DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Tanya Dion, RN	Chairperson
	Tim Crowder	Public Member
	Karen Goldenberg	Public Member
	Shaneika Grey, RPN	Member
	Michael Schroder, NP	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
CHERYL KENNEDY	)	ADRIENNE ANDERSON for
Registration No. 15097155	)	Cheryl Kennedy
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 17, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on January 17, 2022, via videoconference.

Publication Ban

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

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

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(c), (d), (f), 2(c), (d), (f), 3(c), (d) and (f) in the Notice of Hearing dated November 24, 2021. The Panel granted this request. The remaining allegations against Cheryl Kennedy (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 at Quinte Health Corporation - Belleville General Hospital in Belleville, Ontario (the "Hospital"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that on or about June 10, 2020, with respect to Patient 1, you:

    (a) spoke to the patient with an aggressive, raised tone of voice, yelled at the patient and/or spoke to the patient using an inappropriate tone of voice;

    (b) roughly grabbed the patient by one or both arms causing skin tear(s);

    (c) [*Withdrawn*];

    (d) [*Withdrawn*];

    (e) struck the patient on his upper leg and/or knee with a closed fist;

    (f) [*Withdrawn*]; and/or

    (g) made comments that you wanted and/or threatened to "throat punch" the patient or words to that effect; and/or

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, while employed as a Registered Nurse at the Hospital, you verbally, physically or emotionally abused Patient 1 on or about June 10, 2020, when you:

    (a) spoke to the patient with an aggressive, raised tone of voice, yelled at the patient and/or spoke to the patient using an inappropriate tone of voice;

    (b) roughly grabbed the patient by one or both arms causing skin tear(s);

    (c) [*Withdrawn*];

    (d) [*Withdrawn*];

(e) struck the patient on his upper leg and/or knee with a closed fist;

(f) [*Withdrawn*]; and/or

(g) made comments that you wanted and/or threatened to "throat punch" the patient or words to that effect; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at the Hospital, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that on or about June 10, 2020, with respect to Patient 1, you:

(a) spoke to the patient with an aggressive, raised tone of voice, yelled at the patient and/or spoke to the patient using an inappropriate tone of voice;

(b) roughly grabbed the patient by one or both arms causing skin tear(s);

(c) [*Withdrawn*];

(d) [*Withdrawn*];

(e) struck the patient on his upper leg and/or knee with a closed fist;

(f) [*Withdrawn*]; and/or

(g) made comments that you wanted and/or threatened to "throat punch" the patient or words to that effect.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), (b), (e), (g), 2(a), (b), (e), (g), 3(a), (b), (e) and (g) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Cheryl Kennedy (the "Member") obtained a degree in nursing from the University of Windsor in 2015.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on July 10, 2015.

3. The Member's certificate of registration remains active, and she is currently working at Kentwood Park, a long-term care facility.

4. The Member was employed at Quinte Healthcare Corporation's Belleville General Hospital (the "Hospital") from November 2, 2015 to June 15, 2020, when her employment was terminated as a result of the incident described below.

5. On February 18, 2020, prior to the incident described below, the Member completed a course on *Gentle Persuasive Approaches* ("GPA") offered through the Hospital. In addition, the Member completed annual orientation and training on managing responsive behaviours and de-escalation throughout the tenure of her employment, as required by the Hospital.

PRIOR HISTORY

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

THE FACILITY

7. The Hospital is located in Belleville, Ontario.

8. While working at the Hospital, the Member worked on the Acute Care for the Elderly unit (the "Unit"). The patients on the Unit are generally above 65 years of age. They typically require an alternative level of care, are awaiting placement at a long-term care facility, and/or have functional decline and other related illnesses.

9. The nurse-to-patient ratio on the Unit is 1:5 during the day shift and 1:6 during the night shift.

10. The day shift runs from 0730 to 1930 hours and the night shift runs from 1930 to 0730 hours.

11. The Member worked both day and night shifts on the Unit.

12. There are alarms on both the beds and the chairs on the Unit which alert staff that a patient is getting out of the bed or the chair. The sensors are also linked to the call-

bell at the nursing station. When an alarm is activated, a call-bell at the nursing station will also go off.

THE PATIENT

13. [Patient 1] (the "Patient") was 93 years old at the time of the incident.

14. [Patient 1] was admitted to the Hospital on June 4, 2020 due to depression, suicidal thoughts, delirium, and dementia.

15. [Patient 1] had a history of aggressive behaviour that included instances of physical violence with other Hospital staff in the days leading up to the incident described below.

16. He was also at high risk of falls. As a result, there was an order to use restraints for safety concerns.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

17. On June 10, 2020, [Patient 1] was delirious and confused periodically and increasingly agitated over the course of the day, as set out in multiple entries in his chart.

18. Near the end of the day shift, at around 1840 hours, the Patient's bed or chair alarm sounded and the Member entered his room with a new RN, [Nurse A], who was shadowing the Member that day.

19. [Patient 1] was trying to get out of his bed or chair. The Member and [Nurse A] were concerned because he was at a high risk for falling.

20. [Patient 1] tried to hit the Member and [Nurse A] during the commotion that ensued.

21. The Member grabbed [Patient 1]'s left arm near his elbow, resulting in skin tears.

22. If the Member were to testify, she would state that her intention in grabbing the Patient's arm was to prevent him from falling forward and hitting his head on the wall or on the floor as he was unsteady.

23. The Member spoke to [Patient 1] with a raised and inappropriate tone of voice.

24. Two of the Member's colleagues were completing charting at the nursing station at the time: [Nurse B], Registered Practical Nurse ("RPN") and [Nurse C], RN.

25. Both [Nurse B] and [Nurse C] observed the Member and [Nurse A] enter the Patient's room and overheard the Member saying to [Patient 1], "sit down, sit down" in a tone that indicated frustration and anger. They went to [Patient 1]'s room to find out what was going on.

26. The Member raised her voice and in an angry tone, stated to [Patient 1]: "sit down, you can't get up right now" and "stop kicking me, stop kicking me" or words to that effect.

27. The Patient was placed in a lumex chair.

28. [Nurse B] and [Nurse C] observed the Member strike [Patient 1] on the upper leg above the knee with the side of her closed fist, which they interpreted to be intentional.

29. If the Member were to testify, she would state that striking [Patient 1] with a closed fist was an accident that occurred when she placed her hand down to stabilize herself after [Patient 1] had kicked her and made contact with her knee, causing her to lose balance.

30. [Nurse A] and the Member placed [Patient 1] in restraints in the lumex chair and brought him out to the hallway.

31. One or two skin tears on the Patient's left arm were identified at this time and the Member and [Nurse A] went to get dressings for the Patient's injuries.

32. Two security guards, [Security Guard A] and [Security Guard B], arrived at approximately 1907 hours. The Member was heard yelling at [Patient 1] while security was approaching. She stopped speaking to [Patient 1] once security arrived at the scene.

33. Security noted that there were visible injuries on the patient's left arm. [Security Guard A] saw red bruises and [Security Guard B] recalled seeing cuts on his arms as well as five fingerprint marks near to where he had skin tears.

34. The two security guards spoke with the Member in the hallway to investigate the events leading to the request for their assistance. During the conversation with security, and in the presence of [Nurse A] and [Patient 1], the Member commented that she wanted to "throat punch" [Patient 1].

35. [Patient 1] looked at the security guards and stated that this was how the Member had been treating him all day.

36. The security guards remained on the Unit for approximately 20 minutes until everyone calmed down. When they left the Unit, [Patient 1] was calm and sitting in the chair in the hallway unrestrained. He was given medication by another nurse.

37. The Member documented the incident in the Patient's chart at 1925, as follows:

F: Behaviours-Responsive

A: Patient began swinging at writer with a closed fist. Patient was pressing body into writer. Patient was reoriented to situation and location. Patient called writer a "liar" and became more aggressive when he was identified. He started banging his open hand against the table saying it was not him on the identification band. Patient became even more aggressive at this point. Patient pushed writer out of the way. Patient was asked to sit in the chair and patient pushed writer again.

I: Security was called the second time the patient pushed the writer. The patient turned toward the writer as if to swing with a closed first. Patient was then held by the arms with a single hand to each arm. Patient continued to fight and Patient sustained a small skin tear to the left arm. This was covered with Tegasorb. Patient continued to demonstrate aggression. The Patient then kicked the writer in the right knee and the left shin. Patient was forcefully placed in the chair and received in this process an accidental blow to the knee while attempting to get patient into the chair. Patient was yelling at writer to "Not hit me!" Writer told patient "don't kick me!" Security arrived at this time and patient remained calm.

O: Skin tear to the arm was covered with Tegasorb and patient was reoriented by security.

CNO STANDARDS

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

39. CNO's *Professional Standards* further provides, in relation to the *Relationships S*tandard, that each nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships and a nurse demonstrates this standard by demonstrating respect and empathy for, and interest in patients.

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

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

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

    - modifying communication style, as necessary, to meet the needs of the [patient]; and

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

42. The *TNCR Standard* also requires nurses to protect the patient from harm by ensuring that abuse is prevented or stopped and reported. With respect to protecting the patient from abuse, a nurse demonstrates having met the standard by:

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

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

43. In addition, the *TNCR Standard* provides examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, intimidation including threatening gestures, teasing or taunting, insensitivity to the patient's preferences and an inappropriate tone of voice, such as one expressing impatience. Physical abuse includes using force and handling a patient in a rough manner.

44. The Member admits and acknowledges that she spoke to the Patient with a raised voice and inappropriate tone, roughly grabbed his arm causing skin tears, struck his leg with a closed fist, and commented that she wanted to "throat punch" the Patient, while in his presence. The Member admits that this conduct was a breach of the standards of practice of the profession.

45. The Member further admits and acknowledges that her tone of voice, comment about "throat punching" the Patient and use of force and handling of the Patient in a rough manner amounted to verbal, physical and emotional abuse. She acknowledges that this was contrary to the GPA techniques she was familiar with, which state that a nurse is supposed to use a calm low tone of voice.

46. If the Member were to testify, she would state that at the time of the incident, she was frustrated, overwhelmed, and not thinking clearly. She had no intention to cause any harm to the Patient or act on the comment uttered about punching the Patient.

47. If the Member were to testify, she would say she is remorseful, and she has taken steps to prevent such conduct from ever recurring. The Member would further testify that she has engaged in proactive remediation by completing a written reflection and the One is One Too Many Workbook. She has also reviewed a GPA textbook.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

48. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), (b), (e) and (g) of the Notice of Hearing, as described in paragraphs 17-35 and 38-44 above.

49. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a), (b), (e) and (g) of the Notice of Hearing, and in particular her conduct constitutes verbal, physical, and emotional abuse, as described in paragraphs 17-35 and 38-45 above.

50. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3(a), (b), (e) and (g) of the Notice of Hearing, and in particular that she engaged in conduct relevant to the practice of nursing, that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional, as described in paragraphs 17-35, 38-45 above.

OTHER

51. With the leave of the Panel of the Discipline Committee, CNO withdraws the remaining allegations in the Notice of Hearing, which are as follows:

    - 1(c), (d) and (f).
    - 2(c), (d) and (f).
    - 3(c), (d) and (f).

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), (b), (e), (g), 2(a), (b), (e), (g), 3(a), (b), (e) and (g) of the Notice of Hearing. With respect to allegations #2(a), (b), (e) and (g), the Panel finds that the Member verbally, physically and emotionally abused a patient. As to allegations #3(a), (b), (e) and (g), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1(a) in the Notice of Hearing is supported by paragraphs 23, 25, 26, 38-44 and 48 in the Agreed Statement of Facts. While the Patient was trying to get out of his bed or chair, the Member spoke to him in a raised and inappropriate tone of voice. The Member stated "sit down, sit down" in a tone that indicated frustration and anger. The Member also stated to the Patient in a raised voice and angry tone "sit down, you can't get up right now" and "stop kicking me, stop kicking me". The Member breached the *Therapeutic Nurse-Client Relationship* Standard ("*TNCR* Standard") as she was not aware of her communication style and how the Patient may have perceived it. The Member breached the *Professional Standards* as her communication style demonstrated a lack of respect and empathy for the Patient. The Member admitted that her conduct was a breach of the standards of the profession.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 21, 22, 31, 33, 37-44 and 48 in the Agreed Statement of Facts. The Patient was attempting to get out of his bed or chair and a commotion ensued whereby the Patient attempted to hit the Member. The Member responded by grabbing the Patient by his left arm, near the elbow, causing a skin tear. The Member did not meet the *TNCR* Standard as she failed to appreciate the cause of the Patient exiting out of the bed or chair, and instead reacted by grabbing his left arm causing a skin tear. The Member breached the *Professional Standards* as she failed to provide the best possible care to the Patient. The Member admitted that her conduct was a breach of the standards of the profession.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 28, 29, 37-44 and 48 in the Agreed Statement of Facts. Two of the Member's colleagues, [Nurse B] a Registered Practical Nurse and [Nurse C] a Registered Nurse observed the Member strike the Patient on the upper leg above the knee with the side of her closed fist, which they perceived to be intentional. The Member documented "Patient was forcefully placed in the chair and received in the process an

accidental blow to the knee while attempting to get patient into the chair". The *TNCR* Standard provides that a nurse meets the standard by the "appropriate use of power inherent in the care provider's role". The Member abused her power by striking the Patient, a vulnerable patient with dementia, in order to make him comply with sitting in the Lumex chair. The Member breached the *Professional Standards* as she failed to maintain a respectful and therapeutic relationship with the Patient through striking the Patient with her closed fist. The Member admitted that her conduct was a breach of the standards of the profession.

Allegation #1(g) in the Notice of Hearing is supported by paragraphs 34, 39-44 and 48 in the Agreed Statement of Facts. During an interview with two security guards which was conducted within earshot of the Patient, the Member indicated that she wanted to "throat punch" the Patient. The *Professional Standards* provides "that each nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships and a nurse demonstrates this standard by demonstrating respect and empathy for, and interest in patients". The Member's comment of wanting to "throat punch" the Patient demonstrated a lack of empathy and respect for a patient living with dementia and depression. The Member breached the *TNCR* Standard as she was not aware of her verbal communication style as the Patient may have perceived her comment to be threatening, intimidating, and likely to inflict physical harm. The Member admitted that her conduct was a breach of the standards of the profession.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 23, 25, 26, 40-43, 45 and 49 in the Agreed Statement of Facts. While the Patient was trying to get out of his bed or chair, the Member spoke to him in a raised and inappropriate tone of voice. The Member stated "sit down, sit down" in a tone that indicated frustration and anger. The Member also stated to the Patient in a raised voice and angry tone "sit down, you can't get up right now" and "stop kicking me, stop kicking me". The *TNCR* Standard states that abusive behaviours include using an inappropriate tone of voice, including expressing impatience. The Member exhibited verbal behaviours that demonstrated disrespect for the Patient constituting verbal and emotional abuse. The Member admitted that her conduct constitutes verbal and emotional abuse.

Allegation #2(b) in the Notice of Hearing is supported by paragraphs 21, 22, 31, 33, 37, 40—43, 45 and 49 in the Agreed Statement of Facts. The Patient was attempting to get out of his bed or chair and a commotion ensued whereby the Patient attempted to hit the Member. The Member responded by grabbing the Patient by his left arm, near the elbow, causing a skin tear. The *TNCR* Standard states that physical abuse includes using force and handling the patient in a rough manner. The resulting skin tears demonstrate that the Member used an excessive amount of force constituting physical abuse. The Member admitted that her conduct constitutes physical abuse.

Allegation #2(e) in the Notice of Hearing is supported by paragraphs 28, 29, 37, 40-43, 45 and 49 in the Agreed Statement of Facts. [Nurse B] and [Nurse C] observed the Member strike the Patient on the upper leg above the knee with the side of her closed fist, which they perceived to be intentional. The Member documented "Patient was forcefully placed in the chair and received in this process an accidental blow to the knee while attempting to get patient into the

chair". The *TNCR* Standard states that abuse includes using force and handling a patient in a rough manner. The intentional nature of the strike demonstrates the Member's motive to inflict harm on the Patient in order to have him comply with her demands. The Member admitted that her conduct constitutes physical abuse.

Allegation #2(g) in the Notice of Hearing is supported by paragraphs 34-35, 40-43, 45 and 49 in the Agreed Statement of Facts. During an interview with two security guards which was conducted within earshot of the Patient, the Member indicated that she wanted to "throat punch" the Patient. According to the *TNCR* Standard, the comment is verbally abusive as it is considered threatening and intimidating. The Patient stated after the Member's comment that "this is how the Member had been treating him all day". The Member engaged in verbal behaviour toward the Patient that would reasonably be perceived by the Patient as violent and intending to inflict physical harm, constituting verbal and emotional abuse. The Member admitted that her conduct constitutes verbal and emotional abuse.

With respect to allegations #3(a), (b), (e) and (g), the Panel finds that the Member's conduct in making threatening remarks towards the Patient and roughly handling him was unprofessional as it demonstrated a serious disregard for her professional obligations.

The Panel also finds that the Member's conduct was dishonourable. The Member stuck the Patient on the leg with the side of her closed fist which the Member's co-workers interpreted to be intentional. The Member knew or ought to have known that her conduct would be unacceptable and fell below the standards of a professional.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The Member's conduct of verbally abusing the Patient by indicating an intention to "throat punch" the Patient casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

Penalty

College Counsel and the Member's Counsel advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows:

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 3 months. This suspension shall take effect from the date that this Order becomes final.

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

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

        i. The Expert has expertise in nursing regulation and has been approved by the Director of 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,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

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

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

        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, online participation forms and Nurses' Workbook;

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

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

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

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

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

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

b) For a period of 12 months from the date this Order becomes final, the Member will notify her 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 her employer(s) with a copy of:

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

iii. 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.

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were that the conduct was quite serious as there was abuse directed towards the Patient. Furthermore, the Member's abusive conduct was intentional and resulted in harm to the Patient.

The mitigating factors in this case were that the Member has no prior discipline history with the College. The incident was an isolated one, involving one patient who was demonstrating aggressive behaviour towards staff. The Member has cooperated with the College and taken responsibility and accountability for her conduct by entering into an Agreed Statement of Facts and a Joint Submission on Order. The Member has proactively engaged in remediation activities.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3 month suspension of the Member's certificate of registration as it demonstrates the seriousness of the conduct to the Member.

Overall, the public is protected through the 12 months of employer notification as there will be greater vigilance by the employer on the Member's return to practice.

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

CNO v. Brosso (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member made inappropriate and abusive comments about patients and took inappropriate videos of patients. The conduct was found to be unprofessional, dishonourable and disgraceful. The penalty included an oral reprimand, a 3 month suspension, a minimum of 2 meetings with a Regulatory Expert and 12 months of employer notification.

CNO v. Hope (Discipline Committee, 2021): The conduct involved the member responding dismissively to the patient's complaint that the blood pressure cuff was too tight on her arm. The member placed the blood pressure cuff on the patient in a rough manner. The member used insensitive language towards the patient. The panel found that the member's conduct was physically, verbally and emotionally abusive towards the patient and unprofessional,

dishonourable and disgraceful. The penalty included an oral reprimand, a 3 month suspension, a minimum of 2 meetings with a Regulatory Expert and 18 months of employer notification.

Submissions were made by the Member's Counsel.

The Member's Counsel submitted that the Member is dedicated, hardworking and admired by her colleagues. The additional mitigating factors were that this incident was not reflective of her practice and was out of character for her. The Member is remorseful and has taken responsibility for her actions. The Member's intention throughout this incident was to ensure the Patient's safety rather than to cause any harm. The Member is currently employed at a long term care home and her employer is content with the quality of care the Member provides to the patients. The Member's current employer is aware of the allegations and has been supportive throughout this process.

Penalty Decision

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

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

2. The Executive Director is directed to suspend the Member's certificate of registration for 3 months. This suspension shall take effect from the date that this Order becomes final.

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

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

        i. The Expert has expertise in nursing regulation and has been approved by the Director of 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,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

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

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

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, online participation forms and Nurses' Workbook;

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

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

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

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

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

b) For a period of 12 months from the date this Order becomes final, the Member will notify her 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 her employer(s) with a copy of:

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

   iii. 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.

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

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the oral reprimand and the 3 month suspension satisfies the principle of specific deterrence as it demonstrates the seriousness of the conduct to the Member. The Panel finds that the 3 month suspension satisfies the principle of general deterrence as it sends a strong message to the membership that there are serious consequences for abuse of a patient. The 2 meetings with a Regulatory Expert will assist with remediation and rehabilitation of the Member by allowing her to gain greater insight into her

conduct. The public is protected through the 12 months of employer notification as there will be greater vigilance by the employer on the Member's return to practice.

The penalty demonstrates to the membership and the public that the College shows zero tolerance with respect to abusive actions towards patients.

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

I, Tanya Dion, 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.