

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

<b>PANEL:</b>	David Edwards, RPN	Chairperson
	Ramona Dunn, RN	Member
	Sandra Larmour	Public Member
	Michael Schroder, NP	Member

**BETWEEN:**

COLLEGE OF NURSES OF ONTARIO	)	<u>DENISE COONEY</u> for
	)	College of Nurses of Ontario
- and -	)	
	)	
TITI DIAVITA	)	<u>NO REPRESENTATION</u> for
Registration No. AD078008	)	Titi Diavita
	)	
	)	<u>CHRISTOPHER WIRTH</u>
	)	Independent Legal Counsel
	)	
	)	Heard: June 10, 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 June 10, 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 the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented at the Discipline hearing of Titi Diavita.

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

## **The Allegations**

The allegations against Titi Diavita (the “Member”) as stated in the Notice of Hearing dated April 8, 2022 are as follows:

### **IT IS ALLEGED THAT:**

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse (“RPN”) at All Seniors Care Living Centres - Chapel Hill Retirement Residence in Ottawa, Ontario (the “Facility”), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession as follows:
  - a. On June 10, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$50.85 purchase at the LCBO located at 457 Hazeldean Road, Ottawa;
  - b. On July 2, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$49.25 purchase at the LCBO located at 4220 Innes Road, Ottawa;
  - c. On July 6, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$61.00 purchase at the LCBO located at 4220 Innes Road, Ottawa; and/or
  - d. On July 7, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$70.30 purchase at the LCBO located at 457 Hazeldean Road, Ottawa; 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(8) of *Ontario Regulation 799/93*, in that while employed as an RPN at the Facility, you misappropriated property from a client or workplace on the following occasions:
  - a. On June 10, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$50.85 purchase at the LCBO located at 457 Hazeldean Road, Ottawa;
  - b. On July 2, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$49.25 purchase at the LCBO located at 4220 Innes Road, Ottawa;
  - c. On July 6, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$61.00 purchase at the LCBO located at 4220 Innes Road, Ottawa; and/or

- d. On July 7, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$70.30 purchase at the LCBO located at 457 Hazeldean Road, Ottawa; and/or
- 3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93*, in that while registered as an RPN, you contravened a term, condition or limitation on your certificate of registration, as provided in subsections 1.5(1)1. (ii) of *O. Reg. 275/94*, in that you failed to provide the Executive Director of the College of Nurses of Ontario (“CNO”) with details of criminal charges that you were subject to, as follows:
  - a. On or about August 9, 2019, you were charged with three counts of fraud under \$5,000, contrary to s.380(1)(b) the *Criminal Code*, and three counts of possession of property obtained by crime, contrary to s.354(1)(b) of the *Criminal Code*; and/or
- 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 registered 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 of the profession as disgraceful, dishonourable or unprofessional, as follows:
  - a. On June 10, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$50.85 purchase at the LCBO located at 457 Hazeldean Road, Ottawa;
  - b. On July 2, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$49.25 purchase at the LCBO located at 4220 Innes Road, Ottawa;
  - c. On July 6, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$61.00 purchase at the LCBO located at 4220 Innes Road, Ottawa;
  - d. On July 7, 2019, you used the debit card belonging to [the Patient], a resident of the Facility, to make a \$70.30 purchase at the LCBO located at 457 Hazeldean Road, Ottawa; and/or
  - e. You failed to provide the Executive Director of CNO with the details of criminal charges that you were subject to, as follows:
    - i. On or about August 9, 2019, you were charged with three counts of fraud under \$5,000, contrary to s.380(1)(b) the *Criminal Code*, and three counts of possession of property obtained by crime, contrary to s.354(1)(b) of the *Criminal Code*.

## **Member's Plea**

The Member admitted the allegations set out in paragraphs 1(a), (b), (c), (d), 2(a), (b), (c), (d), 3(a), 4(a), (b), (c), (d) and (e)(i) 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 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. Titi Diavita (the "Member") graduated with a diploma in nursing from La Cite Collegial – Ottawa Campus on May 30, 2014.
2. The Member first registered with the College of Nurses of Ontario (the "CNO") as a Registered Practical Nurse ("RPN") on November 4, 2014.
3. The Member is currently employed as a full-time night shift RPN with the Salvation Army – Ottawa Grace Manor.
4. The Member has no prior discipline findings with CNO.

### **THE FACILITY**

5. The Member was employed as a part-time night shift RPN at All Seniors Care Living Centre – Chapel Hill Retirement Residence in Ottawa, Ontario (the "Facility") from July 1, 2017 until July 16, 2019.
6. The Facility is a retirement residence in Ottawa, Ontario with 157 beds, approximately 93 of which were reserved for patients with varying degrees of independence.
7. The Facility terminated the Member's employment in relation to the incidents which give rise to the professional misconduct set out in the Notice of Hearing, and described below.

### **THE PATIENT**

8. Patient [ ] (the "Patient") was a 68-year-old woman with moderate dementia and epilepsy. She lived in the independent residence portion of the Facility. The Patient required assistance with certain activities of daily living, including leaving the Facility for errands and making purchases. She was only able to make purchases and run errands when accompanied by one of her daughters.

9. The Patient was unable to consume alcohol due to a seizure disorder.

## **INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

### **A) The Member Used the Patient's Debit Card to Make Purchases at the LCBO**

10. The Member used the Patient's debit card to make four LCBO purchases in the approximate amount of \$231.40.
11. In or around June 2019, the Member came to unlawfully possess the Patient's debit card. If the Member were to testify, he would say that someone found the Patient's debit card and turned it into him while he was working at the Facility's nursing station. The Member did not report the debit card to the Facility or return it to the Patient. Rather, the Member kept the Patient's debit card at the nursing station and used it to make four separate purchases for his own benefit at the LCBO in June and July 2019. When the Patient advised the Member that she had lost her debit card, he returned the debit card to her without advising that he had used it to make purchases at the LCBO.
12. On July 9, 2019, the Patient's daughter and Power of Attorney ("Daughter A") identified four LCBO purchases charged to the Patient's debit card that she believed might be fraudulent. These purchases were as follows:
- On June 10, 2019, a \$50.85 purchase at the LCBO located at 457 Hazeldean Road, Ottawa;
  - On July 2, 2019, a \$49.25 purchase at the LCBO located at 4220 Innes Road, Ottawa;
  - On July 6, 2019, a \$61.00 purchase at the LCBO located at 4220 Innes Road, Ottawa; and
  - On July 7, 2019, a \$70.30 purchase at the LCBO located at 457 Hazeldean Road, Ottawa.
13. Daughter A identified the LCBO charges as fraudulent because the Patient is unable to drink alcohol due to a significant seizure disorder. The Patient is also unable to make purchases using her debit card without the assistance of one of her two daughters.
14. Neither of the Patient's daughters assisted the Patient in making purchases at the LCBO. Rather, the Member made each of the four LCBO purchases identified as fraudulent by Daughter A, and set out at paragraph 12 above, using the tap function on the Patient's debit card. The Member made these purchases for his own personal benefit.

15. Staff at the Patient's bank advised Daughter A that the LCBO purchases had all been made using the "tap" function on the Patient's debit card. As a result, Daughter A cancelled the Patient's debit card and reported the fraudulent charges to the Ottawa Police Service and the Facility.
16. The LCBO provided surveillance footage to the Ottawa Police Service. This surveillance footage shows the Member using the Patient's debit card to complete "tap" transactions at the LCBO on July 2, 6 and 7, 2019.
17. On July 16, 2019, the Member was interviewed by Constable D. Tessier of the Ottawa Police Service. The Member made the following admissions during this interview:
  - The Member attended at the LCBO on July 2, 6, and 7, 2019 and made purchases with a card that did not belong to him;
  - The Member acknowledged that he was the one making the transactions on the Patient's debit card captured in still shots from the LCBO's video footage.
  - The Member was working and someone told him they had found a card;
  - He kept the card at the nursing station and used it to make purchases;
  - A woman approached him and said she had lost a card;
  - He showed her the card at the nursing station, and she confirmed it was her card; and
  - The Member returned the card, but he did not tell the woman he had made purchases using her debit card.
18. The Member was released from police custody on a promise to appear in Court on August 13, 2019. He acknowledged to Constable Tessier that he had committed three counts of fraud and three counts of possession of property obtained by crime at that time in relation to the three July 2019 LCBO transactions. The Member was prohibited from returning to the Facility and contacting the Patient and her family.
19. The Facility terminated the Member's employment on July 16, 2019.
20. On August 9, 2019, the Member was formally charged with three counts of fraud under \$5,000, and three counts of possession of property obtained by crime, contrary to sections 380(1)(b) and 354(1)(b) of the *Criminal Code*.

21. The Member completed a Direct Accountability Program (the “Program”) in connection with his criminal charges. This program required the Member to complete 60 hours of community service, attend a theft prevention seminar, and pay restitution in the amount of \$180.23.
22. The criminal charges against the Member were withdrawn on October 1, 2019 as a result of his participation in the Program and for his restitution payment.
23. As set out above, the Member admits that he made the June 10, 2019 LBCO purchase on the Patient’s debit card in addition to the July 2019 LCBO purchases for which he was criminally charged.
24. If the Member were to testify, he would state that he is remorseful and regrets his decision, which fundamentally violated the therapeutic nurse-patient relationship. The Member further acknowledges that his actions were inexcusable.

**B) The Member Failed to Comply with CNO Reporting Obligations**

25. The Member was obligated to provide the Executive Director of CNO with details of the criminal charges against him, pursuant to section 1.5(1)1.(ii) of *Ontario Regulation 275/94*.
26. The Member did not report the criminal charges against him to CNO at any time. He failed to meet his reporting obligations as a result.

**CNO STANDARDS OF PRACTICE**

27. CNO publishes nursing standards to set out the expectations for the practice of nursing. CNO’s published standards inform nurses of their accountabilities and apply to all nurses regardless of their role, job description or area of practice.
28. This case engages the following practice standards: *Code of Conduct*, *Professional Standards*, and *Therapeutic Nurse-Client Standard*.
29. The *Code of Conduct* states that all nurses are expected to prevent harm to patients and protect patients from harm. To meet this requirement, nurses must maintain appropriate professional relationships. They must not exploit the power imbalance inherent in the nurse-patient relationship to obtain personal or financial gain. Nurses meet professional standards by ensuring that their individual needs are met outside of the therapeutic nurse-patient relationship and never at the expense of a patient.
30. This is reflected in CNO’s *Professional Standards*, which provides that each nurse is accountable for conducting themselves in ways that promote respect for the profession.

31. CNO's *Therapeutic Nurse-Client Relationship Standard* ("TNCR Standard") places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse. The *TNCR Standard* provides that the nurse-patient relationship is based on trust and respect, and requires appropriate use of the authority inherent in the health care provider's role.
32. Importantly, the *TNCR Standard* further develops this obligation by explicitly stating that nurses must protect patients from harm by not engaging in activities that could result in monetary or other material benefit, gain or profit (other than the appropriate remuneration for nursing care or services) or result in monetary or personal loss for the patient.

### **ADMISSIONS OF PROFESSIONAL MISCONDUCT**

33. The Member admits that using the Patient's debit card to make personal purchases at the LCBO on four occasions without the Patient's knowledge, consent or authorization breached the standards of practice as set out in CNO's *Code of Conduct*, *Professional Standards*, and *TNCR Standard*.
34. The Member admits that he committed the acts of professional misconduct in paragraphs 1(a)-(d) of the Notice of Hearing, as described in paragraphs 10-24 above, and in particular, that he breached the standards of the profession by using the Patient's debit card to make personal purchases at the LCBO on four occasions without the Patient's knowledge, consent, or authorization.
35. The Member admits that he committed the acts of professional misconduct in paragraphs 2(a)-(d) of the Notice of Hearing, as described in paragraphs 10-24 above, and in particular, that he misappropriated property from the Patient when he used the Patient's debit card to make personal purchases at the LCBO on four occasions without the Patient's knowledge, consent, or authorization.
36. The Member admits that he committed the acts of professional misconduct in paragraphs 3(a) of the Notice of Hearing, as described in paragraphs 25-26 above, and in particular, that he contravened a term, condition or limitation on his certificate of registration when he failed to report the six criminal charges against him to the Executive Director of CNO.
37. The Member admits that he committed the acts of professional misconduct in paragraphs 4(a)-(e) of the Notice of Hearing, as described in paragraphs 10-26 above, and in particular, that his conduct involving the Patient was disgraceful, dishonourable and unprofessional.

### **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), (d), 2(a), (b), (c), (d), 3(a), 4(a), (b), (c), (d) and (e)(i) of the Notice of Hearing. As to allegations #4(a), (b), (c), (d) and (e)(i), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession 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), (b), (c) and (d) in the Notice of Hearing are supported by paragraphs 10-18, 20-24, 27-32 and 33-34 in the Agreed Statement of Facts. The Member violated the *Code of Conduct* by exploiting the power imbalance in the nurse-patient relationship for his personal gain. Furthermore, the Member met his personal desire for alcohol at the expense of [the Patient]. The Member contravened the *Professional Standards* as he demonstrated a lack of respect for the profession of nursing by misappropriating the [the Patient]'s debit card and using it to purchase alcohol for his personal consumption. A nurse meets the *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard*") by refraining from activities that "could result in monetary or personal loss for the client". The Member breached the *TNCR Standard* when he made four purchases at the LCBO using [the Patient]'s debit card which created a monetary loss for [the Patient] in the amount of \$231.40.

The Member admitted that he committed the acts of professional misconduct by breaching the standards of the profession.

Allegations #2(a), (b), (c) and (d) in the Notice of Hearing are supported by paragraphs 10-18, 20-23 and 35 in the Agreed Statement of Facts. The Member used [the Patient]'s debit card to purchase alcohol at the LCBO on four separate occasions. This created a monetary loss for [the Patient] in a total amount of \$231.40. The Member admitted and the Panel finds that when he used [the Patient]'s debit card without the Patient's knowledge, consent or authorization, he misappropriated property from the Patient and thus committed acts of professional misconduct.

Allegation #3(a) in the Notice of Hearing is supported by paragraphs 15-18, 20-23, 25-26 and 36. On August 9, 2019, the Member was formally charged with three counts of fraud under \$5,000 and three counts of possession of property obtained by crime, contrary to sections 380(1)(b) and 354(1)(b) of the *Criminal Code*. The Member was obligated, as part of a term, condition or limitation on his certificate of registration, to inform the Executive Director of the College of the criminal charges within 30 days. The Member admitted that he failed to report the six criminal charges against him to the Executive Director of the College. The Panel finds that the Member's failure to report the criminal charges to the Executive Director of the College at anytime, contravened the reporting obligation, term, condition or limitation on his certificate of registration and thus constituted professional misconduct.

With respect to allegations #4(a), (b), (c), (d), and (e)(i), the Panel finds that the Member's conduct in misappropriating [the Patient]'s debit card in order to make four purchases at the LCBO was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through intentionally making purchases with [the Patient]'s debit card and not disclosing this to [the Patient] upon return of the debit card. The Member knew or ought to have known that his conduct was unacceptable and fell well below the standards of a professional.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct of financially abusing a vulnerable older adult patient on four separate occurrences for his own personal gain casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

### **Penalty**

College Counsel and the Member 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 3 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, 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. *Therapeutic Nurse-Client Relationship*;
- iv. Before the first meeting, the Member reviews and completes the CNO's self-directed learning package, *One is One Too Many*, at his own expense, including the self-directed *Nurses' Workbook*;
- v. At least 5 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and *Nurses' Workbook*;
- vi. 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;
- vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her 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;
- viii. 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 24 months from the date on which the Member returns to the practise of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:
- i. Ensure that CNO is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
  - ii. Provide his employer(s) with a copy of:
    1. the Panel's Order,
    2. the Notice of Hearing,
    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) The Member shall not practice independently in the community for a period of 18 months from the date on which the Member returns to the practise of nursing.

All documents delivered by the Member to the 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 misconduct was serious;
- The Member showed a serious and persistent disregard for his professional obligations to both [the Patient] and the College;
- The Member used [the Patient]'s debit card on four separate occasions for his own personal gain;

- The conduct involved dishonesty and a breach of trust; and
- The conduct was found to be disgraceful, dishonourable and unprofessional.

The mitigating factors in this case were:

- The Member made restitution with respect to the amounts he misappropriated from [the Patient];
- The Member has taken responsibility by admitting to the professional misconduct;
- The Member has cooperated with the College by entering into an Agreed Statement of Facts and a Joint Submission on Order; and
- The Member has no prior discipline history with the College.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3 month suspension of the Member's certificate of registration, which sends a signal to the Member that this behaviour is unacceptable and will deter him from repeating the conduct going forward.

The proposed penalty provides for general deterrence through the 3 month suspension of the Member's certificate of registration, which sends a signal to other members of the profession that this behaviour will not be tolerated.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert. The Member will be afforded an opportunity to learn from his mistakes in order to return to safe and ethical nursing practice.

Overall, the public is protected because the penalty will deter similar misconduct from being repeated by both the Member and members of the profession. The public is also protected through the 24 months of employer notification provision and the 18 months of restriction on independent practice as the Member's employers will provide increased vigilance on the Member's practice on his return to nursing.

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. Visca* (Discipline Committee, 2017): This case proceeded on a contested basis which is different from the case before this Panel. The member was alleged to have stolen money from two patients. The panel found that the allegations of money being stolen from one patient were proven. The member misappropriated an amount of between \$20.00-\$30.00. The member was charged criminally, pleaded guilty and was found guilty of theft. The penalty included an oral reprimand, a five month suspension of the member's certificate of registration, two meetings with a Nursing Expert, a period of 24 months of employer notification and a prohibition on independent practice for 18 months. The conduct is similar to the case before this Panel in that it involves the theft of a relatively small sum of money from a vulnerable patient and criminal charges followed. A lower suspension is appropriate in the case before this Panel as the Member has accepted responsibility.

*CNO v. Lane* (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member admitted to stealing \$150.00 in gift cards from a patient's room at a retirement residence and redeeming the gift cards for meals at a restaurant. The penalty included an oral reprimand, a 3 month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert, 18 months of employer notification and a prohibition on independent practice for 12 months. The penalty is similar to the case before this Panel as both cases involved similar monetary amounts being misappropriated. The case before this Panel involves a longer period of employer notification and prohibition on independent practice as the conduct was repeated over four separate occasions and the Member failed to report the criminal charges to the College.

The Member made no submissions on penalty.

### **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 3 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, 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. *Therapeutic Nurse-Client Relationship*;
- iv. Before the first meeting, the Member reviews and completes the CNO's self-directed learning package, *One is One Too Many*, at his own expense, including the self-directed *Nurses' Workbook*;
- v. At least 5 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and *Nurses' Workbook*;
- vi. 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;
- vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her 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;
- viii. 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 24 months from the date on which the Member returns to the practise of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:
    - i. Ensure that CNO is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;
    - ii. Provide his employer(s) with a copy of:
      - 1. the Panel's Order,
      - 2. the Notice of Hearing,
      - 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) The Member shall not practice independently in the community for a period of 18 months from the date on which the Member returns to the practise of nursing.
4. All documents delivered by the Member to the 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. The oral reprimand and the 3 month suspension of the Member's certificate of registration satisfies the principles of specific deterrence as it sends a message to the Member that this type of conduct is not acceptable. General deterrence is addressed by the 3 month suspension of the Member's certificate of registration which sends a message to members of the profession that this type of conduct will not be tolerated.

The minimum of 2 meetings with a Regulatory Expert will provide for rehabilitation and remediation as the Member will have an opportunity to gain insight into the wrongfulness of his misconduct. The public is protected through the 24 months of employer notification and the 18 months of prohibition on independent practice as the Member's employer will provide a heightened level of oversight on the Member's practice during these periods. The penalty demonstrates that financial abuse of vulnerable older adults will not be tolerated by the profession. This penalty provides confidence to the public in the College's ability to regulate the profession of nursing.

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.