DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Terry Holland, RPN	Chairperson
	Sylvia Douglas	Public Member
	Lalitha Poonasamy	Public Member
	Michael Schroder, NP	Member
	Heather Stevanka, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
KEVIN LINNEN	)	PHILIP B. ABBINK for
Registration No. 9608399	)	Kevin Linnen
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 20, 2020

AMENDED 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 July 20, 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 Kevin Linnen.

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 Kevin Linnen.

The Allegations

The allegations against Kevin Linnen (the "Member") as stated in the amended Notice of Hearing dated July 9, 2020 are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.1) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, in that while practicing as a Registered Nurse in the Extended Class at the Georgian Nurse Practitioner Led Clinic (the "Facility"), you sexually abused [Patient A] on or about September 22, 2016, when in the course of performing a pap smear you made remarks of a sexual nature, including remarks to the effect of:

    (a) the use of a pediatric speculum;

    (b) the strength of [Patient A]'s pelvic muscles; and/or

    (c) [Patient A]'s boyfriend must like her pelvic muscles.

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(1) of *Ontario Regulation 799/93*, in that while practicing as a Registered Nurse in the Extended Class at the Facility, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

    (a) you performed the controlled act of prescribing, dispensing, selling or compounding a drug, in violation of s. 27(1) of the *Regulated Health Professions Act, 1991*, and/or s. 4 and/or s. 5.1(1) of the *Nursing Act, 1991*, in that:

        i. on or about September 26, 2012, you signed a prescription for ativan for [Patient B];

        ii. on or about January 25, 2013, you signed a prescription for lorazepam for [Patient C];

        iii. on or about April 16, 2013, you signed a prescription for lorazepam for [Patient C];

        iv. on or about May 5, 2013, you signed a prescription for lorazepam for [Patient C];

    (b) you failed to adequately assess and/or document your assessment prior to signing prescriptions for [Patient D] on or about July 9, 2016;

    (c) you failed to appropriately document prescriptions for [Patient D] on or about July 9, 2016;

    (d) you misrepresented the reason for the quantity of medications to be prescribed to [Patient D], on or about July 9, 2016;

    (e) you failed to maintain appropriate therapeutic nurse-client boundaries with [Patient E], including asking her out to dinner, in or around Summer 2016;

(f) you failed to maintain appropriate therapeutic nurse-client boundaries with [Patient A] on or about September 22, 2016, when in the course of performing a pap smear you made remarks of a sexual nature, including remarks to the effect of:

i. the use of a pediatric speculum;

ii. the strength of [Patient A]'s pelvic muscles; and/or

iii. [Patient A]'s boyfriend must like her pelvic muscles.

(g) you failed to appropriately formulate and implement an appropriate plan of care for [Patient F] between April 2017 and May 2018, including:

i. you prescribed excessive kinds, amounts and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications which were not indicated by [Patient F]'s diagnoses and/or failed to document [Patient F]'s diagnoses; and/or

v. you prescribed [Patient F] controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications;

(h) you failed to appropriately formulate and implement an appropriate plan of care for [Patient G] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications which were not indicated by [Patient G]'s diagnoses and/or failed to document her diagnoses;

v. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

vi. you failed to intervene appropriately with respect to [Patient G]'s potential substance misuse, and/or addiction and/or failed to document your intervention;

(i) you failed to appropriately formulate and implement an appropriate plan of care for [Patient H] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

v. you failed to intervene appropriately with respect to [Patient H]'s potential substance misuse, and/or addiction and/or failed to document your intervention;

(j) you failed to appropriately formulate and implement an appropriate plan of care for [Patient I] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use; and/or

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

(k) you failed to appropriately formulate and implement an appropriate plan of care for [Patient I] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use; and/or

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications.

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, while practicing as a Registered Nurse in the Extended Class at the Facility, you failed to keep records as required, and in particular:

(a) you failed to appropriately document your assessment prior to signing prescriptions for [Patient D] on or about July 9, 2016;

(b) you failed to appropriately document prescriptions for [Patient D] on or about July 9, 2016;

(c) you failed to appropriately document the care you provided [Patient F] between April 2017 and May 2018, including:

i. you failed to adequately document prescriptions of controlled substances and/or other medications;

ii. you failed to adequately document [Patient F]'s diagnoses;

iii. you failed to adequately document your assessments in relation to the prescription of controlled substances and/or other medications;

iv. you failed to adequately document your monitoring of [Patient F]'s use in relation to the prescription of controlled substances and/or other medications;

(d) you failed to document the care you provided [Patient G] between April 2017 and May 2018, including:

i. you failed to adequately document prescriptions of controlled substances and/or other medications;

ii. you failed to adequately document your assessments in relation to the prescription of controlled substances and/or other medications;

iii. you failed to adequately document your monitoring of [Patient G]'s use in relation to the prescription of controlled substances and/or other medications;

iv. you failed to adequately document any intervention with respect to [Patient G]'s potential substance misuse, and/or addiction;

(e) you failed to document the care you provided [Patient H] between April 2017 and May 2018, including:

i. you failed to adequately document prescriptions of controlled substances and/or other medications;

ii. you failed to adequately document your assessments in relation to the prescription of controlled substances and/or other medications;

iii. you failed to adequately document your monitoring of [Patient H]'s use in relation to the prescription of controlled substances and/or other medications;

iv. you failed to adequately document any intervention with respect to [Patient H]'s potential substance misuse, and/or addiction;

(f) you failed to document the care you provided [Patient I] between April 2017 and May 2018, including:

i. you failed to adequately document prescriptions of controlled substances and/or other medications;

ii. you failed to adequately document your assessments in relation to the prescription of controlled substances and/or other medications; and/or

iii. you failed to adequately document your monitoring of [Patient I]'s use in relation to the prescription of controlled substances and/or other medications; and/or

(g) you failed to document the care you provided [Patient J] between April 2017 and May 2018, including:

i. you failed to adequately document prescriptions of controlled substances and/or other medications;

ii. you failed to adequately document your assessments in relation to the prescription of controlled substances and/or other medications; and/or

iii. you failed to adequately document your monitoring of [Patient J]'s use in relation to the prescription of controlled substances and/or other medications.

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(15) of Ontario Regulation 799/93, in that, while in that, while practicing as a Registered Nurse in the Extended Class at the Facility, you signed or issued, in your professional capacity, a document that you knew, or ought to have known contained a false or misleading statement with respect to the reason for the quantity of medications prescribed to Patient [D], on or about July 9, 2016.

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 while practicing as a Registered Nurse in the Extended Class at the Facility, you engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

   (a) you performed the controlled act of prescribing, dispensing, selling or compounding a drug, in violation of s. 27(1) of the *Regulated Health Professions Act, 1991*, and/or s. 4 and/or s. 5.1(1) of the *Nursing Act, 1991*, in that:

      i. on or about September 26, 2012, you signed a prescription for ativan for Patient [B];

      ii. on or about January 25, 2013, you signed a prescription for lorazepam for Patient [C];

      iii. on or about April 16, 2013, you signed a prescription for lorazepam for Patient [C]; and/or

      iv. on or about May 5, 2013, you signed a prescription for lorazepam for Patient [C];

   (b) you failed to adequately assess and/or document your assessment prior to signing prescriptions for Patient [D] on or about July 9, 2016;

   (c) you failed to appropriately document prescriptions for Patient [D] on or about July 9, 2016;

   (d) you misrepresented the reason for the quantity of medications to be prescribed to Patient [D], on or about July 9, 2016;

   (e) you failed to maintain appropriate therapeutic nurse-client boundaries with Patient [E], including asking her out to dinner, in or around Summer 2016;

(f) you failed to maintain appropriate therapeutic nurse-client boundaries with Patient [A] on or about September 22, 2016, when in the course of performing a pap smear you made remarks of a sexual nature, including remarks to the effect of:

i. the use of a pediatric speculum;

ii. the strength of [Patient A]'s pelvic muscles; and/or

iii. [Patient A]'s boyfriend must like her pelvic muscles.

(g) you failed to appropriately formulate and implement an appropriate plan of care for Patient [F] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications which were not indicated by [Patient F]'s diagnoses and/or failed to document [Patient F]'s diagnoses; and/or

v. you prescribed [Patient F] controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications;

(h) you failed to appropriately formulate and implement an appropriate plan of care for [Patient G] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications which were not indicated by [Patient G]'s diagnoses and/or failed to document her diagnoses;

v. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

vi. you failed to intervene appropriately with respect to [Patient G]'s potential substance misuse, and/or addiction and/or failed to document your intervention;

(i) you failed to appropriately formulate and implement an appropriate plan of care for Patient [H] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use;

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

v. you failed to intervene appropriately with respect to [Patient H]'s potential substance misuse, and/or addiction and/or failed to document your intervention;

(j) you failed to appropriately formulate and implement an appropriate plan of care for Patient [I] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use; and/or

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications; and/or

(k) you failed to appropriately formulate and implement an appropriate plan of care for Patient [J] between April 2017 and May 2018, including:

i. you prescribed excessive numbers and/or doses of controlled substances and/or other medications;

ii. you prescribed controlled substances and/or other medications without adequate assessments and/or failed to document your assessments;

iii. you prescribed controlled substances and/or other medications without adequately monitoring use and/or failed to document your monitoring of use; and/or

iv. you prescribed controlled substances and/or other medications without adequate documentation supporting the appropriateness of prescribing these controlled substances and/or medications.

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 while practicing as a Registered Nurse in the Extended Class at the Georgian Nurse Practitioner Led Clinic in Barrie, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

   (a) you failed to maintain appropriate boundaries of the therapeutic nurse-patient relationship with Patient [K], including but not limited to the following:

      i. you made inappropriate remarks to Patient [K], including but not limited to:

         1. remarks about her height;
         2. remarks about her hair;
         3. remarks about her "modelling career", or words to that effect; and/or
         4. remarks about how "beautiful" she was, or words to that effect;

      ii. you touched and/or stroked Patient [K] for no clinical purpose; and/or

      iii. you told Patient [K] she could contact you outside of her patient appointments for no articulated therapeutic need; and/or

   (b) you suggested to Patient [K] she should select the medication(s) she wanted to be prescribed.

7. You have committed an act of professional misconduct as provided by sub-section 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991, S.O. 1991, c. 32, as amended, and sub-section 1(7) of *Ontario Regulation 799/93* in that while practicing as a Registered Nurse in the Extended Class at the Facility, you abused a client, verbally, physically and/or emotionally in that:

   (a) you made inappropriate remarks to Patient [K], including but not limited to:

i. remarks about her height;
ii. remarks about her hair;
iii. remarks about her "modelling career", or words to that effect; and/or
iv. remarks about how "beautiful" she was, or words to that effect;

(b) you touched and/or stroked Patient [K] for no clinical purpose.

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 while practicing as a Registered Nurse in the Extended Class at the Facility, you engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

(a) you made inappropriate remarks to Patient [K], including but not limited to:

i. remarks about her height;
ii. remarks about her hair;
iii. remarks about her "modelling career", or words to that effect; and/or
iv. remarks about how "beautiful" she was, or words to that effect;

(b) you told Patient [K] she could contact you outside of her patient appointments for no articulated therapeutic need;

(c) you touched and/or stroked Patient [K] for no clinical purpose; and/or

(d) you suggested to Patient [K] she should select the medication(s) she wanted to be prescribed.

Member's Plea

The Member admitted the allegations set out in paragraphs #1(a), (b), (c), #2(a)(i), (ii), (iii), (iv), #2(b), #2(c), #2(d), #2(e), #2(f)(i), (ii), (iii),#2(g)(i), (ii), (iii), (iv), (v),#2(h)(i), (ii), (iii), (iv), (v), (vi), #2(i)(i), (ii), (iii), (iv), (v), #2(j)(i), (ii), (iii), (iv), #2(k)(i), (ii), (iii), (iv), 3(a), #3(b), #3(c)(i), (ii), (iii), (iv), #3(d)(i), (ii), (iii), (iv), #3(e)(i), (ii), (iii), (iv), #3(f)(i), (ii), (iii), #3(g)(i), (ii), (iii), #4, #5(a)(i), (ii), (iii), (iv), #5(b), #5(c), #5(d), #5(e), #5(f)(i), (ii), (iii), #5(g)(i), (ii), (iii), (iv), (v), #5(h)(i), (ii), (iii), (iv), (v), (vi), #5(i)(i), (ii), (iii), (iv), (v), #5(j)(i), (ii), (iii), (iv), #5(k)(i), (ii), (iii), (iv), #6(a)(i)(1,2,3,4), (ii), (iii), #6(b), #7(a)(i), (ii), (iii), (iv), #7(b) and #8(a) (i), (ii), (iii), (iv), #8(b), #8(c), #8(d) in the Notice of Hearing.

The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Kevin Linnen (the "Member") graduated from a nursing program at the University of Saskatchewan in 1989.

2. The Member initially registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on November 28, 1995. The Member has been registered in the Extended Class since November 22, 2004, practicing as a Nurse Practitioner ("NP"). The Member's certificate of registration was suspended on an interim basis from June 27, 2018 to October 31, 2018. Since October 31, 2018, interim terms, conditions or limitations have been in place on the Member's certificate of registration.

3. The incidents took place while the Member was employed at the Georgian Nurse Practitioner Led Clinic in Barrie, Ontario (the "Clinic"). His employment was terminated on May 8, 2018, for reasons unrelated to the indents relevant to the allegations of professional misconduct.

4. If the Member were to testify, he would say that he has always strived to provide the highest quality healthcare possible to his patients. He would further testify that he has tried to be a caring, conscientious practitioner, with a commitment to lifelong learning in an effort to optimize the care he provides. He is deeply apologetic for any harm his conduct caused.

5. If the Member were to testify, he would say that at the time of these incidents, there was a profound shortage of primary health care providers at the Clinic. The Member acknowledges that this does not relieve him of his professional obligations.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Breach of Boundaries and Sexual Abuse

Patient [E]

6. The Member provided care to [Patient E] between at least 2016 and 2018. In the summer of 2016, the Member asked [Patient E] out to dinner, telling her that she was "like the daughter he never had."

7. The Member admits and acknowledges that this conduct was a breach of the standards of practice, including CNO's *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard*"), which requires nurses to set and maintain appropriate boundaries within the therapeutic relationship. The Member further admits and acknowledges that this conduct was a breach of the boundaries of the nurse-patient relationship.

Patient [A]

8. On September 22, 2016, during the course of performing a pap smear on [Patient A], the Member told her that he had to use a pediatric speculum, her pelvic muscles were strong, and that her "boyfriend must like that."

9. [Patient A] described the Member's comments as "creepy and inappropriate", as she was in a vulnerable position, laying on her back and exposed. If the Member were to testify, he would note that [Patient A] also described him as an "excellent nurse".

10. The Member nevertheless admits and acknowledges that his comments amounted to sexual abuse as they were remarks of a sexual nature. He further admits and acknowledges that his comments were a breach of the standards of practice, and the boundaries of the nurse-patient relationship.

Patient [K]

11. The Member provided [Patient K] with care between August 2013 and March 2018.

12. On [Patient K]'s first or second visit with the Member, which took place in 2013, the Member made comments about her height, her hair and her modeling career. [Patient K] describes that the Member "hit on" her.

13. On one occasion during the period the Member provided [Patient K] with care, he used words to the effect of how "beautiful" she was when he drew [Patient K]'s blood. On this occasion, the Member also engaged in inappropriate physical contact in that he:

    - stroked [Patient K]'s neck;
    - held and stroked [Patient K]'s hand; and
    - when he drew blood from [Patient K], he ran his fingers up and down [Patient K]'s arm.

14. The Member also gave [Patient K] his business card and told her words of the effect to "text me anytime, don't go to a walk-in, text me anything you need and I'll get it for you."

15. In addition, on another visit, the Member opened a book of medication and told [Patient K] to pick whatever she wanted.

16. The Member admits and acknowledges that this conduct towards Patient [K] was a breach of the standards of practice, and a breach of the boundaries of the nurse-patient relationship.

Prescription Issues

Patients [B] and Patient [C]

17. On September 26, 2012, the Member signed a prescription for Ativan for [Patient B].

18. On January 25, 2013, April 16, 2013 and May 5, 2013, the Member signed prescriptions for lorazepam for [Patient C].

19. Ativan and lorazepam are controlled substances, which NPs were not authorized to prescribe at the time the Member prescribed these substances to [Patient B] and [Patient C]. If the Member were to testify, he would say that the practice at the Facility at the time was that a physician would co-sign prescriptions for controlled substances. If the Member were to testify, he would also state that many, if not most, of his prescriptions around this time followed this practice of obtaining the approval and co-signature of a physician. If the Member were to further testify, he would testify that these incidents were errors, and it was never his intention to prescribe controlled substances without authorization. The Member, however, acknowledges that in prescribing these controlled substances, he performed a controlled act which he was not authorized to perform, contrary to the *Regulated Health Professions Act, 1991*.

Patient [D]

20. On July 8, 2016, [Patient D] sent the Member a text message asking him to submit a prescription to her pharmacy for a "new antibiotic" for her acne. She also requested refills of two drugs, one of which was clonazepam, a controlled substance.

21. The following day, on July 9, 2016, [Patient D] sent the Member another text message asking the Member for refills so she could "stock up on" her medications before her benefits ran out. [Patient D] specifically asked the Member for prescriptions for cipralex, clonazepam, tricyclene lo and "monocyclene".

22. The Member responded that he would prescribe [Patient D] those medications and that he would say the reason for the increased quantity was that [Patient D] was travelling for 4-5 months.

23. On July 8, 2016, the Member prescribed [Patient D] cipralex, try-cyclen and minocycline without completing an assessment of [Patient D], and without documenting the prescriptions in [Patient D]'s health records.

24. The Member admits and acknowledges that his conduct was contrary to the *Documentation* and the *Nurse Practitioner* Standards which require that NPs record prescriptions in a patient's health records.

25. The same day, [Doctor A] prescribed [Patient D] clonazepam. The Member sent [Doctor A] a note stating, "patient travelling, increased quantity authorized". The Member acknowledges this statement was untrue and/or misleading.

Patient [F]

26. The Member provided care to [Patient F] between August 2013 and April 2018. [Patient F] had arthritis, which her rheumatologist agreed required opioid treatment.

27. The Member prescribed [Patient F] large quantities of hydromorphone and Percocet, being more than one class of opioids, as well as benzodiazepines. When another NP assumed [Patient F]'s care after the Member, [Patient F] reported that "I feel I have been over-prescribed, misguided, and I don't want to be on this stuff anymore."

28. The following concerns also arose out of the care the Member provided to [Patient F]:

    - Most of the Member's appointments with [Patient F] between April 2017 and May 2018 were phone appointments, including at least nine occasions on which the Member prescribed her lorazepam, a controlled substance, on the basis of a phone call.

    - The Member prescribed [Patient F] lorazepam for what the Member recorded as a "general anxiety disorder"; however, there are no notes or assessment supporting this diagnosis.

    - The Member's clinical notes do not record assessments of the appropriateness of the prescriptions for [Patient F]'s diagnosis prior to prescription.

    - In July 2017, [Patient F] attended a chronic pain consultation where her urine drug screen tested positive for cocaine. The physician pain specialist recommended that [Patient F]'s health care providers warn [Patient F] that they would be unable to provide her with opioids if urine drug screens continued to test positive for cocaine. There is no record that the Member performed urine screening tests to determine if she was still using cocaine. The pain specialist also recommended that [Patient F]'s opioid regime be simplified from three opioids to one. The Member continued to prescribe [Patient F] analgesics as before.

<u>Patient [G]</u>

29. The Member provided care to [Patient G] between April 2015 and May 2018. [Patient G] had a history of substance use with alcohol and narcotics.

30. The Member prescribed too many medications to [Patient G] in too large a dose for a patient with [Patient G]'s narcotic and alcohol history. The Member prescribed [Patient G] both controlled substances and other analgesics, including trazadone and Imovane at bedtime, hydromorphone, Percocet, Tylenol 3, and a muscle relaxant typically used for patients with MS or severe back issues. There was also no narcotic contract and no random drug screening was in place.

31. The following concerns also arose out of the care the Member provided to [Patient G]:

- The Member's charting was sparse and suggests most of his appointments with [Patient G] were phone appointments. The Member completed minimal charting which explained the basis on which he prescribed the various medications. The only diagnosis apparent from the Member's records is for a chronic headache.

- [Patient G] had also been calling in frequently for early releases, increased dosages, and her boyfriend was calling in, all of which should have alerted the Member to a concern.

- While the Member may have been attempting to wean [Patient G] off some of her medications, there is no indication that the Member took concrete steps to ensure she received comprehensive in-patient treatment promptly. The NP who assumed [Patient G]'s care after the Member, referred [Patient G] to a substance use program almost immediately upon assuming care.

Patient [H]

32. The Member provided Patient [H] with care between March 2014 and May 2018. [Patient H] had a history of grief, depression, substance abuse, and ADHD.

33. The Member prescribed [Patient H] Xanax at bedtime, and an increasing dosage of clonazepam. Both drugs are benzodiazepines, which are a last resort, and should not both be prescribed at the same time. The Member's clinical note on April 28, 2017, recorded that it was "not ideal" that [Patient H] was on two benzodiazepines; however, he appears to have continued to prescribe two different benzodiazepines until May 2018.

34. Also of concern is that the Member did not document and/or complete an assessment of [Patient H]'s risk of use, and most of the Member's appointments with [Patient H] were phone appointments.

Patient [I]

35. The Member provided [Patient I] with care between July 2015 and April 2018. [Patient I] had a significant mental health history.

36. The NP who assumed [Patient I]'s care from the Member in May 2018 had difficulty doing so, including determining her current medication list, because the Member had documented very little on [Patient I]'s chart.

37. Based on what the Member did record, he prescribed [Patient I] Ativan at some time before March 2018, when he refilled the prescription, however it is not clear from his documentation when he initially did so, or the basis on which he did.

38. The Member also overprescribed [Patient I] benzodiazepines which were not working for [Patient I] at the time the following NP assumed care. There was no narcotic contract on file, no documentation reviewing or assessing her condition, no screening tools for her risk of use, and a number of [Patient I]'s appointments were telephone appointments.

Patient [J]

39. The Member provided [Patient J] with care between July 2013 and May 2018. [Patient J] experienced sleep issues, an anxiety disorder, and injuries which required analgesics.

40. The NP who assumed [Patient J]'s care from the Member in May 2018 had difficulty doing so because of the Member's lack of documentation.

41. Based on what the Member did record, he prescribed [Patient J] two benzodiazepines, temazepam, and oxazepam. There was no narcotic contract on file, no documentation reviewing or assessing [Patient J]'s condition on an ongoing basis, no screening tools for her risk of use, and a number of the appointments following which the Member refilled her benzodiazepine prescriptions were telephone appointments.

42. In addition, [Patient J] was also taking other pain medications, Tylenol 2 and Tylenol 3, as well as Toradol, with no meaningful care plan to manage her pain.

CNO STANDARDS

43. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets legislative requirements and the standards of practice of the profession. A nurse demonstrates this standard by providing, facilitating, advocating and promoting the best possible care for patients.

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

45. In addition, CNO's *Professional Standards* further provides that a nurse demonstrates leadership by actions such as role-modelling professional values, beliefs and attributes.

46. CNO's *TNCR Standard* places the responsibility for establishing and maintaining the limits and boundaries in the therapeutic nurse-patient relationship on the nurse. The *TNCR Standard* provides that:

> crossing a boundary means that the care provider is misusing the power in the relationship to meet his/her personal needs, rather than the needs of the [patient], or behaving in an unprofessional manner with the [patient].

47. With respect to maintaining boundaries, a nurse demonstrates having met the *TNCR Standard* by actions such as:

- setting and maintaining the appropriate boundaries within the relationship, and helping [patients] understand when their requests are beyond the limits of the therapeutic relationship;

- developing and following a comprehensive care plan with the [patient] and health care team that aims to meet the [patient's] needs

- ensuring that any approach or activity that could be perceived as a boundary crossing is included in the care plan developed by the health care team;

- continually clarifying her/his role in the therapeutic relationship, especially in situations in which the [patient] may become unclear about the boundaries and limits of the relationship;

- consulting with colleagues and/or the manager in any situation in which it is unclear whether a behaviour may cross a boundary of the therapeutic relationship; and

- documenting [patient]-specific information in the [patient's] record regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation.

48. CNO's *TNCR Standard* also requires nurses to protect the patient from harm by ensuring that abuse is prevented or stopped and reported. With respect to protecting the patient from abuse, a nurse demonstrates having met the *TNCR Standard* by actions such as:

    - not engaging in behaviours toward a [patient] that may be perceived by the [patient] and/or others to be violent, threatening or intending to inflict physical harm;

    - not engaging in behaviours with a [patient] or making remarks that may reasonably be perceived by other nurses and/or others to be romantic, sexually suggestive, exploitive and/or sexually abusive; and

    - not exhibiting physical, verbal and non-verbal behaviours toward a [patient] that demonstrate disrespect for the [patient] and/or are perceived by the [patient] and/or others as abusive.

49. In addition, the *TNCR Standard* further provides that sexual abuse includes sexually demeaning, seductive, suggestive, exploitative, derogatory or humiliating behaviour, comments or language toward a patient, and touching of a sexual nature or touching that may be perceived by the patient or others to be sexual.

50. CNO's *Documentation Standard* provides that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. The *Documentation 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 both objective and subjective data ensuring that the plan of care is clear, current, relevant and individualized to meet the [patient's] needs and wishes;

- documenting the nursing care provided when using information and telecommunication technologies; and

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

51. CNO's *Nurse Practitioner Standard* provides that NP practice is grounded in the values, knowledge and theories of professional nursing practice. The standard further provides that NPs are accountable for:

    - their decisions and actions;

    - working within their legal scope of practice and their level of knowledge, skill and judgment;

    - documenting all aspects of their practice, including but not limited to:
        - assessments;
        - tests they have ordered or performed and that the results have been reviewed;
        - diagnoses;
        - treatments they have ordered or administered;
        - procedures or interventions they have ordered or performed;
        - that consent was obtained;
        - communication with [patients]; and
        - consultation with others, referrals made to and received from others.

52. The *Nurse Practitioner Standard* further provides when prescribing medication, NPs are accountable for:

    - determining whether the medication provides safe and effective treatment for the [patient];

    - reviewing the best possible medication history to obtain a complete understanding of the medication the [patient] is using;

    - deciding that the medication is warranted;

    - explaining to the [patient] the rationale for the medication, expected therapeutic effects, and potential side effects, contraindications and precautions, as appropriate;

- monitoring the [patient's] response to treatment, as appropriate; and
- reporting any adverse reactions.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

53. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a) to (c) of the Notice of Hearing in that he sexually abused Patient [A], as described in paragraphs 8 to 10 above.

54. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2(a) to (k) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 6 to 10 and 17 to 52 above.

55. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a) to (g) of the Notice of Hearing in that he failed to keep records as required, as described in paragraphs 20 to 42 above.

56. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 4 of the Notice of Hearing in that he signed or issued, in his professional capacity, a document that he knew, or ought to have known contained a false or misleading statement with respect to the reason for the quantity of medications prescribed to Patient [D], as described in paragraphs 20 to 25 above.

57. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 5 (a) to (k) of the Notice of Hearing, and in particular his conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 6 to 10 and 17 to 42 above.

58. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 6(a) to (b) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 11 to 16 and 43 to 52 above.

59. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 7(a) to (b) of the Notice of Hearing in that he abused Patient [K] verbally, physically and emotionally, as described in paragraphs 11 to 16 above.

60. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 8 (a) to (d) of the Notice of Hearing, and in particular his conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 11 to 16 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), #1(b), #1(c), #2(a)(i), (ii), (iii), (iv), #2(b), #2(c), #2(d), #2(e), #2(f)(i), (ii), (iii), #2(g)(i), (ii), (iii), (iv), (v), #2(h)(i), (ii), (iii), (iv), (v), (vi), #2(i)(i), (ii), (iii), (iv), (v), #2(j)(i), (ii), (iii), (iv), #2(k)(i), (ii), (iii), (iv), #3(a), #3(b), #3(c)(i), (ii), (iii), (iv), #3(d)(i), (ii), (iii), (iv), #3(e)(i), (ii), (iii), (iv), #3(f)(i), (ii), (iii), #3(g)(i), (ii), (iii), #4, #5(a)(i), (ii), (iii), (iv), #5(b), #5(c), #5(d), #5(e), #5(f)(i), (ii), (iii), #5(g)(i), (ii), (iii), (iv), (v), #5(h)(i), (ii), (iii), (iv), (v), (vi), #5(i)(i), (ii), (iii), (iv), (v), #5(j)(i), (ii), (iii), (iv), #5(k)(i), (ii), (iii), (iv), #6(a)(i) (1, 2, 3, 4), #6(a)(ii), #6(a)(iii), #6(b), #7(a)(i), (ii), (iii), (iv) and #7(b), and #8(a)(i), (ii), (iii), (iv) and #8(b), #8(c), #8(d) of the Notice of Hearing.

With respect to allegations #7(a)(i), (ii), (iii), (iv) and #7(b), the Panel finds that the Member verbally, physically and emotionally abused the Patient.

As to Allegations #5(a)(i), (ii), (iii), (iv), #5(b), #5(c), #5(d), #5(e), #5(f)(i), (ii), (iii), #5(g)(i), (ii), (iii), (iv), (v), #5(h)(i), (ii), (iii), (iv), (v), (vi), #5(i)(i), (ii), (iii), (iv), (v), #5(j)(i), (ii), (iii), (iv), #5(k)(i), (ii), (iii), (iv), and #8(a)(i), (ii), (iii), (iv) and #8(b), #8(c), #8(d), 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) and (c), in the Notice of Hearing are supported by paragraphs 8 to 10 and 53 in the Agreed Statement of Facts. The Member admits he committed the acts of professional misconduct in that he sexually abused Patient [A] during the course of performing a pap smear when he told [Patient A] he had to use a pediatric speculum, her pelvic muscles were strong, and that her "boyfriend must like that." [Patient A] described the Member's comments as "creepy and inappropriate", [Patient A] was in a vulnerable position laying on her back and exposed. The Member admitted that his comments amounted to sexual abuse as they were sexual in nature.

Allegations #2(a)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 17 to 19 and 54 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct when he contravened a standard of practice of the profession when he prescribed controlled substances and performed a controlled act which he was not authorized to perform. Nurse Practitioners were not authorized to prescribe at the time the Member prescribed these substances to [Patient B] on September 26, 2012, and [Patient C] on January 25, 2013, April 16, 2013 and May 5, 2013.

Allegations #2(b), (c) and (d) in the Notice of Hearing are supported by paragraphs 20 to 25, 43, 44, 50 to 52 and 54 in the Agreed Statement of Facts. The Member failed to assess Patient [D] prior to signing prescriptions. The Member increased the quantity of [Patient D]'s prescription and put the reason as [Patient D] was travelling for 4 to 5 months. The Member admitted that this statement was untrue and misleading. [Patient D] had told the Member she wanted to "stock up on" her medication before her

benefits ran out. The Member admitted and acknowledged that he breached the *Documentation Standard* and the *Nurse Practitioner Standard*.

Allegations #2(e), (f)(i), (ii) and (iii) in the Notice of Hearing are supported by paragraphs 8 to 10, 43 to 49, 52 and 54 in the Agreed Statement of Facts. The Member admits to sexual abuse regarding Patient [A] and made Patient [E] uncomfortable when he made seductive and suggestive comments to both of these patients. The Member admitted and acknowledged that he breached the *TNCR Standard.* The Member further admitted that his comments were a breach of the Standards of Practice.

Allegations #2(g)(i), (ii), (iii), (iv) and (v) in the Notice of Hearing are supported by paragraphs 26 to 28, 52 and 54 in the Agreed Statement of Facts. The Member failed to appropriately formulate and implement an appropriate plan of care for Patient [F]. The Member prescribed large quantities of hydromorphone, Percocet and benzodiazepines. [Patient F] told another Nurse Practitioner ("NP") that she felt she had "been over-prescribed and was misguided." The Member prescribed Lorazepam for [Patient F], on at least nine occasions, based on a phone call. [Patient F] was prescribed Lorazepam for a "general anxiety disorder." The Member did not make any notes or perform an assessment supporting this diagnosis.

Allegations #2(h)(i), (ii), (iii), (iv), (v) and (vi) in the Notice of Hearing are supported by paragraphs 29 to 31, 52 and 54 in the Agreed Statement of Facts. The Member prescribed excessive amounts of both controlled substances and other analgesics to Patient [G]. [Patient G] had a history of substance misuse with alcohol and narcotics. The Member did not adequately assess, monitor or document and failed to intervene appropriately. [Patient G] was frequently calling for early releases and increased dosages of her medication, which the Member then prescribed.

Allegations #2(i)(i), (ii), (iii), (iv) and (v) in the Notice of Hearing are supported by paragraphs 32 to 34, 52 and 54 in the Agreed Statement of Facts. The Member prescribed excessive amounts of benzodiazepines knowing that Xanax and Clonazepam should not be prescribed at the same time. The Member recorded in his notes that such a prescription was "not ideal." The Member failed to adequately assess or monitor Patient [H]. The Member failed to document the appropriateness of the medication being prescribed. Lastly, the Member failed to intervene appropriately with respect to [Patient H]'s potential substance misuse.

Allegations # 2(j)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 35 to 38, 52 and 54 in the Agreed Statement of Facts. The Member prescribed excessive amounts of a controlled substance without adequate documentation. The Member failed to include the narcotic contract; there was no documentation reviewing or assessing [Patient I]'s condition. There were no screening tools for her risk of narcotic use, and a number of [Patient I]'s appointments were by phone only.

Allegations #2(k)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 39 to 42, 52 and 54 in the Agreed Statement of Facts. The Member prescribed two benzodiazepines to Patient [J]. The Member's documentation was missing the narcotic contract, there was no documentation reviewing or assessing [Patient J]'s condition on an ongoing basis, no screening tools and a number of the appointments were by phone only.

Allegations #3(a) and (b) in the Notice of Hearing are supported by paragraphs 20 to 25 and 55. The Member failed to assess Patient [K] prior to prescribing Cipralex and other medications. The Member failed to document these medications in [Patient D]'s chart.

Allegations #3(c)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 26 to 28 and 55 in the Agreed Statement of Facts. The Member failed to document prescriptions, failed to document [Patient F]'s diagnosis and failed to monitor [Patient F]'s use in relation to the prescriptions.

Allegations #3(d)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 29 to 31 and 55 in the Agreed Statement of Facts. The Member failed to document prescriptions, failed to document assessments, failed to monitor [Patient G] in relation to the prescription of a controlled substance, and failed to adequately document interventions with respect to [Patient G]'s potential substance misuse history.

Allegations #3(e)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 32 to 34 and 55 in the Agreed Statement of Facts. The Member failed to document prescriptions, failed to adequately document assessment in relation to prescribed medication and failed to adequately document interventions with respect to [Patient H]'s potential substance misuse.

Allegations #3(f)(i), (ii) and (iii) in the Notice of Hearing are supported by paragraphs 35 to 38 and 55 in the Agreed Statement of Facts. The Member over prescribed benzodiazepines which were not working for [Patient I]. The Member failed to document, when he initially prescribed Ativan, on what basis it was prescribed. The Member failed to document assessments, the use of a narcotic contract, the use of a screening tool for risk and failed to document reviewing or assessment of [Patient I].

Allegations #3(g)(i), (ii) and (iii) in the Notice of Hearing are supported by paragraphs 39 to 42 and 55 in the Agreed Statement of Facts. The Member prescribed two benzodiazepines for [Patient J]. The Member failed to document an assessment, there was no narcotic contract on file, no screening tools for risk of use, and no documentation reviewing or assessing [Patient J]. The Member refilled [Patient J]'s prescriptions by phone appointment.

Allegation #4 in the Notice of Hearing is supported by paragraphs 20 to 25 and 56 in the Agreed Statement of Facts. The Member made a false and misleading statement when he told [Doctor A] that Patient [D] was going on vacation for 4 to 5 months and required an increased quantity of her prescribed medication.

Allegations #5(a) to (k) in the Notice of Hearing are supported by paragraphs 6 to 10, 17 to 42 and 57 in the Agreed Statement of Facts. The Member signed prescriptions for multiple patients before he had adequately assessed them. The Member failed to document his assessments on multiple patients. The Member misrepresented the reason for the increased quantity of prescribed medication to [Patient D]. The Member failed to maintain appropriate therapeutic nurse-client boundaries with Patients [A] and [E]. The Member failed to appropriately formulate and implement appropriate plans of care for multiple patients in his care. The Member over prescribed excessive numbers and doses of a controlled substance and other medications.

Allegations #6(a) and (b) in the Notice of Hearing are supported by paragraphs 11 to 16, 43 to 52 and 58 in the Agreed Statement of Facts. The Member failed to maintain appropriate boundaries of the therapeutic nurse-client relationship when he made remarks about Patient [K]'s height, hair and asked her about a "modelling career." The Member made remarks about how "beautiful she was." The Member stroked Patient [K]'s neck, and held and stroked her hand, when he drew blood, the Member also ran his finger up and down [Patient K]'s arm. The Member also gave [Patient K] his business card and told her words to the effect "text me anytime." The Member also opened a book of medication and told [Patient K] to "pick whatever she wanted." The Member admits and acknowledges that this conduct is a breach of the boundaries of the nurse-client relationship.

Allegations #7(a) and (b) in the Notice of Hearing are supported by paragraphs 11 to 16 and 59 in the Agreed Statement of Facts. The Member verbally, physically and emotionally abused Patient [K] when he remarked about [Patient K]'s height, hair, and referenced she was beautiful and engaged in inappropriate physical contact when he stroked [Patient K]'s neck and hand and ran his fingers up and down her arm.

Allegations #8(a) and (b) in the Notice of Hearing are supported by paragraphs 11 to 16 and 60 in the Agreed Statement of Facts. The Member admits that he committed acts of professional misconduct as alleged and, in particular, that his conduct was disgraceful, dishonourable and unprofessional. The Member verbally, physically and emotionally abused Patient [K]. The Member remarked about Patient [K]'s height, hair, and he referenced she was beautiful and offered to let Patient [K] "pick whatever drugs she wanted."

As noted above, with respect to Allegations # 5(a)(i), (ii), (iii), (iv), #5(b), (c), (d), (e), #5(f)(i), (ii), (iii), #5(g)(i), (ii), (iii), (iv), (v), #5(h)(i), (ii), (iii), (iv), (v), (vi), #5(i)(i), (ii), (iii), (iv), (v), #5(j)(i), (ii), (iii), (iv), #5(k)(i), (ii), (iii), (iv), (iv), #8(a)(i), (ii), (iii), (iv), and #8(b), (c), (d), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional.

The Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations. Nurses are accountable for practising in accordance with the *Professional Standards*, practice expectations, legislation and regulations. The Member failed to provide, facilitate, advocate and promote the best possible care for his patients when he deliberately and knowingly over prescribed a controlled drug.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through prescribing medication to multiple patients that he knew had the potential to be addictive and misused. The Member prescribed medication without assessing patients, or documenting his findings, thereby putting patients at risk. The Member failed to document his assessments, reassessments or care. The Member's dishonourable conduct has an element of moral failing; the Member knew or ought to have known that his conduct was unacceptable and fell 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 Member knowingly sexually abused Patient [A] when he made remarks of a sexual nature to her. He verbally, physically and emotionally abused Patient [K] when he made

comments about her height, her hair, and referenced she was beautiful and engaged in inappropriate physical contact when he touched and stroked her for no clinical purpose. The conduct casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet. The Member demonstrated a lack of integrity, dishonesty, abuse of power and disregard for the welfare and safety of the patients in his care. The health profession will not tolerate this conduct. The Member's conduct has brought shame not only on himself but also 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 this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 10 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the 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 session 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 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 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. 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, decision tools and online participation forms (where applicable):

1. *Professional Standards*,
2. *Therapeutic Nurse-Client Relationship*,
3. *Documentation*,
4. *Nurse Practitioner*,
5. *RHPA: Scope of Practice, Controlled Acts Model*,
6. *Code of Conduct*,

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 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 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 18 months from the date the Member returns to the practice of nursing, the Member will notify his 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 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. 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
3. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director after each audit regarding the results of each audit:

a. the first audit shall take place within 3 months from the date the Member begins or resumes employment with the employer,
b. the second audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
c. the third audit shall take place within 9 months from the date the Member begins or resumes employment with the employer,
d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer.

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 5 patient records to ensure they meet both CNO and employer standards;

2. reviewing a random selection of at least 5 prescriptions to ensure they meet both CNO standards, particularly the *Nurse Practitioner* Standard, and employer standards; and
3. discussing (by telephone or in person), with at least 3 of the Member's patients, the care provided by the Member to ensure that the Member is utilizing appropriate communication techniques consistent with the *Therapeutic Nurse-Client Relationship Standard* and employer standards.

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 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 Member's conduct was serious;
The Member took advantage of vulnerable patients;
The Member over-prescribed medication, which put patients at risk;
The Member provided substandard care;
The Member persistently neglected to document his assessments and plan of care;
The Member abused the trust and autonomy that he has been granted as an NP.

The mitigating factors in this case were:
The Member participated and accepted responsibility for his actions;
The Member saved the College time and money in prosecuting this matter in a timely fashion;
The Member agreed to the Agreed Statement of Facts and the Joint Submission on Order.

The proposed penalty provides for general deterrence through the oral reprimand and the suspension sending a clear message to the profession as a whole that over-prescribing medication, and not documenting care, are severe breaches and will not be tolerated.

The proposed penalty provides for specific deterrence through the 10-month suspension of the Member's certificate and the oral reprimand.

The proposed penalty provides for remediation and rehabilitation through the meetings with the Regulatory Expert. It will provide the Member with the opportunity to improve his practice by re-educating himself in the area of *Professional Standards*, the *TNCR Standard*, *Documentation Standard*, *Nurse Practitioner Standard*, *RHPA*: Scope of Practice, *Controlled Acts Model* and lastly *Code of Conduct*. The Member will have time to reflect on his errors in judgement and learn from his experience.

The terms, conditions and limitations on the Member's Certificate of Registration provide that the Member will have 2 meetings with a Regulatory Expert at the Member's expense, an 18-month employer notification and 4 random spot audits conducted by the Member's employer. The Member's employer will audit a random selection of 5 patients' records to ensure they meet both the College's and the employer's standards. The Member's employer will audit 5 random prescriptions selected to ensure they meet both the College's Standards, the *Nurse Practitioner Standard* and the *Employer Standard*. The Member will discuss with at least 3 of his patients the care he has provided, and lastly the Member will not practice independently in the community for a period of 18-months. All of these should deter the Member from future misconduct. It sends a strong message to the profession that this behaviour will not be tolerated.

Overall, the public is protected because all aspects of the penalty address the most critical issue of public protection, and the penalty sends a powerful message to the public that this behaviour is not acceptable and will not be tolerated by the profession. The Member will have an opportunity to reflect on his conduct and gain insight into his actions and improve his practice. The nurse-client relationship is built on trust, respect and the patient's right to be cared for professionally.

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 David Rivard (Discipline Committee, April 23, 2012)
This case is similar in that the member made remarks of a sexual nature towards his patient. This member also verbally and emotionally abused patients. This member did not maintain the boundaries of the nurse-client relationship. The member received an oral reprimand, a 3-month suspension of his certificate, 2 meetings with a *Nursing Expert* at his expense, and a 24-month employer notification.

CNO v Ann Marie Desrosiers (Discipline Committee, June 25, 2014)
This case is vastly different in that the member failed to participate in the Quality Assurance Committee practice assessment in March-September 2011. This member also failed to carry out an agreement with the College regarding the alternative dispute resolution of the complaint in or about February-April 2012. Lastly, the member performed controlled acts for which she was not authorized when she prescribed controlled substances to 4 patients. The member received an oral reprimand, a 9-month suspension of her certificate, 2 meetings with the Nursing Expert at her expense, and an 18-month employer notification.

The Member's Counsel indicated that he agreed with those submissions.

The Member's Counsel submitted that the Member's plea of guilty saved time and expense that would ordinarily be associated with a lengthy hearing. The agreement also saved witnesses the emotional expense of having to testify. The Member's acknowledgement is significant, accepting responsibility for his conduct and indicates his willingness to improve his practice.

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 10 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the 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 session 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 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 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. 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, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Therapeutic Nurse-Client Relationship,*
            3. *Documentation,*
            4. *Nurse Practitioner,*
            5. *RHPA: Scope of Practice, Controlled Acts Model,*
            6. *Code of Conduct,*

        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 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 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 18 months from the date the Member returns to the practice of nursing, the Member will notify his 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 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. 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
3. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director after each audit regarding the results of each audit:

    a. the first audit shall take place within 3 months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
    c. the third audit shall take place within 9 months from the date the Member begins or resumes employment with the employer,
    d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer.

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 5 patient records to ensure they meet both CNO and employer standards;
2. reviewing a random selection of at least 5 prescriptions to ensure they meet both CNO standards, particularly the *Nurse Practitioner Standard*, and employer standards; and
3. discussing (by telephone or in person), with at least 3 of the Member's patients, the care provided by the Member to ensure that the Member is utilizing appropriate communication techniques consistent with the *Therapeutic Nurse-Client Relationship Standard* and employer standards.

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 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. Specific deterrence is met through the Member's suspension and oral reprimand. General deterrence is met through the suspension and the terms, conditions and limitations on the Member's certificate. Rehabilitation and remediation are accomplished through the Member's meeting with the Nursing Regulatory Expert, giving him the opportunity to reflect on the issues that brought him before the College, gain insight and improve his practice going forward. Public protection is accomplished through all of these aspects of the penalty and through the employer notification, audits and monitoring requirements. The Member will not be able to practice independently in the community for a significant length of time which will protect the public while the Member improves his practice.

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

I, Heather Stevanka, RN, sign this amended 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.