DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Michael Hogard, RPN	Chairperson
	Tim Crowder	Public Member
	Jean-Laurent Domingue, RN	Member
	Carly Gilchrist, RPN	Member
	Sandra Larmour	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
VIVIAN PARAON	)	JASON HUANG-KUNG for
Registration No. AE094185	)	Vivian Paraon
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: October 26, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on October 26, 2022, via videoconference.

Publication Ban

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

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

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(b), 2(b) and 4(b) in the Amended Notice of Hearing dated June 28, 2022. The Panel granted this request. The remaining allegations against Vivian Paraon (the "Member") are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Chartwell Pine Grove Long Term Care in Vaughan, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that on or about May 17, 2020, with respect to [the Patient], you:

    (a) physically restrained the patient in a wheelchair without clinical order by tying both of the patient's elbows to the wheelchair armrests;

    (b) [withdrawn];

    (c) failed to appropriately monitor and/or assess the patient while he was restrained; and/or

    (d) failed to properly document the physical restraint of the patient;

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation* 799/93, while employed as a Registered Practical Nurse at Chartwell Pine Grove Long Term Care in Vaughan, Ontario, you verbally, physically or emotionally abused a patient in that on or about May 17, 2020, with respect to [the Patient] you:

    (a) physically restrained the patient in a wheelchair without clinical order by tying both of the patient's elbows to the wheelchair armrests;

    (b) [withdrawn]; and/or

    (c) failed to appropriately monitor and/or assess the patient while he was restrained;

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(13) of *Ontario Regulation* 799/93, while employed as a Registered Practical Nurse at Chartwell Pine Grove Long Term Care in Vaughan, Ontario, you failed to

keep records as required in that on May 17, 2020 you failed to document the physical restraint of [the Patient]; 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(37) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at Chartwell Pine Grove Long Term Care in Vaughan, 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, in that on or about May 17, 2020, in relation to [the Patient], you:

   (a) physically restrained the patient in a wheelchair without clinical order by tying both of the patient's elbows to the wheelchair armrests;

   (b) [withdrawn];

   (c) failed to appropriately monitor and/or assess the patient while he was restrained; and/or

   (d) failed to properly document the physical restraint of the patient.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), (c), (d), 2(a), (c), 3, 4(a), (c) and (d) in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Vivian Paraon (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on March 2, 2015. The Member has no prior disciplinary findings with CNO.

2. The Member was employed as a part-time RPN at Chartwell Pine Grove Long Term Care in Vaughan, Ontario (the "Facility") from April 23, 2015 to June 8, 2020, when her employment was terminated as a result of the incident described below. The Member's first employment as an RPN after being registered with CNO was at the Facility.

THE FACILITY

3. The Member primarily worked evening shifts from 1500-2300 hours on the 1st floor unit of the Facility (the "Unit").

4. The nurse-to-patient ratio on the Unit was 1:32. There were also 3 to 4 Personal Support Workers ("PSWs") on the Unit who the Member supervised. A Registered Nurse ("RN") at the Facility provided supervision for all RPNs.

5. As a RPN, the Member's responsibilities included providing care for patients who had a mixture of needs, ranging from light to moderate to heavy.

THE PATIENT

6. [The Patient] (the "Patient") was 78 years old at the time of the incident.

7. The Patient was admitted to the Facility on November 21, 2019. The Patient had Parkinson's disease and unspecified dementia. His care plan provided techniques for managing resistant or aggressive behaviours. The use of restraints was not a technique included in the Patient's care plan.

8. If the Member were to testify, she would say that she knew the Patient to be aggressive from personal experience in handling his care. The Patient's health records noted his aggressive behaviour in response to the COVID-19 pandemic and lockdown at the Facility which prevented his family from visiting.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

9. On May 17, 2020, at approximately 2230 hours, the Patient was agitated and restless. He became physically aggressive towards PSWs as they attempted to put him to bed. The Member and the evening shift RN, [Nurse A], were near-by doing documentation and they intervened and assisted the PSWs with the Patient.

10. [Nurse A] instructed the Member to place the Patient in a wheelchair by the nursing station so he could be monitored. [Nurse A] then left to attend to documentation on another unit and provide care to a palliative patient on the Unit.

11. If the Member were to testify, she would say:
    - she placed the Patient in a wheelchair and positioned him in the hallway by the nursing station so that he could be monitored;
    - when the Patient was placed in the wheelchair, he was trying to get up from the wheelchair and the PSWs attempted to pacify him;
    - the Patient was agitated and began punching, kicking and spitting at the PSWs;

- the Member was at the nursing station during this time and observed the Patient's wheelchair moving as he attempted to stand up, punch and kick; and
- the Member was concerned that the Patient would fall over on the wheelchair and injure himself.

12. If the Member were to testify, she would say that May 2020 was still the very beginning of the COVID-19 pandemic during a time of great uncertainty related to the contagiousness and severity of COVID-19 and measures such as wearing face masks and physical distancing were required at the Facility.

13. If the Member were to testify, she would say that another patient on the Unit was dying on the night of May 17, 2020. The Member would further testify that, given COVID-19 restrictions, family members were only permitted to visit the patient in pairs of two and, as such, there was unusually heavy traffic of family members entering and exiting the Unit that night. Further the Member would testify that the nursing station where the Member and the Patient were located is near the 1st floor entrance where those family members were entering and exiting.

14. In or around 2240 on May 17, 2020, the Member moved the Patient to the dining room adjacent to the nursing station and physically restrained him by tying his elbows to the wheelchair armrests using two garbage bags with the assistance of two PSWs. The Patient did not have an order for the use of physical restraints.

15. If the Member were to testify, she would say that the reason for moving the Patient to the dining room was so that he was not in close contact with the family members of the other patient who were entering and exiting the Unit to avoid exposure and risk of contracting COVID-19. The Member would further testify that the reason she physically restrained the Patient was because he was agitated, aggressive and attempting to get up from in his wheelchair, which she felt posed a risk of harm to the Patient.

16. The Member spoke again to [Nurse A] about the Patient and his behaviour. [Nurse A] recommended that the Member place the Patient on a mat as they have done in the past to help him calm down. [Nurse A] also told the Member restraints are not part of the Facility's policy.

17. The Facility's policy, "Restraint Management – Physical & Environmental" provides that if a patient shows behaviour that could put them at risk of restraint, several steps must be completed including, but not limited to, a referral to appropriate health services for a comprehensive assessment and the behaviour must be monitored for at least three days before a restraint can be implemented. With respect to emergency situations, the policy provides that restraints may only be used in an emergency situation after all assessments have been completed. The physician must be notified within 24 hours and an order must be obtained for the restraint. A legal representative/family must also be notified, and their consent must be obtained. The nurse is also required to use the least restrictive device and

take a number of steps including, but not limited to, monitoring the patient at a minimum, every 30 minutes for the first 24 hours.

18. After restraining the Patient, the Member left the dining room to return to the nursing station. A stool was left between the dining room door, leaving the door ajar and permitting light from the hallway into the dining room. There is a window between the nursing station and the dining room. While sitting at the nursing station, an individual was able to see the Patient from the neck up. When standing at the nursing station, an individual was able to see the Patient in full. If the Member were to testify, she would say that an individual sitting at the nursing station could see the Patient in full. The lighting in the dining room was motion activated. If the lights are off in the dining room, the lights from the hallway and the nursing station illuminate the front part of the dining room where the Patient was left.

19. If the Member were to testify, she would say that she monitored the Patient from the nursing station, she maintained eye contact with the Patient while he was in the dining room and gestured for him to calm down using her hands. The Member, did not, however, go back into the dining room to assess the Patient. If the Member were to testify, she would say that between the time of restraint and the Member leaving the Facility around 2315/2320, she believed that PSWs re-entered the dining room to assess the Patient, but acknowledges that it was her responsibility to assess and monitor the Patient.

20. [PSW A], a PSW at the Facility, was working on the Unit during the night shift from 2300 to 0700 hours on May 17, 2020. At approximately 2315 hours, [PSW A] entered the dining room to remove a stool that she noticed was placed between the dining room doors. She assumed the room was empty as the lights were off. When she entered, she saw the Patient in a wheelchair with his elbows tied to the arms of the wheelchair with plastic garbage bags.

21. [PSW A]was frightened to see a patient like this and asked a nearby staff why the Patient was tied up. She was told that he was being aggressive. The Member was at the nursing station and also advised [PSW A] that the Patient had been aggressive and that his family was informed.

22. If the Member were to testify, she would say that she gave report to [PSW A] at the beginning of [PSW A]'s shift informing her and the night RN, [Nurse B] that the Patient was physically restrained to his wheelchair and in the dining room. [PSW A] and [Nurse B] do not recall receiving any such report from the Member.

23. [PSW B], a PSW at the Facility, was working on the Unit during the night shift from 2300 to 0700 hours on May 17, 2020 and was assigned to the Patient's care. At the start of her shift, she saw the Member briefly at the nursing station. The Member did not advise [PSW B]of anything relating to the Patient's behaviour. [PSW B] noticed that the Patient was in

the dining room when she arrived on shift because she saw his feet from the nursing station.

24. Shortly after 2315 hours, [PSW B] went into the dining room to check on the Patient. The lights turned on automatically and [PSW B] saw that the Patient was alone, and his arms were tied at the elbows to the arms of the wheelchair with plastic garbage bags. The Patient was able to move his fingers and wrists, but not his elbows. [PSW B] was frightened and screamed immediately, "why is he tied up like that?" She recalls an indistinct voice from outside the room respond, "because he was aggressive." She responded, "was he this aggressive for him to be tied up?" She did not receive a response.

25. [PSW B] immediately exited the dining room to obtain scissors to cut the plastic off. [PSW B] returned to the Patient and cut him loose. She reported the incident to the night RN, [Nurse B], who in turn told [PSW B] that she had been advised the Patient was in a wheelchair, but not that he was tied up. [PSW B] and [Nurse B] reviewed the progress notes, but they did not locate any mention of the Patient's aggressive behaviour or him being restrained.

26. The Member failed to document anything in the Patient's progress notes on May 17, 2020.

27. [Nurse B] and [PSW A] subsequently assessed the Patient and helped transfer him to his bed. He did not have any bruises as a result of the restraint. He was not in distress at the time of their assessment.

28. The Member reported the incident to [ ], the Facility's Administrator, the following day. The Member was immediately placed on administrative leave pending an investigation.

29. Following the investigation, the Facility terminated the Member's employment on June 8, 2020.

30. If the Member were to testify, she would say that she has learned from her mistakes and has been mindful of it in her employment as an RPN at another employer for the last approximately two years.

CNO STANDARDS

Code of Conduct

31. CNO's *Code of Conduct* is a standard of practice describing the accountabilities all Ontario nurses have to the public. The *Code of Conduct* consists of six principles including:

    - Nurses respect the dignity of patients and treat them as individuals;

    - Nurses work together to promote patient well-being;

- Nurses maintain patients' trust by providing safe and competent care;
- Nurses work respectfully with colleagues to best meet patients' needs;
- Nurses act with integrity to maintain patients' trust; and
- Nurses maintain public confidence in the nursing profession.

32. With respect to the principle requiring nurses to respect the dignity of patients and treat them as individuals, the *Code of Conduct* provides that nurses treat patients with care and compassion.

33. Regarding the principle requiring nurses to maintain patients' trust by providing safe and competent care, the *Code of Conduct* provides that:

    - Nurses maintain complete, accurate and timely documentation in their practice; and
    - Nurses are accountable to, and practice under, relevant laws and CNO's standards of practice.

Professional Standards

34. CNO's *Professional Standards* provides an overall framework for the practice of nursing and a link with other standards, guidelines and competencies developed by CNO. It includes seven broad standard statements pertaining to accountability, continuing competence, ethics, knowledge, knowledge application, leadership and relationships.

35. CNO's *Professional Standards* provides, in relation to the accountability standard, that nurses are accountable to the public and responsible for ensuring their practice and conduct meets the legislative requirements and the standards of the profession. Nurses are responsible for their actions and the consequences of those actions as well as for conducting themselves in ways that promote respect for the profession. A nurse demonstrates this standard by actions such as:

    - providing, facilitating, advocating and promoting the best possible care for [patients];
    - advocating on behalf of [patients];
    - seeking assistance appropriately and in a timely manner;
    - 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.

36. CNO's *Professional Standards* further provides, in relation to the knowledge application standard, a nurse demonstrates this standard by actions such as identifying/recognizing abnormal or unexpected client responses and acting appropriately.

37. In addition, CNO's *Professional Standards* provides, in relation to the leadership standard, that all nurses, regardless of their position have opportunities for leadership. A nurse demonstrates this standard by actions such as:

    - role-modelling professional values, beliefs and attributes; and

    - collaborating with [patients] and the health care team to provide professional practice that respects the rights of [patients].

Therapeutic Nurse-Client Relationship

38. CNO's *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard*") contains four standard statements which describe nurses' accountabilities with respect to therapeutic communication, patient-centred care, maintaining boundaries and protecting the patient from abuse. The *TNCR Standard* provides that the nurse-patient relationship is built on trust, respect, empathy, professional intimacy and requires the appropriate use of power inherent in the care provider's role.

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

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

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

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

40. The *TNCR Standard* provides, in relation to patient-centred care, that nurses work with the patient to ensure that all professional behaviours and actions meet the therapeutic needs of the patient. A nurse meets the standard by:

- gaining an understanding of the [patient's] abilities, limitations and needs related to his/her health condition and the [patient's] needs for nursing care or services; and

- recognizing that the [patient's] well-being is affected by the nurse's ability to effectively establish and maintain a therapeutic relationship.

41. The *TNCR Standard* also provides, in relation to protecting the patient from abuse, that nurses protect the patient from harm by ensuring that abuse is prevented or stopped and reported. A nurse meets this standard by actions such as:

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

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

42. In addition, the *TNCR Standard* provides examples of abusive behaviours. Verbal and emotional abuse includes, but is not limited to, intimidation including threatening gestures/actions and insensitivity to the patient's preferences. Physical abuse includes, but is not limited to, using force and handling a patient in a rough manner.

Documentation

43. CNO's *Documentation* standard includes three standard statements and indicators pertaining to communication, accountability and security.

44. CNO's *Documentation* standard provides in relation to communication, that nurses ensure that documentation presents an accurate, clear and comprehensive picture of the patient's needs, the nurse's interventions and the patient's outcomes. A nurse meets the standard by actions such as 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 evaluation.

45. CNO's *Documentation* standard further provides, in relation to accountability, that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. A nurse meets the standards by actions such as:

    - documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; and

- documenting the date and time that care was provided and when it was recorded.

46. The Member admits and acknowledges that she contravened CNO's *Code of Conduct*, *Professional Standards* and *TNCR Standard* when she physically restrained the Patient in a wheelchair without a clinical order by tying both of the Patient's elbows to the wheelchair armrests and failed to appropriately monitor and assess the Patient while he was restrained.

47. The Member further admits and acknowledges that she contravened CNO's *Code of Conduct* and *Documentation* standard when she failed to properly document the physical restraint of the Patient.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

48. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), (c) and (d) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 9 to 47 above.

49. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a) and (c) of the Notice of Hearing in that she emotionally and physically abused the Patient, as described in paragraphs 9 to 30 and 41 to 42 above.

50. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3 of the Notice of Hearing in that she failed to keep records as required, as described in paragraphs 9 to 30, 33, 43 to 45 and 47 above.

51. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 4(a), (c) and (d) of the Notice of Hearing, and in particular her conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 9 to 47 above.

OTHER

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

    - 1(b)
    - 2(b)
    - 4(b)

Submissions on liability were made by College Counsel.

College Counsel asked the Panel to accept the Agreed Statement of Facts and the Member's admissions and to make findings of professional misconduct with respect to the allegations in the Amended Notice of Hearing.

With respect to allegation #1, College Counsel submitted that the Agreed Statements Facts provides the Panel with the relevant standards to make a finding of a breach of the standards of practice. These standards include the *Code of Conduct*, the *Professional Standards*, the *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard*") and the *Documentation* Standard. College Counsel submitted that physically restraining [the Patient] while he was sitting in a wheelchair with two garbage bags without a clinical order, failing to assess and monitor [the Patient] while he was restrained, and failing to document the restraint all constitute breaches of the College's standards of practice.

College Counsel submitted that, to make a finding of misconduct with respect to allegation #4, the Panel needs to satisfy itself that the conduct of the Member is relevant to the act of nursing. College Counsel submitted that in this case the conduct all relates to and occurred during the provision of nursing care. After finding that the conduct is relevant to the practice of nursing, the Panel needs to be satisfied that members of the profession would find this conduct to be disgraceful, dishonourable or unprofessional. College Counsel submitted that this is a disjunctive classification in that the Panel may make a finding regarding one, two or all three categories for the misconduct to be made out. College Counsel submitted that the Panel does not need to specify which category or categories of disgraceful, dishonourable or unprofessional the conduct falls into, and need only indicate if the conduct is captured under the broad disgraceful, dishonourable or unprofessional categorization.

College Counsel submitted that in this case the Member's conduct, as admitted in the Agreed Statement of Facts, amounted to all three unprofessional, dishonourable and disgraceful conduct.

College Counsel submitted that the Member's conduct was unprofessional in that the Member's conduct displayed a serious disregard for her professional obligations. The conduct was also unprofessional as the Member knew or ought to have known that her conduct fell below the standards of the profession.

College Counsel submitted that the conduct was dishonourable as there was an element of moral failing when the Member made the decision to restrain a vulnerable patient without a proper authorized device by the use of garbage bags and also without a clinical order.

College Counsel submitted that the Member's conduct was also disgraceful in that it brings shame on the Member and by extension the profession.

College Counsel submitted the following cases to the Panel to aid it with deliberations:

CNO v. Farah (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts. In this case, the member restrained a patient by placing a bed sheet covering the patient's lap belt while he was sitting in a wheelchair. The member did this without proper clinical assessments or reassessments. The member did not receive a clinical order and she failed to document the use of a

restraint. The allegations in this case were a breach of the standards and failure to keep appropriate records. There were no abuse allegations. Findings were made with respect to the breach of the *Professional Standards*, the *TNCR* Standard and the *Documentation* Standard, failure to keep records as required and the member's conduct was found to be disgraceful, dishonourable and unprofessional.

CNO v. Johnston (Discipline Committee, 2022): This case proceeded by way of an Agreed Statement of Facts. In this case, the patient was admitted to an inpatient Mental Health unit. Restraints were used and there was an appropriate physician order for use of a restraint. The primary issue surrounding this case was not the restraint itself, but the way in which the member applied the restraint. The allegations in this case were that the member failed to remove herself from a situation where she could not practice safely, she used improper technique/or excessive force while placing the shoulder restraints and dismissed concerns raised by a security guard of the inappropriateness of the restraint. The panel found that there was a breach of the *Professional Standards* and the *TNCR* Standard, physical abuse and the conduct amounted to unprofessional conduct.

CNO v. Mollanedjad (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts. The facts in this case are not identical to the case before this Panel. In this case, the member at issue was not the individual who placed the restraints on the patient, however, she observed the actions of her fellow nurse. The member did not assess the appropriateness of the restraint or complete documentation on the application of the restraint. The member and her colleagues left the patient restrained in the dining room. There was no monitoring and the patient was left unattended for 5-6 hours before any individual assessed the patient. On assessment, the patient was found deceased. The member and her colleague transferred the deceased patient back into his room without telling the facility that the patient was deceased. Findings were made against the member for breaching the *Professional Standards*, the *TNCR* Standard and the *Documentation* Standard. There were findings of both physical and emotional abuse, a failure to keep records, and falsification of records. The panel found the member's conduct to be unprofessional and dishonourable.

The Member's Counsel made no submissions on liability.

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), (c), (d), 2(a), (c), 3, 4(a), (c) and (d) of the Notice of Hearing. With respect to allegations #2(a) and (c), the Panel finds that the Member emotionally and physically abused [the Patient]. As to allegations #4(a), (c) and (d), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

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

Allegations #1(a), (c) and (d) in the Notice of Hearing are supported by paragraphs 9-48 in the Agreed Statement of Facts. The Member admitted that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession. On May 17, 2020 while working as a part-time Registered Practical Nurse ("RPN") at Chartwell Pine Grove Long Term Care (the "Facility") at approximately 2230 hours, [the Patient] was agitated and restless. He became physically aggressive towards the Personal Support Workers (the "PSWs") as they attempted to assist him to bed. The Member was instructed by a co-worker to place [the Patient] in a wheelchair by the nursing station so he could be monitored. [The Patient] was attempting to get up from his wheelchair and the PSWs attempted to pacify him. [The Patient] was agitated and began punching, kicking and spitting at the PSWs. In response to this aggression, the Member moved [the Patient] to the dining room adjacent to the nursing station and physically restrained him by tying his elbows to the wheelchair armrests with two garbage bags with the assistance of two PSWs. If the Member were to testify, she would indicate that the reason she physically restrained [the Patient] was because he was agitated, aggressive and attempting to get up from the wheelchair, which she felt posed a risk of harm to him. The Member failed to assess [the Patient]. If the Member were to testify, she would say that she monitored [the Patient] from the nursing station by maintaining eye contact with him while he was in the dining room and gestured for him to calm down using her hands. However, the Member admitted that she did not go back into the dining room to assess [the Patient]. The Member acknowledged that it was her responsibility to assess and monitor [the Patient]. Staff from the oncoming shift reviewed the progress notes and documentation, but they did not locate any mention of [the Patient]'s aggressive behaviour and use of restraints. The Facility's policy "Restraint Management - Physical & Environmental" (the "Restraint Policy") provides that a physician must be notified within 24 hours and an order must be obtained for the restraint.

The College's *Code of Conduct* consists of six principles which cite that nurses must work together to promote patient well-being and nurses respect the dignity of patients and treat them as individuals which involves care and compassion. The College's *Professional Standards* provides that nurses are accountable to the public and responsible for ensuring their practice and conduct meets the legislative requirements and the standards of the profession which involves taking action in situations in which patient safety and well-being are compromised. The nurse must collaborate with the patient and the health care team to provide professional practice that respects the rights of patients. The College's *TNCR* Standard provides that the nurse-patient relationship is built on trust, respect and requires the appropriate use of power inherent in the care provider's role. A nurse also meets this standard by recognizing that all behaviour has meaning and seeking to understand the cause of a patient's behaviour. The College's *Documentation* Standard provides that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. A nurse documents in a timely manner and completing documentation during or as soon as possible after, the care or event. The Member's conduct amounts to a breach of each of these Standards.

Allegations #2(a) and (c) in the Notice of Hearing are supported by paragraphs 9-30, 41, 42 and 49 in the Agreed Statement of Facts. The Member admitted that she emotionally and physically abused [the Patient] when she physically restrained him in a wheelchair without clinical order and failed to appropriately monitor and/or assess him while he was restrained. The Panel closely reviewed the evidence presented in the Agreed Statement of Facts which includes a nurse's accountability with respect to protecting a patient from abuse as well as physical, verbal and non-verbal behaviours toward a patient and/or perceived by the patient and/or others as abusive. The Panel also reviewed the *TNCR* Standard in the Agreed Statement of Facts which provides examples of abusive behaviour. Verbal and emotional abuse includes, but is not limited to, intimidation and insensitivity to the patient's preferences. Physical abuse includes, but is not limited to, using force and handling a patient in a rough manner. Based on the evidence provided in the Agreed Statement of Facts the Panel concluded that the Member emotionally and physically abused [the Patient] by her actions.

Allegation #3 in the Notice of Hearing is supported by paragraphs 9-30, 33, 43-45, 47 and 50 in the Agreed Statement of Facts. The Member admitted that she failed to keep records as required. The Member failed to document in [the Patient]'s progress notes on May 17, 2020. When staff from the oncoming shift reviewed [the Patient]'s progress notes they did not reflect his aggressive behaviour and him being restrained. Nurses are accountable for completing a fulsome and accurate clinical picture of the care provided to a patient. Accordingly, the facts support the allegation that the Member failed to keep records as required.

Allegations #4(a), (c) and (d) in the Notice of Hearing are supported by paragraphs 9-47 and 51 in the Agreed Statement of Facts. The Panel finds that the Member's conduct was clearly relevant to the practice of nursing and was unprofessional as she breached the *Code of Conduct*, the *Professional Standards*, the *TNCR* Standard and the *Documentation* Standard. The Member knew or ought to have known that her conduct was unacceptable and in disregard of her professional obligations when she restrained [the Patient] in such an inappropriate manner and failed to follow the Facility's Restraint Policy.

The Panel also finds that the Member's conduct was dishonourable and that it demonstrated an element of moral failing. The Member knew or ought to have known that her actions toward [the Patient] were not acceptable.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and the profession. The Member admitted to physically restraining [the Patient] by tying his elbows to the wheelchair arm rests using two garbage bags. This conduct is unacceptable and casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 3 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in a practicing class.

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

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

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, 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 and decision tools (where applicable):

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

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

        v. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires and *Nurses' Workbook*;

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

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

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, 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 the Member's behaviour;

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

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO 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;

iii. Provide the Member's 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;

iv. 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 CNO, in which it will confirm:

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

4. All documents delivered by the Member to 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.

College Counsel submitted to the Panel that it should be mindful of various considerations when assessing the proposed penalty and whether it is appropriate or not. College Counsel submitted that a penalty is intended to protect the public and enhance public confidence in the College's ability to self-regulate nurses in Ontario. An appropriate penalty that meets the requirement for public protection is achieved through specific deterrence to the Member, general deterrence to the profession as a whole and, where appropriate, rehabilitation and remediation of the Member. College Counsel submitted that the Panel should consider both aggravating and mitigating circumstances.

The aggravating factors in this case were:

- The Member's misconduct was serious as it involved a very vulnerable patient who was physically restrained with garbage bags and placed in the dining room for under one hour;
- The Member did not monitor [the Patient] by physically going into the dining room and assessing his condition and whether or not he showed signs of distress as a result of being restrained;
- This type of conduct and treatment causes harm to a patient and it was found to be both physical and emotional abuse; and
- The conduct brought discredit to the nursing profession.

The mitigating factors in this case were:

- The Member did not intend to cause harm to [the Patient] and from her perspective she was trying to protect the safety of [the Patient];
- This was an isolated incident, one patient, one time;
- The Member has no prior discipline history with the College; and
- The Member has admitted to her misconduct, demonstrated remorse and has taken accountability and responsibility of her actions by participating in the hearing and by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College.

College Counsel submitted that the Joint Submission on Order reflects the various objectives that the Panel needs to consider. Members of the profession more broadly can understand and appreciate that the College will not tolerate this kind of misconduct and that there are significant consequences when this misconduct is demonstrated.

The proposed penalty provides for general deterrence through:

- The 3-month suspension of the Member's certificate of registration.

The proposed penalty provides for specific deterrence through:

- The oral Reprimand; and
- The 3-month suspension of the Member's certificate of registration.

The proposed penalty provides for remediation and rehabilitation through:

- The 2 meetings with a Regulatory Expert; and
- Review of the College's publications.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. This will inform her practice in the future. The 12 months of employer notification will ensure that the Member's practice is monitored for a significant amount of time when she returns to the nursing profession.

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

CNO v. Farah (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and Joint Submission on Order. In this case, the member restrained a patient by placing a bed sheet around the patient's lap belt while he was sitting in a wheelchair. The penalty included an oral reprimand, a two-month suspension of the member's certificate of registration, a minimum of two meetings with a Regulatory Expert and 12 months of employer notification which is an almost identical penalty to the one proposed in the case before this Panel with the only difference being the two-month suspension of the member's certificate of registration. College Counsel submitted that there is a difference in penalties because there were no findings of abuse in this case and there is a different level of severity in this misconduct. The manner in which the patient was restrained differed as the patient was at the nursing station and the bedsheet was around the patient's waist. The policies between the facilities differed and there was clear evidence of a safety concern with this patient. Many attempts were made to keep the patient seated in his wheelchair before the bed sheet was applied as a restraint. In the case before this Panel, [the Patient]'s arms were restrained and his movements were restricted.

CNO v. Johnston (Discipline Committee, 2022): This case proceeded by way of an Agreed Statement of Facts and Joint Submission on Order. In this case, the patient was admitted to an inpatient Mental Health unit. Restraints were used and there were appropriate physician orders for the use of restraints. The primary issue surrounding this case was not the restraint itself, but the way in which the member applied the restraint. The penalty included an oral reprimand, a 3-month suspension of

the member's certificate of registration, 2 meetings with a Regulatory Expert and 12 months of employer notification, which is the exact penalty proposed in the case before this Panel.

CNO v. Mollanedjad (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and Joint Submission on Penalty. The facts in this case are not identical. College Counsel submitted that there was a serious difference in the outcome for the patient as a result of the member's misconduct. In this case, the member's colleagues placed the restraint, however, the member observed the conduct and there was no documentation to reflect the use of a restraint and the patient was left for many hours without monitoring. The patient in this case, ultimately was found deceased. The severity of the case is demonstrated by the more severe penalty. The penalty included an oral reprimand, a 4-month suspension of the member's certificate of registration, a minimum of 2 meetings with a Regulatory Expert, 24 months of employer notification, 6 random spot audits of the member's documentation and no independent practice in the community for 24 months.

College Counsel reminded the Panel that it is generally expected to accept the Joint Submission on Order unless doing so would be contrary to the public interest and bring the administration of justice into disrepute. College Counsel submitted that the Panel has an agreement between the parties on penalty that is reasonable, it is in line with the goals and objectives of penalty including the protection of the public. College Counsel submitted that the penalty has been negotiated by experienced Counsel and falls within the range of penalties that have been ordered by previous Discipline Committee panels.

Submissions were made by the Member's Counsel.

The Member's Counsel requested the Panel to accept the Joint Submission on Order as proposed. It was a product of negotiations and was agreed to by the parties. The Member's Counsel submitted factors for the Panel to consider in deliberations. The Member's Counsel provided a response to College Counsel's two submitted aggravated factors which were: 1) the Member did not monitor [the Patient] by physically entering the dining room. The Member's Counsel submitted as indicated in the Agreed Statement of Facts that the Member would have testified that she monitored [the Patient] through the window; 2) In regards to the statement of "there was clear harm to the patient", the Member's Counsel submitted that the Agreed Statement of Facts provided no evidence of any clear harm to [the Patient] and to the contrary the Agreed Statement of Facts indicated at the time of the assessment after the restraint was removed, there were no bruises and [the Patient] was not in distress at this time.

The Member's Counsel submitted the following further mitigating factors:

- The Member was a relatively junior practicing nurse (approximately 5 years from registration);
- This was the Member's first nursing position as an RPN at the Facility;
- The incident was a single incident;
- This was the Member's first and only offence with the College;
- It was the beginning of the COVID-19 Pandemic, stressful time, new regulations;
- The Member self-reported the incident to the Facility Administrator on the next day;

- For the last two years the Member has continued to work as an RPN with a different employer and no further complaints have been made against her; and
- The Member is remorseful, regrets her decision and learned from her mistakes.

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 3 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 a practicing class.

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

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

        i. The Expert has expertise in nursing regulation and has been approved by CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, 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 and decision tools (where applicable):

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

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

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

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

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, 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 the Member's behaviour;

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

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO 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;

iii. Provide the Member's 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;

iv. 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 CNO, in which it will confirm:

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

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility.

The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The penalty provides for specific deterrence through the 3-month suspension of the Member's certificate of registration. 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 penalty provides for general deterrence through the 3-month suspension of the Member's certificate of registration. This sends a clear message to the profession that the failure to meet one's professional obligations can result in serious disciplinary sanctions. Furthermore, the terms, conditions and limitations on the Member's certificate indicate to the membership, and the public

that this type of behaviour is taken seriously by the College and the Discipline Committee. It also sends a strong message that this profession is capable of governing itself.

The penalty provides for remediation and rehabilitation through the 2 meetings with a Regulatory Expert and the review of the College's publications. These requirements will help deepen the Member's understanding of her misconduct and will help ensure that this conduct is not repeated.

Overall, the public is protected through the 12 months of employer notification which will provide the Member additional oversight on her practice.

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

I, Michael Hogard, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.