DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Terry Holland, RPN	Chairperson
	Sylvia Douglas	Public Member
	Linda Marie Pacheco, RN	Member
	Lalitha Poonasamy	Public Member
	Sherry Szucsko-Bedard, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
KENNETH N. TAYLOR	)	SHEILA RIDDELL for
Registration No.: 8322158	)	Kenneth N. Taylor
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	
	)	Heard: July 14, 2020

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 July 14, 2020, via videoconference. Kenneth N. Taylor attended the hearing via telephone.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991, for an order preventing the public disclosure of the identities of the patients in the Discipline hearing of Kenneth N. Taylor or any information that could disclose the patients' identities, including a ban on the publication or broadcasting of this information. The Member's Counsel had no objection to the order being made.

The Panel considered the submissions of the Parties and decided that there be an order preventing the public disclosure of the identities of the patients in the Discipline hearing of Kenneth N. Taylor or any information that could disclose the patients' identities, including a ban on the publication or broadcasting of this information.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(a)(i), (ii), (iii), 1(c), 1(d), 1(g), 1(h), 2(a), 2(d), 3(a)(i), (ii), (iii), 3(c), 3(d), 3(g) and 3(h) of the Notice of Hearing dated July 6, 2020. The Panel granted this request. The remaining allegations against the Member are as follows:

IT IS ALLEGED THAT:

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

    a. on or about February 23 to March 11, 2015, you failed to provide appropriate care and treatment to your patient, [Patient 1], including but not limited to:

        i. [*Withdrawn*];
        ii. [*Withdrawn*];
        iii. [*Withdrawn*]; and/or
        iv. failing to discontinue seclusion of [Patient 1] in a timely manner, once she was no longer agitated, on or about February 25, 2015;

    b. on or about February 23 to March 11, 2015, you referred to a colleague as "incompetent" to one or more colleagues;

    c. [*Withdrawn*];

    d. [*Withdrawn*];

    e. on or about March 10, 2015, you physically restrained your patient, [Patient 2], when doing so was not necessary;

    f. on or about March 10, 2015, you used an improper technique to physically restrain your patient, [Patient 2];

    g. [*Withdrawn*]; and/or

    h. [*Withdrawn*]; 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*, in that during your

employment as a Registered Nurse for the Facility in Guelph, Ontario, you verbally, physically or emotionally abused a client as follows:

a. [*Withdrawn*];

b. on or about March 10, 2015, you physically restrained your patient, [Patient 2], when doing so was not necessary;

c. on or about March 10, 2015, you used an improper technique to physically restrain your patient, [Patient 2]; and/or

d. [*Withdrawn*]; 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 during your employment as a Registered Nurse for the Facility in Guelph, Ontario, 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, as follows:

a. on or about February 23 to March 11, 2015, you failed to provide appropriate care and treatment to your patient, [Patient 1], including but not limited to:

i. [*Withdrawn*];
ii. [*Withdrawn*];
iii. [*Withdrawn*]; and/or
iv. failing to discontinue seclusion of [Patient 1] in a timely manner, once she was no longer agitated, on or about February 25, 2015;

b. on or about February 23 to March 11, 2015, you referred to a colleague as "incompetent" to one or more colleagues;

c. [*Withdrawn*];

d. [*Withdrawn*];

e. on or about March 10, 2015, you physically restrained your patient, [Patient 2], when doing so was not necessary;

f. on or about March 10, 2015, you used an improper technique to physically restrain your patient, [Patient 2];

g. [*Withdrawn*]; and/or

h. [*Withdrawn*].

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(iv), 1(b), 1(e), 1(f), 2(b), 2(c), 3(a)(iv), 3(b), 3(e) and 3(f) 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 as amended reads, unedited, as follows:

THE MEMBER

1. Kenneth N. Taylor (the "Member") obtained a diploma in nursing from Conestoga College—Guelph Campus in 1982.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on January 1, 1983 and resigned his certificate of registration on February 21, 2017.

3. The Member was employed as a full-time staff nurse at the Facility from March 2002 to March 2015, when he left his employment following the incidents described below.

4. Prior to the incidents in question, the Member did not have any disciplinary history at CNO.

THE FACILITY

5. The Member worked on a locked six-bed acute psychiatric assessment unit with one seclusion bed (the "Unit"). The Unit is staffed with two RNs and one Registered Practical Nurse ("RPN") on days and evenings, and one RN and one RPN on night shifts.

6. The Unit has a policy of least restraint for physical and chemical restraints. Given the high acuity of the Unit's patient population, staff may be required to use physical and chemical restraints, including seclusion and prescribed medications.

7. If the Member were to testify, he would state that, over his 34 year nursing career, he was routinely assigned the most challenging and/or aggressive patients on the Unit and accepted these assignments willingly.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incidents Related to Patient 1

8. Patient 1 was an in-patient admitted to the Unit from February 13, 2015 to March 11, 2015. She had a mental health diagnosis and a history of substance use. She was described by nursing staff as "intrusive and med-seeking". The Member was assigned as the nurse with primary responsibility of Patient 1.

9. The Member was scheduled on day shifts from February 23 to March 1, and evening shifts on March 4 and March 9-11, 2015.

10. Prior to the Member's shift on February 23, 2015, Patient 1 had been placed in seclusion at least twice by other staff, and was administered a number of PRN medications, as ordered by her psychiatrist.

11. On February 23, 2015, at 0945, Patient 1's psychiatrist documented a treatment plan for staff to reduce her use of Ativan and Percocet, which Patient 1 was prescribed on an as-needed/PRN basis. Although the treatment plan was to reduce her use of these medications, her psychiatrist continued the orders for these medications to be provided on a PRN basis.

12. If the Member were to testify, he would state that he believed it was clinically appropriate to firmly resist Patient 1's drug seeking behaviour whenever possible as part of the treatment plan to reduce her use of Ativan and Percocet. The Member would also testify that he perceived that other nursing staff did not use the same approach he used with Patient 1. The Member acknowledges that the treatment plan did not set out the process for nursing staff to reduce Patient 1's use of Ativan and Percocet and that Patient 1 did have an order for these medications to be provided on a PRN basis.

13. On February 23, 2015, the Member worked from 0700 to 1500. During this shift, Patient 1 became extremely agitated when the Member refused to provide her with Percocet for non-specified pain. After coaching and feedback, the Member administered Naproxen and Olanzapine, which were also ordered. The Member documented that Patient 1 finally settled with close coaching and cueing and that she was "pleasant and chatty" by the end of their interaction.

14. On February 24, 2015, the Member worked from 0700 to 1500. Patient 1 was agitated and unstable. During the shift, Patient 1 made several requests for narcotic pain medication, which the Member did not provide, given his understanding and approach to her treatment plan. The Member documented that Patient 1 was engaged in "extreme histrionic behaviour, verbal abuse directed at staff, personal insults, racial epithets, essentially an extreme tantrum related to frustration over med-seeking management." The Member placed Patient 1 in seclusion at 1300. He charted that she was "hostile, angry, disrobing…banging, yelling…agitated" at 1330, 1400 and 1500. At 1500, the oncoming nurse received Patient 1 into her care and discontinued the seclusion shortly thereafter.

15. On February 25, 2015, Patient 1 was agitated at 0645, and was described as difficult to redirect. However, Patient 1 de-escalated and agreed to settle. At 0700, the Member commenced his 0700 to 1500 shift. At 0700, Patient 1 continued to display agitated behaviour, including banging on the nursing station window, swearing and uttering threats. The Member advised Patient 1 that he would place her in seclusion if her behaviour did not improve.

16. The Member placed her in seclusion at 0700. Patient 1 tore her linens, pillows and mattress while in seclusion. The Patient later reported to another nurse that she had scratched her arms

and punched herself in the face while in seclusion, although there is no documentation that Patient 1 engaged in this self-harm or if she did, that any staff observed it.

17. The Member acknowledges that he did not take sufficient steps and was not successful in de-escalating Patient 1's behaviour while in seclusion, which could have included therapeutic conversation and active listening.

18. If Nurse A, another nurse on shift on February 25, 2015 were to testify, she would state that she entered the seclusion room and was able to de-escalate Patient 1 through therapeutic conversation. The Member documented that Patient 1 was relaxed from 1200 to 1300, although she defecated in her blanket. She was cooperative from 1245 to 1400. The Member took Patient 1 to have a shower at 1300 and released her from seclusion at 1400.

19. If the Member were to testify, he would state that Patient 1's behaviour required seclusion for her safety and the safety of others.

20. The Member acknowledges that Patient 1 was relaxed and cooperative from 1200 to 1400 on February 25, 2015. He admits and acknowledges that he could have discontinued her seclusion at some point between 1300 and 1400 and failed to do so. If the Member were to testify, he would say he did not intentionally prolong Patient 1's seclusion unnecessarily. The Member would also testify that there are many factors that can result in a slight delay in releasing a patient from seclusion, including acuity on the Unit and inadequate staff available to ensure supervision and care of the patient when they are released. However, he acknowledges that he could have and should have taken steps to release Patient 1 from seclusion prior to 1400.

21. Between February 25, 2015 and March 9, 2015, Patient 1 stabilized to the point that her care team recommended that she be moved to an unlocked psychiatric unit in the Facility. The Member did not work with her during this time. If Nurse A were to testify, she would state that she elected to take on Patient 1's care, because she perceived tension in the Member and Patient 1's therapeutic relationship.

22. On March 9, 2015, the Member worked from 1500 to 2300. During that shift, the Member documented that Patient 1 requested and received a PRN medication (Percocet) and Benadryl for nasal congestion. At the end of the shift, he also documented that she was "occasionally testy but generally displayed adequate self-control". However, during the shift and after an interaction with Patient 1, he commented to Patient 1's psychiatrist that Patient 1 was "heading for seclusion".

23. The psychiatrist was concerned and confused about the Member's comment because he had not observed any behaviour that would warrant seclusion and Patient 1 had not been secluded for several days. If the Member were to testify, he would state that Patient 1 was engaged in "precursor" behaviour on March 9, which resolved without the need for intervention. The Member did not put Patient 1 in seclusion on this date.

24. On March 11, 2015, Patient 1 was transferred to the unlocked psychiatric unit in the Facility. She then reported to her psychiatrist that she had been in conflict with the Member during her

stay on the Unit. The psychiatrist reported his March 9, 2015 interaction with the Member and Patient 1's complaints about the Member to his (the psychiatrist's) supervisor following the events involving Patient 2 detailed below.

Improper Communication regarding a Colleague

25. On February 25, 2015, Nurse A took over the care of Patient 1, on her own initiative and without the Member's agreement, during the Member's assignment away from the unit. Nurse A then administered Percocet, instead of a non-narcotic alternative, against the Member's objection. The Member and Nurse A engaged in a disagreement. Following this disagreement, the Member privately stated to a second colleague, "That's not competent", in reference to Nurse A's administration of the narcotic to Patient 1. The Member admits and acknowledges that he made comments to the effect that Nurse A's action was incompetent, and that doing so was unprofessional. The Member acknowledges that he should have approached a Nurse Manager about his concerns, rather than a colleague. If he were to testify, he would state that he felt undermined by Nurse A's decision to assume care of Patient 1 without consulting him and to administer Percocet to Patient 1.

Incidents Related to Patient 2

26. On March 10, 2015, the Member worked from 1500 to 2300. In 2015, the Member was 60 years old.

27. Patient 2 was a patient in the Unit. Patient 2, who was 24 years old and physically fit, had a history of aggression and had to be physically restrained by Unit staff on past occasions, including on the previous shift, when one incident had required restraint by five staff.

28. The Member had not provided care to Patient 2 prior to March 10, 2015. He was not assigned to Patient 2 on that day. The Member was aware of Patient 2's history of aggression. If the Member were to testify, he would state that he had also been informed that Patient 2 had ingested crystal meth while he was in the Facility.

29. On March 10, 2015, at 1705, the Member heard yelling or moaning from the seclusion room where Patient 2 had been placed that morning. Three staff - the Member, Nurse B and Nurse C - checked on the patients in the Unit and then went to check on Patient 2 in the seclusion room. Patient 2 appeared to be resting on a mattress.

30. Patient 2 had recently received PRN medication. If the Member were to testify, he would state that he decided to enter the seclusion room to ensure that Patient 2 was safe because he attempted to communicate with Patient 2 through the door and received no response.

31. The events of the interaction in the seclusion room were video-recorded.

32. The Member spoke to Patient 2 as he entered the seclusion room, but received no response. As the Member neared Patient 2 and bent down close to his mattress, Patient 2 became extremely verbally agitated, yelling and swearing at the Member and started to get up from the mattress.

The Member believed Nurse B had entered the seclusion room with him and was behind him, but Nurse B had left the room.

33. The Member acknowledges that it was an error in judgment to approach to Patient 2 so closely, by himself, and that this approach escalated Patient 2, which in turn led to his restraint.

34. The Member moved to restrain Patient 2. The Member physically subdued Patient 2, with the Member's weight on Patient 2's back. The Member held Patient 2's wrist against the small of his back while Patient 2 struggled. If the Member were to testify, he would say he believed that, if he allowed Patient 2 to get to his feet, Patient 2 would injure the Member, Nurse B and himself.

35. Nurse B, who was outside the room, called a Code White, the code used to respond to aggressive patients. Several staff attended, including Patient 2's psychiatrist. During the Code White, while restrained by the Member, Patient 2 stated that he could not breathe and that his arm was in pain. If the Member were to testify, he would state that he heard Patient 2 state that he could not breathe and immediately released his weight on Patient 2's back. If other staff were to testify, they would state that the Member did not immediately release his weight on Patient 2's back.

36. At some point, the Member did shift his weight from Patient 2's back. If the Member were to testify, he would say that he asked the two other staff to assist with the restraint and none assisted until after the Code White was underway, and he did not feel it was safe to shift his weight.

37. The Member admits and acknowledges that he should not have restrained Patient 2 in this way (with Patient 2's arm behind his back and the Member's weight on his back) at any point.

38. Patient 2 de-escalated during the physical restraint and was administered PRN medication.

39. Following the Code White, several staff observed that Patient 2 had a small amount of blood around his mouth. It could not be determined if the blood was caused by the restraint or had occurred prior to the incident.

STANDARDS OF PRACTICE

40. CNO has published nursing standards to set out the expectations for the practice of nursing. CNO's standards inform nurses of their accountabilities and apply to all nurses regardless of their role, job description, or area of practice

Therapeutic Nurse-Client [or Patient] Relationship Standard

41. CNO's *Therapeutic Nurse-Client Relationship Standard* ("TNCR Standard") provides guidance to nurses on establishing and maintaining appropriate relationships with patients. The TNCR Standard notes that the therapeutic relationship with patients is at the core of the practice of nursing.

42. The TNCR Standard specifies that nurses meet the standard for "therapeutic communication" through "effective communication strategies and interpersonal skills". In addition, a nurse meets the standard by:

    a. …being aware of her/his verbal and non-verbal communication style and how [patients] might perceive it;
    b. modifying communication style, as necessary, to meet the needs of the [patient] (for example, to accommodate a different language, literacy level, developmental stage or cognitive status); …
    c. listening to, understanding and respecting the [patient's] values, opinions, needs and ethnocultural beliefs and integrating these elements into the care plan with the [patient's] help; ...
    d. recognizing that all behaviour has meaning and seeking to understand the cause of a [patient's] unusual comment, attitude or behaviour…; [and]
    e. reflecting on interactions with a [patient] and the health care team, and investing time and effort to continually improve communication skills… .

43. Nurses are responsible for ensuring that all professional behaviours and actions meet the therapeutic needs of the patient.

44. The TNCR Standard defines "abuse" as:

    > The misuse of the power imbalance intrinsic in the nurse-client relationship. It can also mean the nurse betraying the [patient's] trust, or violating the respect or professional intimacy inherent in the relationship, when the nurse knew, or ought to have known, the action could cause, or could be reasonably expected to cause physical, emotional or spiritual harm to the [patient]. Abuse may be verbal, emotional, physical, sexual, financial or take the form of neglect. The intent of the nurse does not justify a misuse of power within the nurse-[patient] relationship.

45. The TNCR Standard includes examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, retaliation or revenge, teasing or taunting, and an inappropriate tone of voice, such as one expressing impatience. Physical abuse includes hitting, pushing, using force, and handling a patient in a rough manner.

46. Nurses are required to protect patients from abuse. The TNCR Standard sets out indicators by which the nurse meets this standard:

    a. …not engaging in behaviours toward a [patient] that may be perceived by the [patient] and/or others to be violent, threatening or intended to inflict physical harm; … [and]
    b. not exhibiting physical, verbal and non-verbal behaviours toward a [patient] that demonstrate disrespect for the [patient] and/or are perceived by the [patient] and/or others as abusive…;
    c. not neglecting a [patient] by failing to meet or withholding his/her basic assessed needs… .

Professional Standards

47. CNO's *Professional Standards* ("Professional Standards") provides that "[e]ach nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships." One way of doing so is "demonstrating respect and empathy for, and interest in [patient]."

48. In terms of accountability, the standard sets out indicators nurses must demonstrate, including:

    - … ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation; [and]
    - taking action in situations in which [patient] safety and well-being are compromised… .

Standards of Practice Regarding Restraints

49. CNO's *Restraints* Practice Standard in force at the time of the incidents above stated that nursing interventions promote well-being and prevent harm. Nurses respect the dignity of the individual and advocate for an environment that promotes a patient's quality of life.

50. That published Standard endorsed and the standards of practice require the use of a least restraint approach, meaning that the least restrictive form of restraint to meet the patient's needs should be used. Nurses are expected to collaborate with other members of the health care team to assess, plan and evaluate patient care to eliminate restraint use. Nurses are expected to assess and implement alternative measures before using any form of restraint following consultation with the patient or substitute decision-maker. In addition, as a standard of practice, nurses are accountable for reviewing the continued use of restraints on an ongoing basis, which includes the modification of restraints or holds.

51. Consistent with the standards of practice, the Unit's practice was to use de-escalation techniques prior to engaging in physical or chemical restraint, and to plan a restraint in advance (where possible), in part to avoid situations in which only one staff member is involved in restraining a patient.

The Member's Breach of the Standards of Practice

52. The Member admits and acknowledges that he failed to discontinue seclusion of Patient 1 in a timely manner, once she was no longer agitated on February 25, 2015. He admits and acknowledges that this action (by omission) constitutes a breach of the standards of practice.

53. The Member admits and acknowledges that he referred to the actions of his colleague, Nurse A, as "incompetent" to one of their colleagues, and that doing so was a breach of CNO's *Professional Standards*, which require nurses to maintain respectful and collaborative professional relationships.

54. The Member admits and acknowledges that on March 10, 2015, he entered Patient 2's seclusion room, which escalated the patient's behaviour, and physically restrained Patient 2 when it was not necessary to do so. He further admits and acknowledges that he used an improper technique

to physically restrain Patient 2 (with his arm behind his back and by-placing weight on a patient's back).

55. The Member admits and acknowledges that these actions constitute a breach of the standards of practice.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

56. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a)(iv), (b), (e), and (f) of the Notice of Hearing, as described in paragraphs 8 to 55 above, in that he breached the standards of practice.

57. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2 (b) and (c) of the Notice of Hearing, as described in paragraphs 26 to 55 above, in that the Member physically abused Patient 2.

58. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a)(iv), (b), (e) to (f) of the Notice of Hearing, and in particular, that his conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 8 to 55 above.

59. With leave of the Discipline Committee, CNO withdraws the following allegations in the Notice of Hearing:

    a. 1(a)(i), (ii) and (iii), (c), (d), (g) and (h);
    b. 2(a) and (d); and
    c. 3(a)(i), (ii) and (iii), (c), (d), (g) and (h).

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)(iv), 1(b), 1(e), 1(f), 2(b), and 2(c) of the Notice of Hearing. As to allegation #3(a)(iv), 3(b), 3(e) and 3(f), 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 the evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegations #1(a)(iv), 1(b), 1(e) and 1(f) in the Notice of Hearing are supported by paragraphs 8-56 in the Agreed Statement of Facts. The Member committed an act of professional misconduct when he failed to meet the standards of practice when he did not discontinue Patient 1's seclusion even though he acknowledged Patient 1 was relaxed and cooperative during the period of seclusion. The Member

acknowledged that he did not take sufficient steps to de-escalate Patient 1 which could have included therapeutic conversation and active listening. The *Therapeutic Nurse-Client Relationship Standard* (the "*TNCR Standard*") sets out that nurses need to modify their communication style to accommodate different patients' cognitive status.

The Member admitted that he referred to one of his colleagues as "incompetent" and in doing so was in breach of the College's *Professional Standards* which sets out that nurses are expected to maintain professional and respectful relationships with their colleagues.

The Member failed to meet the standards of practice when he used improper technique to physically restrain Patient 2 when he placed his weight on the Patient's back and held the Patient's arm behind his back. The Member acknowledged that he should not have restrained Patient 2 in this way. The College's *Restraints* Practice Standard at the time of the incident provided guidance on the use of least restraint and using nursing interventions that promote well-being and prevent harm.

Allegations #2(b) and 2(c) in the Notice of Hearing are supported by paragraphs 26-55 and 57 in the Agreed Statement of Facts. The Member committed an act of professional misconduct when he physically abused Patient 2. The *TNCR Standard* defines physical abuse as hitting, pushing, using force and handling a patient in a rough manner. The Member admitted that he physically abused Patient 2 in his interactions with him when he had his weight on the small of his back while Patient 2 struggled.

Allegations #3(a)(iv), 3(b), 3(e) and 3(f) in the Notice of Hearing are supported by paragraphs 8-55 and 58 in the Agreed Statement of Facts. The Member admitted that he committed professional misconduct as alleged in paragraphs 8-55 and that his conduct would reasonably be regarded by members as disgraceful, dishonourable and unprofessional.

The Member's conduct while caring for Patient 1 and Patient 2 demonstrated a serious and persistent disregard for his professional obligations and casts serious doubts on the Member's moral fitness and ability to discharge the higher obligations the public expects healthcare professionals to meet. The Member knew or ought to have known that his conduct was unacceptable and fell below the standards of a professional. The Member's conduct also had the effect of shaming the Member and by extension the profession. Accordingly, the Panel finds that the conduct of the Member was relevant to the practice of nursing and that, having regard to all the circumstances, members would reasonably regard it to be disgraceful, dishonourable and unprofessional.

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.

Penalty Submissions

Submissions were made by College Counsel.

College Counsel stated the Member resigned from the College effective February 21, 2017 and has signed an Undertaking with the College in which he undertakes as follows:

1. to confirm that my resignation as a member of CNO is indefinite and permanent, effective from the date upon which CNO accepts this Undertaking;

2. to not apply for membership with CNO as a Registered Nurse or Registered Practical Nurse at any time in the future.

Pursuant to the Undertaking, the member also confirms, acknowledges and agrees that:

3. The public portion of the Register maintained by CNO will indefinitely reflect that I entered into an Undertaking with the Executive Director to permanently resign as a member of CNO as part of an agreed resolution of allegations of professional misconduct heard by a Panel of the Discipline Committee, in addition to any other information that is required to be posted;

4. By permanently resigning as a member of CNO, I no longer have a right to:

    a) the issuance or reinstatement of a Certificate of Registration from CNO;
    b) use the title "Nurse", "Registered Nurse", "Registered Practical Nurse", "RN", "RPN" or a variation, an abbreviation or an equivalent in another language;
    c) to hold myself out as a Nurse, Registered Nurse, Registered Practical Nurse or as a person who is qualified to practise in Ontario as a Nurse, Registered Nurse or Registered Practical Nurse; and/or
    d) to engage in the practice of nursing in any capacity;

5. CNO is authorized to and may, in its sole discretion, provide a copy of this Undertaking and/or its terms to a governing body that regulates nursing in Canada or elsewhere in response to an inquiry or otherwise;

6. The Panel is not obliged to accept any agreement entered into between CNO and myself, including any order that we jointly request.

College Counsel submitted that this Undertaking has been jointly agreed to by the parties and in this case, this resolution is in the public interest.

The aggravating factors in this case were:

- The seriousness of the Member's conduct;
- The vulnerable patient population for whom the Member was caring.

The mitigating factors in this case were:

- The Member had no past disciplinary record with the College;
- The Member cooperated with the College;
- The Member had taken responsibility for his actions and did not contest the hearing.

College Counsel submitted that ordinarily the Member's conduct would require a significant regulatory response in order to meet the goals of penalty.

College Counsel would have normally requested a suspension and remediation program, however, the parties have agreed on the reprimand on the basis of the Undertaking of the Member given to the College. The Member voluntarily resigned in 2017. In the Undertaking, which is attached to the Joint Submission on Order, the Member has given up his right to reactivate his registration.

The proposed penalty provides for general deterrence through the oral reprimand and demonstrates that these behaviours will not be tolerated and discourages other members of the profession from engaging in similar behaviour.

College Counsel further submitted that specific deterrence and rehabilitation or remediation are also goals of penalty that panels generally consider; however they are not required where the Member has resigned and will not be practicing in the profession in the future.

Overall, the public is protected because the Member has resigned his certificate of registration and that guarantees protection of the public. The penalty further meets the goals of maintaining public confidence in the regulation of the profession and provides transparency through the posting of the Undertaking and the publication of the findings that have been made.

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. Doey (Discipline Committee, 2019)
In this case, the member failed to meet the standards of practice when she used profanity in the presence of the client; used a derogatory term for a Patient Care Attendant, transferred a patient without assistance and refused to provide medication to a client. The penalty was an oral reprimand and the member entered into an undertaking with the College to resign.

CNO v. O'Neill (Discipline Committee, 2016)
In this case, the member contravened the *Professional Standards*, *Ethics*, and *TNCR Standard* when she attempted to make the client take medications without consent and by pinching the client when she refused. The penalty was an oral reprimand and the member entered into an undertaking with the College to resign and to never reapply for registration in Ontario or any other jurisdiction as a nurse in the future.

CNO v. Smith (Discipline Committee, 2017)
In this case, the member failed to meet the *TNCR Standard* and physically abused the client when she grabbed the client's blouse and shook her. The penalty was an oral reprimand and the member entered into an undertaking with the College to resign.

The Member's Counsel stated she took no issue with the submissions made by College Counsel and that the case law examples were accurate. The Member's Counsel agreed that the reprimand in light of the Undertaking is an appropriate penalty.

The Member's Counsel also pointed out mitigating factors which included the fact that the Member was a long serving Registered Nurse with 34 years' experience, no prior discipline on his record with the College, has paid a high price and left his employment when the allegations came to light. The Member's Counsel further stated these were extremely challenging patients and the Member would volunteer to care for the most difficult patients. The Member's Counsel indicated there was no evidence provided that the Member had premeditation or an intention to do harm. The Member has shown accountability.

Penalty Decision

The Panel accepts the Joint Submission on to 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.

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 general deterrence and public protection. Since the Member has permanently resigned his registration, the ultimate goal of public protection has been met. The transparency of posting the Member's resignation and reprimand on the College's register will maintain public confidence and demonstrate the College's ability to regulate nurses.

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

I, Terry Holland, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.