DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Sherry Szucsko-Bedard, RN	Chairperson
David Edwards, RPN	Member
Carly Hourigan	Public Member
Aisha Jahangir, RN	Member
Sandra Larmour	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
FRANCIS OSAKUE	)	NO REPRESENTATION for
Registration No. 0311639	)	Francis Osakue
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: December 13-14, 2021

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") commencing on December 13, 2021, via videoconference.

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

College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing on October 26, 2021 by way of an affidavit from [College Staff Member], Prosecutions Clerk, dated November 3, 2021, confirming that [College Staff Member] sent correspondence, which included the Notice of Hearing, on October 26, 2021 to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if he did not participate in the hearing, it may proceed without his participation. Accordingly, the Panel decided to proceed with the hearing in the Member's absence.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, *1991*, for an order preventing public disclosure and banning the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented in the Discipline hearing of Francis Osakue.

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

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegation set out in paragraph #4 in the Notice of Hearing dated October 25, 2021. The Panel granted this request. The remaining allegations against 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, while employed as a Registered Nurse ("RN") at Sherwood Court in Maple, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that:

    a) on or about October 19, 2016, you failed to conduct and/or document an adequate post-fall assessment of Patient [A];

    b) on or about October 19, 2016, you inappropriately transferred Patient [A] from the floor to the bed without using a mechanical lift, despite Patient [A] vocalizing her pain and distress when you palpated her hips;

    c) on or about February 13, 14 and 21, 2017, you failed to maintain the boundaries of the therapeutic nurse-patient relationship with Patient [B] when you accessed Patient [B]'s private telephone to make personal long-distance calls for which charges were incurred while Patient [B] was asleep and/or without her consent; and/or

d) on or about March 31, 2017, you failed to conduct and/or document an adequate post-fall assessment of Patient [C];

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation 799/93*, in that, on or about February 13, 14 and 21, 2017, while employed as an RN at the Facility, you abused Patient [B] verbally, physically and/or emotionally when you accessed Patient [B]'s private telephone to make personal long-distance calls for which charges were incurred while Patient [B] was asleep and/or without her consent;

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(8) of *Ontario Regulation 799/93*, in that, on or about February 13, 14 and 21, 2017, while employed as an RN at the Facility, you misappropriated property from a patient or work place with respect to misappropriating Patient [B]'s telephone without her consent and/or while she was asleep and using it to make long-distance phone calls for your own personal use;

4. [withdrawn]; and/or

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

   a) on or about October 19, 2016, you failed to conduct and/or document an adequate post-fall assessment of Patient [A];

   b) on or about October 19, 2016, you inappropriately transferred Patient [A] from the floor to the bed without using a mechanical lift, despite Patient [A] vocalizing her pain and distress when you palpated her hips;

   c) on or about February 13, 14 and 21, 2017, you failed to maintain the boundaries of the therapeutic nurse-patient relationship with Patient [B] when you accessed Patient [B]'s private telephone to make personal long-distance calls for which charges were incurred while Patient [B] was asleep and/or without her consent; and/or

   d) on or about March 31, 2017, you failed to conduct and/or document an adequate post-fall assessment of Patient [C]

Member's Plea

Given that the Member was not present nor represented, he 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 a Registered Nurse ("RN") from July 2003 up until February 2020 when his certificate of registration was placed on administrative suspension. The suspension was lifted in March 2020 until February 2021, when the Member was again suspended. The Member's certificate of registration expired in March of 2021. At the time of the incidents in question, the Member worked for Sherwood Court Long Term Care Home ("the Facility") in Maple, Ontario as an RN assigned to the role of night shift Charge Nurse. As the Charge Nurse, the Member was responsible for overseeing the welfare of all residents, supervising unregulated care providers and taking the lead in any emergency management situations.

Multiple reports about the Member were escalated to management while the Member was working in the role of Charge Nurse at the Facility.

The first incident occurred in the early morning of October 19, 2016, when the Member was alerted by a Personal Support Worker ("PSW") to an unwitnessed fall involving Patient [A]. The Member was alleged to have failed to conduct a complete post-fall assessment and inappropriately transferred Patient [A] to her bed without the use of a mechanical lift. Patient [A] was subsequently assessed by paramedics and sent to hospital where she was admitted for several days with a fractured hip.

The second set of incidents occurred on February 13, 14 and 21, 2017 when the Member was alleged to have used Patient [B]'s telephone to make personal long-distance calls while Patient [B] was asleep, without her consent, and for which charges were incurred by Patient [B].

The third incident occurred on March 31, 2017, when the Member was alleged to have failed to conduct an adequate post-fall assessment on Patient [C]. It was alleged that the Member did not take Patient [C]'s vital signs or assess an injury that remained untreated by the Member. It was also alleged that the Member left Patient [C] to call 911 and did not return until paramedics arrived to take the resident to the hospital.

With respect to the allegations pertaining to Patient [B], the Panel had to determine whether the conduct amounted to verbal, physical, and/or emotional abuse. The Panel also had to determine whether the Member misappropriated property from the same resident when he used her private phone to make personal long-distance calls for which charges were subsequently incurred by Patient [B].

With respect to all of the allegations, the Panel had to determine whether the Member's conduct contravened or failed to meet a standard of practice of the profession and would amount to disgraceful, dishonourable and unprofessional conduct.

The Panel heard from three fact witnesses and one expert witness and received and reviewed 34 exhibits and a Book of Authorities containing past Discipline Committee decisions and reasons. The exhibits included the facility's orientation packages, policies and procedures, work schedules, incident reports, hospital assessments, progress notes, interview notes and a selection of the College's standards of practice.

Based on the evidence, the Panel made findings on allegation #1 that the Member committed acts of professional misconduct in relation to contravening the standards of practice of the profession. With respect to allegation #2, the Panel found that the Member emotionally abused a patient. As to allegation #3, the Panel found that the Member misappropriated property from Patient [B] when he used her phone to make personal calls. Regarding allegations #5(a), 5(b), 5(c) and 5(d), the Panel found that the Member's conduct would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

The Evidence

College Counsel submitted 34 exhibits into evidence, including a signed affidavit affirming the attempted delivery of the Notice of Hearing to the Member, the Public Register Report of the Member, the Facility's orientation package, policies and procedures, work schedules, incident reports, hospital assessments, progress notes, interview notes and a selection of the College's standards of practice.

Testimony was heard from four witnesses: the Member's former employer, the son of Patient [B], the PSW for Patient [C], and an expert witness.

Oral Evidence

Witness 1 – [ ] ("[Witness A]")

[Witness A] is an RN registered with the College since 2009 and was employed as Director of Care at Sherwood Court during the relevant times. [Witness A] testified to the general specifications of the facility including that the Long-Term Care Home houses around 100 individuals in the three-storey building. With respect to staffing, [Witness A] described a ratio of 1 RN and 4 PSW during a standard 11:00 pm to 7:00 am night shift for which he hired the Member to work. [Witness A] asserted that as the registered staff working the night shift, the Member was working in a Charge Nurse capacity. He went on to describe the Member's responsibilities as securing quality care for the residents and ensuring that the PSWs are doing their regular routine. From an administrative perspective, the Charge Nurse is also responsible

for leading any emergency management initiatives and confirming that the building is properly secured.

In describing the incident of October 19, 2016, involving [Patient A], it was determined during the investigation and ensuing conversations with the Member, that the Member did not follow proper protocol as the resident was in severe pain, was transferred to her bed and subsequently diagnosed in hospital with a fracture.

With respect to the incidents of February 13, 14 and 21, 2017 regarding [Patient B], [Witness A] testified that he first learned there was a problem from a report lodged by the resident's son. [Witness A] stated that after he identified the dates of the calls, he called the number and had the opportunity to talk to a woman on the line who confirmed she received multiple calls from a male staff member threatening her which led her to block the Member's number. [Witness A] testified that he believed this is what prompted the Member to use the resident's phone at Sherwood Court. College Counsel asked if the woman gave the staff member's name, to which [Witness A] testified that it was the Member.

With respect to the incident of March 31, 2017, [Witness A] testified that he was made aware of [Patient C] falling and that he filed a mandatory report to the Ministry along with conducting investigations with the Member and the 1 on 1 PSW. [Witness A] recalls being advised by the PSW that the PSW called the Member who came in and had a look at the resident but did not do a head-to-toe assessment, take vitals, or provide any first aid treatment for a laceration which the resident had sustained.

[Witness A] also identified the following documentary evidence:

Revera Long Term Care Employee Workbook (Exhibit #4)

[Witness A] identified this document as the general orientation workbook given to and signed by the Member which includes policies that employees are required to read and sign prior to starting on their respective units. Policies include, confidentiality, conflict of interest, code of conduct, non-abuse, and the resident bill of rights and responsibilities. Included in the workbook are quizzes to measure an employee's understanding of the resident's rights and responsibilities and non-abuse definitions.

Revera New Employee Pre-Work Information Package (Exhibit #5)

College Counsel provided the Panel with a copy of this document which [Witness A] identified as a high-level document indicating that all staff will be provided with a package, and that it must be brought to all orientation days. The document lists all policies and procedures that staff must read and review and is signed by the Member acknowledging he has received and read all of the policies listed.

Revera Fall Interventions Risk Management Policy (Exhibit #6)

College Counsel inquired if fall and post-fall management was included in the training program for Registered Nurses. [Witness A] was directed to review and identify this document, which he testified was the policy and protocol at Revera necessary for all registered staff to follow and uphold in the event a resident has a fall.

Revera Post-Fall Management Procedure (Exhibit #7)

The Panel was provided with a copy of the Post-Fall Management Procedure which [Witness A] testified is the actual step-by-step procedure on what to do during and after a resident fall. College Counsel made special reference to step #1 which states, "*If there is any sign or concern of a fracture, the Resident will not be moved, and 911 is called."* College Counsel asked [Witness A] to list signs of a fracture and what the expectation is for the RN if they see those signs. He testified that if a resident is showing signs of a fracture, they should not be moved and 911 must be called as moving the resident may aggravate the injury.

Revera Resident Non-Abuse Policy (Exhibit #8)

[Witness A] reviewed this document as the specific policy pertaining to the non-abuse of residents. He went on to say that the document is used to protect a resident from abuse. [Witness A] confirmed that the policy was in effect during the Member's employment.

Revera Types & Definitions of Abuse or Neglect (Exhibit #9)

College Counsel directed [Witness A] to page 2 of this document which sets out the Facility's definition of financial abuse.

Sherwood Court LTCC: Daily Schedule (Exhibit #10)

The Panel was provided with a copy of the daily work schedule for October 18, 2016 that [Witness A] testified shows the Member scheduled to work the night shift 11:00 pm to 7:00 am. On the same document, College Counsel pointed out a checkmark beside the Member's name which [Witness A] advised was placed there to confirm that the Member did show up to the shift.

Ministry of Health and Long Term Care ("*MOHLTC*)" *Critical Incident Report dated October 19, 2016 (Exhibit #11)*

[Witness A] identified this document as the mandatory reporting form that he submitted to the MOHLTC on October 19, 2016, relating to the fall sustained by [Patient A]. [Witness A] stated that as the incident caused a significant injury to the resident, the Ministry mandates prompt

reporting of these matters. College Counsel directed [Witness A] to the section he filled in that lists the resident's clinical condition. [Witness A] states in the document that prior to the fall, the resident walked independently and suffered from osteoporosis, and Alzheimer's disease among other illnesses and that she had a CPS score of 5 which [Witness A] testified meant that her cognitive status is such that she can no longer make wise decisions for herself.

Mackenzie Health Patient Summary Sheet for [Patient A] (Exhibit #12)

At the direction of College Counsel, [Witness A] identified this document as the discharge report sheet that the Facility received when [Patient A] returned home from the hospital. The document shows the admitting diagnosis of a left hip fracture.

[Patient A] Progress Notes from Sherwood Court (Exhibit #13)

[Witness A] testified that this document is a print-out from their electronic documentation tool, 'Point Click Care'. He continued by stating that the documentation specifically recounted the post-fall incident for [Patient A] from the time she had the fall. College Counsel directed [Witness A] to the Member's assessment which shows a pain score of 9 out of 10. [Witness A] stated that would mean the resident was in severe pain at the time. [Witness A] also pointed to the Member's documentation which stated, "*Screaming louder when hips palpated*," categorizing it as a manifestation of the injury due to the fall. [Witness A] noted for the Panel that the documentation neglects to show the resident's blood pressure and pulse at the time of the fall. He stated, "If it is not documented, it is not done".

[Patient A] Fall Assessment Report (Exhibit #14) and [Patient A] Post Fall Assessment (Exhibit #15)

The Panel was provided with a copy of the fall assessment report which [Witness A] testified was the post fall documentation completed by the Member and describes that the Member acknowledged there were no visible injuries and that the Member attempted to stand the resident up with another staff member despite the resident's continued screams.

[Witness A] Notes dated October 19, 2016 (Exhibit #16)

[Witness A] reviewed this document and advised the Panel that the document shows notes he made during his conversation with the Member about the incident on October 19, 2016. [Witness A]'s notes described the Member stating that he did the assessment for the resident and that the resident was in severe pain when he palpated her hips. [Witness A] went on to read his note where the Member acknowledged he should not have moved the resident quoting the Member as saying, "That's what the paramedics told me", and inferring the Member knew he should not have done that. College Counsel directed [Witness A] to a section of his notes where he asks the Member if he used a mechanical lift and the Member confirmed he had not, instead saying that two staff assisted him to transfer the resident. [Witness A]

testified that the Facility has a “No lift policy” and after doing an assessment, if a Nurse finds a resident cannot get up on their own, they are to use a mechanical lift.

MOHLTC Critical Incident Report dated April 3, 2017 (Exhibit #20)

[Witness A] described [Patient C] to the Panel as a 75-year-old gentleman with a diagnosis of dementia, and a CPS score of 4 which means the resident cannot make safe decisions for himself. After reviewing this document, [Witness A] identified this as the mandatory reporting form that he submitted to the MOHLTC on April 3, 2017, relating to the fall sustained by [Patient C]. [Witness A] informed the Panel that the resident had a dedicated 1 on 1 PSW hired to monitor the behaviour of the resident because he had what [Witness A] described as responsive behaviours. [Witness A] reviewed the document stating that the resident had a fall witnessed by the 1 on 1 PSW and that he was subsequently sent to the hospital where he received a diagnosis of spinal fracture and subsequently passed away 12 days later.

[Witness A] Notes dated April 5, 2017 (Exhibit #21)

[Witness A] identified this document as his hand-written notes he took while he was in a meeting with the son of [Patient B]. [Witness A] recalled the meeting concerning someone using a resident’s personal phone. He went on to tell the Panel that the resident’s son was very upset, felt disrespected and was worried about what she might have heard as the phone is beside the resident’s headboard.

Screenshot of [Patient B]’s phone bill (Exhibit #22)

The Panel was provided with a copy of the screenshot which [Witness A] identified as the resident’s phone bill confirming the dates of February 13, 14 and 21, 2017 when the calls were made as well as the times which all occurred between the hours of 1:00 am – 6:11 am.

Sherwood Court LTCC: Daily Schedule (Exhibit #23)

The Panel was provided with a copy of the daily work schedules for February 13, 14 and 21, 2017. [Witness A] testified that the schedules show that the Member worked the night shift 11:00 pm to 7:00 am on all three dates. College Counsel confirmed with [Witness A] that the hours the Member worked corresponded to the dates and times in the phone bill and that he was the only male nurse working the night shift.

Notes of April 6, 2017 meeting (Exhibit #24)

[Witness A] identified his notes of his April 6, 2017 meeting with the Member and testified that the Member did not grasp that the bigger issues were his breach of policy and the lack of trust.

[Witness A] further testified that following the April 6, 2017 meeting, the Member's employment was terminated.

MOHLTC Critical Incident Report submitted April 7, 2017 and amended April 21, 2017 (Exhibit #25)

[Witness A] identified this as the Critical Incident Report submitted to the Ministry for the Member's use of [Patient B]'s personal phone.

Witness 2 – [ ] ("[Witness B]")

[Witness B] introduced himself to the Panel and advised that his mother was [Patient B] and that she originally moved into the Facility because her advancing Alzheimer's disease and other physical ailments required her to have 24-hour care. He was her primary caregiver and took care of her bills.

[Witness B] testified that he recalled an incident with his mother's phone bill that came to his attention when he was reviewing his mother's bills and found it unusual that she would be calling long-distance to Guelph. [Witness B] told the Panel that he had originally let the issue go until he saw more charges on the following month's phone bill for phone calls to Guelph in the middle of the night. College Counsel questioned [Witness B] on his actions after he realized there was an issue. [Witness B] told the Panel that he called the number and that a woman answered the phone and told him she was being harassed by an ex-boyfriend. [Witness B] testified he then went to Sherwood Court and notified them about what was going on. [Witness B] recalled providing his statement to the Facility, as well as a copy of the phone bill.

Witness 3 – [ ] ("[Witness C]")

[Witness C] is a PSW who immigrated to Canada from Nigeria. In Nigeria he received a Pharmacy degree. While in Canada he completed a course to become a PSW and began working in the field in 2009. During the relevant time, [Witness C] worked for Spartan Healthcare, which he describes as a staffing agency for hospitals and other healthcare facilities to take care of their patients and at times he would also be asked to provide 1 on 1 client care.

[Witness C] testified that he recalled the resident in question, [Patient C] and that he required 1 on 1 care because clinical staff wanted to prevent him from having a negative impact on other residents.

On the date in question, [Witness C] recalled his shift started out normally. [Patient C] woke up early and [Witness C] took him down the halls in his wheelchair and to the nurses' station where the resident briefly chatted with staff before going back down the hall to his room. [Witness C] testified that he was sitting in a chair behind the resident's wheelchair and before he was able to respond, [Patient C] stood up from his wheelchair and fell. [Witness C] described seeing the resident "entangled" in the footrest and then proceeding to fall between the wall

and the door. [Witness C] testified that he immediately rushed to the nursing station and spoke to a nurse that he recalls as Francis. [Witness C] said that the Member followed him to the resident's room, looked at the resident and then left the room to call for paramedics. [Witness C] did not see the Member conduct any physical assessment of [Patient C]. He recalls the next person to come into the room was another PSW and that the Member did not re-enter the room again until the paramedics arrived.

Expert Witness – Susan Ash ("Ms. Ash")

College Counsel proceeded with the expert witness first by establishing her credentials. According to her Curriculum Vitae which was confirmed by Ms. Ash in her testimony, she is an RN, first registered with the College in 1979. Ms. Ash has extensive experience in the long-term care field as Director of Care for multiple facilities accompanied by a well-rounded education in long-term care management, administrator training, and upgrading to meet new MOHLTC legislation.

College Counsel advised the Panel of the College's intention to tender Ms. Ash as an expert in the standards of care in long-term care settings. The Panel agreed to qualify her as an expert witness.

Ms. Ash was provided with hypothetical scenarios similar to the conduct alleged in the Notice of Hearing. Ms. Ash testified that she reviewed the College's standards of practice including the *Professional Standards*, the *Therapeutic Nurse-Client Relationship* Standard ("*TNCR* Standard"), as well as the *Documentation* Standard to form the basis of her opinion. College Counsel confirmed that Ms. Ash had reviewed the documents that were in force during the time of the relevant incidents.

With respect to the incident on October 19, 2016, Ms. Ash testified that the Member did not conduct an appropriate post-fall assessment. In a follow-up question from College Counsel, Ms. Ash explained that there was no evidence of blood pressure or pulse being taken, and that vital signs are a basic component of an accurate post-fall assessment. Ms. Ash continued that as the full clinical picture was not properly noted, this would be a contravention of the College's *Documentation* Standard. Ms. Ash also pointed to a breach of the *Professional Standards* for the Member's failure to provide the clinical care that was needed and warranted. Ms. Ash further opined that the Member breached the *TNCR* Standard by not demonstrating a strong understanding of the necessities to provide care to a complex client. Concerning transferring of the resident, Ms. Ash testified that it was inappropriate to transfer her as the resident was in severe pain and had a medical history that could complicate any fall-associated injuries and that it was the Member's responsibility to know the resident's plan of care and act accordingly. Ms. Ash testified that the Member breached the ethics component of the *Professional Standards* as the Member did not appear to operate with integrity.

With respect to the incidents occurring on February 13, 14 and 21, 2017, Ms. Ash testified that the Member, by putting his personal needs before meeting the needs of the resident, crossed

the boundary of professionalism and breached the College's *TNCR* Standard. Specifically, Ms. Ash directed the Panel to some excerpts from the Standard, most notably, that Nurses are supposed to protect clients from abuse. Nurses are to conduct themselves with integrity, which Ms. Ash stated did not happen in this case. Ms. Ash added that the Member misused his power when he used the client's phone and that this conduct would also be considered financial abuse.

Finally, with respect to [Patient C], Ms. Ash testified that she did not see any evidence of a post-fall assessment and by simply observing the resident and not providing any wound care or treatment whatsoever, the Member demonstrated a gross lack of empathy for the patient. Ms. Ash testified that under the *TNCR* Standard, the Member did not provide the care required and that the Member breached the leadership component and the knowledge application components of the *Professional Standards*.

Final Submissions

College Counsel submitted a detailed summary of the documentary and witness evidence for each allegation contained in the Notice of Hearing. College Counsel reminded the Panel that 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.

College Counsel also reminded the Panel that as the Member did not participate, he is deemed to have denied the allegations made against him and that the Panel must weigh the evidence and determine if it was more likely than not that the Member engaged in the conduct alleged.

Assessing Credibility

In determining if the evidence of the witnesses was clear, cogent and convincing, College Counsel cited the multiple factors as set out in *Pitts v. Ontario (Director of Family Benefits, Ministry of Community & Social Services), 1985* whereby the Divisional Court suggested tribunals consider the following in assessing credibility:

- The appearance and demeanor of the witness and the manner in which they testified;
- The extent of the witness' opportunity to observe the matter about which they testified;
- Has the witness any interest in the outcome of the case;
- The extent to which a witness demonstrated signs of partisanship towards one side or another;
- The probability or improbability of the witness' story;
- Whether the witness has given any previous inconsistent evidence;
- Whether the testimony of the witness was contradicted by the evidence of a worthier witness.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 1(c), 1(d), 2, 3, 5(a), 5(b), 5(c) and 5(d) in the Notice of Hearing. Concerning allegation 2 of the Notice of Hearing, the Panel finds emotional abuse. With respect to allegations #5(a), 5(b), 5(c) and 5(d), the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel undertook credibility assessments of each witness, using the criteria as set out in *Pitts v. Ontario (Director of Family Benefits, Ministry of Community & Social Services), 1985.* The Panel also considered the evidence of each of the witnesses both individually and taken together 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 A]'s testimony, he readily admitted when he did not recall specifics of certain events and interactions between himself and the Member. The Panel considered these lapses as understandable degradations of memory given the events in question occurred several years prior. The Panel found that any lapses in his memory during his testimony were reasonable given the length of time since the incidents and were not relevant to the allegations. The Panel found the witness to be credible and reliable.

Ms. Ash provided the Panel with her expert opinion on the College's practice standards as they relate to the context of long-term care homes. The Panel agreed that Ms. Ash had a sizeable nursing career with an emphasis on leadership and administration in the long-term care sector. The Panel also concluded that her testimony as it related to the hypothetical scenarios provided were well-informed and provided insight into the connections between the College's standards and the Member's misconduct.

Regarding the witness, [Witness B], College Counsel submitted no documentary evidence to review with him and the Panel had to gauge his credibility based completely on his independent memory of the facts in question. The Panel determined [Witness B] to be honest and forthright in his testimony and his independent recall of the events in question meshed consistently enough with that of other witnesses and documentary evidence reviewed throughout the hearing. The Panel found this witness to be credible and reliable.

In terms of the witness testimony provided by [Witness C], College Counsel submitted no documentary evidence to review with him and the Panel measured his credibility based entirely on his independent memory of the events he witnessed. The Panel found that [Witness C] was

able to remember the events regarding [Patient C] in a way that was consistent with previous witness testimony and documentary evidence reviewed. The Panel determined this witness to be credible and reliable.

In the Case of Patient [A] (allegations #1(a) and #1(b)):

Based on the Member's assessment, it was determined that [Patient A] had a severe injury, likely to be a fracture, as that is what he communicated to the Director of Care. Recognizing that was his finding and based on the institutional policy, the Member should not have moved Patient [A]. Furthermore, paramedics advised that the individual should not have been moved.

The Panel accepted the evidence of Ms. Ash that the Member had breached the standards of practice of the profession. Further, the documentary evidence, specifically the critical incident report submitted by [Witness A], along with the relevant policies and assessment documentation and witness testimony all strongly supported the allegations in the Notice of Hearing. Consequently, the Panel found that the conduct occurred as alleged and was a breach of the College's *Documentation* Standard, *Therapeutic Nurse Client Relationship* Standard, and *Professional Standards*.

In the Case of Patient [B] (allegations #1(c), #2 and #3):

The Panel found that the conduct occurred as alleged. The Panel accepted Ms. Ash's evidence and found that the Member breached the College's *TNCR* Standard. The Panel reviewed the phone bill for Patient [B] along with the Member's work schedule. Both documents support that the Member was working 11:00 pm to 7:00 am during the dates and times the calls were placed. Further supporting the Panel's finding were [Witness B] and [Witness A] testifying to calling the number on the phone bill and speaking to the woman who identified the Member as the caller. The Member's conduct was also a gross violation of his obligation to secure the safety and well-being of Patient [B] and demonstrated no regard for the emotional well-being of Patient [B] when he used her phone in the middle of the night while she was in the bed next to it. The evidence shows the phone calls at times were loud. The Panel found that by these actions, the Member committed emotional abuse of the Patient [B]. The Member also misappropriated property of Patient [B] by making long distance phone calls on her telephone, the charges for which were incurred by Patient [B].

In the Case of Patient [C] (allegation #1(d)):

The Panel notes there was the lack of any documentary evidence including any post-fall assessments to assist in their decision making. The Panel heard testimony from [Witness C] where he recalled that the Member attended the Patient's room, looked at the Patient and proceeded to leave to call 911 without assessing vital signs or conducting a head-to-toe assessment. The Panel also agreed with the expert evidence of Ms. Ash that the apparent lack of a post fall assessment equated to the assessment not being completed at all. The Panel

accepted the evidence of [Witness C] and Ms. Ash and found that the conduct occurred as alleged and was a breach of the College's *Professional Standards* and the *TNCR* Standard.

With respect to allegations #5(a), 5(b), 5(c) and 5(d), the Panel found that the Member's conduct would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional. The conduct was clearly relevant to the practice of nursing and was unprofessional as it displayed a serious and persistent disregard for the Member's professional obligations. It was dishonourable as the Member knew or ought to have known that his conduct was unacceptable and fell well below the standards of a professional. Further, it was disgraceful as it had the effect of shaming the Member and by extension this profession and cast serious doubt on the Member's ability to discharge the higher obligations the public expects professionals to meet.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should make an Order as follows:

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 5 months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director, Professional Conduct (the "Director") in advance of the meetings;

ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

    1. the Panel's Order,
    2. the Notice of Hearing, and
    3. if available, a copy of the Panel's Decision and Reasons;

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

    1. *Professional Standards*,
    2. *Documentation*,
    3. *Therapeutic Nurse-Client Relationship Standard,* and
    4. *Code of Conduct;*

iv. Before the first meeting, the Member reviews and completes the CNO's self-directed learning package, *One is One Too Many*, at her own expense, including the self-directed *Nurses' Workbook*;

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

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

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

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

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

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:

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

ii. Provide his employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

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

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

c) The Member shall not practice independently in the community for a period of 12 months from the date the Member returns to the practice of nursing.

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

College Counsel submitted that there are a number of interests the Panel must consider when determining the proper penalty:

1. Protection of the public;

2. The maintenance of public confidence in the College's ability to self-regulate its members;
3. The Member's personal circumstances;
4. General deterrence to the membership at large;
5. Specific deterrence to the Member.

College Counsel also submitted that in determining a penalty the Panel must review the aggravating and mitigating factors surrounding the Member.

The aggravating factors in this case were:

- The seriousness of the Member's conduct;
- The Member's failure to conduct post-fall assessments;
- The Member took advantage of and abused a vulnerable patient;
- The Member's conduct demonstrates a flagrant breach of the College's standards;
- The Member's conduct showed a serious disregard for his professional obligations and brought discredit and shame.

The mitigating factor in this case was:

- The Member had no prior discipline history with the College.

College Counsel submitted to the Panel, in writing, the College Submission on Order which sought an oral reprimand, a 5-month suspension and terms, conditions and limitations on the Member's certificate of registration which included a minimum of 2 meetings with a Regulatory Expert, 18 months of employer notification and a prohibition on independent practice for a period of 12 months.

In terms of public protection, the suspension, the Regulatory Expert meetings, the employer notification, and the restriction on independent practice work together to protect the public by ensuring the Member is closely monitored for a sufficient period of time if he elects to rejoin the nursing profession in the future.

The proposed penalty provides for general deterrence through the 5-month suspension, which sends a clear message to the membership that this conduct will not be tolerated, and hopefully other members of the profession will learn from the Member's mistakes.

The proposed penalty provides for specific deterrence through the oral reprimand and the 5-month suspension which will clearly communicate to the Member that engaging in this conduct has severe consequences and it is the hope of the Panel that the Member will refrain from engaging in this conduct again.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert, which will allow the Member to learn and improve his practice.

College Counsel submitted three cases to the Panel, which in some respects were comparable but were not identical to the case at hand, to demonstrate that the proposed penalty fell within the penalty range of similar cases from this Discipline Committee.

CNO v. Campeau (Discipline Committee, 2020): In this case, the member was present at the hearing which proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. This case involved a Charge Nurse in a long-term care facility who failed to conduct a post-fall assessment of a patient who fell coming out of a wheel-trans vehicle. The Panel made findings of misconduct and the penalty included an oral reprimand, a three-month suspension, two meetings with a Regulatory Expert and 12 months of employer notification.

CNO v. Lane (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The case involved a nurse stealing two Keg gift cards totalling $150.00 in value. The panel found that the member had breached the *Professional Standards* and misappropriated property. The conduct was also found to be considered disgraceful, dishonourable and unprofessional. The penalty included an oral reprimand, a three-month suspension, two meetings with a Regulatory Expert, 18 months of employer notification and 12 months of no independent practice in the community.

CNO v. Visca (Discipline Committee, 2017): In this case the member did not attend the hearing. This case involved a homecare nurse who stole a small amount of money and narcotics from a patient. The panel found that the member breached the standards of practice of the profession, misappropriated a patient's property and that the conduct would be regarded as disgraceful, dishonourable and unprofessional. The penalty included an oral reprimand, a five-month suspension, two meetings with a Nursing Expert, 24 months of employer notification and 18 months of no independent practice in the community.

Penalty Decision

The Panel accepts the College's 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 5 months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at his own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

   i. The Expert has expertise in nursing regulation and has been approved by the Director, Professional Conduct (the "Director") in advance of the meetings;

   ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

      1. the Panel's Order,
      2. the Notice of Hearing, and
      3. if available, a copy of the Panel's Decision and Reasons;

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

      1. *Professional Standards*,
      2. *Documentation*,
      3. *Therapeutic Nurse-Client Relationship Standard,* and
      4. *Code of Conduct;*

   iv. Before the first meeting, the Member reviews and completes the CNO's self-directed learning package, *One is One Too Many*, at his own expense, including the self-directed *Nurses' Workbook*;

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

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

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

3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify his employers of the decision. To comply, the Member is required to:

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

ii. Provide his employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

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

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

c) The Member shall not practice independently in the community for a period of 12 months from the date the Member returns to the practice of nursing.

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

Reasons for Penalty Decision

The Panel 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 concluded that the proposed penalty is reasonable and in the public interest. Though the Member has not cooperated with the College, the Panel finds that the penalty satisfies the principles of specific and general deterrence. It sends a strong message to the Member and the membership as a whole, that actions such as these will not be tolerated. Members must ensure that their actions are always guided by the College's standards of practice and that the public expects members to consistently maintain high professional and ethical standards. This is particularly applicable in this case where the Member engaged in unsafe and abusive practice with a vulnerable population.

The proposed penalty also provides for rehabilitation and remediation of the Member by the terms, conditions and limitations placed on his certificate of registration.

Overall, the proposed penalty ensures that the public is protected.

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

I, Sherry Szucsko-Bedard, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.