DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Grace Fox, NP	Chairperson
David Edwards, RPN	Member
Carolyn Kargiannakis, RN	Member
Dale Lafontaine	Public Member
Devinder Walia	Public Member

BETWEEN:

THE COLLEGE OF NURSES OF ONTARIO	(	NICK COLEMAN for the
	(	College of Nurses of Ontario
	(	
-and-	(	
	(	
	(	
GEMMA BOWLES	(	NO REPRESENTATION for
Registration No.: AA780478	(	Gemma Bowles
	(	
	(	
	(	KIMBERLEY ISHMAEL and
	(	CHRISTOPHER WIRTH
	(	Independent Legal Counsel
	(	
	(	Heard: January 29-31, 2019

AMENDED DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on January 29, 2019 at the College of Nurses of Ontario (the "College") at Toronto.

As Gemma Bowles (the "Member") was not present, the commencement of the hearing was postponed by 15 minutes to allow time for the Member to appear. Upon convening, the Panel noted that the Member was not in attendance.

College Counsel provided the Panel with evidence that the Member had been served with the Notice of Hearing on January 7, 2019 (Exhibit #2). The Panel was satisfied that the Member had received adequate notice and therefore proceeded with the hearing in the Member's absence.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991* for an order preventing the public disclosure of matters disclosed at the hearing, including the banning of the publication and broadcasting of the names of the clients or any information that could disclose the clients' identities referred to in this hearing.

The Panel considered the submissions of College Counsel and decided that there be an order banning the disclosure, including banning the publication and broadcasting, of the identities of the clients referred to in this hearing or any information that could disclose the clients' identities, including any reference to the clients' names contained in the Notice of Hearing, the evidence of the witnesses, and in any exhibits filed with the Panel.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(b)(i), 2(b)(i), 4(a) and 7(b)(ii) of the Notice of Hearing dated December 19, 2018. The Panel granted this request. The remaining allegations set out in the Notice of Hearing 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, as a Registered Practical Nurse, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in relation to:

    (a) your employment as a Personal Support Worker at ParaMed Home Health in Windsor, Ontario, with respect to the following incidents:

        (i) you disclosed personal health or other confidential information regarding the identity and residence of the client, [Client A], without the consent of the client or other authorization, when you asked your boyfriend to deliver care provider gloves from the ParaMed Home Health office to you at the client's residence on or about September 3, 2015;

        (ii) you disclosed personal health or other confidential information regarding the identity and place of residence of the clients, [Client B] and/or [Client C], without the consent of the clients or other authorization, and/or failed to maintain appropriate professional-client boundaries, when you invited your daughter to the clients' homes while you were providing care to the clients on or about March 10, 2016; and/or

        (iii) you misappropriated funds from the client, [Client D], by falsifying a cheque to yourself from the client in the amount of $400.00 on or about March 16, 2016; and/or

(b) your employment as a Registered Practical Nurse at Victoria Manor in Windsor, Ontario, with respect to the following incidents:

(i) [withdrawn];

(ii) with respect to the client, [Client E], on or about July 29, 2016,

a. you misappropriated Percocet intended for the client,

b. you administered more Percocet to the client than had been authorized by a physician; and/or

c. you falsified and/or altered in error the narcotic count record regarding Percocet administered to the client; and/or

(iii) with respect to the client, [Client E], at or about 0800 hours, on or about August 1, 2016,

a. you misappropriated Percocet intended for the client,

b. you administered more Percocet to the client than had been authorized by a physician; and/or

c. you falsified and/or entered the incorrect quantity in the medication administration record regarding the quantity of Percocet administered to the client.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(8) of *Ontario Regulation 799/93*, in that, as a Registered Practical Nurse, you misappropriated property from a client or work place in relation to:

(a) your employment as a Personal Support Worker at ParaMed Home Health in Windsor, Ontario, with respect to misappropriating funds from the client, [Client D] by falsifying a cheque to yourself from the client in the amount of $400.00 on or about March 16, 2016; and/or

(b) your employment as a Registered Practical Nurse at Victoria Manor in Windsor, Ontario, with respect to the following incidents:

(i) [withdrawn];

(ii) you misappropriated Percocet intended for the client, [Client E], on or about July 29, 2016; and/or

(iii) you misappropriated Percocet intended for the client, [Client E], at or about 0800 hours, on or about August 1, 2016.

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(10) of *Ontario Regulation 799/93,* in that, while employed as a Personal Support Worker at ParaMed Home Health in Windsor, Ontario, you gave information about a client to a person other than the client or his or her authorized representative without the consent of the client or his or her authorized representative or as required or allowed by law with respect to the following incidents:

   (a) you disclosed personal health or other confidential information regarding the identity and residence of the client, [Client A], without the consent of the client or other authorization, when you asked your boyfriend to deliver care provider gloves from the ParaMed Home Health office to you at the client's residence on or about September 3, 2015; and/or

   (b) you disclosed personal health or other confidential information regarding the identity and place of residence of the clients, [Client B] and/or [Client C], without the consent of the clients or other authorization, when you invited your daughter to the clients' homes while you were providing care to the clients on or about March 10, 2016.

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(13) of *Ontario Regulation 799/93,* in that, while employed as a Registered Practical Nurse at Victoria Manor in Windsor, Ontario, you failed to keep records as required with respect to the following incidents:

   (a) [withdrawn];

   (b) you improperly altered the narcotic count record regarding Percocet administered to the client, [Client E], on or about July 29, 2016; and/or

   (c) you entered the incorrect quantity in the medication administration record regarding the quantity of Percocet administered to the client, [Client E], at or about 0800 hours, on or about August 1, 2016.

5. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(14) of *Ontario Regulation 799/93,* in that, while employed as Registered Practical Nurse at Victoria Manor in Windsor, Ontario, you falsified a record relating to your practice with respect to the following incidents:

   (a) you falsified the narcotic count record regarding Percocet administered to the client, [Client E], on or about July 29, 2016; and/or

   (b) you falsified the medication administration record regarding the quantity of Percocet administered to the client, [Client E], at or about 0800 hours, on or about August 1, 2016.

6. You have committed an act of professional misconduct as provided by subsection 51(1)(a) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(18) of *Ontario Regulation 799/93,* in that, while employed as a Registered Practical Nurse at Victoria Manor in Windsor, Ontario, you contravened a term, condition or limitation on your certificate of registration with respect failing to comply with terms, conditions or limitations on your certificate of registration imposed by interim order of the Inquiries, Complaints and Reports Committee dated March 23, 2016, and in particular:

   (a) you contravened the restriction with respect to accessing and/or administering controlled substances, including narcotics, in or about May-August 2016,

   (b) you failed to notify your employer in or about May 2016 that the question of your capacity had been referred to the Fitness to Practise Committee and had not yet been decided, and/or

   (c) you failed to notify the College of Nurses of Ontario in or about May 2016 regarding your place of employment and the signed statement from the employer confirming that the employer had received the required notification regarding the referral to the Fitness to Practise Committee.

7. 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, as a Registered Practical Nurse, 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 relation to:

   (a) your employment as a Personal Support Worker at ParaMed Home Health in Windsor, Ontario, with respect to the following incidents:

      (i) you disclosed personal health or other confidential information regarding the identity and residence of the client, [Client A], without the consent of the client or other authorization, when you asked your boyfriend to deliver care provider gloves from the ParaMed Home Health office to you at the client's residence on or about September 3, 2015;

      (ii) you disclosed personal health or other confidential information regarding the identity and place of residence of the clients, [Client B]. and/or [Client C], without the consent of the clients or other authorization, and/or failed to maintain appropriate professional-client boundaries, when you invited your daughter to the clients' homes while you were providing care to the clients on or about March 10, 2016; and/or

      (iii) you misappropriated funds from the client, [Client D], by falsifying a cheque to yourself from the client in the amount of $400.00 on or about March 16, 2016; and/or

(b) your employment as a Registered Practical Nurse at Victoria Manor in Windsor, Ontario, with respect to the following incidents:

(i) you failed to comply with terms, conditions and limitations on your certificate of registration imposed by interim order of the Inquiries, Complaints and Reports Committee dated March 23, 2016, and in particular:

a. you contravened the restriction with respect to accessing and/or administering controlled substances, including narcotics, in or about May-August 2016,

b. you failed to notify your employer in or about May 2016 that the question of your capacity had been referred to the Fitness to Practise Committee and had not yet been decided, and/or

c. you failed to notify the of College of Nurses of Ontario in or about May 2016 regarding your place of employment and the signed statement from the employer confirming that the employer had received the required notification regarding the referral to the Fitness to Practise Committee;

(ii) [withdrawn];

(iii) with respect to the client, [Client E], on or about July 29, 2016,

a. you misappropriated Percocet intended for the client,

b. you administered more Percocet to the client than had been authorized by a physician; and/or

c. you falsified and/or altered in error the narcotic count record regarding Percocet administered to the client; and/or

(iv) with respect to the client, [Client E], at or about 0800 hours, on or about August 1, 2016,

a. you misappropriated Percocet intended for the client,

b. you administered more Percocet to the client than had been authorized by a physician; and/or

c. you falsified and/or entered the incorrect quantity in the medication administration record regarding the quantity of Percocet administered to the client.

Member's Plea

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

Overview

The Member was registered as a Registered Practical Nurse ("RPN") with the College on January 4, 2011 until May 14, 2015 when her registration was suspended by an interim order of the Inquiries, Complaints and Review Committee ("ICRC"). On December 30, 2015, the Member's certificate of registration was reinstated. Following the outcome of a decision of the ICRC on March 23, 2016, terms, conditions and limitations were placed on the Member's certificate of registration pending the outcome of a hearing before the Fitness to Practise Committee. Subsequently, the Member voluntarily surrendered her certificate of registration on September 9, 2016.

A number of incidents from two facilities were brought to the College's attention and were the focus of this hearing. On June 15, 2015, the Member was hired as a Personal Support Worker ("PSW") at ParaMed Home Health in Windsor, Ontario ("Facility A"). The Panel agreed with the College's submission that while the incidents at Facility A occurred while the Member was employed as a PSW, she had an active certificate of registration with the College and was thus subject to all the standards that members of the profession are held to.

The first incident occurred at Facility A on September 3, 2015 when the Member ran out of gloves and contacted her boyfriend to pick up more at Facility A's office. The Member, without consent of the client or other authorization, proceeded to disclose to her boyfriend the identity and residence of [Client A] in order to obtain the gloves.

The second incident at Facility A occurred on March 10, 2016 when the Member disclosed confidential information regarding the identity and place of residence of [Client B] and [Client C] by having the Member's daughter accompany her to the clients' private residences without the clients' consent or other authorization.

The final incident at Facility A occurred on March 16, 2016 when the Member misappropriated funds from [Client D] by falsifying a cheque to herself from the client in the amount of $400.00. Following a supervisory meeting at Facility A related to this incident, the Member was placed on a non-disciplinary leave and did not return to continue her employment.

On March 23, 2016 the ICRC imposed terms, conditions and limitations on the Member's certificate of registration on an interim basis pending the outcome of a hearing before the Fitness to Practise Committee. Included in these terms, was that the Member must inform her employer of the conditions and limitations and that she was also restricted from accessing or administering controlled substances.

In May of 2016, the Member was hired for a casual position at Victoria Manor ("Facility B") in Windsor, Ontario. The position was originally posted as working as both a PSW and as an RPN however when she was hired, she was placed into an RPN line.

The incidents at Facility B occurred on July 29, 2016 and August 1, 2016. On both dates, the Member misappropriated Percocet intended for [Client E]. According to medication records, a greater number of Percocet was administered than ordered by a physician. Upon further investigation of medication records, it was alleged that the Member falsified and altered the narcotic count and quantity of Percocet administered.

The incidents at Facility B occurred during the period of time in which the terms, conditions and limitations were in effect, thus the Member was also in contravention of those terms.

With respect to the allegation relating to [Client A], the Panel had to determine whether the Member disclosed confidential information when she had her boyfriend deliver a supply of gloves to the client's home.

With respect to [Client B] and [Client C], the Panel had to determine whether the Member disclosed confidential information when she invited her daughter to the client's homes while she was providing care.

With respect to the allegations relating to [Client E], the Panel had to determine whether the Member misappropriated Percocet, administered more Percocet than ordered, falsified and/or altered in error the narcotic count record, and falsified and/or entered the incorrect quantity in the medication administration record on two separate dates at Facility B.

With respect to the allegations relating to contravening terms, conditions and limitations on her certificate of registration, the Panel had to determine whether the Member failed to notify her employer and whether the Member failed to notify the College when she commenced employment at Facility B.

Finally, the Panel had to determine whether the conduct would be regarded by members of the profession as disgraceful, dishonourable and/or unprofessional.

The Panel heard from three fact witnesses, one expert witness, and reviewed 38 exhibits, including the Member's registration history with the College, facility policies and procedures, position descriptions, work schedules, performance correction notices, bank account statements, copies of cheques, medication records, and College practice standards.

The Panel found the Member committed acts of professional misconduct as alleged in allegations 1(a)(i), 1(a)(ii),1(a)(iii), 1(b)(ii), 1(b)(iii), 2(a), 2(b)(ii), 2(b)(iii), 3(a), 3(b), 4(b),4(c), 5(a), 5(b), 6(a), 6(b), 6(c), 7(a)(i), 7(a)(ii), 7(a)(iii), 7(b)(i), 7(b)(iii) and 7(b)(iv).

With respect to allegations 7(a)(i) and 7(a)(ii), the Panel found that the Member's actions would reasonably be regarded by members of the profession as unprofessional.

With respect to allegations 7(a)(iii), 7(b)(i), 7(b)(iii) and 7(b)(iv), the Panel found that the Member's actions would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

The Evidence

At the outset of the hearing, the Panel was provided with a book of documents. Each Tab in the book of documents was entered as an individual exhibit. College Counsel called three fact witnesses to provide in-person evidence and one expert witness to provide an expert opinion on the College's Practice Standards.

Witness #1 – [ ], former Supervisor at ParaMed Home Health ("Facility A")

College Counsel presented the first witness, [Witness 1], a retired Supervisor at Facility A, a homecare agency that provides personal support services to clients in their own homes. Registered with the College as a Registered Nurse in [ ], [Witness 1] was the Supervisor at the time of the incidents involving clients [Client A], [Client B], [Client C] and [Client D]. In describing her employment history, [Witness 1] testified she was employed at Facility A from [ ] as a staff nurse and then became Supervisor [ ] at the same facility until her retirement in [ ]. As Supervisor, [Witness 1] advised she was responsible for 60 of the approximately 100 PSWs hired at Facility A and that her duties included hiring, firing, conducting interviews and providing performance correction and discipline.

[Witness 1] testified that the Member was employed at Facility A from June 2015 until April 2016. In reviewing documents, the witness confirmed that the Member completed her orientation which included reviewing the facility's Standards of Confidentiality, Standards of Conduct, Staff Commitment document and Confidentiality Policy – Client Records/Information document. Added attention was given during the orientation to a number of bullets in the documents which detailed staff members' commitments such as, *"I will give priority to the welfare and safety of the client while performing my assignment."* and *"I will respect the confidentiality of all client information. I will disclose such information only when authorized by ParaMed to do so."* The Member signed the ParaMed Staff Commitment document on June 15, 2015.

The witness testified that she was involved in an incident with the Member in relation to the Member's boyfriend coming to the office to get more gloves for her. During the boyfriend's interaction in the office, [Witness 1] testified that when he came in, he stated the name and address of [Client A] where he was to deliver the gloves. College counsel asked if this would be considered a breach of the confidentiality policy of Facility A. [Witness 1] agreed and stated that she proceeded to set up a Performance Correction meeting with the Member. The performance correction exhibit was reviewed by College Counsel and [Witness 1] confirmed that the Member wrote an admission of the incident and that the Member's signature was present on the document dated September 11, 2015.

College Counsel proceeded to review with the witness the second incident which occurred approximately 6 months after the first. [Witness 1] testified that this issue came to light when the [family member] of [Client B] called into the office to report that the Member had brought her own daughter to the client's home. [Witness 1] testified that following the phone call, she contacted all clients whom the Member was scheduled to see on the date of the incident. [Witness 1] was able to confirm that the Member had brought her daughter to the homes of [Client B] and [Client C]. After confirming the incidents with the clients, [Witness 1] subsequently brought the Member in for

another Performance Correction meeting. That document was entered as an exhibit and confirmed by [Witness 1] to have the Member's written admission of the events and the Member's signature.

The final incident at Facility A occurred when the [family member] of [Client D] notified [Witness 1] that a cheque in the amount of $400.00 was made payable to the Member from the client but was not written or signed by the client. [Witness 1] testified that she had set up a meeting with the Member the very day they heard from the client's [family member]. [Witness 1] testified that during the meeting the Member did not deny receiving the cheque and that the Member reported that the cheque was in payment for two large figurines. In reviewing the Interview Findings document dated April 8, 2016, it was confirmed that the Member went to [Client D's] house outside of work time to show the client the figurines (Exhibit 15). In the Interview Findings document, the Member was not sure of the exact date but that it was sometime between March 7 and March 20, 2016. The date on the cheque, made payable to the Member, corresponded to this timeframe. [Witness 1] testified that during this meeting, the Member was given a letter explaining that she was placed on a non-disciplinary leave of absence effective immediately. The Member was to return her company Blackberry device and I.D. badge. [Witness 1] explained that Facility A had fully compensated the client for the $400. The Member was to repay Facility A but that did not occur. College Counsel asked if the Member had resigned her employment as a result of the investigation. [Witness 1] testified that Facility A had lost contact with the Member.

The Panel conducted a credibility assessment of [Witness 1] and accepts her testimony as credible.

Witness #2 – [ ], [family member] of [Client D]

College Counsel presented [Witness 2] as the second witness. [Witness 2] is the [family member] of [Client D] and the individual who first noted that there was a discrepancy with one of [Client D's] cheques. By way of background, [Witness 2] testified that [Client D] lived alone in an apartment and received assistance from Facility A, Anne's Helping Hands and a neighbour [ ]. [Witness 2] confirmed that he had access to [Client D's] bank account information and that it was his general practice to check her online account to reconcile her expenses. College Counsel asked the witness to describe how this issue came to his attention. [Witness 2] described that when he was reviewing [Client D's] account, he came across a cheque for $400.00 which he could not reconcile with the chequebook. He testified that he followed-up with [Client D] but she could not reconcile the cheque either so he proceeded to the bank. [Witness 2] explained that it took some time to be connected to an individual at the bank who was able to help. Once connected, he was able to view a copy of the cheque. The witness identified Exhibit 24 as a copy of the cheque. College Counsel asked if the witness was familiar with [Client D's] handwriting. [Witness 2] responded that he was and that the writing on the body of the cheque and the signature were not [Client D's]. Below the copy of the cheque in Exhibit 14 was another signature which a staff person from Facility A had obtained from [Client D] to assist in comparing [Client D's] actual signature to the signature on the cheque. [Witness 2] confirmed the signature below the copy was [Client D's] actual signature. Additional documents were entered into evidence which showed the amount of $400 was withdrawn from [Client D's] account via a cheque whose number matched that of the cheque given to the Member. Copies of cheques that were signed by [Client D] were also entered into evidence to assist in comparing writing styles and signatures. [Witness 2] testified that

[Client D] kept her cheques in an unsecured wooden box on a counter in her kitchen. They were readily available to those who were familiar with [Client D's] home.

The Panel conducted a credibility assessment of [Witness 2] and accepts his testimony as credible.

Witness #3 – [ ], Director of [ ] at Victoria Manor ("Facility B")

College Counsel presented their next witness [Witness 3]. [Witness 3] is the Director of [ ] at Facility B and has been employed in this position since 2013. Prior to her employment at Facility B, she attended [ ]. [Witness 3] explained that Facility B is a Housing with Supports home and is a 114-bed open facility which means residents are free to come and go as they please, however the front door is locked for safety purposes. [Witness 3] also explained that in her position as Director, she is responsible for all staff and issues with residents as they arise.

[Witness 3] confirmed that the Member was hired in May of 2016 and was subsequently terminated in August of 2016. The following documents were entered into evidence through the witness: the Member's employment interview notes ("Exhibit #17"), minimum requirements for Charge Nurse position ("Exhibit #18"), position descriptions for each shift ("Exhibit #19"), a list of documents for employee review ("Exhibit #20"), the facility's rules of conduct ("Exhibit #21"), the facility narcotics policy ("Exhibit #22"), the Member's work schedule ("Exhibit #24" and "Exhibit #25").

With respect to Exhibit #21, the Panel noted the document was updated after the events at issue. [Witness 3] confirmed that the additions were the last four bullets. The Panel could not and did not take into account these last four bullets into its decision.

[Witness 3] testified that narcotic medications are packaged separately from a resident's routine medications and that narcotics are kept in a separate locked drawer in the medication cart. She explained that each resident has their own designated narcotic blister pack, separated by dividers with the resident's name. Counsel proceeded to walk the witness through the various medication records. [Witness 3] explained with respect to the administration of 'as needed' ("PRN") narcotic medications, staff are to record on the Medication Administration Record ("MAR"), Narcotic Count Card, and the Narcotic Shift Count sheet. [Witness 3] also stated that the type of information noted on the various sheets has to include: who administered the medication, the date and time of administration, the amount given, amount wasted and the amount on hand after administration.

With respect to the incident involving [Client E] on July 29, 2016, [Witness 3] confirmed the client was prescribed Percocet with the instructions to take one or two tablets by mouth daily as needed. She explained that it was considered a normal pattern for the client to receive one tablet at 0200 hours during the midnight shift. College Counsel reviewed the *Shift Change Narcotic Drug Count Record*. [Witness 3] confirmed that the Member worked 0700 to 1500 hours on July 29, 2016 and the Drug Count record indicates that there were 15 Percocet remaining in stock for [Client E] at the beginning of the Member's shift. Exhibit #27 was entered into evidence which [Witness 3] confirmed was a zoomed-in photograph version of the Percocet Narcotic Count Card for [Client E] from the dates of July 20, 2016 to August 8, 2016. [Witness 3] indicated that according to this record it appeared the 0200 hour dose was adjusted after the fact to show two pills were administered instead of the one Percocet that was standard practice for [Client E] to receive.

[Witness 3] testified this would bring the count from 16 to 14 but the record shows 15 and the number appears to be "smudged". [Witness 3] also testified that the Narcotic Count Card shows two more Percocets were administered by the Member at 0800 hours on July 29, 2016 which the count sheet indicated 13 tablets remained in stock. [Witness 3] testified that the Narcotic Count Sheet showed the Member signed that 15 Percocet were remaining at the beginning of her shift and that 12 were remaining at the end of her shift. This discrepancy was confirmed by the oncoming charge nurse for the 1500 to 2300 shift who clarified on the Medication Administration record *"Rec'd 30-7-16 12 Tabs."*

With respect to the incident involving [Client E] on August 1, 2016, [Witness 3] confirmed the work schedule entered as Exhibit #24 indicated the Member worked 0700 to 1500 hours on August 1, 2016. College Counsel referred the witness to a number of Exhibits and she confirmed the Percocet count at the beginning of the Member's shift was nine. [Witness 3] confirmed that there was no shift change record for August 1, 2016 as they were unable to locate it. [Witness 3] testified that according to Medication Administration records for August 1, 2016, the Member's initials were placed under the written administration time of 1000 hours. She also testified that the Narcotic Count Card shows two Percocet were administered at 0900. This dose of Percocet would be in contravention of the amount ordered by the Physician.

With respect to the issue of the Member's practise restrictions, College Counsel asked [Witness 3], whether or not the Member advised management that there were restrictions on her certificate of registration. She testified that they were not made aware of this until another nurse noticed the amount of Percocet given to [Client E] was adjusted and that nurse told [Witness 3] to check the College's register. [Witness 3] testified that up to that point, she had not checked the register. College Counsel reviewed Exhibit #28 which was a printed copy of the College's register information on the Member dated August 2, 2016. [Witness 3] told the Panel it was at this time a meeting was set up and the Member was subsequently terminated and reported to the College.

The Panel conducted a credibility assessment on [Witness 3] and accepts her testimony as credible.

Expert Witness – Elizabeth Krestick

The College tendered Ms. Elizabeth Krestick ("Ms. Krestick") as an expert witness on the standards of practice as it relates to the allegations in the Notice of Hearing. College Counsel entered Ms. Krestick's Curriculum Vitae as evidence ("Exhibit #29"). According to Exhibit #29, Ms. Krestick obtained her Diploma in Nursing from Grace Salvation Army School of Nursing in 1971, her Bachelor of Science in Nursing from Niagara University in 1991, her Master of Science in Nursing from the University of Western Ontario in 2006 and throughout her career has received added credentials in Healthcare Administration and Lean Six Sigma. Ms. Krestick's employment history was explored and detailed a wide variety of Administrative nursing positions including multiple management positions within the former Community Care Access Centre. With respect to her employment history, the Panel notes of particular relevance was Ms. Krestick's experience as a Consultant working on Documentation Framework and Practice Standards Quality Improvement Initiatives and her position with McMaster University teaching fourth year Professional Practice and third year Professional Community Nursing Practice courses. After reviewing her Curriculum

Vitae, the Panel accepted Ms. Krestick as an expert in the areas of professional practice as it relates to Home and Community Care.

With respect to allegations pertaining to disclosure of personal information, Ms. Krestick testified that in her opinion, the Member's actions amounted to a contravention of the standards of practice. In particular, she referenced to the *Professional Standards*, Revised 2002, pages 6 and 7, the *Confidentiality and Privacy—Personal Health Information* Standard page 3, and the *Therapeutic Nurse-Client Relationship* Standard, Revised 2006 pages 4 and 7.

With respect to the allegation of misappropriating funds and falsifying a client's cheque, Ms. Krestick opined that this was a contravention of the standards which note a nurse's responsibility to protect clients from abuse. Ms. Krestick also added that whether the client was willing to give the Member money or not, this act continues to be a contravention of the standards. In citing the standards, she made specific reference to the *Therapeutic Nurse-Client Relationship* standard, Revised 2006 pages 7(i), 8(a), 9(k) and 16.

With respect to the allegations of misappropriating narcotics, it was Ms. Krestick's opinion that the Member's actions would be a contravention of the *Documentation* standard and specifically referenced pages 6 and 7(f) and (g). Ms. Krestick testified that this issue is a matter of charting. In terms of documenting on the MARs, a nurse must include the dose (in milligrams), number of tablets, date and time and signature or initials.

With respect to the allegations of administering more narcotics than had been ordered, Ms. Krestick testified that this conduct would be a contravention of the standards of practice. In particular, she referenced the *Medication* Standard, revised 2015, citing page 3 whereas; *"[Nurses] require an order for a medication practice when a controlled act is involved, administering a prescription medication, or it is required by legislation that applies to a practice setting."* (CNO Practice Standard: *Medication*, revised 2015).

With respect to the allegation pertaining to the falsification and/or alteration of the narcotic count record, it was Ms. Krestick's opinion that the Member's conduct would be a contravention of the standards. Ms. Krestick referenced the *Documentation* Standard (revised 2008) specifically pages 6 and 7.

Finally, with respect to the allegation pertaining to the falsification and/or entering the incorrect quantity in the medication administration record, though no specific pages were cited, Ms. Krestick was very confident in her answer that this would be a contravention of the standards of practice and that obscuring the quantity of a medication is an example of pure drug diversion.

Final Submissions

College Counsel began closing submissions by reminding the Panel of the civil standard where findings of professional misconduct are weighed on a balance of probabilities and that the Panel must be satisfied it was more likely than not that the Member committed the acts as alleged. College Counsel summarized each incident for the Panel providing final comments on the evidence submitted and findings that should be made.

College Counsel clarified for the Panel that in some of the allegations, even though the Member was employed as a Personal Support Worker, the College standards apply as the Member regarded herself as an RPN, she engaged in health care activities and had an active certificate of registration with the College at the time of the incidents.

In making a decision on whether the delivery of gloves by the Member's boyfriend amounted to breaching confidentiality, College Counsel reiterated that the Member gave the name and address of the client to him thereby constituting a breach of the standards of practice relating to confidentiality. College Counsel referenced the Performance Correction notices in which the Member acknowledged the incident occurred. It was the College's position that this was a breach of the standards of practice and would reasonably be regarded by members of the profession as unprofessional.

With respect to whether the Member having her daughter accompany her to clients' homes was a breach of the standards, College Counsel submitted that the Member was placing her personal needs over the needs of the client thus breaching the standards. College Counsel added that members of the profession would reasonably regard this conduct as unprofessional.

College Counsel submitted to the Panel that with respect to the incident surrounding the misappropriation of funds and falsifying a cheque from a client, the evidence supports the conclusion that the cheque had a forged signature. In coming to this conclusion, College Counsel cited the testimony of the client's [family member] who was familiar with the client's handwriting and was able to provide comparisons of the cheque in question with cheques that were signed by the client. These actions of the Member would be a serious breach of the standards of the profession. College Counsel continued by submitting that the conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

With respect to the incidents at Facility B, College Counsel submitted that any dispensing of more than two tablets of Percocet would be contrary to Physicians' orders, which the evidence shows occurred in this case. College Counsel reiterated that the normal pattern for the client was to take one Percocet at 0200 hours and the only exceptions occurred on days the Member was responsible for administering the medications.

College Counsel submitted that the evidence before the Panel suggested the Member was trying to cover her tracks by altering medication administration records and that the Member was misappropriating narcotics. Given the evidence, College Counsel submitted this amounted to misappropriation of narcotics, failing to keep records as required and falsifying records. This conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.
Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i), 1(a)(ii),

1(a)(iii), 1(b)(ii), 1(b)(iii), 2(a), 2(b)(ii), 2(b)(iii), 3(a), 3(b), 4(b), 4(c), 5(a), 5(b), 6(a), 6(b), 6(c), 7(a)(i), 7(a)(ii), 7(a)(iii), 7(b)(i), 7(b)(iii) and 7(b)(iv).

With respect to allegations 7(a)(i) and 7(a)(ii), the Member engaged in conduct that would reasonably be regarded by members of the profession as unprofessional by disclosing confidential information regarding the identity and residence of clients in her care.

Additionally, with respect to allegations 7(a)(iii), 7(b)(i), 7(b)(iii) and 7(b)(iv), the Panel found the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional by misappropriating funds from clients in her care, misappropriating narcotics, administering more narcotics than ordered by a Physician, falsifying narcotic count cards and medication administration records as well as contravening the terms, conditions and limitations placed on her certificate of registration by an interim order of the ICRC.

Reasons for Decision

The Panel undertook a credibility assessment of each witness, using the criteria as set out in *Pitts v. Ontario (Director of Family Benefits, Ministry of Community and Social Services)*, 1985 CanLII 2053, (1985), 51 O.R. (2d) 302 (Ont. Div. Ct.). The Panel then considered the evidence of each of the witnesses both individually and as a whole, with attention to their evidence, explanations for any inconsistencies, and the potential impact any inconsistencies would have on their credibility and reliability.

With respect to [Witness 1's] testimony, the Panel found her to be honest, and forthright. In her position as Supervisor, she had direct knowledge of the incidents at issue and her testimony was consistent with documentary evidence. The witness had the opportunity to make direct observations and followed up on all the issues as evidenced by the Performance Correction exhibits. She testified clearly and her story remained consistent throughout. The Panel accepts the testimony of [Witness 1] as credible.

With respect to [Witness 2], the Panel found his testimony to be forthright and truthful. [Witness 2's] observations were based on the routine review of documentary evidence in reconciling [Client D's] expenses. The Panel accepts that this unusual incident would stand out in the witness's memory. [Witness 2's] testimony was considered reasonable, factual and consistent with the evidence. The Panel accepts the testimony of [Witness 2] as credible.

The Panel found [Witness 3] to be forthright and truthful. In her position as Director of [ ], she was directly involved in the investigation and subsequent termination of the Member from Facility B and thus was able to clearly explain the incidents that occurred. The Panel notes the witness relied heavily on documentary evidence to refresh her memory on the incidents and her knowledge and understanding of the medication policies. The Panel understands that while the witness is not a nurse herself, she was able to accurately explain the medication policies and processes. The Panel accepts the testimony of [Witness 3] as credible.

The Panel found the expert evidence provided by Ms. Krestick was credible and accepted her opinion as it pertained to the College's Standards of Practise. The Panel was satisfied that Ms. Krestick had a well-rounded expertise as evidenced by her Curriculum Vitae. Of significant

importance, the Panel acknowledged her experience in teaching Professional Practice at McMaster University coupled with her significant hands-on experience she has obtained in the field of nursing since 1971.

The Panel found that the Member contravened the standards of practice of the profession by disclosing the name and address of a client under her care to her boyfriend without the consent of the client. Additionally, the Member disclosed confidential information relating to two other clients when the Member invited her daughter to their homes. These incidents demonstrated a complete disregard of the *Confidentiality and Privacy – Personal Health Information* and *Therapeutic Nurse-Client Relationship* Practice Standards as noted by the College's expert witness. The Member's conduct also showed an indifference to Facility A's Standards of Confidentiality as noted by the witness from the facility.

The Member was also found by the Panel to have misappropriated funds from a client in the amount of $400.00 when she falsified a cheque and forged the signature of a client in her care. This serious unprofessional conduct demonstrates a complete contravention of the College's *Professional Standards*, and the *Therapeutic Nurse-Client Relationship* Practice Standard. This act of misappropriating funds from a client also demonstrates a gross breach of the Standards of Conduct of Facility A. With the addition of [Witness 2's] evidence showing the falsified cheque with the actual signature of [Client D] under the signature on the cheque, the Panel has no doubt this unequivocally establishes that the Member misappropriated property of a client in her care.

With respect to the allegations pertaining to Facility B, the Panel was provided with convincing documentary evidence showing that on two separate dates the Member was working and had access to narcotics and did fail to document the administration of Percocet to [Client E]. The Panel also was provided with evidence that supported that the Member had misappropriated Percocet or administered more Percocet to the client than had been ordered by a Physician. The level of seriousness of this conduct demonstrates a complete disregard of the College's *Professional Standards, Documentation, Medication* and *Therapeutic Nurse-Client Relationship* Practice Standards and was evidenced strongly by the expert testimony provided to the Panel. Additionally this conduct is in contravention of Facility B's Rules of Conduct and Narcotics Policy.

The Panel was satisfied with the testimony provided by [Witness 3] where she showed the medication record documents that appeared to have been altered by the Member. The Panel agrees that this falsification was in order to appear as if a higher dose of Percocet was given to the Client in an act of misappropriation. The Panel found the Member did falsify medication records.

It is accepted by the Panel that the Member knew she had a responsibility to notify any and all employers of the terms, conditions and limitations ("TCL") placed on her certificate of registration and that she understood clearly that by not doing so, she would be in direct contravention of the TCLs. To support these findings of professional misconduct the Panel was assisted by several Exhibits showing the official TCLs imposed by the Interim Order of the ICRC, the Member's work schedule and medication administration record showing she handled narcotics during the period of time in which she was ordered not to.

By deeming the Director of Facility B credible, the Panel also accepts the testimony she provided stating that she was not made aware of the TCL's placed on the Member's certificate of registration. The Panel notes that it was up to the Member to ensure the Facility knew she was working with restrictions and that this conduct demonstrates an act of professional misconduct and is a breach of the *Professional Standards*.

The Panel found that the Member failed to notify the College regarding her place of employment. The Panel also found that the Member did not obtain a signed statement from her employer confirming they had received the required notification regarding the referral to the Fitness to Practise Committee.

The Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession as unprofessional by disclosing personal health information and other confidential information including the name and address of a client to her boyfriend. The Panel accepted the testimony of the Expert Witness, in particular that members of the College must utilize critical thinking skills and the Member could have met her boyfriend in a neutral area to get what she needed to provide care to her clients.

The Panel also found that the Member engaged in conduct that would reasonably be regarded by members of the profession as unprofessional by disclosing personal health or other confidential information including the identity and place of residence of two clients by inviting her daughter to the homes of clients in her care. The Panel accepted the testimony of the Expert Witness and in particular that the daughter, especially being a minor, should not be privy to who the clients are and what care is being provided to them.

With respect to the misappropriation of funds in the amount of $400.00, the Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. The Panel's finding was supported by the Expert Witness' testimony where she indicated that regardless of whether the client willingly gave her money or not, the Member was putting her own personal needs over her professional obligations and this was wholly inappropriate. Additionally, the falsification of a cheque and forging a signature of anyone whether they are a client or not is completely disregarding the professional obligations that all nurses must adhere to.

With respect to the allegations relating to [Client E], the Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. Not only did the Member fail to meet the standards of the profession and the policies and procedures of Facility B, the Member was in contravention of the TCLs put in place to ensure that incidents like this would not occur.

Ultimately, in carefully considering the standard of proof, that being on a balance of probabilities, given the totality of the evidence before it, the Panel was able to find that the incidents as alleged were more likely than not to have occurred.

Penalty

College Counsel submitted that the Panel should impose the following penalty:

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. Directing the Executive Director to revoke immediately the Member's certificate of registration.

Penalty Submissions

College Counsel presented an overview of the Member's conduct describing it as serious acts of professional misconduct that occurred over a period of time deeming her ungovernable. Counsel submitted that there are serious aggravating factors in this case. He stated that the Member was not present during the hearing to provide any mitigating factors. College Counsel continued submissions by explaining that as there was no Joint Submission on Order, the Panel was not bound to order the proposed penalty. However, College Counsel submitted that the appropriate order is a reprimand and revocation of the Member's certificate of registration.

College Counsel submitted the aggravating factors were the seriousness of the misconduct ranging from breaching the confidentiality of three clients, to inciting conflicts of interests by mixing personal and professional obligations. With respect to misappropriation of funds, the facility's policies clearly described this as inappropriate behaviour and the Member proceeded with the conduct regardless by taking advantage of an elderly woman for $400.00.

College Counsel submitted that from the commencement of her employment at Facility B, the Member contravened TCL's imposed by an interim order of the ICRC. The Member did not notify the facility of the TCL's and by not reporting them to the employer, the employer subsequently never notified the College of the Member's employment. College Counsel submitted the Member contravened restrictions on accessing and administering narcotics and suggested that the Member went on to do what the TCL's were intended to prevent. In addition to contravening the TCL's, College Counsel submitted that rather than attending the Fitness to Practise hearing, the Member instead surrendered her certificate of registration and did not attempt to answer for herself or even dispute the allegations.

The Panel was provided with nine previous cases separated into three categories:
1. Breach of confidentiality;
2. Misappropriation of funds and narcotics; and
3. Failure to comply with interim orders.

With respect to category one, the College presented the Panel with the following cases:

College of Nurses of Ontario v. Eurestica Anasarias (June 1, 2017). This case dealt with a member accessing personal health information without the consent or authorization of one client on one occasion. The member accessed electronic health records of a client who was in a separate unit and

when there was no professional purpose to do so. In delivering their penalty, the panel ordered a one month suspension, reprimand and imposed terms, conditions and limitations on the member's certificate of registration.

College of Nurses of Ontario v. Jennifer Billesberger (March 29, 2011). In this case, the member accessed health records of an estranged family member and proceeded to disclose the information without the consent or authorization of the client or their legal guardian. The panel found the member committed acts of professional misconduct and ordered a one month suspension, reprimand and imposed terms, conditions and limitations on the member's certificate of registration.

In regards to category two, the College presented the Panel with the following cases:

College of Nurses of Ontario v. Marisa Monique Genereaux (January 15, 2018). In this case, the member was found to have committed theft of narcotics from two clients on three occasions and that the member failed to report criminal charges to the College. During the hearing, the member failed to appear nor had legal representation. The panel ordered a seven month suspension, oral reprimand and imposed terms, conditions and limitations on the member's certificate of registration.

College of Nurses of Ontario v. Melissa Visca (November 23-24, 2017). In this case, the member was found to have stolen $20.00 from a client. During the hearing, the member failed to appear and did not have legal representation. The panel ordered a five month suspension, oral reprimand and imposed terms, conditions and limitations on the member's certificate of registration.

College of Nurses of Ontario v. Melanie Burton (February 25, 2013). In this case, the member was found to have stolen $215.00 from a client and was subsequently found guilty under the *Criminal Code of Canada*. During the hearing, the member failed to appear and had no legal representation attend in her absence. The panel ordered a four month suspension, oral reprimand and imposed terms, conditions and limitations on the member's certificate of registration.

With respect to category three, the College presented the Panel with the following cases:

College of Nurses of Ontario v. Terri-Ann Basilio (April 4, 2016). In this case, the member had terms conditions and limitations imposed on her certificate of registration by an order of the Fitness to Practise Committee which included working only with a Monitor present. The member was found to have failed to comply by not reporting the terms, conditions and limitations to her employer and proceeded to work for several weeks without a Monitor. During the Discipline hearing, the member was present and entered into a Joint Submission on Order which the panel ordered and included a three month suspension, oral reprimand and terms, conditions and limitations imposed on her certificate of registration.

College of Nurses of Ontario v. Nicole Kruczek (October 21, 2014). In this case, the member had a prior discipline proceeding in 2012 related to the stealing from a client. During that case which proceeded by Agreed Statement of Fact and Joint Submission on Order, the Panel ordered a suspension for which the Member did not report to her employer that she was suspended. During

the 2014 discipline hearing, the panel heard the Member was unemployed and had removed all employers from the College's registry however the panel found she was working the entire time. At the conclusion of the member's final discipline hearing, the panel ordered an oral reprimand and revocation of the member's certificate of registration.

College of Nurses of Ontario v. Papiya Mia Sircar (June 18, 2014). In this case, the member had a prior discipline order and was to be suspended for five months, however while suspended the member was found to have continued working and failed to advise the employer of the suspension. In this case, the panel found the member to be ungovernable and ordered an oral reprimand and revocation of the member's certificate of registration.

College of Nurses of Ontario v. D'Arcie Hunter (April 7, 2014). In this case, the member had two prior discipline proceedings and two orders requiring the member to attend for reprimand and nursing expert visits. The member attended the first reprimand outside of the three month timeline allotted and did not meet with the nursing expert despite repeated reminders from the College. The panel found the member to be ungovernable, as evidenced by the member not attending the final Discipline proceedings. The panel ordered revocation of the member's certificate of registration.

Penalty Decision

The Panel makes the following Penalty Order:

1. The Member is directed to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.
2. The Executive Director is directed to revoke immediately the Member's certificate of registration.

Reasons for Penalty Decision

The Panel appreciates and considers the interest of public protection to be paramount to any penalty a Discipline panel can order. In the interest of maintaining public confidence in the self-regulatory process of the College, the Panel concludes this order demonstrates to the public that this profession can govern itself in the public interest.

The Member's interests were of little relevance in this case as evidenced by the Member's surrendering her certificate of registration approximately two and a half years ago. However, the Panel does appreciate the College's processes if the Member were to rehabilitate herself and undergo the rigorous process involved in reinstatement.

The Panel concluded that the proposed penalty is reasonable and proportional to the allegations and findings. The Panel finds that the oral reprimand and the revocation of the Member's certificate of registration satisfies the principles of specific and general deterrence and public protection. The Panel finds that as the Member's certificate of registration will be revoked, the goals of rehabilitation and remediation do not apply.

I, Grace Fox, 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.