, RN | Member |
| | Natalie Montgomery | Public Member |

**BETWEEN:**

| | | |
|---|---|---|
| COLLEGE OF NURSES OF ONTARIO | ) | DENISE COONEY for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| ROSA ANNA RUBINI-CATALANO | ) | PHILIP ABBINK for |
| Registration No. 0560607 | ) | Rosa Anna Rubini-Catalano |
| | ) | |
| | ) | CHRISTOPHER WIRTH |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | Heard: November 9, 2020 |

## 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 November 9, 2020, 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 names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of Rosa Anna Rubini-Catalano.

The Panel considered the submissions of the Parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of Rosa Anna Rubini-Catalano.

## The Allegations

The allegations against Rosa Anna Rubini-Catalano (the "Member") as stated in the Notice of Hearing dated October 1, 2020 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 you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

    (a) in or around March 14-16, 2014, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you provided inadequate care to [Patient A] and/or inadequately documented the care you provided to [Patient A], including but not limited to the following:

        i. you administered insulin to [Patient A], contrary to a physician's order; and/or

        ii. you altered [Patient A]'s medication administration record to indicate you had not administered insulin to [Patient A] when you had;

    (b) on or around December 19, 2015, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you administered heparin to [Patient B] at an incorrect drip rate;

    (c) in or around January 2016 to April 2016, you applied for and received short term disability benefits from your employer, William Osler Health System Brampton Civic Hospital, while working at York University;

    (d) on or around March 1, 2017, while employed as a Registered Nurse at Mackenzie Health, you administered heparin to [Patient C] when dalteparin had been ordered;

    (e) on or around February 27, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to transcribe a change to the physician's order for Lasix to [Patient D]'s medication administration record;

    (f) on or around July 29, 2017, while employed as a Registered Nurse at Mackenzie Health you provided inadequate care to [Patient E] and/or inadequately documented the care you provided to [Patient E], including but not limited to the following:

        i. you administered epinephrine to [Patient E] by intravenous injection, when it was to be administered by intramuscular injection;

        ii. you documented that you had administered epinephrine to [Patient E] by intramuscular injection, when you had administered it by intravenous injection;

    (g) in or around December 8-10, 2017, while employed as a Registered Nurse at Mackenzie Health, you provided inadequate care to [Patient F] and/or inadequately documented the care you provided to [Patient F], including but not limited to the following:

i. you failed to document the application of restraints to [Patient F];

ii. you failed to consider and/or inadequately documented your consideration of available alternatives to restraints before applying restraints to [Patient F];

iii. you failed to obtain a physician's order for the application of restraints prior to and/or following the application of restraints to [Patient F];

iv. you failed to obtain consent from [Patient F] and/or her substitute decision-maker before applying restraints to [Patient F]; and/or

v. you failed to assess and/or inadequately documented the ongoing need for restraints on [Patient F];

(h) in or around December 28, 2017, while employed as a Registered Nurse at Mackenzie Health, you administered insulin to [Patient G] subcutaneously, when the physician's order was that it be administered intravenously; and/or

(i) in or around December 28, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to listen to and act on the concerns of [Colleague A] about the care you provided to [Patient G].

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(8) of *Ontario Regulation 799/93*, in that while working as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you misappropriated property from a workplace when, in or around January 2016 to April 2016, you applied for and received short term disability benefits from William Osler Health System Brampton Civic Hospital, and were employed at York University.

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 paragraph 1(13) of *Ontario Regulation 799/93*, in that you failed to keep records as required, and in particular:

(a) in or about March 16, 2014, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you altered [Patient A]'s medication administration record to indicate you had not administered insulin to [Patient A] when you had;

(b) in or around February 27, 2017, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to transcribe a change to the physician's order for Lasix to [Patient D]'s medication administration record;

(c) in or around July 29, 2017, while employed as a Registered Nurse at Mackenzie Health, you documented that you had administered epinephrine to [Patient E] by intramuscular injection, when you had administered it by intravenous injection; and/or

(d) in or around December 8-10, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to document the care you provided to [Patient F], including but limited to the following:

i. you failed to document the application of restraints to [Patient F];

ii. you failed to document your consideration of available alternatives to restraints before applying restraints to [Patient F];

iii. you failed to document your obtaining of a physician's order for the application of restraints prior to and/or following the application of restraints to [Patient F]; and/or

iv. you failed to document the ongoing need for restraints on [Patient F].

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 paragraph 1(14) of *Ontario Regulation 799/93*, in that you falsified a record relating to your practice, and in particular:

(a) in or around March 16, 2014, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you altered [Patient A]'s medication administration record to indicate you had not administered insulin to [Patient A] when you had; and/or

(b) in or around July 29, 2017, while employed as a Registered Nurse at Mackenzie Health, you documented that you had administered epinephrine to [Patient E] by intramuscular injection, when you had administered it by intravenous injection.

5. 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 you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to the following incidents:

(a) in or around March 2014, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you provided inadequate care to [Patient A] and/or inadequately documented the care you provided to [Patient A], including but not limited to the following:

i. you administered insulin to [Patient A], contrary to a physician's order; and/or

ii. you altered [Patient A]'s medication administration record to indicate you had not administered insulin to [Patient A] when you had;

(b) on or around December 19, 2015, while employed as a Registered Nurse at William Osler Health System Brampton Civic Hospital, you administered heparin to [Patient B] at an incorrect drip rate;

(c) in or around January 2016 to April 2016, you applied for and received short term disability benefits from your employer, William Osler Health System Brampton Civic Hospital, while working at York University;

(d) on or around March 1, 2017, while employed as a Registered Nurse at Mackenzie Health, you administered heparin to [Patient C] when dalteparin had been ordered;

(e) on or around February 27, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to transcribe a change to the physician's order for Lasix to [Patient D]'s medication administration record;

(f) on or around July 29, 2017, while employed as a Registered Nurse at Mackenzie Health you provided inadequate care to [Patient E] and/or inadequately documented the care you provided to [Patient E], including but not limited to the following:

i. you administered epinephrine to [Patient E] by intravenous injection, when it was to be administered by intramuscular injection; and/or

ii. you documented that you had administered epinephrine to [Patient E] by intramuscular injection, when you had administered it by intravenous injection;

(g) in or around December 8-10, 2017, while employed as a Registered Nurse at Mackenzie Health, you provided inadequate care to [Patient F] and/or inadequately documented the care you provided to [Patient F], including but not limited to the following:

i. you failed to document the application of restraints to [Patient F];

ii. you failed to consider and/or inadequately documented your consideration of available alternatives to restraints before applying restraints to [Patient F];

iii. you failed to obtain a physician's order prior to and/or following the application of restraints to [Patient F];

iv. you failed to obtain consent from [Patient F] and/or her substitute decision-maker before applying restraints to [Patient F]; and/or

v. you failed to assess and/or inadequately documented the ongoing need for restraints on [Patient F];

(h) in or around December 28, 2017, while employed as a Registered Nurse at Mackenzie Health, you administered insulin to [Patient G] subcutaneously, when the physician's order was that it be administered intravenously; and/or

(i) in or around December 28, 2017, while employed as a Registered Nurse at Mackenzie Health, you failed to listen to and act on the concerns of [Colleague A] about the care you provided to [Patient G].

6. 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 you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

(a) in or about March 2019, while applying for a nursing position at the Markham Stouffville Hospital, Uxbridge Site, in Uxbridge, Ontario (the "Hospital") and/or while employed as a Registered Nurse at the Hospital, you provided false information to the Hospital about your history with the College of Nurses of Ontario ("CNO"); and/or

(b) on or about June 20, 2019, while employed as a Registered Nurse at the Hospital, you drew blood from [Patient H] when he did not have an order for blood to be drawn.

7. 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 paragraph 1(15) of *Ontario Regulation 799/93*, in that while applying for a nursing position at the Hospital, and/or while employed as a Registered Nurse at the Hospital, you signed or issued, in your professional capacity, a document that you knew, or ought to have known contained a false or misleading statement and in particular, in or about March, 2019, you provided false information to the Hospital about your history with CNO on your application for a nursing position.

8. 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 you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to the following incidents:

   (a) in or about March 2019, while applying for a nursing position at the Hospital and/or while employed as a Registered Nurse at the Hospital, you provided false information to the Hospital about your history with CNO; and/or

   (b) on or about June 20, 2019, while employed as a Registered Nurse at the Hospital, you drew blood from [Patient H] when he did not have an order for blood to be drawn.

**Member's Plea**

The Member admitted the allegations set out in paragraphs 1(a)(i), (ii), (b), (c) (d), (e), (f)(i), (ii), (g)(i), (ii), (iii), (iv), (v), (h), (i), 2, 3(a), (b), (c), (d)(i), (ii), (iii), (iv), 4(a), (b), 5(a)(i), (ii), (b), (c), (d), (e), (f)(i), (ii), (g)(i), (ii), (iii), (iv), (v), (h), (i), 6(a), (b), 7, 8(a) and (b) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

**Agreed Statement of Facts**

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 reads, unedited, as follows:

**THE MEMBER**

1. Rosa Anna Rubini-Catalano (the "Member") obtained a diploma in nursing from York University in 2005.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse in the General Class on November 23, 2005.

**INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

**William Osler Health Centre – Brampton Civic Hospital**

3. The Member was employed at William Osler Health Centre – Brampton Civic Hospital in Brampton, Ontario ("William Osler") from September 10, 2007 to April 19, 2016. The Member worked at William Osler on a full-time basis as a staff nurse on the Neurology Unit. Her employment was terminated in relation to an incident at York University as described below.

[Patient A]

4. On March 14, 2014, the Member administered insulin to [Patient A] contrary to a physician's order. The order stated that the medication was only to be administered if [Patient A]'s blood glucose level was greater than 10 mmol/l; however, the Member administered insulin when [Patient A]'s blood glucose level was 8.5 mmol/l.

5. One of the Member's nursing colleagues discovered the Member's error and completed an incident report.

6. If the Member were to testify, she would say that she advised the responsible physician of her error the next day.

7. Two days after the medication error, on March 16, 2014 at 0931, the Member attempted to alter [Patient A]'s patient record to indicate that she had not administered the insulin to [Patient A].

[Patient B]

8. [Patient B]'s physician ordered that he be administered heparin, a blood thinner, by IV, at a drip rate determined based on daily test results.

9. William Osler had an *IV Heparin Standard Protocol* and a *Safe Medication Administration Practice*, which required nurses to perform independent double checks when administering heparin, and to review positive patient identification when reviewing blood work.

10. On December 19, 2015, the Member failed to administer the IV as ordered by the physician. The Member had reviewed [Patient B]'s test results from the previous day, and accordingly failed to increase the drip rate based on the current test results.

11. The Member's error and a delay in lab results resulted in [Patient B] being underdosed for approximately 12 hours, which led to an increased risk of potential clot formation.

12. Staff on the oncoming shift discovered the Member's error and corrected the drip rate.

*York University*

13. Between January 4, 2016 to April 28, 2016, the Member was on short-term disability leave from William Osler and collected short-term disability benefits. William Osler offered the Member a return to work plan, which would include work which was less stressful, and the Member responded that she was not ready to return to work.

14. During this period, while the Member was collecting short-term disability benefits, the Member was working at York University as a Clinical Instructor. In her role at York University, the Member was working 12 hour shifts with two clinical groups on Mondays and Tuesdays.

15. If the Member were to testify, she would say that during this period of time she was experiencing significant and stressful marital difficulties. The Member would further testify, that in part because of this stress, she had taken sick leave from her employment at William Osler. She found the clinical instruction work at York University significantly less stressful than her work at William Osler. The Member would also testify that because of the difference in the working environments, she was not aware that working at York University might be inconsistent with collecting short-term disability benefits in relation to her employment at William Osler. The Member admits and acknowledges that collecting short-term disability benefits was inconsistent with working for York University.

16. The disability benefits paid to the Member were ultimately recovered.

**Mackenzie Health**

17. The Member was employed at Mackenzie Health in Richmond Hill, Ontario from May 9, 2016 to February 26, 2018. The Member was employed as a full-time staff nurse in the Emergency Department. She resigned her employment on the basis of family issues.

[Patient C]

18. On March 1, 2017, the Member administered the incorrect anticoagulant to [Patient C]. Specifically, the Member administered Heparin to [Patient C] when Dalteparin had been ordered by the physician.

19. The Member's error was discovered on a shift following the Member's shift. The error resulted in mild harm to [Patient C].

20. If the Member were to testify, she would say that Mackenzie Health addressed this incident though a verbal discussion with the Nurse Educator.

[Patient D]

21. [Patient D]'s physician changed her order for Lasix (Furosemide) from 40 mg twice a day to 40 mg once a day.

22. Mackenzie Health's *Medication Administration Process and Orders Transcription* Policy required nurses to validate the accuracy and completeness of the transcription of medication prior to administration.

23. On or around February 27, 2017, the Member failed to transcribe the new order to [Patient D]'s Medication Administration Record. There was no harm to [Patient D] as a result of the Member's error.

24. If the Member were to testify, she would say that in all other areas of Mackenzie Health in which she had worked, there was a system of double-checks to confirm that all orders had been transcribed, but that this system was not in place in the Emergency Department.

[Patient E]

25. On or around July 29, 2017, the Member administered epinephrine by intravenous injection to [Patient E]; however, the injection was to be administered by intramuscular injection. As a result of the Member's error, [Patient E] experienced chest tightness and was moved to the acute area.

26. The Member subsequently documented that she administered the epinephrine by intramuscular injection in [Patient E]'s left deltoid, when she actually administered it intravenously.

27. If the Member were to testify, she would say that after this error was discovered, she and the attending physician went to speak with [Patient E]'s family.

[Patient G]

28. [Patient G]'s physician ordered that she receive 10 units of insulin administered intravenously; however, the order was incorrectly transcribed, by someone other than the Member, and stated the insulin should be administered subcutaneously.

29. One of the Member's nursing colleagues alerted the Member to this error. Despite the Member's nursing colleague's notification, on or around December 28, 2017, the Member insisted on administering the insulin to [Patient G] subcutaneously. There was mild harm to [Patient G] as a result of the Member's conduct.

[Patient F]

30. Mackenzie Health's *Least Restraint Policy* limited the circumstances in which restraints may be applied to situations where patients were at risk of causing serious bodily harm to themselves or to others, and when following a plan of treatment that was consented to by the patient or his/her substitute decision maker. The restraint of a patient should only be considered after all available alternatives were proven to be inadequate, and the least restrictive measure should be used with ongoing assessment every 15 minutes. The use of

the restraints must be documented, including a description of any alternatives considered or tried and the reason for the restraint.

31. The Member failed to adhere to these requirements in her care for [Patient F]. On or around December 8, 2017, the Member applied restraints to [Patient F]. Prior to doing so, she did not obtain a physician's order for the application of restraints, or obtain consent from [Patient F] or her substitute decision-maker before applying the restraints. The Member did not document the application of restraints at all, and there was no documentation or evidence of the consideration of available alternatives to restraint, the reason for the restraint, the type of restraint, or how long the restraint was applied for.

32. If the Member were to testify, she would say that she recalls obtaining a verbal order for restraints from a physician, and had understood the physician would document that order. The Member does, however, acknowledge there is no documentation of any order in the clinical record.

**Markham Stouffville Hospital – Uxbridge Site**

33. The Member was employed at Markham Stouffville Hospital, Uxbridge Site ("Markham Stouffville") from April 1, 2019 to June 28, 2019, when she was released from her probationary period following the incidents described below.

[Patient H]

34. On June 20, 2019, the Member drew blood from [Patient H], though [Patient H] did not have an order for bloodwork. On the blood draw cart next to [Patient H], the Member had labels that were to be applied to the vials. These labels belonged to a different patient, who did have orders for blood work.

35. Markham Stouffville had a policy, *Positive Patient Identification*, which required that patients be positively identified by two patient identifiers prior to any service. The Member failed to follow this policy before drawing blood from [Patient H].

36. The Member's error was observed by a nursing colleague and there was no patient harm as a result of the incident.

*Disclosure of CNO Matters*

37. On March 15, 2019, as part of her application to work at Markham Stouffville, the Member completed a form in which she was asked: "Have you ever been the subject of an investigation or inquiry by a provincial or territorial registering/licensing/regulatory authority?" The Member checked off the box for "No".

38. The Member then signed the form, which included the following acknowledgment:

> I agree that should I become employed with Markham Stouffville Hospital I will advise the Hospital immediately if I am the subject of an Investigation or Inquiry by a registering/licensing/regulatory authority during the course of my employment.
>
> […]
>
> I acknowledge that I have read the above statements and have answered the questions truthfully. I also understand the information above and agree to these employment expectations.

39. The Member's statement that she had not "ever been the subject of an investigation by a provincial registering/licensing/regulatory authority" was untrue. As of the date she signed the form, CNO had conducted several investigations or inquiries into the Member's practice including:

    - An investigation pursuant to s. 75 of the *Health Professions Procedural Code* between 2009-2012, which resulted in CNO's Inquiries Complaints and Reports Committee ("ICRC") in 2012:
        - ordering the Member to complete a Specified Continuing Education or Remediation Program;
        - issuing her a letter of caution; and
        - ordering her to attend before the ICRC to receive an oral caution;
    - A complaint in 2010 which resulted in the ICRC issuing a letter of concern to the Member in 2012; and
    - A s. 75 investigation into reports received from William Osler and Mackenzie Health. Those investigations resulted in a referral of allegations of professional misconduct (some being the allegations before the Discipline Committee in this matter) to the Discipline Committee on March 13, 2019, two days before the Member completed the form.

40. If the Member were to testify, she would say that she understood all prior CNO matters, as well as the current issues, were confidential, such that she was not supposed to disclose them. She would further testify that, at the time she completed the form, she had not yet been advised of the referral to the Discipline Committee, which had just been published on Find a Nurse. The Member does, however, acknowledge that her statement on the form was inaccurate.

**Member's Health**

41. If the Member were to testify, she would state that she was suffering from a health condition during the relevant time period which affected her behaviour and judgment. She would further testify that she has since sought treatment for her health condition.

**CNO STANDARDS**

42. 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 legislative requirements and the standard of the profession. Nurses are responsible for their actions and the consequences of those actions. A nurse demonstrates accountability by actions such as:

    - Providing, facilitating, advocating and promoting the best possible care for [patients];
    - Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;
    - 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.

43. In addition, CNO's *Professional Standards* provides that each nurse continually improves the application of professional knowledge and demonstrates knowledge application by actions such as identifying and addressing practice-related issues.

44. CNO's *Professional Standards* further state that ethical nursing includes acting with integrity, honesty and professionalism in all dealings with the patient and other health care team members.

45. CNO's *Medication* standard provides that three principles outline the expectations related to medication practices that promote public protection: authority, competence, and safety.

46. With respect to competence, nurses must ensure that they have the knowledge, skill and judgment needed to perform medication practices safely.

47. With respect to safety, nurses must promote safe care and contribute to a culture of safety within their practice environment, when involved in medication practices. The *Medication* standard requires that nurses:

    - take appropriate action to resolve or minimize the risk of harm to a [patient] from a medication error or adverse reaction; and
    - report medication errors, near misses or adverse reactions in a timely manner.

48. 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;

- Indicating when an entry is late as defined by organizational policies; and

- Ensuring that relevant [patient] care information is captured in a permanent record.

49. CNO's *Ethics* standard describes the ethical values that are most important to the nursing profession in Ontario. One of the most important ethical values in providing nurse care is truthfulness.

**ADMISSIONS OF PROFESSIONAL MISCONDUCT**

50. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a) to (i) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 3 to 32 and 42 to 49 above.

51. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, in that she misappropriated property from her workplace when she applied for and received short term disability benefits from William Osler while employed at York University, as described in paragraphs 13 to 16 above.

52. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a) to (d) of the Notice of Hearing in that she failed to keep records as required, as described in paragraphs 4 to 7, 21 to 27 and 30 to 32 above.

53. The Member admits that she falsified a record relating to her practice, as alleged in paragraphs 4(a) and (b) of the Notice of Hearing, as described in paragraphs 4 to 7 and 25to 27 above.

54. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 5(a) to (i) of the Notice of Hearing, and in particular her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 3 to 32 and 42 to 49 above.

55. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 6(a) and (b) of the Notice of Hearing in that she contravened a standard of

practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 33 to 40 and 42 to 49 above.

56. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 7 of the Notice of Hearing, in that she signed or issued, in her professional capacity, a document that she knew, or ought to have known contained a false or misleading statement when she provided false information to Markham Stouffville about her history with CNO on her application for a nursing position, as described in paragraphs 37 to 40 above.

57. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 8 (a) and (b) of the Notice of Hearing, and in particular her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 33 to 40 and 42 to 49 above.

**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), (b), (c), (d), (e), (f)(i), (ii), (g)(i), (ii), (iii), (iv), (v), (h), (i), 2, 3(a), (b), (c), (d)(i), (ii), (iii), (iv), 4(a), (b), 5(a)(i), (ii), (b), (c), (d), (e), (f)(i), (ii), (g)(i), (ii), (iii), (iv), (v), (h), (i), 6(a), (b), 7, 8(a) and (b) of the Notice of Hearing. With respect to allegations 5(a)(i), (ii), (b), (c), (d), (e), (f)(i), (ii), (g)(i), (ii), (iii), (iv), (v), (h), (i), 8(a) and (b), 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 Notice of Hearing.

Allegations #1(a) to (i) in the Notice of Hearing are supported by paragraphs 3-32, 42-49 and 50 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member contravened the College's *Professional Standards*, *Medication* Standard and *Documentation* Standard in various important ways and with multiple patients, including through providing inadequate care, inadequately documenting care; specifically, by administering medication contrary to doctor's orders or without a doctor's order. The Member collected short term disability benefits from one employer while working for another employer. The Member disregarded concerns about her practice as noted to her by her colleagues.

Allegation #2 in the Notice of Hearing is supported by paragraphs 13 to 16 and 51 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member committed professional misconduct by misappropriating property from her workplace when she received short term disability benefits from one employer while working for another employer.

Allegations #3(a) to (d) in the Notice of Hearing are supported by paragraphs 4-7, 21-27, 30-32, 48 and 52 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member committed professional misconduct by failing to keep records as required for multiple patients when recording medication she had administered, when she did not transcribe a change to a physician's order, inaccurately documented the route used for administering an injection, failed to document the use of restraints, her consideration of available alternatives before applying restraints, her failure to document obtaining an order to use restraints and her failure to document the ongoing need for restraints.

Allegations #4(a) and (b) in the Notice of Hearing are supported by paragraphs 4-7, 25-27, 48, 49 and 53 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member committed professional misconduct by falsifying records for more than one patient in more than one hospital setting.

With respect to Allegations #5(a) to (i) in the Notice of Hearing they are supported by paragraphs 3-32, 42-49 and 54 in the Agreed Statement of Facts. The Member contravened the standards of practice of the profession, misappropriated property from a workplace, failed to keep records as required, falsified a record relating to her practice, and provided false information about her history with the CNO to an employer. This conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. It was dishonourable as the Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional. The Member's conduct in altering documentation was disgraceful as it brought shame on her and by extension, the profession.

Allegations #6(a) and (b) in the Notice of Hearing are supported by paragraphs 33-40, 42-49 and 55 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member engaged in professional misconduct by contravening or failing to meet the standards of practice of the profession when she provided false information to an employer about her history with the CNO and drew blood from a patient, when the patient did not have an order for blood to be drawn.

And Allegation #7 in the Notice of Hearing is supported by paragraphs 37-40, 49 and 56 in the Agreed Statement of Facts. These paragraphs demonstrate that the Member engaged in professional misconduct when applying for a job at a hospital, by completing and signing an application form in which she provided false information about her history with the CNO.

Allegations #8(a) and (b) in the Notice of Hearing are supported by paragraphs 33-40, 42, 48, 49 and 57 in the Agreed Statement of Facts. The Member's conduct was unprofessional when she did not follow Markham Stouffville's Positive Patient Identification Policy, and provided false information to an employer about her history with the CNO thereby demonstrating a serious and persistent disregard for her professional obligations. The Member's conduct in providing false information to her employer was dishonourable as it demonstrated an element of dishonesty and deceit. This conduct was disgraceful as it brought shame on herself and by extension, on the profession.

**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 the Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 7 months. The suspension shall take effect from the date that the 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) Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that the Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") 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 the 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 the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least 7 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. the 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, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Medication*,
            3. *Documentation*, and
            4. *Code of Conduct*;

        iv. At least 7 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 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 her/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 24 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. the Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

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

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

c) For a period of at least 12 months from the date the Member returns to the practice of nursing, 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 her efforts to ensure that her 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 12 month period identified in 3(c) above, the Mentor will determine whether further meetings are required and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

e) The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

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

**Penalty Submissions**

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member had a very broad and persistent range of behaviours towards 8 patients that she was providing care to;
- The Member made multiple, very serious medication errors, that could have had serious consequences for the patients;
- The Member failed to take accountability when confronted by colleagues;
- The Member falsified records twice concerning medication errors she was responsible for;
- The Member failed to document her use of restraints, consent to use of restraints, and consideration of alternate methods prior to using restraints;
- The Member exhibited patterns of deceit and dishonesty;
- The Member was dishonest to two nursing employers as she admitted to taking short term disability from one employer while being employed at another agency;
- The Member provided false and misleading statements about her history with the College;
- The Member's particular conduct covered a span of time from 2014 to 2019.

The mitigating factors in this case were:

- The Member accepted responsibility for her conduct by agreeing to the Agreed Statement of Facts and the Joint Submission on Order;
- The Member pleaded guilty to the allegations;
- The Member was suffering from a health condition that affected her behaviour and judgement;
- If the Member were to testify, she would say she has sought treatment for her heath conditions.

The proposed penalty meets all goals of penalty and the overarching goal of protecting the public. General deterrence is met through the 7 month suspension and reprimand sending a message to all nurses that there are consequences for this type of behaviour.

The proposed penalty provides for specific deterrence through the oral reprimand and the 7 month suspension, sending a message to the Member that conduct of this nature will not be tolerated.

The proposed penalty provides for remediation and rehabilitation through the terms, conditions and limitations placed upon the Member's certificate of registration including two meetings with a Regulatory Expert and a mentoring relationship when the Member returns to practice.

Overall, the public is protected because of the suspension and the terms, conditions and limitations which include a 24 month restriction on the Member practicing independently in the community. The public can be assured that the conduct will not be repeated.

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

*CNO v. Simeone* (Discipline Committee, 2017). In this case, the member committed similar acts of misconduct but had no health issues. The member's conduct was very serious, with multiple incidents, involving six patients over two years. The Member received an oral reprimand, a five month suspension and terms, conditions and limitations on her certificate of registration which included two meetings with a Nursing Expert, 18 months of employer notification, 12 months of employer reporting with random spot audits and no independent practice in the community for a period of 18 months.

*CNO v. Lewis* (Discipline Committee, 2013). In this case, the member committed similar acts of misconduct but had no health issues and unlike the current case, the member used abusive language. The member received an oral reprimand, a 6 month suspension and terms, conditions and limitations on her certificate of registration which included three meetings with a Nursing Expert, 24 months of employer notification, 12 months of employer reporting with random spot audits and no independent practice in the community for 12 months. In this particular case the Member's allegation included verbal abuse and a lack of empathy which is not the situation in the current case.

*CNO v. Zhou* (Discipline Committee, 2018). In this case, the member's conduct was more deliberate and dishonest by taking sick leave from one employer while working for her other employer. This case involved a level of deceit that was more deliberate which is not the situation in the current case. This member received an oral reprimand, a 7 month suspension and terms, conditions and limitations on her certificate of registration which included two meetings with a Nursing Expert, and 24 months of employer notification. There was no money recovered from this member which is not the situation in the current case.

*CNO v. Jelley* (Discipline Committee, 2006). In this case, the member's conduct was over two instances but much more serious. The member restrained a patient inappropriately and there were several breaches related to restraint use. The circumstances and failures were more significant and serious than the current case. The member received an oral reprimand, a 3 month suspension and terms, conditions and limitations on her certificate of registration which included completing the College's self-directed learning package, *One Is One Too Many* and thereafter meeting with a College Practice Consultant to discuss it and 18 months of employer notification.

The Member's Counsel submitted that the Member is remorseful, accepts the Joint Submission on Order and understands the function of the College. The Joint Submission on Order offers the Member the opportunity to start making amends.

The Member's Counsel also submitted that mitigating factors were that the Member suffered from a medical condition that influenced her conduct. Furthermore, the Member accepting responsibility for her conduct demonstrates accountability and saves the College time and the expense of prosecution.

The Member's Counsel stated that the Member took actions to remediate and mitigate some of her errors, including repaying the hospital for the disability benefits she received, acknowledging and following up on the medication errors and remediation with the clinical educator.

Finally, the Member's Counsel submitted that the Member thought that the ICRC process was confidential and so she did not have to advise of it and that at the time she completed the form, she was not aware that the matter had been referred to the Discipline Committee.

The Member's Counsel submitted that the penalty as presented ensures additional safeguards are in place and serves the public interest.

**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 the Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 7 months. The suspension shall take effect from the date that the 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) Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that the Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") 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 the 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 the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least 7 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. the 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, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Medication*,
            3. *Documentation*, and
            4. *Code of Conduct*;

        iv. At least 7 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 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 her/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 24 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. the Joint Submission on Order, and
5. a copy of the Panel's Decision and Reasons, once available;

iii. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

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

c) For a period of at least 12 months from the date the Member returns to the practice of nursing, 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 her efforts to ensure that her 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 12 month period identified in 3(c) above, the Mentor will determine whether further meetings are required and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

e) The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

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

**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. Specific deterrence is met through the oral reprimand and the suspension. General deterrence is met through the oral reprimand and the suspension discouraging nurses from engaging in this type of behaviour. Remediation and rehabilitation is met through the meetings with the Nursing Expert allowing the member to reflect and deepen her understanding of her professional misconduct to help ensure that it does not happen again and to protect the public through the terms, conditions and limitations, remediation and rehabilitation, mentoring and the employer notification. The penalty is also in line with what has been ordered in previous cases.

I, Andrea Arkell, Public Member sign this decision and reasons for the decision on behalf of the Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.