DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Terry Holland, RPN	Panel Chair
Margarita Cleghorne, RPN	Member
Karen Goldenberg	Public Member
Martin Sabourin, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
MELANIE RIDDELL	)	NO REPRESENTATION for
Registration No. JJ12492	)	Melanie Riddell
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: November 18-20, 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") commencing on November 18, 2020, via videoconference.

As Melanie Riddell (the "Member") was not present, the hearing recessed for 15 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was not in attendance.

College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing on August 21, 2020 by way of an affidavit from [College Staff Member], Prosecutions Clerk, dated August 24, 2020, confirming that [College Staff Member] sent correspondence which included the Notice of Hearing, on August 21, 2020 to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if she did not participate in the hearing, it may proceed

without her participation. Accordingly, the Panel decided to proceed with the hearing in the Member's absence.

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 the public disclosure and banning publication or broadcasting of the names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of the Member.

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

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated August 20, 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 while you were employed as a Registered Practical Nurse at Bluewater Health in Sarnia, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to the following incidents:

    a. on or around March 14, 2016, when providing care to [Patient A], you:

        i. yelled at the patient and said words to the effect of "you are not allowed to wear these gloves" and/or "you are a liar, that's what you are, you are a liar";

        ii. ripped off and/or removed the patient's gloves in an aggressive manner; and/or

        iii. said to the patient "you are a little whoo hoo, that's what I think you are" or words to that effect;

    b. on or around July 9, 2016, when providing care to [Patient B], you wrapped a blanket and/or face mask around the patient's head and eyes; and/or

    c. on or around July 10, 2016, when providing care to [Patient C], you placed a towel in the patient's mouth; 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(7) of *Ontario Regulation 799/93*, in that while you were

employed as a Registered Practical Nurse at the Facility, you verbally, physically, and/or emotionally abused patients with respect to the following incidents:

a. on or around March 14, 2016, when providing care to [Patient A], you:

   i. yelled at the patient and said words to the effect of "you are not allowed to wear these gloves" and/or "you are a liar, that's what you are, you are a liar";

   ii. ripped off and/or removed the patient's gloves in an aggressive manner; and

   iii. said to the patient "you are a little whoo hoo, that's what I think you are" or words to that effect;

b. on or around July 9, 2016, when providing care to [Patient B], you wrapped a blanket and/or face mask around the patient's head and eyes; and/or

c. on or around July 10, 2016, when providing care to [Patient C], you placed a towel in the patient's mouth; and/or;

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while you were employed as a Registered Practical Nurse at the Facility, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional with respect to the following incidents:

   a. on or around March 14, 2016, when providing care to [Patient A], you:

      i. yelled at the patient and said words to the effect of "you are not allowed to wear these gloves" and/or "you are a liar, that's what you are, you are a liar";

      ii. ripped off and/or removed the patient's gloves in an aggressive manner; and/or

      iii. said to the patient "you are a little whoo hoo, that's what I think you are" or words to that effect;

   b. on or around July 9, 2016, when providing care to [Patient B], you wrapped a blanket and/or face mask around the patient's head and eyes; and/or

   c. on or around July 10, 2016, when providing care to [Patient C], you placed a towel in the patient's mouth.

Member's Plea

Given that the Member was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member first registered with the College as a Registered Practical Nurse ("RPN") in October 2000. She practiced as an RPN from October 2000 until December 2016, when she resigned.

The allegations in the Notice of Hearing pertain to three different patients. In summary, it is alleged that on or around March 14, 2016 while a registered Member of the College and working as an RPN at Bluewater Health in Sarnia, Ontario (the "Facility"), the Member yelled at and made an inappropriate comment towards Patient A, and ripped off and/or removed Patient A's gloves in an aggressive manner. As a result of her conduct, the Member was placed on a 1 day suspension and instructed to complete a Performance Improvement Plan. It is further alleged that on July 9, 2016, the Member wrapped a blanket and/or face mask around Patient B's head and eyes. Finally, it is alleged that on July 10, 2016 the Member placed a towel in Patient C's mouth.

As described in detail below, the Panel found that the facts and evidence supported the description of the Member's conduct as set out in the Notice of Hearing. The Panel then identified the following issues for it to consider:

a. Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she yelled at and made inappropriate comments in reference to Patient A?

b. Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she ripped gloves off of Patient A in an aggressive manner?

c. Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she wrapped a blanket around Patient B's head and eyes?

d. Did the Member contravene a standard of practice of the profession or fail to meet standards of practice when she placed a towel in Patient C's mouth?

e. Did the Member abuse Patient A verbally, physically or emotionally when she yelled at and made inappropriate comments to Patient A and ripped off and/or removed the patient's gloves?

f. Did the Member abuse Patient B verbally, physically or emotionally when she wrapped a blanket around Patient B's head and eyes?

g. Did the Member abuse Patient C verbally, physically or emotionally when she placed a towel in the Patient C's mouth?

h. Did the Member commit professional misconduct by engaging in conduct that would be considered by members of the profession to be disgraceful, dishonourable and/or unprofessional?

The Evidence

The Panel received 18 exhibits from the College and heard testimony from 4 witnesses and one expert witness

Witness 1 - [Witness A] - Manager ("[Witness A]")

[Witness A] obtained an Honours Bachelor of Applied Science in Gerontology from the University of Guelph in 1996. [Witness A] worked in management in other organizations, and is currently the manager of the Cognitive Complex Continuing Care and Palliative Care unit (the "Unit"), where the Member worked. [Witness A] was responsible for the day-to-day operations of the Unit, working Monday to Friday 0830 to 1630.

[Witness A] described the patients on the Unit as vulnerable, awaiting Long-Term Care, unable to care for themselves and requiring 24-hour supervision. The staffing ratio was reflective of the complexity of the patients. Furthermore, due to the needs of the patient population, extra training and support was given to staff. This training was provided by hospital education staff. Further education was provided about memory loss and dementia, including education on the Gentle Persuasive Approach ("GPA"), a program which teaches strategies to approach and gently persuade a client to accept care; the P.I.E.C.E.S Program, which involves Physical, Intellectual, Emotional, Capabilities, Environmental and Social health; and a training program for nurses caring for patients with dementia. [Witness A] confirmed that the Member received such training.

[Witness A] described the routine of the Unit which included daily morning huddles. Team members worked together to provide care and ensure the safety of patients and staff.

[Witness A] testified that Patient A was admitted to the facility in late 2015. Patient A had a diagnosis of neurocognitive impairment with secondary agitation. She had experienced several falls and demonstrated difficulties consistent with cognitive impairment secondary to repeat subdural haematoma. Patient A was known to wear disposable gloves. Charting confirmed that Patient A is fixated on using the washroom, wearing gloves, ringing the call bell repeatedly and calling out for a nurse.

[Witness A] testified that on March 14, 2016 the Member ripped the gloves from Patient A's hand in an aggressive manner. [Witness A] was not present during this encounter, but it was relayed to her by Unit Helper, [Witness B], who observed the incident. [Witness A] asked [Witness B], the unit helper to provide details of the alleged incident via an email to her, which [Witness B] did.

[Witness A] confirmed that, as a result of the interaction with Patient A, the Member received a disciplinary action letter which indicated a one-day suspension and participation in a learning plan, which consisted of an Empathy video and the "*Power of Words*" video, as well the College's "*One is One Too Many*" video and the review of the College's *Therapeutic Nurse-Client Relationship Standard* (*"TNCR* Standard"). [Witness A] further testified that the abrupt removal of gloves from Patient A's hands and the comments made by the Member about Patient A do not fit with the Vision, Mission and Values of the organization in which the Member worked.

[Witness A] testified that another nurse, [Witness C], RPN, approached her regarding incidents involving the Member and Patient B and Patient C which occurred over the weekend of July 9 and

10, 2016. [Witness C] sent an email to [Witness A] (Exhibit 11) describing the incidents. She also received an email from [Witness D], RPN, who was a witness to the July 10, 2016 interaction. [Witness A] confirmed that Exhibits 11 and 13 respectively were those emails.

[Witness A] testified that she prepared and sent an email detailing the July 9 and 10 incidents to the Human Resources Department and the Executive team. [Witness A] was not able to speak to the Member, as in the interim, the Member had resigned from her position.

[Witness A] confirmed that the Member worked on Saturday, July 9, 2016 using the Daily Assignment sheet (Exhibit 10). [Witness A] testified that the two staff members [Witness C] and [Witness D] came to her with concerns about working with the Member and their hesitancy about making those concerns known out of concern that they might experience repercussions from reporting a colleague. The staff members were encouraged to provide their account of the incidents (Exhibit 8). Patient B suffered from Huntington's disease and experienced a lack of muscle control, including a lack of control over sudden movements. Patient B communicates using short words and can move from smiling to crying within seconds. Patient B is known to use a calming blanket which is gently laid on her face. During the alleged incident the Member was seen to have aggressively wrapped the patient's personal blanket around the patient's head, covering the patient's head and face which increased the patient's agitation level. The Member was then alleged to have put an eye mask on the patient and said, "if you can't see, then maybe you won't kick". The other team members and the manager were upset because a person with Huntington's disease requires kind and compassionate care. [Witness A] summarized what she was told in the emails. [Witness A] was not present for any of the allegations.

[Witness A] confirmed that the Member worked on Sunday, July 10, 2016 using the Daily Assignment sheet (Exhibit 12). The alleged incident occurred on July 10, 2016 to Patient C who was admitted in 2005 with obesity, personality disorder and long standing sacral and gluteal ulcers. Patient C was confined to a bed which made care difficult due to the positioning of the wound. Several staff were required to assist in moving Patient C. Wound care was known to be very painful and often the patient cried out in pain. According to other staff who were in the room at the time (Exhibits 8 and 11) the Member attempted to place a towel in Patient C's mouth in efforts to quiet her.

Witness 2 - [Witness B] - Unit Helper ("[Witness B]")

[Witness B] obtained a diploma in Social Service Work from Lambton College in 2006. [Witness B] received Gentle Persuasive Approach (GPA) and concurrent disorder training from the Facility. [Witness B] worked for 18 years on several units, including the Unit. [Witness B]'s role as a Unit Helper included helping the nurses, stocking shelves, making beds, and transporting patients. [Witness B] worked on the Unit during the time of the alleged incident on March 14, 2016. [Witness B] confirmed that information was received regarding patients during shift report, and that she received information not to stock shelves with gloves due to an infection control issue with Patient A wanting to wear gloves. [Witness B] testified that the wearing of gloves was a common type of occurrence with Patient A as she wanted to always wear them due to level of cognition.

On the day of the alleged incident, [Witness B] was preparing a lunch tray for Patient A when the Member aggressively ripped off the gloves from Patient A while yelling "you are not allowed to wear these gloves", "you are a liar" and "you are a little whoo hoo". [Witness B] noted Patient A was upset and yelled back at the Member. [Witness B] further testified that the Member did not ask Patient A to remove the gloves. [Witness B] further indicated that calling Patient A a liar was very inappropriate and abusive. [Witness B] testified that she worked the remainder of the shift without telling anyone what had happened but that she was in shock and very upset and was not sure what to do next. [Witness B] contacted her brother who is an RN, explained the situation to him and he then told her that she needed to report the behaviour to her manager. [Witness B] met with her manager to report the incident. [Witness B] never spoke to the Member regarding the incident and did not notice if the Patient was injured.

Witness 3 - [Witness C] – RPN ("[Witness C]")

[Witness C] obtained a diploma in the Practical Nurse Program from Lambton College, located in Sarnia, in 2014 and is a member of the College as an RPN. [Witness C] commenced working on the Unit in the late summer of 2015. [Witness C] testified that her responsibilities on the Unit included administering medications, providing personal care, providing baths, which required 2 staff members, and to get patients out of bed. The typical approach on the Unit is a team model and the team members assist each other in their duties. [Witness C] remembered working with the Member often and recalled Patient B as having Huntington's disease with a steady progression where the disease impacted the patient's involuntary muscles causing the patient to hit the staff.

[Witness C] recalled the alleged incident on July 9, 2016. The assigned staff member, confirmed by Exhibit 10, the Daily Assignment sheet, had commenced care to Patient B. [Witness C] responded to a noise or the call bell. [Witness C] provided a detailed description of the placement of team members as they were positioned in the room. [Witness C] noted that she was standing at the head of the bed on the right side, while the Member was on the left side of the bed. Patient B has a lightweight blanket, like a baby blanket, which was placed on her face to calm her down to fall asleep. The Member placed a blanket over Patient B's head and the patient was swearing and asked for the blanket to be removed. The Member got another blanket, similar in weight to a throw, which was purple and placed it over Patient B's head. Patient B became more aggressive. The Member was heard to have said "if you can't see us, you can't hit us." The purple blanket was removed by [Witness C] who was providing care. [Witness C] noted Patient B was swearing and upset.

[Witness C] noted that the Member's conduct in putting the blanket on the head of Patient B when it could not be removed on her own is not therapeutic. Patient B did not have the coordination to remove the blanket. [Witness C] stated that "this case has stayed with her even to this day". [Witness C] stated that she was "in shock" and wondered "what the Member was doing behind closed doors." [Witness C] testified to the vulnerability of the patients on the Unit, that they are unable to get out of bed, and require antipsychotic medications due to their behaviours. [Witness C] noted that the Member's conduct escalated the behaviours of Patient B. [Witness C] stated that she "had a therapeutic relation with Patient B". [Witness C] did not speak to the Member and stated that the Member "intimidates other team members and would throw fits" if the Member "did not get her way". [Witness C] spoke to her manager, [Witness A], regarding the alleged incident. [Witness A] requested an email with the details, which [Witness C] provided (Exhibit 11).

[Witness C] recalled being on shift with the Member, which was verified in Exhibit 12, the Daily Assignment sheet for July 10, 2016 the day of the alleged incident. Patient C was obese and suffered from dementia. Patient C had multiple wounds which required extensive care, Patient C was also incontinent which would cause dressing to become soiled and required frequent changes. Patient C required several staff to assist with positioning during wound care. On the day of the alleged incident [Witness C] was present in the room along with the Member. Patient C was yelling, and medication was given for pain but due to extensive wounds and the conditions of the wounds Patient C remained in pain. [Witness C] testified that the Member took a towel and tried to shove it in Patient C's mouth to shut her up. [Witness C] recalled grabbing the towel from the Member. The Member removed the towel from Patient C's mouth. [Witness C] spoke to [Witness A], who was the manager, [Witness A] requested an email regarding the Member's attempt to place a towel in Patient C's mouth in efforts to quiet her (Exhibit 11).

[Witness C] noted that the Member resigned before any communication could occur and there has been no further contact with the Member since her resignation.

Witness 4 - [Witness D] – RPN ("[Witness D]")

[Witness D] received a diploma from Lambton College in 2014 in the Practical Nurse program and has been a member of the College since 2014. [Witness D] worked on the Unit for 5 years before moving on to work as an RN. [Witness D] recalled working with the Member on the day of the incident on July 10, 2016, which is verified by (Exhibit 12), the Daily Assignment sheet.

[Witness D] recalled the events of July 10, 2016, and that Patient C was unable to ambulate, required extensive dressing and had comorbidities resulting in responsive behaviours. [Witness D] noted that wound dressing changes were very involved, which required 45 minutes to an hour, and up to 4 or more staff members, including security. Patient C was a heavy lady who could not stay on her side. [Witness D] recalled that on the day of the alleged incident, security was unable to attend due to an emergency. [Witness D] recalled that she was assigned to Patient C, hence, it was her responsibility to complete the wound dressing. [Witness D] noted that she was behind Patient C, who was lying on her left side. The Member was present in the room along with [Witness C] and [Witness D]. [Witness D] noted that she witnessed the action of the Member placing a face cloth to the face and mouth of Patient C in an attempt to stop Patient C from talking. [Witness D] did not recall who removed the cloth. [Witness D] stated that she did not recall leaving the room or speaking to the Member. [Witness D] described her reaction to the incident as being shocked, unnerved, and emotional. The incident was reported to her manager, [Witness A], by [Witness C]. [Witness A] called [Witness D] at home regarding the alleged incident. [Witness A] instructed [Witness D] to describe the incident via email on her next scheduled shift, which she did (Exhibit 3). [Witness D] never saw the Member again.

Expert Witness - Nicole T. Kirwan ("Ms. Kirwan")

Ms. Kirwan is a Mental Health Nurse for the Canadian Nurses Association, Certified Patient Safety Education Trainer, Inpatient Mental Health Nurse, and an expert in the area of nursing standards in cognitive complex disorders, working with vulnerable patients and in mental health. She was tendered by the College as an expert to provide opinions on whether the Member met the standards of practice. Ms. Kirwan provided her extensive curriculum vitae, which outlined her education

focused on mental health. Ms. Kirwan explained her background is in mental health and working with geriatric, often vulnerable patient populations, and that she has held a number of leadership roles specializing in mental health. Ms. Kirwan is well published with respect to mental health. The Panel qualified Ms. Kirwan as an expert in nursing practice in the areas of cognitive complex disorders and mental health.

College Counsel provided Ms. Kirwan with a hypothetical scenario to review and for her to give her expert opinion. The scenario detailed what happened between the Member and Patients A, B, and C. Ms. Kirwan reviewed this scenario and discussed expectations within the College's standards, including the *Professional Standards* and the *TNCR* Standard. Ms. Kirwan further reviewed her own practice and her expectations for her own students at the facility in which she works.

Ms. Kirwan highlighted the language in the *TNCR* Standard, on how to practice, that the practice applies to everyone, and the expectation is to have a professional relationship to improve the health and wellbeing of the patients. The *TNCR* Standard addresses the components of a therapeutic relationship, how to maintain proper practices, how to communicate effectively with patients, treating them with dignity and respect, taking the required time for care and modify as needed. It speaks about abusive behaviour, including verbal, emotional and physical abuse. Nurses should use a wide range of effective communication strategies. The Member's conduct was not what we expect of a nurse and empathy is far more helpful. Ms. Kirwan further stated that all behaviours have meaning and nurses must try to understand their clients' behaviour. Name calling of any kind is never acceptable.

In the hypothetical scenario, Ms. Kirwan spoke to the care of the vulnerable patient population, who may have difficulty expressing needs to their nurse. The nurse needs to understand the reason behind the behaviour. Yelling at patients, calling them a liar or name calling is not acceptable behaviour and is a breach of the *TNCR* Standard.

Ms. Kirwan referred to the *Professional Standards*, a guideline for all nurses to ensure they are engaged in best practices and their practice is in accordance with the required standards. Wrapping a patient's head is upsetting and scary for the patient and a use of force to have the blanket stay on. These behaviours are unacceptable, unprofessional and disgraceful. The Member did not consider the safety of the patient when she placed a towel in the patient's mouth, there is no therapeutic value for this behaviour and this behaviour does not demonstrate respect.

Ms. Kirwan further reviewed the expectations within the *TNCR* Standard related to dignity and respect. The Member did not understand the behaviour and did not adjust care based on the patient's needs. The Member's inappropriate comments to the patients constitute verbal abuse. Nurses need to understand behaviours. Not demonstrating empathy can cause harm to the patient. Using a loud threatening tone can make one more afraid; doing it in public as was done in the dining room, can further be embarrassing to the patient. These behaviours further constitute emotional abuse.

Taunting a person and attempting to intimidate a patient is not acceptable. The Member's actions demonstrated a lack of understanding. The Member demonstrated disrespect for the patients.

Ms. Kirwan was questioned on whether removing the gloves from the patient in an aggressive manner is a form of physical abuse. Ms. Kirwan testified that it was a breach of both the *Professional Standards* and the *TNCR* Standard, but that as there was no video she could not definitely say that it was abuse.

Ms. Kirwan testified that the Member's action in this case contravened and failed to meet the standards of practice of the profession.

Final Submissions

College Counsel submitted that the Member's conduct constitutes professional misconduct, a breach of the standards of practice, verbal, physical and emotional abuse, and should be considered dishonourable, disgraceful and unprofessional conduct. College Counsel asked the Panel to find that the alleged conduct did occur. College Counsel submitted that the clear and cogent evidence established the misconduct as set out in the Notice of Hearing and that, on that basis, the Panel should be able to make findings of misconduct as alleged in the Notice of Hearing. The College submitted that it had met the required onus and standard of proof.

College Counsel submitted that the testimony of the 4 fact witnesses was consistent as between each other and with the documents. There were no inconsistencies between them on the key points. College Counsel submitted that all of the witnesses were credible and reliable.

For allegations 1(a)(i), (ii), (iii), 2(a)(i), (ii), (iii), 3(a)(i), (ii) and (iii) in the Notice of Hearing, the evidence from the witnesses demonstrated that the Member ripped off Patient A's gloves without warning or consent and made inappropriate comments to Patient A. [Witness B] testified that the Member called Patient A a liar, and a "little whoo hoo" while gesturing to her head. This was upsetting to [Witness B]. [Witness A] testified that the Member received a one-day suspension and was placed on a Performance Improvement Plan (Exhibits 5 & 6) as a result of the interaction with Patient A.

With respect to allegations 1(b), 2(b) and 3(b) in the Notice of Hearing, the evidence demonstrated that Patient B kicked out at staff often as a result of the patient's involuntary movement, striking out hitting staff. [Witness C] reported on July 9, 2016, 2 months after the Member completed her Performance Improvement Plan, in an effort to stop the patient from hitting the Member, she wrapped a blanket around Patient B's head so that the patient could not remove it, causing distress to the patient who said "fucking eyes off eyes". The blanket was removed and was then replaced by the Member with a thicker blanket. This was upsetting to [Witness C]. The expert witness Ms. Kirwan noted that the Member by wrapping the blanket around the patient's head breached the *Professional Standards*, the *TNCR* Standard and her conduct is both physical and emotional abuse.

Concerning allegations 1(c), 2(c) and 3(c) in the Notice of Hearing, Patient C often screamed during wound care. While Patient C was in pain, one witness saw the Member place a towel over her face and mouth, while another saw the Member place the towel over Patient C's face and into the patient's mouth. Touching without consent is considered physical abuse. It could also leave an impact on the patient's trust of nurses going forward.

For allegations 1(a)(i), (ii) and (iii) in the Notice of Hearing, Ms. Kirwan noted that yelling at a patient and saying that you are not allowed to wear gloves, and you are a liar, does not demonstrate best practice and is a breach of the *Professional Standards* and the *TNCR* Standard. Ms. Kirwan noted that ripping off gloves from the patient's hand is a breach of the *Professional Standards* and the *TNCR* Standard and is disrespectful and alarming. Ms. Kirwan noted that calling the patient a "little whoo hoo", is disrespectful and belittling and, in the presence of others, likely is embarrassing and also a breach of the *Professional Standards* and the *TNCR* Standard.

Yelling at the patient as alleged in allegations 2(a)(i), (ii) and (iii) in the Notice of Hearing, is verbal abuse, as is calling a client names. Ripping off the patient's gloves constitutes physical abuse without providing any other strategies to help the patient remove the gloves.

With respect to allegations 3(a)(i), (ii), (iii), 3(b) and 3(c) in the Notice of Hearing, yelling at a patient, ripping gloves from a patient's hand, wrapping the patient's face with a blanket and placing a towel in a patient's mouth is disgraceful, dishonourable and unprofessional conduct, especially given the vulnerability of the residents. It is a serious breach of trust as the patients are reliant on the nurse for care.

College Counsel provided the Panel with two cases for consideration.

CNO v. Cook (Discipline Committee, 2018) was a case in which the Panel found the member's conduct to be verbal and physical abuse and reasonably regarded as disgraceful, dishonourable and unprofessional.

CNO v. Agustin (Discipline Committee, 2019) was a similar case involving abuse of an elderly client with dementia towards whom the member exhibited taunting and demeaning behaviour. The member admitted to the facts and her conduct was found to be a breach of the standards, abusive and 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)(i), (ii), (iii), 1(b), 1(c), 2(a)(i), (ii), (iii), 2(b) and 2(c) of the Notice of Hearing. With respect to allegations 2(a)(i), (ii), (iii), 2(b) and 2(c), the Panel finds that the Member verbally, physically and emotionally abused the patients. As to allegations 3(a)(i), (ii), (iii), 3(b) and 3(c), 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 credibility of each witness was assessed by the Panel based on the criteria laid out in *Re Pitts and Director of Family Benefits Branch of the Ministry of Community & Social Services* (1985), 51 O.R. 2(d) 302.

The Panel considered the recollections and consistency of the testimony of all four fact witnesses who were present for the incidents. The Panel determined that the evidence provided by the witnesses was credible and clear, cogent and convincing. They were able to describe the Member ripping gloves off Patient A's hand, yelling and calling the patient inappropriate names, wrapping Patient B's head with a blanket, and placing a towel in Patient C's mouth. [Witness B] described the Member ripping the gloves from Patient A's hand and also using terms such as "you are a liar, and you are a little whoo hoo". [Witness C] and [Witness D] both described the Member placing a towel on Patient C's face. The similarity of the witnesses' descriptions of the Member's actions and attitude during the incidents, and the details that they provided were considered by the Panel in accepting their evidence in making the decision concerning the Member's verbal and emotional abuse of the patient.

Ms. Kirwan, the expert witness was qualified by the Panel as an expert in nursing practice in the area of cognitive complex issues.

Ms. Kirwan's opinion was objective, reasonable and impartial. It was substantiated by the factual evidence accepted by the Panel. The Panel found her to be credible and accepted and relied on her opinion evidence to find that the Member's conduct constituted a breach of the *Professional Standards* and the *TNCR* Standard.

Ms. Kirwan also highlighted the *TNCR* Standard that addresses abuse of a patient, the prevention of abuse and also speaks to communicating with the patient, treating them with dignity and respect, taking the required time to do the care and modifying as needed. The Member's actions of placing a towel in Patient C's mouth and wrapping a blanket around Patient B's head and the words and tone of voice used towards the patients all breached the expectations set out in the *TNCR* Standard.

Ms. Kirwan stated that the use of inappropriate comments by the Member is considered verbal and emotional abuse as the comments are disrespectful.

Ms. Kirwan's opinion was objective, reasonable and impartial. It was substantiated by the factual evidence accepted by the Panel. The Panel found her to be credible and accepted and relied on her opinion evidence to find that the Member's conduct constituted a breach of *Professional Standards* and the *TNCR* Standard.

As such, having accepted the evidence of the witnesses including that of Ms. Kirwan, the Panel was satisfied that the member verbally, physically and emotionally abused the patients as alleged.

With regards to the allegations in paragraph 3 of the Notice of Hearing, the Panel found the Member's conduct would be considered by members of the profession to be disgraceful, dishonourable and unprofessional. The Member's comments and actions in (a) ripping gloves off of Patient A's hand and making inappropriate comments about the resident; (b) wrapping the blanket on Patient B's head and (c) placing a towel in Patient C's mouth, were unprofessional as these actions showed a serious disregard for her professional obligations. Her conduct was dishonourable as she failed to live up to the standards expected of her as a professional and she knew or ought to have known that her conduct was unacceptable. The Member's conduct was also disgraceful as she

shamed herself and the profession. Her conduct casts serious doubt on her moral fitness and inherent ability to discharge the higher obligations the public expects the profession to meet. The Member should have known that her actions and comments were wrong and as a professional should have taken steps to protect the vulnerable patients in her care.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should 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 6 months. This suspension shall take effect from the date the Member obtains an active certificate of registration 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 her own expense and within 6 months from the date the Member obtains an active certificate of registration. If the Expert determines that a greater number of session are required, the Expert will advise the Director, 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 the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by 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, and
            3. 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. *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 her own expense, including the self-directed *Nurses' Workbook*;

v. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms 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 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;

viii. If the Member does not comply with any 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 18 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, and
      3. a copy of the Panel's Decision and Reasons, once available;

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

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

c) The Member shall not practice independently in the community for a period of 18 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.

College Counsel submitted that there are multiple factors to consider with respect to the penalty. Protection of the public is the primary duty of the College, along with maintaining public confidence and the effectiveness of the College to self-regulate. Specific deterrence to the Member and general deterrence to the other members of the College are all considerations for the Panel when making a penalty decision.

The aggravating factors were that the Member's conduct was serious and showed a lack of respect and empathy for vulnerable patients. It showed poor judgment and questions her moral fitness. It also brings discredit and shame to the profession.

The Member did not attend the hearing, so there is no information concerning the Member's circumstances in mitigation of the penalty apart from the fact that she has no prior discipline history with the College.

The Member's conduct calls for a significant suspension and remedial training.

The College submitted that the penalty that it seeks is consistent with that found in other cases, protects the public, and meets all of the requirements of a self-regulating body.

College Counsel provided four cases which are previous cases of the Discipline Committee for the Panel to consider. All four cases contain some similar aspects to the case before this Panel. The penalties ordered in the precedent cases are consistent with what the College is asking for in this case.

CNO v. Agustin (Discipline Committee, 2019). In this case, the member spoke to the client in a raised voiced and/or with an angry tone and/or used words to the effect of "oh there is shit everywhere" and struck a client on or around the face with the client's shoe and/or slipper. The member also failed to appropriately document and or follow-up on having struck a client on or around the face with the client's shoe and/or slipper. The member was given an oral reprimand, a four month suspension, two meetings with a Nursing Expert and 18 months of employer notification.

CNO v. Klein (Discipline Committee, 2019). In this case, the member raised his voice in an inappropriate, unprofessional and/or non-therapeutic manner, made inappropriate, unprofessional and/or non-therapeutic comments, and left a patient crying and naked in bed. This case involved three separate patients and the conduct constituted a breach of the standards and verbal abuse. The member received an oral reprimand, a five month suspension, two meetings with a Regulatory Expert and 18 months of employer notification.

CNO v. Thompson (Discipline Committee, 2019). In this case, the member failed to engage in therapeutic communications with the patient, used excessive force and/or held the patient down on the stretcher. The member received an oral reprimand, a six month suspension, two meetings with a Regulatory Expert, 18 months of employer notification and 18 months of no independent practice in the community

CNO v. Cook (Discipline Committee, 2018). In this case, the member was not present. The allegations were that the member made rude and inappropriate comments about the client and threw bunched up paper towel(s) at the client's face. The member was given an oral reprimand, a six month suspension, two meetings with a Regulatory Expert and 18 months of employer notification.

Penalty Decision

The Panel deliberated and decided to accept the College's proposed order on penalty 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 6 months. This suspension shall take effect from the date the Member obtains an active

certificate of registration 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 her own expense and within 6 months from the date the Member obtains an active certificate of registration. If the Expert determines that a greater number of session are required, the Expert will advise the Director, 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 the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by 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, and
            3. 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. *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 her own expense, including the self-directed *Nurses' Workbook*;

        v. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms 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 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;

viii. If the Member does not comply with any 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 18 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, and
3. a copy of the Panel's Decision and Reasons, once available;

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

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

c) The Member shall not practice independently in the community for a period of 18 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 found that the terms of the order set out by the College met all of the principles required of a penalty.

The suspension of six months, the two meetings with a Regulatory Expert, the 18 months of employer notification requirement and 18 months of not being able to practice independently will protect the public by ensuring that the Member will be monitored and that she is not given the chance to harm the public any further. It will also provide the Member with the opportunity to remediate her practice while showing that the College takes such misconduct seriously.
The oral reprimand and suspension will act as specific deterrence to the Member. They will also act as general deterrence to other members of the College by sending a message that there are serious consequences for this kind of behaviour. Other members will have the opportunity to learn from this Member's mistakes and ensure that they do not repeat them in their own practice as abusive behaviour is never tolerated.

The penalty is in line with what has been ordered in previous cases in similar circumstances.

I, Margarita Cleghorne, RPN, sign this decision and reasons for the decision on behalf of the Chairperson of this Discipline Panel and the members of the Discipline Panel.