DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Ingrid Wiltshire-Stoby, NP	Chairperson
	Sandra Larmour	Public Member
	Mary MacNeil, RN	Member
	Donna May, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	GLYNNIS HAWE for
	)	College of Nurses of Ontario
- and -	)	
	)	
SARAH GREIG	)	MONICA TESSIER for
Registration No. 06274505	)	Sarah Greig
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: October 3, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on October 3, 2022, via videoconference.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, *1991*, for an order preventing public disclosure and banning publication or broadcasting of the name(s) of the patient(s), or any information that could disclose the identity(ies) of the patient(s) referred to orally or in any documents presented in the Discipline hearing of Sarah Greig.

The Panel considered the submissions of College Counsel and Member's Counsel and decided that there be an order preventing public disclosure and banning publication or broadcasting of the name(s) of the patient(s), or any information that could disclose the identity(ies) of the patient(s) referred to orally or in any documents presented in the Discipline hearing of Sarah Greig.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs #1(a), #1(b), #1(c), #1(e)(i), (ii), (iv); #2(a)(i), (ii), (iii); #3(a), #3(b), #3(c), #3(e)(i), (ii) and (iv) in the Notice of Hearing dated August 24, 2022. The Panel granted this request. The remaining allegations against Sarah Greig (the "Member") are as follows:

IT IS ALLEGED THAT:

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

    a) [*Withdrawn*];

    b) [*Withdrawn*];

    c) [*Withdrawn*];

    d) on or about October 7, 2017, while working as a RN at Terrace Lodge in Aylmer, Ontario (the "Terrace Facility"), you failed to conduct a pain assessment, and/or to administer pain medication, to [the Patient] in a timely manner;

    e) on or about October 7, 2017, while working as a RN at the Terrace Facility, while feeding [the Patient], you:

        i. [*Withdrawn*];

        ii. [*Withdrawn*];

        iii. used a towel that had been used to clean [the Patient's] vomit to also clean [the Patient's] mouth; and/or

        iv. [*Withdrawn*];

2. [*Withdrawn*];

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

    a) [*Withdrawn*];

    b) [*Withdrawn*];

    c) [*Withdrawn*];

d) on or about October 7, 2017, while working as a RN at the Terrace Facility, you failed to conduct a pain assessment, and/or to administer pain medication, to [the Patient] in a timely manner;

e) on or about October 7, 2017, while working as a RN at the Terrace Facility, while feeding [the Patient], you:

i. [*Withdrawn*];

ii. [*Withdrawn*];

iii. used a towel that had been used to clean [the Patient's] vomit to also clean [the Patient's] mouth; and/or

iv. [*Withdrawn*].

Member's Plea

The Member admitted the allegations set out in paragraphs #1(d), #1(e)(iii), #3(d) and #3(e)(iii) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Sarah Greig (the "Member") obtained a diploma in nursing in Zimbabwe in 1979 and a diploma in midwifery in Zimbabwe in 1981. She attained her licence to practice nursing and midwifery from the Nurses' Council of Zimbabwe in 1981.

2. The Member emigrated from Zimbabwe to England in 2002. She attained her licence to practice nursing and midwifery from the United Kingdom's Nursing and Midwifery Council in 2002.

3. The Member immigrated to Canada in 2005. She registered with the College of Nurses of Ontario (the "CNO") as a Registered Nurse ("RN") on March 3, 2006. She is entitled to practice nursing in Ontario without restrictions.

4. The Member was employed on a casual basis at Terrace Lodge from May 18, 2017, to October 31, 2017, at which time her employment was terminated in relation to the incident described below.

5. The Member is currently employed at St. Joseph's Southwest Centre for Forensic Mental Health Care in St. Thomas, Ontario. She began working for St. Joseph's Healthcare in 2006.

PRIOR HISTORY

6. The Member has no prior disciplinary findings with CNO.

THE FACILITY

7. Terrace Lodge is located in Aylmer, Ontario.

8. Terrace Lodge is a long-term care home with approximately 100 residents.

THE INCIDENT

9. On October 7, 2017, the Member worked the 07:00-19:00 shift at Terrace Lodge. She was assigned to work in the Lower South Unit (the "Unit").

10. The Member was the charge nurse for Terrace Lodge's 100 residents and the primary nurse for approximately 30 residents, including [the Patient]. As the Member was a casual nurse at Terrace Lodge, she had at that point provided direct care to [the Patient] as a palliative patient approximately three times.

11. [The Patient] was 99-years old at the time of the incident. He had been diagnosed with Parkinson's disease and stroke, among a number of other co-morbidities.

12. At the time of the incident, [the Patient] was under palliative care orders. [The Patient] was ordered to receive 0.5-1mg of hydromorphone 2 mg/ml (Dilaudid) subcutaneously up to every 30 minutes as required for shortness of breath or pain.

13. In the week prior to the date of the incident, [the Patient] typically received two doses (1mg each) of hydromorphone during the day shift, with the first dose typically administered between 07:00 and 09:00.

14. On the day before the incident, October 6, 2017, [the Patient] had required and was given four injections of 1mg of hydromorphone, at 04:11, 11:17, 18:03, and 22:08.

15. On the Unit, it is common for staff or family members to advocate for comfort of the palliative patients. This is because the long-term effects of opioids are no longer a serious concern, and the goal of care becomes making the patient as comfortable and pain free as possible.

16. [The Patient's] two daughters, [Daughter 1] and [Daughter 2], visited him on a daily basis. [Daughter 2] is no longer available to testify.

17. If [Daughter 1] were to testify, she would state that she arrived at her father's bedside at approximately 07:00 on October 7, 2017, and that [Daughter 2] arrived at approximately 08:00.

18. If [Daughter 1] were to testify, she would state that [the Patient] was exhibiting signs of experiencing high levels of pain shortly after her arrival, including moaning and groaning and pointing to his hip to indicate that it was one of the sources of his distress. She would state that, beginning at or around 08:00, she asked the Member for assistance with [the Patient's] pain three times, that the Member acknowledged her requests, but that the Member did not attend the patient's room.

19. Two PSWs ([PSW 1] and [PSW 2]) were assigned to the Unit on October 7, 2017. [PSW 2] is no longer available to testify. If [PSW 1] were to testify, she would state that she and [PSW 2] attended [the Patient's] room together at around 10:00 and found him wincing and moaning in pain.

20. If [PSW 1] were to testify, she would state that at around 10:10, [PSW 2] called the Member to request the Member assess the patient and give him pain medication. At around 10:30, when the Member had not yet attended, [PSW 1] then went to the Member to ask her to assist with [the Patient's] pain. [PSW 1] would also state that the Member acknowledged that she had been informed about the patient's pain but did not attend.

21. At approximately 10:40, [PSW 1] informed the RPN on shift, [RPN 1], that when the PSWs repositioned [the Patient], he exhibited signs of pain including moaning, facial grimacing, and restlessness. [PSW 1] told the RPN that [the Patient's] family members, two PSWs, and a member of housekeeping staff had each made requests of the Member to administer pain medication to [the Patient], but that the Member had not yet attended to assess [the Patient's] pain and administer medication.

22. The RPN attended [the Patient's] room shortly thereafter. The Member had documented administering pain medication to [the Patient] for the first time that morning only a few minutes before the RPN arrived at [the Patient's] room, at 10:47. Ultimately, the Member administered four injections of pain medication to [the Patient] during her shift, at 10:47, 12:36, 14:21 and 17:17.

23. If [Daughter 1] were to testify, she would state that the time between her first request and the time the Member attended to [the Patient] was around 2-3 hours.

24. While in [the Patient's] room, [the Patient's] daughters informed the RPN that the Member had also fed their father very quickly, and that he had vomited.

25. If [Daughter 1] were to testify, she would state that the Member came to [the Patient's] room with thickened apple juice, which they informed the Member he

didn’t like. She would also state that the Member proceeded to feed him the thickened apple juice very quickly.

26. While the Member was feeding [the Patient] thickened apple juice, he vomited. If [Daughter 1] were to testify, she would state that the Member used a towel to clean up the vomit. [Daughter 1] would testify that the Member then used the same soiled towel to wipe in and around [the Patient’s] mouth.

27. If the Member were to testify, she would state that when she began her shift, she was informed by the outgoing charge nurse that [the Patient’s] comfort level had been maintained with one pain medication injection during the previous nightshift and two during the previous dayshift. The Member checked the MAR and confirmed that this information was accurate.

28. If the Member were to testify, she would state that she began her first round of resident visits at approximately 07:15. She checked on [the Patient] and found him sleeping comfortably. Without disturbing [the Patient] from his sleep, she completed a pain assessment using the PAINAD criteria. [The Patient] exhibited no pain indicators. She documented her findings. [The Patient’s] daughters were not in the room during this visit and assessment.

29. If the Member were to testify, she would state that she next attended to her direct-care diabetic patients, as they required blood glucose testing and insulin administration to be completed before being taken to the dining hall for breakfast.

30. If the Member were to testify, she would admit she was informed by the two PSWs and at least one family member of [the Patient] that he required pain medication. As a result, at 10:47 the Member attended [the Patient's] room and administered 1mg of hydromorphone.

31. The Member admits that given [the Patient’s] palliative condition, she ought to have attended to assess his pain level more frequently on the morning of the incident, particularly given that he typically required and received hydromorphone between 07:00 and 09:00 in the days prior. The Member also admits that she ought to have attended immediately to assess [the Patient’s] pain upon being notified that he was awake and showing visible signs of pain.

32. If the Member were to testify, she would state that on the day of the incident the Unit was understaffed and that, as the only RN on the Unit, she was having some trouble keeping up with patient care demands that morning. She would also state that she was required to attend with the Facility physician during patient rounds that morning, which was also placing extra demands on her time. Nevertheless, the Member admits that she ought to have attended to [the Patient] earlier than she ultimately did.

33. The Member also admits that she fed thickened apple juice to [the Patient], which he then vomited. The Member does not recall being told by [the Patient's] family that he did not like thickened apple juice. If the Member were to testify, she would deny that she fed [the Patient] quickly. She would state that she believed she was feeding [the Patient] in a safe and appropriate manner.

34. If the Member were to testify, she would state that she retrieved clean linens from the clean linens room which she used to clean the vomit from [the Patient's] face and chest. The Member admits that she then used the soiled towel to clean [the Patient's] mouth, although if she were to testify, she would state that she did not intend to disrespect [the Patient] in doing so. The Member denies that she used the soiled towel to wipe the inside of [the Patient's] mouth.

35. Nevertheless, the Member admits that her cleaning [the Patient's] mouth with a soiled towel fell below the standards of practice. She appreciates that her demeanour and actions were perceived by [the Patient's] family as disrespectful. Even though she did not intend any disrespect during her interactions with [the Patient] and/or his family members, the Member regrets that her actions were perceived as such by [the Patient's] family. If the Member were to testify, she would state that she had great respect for [the Patient] and felt they enjoyed a good nurse-patient relationship to that point. The Member admits, however, that it was her responsibility to ensure that she made [the Patient's] family members feel comfortable and supported throughout the time that she was providing care to [the Patient].

36. [The Patient] ultimately passed away two days after the incident, on October 9, 2017. The cause of [the Patient's] death was unrelated and not in any way attributed to the Member's conduct.

CNO STANDARDS

37. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her practice and conduct meets the legislative requirements and the standard of the profession. Nurses are responsible for their actions and the consequences of those actions. A nurse demonstrates accountability by actions such as:

    a. Providing, facilitating, advocating and promoting the best possible care for [patients];

    b. Assessing/describing the [patient] situation using a theory, framework or evidence-based tool and identifying/recognizing abnormal or unexpected client responses and taking action appropriately;

c. Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;

d. Seeking assistance appropriately and in a timely manner;

e. Taking action in situations in which [patient] safety and well-being are compromised;

f. Evaluating/describing the outcomes of specific interventions and modifying the plan/approach; and

g. Taking responsibility for errors when they occur and taking appropriate action to maintain [patient] safety.

38. CNO's *Professional Standards* provide that professional relationships are based on trust and respect, and result in improved client care. A nurse demonstrates having met this standard by actions such as:

a. role-modelling positive collegial relationships;

b. demonstrating effective conflict-resolution skills; and

c. using a wide range of communication and interpersonal skills to effectively establish and maintain collegial relationships.

39. In addition, CNO's *Professional Standards* further provides that a nurse demonstrates leadership by providing, facilitating and promoting the best possible care/service to the public. A nurse demonstrates this standard by actions such as role-modelling professional values, beliefs and attributes.

40. CNO's *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard")* places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse. The *TNCR Standard* further provides that the relationship is based on trust, respect, empathy, and professional intimacy, and requires the appropriate use of power inherent in the care provider's role.

41. The *TNCR Standard* provides that nurses use a wide range of effective communication strategies and interpersonal skills to appropriately establish, maintain, re-establish, and terminate the nurse-patient relationship. A nurse meets the standard by:

a. being aware of her/his verbal and non-verbal communication style and how [patients] might perceive it;

b. assisting a [patient] to find the best possible care solution by assessing the [patient's] level of knowledge and discussing the [patient's] beliefs and wishes;

c. modifying communication style, as necessary, to meet the needs of the [patient];

d. recognizing that all behaviour has meaning and seeking to understand the cause of a [patient's] unusual comment, attitude, or behaviour; and

e. listening to the concerns of the family of a patient and acting on those concerns when appropriate and consistent with the [patient's] wishes.

42. The *TNCR Standard* also requires nurses to protect patients. A nurse demonstrates having met the standard by not exhibiting physical, verbal, and non-verbal behaviours toward a [patient] that demonstrate disrespect for the client or are perceived as such by the patient or others.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

43. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(d) and 1(e)(iii) of the Notice of Hearing, as described in paragraphs 9-42, above.

44. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(d) and 3(e)(iii) of the Notice of Hearing, and in particular that her conduct was unprofessional, as described in paragraphs 9-36, above.

OTHER

45. With the leave of the Panel of the Discipline Committee, CNO withdraws the remaining allegations in the Notice of Hearing, which are as follows:
    i. 1(a), 1(b), 1(c), 1(e)(i), 1(e)(ii), and 1(e)(iv);
    ii. 2(a)(i), 2(a)(ii), and 2(a)(iii);
    iii. 3(a), 3(b), 3(c), 3(e)(i), 3(e)(ii), and 3(e)(iv).

Submissions on liability were made by College Counsel.

College Counsel submitted that contained in the Agreed Statement of Facts are the Member's admissions along with reference to the relevant paragraphs containing the facts. With regard to allegations #1(d) and #1(e)(iii), the relevant College standards are included in the Agreed Statement of Facts along with the Member's admissions that the standards were breached. With regard to allegations #3(d) and #3(e)(iii), the allegations have arisen from the course of providing care and are therefore relevant to the practice of nursing. The Member's conduct was

unprofessional as it constituted a serious disregard to act with care and empathy, and respond promptly to a palliative care patient. College Counsel submitted that the Panel has sufficient bases to make findings on the allegations.

Submissions on liability were made by the Member's Counsel.

The Member's Counsel agreed that the facts support the allegations of professional misconduct as admitted in the Agreed Statement of Facts in paragraphs 43-44. The Panel was asked to accept the facts and make findings of professional misconduct in accordance with the Member's admissions.

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(d), #1(e)(iii), #3(d) and #3(e)(iii) of the Notice of Hearing. As to allegations #3(d) and 3(e)(iii), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that the evidence supports findings of professional misconduct as alleged in the Notice of Hearing. Allegations #1(d) and #1(e)(iii) in the Notice of Hearing are supported by paragraphs 9-43 in the Agreed Statement of Facts. [The Patient] was a 99-year-old palliative care patient at Terrace Lodge (the "Facility") in the Lower South Unit (the "Unit") with a number of co-morbidities.

With regard to allegation #1(d), the Member received three requests from [the Patient's] daughter on October 7, 2017 beginning at or around 08:00 and a request from one of Patient [the Patient's] Personal Support Workers ("PSWs") [PSW 2] at 10:10 and another request by [PSW 1] around 10:30. The requests were for assistance to address [the Patient's] pain. Despite acknowledging the requests from [the Patient's] daughter as well as the requests from the PSWs, the Member did not attend to [the Patient's] pain. On the day of the incident the Member was the charge nurse for 100 residents and the primary nurse for approximately 30 residents at the Facility. The Unit was also short staffed and demands were placed on the Member to be present for patient rounds. The Panel acknowledges that this would be a very busy assignment. However, despite assessing [the Patient's] pain at the start of the shift, the Member should have listened to the family member and to her colleagues when they informed her that [the Patient's] condition had changed and required her attention. She should have adjusted her priorities and taken action to ensure [the Patient's] well-being was not compromised. The first documentation of administration of pain medication was at 10:47,

almost three hours following the first request. [The Patient] also required another three doses of pain medication that shift, the last at 17:17, which was more than the typical amount administered during the day shift on the previous week or the previous day. This indicated that [the Patient] may have suffered a particularly painful day on October 7, 2017. Some of this distress may have been avoided had the Member conducted a more appropriate and timely assessment of [the Patient's] condition and administered pain medication earlier. Not appropriately assessing and delaying pain medication for almost three hours failed to provide the best possible care and did not demonstrate timely and appropriate care nor accountability for care and therefore was a breach of the College's *Professional Standards*. As well, [the Patient's] family and the PSWs trusted the Member to appropriately assess and respond to [the Patient's] pain needs in a timely manner. The Member was in a leadership role as the charge nurse and should have role-modelled positive collegial relationships by listening and acting on the concerns of her colleagues. The *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard*") requires nurses to listen to the concerns of the family of a patient and act on those concerns when appropriate. The Member failed to listen to the family and act appropriately when [the Patient] required help for his pain thereby also breaching the *TNCR Standard*.

With regard to allegation #1(e)(iii), the Member admitted that she fed thickened apple juice to [the Patient], [the Patient] vomited and the Member admitted to using a towel soiled with vomit to clean [the Patient's] mouth. The *TNCR Standard* places the responsibility for establishing a therapeutic nurse-patient relationship on the nurse. At the core of this relationship is trust, respect and empathy. This standard requires nurses to be aware of how patients might perceive the actions of a nurse. Nurses must not exhibit behaviors toward a patient that demonstrate disrespect or are perceived as such by others. The Member stated that she did not intend to disrespect [the Patient] with her actions. Intent notwithstanding, the Member's behaviour of wiping [the Patient's] mouth with a towel soiled with vomit would be perceived as disrespectful. The Member's conduct also did not demonstrate respect or empathy and as such is considered a breach of the *TNCR Standard*.

Allegations #3(d) and #3(e)(iii) in the Notice of Hearing are supported by paragraphs 9-36 and 44 in the Agreed Statement of Facts. The Panel finds that the Member's conduct was clearly relevant to the practice of nursing and was unprofessional. The Member demonstrated a serious and persistent disregard for her professional obligations by breaching the expectations laid out in the College's *Professional Standards* and the *TNCR Standard*.

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 2 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in a practicing class.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend 2 meetings with a Regulatory Expert (the "Expert"), at the Member's own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules and decision tools (where applicable):

            1. *Code of Conduct,* and
            2. *Professional Standards*.

        iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

        v. The subject of the sessions with the Expert will include:

            1. the acts or omissions for which the Member was found to have committed professional misconduct,
            2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
            3. strategies for preventing the misconduct from recurring,

4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into the Member's behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on the Member's certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

iii. Provide the Member's 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;

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

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

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

Penalty Submissions

Submissions were made by College Counsel.

College Counsel submitted that the Panel is required to accept a Joint Submission on Order unless to do so would put the administration of justice into disrepute and not be in the public interest. College Counsel submitted that neither of these conditions are present in the case before this Panel.

The aggravating factor in this case was:

- The Member's conduct showed a disregard for her professional obligations with respect to the care of a palliative patient.

The mitigating factors in this case were:

- The Member took responsibility by admitting to the allegations and entering into an Agreed Statement of Facts and a Joint Submission on Order with the College;
- The Member has no prior disciplinary history with the College after a very long career in the practice; and
- The Member has cooperated with the College throughout the discipline process.

College Counsel submitted that the elements of the penalty satisfy the goals of a penalty order which is to protect the public, maintain professional standards, and enhance public confidence in the ability of the College to regulate nurses. This is achieved through specific deterrence to deter this Member from engaging in this conduct in the future. General deterrence is also required to deter the membership at large of similar conduct. Where appropriate, a penalty should also provide for remediation and rehabilitation.

Specific deterrence is provided through the oral reprimand and the 2-month suspension of the Member's certificate of registration. The oral reprimand will assist the Member to understand how her actions are perceived by members of the profession as well as the public. The 2-month suspension sends a strong message that this behaviour is unacceptable and helps to ensure it is not repeated. General deterrence is provided through the 2-month suspension of the Member's certificate of registration, which sends a strong signal to all members of the profession that this type of conduct is unacceptable. Remediation and rehabilitation are provided through the 2 meetings with a Regulatory Expert and the review of the College's publications. These two elements will help prepare the Member to return to practice in a

manner that is expected of her. Public protection is also provided through the 12 months of employer notification as there will be oversight on the Member's practice.

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. Gibson (Discipline Committee, 2014): This case proceeded by way of an Agreed Statement of Facts. The member was alleged to have administered a suppository in a rough manner to a client with co-morbidities. The member also failed to respond to an assistance alarm and once she attended the client, the member handled the client roughly. The panel found the member had breached the standards and that she had conducted herself unprofessionally and dishonourably. The penalty was similar to the penalty proposed in the case before this Panel and included an oral reprimand, a three-month suspension of the member's certificate of registration, terms, conditions and limitations including three meetings with a Nursing Expert, 12 months of employer notification and random spot audits of the member's practice. This case falls within a similar range of penalties although the misconduct is not identical. As well, this case had multiple incidents of unprofessional conduct whereas the case before this Panel involves only one incident with multiple features and thus supports a lower sanction.

CNO v. Campeau (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts. In this case, the member failed to assess a patient who had suffered an injury, failed to complete an incident report and take appropriate actions. The member also failed to take appropriate action with respect to the patient's declining health status and also failed to help another nurse colleague. The member breached the standards, failed to keep records and engaged in unprofessional and dishonourable conduct. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert and 12 months of employer notification. This case is similar in nature to the case before this Panel but has more allegations. As well, the repeated failures to meet the College's standards over time are demonstrably more serious than the case before this Panel.

CNO v. Whyte (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts. In this case, the member failed to assess and respond to changes in a patient's health condition. The member failed to also properly document. The patient's condition deteriorated, and the member failed to take appropriate actions and report the patient's conditions to the patient's daughter. The panel found that the member breached the standards of practice and engaged in dishonourable and unprofessional conduct. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, a minimum of 2 meetings with a Regulatory Expert, a nursing course in health assessment and 24 months of employer notification. The allegations in this case had a greater frequency and contributed to a higher penalty being imposed.

College Counsel submitted that the cases demonstrate that the proposed penalty is within the range of penalties taking into consideration the circumstances of this case. The penalty proposed serves the goals of penalty and considers the aggravating and mitigating factors of the case.

Submissions were made by the Member's Counsel.

The Member's Counsel agreed with the goals of penalty and that the proposed penalty meets those objectives.

The Member's Counsel submitted the following additional mitigating factors:

- The Member has been a nurse for 40 years, and is only a few months from retirement;
- The Member has been registered with the College for 16 years and considers it a privilege to serve the public;
- The Member has devoted her entire career to take care of others;
- The cause of death of [the Patient], happening two days after the events is unrelated to the Member's conduct;
- The Member accepted responsibility through her admissions and by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College; and
- The Member has saved time and resources by avoiding the need for examination and cross examination of witnesses.

The Member's Counsel submitted that the cases submitted by College Counsel support the reasonableness of the penalty that has been put before the Panel. The proposed penalty is also in keeping with the goals of penalty and the public interest.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 2 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in a practicing class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

a) The Member will attend 2 meetings with a Regulatory Expert (the "Expert"), at the Member's own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

   i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

   ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

      1. the Panel's Order,
      2. the Notice of Hearing,
      3. the Agreed Statement of Facts,
      4. this Joint Submission on Order, and
      5. if available, a copy of the Panel's Decision and Reasons;

   iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules and decision tools (where applicable):

      1. *Code of Conduct,* and
      2. *Professional Standards*.

   iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

   v. The subject of the sessions with the Expert will include:
      1. the acts or omissions for which the Member was found to have committed professional misconduct,
      2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
      3. strategies for preventing the misconduct from recurring,
      4. the publications, questionnaires and modules set out above, and
      5. the development of a learning plan in collaboration with the Expert;

   vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, in which the Expert will confirm:

      1. the dates the Member attended the sessions,
      2. that the Expert received the required documents from the Member,

3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into the Member's behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on the Member's certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

iii. Provide the Member's 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;

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

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

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

Reasons for Penalty Decision

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

that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility.

The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2-month suspension of the Member's certificate of registration. The oral reprimand will help the Member gain greater insight as to how her actions are perceived.

The proposed penalty provides for general deterrence through the 2-month suspension of the Member's certificate of registration, which sends a clear message to members of the profession that failure to meet professional obligations can result in serious penalties.

The proposed penalty provides for remediation and rehabilitation through the terms, conditions and limitations on the Member's certificate of registration, which will help educate the Member on professional standards and the *Code of Conduct.* The learning activities and the 2 meetings with a Regulatory Expert will better equip the Member with knowledge and skills and help avoid a repeat occurrence of the misconduct.

The 12 months of employer notification will also ensure the public is protected with ongoing monitoring.

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

I, Ingrid Wiltshire-Stoby, NP, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.