DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Margarita Cleghorne, RPN	Member
Lina Kiskunas, RN	Member
Margaret Tuomi	Public Member
Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
KATSIARYNA HOPKA	)	SHEILA RIDDELL for
Reg. No. 14054391	)	Katsiaryna Hopka
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: May 28, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on Mary 28, 2018 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

The allegations against Katsiaryna Hopka (the "Member") as stated in the Notice of Hearing dated April 5, 2018 are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(a) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, in that on August 16, 2016, in the Superior Court of Justice in Newmarket, Ontario, you were found guilty of offences relevant to your suitability to practise, and in particular, you were found guilty of the following offences:

a. Between March 4, 2015 and December 1, 2015, at the Town of Newmarket in the Regional Municipality of York, you did steal narcotics, the value not exceeding $5,000, the property of the Southlake Regional Health Care [sic] Centre, contrary to section 334(b) of the *Criminal Code of Canada*; 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(18) of *Ontario Regulation* 799/93, in that you contravened a term, condition or limitation on your certificate of registration and in particular:

   a. You failed to provide the Executive Director of the College with the details of the criminal charge of theft contrary to section 334(b) of the *Criminal Code of Canada* laid against you on or about February 16, 2016, as required by section 1.5(1)1ii of *Ontario Regulation* 275/94; and/or

   b. You failed to provide the Executive Director with the details of the finding of guilt of theft contrary to section 334(b) of the *Criminal Code of Canada* made against you on or about August 16, 2016, as required by section 1.5(1)1i of *Ontario Regulation* 275/94*;* 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(19) of *Ontario Regulation* 799/93, in that you contravened the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and in particular:

   a. You failed to file a report in writing with the Executive Director of the College after being found guilty of theft contrary to section 334(b) of the *Criminal Code of Canada* made on or about August 16, 2016, as required by s. 85.6.1 of the *Health Professions Procedural Code;* and/or

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation* 799/93, in that while employed as a Registered Nurse at Southlake Regional Health Centre in Newmarket, 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:

   a. On one or more of the occasions set out in Schedule A, you signed out controlled substances for administration to clients without conducting and/or charting an adequate assessment of the need for the controlled substance and/or you signed out controlled substances when your assessment did not warrant the administration of the controlled substances and/or did not warrant the dosage signed out;

   b. On one or more of the occasions set out in Schedule B, you signed out controlled substances for administration to clients and failed to administer or dispose of those

narcotics, or record the administration or disposal of those controlled substances on the Medication Administration Record; and/or

c. On one or more of the occasions set out in Schedule C, you documented the administration of scheduled medication to clients at times inconsistent with when you signed out the medication and administered the medication; 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(13) of *Ontario Regulation* 799/93, in that while employed as a Registered Nurse at the Hospital, you failed to keep records as required, in that:

a. On one or more of the occasions set out in Schedule A, you signed out controlled substances for administration to clients without adequately charting an assessment of the need for the controlled substance and/or the need for the dosage signed out;

b. On one or more of the occasions set out in Schedule B, you signed out controlled substances for administration to clients and failed to record the administration or disposal of those controlled substances on the Medication Administration Record; and/or

c. On or about November 25, 2015, you failed to document your administration of medication, being Rosuvastatin and Furosemide, to your client [Client A]; and/or

6. 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 while employed as a Registered Nurse at the Hospital, you misappropriated property from your workplace, as follows:

a. On one or more of the occasions set out in Schedule B, you signed out controlled substances for administration to clients and failed to administer or dispose of those controlled substances; and/or

7. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation* 799/93, in that 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:

a. You were found guilty of the following offence: between March 4, 2015 and December 1, 2015, at the Town of Newmarket in the Regional Municipality of York, you did steal narcotics, the value not exceeding $5,000, the property of the Southlake Regional Health Care [sic] Centre, contrary to section 334(b) of the *Criminal Code of Canada*;

b. You failed to provide the Executive Director of the College with the details of the criminal charge of theft contrary to section 334(b) of the *Criminal Code of Canada* laid against you on or about February 16, 2016, as required by section 1.5(1)1ii of *Ontario Regulation* 275/94, thereby contravening a term, condition or limitation on your certification of registration;

c. You failed to provide the Executive Director with the details of the finding of guilt of theft contrary to section 334(b) of the *Criminal Code of Canada* made on or about August 16, 2016, as required by section 1.5(1)1i of *Ontario Regulation* 275/94, thereby contravening a term, condition or limitation on your certification of registration*;*

d. You failed to file a report in writing with the Executive Director of the College after being found guilty of theft contrary to section 334(b) of the *Criminal Code of Canada* made on or about August 16, 2016, as required by s. 85.6.1 of the *Health Professions Procedural Code*, thereby contravening s. 85.6.1 of the *Health Professions Procedural Code;*

e. On one or more of the occasions set out in Schedule A, you signed out controlled substances for administration to clients without conducting or charting an adequate assessment of the need for the controlled substance;

f. On one or more of the occasions set out in Schedule A, you signed out controlled substances for administration to clients when your assessment did not warrant the administration of the controlled substances and/or did not warrant the dosage signed out;

g. On one or more of the occasions set out in Schedule B, you signed out controlled substances for administration to clients and failed to record the administration or disposal of those controlled substances on the Medication Administration Record;

h. On one or more of the occasions set out in Schedule B, you misappropriated controlled substances in that you signed out narcotics for administration to residents and failed to administer or dispose of those controlled substances;

i. On one or more of the occasions set out in Schedule C, you documented the administration of scheduled medication to clients at times inconsistent with when you signed out the medication; and/or

j. On or about November 25, 2015, you failed to document your administration of medication, being Rosuvastatin and Furosemide, to your client [Client A].

Member's Plea

The Member admitted to the allegations set out in paragraphs 1(a), 2(a), 2(b), 3(a), 4(a), 4(b), 4(c), 5(a), 5(b), 5(c), 6(a), and 7(a), 7(b), 7(c), 7(d), 7(e), 7(f), 7(g),7(h), 7(i) and 7(j) 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

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

THE MEMBER

1. Katsiaryna Hopka (the "Member") obtained a degree in nursing from York University in 2014.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on July 28, 2014. The Member's certificate of registration expired on March 24, 2017.

3. The Member worked at Southlake Regional Health Centre (the "Hospital") from August 1, 2014 to December 4, 2015, when she was placed on leave. The Member's employment was terminated on March 23, 2017.

4. On February 7, 2017, a panel of the Inquiries, Complaints and Reports Committee asked that the Member attend an independent medical examination. On March 24, 2017, the Member's certificate of registration expired for non-payment of fees.

THE HOSPITAL

5. The Hospital is located in Newmarket, Ontario.

6. The Member was initially hired under the New Graduate Guarantee program. On March 1, 2015, she moved to a part-time position on the CV Surgical Unit as a staff nurse on the day and night shift.

7. The Hospital used AcuDose, an automated dispensing machine, to track medication withdrawals. AcuDose recorded the identity of the nurse withdrawing medication, the date and time of the withdrawal, and the client for whom the medication was withdrawn.

HOSPITAL POLICIES

8. The Hospital's policy, "Medication Administration – Responsibility of Health Care Professionals" states that all health care professionals "have a responsibility to maintain safe patient medication administration practices." It also outlines that nurses are responsible for documenting the following in the health record:

    - All assessments
    - Medication administration
    - Adverse reactions and related interventions
    - Post administration effectiveness of analgesia

9. The Hospital's policy adopts the College's *Medication* Practice Standard.

COLLEGE STANDARDS

10. The Member acknowledges and agrees that, as a standard of practice of the profession, all nurses must evaluate whether to administer medication that is prescribed on as "as needed" basis (PRN medication), before administering such medication, and to document the reason for, and the effects of, a PRN medication. The administration of PRN medication must also be documented on the Medication Administration Record ("MAR").

11. The College's *Documentation* standard says that a nurse meets the standard by:

> …ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluative.

12. It further requires that nurses document the date and time care was provided and indicate when an entry is late.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

13. On December 1, 2015, a pharmacist at the Hospital noticed an irregular transaction in AcuDose that had occurred overnight. The pharmacist noted that the Member withdrew two tablets of Tylenol 3 from AcuDose without a corresponding order in the client's chart. On further review, it was discovered that the Tylenol 3 was also not documented in the client's MAR.

14. After the initial discovery, the Hospital audited fifteen client charts from November 11-30, 2015 and subsequently completed a more comprehensive audit of the Member's files from March 2015 (when the Member was hired permanently) to October 2015.

15. The Hospital discovered numerous instances in which the Member had withdrawn medication that the Member did not document as being administered or wasted. She also frequently document medication as having been administered at times when it was not possible or not appropriate.

[Client B] – November 11, 2015

16. The Member was assigned to client [Client B] on November 11, 2015 from 0730-1930. [Client B] was palliative. The client had an order for Hydromorphone 1-3mg (tablet) Q1H PRN or 2mg (tablet) QiH PRN or 1-1.5mg injectable SC Q1H, among many other scheduled and PRN medications.

17. At 0758, the Member withdrew two 2mg tablets of Hydromorphone, although the client's pain assessment at 0800 was 0/10. She did not document the administration in the client's MAR nor that she had wasted the tablets.

18. At 1004, the Member withdrew several medications, including two 2mg tablets of Hydromorphone, the administration of which she did not document on the MAR. The Member made no note of a pain assessment at 1000. She documented that she administered Metformin at 0800 (when it was ordered), which she had withdrawn at 1000 (not 0800).

19. At 1622-1623, the Member withdrew one 1mg tablet and one 2mg tablet of Hydromorphone, which was documented in the MAR and was double signed by a colleague. At 1628, she withdrew two 2mg tablets of Hydromorphone, which she did not document in the MAR. The flowsheet does not contain any charting for a pain score assessment after 1100.

20. At 1623, the Member withdrew a Fentanyl patch, which was ordered for [Client B], but not ordered for administration on that day. The patch count moved from 1 to 0. The Member noted the discrepancy in AcuDose, and resolved it (by confirming in AcuDose that the discrepancy was resolved), but the patch count remained at 0 (meaning the patch was not accounted for).

21. At 1803, the Member withdrew 3mg of Hydromorphone, which she documented in the MAR and was doubled signed.

22. The Member admits that she withdrew Hydromorphone tablets from AcuDose at 0758, 1004, and 1628 when her assessment did not warrant their administration.

23. The Member further admits that she withdrew Hydromorphone tablets at 0758, 1004, and 1628 but did not administer these tablets, and she withdrew a Fentanyl patch at 1623 but did not administer it.

    The Member also admits that she documented the administration of Metformin at 0800 when she withdrew it at 1000 and administered it shortly thereafter.

[Client C] – November 11, 2015

24. The Member was assigned to client [Client C] on November 11, 2015 from 0730-1930. [Client C] was palliative. The client had an order for Morphine 2-5mg (IV) q30min PRN, among many other scheduled and PRN medications. She was also ordered Lorazepam 0.5mg tablet QHS PRN (at bedtime, as needed).

25. The Member assessed the client's pain and administered Morphine (IV) appropriately (including having the waste witnessed) throughout the day.

26. At 1100, when the Member withdrew Morphine, she also withdrew Lorazepam 1mg tablet. She did not document why she made the withdrawal. She did not document that it was administered in the flowsheet or in the client's MAR. This tablet was ordered to be administered at bedtime.

27. The Member admits that she withdrew a Lorazepam tablet from AcuDose at 1100 when her assessment did not warrant its administration and at a time of day when it was not ordered to be administered.

28. The Member also admits that she withdrew a Lorazepam tablet from AcuDose at 1100 but did not administer it.

[Client D] – November 11, 2015

29. The Member was assigned to client [Client D] on November 11, 2015 from 0730-1930. The client had an order for Oxycodone 5-10mg (PO) q4h PRN, among many other scheduled and PRN medications.

30. At 0745, the Member charted the client's pain assessment as 2/10 (modified) with analgesics offered. She did not specify what "modified" meant. The Member withdrew one Oxycodone 10 mg tablet at 757, 1040, 1304 and 1628, but none were documented as administered in the MAR, even when other medications that were withdrawn at the same time were documented.

31. The client had not required any Oxycodone on the shifts before or after November 11, 2015, and there was no indication in the charting to warrant 10mg four times in that shift.

32. In addition, the client was scheduled to receive ASA at 0800, but the Member did not withdraw the ASA until 1040. The Member documented that it was administered at 0800, which it could not have been, given that it was withdrawn almost three hours later.

33. The Member admits that she withdrew Oxycodone tablets from AcuDose at 1040, 1304 and 1628 when her assessment did not warrant their administration.

34. The Member further admits that she withdrew Oxycodone tablets at 0758, 1004, 1304 and 1628 but did not administer these tablets.

35. The Member also admits that she documented the administration of ASA at 0800 when she withdrew it at 1040 and administered it shortly thereafter.

[Client E] – November 12 and 13, 2015

36. The Member was assigned to client [Client E] on November 12-13, 2015 from 1930-0730. The client had post-operative delirium. He had an order for Oxycodone 5-10mg (PO) q4h PRN and Acetaminophen q8h, including at 2200, among many other scheduled and PRN medications.

37. At 1950, the Member charted that the client had a pain assessment of 2/10 (medicated). She withdrew Oxycodone 10mg and Acetaminophen at 1957. She did not document the administration of the Oxycodone in the MAR. She administered the Tylenol/Acetaminophen at about 2000.

38. The Member documented the administration of the Acetaminophen at 2200 in the MAR (ordered at 2200) but charted that "pt given HS dose of ER Tylenol early."

39. At 0140 and 0712, the Member withdrew Oxycodone and failed to document its administration. At 0712, the Member also withdrew Acetaminophen, which she documented as administered at 0600. The Client did not have any narcotics on other shifts.

40. The Member admits that she withdrew Oxycodone tablets from AcuDose at 1957, 0140 and 0712 when her assessment did not warrant their administration.

41. The Member further admits that she withdrew Oxycodone tablets at 1957, 0140 and 0712 but did not administer these tablets.

42. The Member also admits that she documented the administration of Tylenol/Acetaminophen at 0600 when she withdrew it at 0712 and administered it shortly thereafter.

[Client F] – November 19, 2015

43. The Member was assigned to client [Client F] on November 19, 2015 from 0730-1930. At 0800, the Member took vitals but did not document any other assessment. The client had an order for Oxycodone 5 or 10mg (PO) q4h PRN, among many other scheduled and PRN medications. The Member withdrew 10mg at 0822 and documented its administration. She did not document why she withdrew 10mg instead of 5mg.

44. The Member charted again at 1100, but she did not complete a pain assessment.

45. At 1108, she withdrew Amlodipine, Clopidogrel, ASA, Pantoprozale, Enoxaparin, Docusate, Potassium, Oxycodone, Clonazepam, Furosemide, and Metoprolol.

46. She documented the administration of these medications as follows:

    0800: ASA, Potassium, Furosemide (All scheduled to be given at 0800)

    1000: Enoxaparin, Clopidogrel, Pantoprozale, Amlodipine (All scheduled to be given at 1000)

47. The Metoprolol was discontinued but the Member did not waste the medication in AcuDose.

48. The Member did not document that Oxycodone and the Clonazepam were administered at 1100. Oxycodone administration was documented both before and after this dose, at 0820 and 1715. The Clonazepam was ordered for bedtime.

49. The Member charted again at 1730. She completed a pain assessment of 5/10. At 1712, Furosemide and Amiodarone were withdrawn (among other medications) but the Member documented their administration at 1600.

50. The Member admits that she withdrew Oxycodone tablets from AcuDose at 0822 and 1108 and Clonazepam at 1108 when her assessment did not warrant their administration and, in respect of the 0822 administration, the administration at this dosage was not warranted.

51. The Member further admits that she withdrew an Oxycodone tablet at 1108 but did not administer this tablet.

52. The Member also admits that she documented the administration of ASA, Potassium, and Furosemide at 0800 (when ordered) when she withdrew them at 1108 and administered them shortly thereafter, and documented the administration of Enoxaparin, Clopidogrel, Pantoprozale, and Amlodipine at 1000 (when ordered) when she withdrew them at 1108 and administered them shortly thereafter.

[Client A] – November 25, 2015

53. The Member was assigned to client [Client A] on November 25, 2015 from 0730-1930.

54. At 0740, the Member assessed the client, and recorded a pain assessment of 2/10.

55. The client had an order for Oxycodone 5 or 10mg (PO) q4h PRN, among many other scheduled and PRN medications. The Member withdrew 10mg at 0843 but did not document its administration. She also failed to document why she withdrew 10mg instead of 5mg.

56. The Member withdrew several medications at 1206: Pantoprozale, Metoprolol, Enoxaparin, Docusate, Furosemide. She documented the administration of these medications as follows:

> 0800: Furosemide (Scheduled to be given at 0800). ASA was charted as given but not withdrawn.
>
> 1000: Enoxaparin, Pantoprozale, Docusate (All scheduled to be given at
>
> 1000)

57. The Metoprolol was discontinued but the Member did not waste the medication in AcuDose.

58. At 1700, the Member assessed the client, and recorded a pain assessment of 2/10. The Member withdrew several medications at 1725: Rosuvastatin, Oxycodone 10mg, and Furosemide. She did not document that she administered any of these medications.

59. At 1819, the Member withdrew 10mg of Oxycodone but did not document the administration in the client's MAR. The Member did not document why she withdrew 10mg instead of 5mg.

60. The Member also failed to document why she provided 20mg of Oxycodone to the client in less than 60 minutes.

61. The Member admits that she withdrew Oxycodone tablets from AcuDose at 0843, 1725, and 1819 when her assessment did not warrant their administration, and, in respect of the 0843 and 1819 administrations, the administration at this dosage was not warranted.

62. The Member further admits that she withdrew an Oxycodone tablet at 0843, 1725, and 1819 but did not administer these tablets.

63. The Member also admits that she documented the administration of Furosemide at 0800 (when ordered) when she withdrew them at 1206 and administered them shortly thereafter, and documented the administration of Enoxaparin, Pantoprozale, and Docusate at 1000 (when ordered) when she withdrew them at 1206 and administered them shortly thereafter.

64. The Member admits that she failed to document the administration of Rosuvastatin and Furosemide, which she withdrew at 1725, and administered shortly thereafter.

[Client I] – November 25, 2015

65. The Member was assigned to client [Client I] on November 25, 2015 from 0730-1930. She did not complete any charting.

66. The client was discharged at 0950, though it is not clear when the client left the Hospital. The discharge note includes a comment that the doctor "left him" with a 25 tablet supply of Percocet for use on a PRN basis.

67. At 0845, the Member withdrew two tablets of Acetaminophen/Oxycodone 325mg (Percocet) and charted the administration at 1000.

68. At 1113, the Member withdrew another two tablets of Acetaminophen/Oxycodone 325mg (Percocet) but did not chart the administration.

69. The Member admits that she documented that she administered two tablets of Acetaminophen/Oxycodone at 1000 (when ordered) when she withdrew them at 0845.

70. The Member also admits that she withdrew two tablets of Acetaminophen/Oxycodone at 1113 but did not administer them.

[Client J] – November 25, 2015

71. The Member was assigned to client [Client J] on November 25, 2015 from 0730-1930.

72. At 0810, the Member took vitals but did not document any other assessment. The client had an order for Dilaudid (Hydromorphone) 6mg (PO) BID at 1000 and 2200 and 1mg q4h PRN, among many other scheduled and PRN medications.

73. The Member withdrew two 1mg tablets at 0844 and documented the administration of one of them, which was double signed. There is no documentation with respect to the second tablet.

74. The Member then withdrew 6mg of Hydromorphone at 1027 (as ordered for administration at 1000), which was documented as administered and double signed by a different nurse.

75. The Member withdrew two 1mg tablets at 1245 and documented the administration of one of them. It was double signed.

76. The Member withdrew one 1mg tablet at 1810 and documented the administration of it. It was double signed.

77. By 2015 (after the end of the Member's shift), the client reported that he was in 8/10 pain but he could not receive another dose until 2230.

78. The Member admits that she withdrew one 1 mg tablet of Dilaudid at 0844 and one 1 mg tablet of Dilaudid at 1245, which she did not administer.

[Client G] – November 28 and 29, 2015

79. The Member was assigned to client [Client G] on November 28 and 29, 2015 from 0730-1930.

80. On November 28, 2015, at 0800, the Member assessed the client, and recorded a pain assessment of 3-4/10. The client had an order for Oxycodone 5 or 10mg (PO) q4h PRN, among many other scheduled and PRN medications. The Member withdrew 10mg at 0811 but did not document its administration. The Member did not document why she withdrew10mg instead of 5mg.

81. The Member withdrew several medications at 1145-1146: ASA, Enoxaparin, Docusate, Polyethylene Glycol, and Oxycodone 10mg. She documented the administration of these medications as follows:

    0800: ASA (Scheduled to be given at 0800).

    1000: Enoxaparin, Docusate, Polyethylene Glycol (Scheduled to be given at 1000)

82. The Member did not document the administration of the Oxycodone.

83. At 1400, the Member assessed the client, and recorded a pain assessment of 3- 4/10. The Member offered and administered Acetaminophen, which she documented.

84. At 1620, the Member assessed the client, and recorded a pain assessment of 5/10. The Member withdrew several medications at 1609: Oxycodone 10mg and Amiodarone, which were documented.

85. At 1830, the Member noted the client's pain was 5/10, and that the client was medicated. However, no medication was withdrawn or administered around that time.

86. On November 29, at 0800, the Member assessed the client, and recorded a pain assessment of 3-4/10. The charting indicates the client was medicated but no medication was documented as administered or withdrawn from AcuDose.

87. The Member withdrew several medications at 11:08: ASA, Amiodarone, Enoxaparin, Docusate, Magnesium, Potassium, and Oxycodone 10mg. She documented the administration of these medications as follows:

    0800: ASA, Amiodarone (Scheduled to be given at 0800)

    0900: Oxycodone

1000: Enoxaparin, Docusate, Magnesium, Potassium (Scheduled to be given at 1000)

88. The Member charted that she administered Rivaroxaban, but she did not withdraw it from AcuDose. The Member gave another dose of Oxycodone at 1308, only two hours after the last dose, without providing a rationale for its administration. The Member documented the administrations as being four hours apart.

89. At 1620, the Member assessed the client, and recorded a pain assessment of 5/10. The Member withdrew several medications at 1609: Oxycodone 10mg and Amiodarone, which were documented.

90. At 1830, the Member noted the client's pain was 5/10, and that the client was medicated but no medication was withdrawn or administered around that time.

91. The Member admits that on November 28, 2015, she withdrew Oxycodone tablets from AcuDose at 0811 when her assessment did not warrant their administration, or the administration at this dosage.

92. The Member further admits that on November 28, 2015, she withdrew Oxycodone tablets at 0811 and 1145 but did not administer these tablets.

93. The Member also admits that on November 28, 2015, she documented the administration of ASA at 0800 (when ordered) when she withdrew it at 1145-1146 and administered it shortly thereafter, and documented the administration of Enoxaparin, Docusate, and Polyethylene Glycol at 1000 (when ordered) when she withdrew them at 1145-1146 and administered them shortly thereafter.

94. The Member admits that on November 29, 2015, she withdrew Oxycodone tablets from AcuDose at 1108 and 1308, when her assessment did not warrant its administration.

95. The Member also admits that on November 29, 2015, she documented the administration of ASA and Amiodarone at 0800 (when ordered), when she withdrew them at 1108 and administered them shortly thereafter, and documented the administration of Enoxaparin, Docusate, Magnesium, and Potassium at 1000 (when ordered), when she withdrew them at 1108 and administered them shortly thereafter.

[Client H] – November 28-29, 2015

96. The Member was assigned to client [Client H] on November 28 and 29, 2015 from 0730-1930.

97. On November 28, at 0740, the Member assessed the client, and recorded a pain assessment of 2/10. The client had an order for Oxycodone 5 or 10mg (PO) q4h PRN, among many other scheduled (including Oxycodone BID 40mg PO) and PRN medications.

98. The Member withdrew 10mg at 0810 and documented its administration. The Member did not document why she withdrew and administered 10mg instead of 5mg.

99. The Member withdrew several medications at 1243-1245: Perindopril, ASA, Metoprolol, Enoxaparin, Docusate, Furosemide, Long acting Oxycodone, and Oxycodone 10mg. She documented the administration of these medications as follows:

    0800: ASA, Furosemide (Scheduled to be given at 0800)

    1000: Enoxaparin, Docusate, Perindopril, Metoprolol, Long acting Oxycodone (Scheduled to be given at 1000)

    1300: Oxycodone 10mg

100. The Member administered the 1000 long acting Oxycodone dose at 1245, and then administered the Oxycodone 10mg dose fifteen minutes later. She documented that the two doses were administered three hours apart.

101. At 1720, the Member assessed the client, and recorded a pain assessment of 3/10. The Member withdrew several medications including Oxycodone 10mg, which she did not document as being administered.

102. On November 29, at 0735, the Member recorded the client's vitals but did not document any other analysis. The client was discharged at some point on November 29, 2015.

103. The Member withdrew several medications at 1036-1037: Perindopril, ASA, Metoprolol, Enoxaparin, Docusate, Furosemide, Long acting Oxycodone, and Oxycodone 10mg. She documented the administration of these medications as follows:

    0800: ASA, Furosemide (Scheduled to be given at 0800)

    1000: Enoxaparin, Docusate, Perindopril, Metoprolol, Long acting Oxycodone (Scheduled to be given at 1000)

    1040: Oxycodone 10mg

104. The Member admits that on November 28, 2015, she withdrew an Oxycodone 10mg tablet from AcuDose at 0810 when her assessment did not warrant its administration, or the administration at this dosage.

105. The Member further admits that on November 28, 2015, she withdrew Oxycodone tablets at 1300 and 1700 but did not administer these tablets.

106. The Member also admits that on November 28, 2015 she documented the administration of ASA and Furosemide at 0800 (when ordered), when she withdrew them at 1243-1245 and administered them shortly thereafter, and documented the administration of Enoxaparin, Docusate, Perindopril, Metoprolol, and Long acting Oxycodone at 1000 (when ordered), when she withdrew them at 1243-1245 and administered them shortly thereafter.

107. The Member further admits that on November 29, 2015, she withdrew one Oxycodone 10mg tablet and one Oxycodone 40mg tablet at 1040 but did not administer these tablets.

108. The Member also admits that on November 29, 2015, she documented the administration of ASA and Furosemide at 0800 (when ordered) when she withdrew them at 1036-1037 and administered them shortly thereafter.

Member's Personal Circumstances

109. If the Member were to testify, she would state that at the time of the allegations, she was struggling with an extremely difficult family situation that was affecting both her physical and mental health.

110. If the Member were to testify, she would state that she sought medical assistance regarding her substance use and completed 32 sessions of substance abuse counseling between February 2016 and July 2016.

Failing to Report Charges and Criminal Conviction

111. On February 16, 2016, the Member was charged with theft of a value not exceeding $5,000, contrary to section 334(b) of the *Criminal Code of Canada*, for theft of narcotics from the Hospital.

112. The Member did not report the charge to the College.

113. On August 16, 2016, the Member pled guilty and was found guilty of theft of narcotics from the Hospital, contrary to section 334(b) of the *Criminal Code of Canada*.

114. The Member completed a seven hour theft intervention program and 75 hours of community service, volunteering with the Salvation Army food bank.

115. The Member did not report the finding of guilt to the College.

116. If the Member were to testify, she would state that, as a new nurse, she was not aware of her obligation to report criminal charges and convictions to the College. However, the Member acknowledges that, as a member of a self-regulating profession, it was her responsibility to be aware of her obligations to the College.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

117. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1(a) of the Notice of Hearing, as described in paragraphs 111 to 116 above, in that she was found guilty of stealing narcotics, contrary to section 334(b) of the *Criminal Code of Canada*, which is an offence relevant to her suitability to practise nursing.

118. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2(a) and (b) and paragraph 3 of the Notice of Hearing, as described in paragraphs 111

to 116 above, in that she failed to report the criminal charges and the criminal finding of guilt to the College, as required.

119. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 4(a), (b) and (c) of the Notice of Hearing, as described in paragraphs 16 to 108, in that she:

    (a) signed out controlled substances for administration to clients, in Schedule A of the Notice of Hearing, without conducting and/or charting an adequate assessment of the need for the controlled substance and/or she signed out controlled substances when her assessment did not warrant the administration of the controlled substances and/or did not warrant the dosage signed out;

    (b) signed out controlled substances for administration to clients, in Schedule B of the Notice of Hearing, and failed to administer or dispose of those narcotics, or record the administration or disposal of those controlled substances on the MAR; and

    (c) documented the administration of scheduled medication to clients, in Schedule C of the Notice of Hearing, at times inconsistent with when she signed out the medication and administered the medication.

120. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 5(a), (b) and (c) of the Notice of Hearing, as described in paragraphs 16 to 108 above, in that she failed to keep records as required in that she:

    (a) signed out controlled substances for administration to clients, in Schedule A of the Notice of Hearing, without adequately charting an assessment of the need for the controlled substance and/or the need for the dosage signed out;

    (b) signed out controlled substances for administration to clients, in Schedule B of the Notice of Hearing, and failed to record the administration or disposal of those controlled substances on the MAR; and

    (c) on November 25, 2015, failed to document the administration of Rosuvastatin and Furosemide to [Client A].

121. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 6(a) of the Notice of Hearing, as described in paragraphs 16 to 108 above, in that she misappropriated property from her workplace when she signed out controlled substances for administration to clients, in Schedule B, and failed to administer or dispose of those controlled substances.

122. The Member admits that she committed the acts of professional misconduct, as alleged in paragraphs 7 (a), (b), (c), (d), (e), (f), (g), (h), (i) and (j) of the Notice of Hearing, and in particular, her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 16 to 116 above.

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), 2(a), 2(b), 3(a), 4(a), 4(b), 4(c), 5(a), 5(b), 5(c), 6(a), 7(a), 7(b), 7(c), 7(d), 7(e), 7(f), 7(g),7(h), 7(i) and 7(j) in the Notice of Hearing. As to the allegations in paragraph 7, the Panel finds that the Member engaged in conduct that would reasonably be considered by members 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 111, 112, 113 and 115 in the Agreed Statement of Facts.

Allegation #2(a) and #2(b) in the Notice of Hearing are supported by paragraphs 112 and 115 in the Agreed Statement of Facts.

Allegation #3(a) in the Notice of Hearing is supported by paragraph 115 in the Agreed Statement of Facts.

Allegations #4(a) and #5(a) in the Notice of Hearing are supported by paragraphs 17, 18, 19, 21, 26, 30, 37, 39, 43, 45, 46, 55, 58, 59, 60, 80, 87, 88, and 98 in the Agreed Statement of Facts.

Allegations #4(b), #5(b) and #6(a) in the Notice of Hearing are supported by paragraphs 17, 18, 19, 20, 26, 30, 37, 39, 45, 48, 55, 58, 59, 68, 73, 75, 80, 81, 82, 99, 100, 101 and 103 in the Agreed Statement of Facts.

Allegations #4 (c) and #5(c) in the Notice of Hearing are supported by paragraphs 18, 32, 37, 38, 45, 46, 48, 49, 56, 67, 81, 87, 99 and 103 in the Agreed Statement of Facts.

With respect to Allegation #7 (a), (b), (c), (d), (e), (f), (g), (h), (i) and (j), the Panel finds that the Member's conduct in failing to document, failing to assess the patients and failing to administer medications at the scheduled times was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through the theft of narcotics and her documentation or lack of documentation.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct of not administering the required medication to her patients at scheduled times, misappropriation of narcotics, and not documenting properly casts serious doubt on

the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

Penalty

Counsel for the College and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission 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 five 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 the practising 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 two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date the Member's suspension ends. 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Professional Standards*,
            2. *Medication*,
            3. *Documentation*,

        iv. 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;

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

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

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards 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;

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

b) For a period of 24 months from the date the Member returns to the practice of nursing, 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; and

4. All documents delivered by the Member to the College, 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 and the Member's Counsel. College Counsel stated that Joint Submission on Order had been carefully negotiated by experienced Counsel and the Member and it should be accepted unless it was so far off that it would put the administration of justice into disrepute. The penalty contains 4 components: a reprimand, five month suspension, terms, conditions and limitations and a 24 month employer notification. The penalty meets the goals of penalty and leaves it open for the Member to return to practice if she so chooses.

The parties agreed that the mitigating factors in this case were: the Member co-operated with the College thus saving everyone from a long hearing, took accountability for her actions and had personal circumstances at the time of the incidents.

The aggravating factors in this case were: extremely serious actions, repeated acts of dishonesty, theft, documentation was incorrect, or not recorded or recorded at a time before the medication was signed out and the Member failed to report charges and a finding of guilt to the College. The documentation errors could have had a significant impact on the patients.

The proposed penalty provides for general deterrence through the five month suspension, 24 month employer reporting, tells the membership that these actions will not be tolerated.

The proposed penalty provides for specific deterrence through the reprimand, five month suspension, two meetings with the expert and 24 month employer notification and sends a strong message to the Member.

The proposed penalty provides for remediation and rehabilitation through the meeting with the expert and the review of professional, medication and documentation standards.

Overall, the public is protected because the full penalty shows the public that the College expects much more from its members, dishonesty will be punished and the Member will be retrained in her areas of weakness to protect the public from future actions of this nature.

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 vs Rzeszutko (2012)
This case was very similar as the member recorded drugs administered when they were not or were partially administered. This member was also in an abusive relationship. The penalty was the same.

CNO vs Spiers (2012)
This case was also very similar in that the member, failed to document or documented the wrong times of administering and falsified records. There was no theft involved. The penalty was similar: a

reprimand, four month suspension, two meetings with an expert, review of standards and 24 month employer notification.

The Member's Counsel agreed with College Counsel's submissions and added the Member was a young woman trapped in a physical and emotionally abusive relationship and turned to self-medication to escape. She also had health problems at the time. She let her registration lapse and got help for herself. She feels a great deal of remorse and realizes the seriousness of her actions. The Member has already paid a great deal as she lost her job, was arrested and convicted of a crime, and she walked away from nursing.

Independent Legal Counsel advised the Panel to consider public protection as paramount, while sending a message of deterrence to the Member and the membership and, where possible, rehabilitation and remediation of the Member. Further, the Panel is obliged to accept the Joint Submission on Order unless the proposed penalty was so disproportionate to the offence in question that to accept it would bring the administration of justice into disrepute or otherwise not be in the public interest.

Penalty Decision

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

1. The Member is required to appear before the Panel to be reprimanded within 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 five 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 the practising 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 two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date the Member's suspension ends. 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

1. *Professional Standards*,
2. *Medication*,
3. *Documentation*,

iv. 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;

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

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

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards 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;

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

b) For a period of 24 months from the date the Member returns to the practice of nursing, 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; and

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The five month suspension and reprimand sends a strong message to the Member. The suspension and meetings with the expert show the membership that these actions will not be tolerated. The suspension, meetings with the expert, and retraining of the Member shows the public that the College can and will self-regulate nurses. The penalty is in line with what has been ordered in previous cases.

I, Dawn Cutler, 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.

_____ _____

Chairperson Date