DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Karen Laforet, RN	Chairperson
	Andrea Arkell	Public Member
	Ramona Dunn, RN	Member
	Sandra Larmour	Public Member
	Emilija Stojsavljevic, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	HAILEY BRUCKNER for
	)	College of Nurses of Ontario
- and -	)	
	)	
LIZA ANNE ROBINSON	)	NO REPRESENTATION for
Registration No. ID07800	)	Liza Anne Robinson
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: February 9, 2023

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 February 9, 2023, via videoconference.

Although Liza Anne Robinson (the "Member") was neither present nor represented, College Counsel advised the Panel that the College had been in touch with the Member, that she was aware of the hearing, had decided she would not attend it and had signed all the necessary documents for the hearing to proceed in her absence.

In that regard, College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing on January 11, 2023 by way of an affidavit from Sarah Hellmann, Prosecutions Associate, dated February 8, 2023, confirming that Ms. Hellmann sent correspondence, which included the Notice of Hearing, on January 11, 2023 to the Member's last known address on the College Register.

In addition, Ms. Hellmann's affidavit also confirmed that the Member had entered into a resolution with the College on an uncontested basis, had signed all the necessary documents,

including an Agreed Statement of Facts and Joint Submission on Order, and that the Member would not be attending the hearing.

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 attend it, the hearing may proceed in her absence. 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 public disclosure and banning the 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 at the Discipline hearing of Liza Anne Robinson.

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

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated January 11, 2023 are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Caressant Care in Lindsay, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession as follows:

    (a) Between January 2019 and April 2020, you failed to administer the following medications to the following patients, but documented that you had administered these medications:

        (i) On or about January 3, 2019, you documented that you had administered Tylenol #3 to [Patient A] at 2100 hrs, but this medication was found in the blister pack on January 4, 2019;

(ii) On or about January 25, 2019, you documented that you had administered Synthroid, Lyrica, Tecta, Lopresor, and Atacand to [Patient B] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iii) On or about January 25, 2019, you documented that you had administered Tylenol ES and Trazodone to [Patient C] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iv) On or about February 5, 2019, you documented that you had administered Acetaminophen, CranMax, and Haloperidol to [Patient D] at 2100 hrs, but these medications were found in [Patient D]'s medication box on February 6, 2019;

(v) On or about May 8, 2019, you documented that you had administered Hydromorphone 18mg, Zopiclone 5mg, and Dilaudid 2mg to [Patient E] at 2100 and 2130 hrs, but these medications were found in a medication cup on [Patient E]'s dresser on May 9, 2019;

(vi) On or about October 20, 2019, you documented that you had administered 2 tablets of Tramadol 50mg to [Patient F] at 1000 hrs, but the count card showed that you only administered one tablet of Tramadol 50mg to [Patient F];

(vii) On or about October 20, 2019, you documented that you had administered Ativan 0.5mg to [Patient G] at 0800 hrs, but this medication was found in its package on October 21, 2019;

(viii) On or about October 20, 2019, you documented that you had administered Percocet 5mg to [Patient G] at 0830hrs, but this medication was found in the medication card on October 21, 2019;

(ix) On or about January 15, 2020, you documented that you had administered Tylenol #3 and Serax 10 mg to [Patient H] at 2100 hrs, but these medications were later found in their blister packs;

(x) On or about February 9, 2020, you documented that you had administered Tylenol #2 to [Patient I] at 1800 hrs, but this medication was found in the narcotics card on February 10, 2020;

(xi) On or about February 21, 2020, you documented that you had administered Citalopram 20mg to [Patient J], but this medication was never administered to [Patient J];

(xii) On or about February 27, 2020, you documented that you had administered Hydromorphone 2mg to [Patient B] at 2100 hrs, but this medication was found in the narcotics bin on February 28, 2020;

(xiii) On or about April 8, 2020, you documented that you had administered Tylenol #3 and Oxazepam 10mg to [Patient H], but these medications were found in the narcotic card on April 10, 2020; and/or

(xiv) On or about April 8, 2020, you documented that you had administered Oxazepam 15mg to [Patient K] at 2100 hrs, but this medication was found in the medication card on April 10, 2020; and/or

(b) On or around January 30, 2019, you administered Diphenhydramine 50mg to [Patient L] when the order was for Gravol 25mg; and/or

(c) On or around January 30, 2019, you documented that you had administered a PRN dose of Gravol 25mg to [Patient L] in the patient's MAR when you had administered Diphenhydramine 50mg to [Patient L]; and/or

(d) On or around January 30, 2019, you documented an order for Diphenhydramine 50mg for [Patient L] in the Facility's Drug Record Book when the order was for Gravol 25mg; and/or

(e) Between July 26 and 28, 2019, you administered more Tylenol #2 to [Patient M] than authorized by the medication order; and/or

(f) On or around February 7, 2020, you failed to appropriately monitor, assess and/or document with respect to [Patient N] after the patient fell; and/or

(g) On or about March 26, 2020, you made inappropriate remarks to or about a colleague, M.D., who was performing the Facility's mandatory screening for Covid-19; and/or

(h) On or around April 8, 2020, you documented that you had applied a Nitro patch to [Patient O], but you never applied this patch to the patient; and/or

(i) On or around April 20, 2020, you altered the count on the Facility's narcotic count sheet from 29 to 27 for [Patient P] contrary to the Facility's "Pharmacy Policy & Procedure"; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Caressant Care in Lindsay, Ontario (the "Facility"), you failed to keep records as required as follows:

(a) Between January 2019 and April 2020, you failed to administer the following medications to the following patients, but documented that you had administered these medications:

(i) On or about January 3, 2019, you documented that you had administered Tylenol #3 to [Patient A] at 2100 hrs, but this medication was found in the blister pack on January 4, 2019;

(ii) On or about January 25, 2019, you documented that you had administered Synthroid, Lyrica, Tecta, Lopresor, and Atacand to [Patient B] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iii) On or about January 25, 2019, you documented that you had administered Tylenol ES and Trazodone to [Patient C] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iv) On or about February 5, 2019, you documented that you had administered Acetaminophen, CranMax, and Haloperidol to [Patient D] at 2100 hrs, but these medications were found in [Patient D]'s medication box on February 6, 2019;

(v) On or about May 8, 2019, you documented that you had administered Hydromorphone 18mg, Zopiclone 5mg, and Dilaudid 2mg to [Patient E] at 2100 and 2130 hrs, but these medications were found in a medication cup on [Patient E]'s dresser on May 9, 2019;

(vi) On or about October 20, 2019, you documented that you had administered 2 tablets of Tramadol 50mg to [Patient F] at 1000 hrs, but the count card showed that you only administered one tablet of Tramadol 50mg to [Patient F];

(vii) On or about October 20, 2019, you documented that you had administered Ativan 0.5mg to [Patient G] at 0800 hrs, but this medication was found in its package on October 21, 2019;

(viii) On or about October 20, 2019, you documented that you had administered Percocet 5mg to [Patient G] at 0830hrs, but this medication was found in the medication card on October 21, 2019;

(ix) On or about January 15, 2020, you documented that you had administered Tylenol #3 and Serax 10 mg to [Patient H] at 2100 hrs, but these medications were later found in their blister packs;

(x) On or about February 9, 2020, you documented that you had administered Tylenol #2 to [Patient I] at 1800 hrs, but this medication was found in the narcotics card on February 10, 2020;

(xi) On or about February 21, 2020, you documented that you had administered Citalopram 20mg to [Patient J], but this medication was never administered to [Patient J];

(xii) On or about February 27, 2020, you documented that you had administered Hydromorphone 2mg to [Patient B] at 2100 hrs, but this medication was found in the narcotics bin on February 28, 2020;

(xiii) On or about April 8, 2020, you documented that you had administered Tylenol #3 and Oxazepam 10mg to [Patient H], but these medications were found in the narcotic card on April 10, 2020; and/or

(xiv) On or about April 8, 2020, you documented that you had administered Oxazepam 15mg to [Patient K] at 2100 hrs, but this medication was found in the medication card on April 10, 2020; and/or

(b) On or around January 30, 2019, you documented that you had administered a PRN dose of Gravol 25mg to [Patient L] in the patient's MAR when you had administered Diphenhydramine 50mg to [Patient L]; and/or

(c) On or around January 30, 2019, you documented an order for Diphenhydramine 50mg for [Patient L] in the Facility's Drug Record Book when the order was for Gravol 25mg; and/or

(d) On or around February 7, 2020, you failed to appropriately monitor, assess and/or document with respect to [Patient N] after the patient fell; and/or

(e) On or around April 8, 2020, you documented that you had applied a Nitro patch to [Patient O], but you never applied this patch to the patient; and/or

(f) On or around April 20, 2020, you altered the count on the Facility's narcotic count sheet from 29 to 27 for [Patient P] contrary to the Facility's "Pharmacy Policy & Procedure"; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(14) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Caressant Care in Lindsay, Ontario (the "Facility"), you falsified a record relating to your practice as follows:

(a) Between January 2019 and April 2020, you failed to administer the following medications to the following patients, but documented that you had administered these medications:

(i) On or about January 3, 2019, you documented that you had administered Tylenol #3 to [Patient A] at 2100 hrs, but this medication was found in the blister pack on January 4, 2019;

(ii) On or about January 25, 2019, you documented that you had administered Synthroid, Lyrica, Tecta, Lopresor, and Atacand to [Patient B] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iii) On or about January 25, 2019, you documented that you had administered Tylenol ES and Trazodone to [Patient C] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iv) On or about February 5, 2019, you documented that you had administered Acetaminophen, CranMax, and Haloperidol to [Patient D] at 2100 hrs, but these medications were found in [Patient D]'s medication box on February 6, 2019;

(v) On or about May 8, 2019, you documented that you had administered Hydromorphone 18mg, Zopiclone 5mg, and Dilaudid 2mg to [Patient E] at 2100 and 2130 hrs, but these medications were found in a medication cup on [Patient E]'s dresser on May 9, 2019;

(vi) On or about October 20, 2019, you documented that you had administered 2 tablets of Tramadol 50mg to [Patient F] at 1000 hrs, but the count card showed that you only administered one tablet of Tramadol 50mg to [Patient F];

(vii) On or about October 20, 2019, you documented that you had administered Ativan 0.5mg to [Patient G] at 0800 hrs, but this medication was found in its package on October 21, 2019;

(viii) On or about October 20, 2019, you documented that you had administered Percocet 5mg to [Patient G] at 0830hrs, but this medication was found in the medication card on October 21, 2019;

(ix) On or about January 15, 2020, you documented that you had administered Tylenol #3 and Serax 10 mg to [Patient H] at 2100 hrs, but these medications were later found in their blister packs;

(x) On or about February 9, 2020, you documented that you had administered Tylenol #2 to [Patient I] at 1800 hrs, but this medication was found in the narcotics card on February 10, 2020;

(xi) On or about February 21, 2020, you documented that you had administered Citalopram 20mg to [Patient J], but this medication was never administered to [Patient J];

(xii) On or about February 27, 2020, you documented that you had administered Hydromorphone 2mg to [Patient B] at 2100 hrs, but this medication was found in the narcotics bin on February 28, 2020;

(xiii) On or about April 8, 2020, you documented that you had administered Tylenol #3 and Oxazepam 10mg to [Patient H], but these medications were found in the narcotic card on April 10, 2020; and/or

(xiv) On or about April 8, 2020, you documented that you had administered Oxazepam 15mg to [Patient K] at 2100 hrs, but this medication was found in the medication card on April 10, 2020; and/or

(b) On or around January 30, 2019, you documented that you had administered a PRN dose of Gravol 25mg to [Patient L] in the patient's MAR when you had administered Diphenhydramine 50mg to [Patient L]; and/or

(c) On or around January 30, 2019, you documented an order for Diphenhydramine 50mg for [Patient L] in the Facility's Drug Record Book when the order was for Gravol 25mg; and/or

(d) On or around April 8, 2020, you documented that you had applied a Nitro patch to [Patient O], but you never applied this patch to the patient; and/or

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Caressant Care in Lindsay, Ontario (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 of the profession as disgraceful, dishonourable or unprofessional, as follows:

(a) Between January 2019 and April 2020, you failed to administer the following medications to the following patients, but documented that you had administered these medications:

(i) On or about January 3, 2019, you documented that you had administered Tylenol #3 to [Patient A] at 2100 hrs, but this medication was found in the blister pack on January 4, 2019;

(ii) On or about January 25, 2019, you documented that you had administered Synthroid, Lyrica, Tecta, Lopresor, and Atacand to [Patient B] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iii) On or about January 25, 2019, you documented that you had administered Tylenol ES and Trazodone to [Patient C] at 2100 hrs, but these medications were found in their packages on January 26, 2019;

(iv) On or about February 5, 2019, you documented that you had administered Acetaminophen, CranMax, and Haloperidol to [Patient D] at 2100 hrs, but these medications were found in [Patient D]'s medication box on February 6, 2019;

(v) On or about May 8, 2019, you documented that you had administered Hydromorphone 18mg, Zopiclone 5mg, and Dilaudid 2mg to [Patient E] at 2100 and 2130 hrs, but these medications were found in a medication cup on [Patient E]'s dresser on May 9, 2019;

(vi) On or about October 20, 2019, you documented that you had administered 2 tablets of Tramadol 50mg to [Patient F] at 1000 hrs, but the count card showed that you only administered one tablet of Tramadol 50mg to [Patient F];

(vii) On or about October 20, 2019, you documented that you had administered Ativan 0.5mg to [Patient G] at 0800 hrs, but this medication was found in its package on October 21, 2019;

(viii) On or about October 20, 2019, you documented that you had administered Percocet 5mg to [Patient G] at 0830hrs, but this medication was found in the medication card on October 21, 2019;

(ix) On or about January 15, 2020, you documented that you had administered Tylenol #3 and Serax 10 mg to [Patient H] at 2100 hrs, but these medications were later found in their blister packs;

(x) On or about February 9, 2020, you documented that you had administered Tylenol #2 to [Patient I] at 1800 hrs, but this medication was found in the narcotics card on February 10, 2020;

(xi) On or about February 21, 2020, you documented that you had administered Citalopram 20mg to [Patient J], but this medication was never administered to [Patient J];

(xii) On or about February 27, 2020, you documented that you had administered Hydromorphone 2mg to [Patient B] at 2100 hrs, but this medication was found in the narcotics bin on February 28, 2020;

(xiii) On or about April 8, 2020, you documented that you had administered Tylenol #3 and Oxazepam 10mg to [Patient H], but these medications were found in the narcotic card on April 10, 2020; and/or

(xiv) On or about April 8, 2020, you documented that you had administered Oxazepam 15mg to [Patient K] at 2100 hrs, but this medication was found in the medication card on April 10, 2020; and/or

(b) On or around January 30, 2019, you administered Diphenhydramine 50mg to [Patient L] when the order was for Gravol 25mg; and/or

(c) On or around January 30, 2019, you documented that you had administered a PRN dose of Gravol 25mg to [Patient L] in the patient's MAR when you had administered Diphenhydramine 50mg to [Patient L].; and/or

(d) On or around January 30, 2019, you documented an order for Diphenhydramine 50mg for [Patient L] in the Facility's Drug Record Book when the order was for Gravol 25mg; and/or

(e) Between July 26 and 28, 2019, you administered more Tylenol #2 to [Patient M] than authorized by the medication order; and/or

(f) On or around February 7, 2020, you failed to appropriately monitor, assess and/or document with respect to [Patient N] after the patient fell; and/or

(g) On or about March 26, 2020, you made inappropriate remarks to or about a colleague, M.D., who was performing the Facility's mandatory screening for Covid-19; and/or

(h) On or around April 8, 2020, you documented that you had applied a Nitro patch to [Patient O], but you never applied this patch to the patient; and/or

(i) On or around April 20, 2020, you altered the count on the Facility's narcotic count sheet from 29 to 27 for [Patient P] contrary to the Facility's "Pharmacy Policy & Procedure".

Member's Plea

As noted above, College Counsel provided the Panel with Exhibit #2, the affidavit of Sarah Hellmann, Prosecutions Associate at the College which sets out that the Member entered into a resolution with the College in which the matter would proceed before a panel of the College's Discipline Committee on an uncontested basis. It also sets out that College Counsel sent at least

two emails to the Member to explain the process and the consequences of a guilty plea. The Member responded to College Counsel's emails and advised that she had resigned her certificate of registration with the College and had no intention of reapplying to the College in the future.

On January 17, 2023, in accordance with the agreement between the College and the Member, the Member signed the Agreed Statement of Facts and completed the written Plea Inquiry.

The Panel relied on Exhibit #2, the Affidavit of Sarah Hellmann, paragraphs 26, 27, 28 and 29 of the Agreed Statement of Facts as well as the written plea inquiry, which was signed by the Member, to satisfy itself that the Member had admitted the allegations set out in paragraphs #1(a)(i) through (xiv), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h), 1(i), #2(a)(i) through (xiv), 2(b), 2(c), 2(d), 2(e), 2(f), #3(a)(i) through (xiv), 3(b), 3(c), 3(d), #4(a)(i) through (xiv), 4(b), 4(c), 4(d), 4(e), 4(f), 4(g), 4(h) and 4(i) in the Notice of Hearing, and that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Liza Anne Robinson (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on August 29, 1994. The Member resigned her certificate of registration on February 24, 2022 and is not entitled to practice nursing in Ontario at this time.

2. The Member worked at Caressant Care Lindsay (the "Facility"), a long-term care home, from November 29, 2018 to May 4, 2020. The Member worked at the Facility on a full-time basis, on the night shift.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Errors in Medication Administration and Documentation

3. On numerous occasions between January 2019 and April 2020, the Member documented that she had administered medications to her patients, when she had not in fact done so, as further particularized below:

    a. On January 3, 2019, the Member documented that she had administered a dose of Tylenol #3 to [Patient A] at 2100 hours. The Member did not administer this medication to [Patient A]. This medication was found in the

blister pack on January 4, 2019 by the oncoming nurse, who reported her discovery to the Facility in a Medication Incident Report that same day.

b. On January 25, 2019, the Member documented that she had administered Atacand, Synthroid, Lyrica, Lopressor and Tecta to [Patient B] at 2100 hours. She also documented that she had administered Tylenol ES and Trazodine to [Patient C] at 2100 hours.

   The Member did not administer this medication to [Patient B] or [Patient C]. A nursing colleague of the Member discovered that the medications for both [Patient B] and [Patient C] were still in their packages when she moved the pill crusher at approximately 1630 hours on January 26, 2019. The Member's nursing colleague reported her discovery to the Facility in a Medication Incident Report that same day.

c. On February 5, 2019, the Member documented that she had administered Acetaminophen, CranMax, and Haloperidol to [Patient D] at 2100 hours. The Member did not administer this medication to the patient. Another nurse at the Facility found these medications in [Patient D]'s medication box the following morning.

d. On May 8, 2019, the Member documented that she had administered Hydromorphone 18 mg, Zopiclone 5 mg, and Dilaudid 2 mg to [Patient E] at 2100 and 2130 hours. The Member did not administer this medication to [Patient E]. Another nurse at the Facility found these medications in a medication cup on [Patient E]'s dresser on May 9, 2019.

e. On October 20, 2019, the Member documented that she had administered 2 tablets of Tramadol 50 mg to [Patient F] at 1000 hours on the PRN count sheet and the electronic Medication Administration Record ("eMAR"). However, the Member only administered one tablet of Tramadol 50 mg to [Patient F]. In a self-reflection the Facility required the Member to complete, the Member admitted that she made a medication error when she stated that she had administered two tablets on the eMAR, rather than one tablet.

f. On October 20, 2019, the Member documented that she had administered Ativan 0.5 mg to [Patient G] at 0800 hours, but the Member did not administer this medication to the patient. Staff at the Facility found this medication in its package on October 21, 2019 at 0700 hours. In a self-reflection the Facility required the Member to complete, the Member admitted that she went to get [Patient G] a coffee during her medication delivery on October 20, 2019 and forgot to administer the Ativan to the patient when she returned.

g. On October 20, 2019, the Member documented that she had administered Percocet 5mg to [Patient G] at 0830 hours, but the Member did not administer this medication to the patient. Staff at the Facility found this medication in the medication card on October 21, 2019. In a self-reflection completed at the Facility's request, the Member admitted that she made a medication error when she failed to administer anxiety and/or pain medication requested by [Patient G] during her shift on October 20, 2019.

h. On January 15, 2020, the Member documented that she had administered Tylenol #3 and Serax 10 mg to [Patient H] at 2100 hours, but the Member did not administer this medication to the patient. Staff at the Facility later found these medications still in their blister packs. In a self-reflection completed at the Facility's request, the Member admitted that [Patient H] had refused the medications and she had failed to record the patient's refusal. Instead, the Member documented that she had administered these medications to [Patient H].

i. On February 9, 2020, the Member documented that she had administered Tylenol #2 to [Patient I] at 1800 hours, but the Member did not administer this medication to the patient. Staff at the Facility found this medication in the narcotics card on February 10, 2020. In a self-reflection completed at the Facility's request, the Member admitted that she omitted to provide a "drug" to [Patient I] on February 9, 2020.

j. On February 21, 2020, the Member documented that she had administered Citalopram 20 mg to [Patient J]. A contemporaneous note from another nurse indicates that this medication was never administered to [Patient J].

k. On February 27, 2020, the Member documented that she had administered Hydromorphone 2 mg to [Patient B] at 2100 hours, but she did not administer this medication to the patient. Another nurse at the Facility found this medication in the narcotics bin on February 28, 2020.

l. On April 8, 2020, the Member documented that she had administered Tylenol #3 and Oxazepam 10 mg to [Patient H], but the Member did not administer these medications to the patient. Staff at the Facility found these medications in the narcotic card on April 10, 2020. In a self-reflection completed at the Facility's request, the Member admitted to "incorrect charting" for [Patient H] and noted that [Patient H] did not take this medication.

m. On April 8, 2020, the Member documented that she had administered Oxazepam 15 mg to [Patient K] at 2100 hours, but the Member did not administer this medication to the patient. Staff at the Facility found this medication in the medication card on April 10, 2020.

n. On April 8, 2020, the Member documented that she had applied a Nitro patch to [Patient O] in the patient's Medication Administration Record ("MAR"), but the Member did not apply this patch to the patient. In a self-reflection completed at the Facility's request, the Member later admitted that she signed out the Nitro patch but failed to administer it to the patient.

4. The Member also made the following medication administration errors:

a. On January 30, 2019, the Member documented administering a PRN dose of Gravol 25 mg to [Patient L] at 2155 hours in the patient's MAR.

However, the Member administered Diphenhydramine 50 mg to [Patient L] instead of Gravol 25 mg. A vial of Diphenhydramine 50 mg was found in the patient's daily drug supply box; the Member incorrectly recorded an order for Diphenhydramine 50 mg (rather than Dimenhydrinate) in the patient's Drug Record Book on January 30, 2019. She wrote: "took from stock box" on this order. The pharmacy received a copy of the Drug Record Book and corrected the order by fax the next day, noting: "New order is for Dimenhydrinate not Diphenhydramine."

b. Between July 26 and 28, 2019, the Member administered more Tylenol #2 to [Patient M] than authorized by the medication order. [Patient M] was authorized to receive 2 tablets of Tylenol #2 over a 24-hour period, with 4 hours between doses.

The Member administered more Tylenol #2 to [Patient M] than authorized on July 26 and 27, 2019. The Member was one of several nurses who contributed to [Patient M] receiving 5 tablets of Tylenol #2 on July 26 and 27, 2019, and 4 tablets of Tylenol #2 on July 28, 2019. The Member filled out a self-reflection admitting that she misunderstood the order and that [Patient M] received "medication more frequently" as a result.

c. On April 20, 2020, the Member altered the Tylenol #2 count on the Facility's narcotic count sheet from 29 to 27 for [Patient P], contrary to the Facility's "Pharmacy Policy & Procedure". This policy specifies that discrepancies in the narcotics count must be reported to the Facility, but the Member did not report the discrepancy in the narcotics count for [Patient P].

If the Member were to testify, she would say that she modified the count to match the actual amount of Tylenol #2 remaining; she believed a nurse on an earlier shift had forgotten to sign the narcotics out and changed the count to address this error. However, the Member acknowledges that it was not acceptable practice to alter the narcotics count on discovering a discrepancy, rather than reporting the discrepancy to the Facility.

Inadequate Post Fall Assessment and Documentation

5. On February 7, 2020, the Member failed to respond appropriately when [Patient N] fell and hit his head.

6. On February 7, 2020, [Patient N] fell and hit his head while he was in the bathroom being assisted by J.L., a Personal Support Worker ("PSW").

7. Another PSW at the Facility, A.G., entered the room at the time of the patient's fall. J.L. asked A.G. to call the Member because the Member was the RPN on duty. A.G. ran down the hall and told the Member that [Patient N] had fallen on his head. When the Member entered the room, J.L. reported the circumstances of [Patient N]'s fall to her.

8. The Facility has a policy in place that directs staff on how to respond when a patient falls. The Facility's *Code Care* policy requires registered staff to call a "Code Care" when a patient falls or on finding a patient on the floor. Among other things, this policy requires that registered staff responding to a *Code Care* complete a head-to-toe assessment of the patient.

9. The Member did not call a *Code Care* on being advised of [Patient N]'s fall by A.G. and J.L. The Member also failed to document [Patient N]'s fall; the Member did not take [Patient N]'s vitals, complete a head-to-toe assessment of [Patient N], or document the patient's fall in a progress note on February 7, 2020.

10. On February 8, 2020, K.O., the oncoming shift nurse, wrote a progress note reporting that she learned of [Patient N]'s fall from J.L. K.O. confirmed in her progress note that the Member had not documented [Patient N]'s fall. K.O. took the patient's vitals and documented observing a small hematoma on the right side of the patient's head during her assessment of the patient on February 8, 2020.

11. The Member made a late entry progress note about the incident on February 9, 2020. In her note, the Member wrote that she was told [Patient N] hit his head on the doorframe, but that he had been assisted into a sitting position. The Member acknowledged in her progress note that she did not do a risk assessment or perform a full assessment of [Patient N]'s vitals on February 7, 2020.

Unprofessional Interaction with Colleague in March 2020

12. On March 26, 2020, the Member made inappropriate remarks about a colleague, M.D., who was performing the Facility's mandatory screening for Covid-19.

13. On March 26, 2020, M.D. was screening Facility staff for Covid-19 as they entered the building, including by taking their temperatures and ensuring staff practiced social distancing while awaiting their screening.

14. When the Member arrived for her shift, M.D. asked her to wait outside while Facility staff ahead of the Member in the screening line were cleared to enter the building.

15. The Member became angry when M.D. asked her to wait outside. The Member called M.D. a "stupid bitch". The Member stated that the Facility's Covid-19 screening protocol was "ridiculous" and pushed past M.D. to get into the building.

16. If the Member were to testify, she would state that the comments she made during her interaction with M.D. on March 26, 2020 were taken out of context and not intended as a personal insult against M.D. The Member nonetheless acknowledges that she made inappropriate remarks about the Facility's screening process and M.D. on March 26, 2020.

Facility Efforts at Remediation

17. The Facility made efforts to remediate the Member's practice on many occasions. For example:

    a. In January 2019, after the Facility learned of the first medication incident involving the Member, the Facility's Director of Nursing spoke with the Member and provided counselling on the Facility's policies and procedures. The Member was advised to double-check strip packs and blister packs for scheduled doses after each medication pass to ensure that no doses were missed. The Director of Nursing also emphasized the importance of providing effective pain management to the patient population at the Facility.

    b. The Member received a verbal warning from the Facility on May 24, 2019 after she made further medications errors. The Facility also had the Member complete a competency test on medication administration and a reflective practice on her medication administration and practice in May 2019.

    c. On October 22, 2019, following additional medication errors by the Member, the Facility counselled the Member again on Facility policy and procedure regarding medication administration and documentation. The Facility required the Member to review the relevant CNO standards at this time.

    d. On January 17, 2020, following additional medication errors by the Member, the Facility counselled the Member again and asked her to complete another self-reflective practice related to medication administration and to review relevant CNO standards.

e. On February 20, 2020, a Resident Care coordinator at the Facility educated the Member regarding appropriate assessment, follow up, and documentation of a patient fall.

f. On April 2, 2020, the Facility sent the Member a warning about her behaviour towards M.D. on March 26, 2020.

g. On April 20, 2020, the Facility suspended the Member pending further investigation after she altered the Tylenol #2 count on the Facility's narcotic count sheet from 29 to 27 for [Patient P].

CNO STANDARDS

18. CNO's *Professional Standards* provides an overall framework for the practice of nursing and a link with other standards, guidelines and competencies. The *Professional Standards* specify that each nurse is accountable to the public and responsible for ensuring their practice and conduct meets legislative requirements and the standards of the profession. Further, nurses are responsible for their actions and the consequences of those actions. They are also accountable for conducting themselves in ways that promote respect for the profession.

19. The *Professional Standards* also expressly reflect that clients are the central focus of the professional services that nurses provide. The goal of professional practice is to obtain the best possible outcome for clients, with no unnecessary exposure to risk of harm.

20. In addition, the *Professional Standards* clearly stipulate that nurses are to establish and maintain respectful, collaborative, therapeutic and professional relationships with colleagues, health care team members, and employers. The Member's conduct towards M.D. fell well below that standard, and was disgraceful, dishonourable or unprofessional.

21. CNO's *Medication Standard* requires that nurses have the necessary authority to perform medication practices, such as administration, dispensing, medication storage, inventory management and disposal. Nurses must promote safe care and contribute to a culture of safety within their practice environments, when involved in medication practices.

22. Nurses are expected to promote and/or implement the secure and appropriate storage, transportation and disposal of medication; take appropriate action to resolve or minimize the risk of harm to a client from a medication error or adverse reaction; report medication errors, near misses or adverse reactions, in a timely manner; and, collaborate in the development, implementation and evaluation of

system approaches that support safe medication practices within the health care team.

23. The Member did not meet the *Medication Standard* or *Professional Standards* in respect of her medication errors set out in paragraphs 3 and 4.

24. The *Documentation Standard* states that nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client's needs, the nurse's interventions and the client's outcomes. Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

25. The Member did not meet the *Documentation Standard* or *Professional Standards* in respect of conduct set out in paragraphs 3, 4, and 5-16.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

26. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 (a)(b)(c)(d)(e)(f)(g)(h) and (i) of the Notice of Hearing, in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 3 and 4-16 above.

27. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 (a)(b)(c)(d) (e) and (f) of the Notice of Hearing, in that she failed to keep records as required, as described in paragraphs 3 and 4-16 above.

28. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3 (a)(b)(c) and (d) of the Notice of Hearing, in that she falsified a record relating to her practice, as described in paragraphs 3 and 4 above.

29. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 4(a)(b)(c) (d) (e) (f) (g) (h) and (i) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 3 and 4-16 above.

College Counsel's Submissions

College Counsel submitted that with regard to Allegation #1, the Member had admitted that she failed to meet the *Professional Standards* and the *Medication Standard*. The Member had admitted to committing multiple acts of professional misconduct as set out in Allegations #2 and #3.

In regard to Allegation #4 College Counsel submitted that the conduct was directly related to the Member's nursing practice and occurred over several occasions. The Member had also

admitted that her conduct was related to nursing and was dishonourable and unprofessional. The Member's conduct was unprofessional in that it showed a serious and persistent disregard for her professional obligations. Her conduct was dishonourable in that she knew or ought to have known her conduct did not meet the standards. Therefore, on the basis of the Agreed Statement of Facts, College Counsel asked the Panel to make findings on all allegations in the Notice of Hearing.

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) through (xiv), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h), 1(i), #2(a)(i) through (xiv), 2(b), 2(c), 2(d), 2(e), 2(f), #3(a)(i) through (xiv), 3(b), 3(c), 3(d), #4(a)(i) through (xiv), 4(b), 4(c), 4(d), 4(e), 4(f), 4(g), 4(h) and 4(i) of the Notice of Hearing. As to allegations #4(a)(i) through (xiv), 4(b), 4(c), 4(d), 4(e), 4(f), 4(g), 4(h) and 4(i), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be 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)(i) through (xiv), 1(b), 1(c), 1(d), 1(e), 1(f), 1(g), 1(h) and 1(i) in the Notice of Hearing are supported by paragraphs 3-16 and 26 in the Agreed Statement of Facts. The Member admitted that while employed as a Registered Practical Nurse ("RPN") at Caressant Care Lindsay (the "Facility") between January 2019 and April 2020 she documented on a number of occasions that she had administered medications to her patients, when she had not in fact done so and had administered different medications than what was ordered and documented that the ordered medications had been administered. On February 7, 2020, the Member failed to appropriately monitor, assess and/or document when [Patient N] fell. On March 26, 2020, the Member made inappropriate remarks to or about Colleague M.D., who was performing the Facility's mandatory screening for COVID-19. On April 8, 2020, the Member documented that she had applied a Nitro patch to [Patient O], when in fact she had not done so. On April 20, 2020, the Member altered the count on the Facility's narcotic count sheet from 29 to 27 for [Patient P] contrary to the Facility's Pharmacy Policy & Procedure. The Member's conduct contravened the College's *Medication Standard* which requires nurses to take appropriate action to resolve or minimize the risk of harm to a client from a medication error and to report medication errors in a timely manner. The Member also contravened the College's *Documentation Standard* which provides that nurses are accountable for ensuring their documentation of client care is accurate, timely and complete. As well, the Member contravened the *Professional Standards* which provides that the goal of professional practice is

to obtain the best possible outcome for clients, with no unnecessary exposure to risk of harm and to establish and maintain respectful professional relationships with colleagues. The Member failed to meet these standards when she failed to administer medications or administered different medications than what was ordered and documented that these medications were administered which exposed her patients to risk of harm.

Allegations #2(a)(i) through (xiv), 2(b), 2(c), 2(d), 2(e) and 2(f) in the Notice of Hearing are supported by paragraphs 3-16 and 27 in the Agreed Statement of Facts. The Member admitted that she failed to keep records as required when she documented that she had administered medications to her patients, when she had not in fact done so and had administered different medications than what was ordered and documented that the ordered medications had been administered. Accordingly, the facts support the allegation that the member failed to keep records as required.

Allegations #3(a)(i) through (xiv), 3(b), 3(c) and 3(d) in the Notice of Hearing are supported by paragraphs 3, 4 and 28 in the Agreed Statement of Facts. The Member admitted that she falsified a record relating to her practice when she documented that she had administered medications to her patients, when she had not in fact done so and had administered different medications than what was ordered and documented that the ordered medications had been administered. Also, when the Member altered the count on the Facility's narcotic count sheet from 29 to 27 for [Patient P] contrary to the Facility's Pharmacy Policy & Procedure she falsified a record relating to her practice.

Allegations #4(a)(i) through (xiv), 4(b), 4(c), 4(d), 4(e), 4(f), 4(g), 4(h) and 4(i) in the Notice of Hearing are supported by paragraphs 3-16 and 29 in the Agreed Statement of Facts. The Panel finds that the Member's conduct in failing to administer medications and administering different medications to her patients than what was ordered and documenting that the ordered medications were administered, failing to appropriately monitor, assess and/or document after [Patient N] had fallen and her inappropriate remarks to or about Colleague M.D. regarding the COVID-19 screening procedure was clearly relevant to the practice of nursing. The Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations as set out in the *Medication Standard*, the *Documentation Standard* and the *Professional Standards*.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through falsifying patient charts by documenting that medications were given when they were not and by altering the Facility's narcotic count sheet. The Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

College 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 three months of the date that this Order becomes final.

Penalty Submissions

Submissions were made by College Counsel.

College Counsel submitted that on January 26, 2023, in accordance with the agreement between the College and the Member, the Member signed the Joint Submission on Order that also provides in Appendix "A" an undertaking and agreement by the Member for the Member's permanent resignation as a member of the College effective January 26, 2023 (the "Undertaking"). Pursuant to this Undertaking, the Member undertook, acknowledged and agreed to:

a) Permanently resign as a member of the College, effective from the date the Member signed the Undertaking;

b) Not apply for membership with the College as a Registered Nurse or Registered Practical Nurse at any time in the future;

c) Agreed that the public portion of the College's Register would indefinitely reflect that the Member entered into an Undertaking with the Executive Director to permanently resign as a member of the College as part of an agreed resolution of allegations of professional misconduct;

d) No longer have a right to the issuance or reinstatement of a Certificate of Registration from the College;

e) No longer have a right to use the title "Nurse", "Registered Nurse", "Registered Practical Nurse", "RN", "RPN" or a variation, an abbreviation or an equivalent in another language;

f) No longer have a right to hold herself out as a Nurse, Registered Nurse, Registered Practical Nurse or as a person who is qualified to practise in Ontario as a Nurse, Registered Nurse or Registered Practical Nurse;

g) No longer have a right to engage in the practice of nursing in any capacity; and

h) Agreed the College was authorized to and could, in its sole discretion, provide a copy of the Undertaking and/or its terms to a governing body that regulates nursing in Canada or elsewhere in response to an inquiry or otherwise.

The aggravating factors in this case were:

- The Member's conduct was serious and took place over a long period time;

- The Member's conduct led to inadequate care for numerous patients and could have led to harm; and
- The Member's conduct brought discredit to the profession.

The mitigating factors in this case were:

- The Member had no prior disciplinary history with the College;
- The Member took responsibility for her conduct by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College; and
- The Member had permanently resigned from nursing.

Specific deterrence was not essential in this case because the Member had already undertaken to permanently resign from the practice of nursing. In such circumstances, the penalty of an oral reprimand was sufficient.

General deterrence would be achieved through the oral reprimand and the fact that the findings would be publicly posted indefinitely. This would send a clear message to other members of the profession that there are serious consequences for this type of conduct.

Overall, the public would be protected by the Member's resignation of her certificate of registration and the ability of the College to communicate this to any governing body that regulates nursing in Canada. Accordingly, the Panel would not need to impose further conditions in order to achieve protection of the public.

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

CNO v. Gault (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member altered records, failed to assess a patient after a fall and misappropriated medication. The penalty was an oral reprimand as the member had signed an undertaking to permanently resign as a member of the College. This penalty is the same as what was being proposed in the case before this Panel.

CNO v. Marcano (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member administered medications not ordered, falsified documents and failed to provide reports to nurses/physicians. The penalty was an oral reprimand as the member had signed an undertaking to permanently resign as a member of the College. This penalty is the same as what was being proposed in the case before this Panel.

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 three months of the date that this Order becomes final.

Reasons for Penalty Decision

The Panel accepts that the Joint Submission on Order was entered into by the parties as set out in the Affidavit of Sarah Hellmann (Exhibit #2), and the exhibits attached thereto.

The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility.

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. 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.

In the normal course, this is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation.

In this case, because the Member has undertaken to permanently resign, the oral reprimand is a sufficient penalty and no other specific deterrence is required.

Furthermore, because of the Member's resignation, it is not necessary to consider rehabilitation and remediation in determining the appropriate penalty.

General deterrence is also addressed as the Panel concluded had the Member's situation been different and no Undertaking given, the Panel would have ordered a suspension, and terms, conditions and limitations on the Member's certificate of registration which would have been in line with previous penalties.

Finally, the penalty of reprimand is appropriate because the public is already protected through the permanent resignation by the Member and her Undertaking to not apply for membership with CNO as a Registered Nurse or Registered Practical Nurse at any time in the future.

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

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