DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Grace Fox, NP	Chairperson
	Margarita Cleghorne, RPN	Member
	Catherine Egerton	Public Member
	Sherry Szucsko-Bedard, RN	Member
	Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
MARY BRUCE	)	JENNIFER MICALLEF for
Registration No. 9207796	)	Mary Bruce
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: December 16, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on December 16, 2019 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

The allegations against Mary Bruce (the "Member") as stated in the Notice of Hearing dated November 18, 2019 are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, while practising as a Registered Nurse at Grand River Hospital in Kitchener, Ontario, you contravened a

standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

(a) on or about June 3, 2015, you spoke to a colleague in a raised voice and/or in an unprofessional manner within earshot of other colleagues and/or patients, and/or stated words to the effect of "don't you dare think that because you have the charge phone that you can tell me what to do";

(b) on or about June 3, 2015, you made disrespectful comments about a colleague and/or colleagues within earshot of other colleagues, and/or stated words to the effect that you would not be "told what to do by those skinny-assed bitches";

(c) on or about September 29, 2015, while working as a triage nurse in the emergency department, you failed to complete the triage process for [Patient 1], including by failing to document that the client had visited the facility, failing to document any care or treatment provided to the client, and/or failing to document any interactions with the client;

(d) on or about September 29, 2015, while working as a triage nurse in the emergency department, you failed to arrange for [Patient 1] to be assessed by a physician when such an assessment was warranted;

(e) on or about May 21, 2016, you communicated inappropriately with a member of [Patient 2's] family, including by stating words to the effect of "sometimes as parents we have to be a bit aggressive. Sometimes we have to spank";

(f) on or about August 21, 2016, you spoke to a colleague in a raised voice and/or in an unprofessional manner within earshot of other colleagues and/or patients, when discussing the appropriate care that was and/or should have been provided to [Patient 3];

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(13) of *Ontario Regulation 799/93*, in that, while practising as a Registered Nurse at Grand River Hospital in Kitchener, Ontario, you failed to keep records as required, and in particular:

(a) on or about September 29, 2015, while working as a triage nurse in the emergency department, you failed to complete the triage process for [Patient 1], including by failing to document that the client had visited the facility, failing to document any care or treatment provided to the client, and/or failing to document any interactions with the client;

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while practising as a Registered Nurse at Grand River Hospital in Kitchener, 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, and in particular:

(a) on or about June 3, 2015, you spoke to a colleague in a raised voice and/or in an unprofessional manner within earshot of other colleagues and/or patients, and/or stated words to the effect of "don't you dare think that because you have the charge phone that you can tell me what to do";

(b) on or about June 3, 2015, you made disrespectful comments about a colleague and/or colleagues within earshot of other colleagues, and/or stated words to the effect that you would not be "told what to do by those skinny-assed bitches";

(c) on or about September 29, 2015, while working as a triage nurse in the emergency department, you failed to complete the triage process for [Patient 1], including by failing to document that the client had visited the facility, failing to document any care or treatment provided to the client, and/or failing to document any interactions with the client;

(d) on or about September 29, 2015, while working as a triage nurse in the emergency department, you failed to arrange for [Patient 1] to be assessed by a physician when such an assessment was warranted;

(e) on or about May 21, 2016, you communicated inappropriately with a member of [Patient 2's] family, including by stating words to the effect of "sometimes as parents we have to be a bit aggressive. Sometimes we have to spank";

(f) on or about August 21, 2016, you spoke to a colleague in a raised voice and/or in an unprofessional manner within earshot of other colleagues and/or patients, when discussing the appropriate care that was and/or should have been provided to [Patient 3].

Member's Plea

The Member admitted the allegations set out in paragraphs #1(a), (b), (c), (d), (e), (f); #2(a); #3(a), (b), (c), (d), (e) and (f) in the Notice of Hearing. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Mary Bruce (the "Member") obtained a diploma in nursing from Confederation College-Thunder Bay Campus in 1991 and completed her BScN from the University of Victoria in May 2009.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on January 22, 1992.

3. The Member was employed in the Emergency Department of Grand River Hospital in Kitchener, Ontario (the "Facility"), from 2013 to September 2016. In September 2016, the Member was issued a three-day suspension by the Facility as a result of the incidents below. She then left her employment at the Facility shortly thereafter.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

June 2015- Improper Communications with Colleagues

4. On or about June 3, 2015, the Member's colleague, [Colleague A], was covering the Charge Nurse role for the Emergency Department at the Facility while the Charge Nurse took a break. [Colleague A] asked the Member to check with another nurse, [Colleague B], to see whether [Colleague B] needed assistance to be able to take a break.

5. Within hearing distance of other colleagues and patients and in an elevated voice, the Member said to [Colleague A], "don't you dare think that because you have the charge phone you can tell me what to do", or words to that effect.

6. Following the incident, the Member discussed [Colleague A] while in the staff lounge with other colleagues. In reference to [Colleague A], the Member said that she would not be "told what to do [by] those skinny-assed bitches."

7. The Member agreed to participate in mediation shortly after this incident occurred and the Member remained "professional" when dealing with [Colleague A] after this incident.

September 2015- Failure to Triage and Document

8. On September 29, 2015, a patient ("Patient 1") attended at a clinic which provided services to patients with HIV (the "Clinic"). She was seen by [ ], an RN at the Clinic.

9. Patient 1 had recently been diagnosed as HIV positive and was distressed. She expressed suicidal ideation to [the RN].

10. [The RN] was unable to calm Patient 1. A physician at the Clinic directed [the RN] to take Patient 1 to be assessed at the Emergency Department at the Facility.

11. [The RN] accompanied Patient 1 to attend the Emergency Department at the Facility. The Member was the triage nurse for Patient 1.

12. The Member asked Patient 1 whether she would carry through with her threatened suicide. Patient 1 stated that she would not and insisted that she was fine and that she did not want to be admitted to the Facility.

13. The Member asked [the RN] whether she was comfortable with Patient 1 leaving the Emergency Department. [The RN] replied that she did not know Patient 1 well, she was not a triage nurse, and therefore was not comfortable making that assessment.

14. The Member asked Patient 1 and [the RN] two to three more times whether [the RN] was comfortable with Patient 1 leaving the Facility. [The RN] eventually stated words to the effect of, "if you're comfortable I'm comfortable, since you're the triage nurse." The Member then said that Patient 1 could leave.

15. [The RN] felt uncomfortable with the Member's response. It was her impression that the Member was advising Patient 1 to leave and discouraging her from being admitted to the Facility.

16. Patient 1 departed the Facility without any further assessment. [The RN] advised the Member that she was driving Patient 1 home and would be seeing her again for an appointment in the morning with her doctor.

17. The Member did not register Patient 1 at the Facility or complete any documentation of her intake assessment of Patient 1. As a result, there was no documentation at the Facility that Patient 1 had ever attended.

18. Patient 1 had been scheduled to attend the Clinic the following day, but she missed her appointment. The Clinic physician was able to access the Facility's records, but could not locate any records about Patient 1's attendance at the Facility the day before. The physician called the Facility, who were also unable to find any documentation of Patient 1's attendance the day before.

19. The Member admits that she failed to complete the triage process for Patient 1 when she failed to complete any documentation related to the patient's visit. The Member further admits that the circumstances and information provided to her required her to ensure that Patient 1 was assessed by a physician, which she failed to do.

20. After leaving the Facility on September 29, 2015, Patient 1 returned to her home and ingested a non-lethal dose of acetaminophen and held a knife up to her neck. She was admitted to the Facility for treatment on September 30, 2015.

21. If the Member were to testify, she would say that she was remorseful when she was told of the patient's suicide attempt and regretted that she had not done more to try and have her admitted.

May 2016- Improper Communication with a Patient's Family

22. On May 21, 2016, three-year-old [ ] ("Patient 2") was brought to the Emergency Department at the Facility by her mother and grandmother.

23. Patient 2 had undergone a tonsillectomy and/or adenoidectomy procedure on May 19, 2016. Her family was having difficulty getting Patient 2 to take her pain medication. Patient 2's

mother had been instructed by the surgeon to attend the Emergency Department if she had difficulty administering the medication.

24. The Member attended to Patient 2 while she was in the Emergency Department. The Member told Patient 2's grandmother and mother words to the effect of, "sometimes as parents we have to be a bit aggressive. Sometimes we have to spank".

25. If the Member were to testify, she would say that she was explaining to Patient 2's mother how she had gotten her own son to take medication when he didn't want to many years ago when he was a child and that she had been more aggressive with her son in order to force him to take his medication.

26. Patient 2's grandmother did not respond positively to the Member's statements, resulting in an argument between Patient 2's grandmother and the Member, after which the Member asked Patient 2's grandmother to leave. The Member apologized to Patient 2's mother and proceeded to administer the medication to Patient 2 without incident.

27. Patient 2's mother was very upset with the Member's comments and the Member's request that Patient 2's grandmother leave the room.

August 2016- Improper Communication with a Colleague

28. On August 21, 2016, a patient ("Patient 3") attended at the Emergency Department due to swelling in her hands. Patient 3 was unable to remove a ring from her finger and did not want the ring to be cut off her finger.

29. The triage nurse, [ ], explained to Patient 3 that it may be possible to use the "string technique" to remove Patient 3's ring without cutting it. [The Triage Nurse] suggested that Patient 3 could make this request to the nurses in the Emergency Department who would be providing care to her. [The Triage Nurse] also explained the process of cutting off the ring to Patient 3.

30. Patient 3 was assigned to the Member's care in the Emergency Department. Patient 3 requested that the Member try the string technique and indicated her preference that the Member not cut off her ring. The Member cut off Patient 3's ring without attempting any other technique to remove it, having determined that it was necessary in the circumstances. Patient 3 expressed her disappointment to the Member, in that she believed the Member had been dismissive of her request to avoid cutting her ring.

31. The Member attended the triage area to confront the triage nurse who had spoken to Patient 3, without knowing that it was [the Triage Nurse]. She loudly asked, "who is the triage nurse who triaged the patient with the rings?" The Member was in a public area, in front of another patient and a clerk.

32. The Member spoke to [the Triage Nurse] in a confrontational manner, standing over her and using a loud and unprofessional tone. The Member stated, "the patient told me that I had to

do the string method first and to cut the ring in 2 places. I cut it in one place, I am the nurse and I am here to cut the ring off", or words to that effect.

33. The Member continued to say that "she did not appreciate the patient telling her what to do", complained that Patient 3 "whined" when the Member approached her with the sharp instruments, and that she felt very frustrated.

34. [The Triage Nurse] invited the Member to sit down next to her to discuss the matter. The Member, however, had become very upset, so much so that she did not believe she could finish her shift. The Member proceeded to leave her shift early, without providing a report to her colleagues about the status of her patients.

CNO STANDARDS

35. 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 Relationship Standard

36. 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.

37. The TNCR Standard places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse. Therapeutic nursing services "contribute to the [patient's] health and well-being" and the relationship is based on "trust, respect, empathy and professional intimacy, and requires the appropriate use of power inherent in the care provider's role."

38. 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…

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

40. The Member admits that she contravened the TNCR Standard through her conduct as described in paragraphs 4 to 34 above.

Documentation

41. CNO's *Documentation* standard states that:

> Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the Patient health record. Documentation — whether paper, electronic, audio or visual — is used to monitor a [patient's] progress and communicate with other care providers. It also reflects the nursing care that is provided to a [patient].

42. A nurse meets the standard by "ensuring their documentation of [patient] care is accurate, timely and complete."

43. The Member admits that she contravened the *Documentation* standard through her conduct as described in paragraphs 8 to 21 above.

Professional Standards

44. 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 [patients]."

45. 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…

46. The Professional Standards also establishes that nurses should establish and maintain "respectful, collaborative, therapeutic and professional relationships." These relationships include patients and "professional relationships with colleagues, health team members and employers."

47. A nurse demonstrates this requirement by "role-modelling positive collegial relationships" and "using a wide range of communication and interpersonal skills" and "demonstrating effective conflict-resolution skills."

48. The Member admits that she contravened the Professional Standards through her conduct as described at paragraphs 4 to 34 above.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

49. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a)-1(f), and 2(a) of the Notice of Hearing, as described in paragraphs 4 to 34 above.

50. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a)- 3(f) of the Notice of Hearing, and in particular, that her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 4 to 34 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), (b), (c), (d), (e) and (f); #2(a); #3(a), (b), (c), (d), (e) and (f) in the Notice of Hearing. As to allegation #3(a), (b), (c), (d), (e) and (f), the Panel finds that the Member engaged in conduct that would reasonably be considered by members of the profession to be 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 5 and 49 in the Agreed Statement of Facts. The Member admits that she had, in an elevated voice, said "don't you dare think that because you have the charge phone you can tell me what to do" or words to that effect.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 6 and 49 in the Agreed Statement of Facts. The Member admitted while in the staff lounge she said she would not be "told what to do (by) those skinny-assed bitches."

Allegations #1(c) and (d) in the Notice of Hearing are supported by paragraphs 17, 18, 19, 43 and 49 in the Agreed Statement of Facts. The Member by her own admission did not register Patient 1 at the Facility or complete documentation of the intake assessment. When Patient 1 failed to attend the Clinic the next day, the Clinic's physician was unable to find any documentation of Patient 1 attending the Facility the prior day.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 24 and 49 in the Agreed Statement of Facts. The Member spoke to Patient 2's grandmother and mother words to the effect of,

"sometimes as parents we have to be a bit aggressive. Sometime we have to spank" when referring to the mother having difficulty administering a medication.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs 31, 32, 33, 39 and 40 in the Agreed Statement of Facts. The Member used a loud and unprofessional tone in a confrontational manner with a colleague.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 17, 18, 19, 43 and 49 in the Agreed Statement of Facts. The Member has admitted to falling below CNO's documentation standard which states in part that "documentation is an important component of nursing practice". "It also reflects the nursing care that is provided to a {patient}". Further the Member admitted to Allegation 1(d), namely that she had failed to arrange for the patient to be assessed by a physician when such an assessment was warranted.

With respect to Allegations #3(a), (b), (c), (d), (e) and (f), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. The Member's conduct had repeatedly fallen below the Professional Standards by not maintaining a respectful and collaborative, therapeutic and professional relationship with both colleagues and patients. The Member failed to meet professional obligations by failing to document as required and through the use of inappropriate words and tone.

The Panel also finds that the Member's conduct was dishonourable. The Member demonstrated an element of dishonesty and deceit through using verbal language that was not in the interest and wellbeing of the patient[.] The Member demonstrated she was in violation of the TNCR by not being aware of verbal communication style. The Member's conduct fell below the documentation standard which had negative effects on the patient for follow up with a Clinical Physician.

The Panel did not agree that the Agreed Statement of Facts supported a finding that the conduct was disgraceful. The Panel did recognize that there were many proven allegations against the Member, but the conduct did not cast serious doubt on the Member's moral fitness and inherent ability to discharge higher obligations the public expects professionals to meet. The Panel did seek clarification from both counsel on this matter. The Panel felt that the allegations were not egregious enough to make a finding of disgraceful conduct. The Panel's decision was based on reviewing all the information provided with the Agreed Statement of Facts and from reviewing the definition of disgraceful and the consensus was this did not fall within those parameters. The allegations are serious but it was felt they fell short of disgraceful and after seeking further verification we as a panel agreed that disgraceful was not met.

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 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 4 months. This suspension shall take effect from the date that this Order becomes final 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in Nursing Regulation and has been approved by the Director in advance of the meetings;

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

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

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

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

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

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

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

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

vi. 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.

c) The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

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

Penalty Submissions

Submissions were made by College Counsel and the Member's Counsel.

College Counsel submitted that the mitigating factors in this case were that the Member has cooperated with the College, admitted the allegations and accepted responsibility for her actions.

The aggravating factors in this case were that the Member failed to document that a patient required a follow up appointment. The Member demonstrated a lack of insight into her practice as she had three other complaints with the College prior to this hearing. The Panel was given copies of three decision letters from the Inquiries, Complaints and Reports Committee ("the ICRC") dated November 17, 2010, February 4, 2015 and December 13, 2017. College Counsel submitted that while the ICRC is not mandated to make findings of fact, it had concluded that the information obtained in the investigation supported that the Member did not meet her professional obligations. The ICRC required the Member to complete remedial activities.

College Counsel submitted that the terms of the Joint Submission on Order were tailored to meet the objectives of:

- Protection of the public and maintenance of public confidence in the disciplinary process,
- General and specific deterrence, and
- Remediation and rehabilitation of the Member's practice.

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

CNO vs Nkwelle (Discipline Committee 2018). The member in this case failed to ensure observation of a client, falsely documented and napped while on duty. The client committed suicide. The member was in attendance at the hearing which proceeded with an Agreed Statement of Facts. The member's conduct was found to be unprofessional and dishonorable. This member was given a three month suspension. Terms, conditions and limitations were placed on his practice including a 12 month employer notification.

CNO vs Powers (Discipline Committee 2007). The member in this case had engaged in inappropriate behaviour with the family member of a client, both physically and verbally. The member was in attendance at the hearing which proceeded with an Agreed Statement of Facts. The conduct was deemed to be unprofessional, dishonourable and disgraceful. This member was suspended for 6 months. Terms, conditions and limitations were placed on her practice including a 12 month employer notification.

CNO vs Hewitt (Discipline Committee 2010). The member's conduct in this case included an extensive pattern of confrontational, demeaning and angry comments and actions towards clients and coworkers. The member was in attendance at the hearing which proceeded with an Agreed Statement of Facts. The member's conduct was found to be unprofessional and dishonorable. This member was given a three

month suspension. Terms, conditions and limitations were placed on his practice including a 24 month employer notification.

The Member's Counsel told the Panel that the Member is remorseful, has taken responsibility for her conduct and has reflected and has insight into her actions.

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 3 months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 4 months. This suspension shall take effect from the date that this Order becomes final 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

        i. The Expert has expertise in Nursing Regulation and has been approved by the Director in advance of the meetings;

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

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

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

            1. *Professional Standards*,
            2. *Code of Conduct*,

3. *Documentation, and*
4. *Therapeutic Nurse-Client Relationship*;

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

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

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

vi. 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.

c) The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

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

Reasons for Penalty Decision

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

The proposed penalty provides for general deterrence through a four month suspension. This sends a clear message to the profession that the failure to meet one's professional obligations can result in serious disciplinary sanctions. The terms, conditions and limitations on the Member's certificate of registration indicate to the membership, and the public, that this type of behaviour is taken very seriously by the College and the Discipline Committee. It also sends a strong message that this profession is capable of governing itself.

The proposed penalty provides for specific deterrence through the four month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of how her actions are perceived by both the profession and the public. The terms, conditions and limitations will provide monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert, the College's publication and the completion of the Reflective Questionnaires and online participation forms. These requirements will help to deepen the Member's understanding of her misconduct and will help assist in this conduct never to be repeated.

Overall, the public is protected because this process will assist the Member in gaining insight and knowledge into her practice. The 24 month employer notification will ensure that the Member's practice is monitored for a significant period of time when she returns to nursing.

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. Members of the profession will be reminded that there can be serious consequences when College standards are not followed.

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

I, Grace Fox, NP, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.