DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Terry Holland, RPN	Member
	Mary MacMillan-Gilkinson	Public Member
	Heather Stevanka, RN	Member
	Margaret Tuomi	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	BONNI ELLIS for
	)	College of Nurses of Ontario
- and -	)	
	)	
KAREN FREYER	)	NO REPRESENTATION for
Reg. No. 0013862	)	Karen Freyer
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: May 22-25, 2018

[September 5, 2018 - Panel note: Following the release of our Decision and Reasons, the College wrote to identify four typographical errors at pages 20, 22 and 25. At page 20, last para, line 11, there was no space between two sentences and the first word of the sentence was not capitalized. At page 22, 2nd last para, there was a numbering error with respect to the reference to allegations 4(b)(iii) and (iv). This should read as 4(c)(i) and (ii) as there are no allegations 4(b)(iii) and (iv). On page 25, under the 2nd full bullet point, The Client was referred to as [ ] instead of [Client N]. Finally on page 25, last para, line 5, the sentence, "College Counsel stated…..into evidence under Rule 49 of the Code" should read, "College Counsel stated….into evidence under Rule 53.02 of the *Rules of Civil Procedure,* such that it could be admitted in accordance with s. 49 of the *Code*. These typographical errors have now been corrected to the text as set out below]

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on May 22, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

As Karen Freyer (the "Member") was not present, the hearing recessed for 15 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was in attendance and was not represented. College Counsel noted that the Member's sister was sitting beside her as a

means of support. College Counsel agreed to this. The Panel permitted the Member's sister to sit beside her.

The Panel ordered a publication ban following a motion brought by College Counsel, pursuant to s.45 (3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*. This order prohibits the publication and broadcasting of the names of the patients referred to orally or in any documents presented in the Discipline hearing or any information that could disclose the identity of the patients. College Counsel also asked that there be an order excluding any witnesses from being present in the gallery. The Panel ordered the witness exclusion.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1 a (i), 4 a and 5 a (i) of the Notice of Hearing dated February 1, 2018. The Panel granted this request. The remaining allegations set out in the Notice of Hearing are as follows.

IT IS ALLEGED THAT:

1. You have committed an act or acts 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 paragraph 1(1) of *Ontario Regulation 799/93* in that, while working as a Registered Nurse at Ottawa Carlton Detention Centre (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession when:

    a. on or about June 9, 2014, you:

        i. [*Withdrawn*];

        ii. left client [Client A's] health care record in the cell she shared with other inmates; and/or

        iii. failed to notice that client [Client A's] health care record was missing or failed to take appropriate action when you were unable to locate [Client A's] health care record;

    b. on or about July 22, 2014, you:

        i. refused to complete your assigned duties when you advised your manager, [the Manager], that you would not be continuing with a narcotic count; and/or

        ii. stated "You expect me to count pills each time? Excuse me I'm fucking not doing that. What the fuck do you think I am? A pill counter? This workplace is fucking crazy", or used words to that effect, when your manager, [the Manager, insisted that you complete the narcotic count that you had started with [the Manager];

    c. on or about March 21, 2015, you:

i. stated to client [Client B] “now go back to bed you big fucking dummy”, or used words to that effect when communicating with [Client B] during medication rounds; and/or

ii. stated to client [Client C] “if you don’t clean up your cell tomorrow you’re not getting your meds” and/or “you’re not an animal so don’t live like one”, or used words to that effect when communicating with [Client C] during medication rounds;

d. on or about April 20, 2015, you:

i. refused to attend a group meeting to discuss client care issues when asked by your manager, [the Manager], to do so; and/or

ii. stated “I don’t care what the fuck you say, I’m tired of being run around”, or used words to that effect, when your manager, [the Manager], advised you that attendance at a group meeting to discuss client care was compulsory;

e. on or about June 22, 2015, you:

i. failed to administer the daily dose of Methadone ordered for clients [Client D], [Client E], [Client F], and/or [Client G];

ii. failed to administer the daily dose of Suboxone ordered for clients [Client H], and/or [Client I]; and/or

iii. failed to advise medical staff that clients [Client D], [Client E], [Client F], [Client G], [Client H], and/or [Client I] had not received their daily dose of Methadone and/or Suboxone;

f. on or about July 17, 2015, you:

i. administered a 20mg dose of Methadone intended for client [Client J] to client [Client K], who was ordered to receive only a 5mg dose;

ii. administered Methadone to client [Client K] without consulting the medication administration record for client [Client K] and/or without following all of the steps for Methadone administration set out in the applicable policy(ies) of the Ottawa Carlton Detention Centre;

iii. failed to document your administration of Methadone to client [Client K] in [Client K’s] medication administration record; and/or

iv. failed to complete a report regarding your medication administration error in relation to client [Client K];

g. on or about January 17, 2016, you:

i. administered a 70mg dose of Methadone intended for client [Client L] to client [Client M], who had already received his once daily dose of 110mg of Methadone;

ii. administered a 22mg dose of Methadone to client [Client N] despite the fact that client [Client N] had already received his once daily dose of 22mg of Methadone;

iii. administered Methadone to clients [Client M] and/or [Client N] without consulting the medication administration record for clients [Client M] and/or [Client N] and/or without following all of the steps for Methadone administration set out in the applicable policy(ies) of the Ottawa Carlton Detention Centre;

iv. failed to document your administration of Methadone to clients [Client M] and/or [Client N] in their medication administration record(s);

v. failed to document or complete a report regarding your medication administration error(s) in relation to clients [Client M] and/or [Client N];

vi. failed to report your medication error(s) in relation to clients [Client M] and/or [Client N] to the on-call physician;

vii. altered the entry made in client [Client M's] medication administration record by another nurse regarding her administration to [Client M] of his daily dose of Methadone at 1430;

viii. failed to appropriately monitor, assess and/or treat client [Client M] for symptoms of overdose after you administered to him an additional 70mg of Methadone beyond his daily dose of 110mg of Methadone, which he had already received; and/or

ix. failed to appropriately monitor, assess and/or treat client [Client N] for symptoms of overdose after you administered to him an additional 22mg of Methadone beyond his daily dose of 22mg of Methadone, which he had already received.

2. You have committed an act or acts 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 paragraph 1(7) of *Ontario Regulation 799/93* in that, while working as a Registered Nurse at the Facility you verbally, physically and/or emotionally abused a client when, on or about March 21, 2015, you:

   a. stated to client [Client B] "now go back to bed you big fucking dummy", or used words to that effect when communicating with [Client B] during medication rounds; and/or

   b. stated to client [Client C] "if you don't clean up your cell tomorrow you're not getting your meds" and/or "you're not an animal so don't live like one", or used words to that effect when communicating with [Client C] during medication rounds.

3. You have committed an act or acts 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 paragraph 1(14) of *Ontario Regulation 799/93* in that, while working as a Registered Nurse at the Facility you falsified a record relating to your practice and, in particular, on or about January 17, 2016, you struck through the entry created by another nurse on client [Client M's] medication administration record in relation to her earlier administration of client [Client M's] daily dose of 110mg Methadone.

4. You have committed an act or acts 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 paragraph 1(13) of *Ontario Regulation 799/93* in that, while working as a Registered Nurse at the Facility, you failed to keep records as required and, in particular:

    a. [*Withdrawn*]; and/or

    b. on or about July 17, 2015, you;

        i. failed to document your administration of Methadone to client [Client K] in [Client K's] medication administration record; and/or

        ii. failed to complete a report regarding your medication administration error in relation to client [Client K];

    c. on or about January 17, 2016, you:

        i. failed to document your administration of Methadone to clients [Client M] and/or [Client N] in their medication administration record(s); and/or

        ii. failed to document or complete a report regarding your medication administration error(s) in relation to clients [Client M] and/or [Client N];

5. You have committed an act or acts 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 paragraph 1(37) of *Ontario Regulation 799/93* in that, while working as a Registered Nurse at the Facility you engaged in conduct that having regard to all the circumstances would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional and, in particular:

    a. on or about June 9, 2014, you:

        i. [*Withdrawn*];

        ii. left client [Client A's] health care record in the cell she shared with other inmates; and/or

        iii. failed to notice that client [Client A's] health care record was missing or failed to take appropriate action when you were unable to locate [Client A's] health care record;

    b. on or about July 22, 2014, you:

        i. refused to complete your assigned duties when you advised your manager, [the Manager], that you would not be continuing with a narcotic count; and/or

        ii. stated "You expect me to count pills each time? Excuse me I'm fucking not doing that. What the fuck do you think I am? A pill counter? This workplace is fucking

crazy", or used words to that effect, when your manager, [the Manager], insisted that you complete the narcotic count that you had started with [the Manager];

c. on or about March 21, 2015, you:

   i. stated to client [Client B] "now go back to bed you big fucking dummy", or used words to that effect when communicating with [Client B] during medication rounds;

   ii. stated to client [Client C] "if you don't clean up your cell tomorrow you're not getting your meds" and/or "you're not an animal so don't live like one", or used words to that effect when communicating with [Client C] during medication rounds; and/or

   iii. stated "would you rather I say 'you son of a bitch'" and/or kicked Correctional Officer [the Correctional Officer] in the knee after he asked you to refrain from saying "goddamn it" and/or using other profanities during medication rounds;

d. on or about April 20, 2015, you:

   i. refused to attend a group meeting to discuss client care issues when asked by your manager, [the Manager], to do so; and/or

   ii. stated "I don't care what the fuck you say, I'm tired of being run around", or used words to that effect, when your manager, [the Manager], advised you that attendance at a group meeting to discuss client care was compulsory;

e. on or about June 22, 2015, you:

   i. failed to administer the daily dose of Methadone ordered for clients [Client D], [Client E], [Client F], and/or [Client G];

   ii. failed to administer the daily dose of Suboxone ordered for clients [Client H], and/or [Client I]; and/or

   iii. failed to advise medical staff that clients [Client D], [Client E], [Client F], [Client G], [Client H], and/or [Client I] had not received their daily dose of Methadone and/or Suboxone;

f. on or about July 17, 2015, you:

   i. administered a 20mg dose of Methadone intended for client [Client J] to client [Client K], who was ordered to receive only a 5mg dose;

   ii. administered Methadone to client [Client K] without consulting the medication administration record for client [Client K] and/or without following all of the steps for Methadone administration set out in the applicable policy(ies) of the Ottawa Carlton Detention Centre;

   iii. failed to document your administration of Methadone to client [Client K] in [Client K's] medication administration record; and/or

iv. failed to complete a report regarding your medication administration error in relation to client [Client K];

g. on or about January 17, 2016 you:

i. struck through the entry created by another nurse on client [Client M's] medication administration record in relation to her earlier administration of client [Client M's] daily dose of 110mg Methadone;

ii. administered a 70mg dose of Methadone intended for client [Client L] to client [Client M], who had already received his once daily dose of 110mg of Methadone;

iii. administered a 22mg dose of Methadone to client [Client N] despite the fact that client [Client N] had already received his once daily dose of 22mg of Methadone;

iv. administered Methadone to clients [Client M] and/or [Client N] without consulting the medication administration record for clients [Client M] and/or [Client N] and/or without following all of the steps for Methadone administration set out in the applicable policy(ies) of the Ottawa Carlton Detention Centre;

v. failed to document your administration of Methadone to clients [Client M] and/or [Client N] in their medication administration record(s);

vi. failed to document or complete a report regarding your medication administration error(s) in relation to clients [Client M] and/or [Client N];

vii. failed to report your medication error(s) in relation to clients [Client M] and/or [Client N] to the on-call physician;

viii. failed to appropriately monitor, assess and/or treat client [Client M] for symptoms of overdose after you administered to him an additional 70mg of Methadone beyond his daily dose of 110mg of Methadone, which he had already received; and/or

ix. failed to appropriately monitor, assess and/or treat client [Client N] for symptoms of overdose after you administered to him an additional 22mg of Methadone beyond his daily dose of 22mg of Methadone, which he had already received;

h. between approximately 2014 and 2017, you engaged in unprofessional written and/or verbal communications with representatives of your employer and/or the College of Nurses of Ontario.

Member's Plea

The Member admitted the allegations set out in paragraphs 1 (a) (ii), (b) (i), (d) (i), (e) (i) (ii) (ii), (f) (i) (ii), (g) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix), 3, 4 (c) (i) (ii) and 5 (h). The Member denied the allegations set out in paragraphs 1 (a) (iii), (b) (ii), (c) (i) (ii), (d) (ii), (f) (iii) (iv), 2 (a), (b), 4 (b) (i) (ii) and 5 (a) (ii) (iii), (b) (i) (ii), (c) (i) (ii) (iii), (d) (i) (ii), (e) (i) (ii) (iii), (f) (i) (ii) (iii) (iv), (g) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix). The Panel conducted an oral plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Overview

The Member has been a Registered Nurse since 2000. The Member came to the attention of the College as a result of incidents that occurred over a one and a half year period at the Ottawa Carlton Detention Centre (the "Facility"). This is a jail for inmates, both male and female, who are serving sentences less than 2 years and a day. It also houses individuals who are awaiting trial. The allegations represent the following issues. These include:

- The Member's management of the health care record of a Client and what the Member did and did not do when it went missing.
- Several problematic communications with her manager, a colleague, the inmates in the Facility and with the College.
- Medication errors, which occurred on three different dates.
- The Member's failure to document the administration of medications made in error and to file reports regarding those incidents.
- The Member's action of striking through another nurse's entry on the Client's medication administration record.
- Allegations which relate to disgraceful, dishonourable and unprofessional conduct.

The Panel considered 52 exhibits, which were entered as evidence. They included documents and standards from the College as well as policies from the Ministry of Community Safety and Correctional Services. In addition, the exhibits also included the health care records of 11 clients, nursing schedules, occurrence reports completed by the Member, her manager and a colleague as well as communications between the College and the Member. The Panel heard from 4 witnesses: the Member's Health Care Manager, a correctional officer at the Facility, an investigator at the College as well as the Member herself.

Having considered the evidence and the onus and standard of proof, the Panel found that the Member committed acts of professional misconduct as alleged in paragraphs 1 (a) (ii) (iii), (b) (i) (ii), (c) (i) (ii), (d) (i) (ii), (e) (i) (ii) (iii), (f) (i) (ii) (iii) (iv), (g) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix), 2 (a) and 2 (b), 3, 4 (b) (i) (ii) and (c) (i) (ii). As to allegation 5, the Panel found that the Member engaged in conduct that would reasonably be considered by members to be:

- unprofessional in (a) (ii) (iii), (d) (i) (ii), (e) (i) (ii), (f) (i) (ii) (iii), (g) (ii) (iii) (iv) (v)
- dishonourable and unprofessional in (b) (i), (c) (iii), (e) (iii), (f) (iv), (g) (i) (vi) (vii)
- disgraceful, dishonourable and unprofessional in allegations (b) (ii), (c) (i) (ii), (g) (viii) (ix) and (h)

The Evidence

The Panel heard evidence from [the Manager] ("[the Manager]") who is the Health Care Manager at the Ottawa Carlton Detention Centre (the "Facility"). He testified that the Member started working at the Facility around 2002. He worked alongside the Member as a general duty nurse from 2010 to 2014 when he became her manager.

[The Manager] testified that the Facility is a jail for inmates, both male and female, who are serving sentences of less than 2 years and a day. It also houses individuals who are awaiting trial. It has a male only minimum security area, a male only maximum security area and a female only unit. It also has a stand-alone Health Care Unit that is separate and houses inmates who are quite ill and/or who may be under observation for suicidal ideation.

As a manager, [the Manager] supervises nursing staff and a few medical clerks. His job is to oversee and develop programs, to introduce policy from the Ministry, to notify staff of any policy updates and to take concerns of staff to higher management. He ensures that there are adequate resources and provisions available in the Facility. He also collects information regarding staff when they are not in compliance with policies.

He testified that when staff is first hired they are required to sign a contract, which details his/her job description. Prior to completing their orientation, each staff member is required to have gone through and understood the policies that apply to them. Staff can continue to access these policies by viewing them through the Internet at the Facility.

Did the Member follow College Standards and Ministry of Community Safety and Correctional Services Policies when she misplaced [Client A's] health care record?

The Member testified that on June 9, 2014, after providing care to Client [Client A], she could not find the client's health care record. She testified that she notified some other nurses that it was missing. She, however, did not tell anyone in authority until the morning of June 10 when she spoke to her manager [the Manager]. The Member testified that she had asked her supervisor on June 10, to check the camera to help determine where she had last been with the file. On June 10, [the Manager] requested that the Member do an Occurrence Report for the Facility. In this report, the Member wrote that her focus had been on [Client A] who had abdominal pain that "appeared crucial" and required an order from an MD. On June 10, the Member wrote that she would continue to look for the file on her 1300 round.

[The Manager] confirmed in his testimony that he first learned of [Client A's] missing health care record on the morning of June 10, 2014 when the Member reported it to him. He acknowledged on cross-examination that he did not pull the camera footage to determine if the Member had liaised with the superintendent. Later on June 10, the superintendent notified [the Manager] that [Client A] had, in fact, found her own health care record in her cell and had kept it there overnight. The superintendent also relayed the fact that [Client A] had contacted the Ministry Client Conflict Resolution Unit (CCRU) and had informed them that she was in possession of her health care file and was surprised when no one came to get it. CCRU immediately notified the Facility. The superintendent then retrieved the file from [Client A's] cell. When the investigation was complete, [the Manager] wrote a report for the Privacy Officer on June 12, 2014. In it, he included the fact that [Client A] had alleged that her cellmates had gained access to her medical file when she was out of the cell. On June 17, 2014, the Deputy of Information Intelligence at the Facility asked the Member to complete an addendum to the initial Occurrence Report as more information was required. In this report, the Member acknowledged that she saw [Client A] just before supper on June 9 and did not complete documentation regarding the missing file until "late in the night

following all the other expectations of my job." She also stated that "charts are often misplaced and if I had thought the chart was not within the HCU I would have notified management."

The College's standards clearly state the legal and ethical requirement of ensuring client well- being by maintaining the confidentiality, privacy and security of client health information. Standards that were in place at the time include: Professional Standards Revised 2002, Confidentiality and Privacy, Documentation and further, the Documentation Standard, Revised 2008. The Professional Standards also state the importance of notifying a contact person within the practice setting when there has been a breach of confidentiality. [The Manager] confirmed that the following are relevant Ministry of Community Safety and Correctional Services ("MCCS") policies that apply to nursing and that they were in effect at that time. These policies mirror, in many ways, the standards of the College, which were also in effect at the time of the allegations.

- MCCS' policy on Health Care Records states records are to be "maintained in a secure and confidential manner."
- MCCS' policy on the Management of Personal Health Information states "Personal health information shall not be disclosed to unauthorized third parties." It also stresses the importance of keeping health care records in the Health Care Unit "separate and apart from inmates institutional file." It states that staff needs to "Be fully aware of the security and confidentiality legislation, protocols and safeguards relevant to his/her role."
- MCCS' Statement of Ethical Principles includes the importance of maintaining the "confidentiality of information acquired through our employment, consistent with relevant legislation and protocols."

[The Manager] testified that he would expect a nurse to follow certain procedures once he/she realized a health care record was missing. This includes retracing one's steps in order to locate a file. He particularly emphasized the importance of notifying a person in authority immediately so that the Client could be notified of the potential breach as soon as possible. He testified that the fact that he did not learn about the incident until the next morning meant that other inmates had additional time to find the missing health care record and potentially begin to peruse [Client A's] private and confidential information. This could have resulted in security challenges for the Facility's staff. It is possible that other inmates might have found the time and dates of [Client A's] appointments and used it for ulterior motives, including helping an inmate escape, to time drop-off of contrabands and/or to schedule an attack. As a consequence of this breach and in order to ensure the safety and security at the Facility, all of [Client A's] appointment dates had to be re-scheduled.

[The Manager] spoke in measured manner throughout his entire testimony. He was articulate and had a good knowledge of MCCS policies and College standards relevant to the allegations. His demeanour was consistently calm throughout his lengthy testimony. His recall was good and consistent. His responses were focused on the question and never digressed.

Did the Member interact and communicate inappropriately with her manager? Did the Member refuse to complete assigned duties?

First Incident: On or Around July 22, 2014.

[The Manager], in his testimony, recounted the details of the events on or around July 22, 2014. His memory was refreshed, and more details of the event were added after he looked at the Occurrence Report that he had completed after the incident. He explained that the Facility does not have its own in-house pharmacist. The Member had approached him and told him that there was a discrepancy with the medications. The Member, [the Manager] and a member of the corporate team, [the Corporate Team Member], then entered the pharmacy together. A witnessed count was necessary, he stated, to ensure the validity of the count. [The Manager] asked the Member to do the count, one pill at a time because the bottle was already open and some pills had been removed. This was not the methodology that the Member was used to doing. She stated to him that she doesn't count each individual pill; she just does the math. He testified that the Member said that "Time was a factor". He recalled that the Member raised her voice and refused to do the count one pill at a time. Her response included profanities, including "You want me to count pills each time? Excuse me I'm fucking not doing that" and "I'm not a fucking pill counter", and was dismissive of the workplace. The Member stated that she wanted to leave but [the Manager] said that he had the authority to demand that she stay and complete the count, and that she would be paid to stay and correct the discrepancy. The Member then threatened to call the RCMP. [The Manager] then released the door to the pharmacy room.

The Member testified that she was assigned the duty of pharmacy nurse and was told that she would be "confined" to the station until the investigation of [Client A] was complete. She testified that she had not been posted there in a long time but had previously done counts with her Health Care Manager. The Member believed that [the Corporate Team Member] was there to coach [the Manager. She recalled notifying [the Manager] that the medication "count was off". She told [the Manager] that she had time constraints as she had an appointment at the west end of town but he said that it should be completed in a half hour. She then said that [the Manager] then wanted to change the way the pills were counted from how, she believed, they had been done in the past. [The Manager] denied that there had ever been a different way of counting medication. In the past, the Member said that they used to take out a specific number of pills, count them in the slider and then subtract that number from the total, seal the top of the pill container with a piece of tape and write the number remaining on the seal. The Member believed that [the Manager] locked her in the pharmacy. She said that she had never been confined and was quite upset and could not attest to what she may have said. She believed that the action of being locked in a room was illegal. The Member told the manager that she would be booking off sick the next day.

Second Incident: On or around April 20, 2015

[The Manager] was given an occurrence report that he authored on April 20, 2015 to help refresh his memory. He testified that, after he became Health Care Manager, he instituted "morning briefings" as a way to help staff become better acquainted with relevant information. He would inform staff through emails when the briefings were taking place and the topic to be discussed. This particular meeting on April 20, was related to patient care. He was also requesting feedback. The meetings would generally last approximately 15 minutes. The Member had previously attended these sessions but was not in attendance that morning. [The Manager] went to look for the Member. The Member stated that she was busy and that she did not have to answer to him. She said that she was not attending. [The Manager] reiterated the importance of the meeting, that it was about patient care and that she had no option but to attend. He testified that the Member's demeanour was "disrespectful" and that her attitude was "condescending" when she refused to attend even after

being ordered to do so. “I’m not coming. I don’t care what you say.” [The Manager] said that if the Member chose not to participate in the meeting then she was not ready to work and hence should go home. He stated that he offered to discuss matters about work but she refused. He believes that the Member then left the Facility. He wrote an occurrence report at 9:55 that morning and reported the incident to the superintendent. [The Manager] stated that this was the first instance that any staff member refused to attend the meeting and he did not want to set a precedent that it was optional.

The Member testified that she had previously attended morning meetings. She had recently asked management for three days off but her request had been denied as a colleague with more seniority had asked for the time off first. The Member testified that she was “exhausted” and was so tired that she “couldn’t see straight.” In hindsight, she acknowledged that she should not have reported to work on that day. She was pouring medication when her Health Care Manager, [the Manager], tapped on the window and asked her to attend. She recalls saying that she was overwhelmed. She remembers shaking her head “No” and stating that she had “too much work to do”. He then ordered her to attend and, if not, go home. She testified that she signed out saying “I’m not going to be fucking bullied” in ear shot distance of a colleague.

College Standards relating to Communication

The Panel was provided with the Professional Standards Revised 2002 document. It states that nurses are “accountable for conducting themselves in ways that promote respect for the profession.” It states that nurses should “demonstrate respect and empathy for, and interest in clients” and should “recognize the potential for client abuse.” It also states that nurses are expected to act with “integrity, honesty and professionalism in all dealings with the client and other health care members.” The Standard includes the statement that nurses are responsible for role modelling positive collegial relationships. It posits that nurses are to “demonstrate effective conflict resolution skills.” In the College’s Therapeutic Nurse-Client Relationship document, it states that the five components to the nurse-client relationship are “trust, respect, professional intimacy, empathy and power.” It says, “The appropriate use of power, in a caring manner, enables the nurse to partner with the client to meet the client’s needs.” It also speaks to the importance of not engaging in conduct that “may be perceived by the client and/or others to be violent, threatening or intending to inflict physical harm.”

MCCS Policies relating to Communication and Compliance

The Panel reviewed the MCCS Statement of Ethical Principles. It states that employees are to fulfill their duties in a “diligent, competent and courteous manner”. They should “Present a professional image, both in words and actions.” They should “Undertake the duties associated with a designated role fully.” It also asserts “Under no circumstances shall any person be subject to threatening, humiliating, bullying or degrading treatment.”

Did the Member speak in a demeaning manner to Client [Client B] and Client [Client C]?

On or Around March 21, 2015.

The Panel heard testimony from [the Correctional Officer]. He has been employed as a correctional officer at the Facility since March 2015. [The Correctional Officer's] duties include ensuring that control is maintained in the Facility and that all staff and inmates are kept safe. He was asked to recall an Occurrence Report that he had written regarding incidents that happened on or about March 21, 2015. He was given the opportunity to review the report to refresh his memory. During medication rounds, he recalled the Member saying to inmate [Client B] "now go to bed you big fucking dummy" or words to that effect. He described the inmate as being "high profile" and recalled that he had recently been beaten up. He also recalled the Member telling Client [Client C] that he was not an animal and saying that if he did not clean up his cell he would not get his medication the next day. He remembered [Client C] as being violent and in segregation. [The Correctional Officer] acknowledged that inmates can be rude and even threatening, and at times, nurses can snap back. However, he acknowledged that he had not heard such disrespectful comments from a nurse before. He testified that provoking an inmate can result in an escalation of behaviour resulting in a "hands on" use of force by the correctional officer in order to subdue the inmate. These incidents all occurred in segregation where inmates have mental health issues and many are often there for serious crimes. Other inmates in the area include those that are violent offenders or inmates that have been aggressive to other inmates or staff. [The Correctional Officer] was concerned with escalating these types of behaviours.

The Member, in her defence, testified that she thought it was not those particular inmates to whom she spoke those words. She believes that she may have said "dummy" to another inmate – a new admission. The Member testified that she never used the word "dummy" out of malice and that she actually apologized to the inmate who she thought she said it to. The Member also testified that she thought it was another inmate – not [Client C]- who she told to clean up his cell. She remembered bringing a book to a different inmate after he cleaned his cell. [The Correctional Officer] reiterated that he was quite confident of the identities of the Clients. The Member testified that she never denied medication to a patient or threatened to deny medication to a patient.

Did the Member speak inappropriately to a correctional officer? Did the Member kick the correctional officer?

[The Correctional Officer] recalled doing rounds with the Member and another correctional officer when the Member said something like "God, damn it" to the other officer. The correctional officer asked her to refrain from using other profanities during medication rounds. The Member ended up kicking him in the knee area. He acknowledged that it wasn't vicious but it did make contact. He recalled the other officer saying, "What was that for?" He said the Member's conduct was not consistent with what he had seen with other nurses.
The Member testified that she did not recall ever working with [the Correctional Officer].

[The Correctional Officer] presented as a confident witness who, once his memory was refreshed, was clear in his recollections.

Did the Member engage in Unprofessional Written and/or Verbal Communications with the College?

[The Investigator] was called by the College to testify regarding her investigation into the Member's allegations. [The Investigator] has been a reports investigator for 4.5 years at the College of Nurses. She was appointed to investigate the Member's practice. In [the Investigator's] first conversation with the Member on June 27, 2016, she confirmed the Member's mailing address with her. Prior to interviewing the Member, she advised the Member that she had the right to retain legal counsel and, if she chose to speak to the College, anything she would say would be documented. [The Investigator] spoke to the Member on the phone while the investigation was underway. After the disclosures, she and the Member communicated by voice mails and emails. [The Investigator] testified that written communication between the College and the Member was difficult because the Member's address was not correct and, even after the address was corrected, it contained a typo. It took three attempts before the disclosure package arrived at the correct address on May 17. 2017. After the Member received the package, she left various voice mails, which sounded deliberately sarcastic, including "I love the witch hunt" and were demeaning "I think you did a really terrible job". The Member also degraded the College saying that she wanted her money back because it was a "terrible, you know, body and governing body." In emails, the Member wrote that she had "absolutely no interest in the process…… I want to express my distain…. I am …saddened that your power is so misdirected, not to mention your lack of either common sense or discretion." The Member's communications with the College are well after her employment was terminated at the Detention Centre. Instead of reflecting during that time, the member responded with vitrioll and with a "tone that was deliberately sarcastic".

The Member in her testimony admitted that she felt "vilified" as a result of the communications with the College. She concluded her testimony by saying, "I lost my job. I lost my house. I lost my mind."

Did the Member fail to administer Methadone or Suboxone to 6 Clients on or around June 22, 2015?

[The Manager] acknowledged that the various College standards and MCCS policies that were placed into evidence were in effect during the time of the allegations. He confirmed by looking at the nursing roster that the Member was working on June 22, 2015. He confirmed that the Member was assigned to the six Clients who did not receive their methadone or their suboxone. Another nurse brought this to his attention on June 23, 2015. The MARS also reflected the fact that the medications had not been given to the Clients. [The Manager] testified that he immediately consulted with a doctor to determine how this might impact the Clients. He then met with the Member to determine why the medications had not been given. He said that she did not take responsibility for her conduct. Instead, she said that she could not administer the medications because of the volume of work. He asked her to document the incident in an Occurrence Report. In it, the Member wrote that [the Manager] had previously told her that there was a "24 hour window and that methadone could be missed and resumed the following day. Therefore methadone was not given." In his testimony, [the Manager] stated that this was incorrect and that he had never advised the Member of this. In the Member's Occurrence Report of June 23, 2015, she stated that on the evening of June 22, she was surprised to find that there were "20 methadones for her two areas" that needed to be administered. No one, she wrote advised her of this fact. She wrote "It is unconscionable to assume that one person could competently and safely handle that workload within an 8 hour shift."

[The Manager] did acknowledge the possibility of a staff shortage the evening of June 22 but he made it clear that patient care cannot be compromised by not following the right rules and standard procedures. He stated that even in the context of work shortages the expectations are not different, particularly related to controlled drugs. Prior to the incident, he recalled speaking to the Member about how to manage when the workload is high. He said that he had relayed some options. For example: she could triage and prioritize her work, liaise with a doctor regarding care, utilize a team approach, contact the operational manager on site and ask for extra time and possibly not attend to a new admission as they have 48 hours to provide care to them. He emphasized, however, that methadone and suboxone have to be administered as ordered unless a staff member has consulted with a physician. He said that a doctor had not been contacted that evening as the consult would have been documented.

[The Manager] testified that when clients do not get their methadone or suboxone as ordered, there can be symptoms of withdrawal such as sweats, anxiety, aches, pains and/or cravings. Each client is different. Withdrawal, he testified, diminishes the goal of methadone and suboxone which is to help with cravings.

Did the Member Commit Medication Errors and Fail to Complete Documentation re. [Client K] on or about July 17, 2015?

[The Manager] testified that he recalled the incident when Client [Client K] was given a 20 mg dose of methadone which was much higher than the 5 mg that were prescribed. The Panel received into evidence [Client K's] prescription which clearly states 5 mg. In fact, [Client K] was given the 20 mg dose that was meant for Client [Client J]. [The Manager] testified to the medication standards that need to be followed when administering a drug. Amongst others, they include checking the information on the the dose with the inmate. These steps are extremely important, according to [the Manager], because an overdose of methadone can be lethal. The Member wrote in Section D of [Client K's] Health Care Record "Im (inmate) was given the incorrect dose of methadone. He received 15 mg more than what is ordered for him. MD called. Im to be monitored for LOC x 1 hr." The Panel was given no evidence of documentation of [Client K] being monitored after the medication error.

The Member wrote in her Occurrence Report of July 22, 2015, that a "staff shortage" had led to this occurring. She stated that she had been advised that there was not enough staff to assist with the distribution" of medication so she poured the medication in advance. Feeling under pressure, she gave the incorrect dose to [Client K] who "just cracked it open and drank it." She wrote that she knew immediately that an error had occurred. She "notified the im" and she "called the MD". The Member testified that she felt that she had "covered all her bases for - [Client K]."

College Standards and MCCS Policies

The Panel received documents into evidence relating to College Standards and MCCS Policies. The College's Professional Standards Revised 2002 states that nurses are to "take appropriate action to resolve or minimize the risk of harm to a client from a medication error. Nurses are to "report medication errors, near misses or adverse reactions in a timely manner". In the

Documentation Standard, Revised 2008, it states that nurses are never to delete, alter or modify anyone else's documentation."

The Panel took into evidence MCCS' policy on the Delivery of Medication. It states "Health care staff are responsible for ensuring that medications are administered to inmates as prescribed and for consulting with the institution physician, when required." It also states that "All prescribed and over the counter medications must be delivered to the correct inmate, in the dose and format prescribed, and at the correct time."

The Panel also received and reviewed MCCS' policy on Methadone Maintenance Treatment. It describes the steps that a nurse is required to follow when administering methadone. This includes checking the MAR and ensuring that the inmate's likeness corresponds with the photograph on the bottle, confirming the dose with the inmate, documenting the ingestion on the MAR etc. It also states that several steps need to occur when a methadone overdose or intoxication is suspected. Some of these include: advising the inmate, moving the inmate to an area for close monitoring, obtaining and monitoring vital signs and oxygen saturation and notifying the MMT Physician immediately. It also states that the inmate may need to be transferred to a hospital for assessment, treatment and monitoring.

Was there Missing Documentation regarding [Client K] on or about July 17, 2015?

The Panel received into evidence [Client K's] MAR which shows that no entry was completed for him by the Member on July 17, 2015. She did, however, write a note in Section D of [Client K's] Health Care Record at 21:30 on July 17th. The Member did not complete an Occurrence Report that day but did so on July 22, 2015. The Member did not complete a Medication System Improvement Report as mandated by MCCS' policy on Medication Error Identification and Reporting.

Response of Facility

In response to these two incidents of medication errors, [the Manager] testified that he required the Member to complete a Learning Plan. Before the Member could administer methadone again, she was required to:

- Review the College's Medication Standard
- Review MCCS' Methadone Treatment Policy
- Observe the administration of medication 3 times.
- Be observed administering medication 3 times.
- Discuss how errors could be mitigated in the future.

The Member successfully completed the Learning Plan.

Was there a Medication Error re [Client N] on or around January 17, 2016?

[The Manager] testified that on January 18, 2016 an RN notified him that the Member had told her that some medication irregularities had occurred on January 17. [The Manager] then asked that

staff member to write an Occurrence Report detailing what the Member had told her. The Panel received this into evidence. In the Occurrence Report it states that the Member told her colleague that she had mistakenly given two doses of methadone to [Client N]. [Client N] was seen by a doctor and was "sent to the hospital for assessment/monitoring." The Panel was provided with a copy of [Client N's] prescription for methadone which showed he was to receive 22 mg per day. The Panel also received into evidence a screen shot of the Member's duty schedule for January 17, 2016 where it confirms that the Member was scheduled to work the night shift from 6:30 PM to 6:30 AM.

In the Member's own Occurrence Report, she wrote "writer returns to methadone cart forgetting that pour for the following day was done earlier and seeing 2 methadones in cart assumed not given." She then stated that she gave [Client N] one methadone, and attempted to give the other methadone to another Client. It was only after the second Client said "I already got one" that the Member knew a mistake had occurred. The Member said that she advised [Client N] of the extra dose and that he would be monitored. She stated that a correctional officer was advised of the mistake. She made no mention of monitoring the client following the error. In her testimony, the Member admitted all of the allegations in 1 (g). She said that she had "no defence" and stated that a person shouldn't be giving out methadone at 2300. The Member testified that she had broken her routine, which led to her being confused. She stated that she didn't realize her error until 3 AM. The Member said that she was sorry that she hadn't addressed the error earlier.
[The Manager] testified that methadone is a potent drug and that when it is not given in the proper dosage, it can affect an individual's ability to breathe. [Client N] was reportedly symptomatic of an overdose. [Client N] was described by a doctor in the Temporary Absent Permit (TAP) as having "pupils pinpoint" and "speech slurred". In the Emergency Room Report from the hospital, it stated that [Client N's] diagnosis was an "Accidental Methadone Overdose".

Was there a failure to monitor, assess and treat [Client N] for the symptoms of his overdose?

[The Manager] testified that there was no note in [Client N's] MAR that showed a doctor had been called immediately after the client's overdose. This is contrary to MCCS policy which states "If the error is considered serious or critical (e.g. medications with vaso-active or metabolic effects or medications that can depress central nervous system function such as Methadone), the primary care physician shall be notified immediately." Even though a correctional officer had been advised of the situation, [the Manager] stated that they are not individuals capable of doing a medical assessment. He further testified that advising a correctional officer in no way changes or replaces MCCS' policy on methadone which states that a doctor needs to be contacted immediately, the client needs to be assessed and monitored, and documentation has to be completed.

Was Documentation Completed for [Client N]?

The MAR for [Client N] shows that another RN gave him his first dose of methadone at 16:20. The second dose that was given by the Member was not documented in his MAR. It was, however, captured on video footage. The Member completed an Occurrence Report on January 18 regarding the events on January 17. A Medication System Improvement Report was not done. MCCS' policy states that this is a requirement.

Was there a Medication Error and a Failure to Document in regards to [Client M] on or around January 17, 2016?

Was there a Medication Error regarding [Client M]?

[Client M's] MAR was entered into evidence. It showed that [Client M] had received his dose of methadone at 1430 from another RN. Later at 2300, his MAR shows that the previous entry had been stroked out and another dose of methadone had been given; this time by the Member. The Member testified, however, that she was unaware of the medication errors until 3 AM. On January 18, [Client M] was "pleading ignorance" regarding the second dose. He was described as "alert, oriented" and "locquacious." [Client M] was described in his Health Care Record as "always seeking methadone."

Was there a Failure to Monitor, Assess and Treat [Client M]?

[Client M's] Medical Order Sheet does not show any close monitoring or any doctor involvement as a result of his overdose. This is contrary to College Standards and MCCS policy. The only note is on January 18 which says "Hold methadone dose today."

Were there Documentation Irregularities regarding [Client M] and were there Failures to Document?

[Client M's] MAR shows that the Member struck through another nurse's entry that had occurred at 1430. This is contrary to the College's Documentation Standard which states that a nurse should never delete or modify anyone else's documentation. The Member, when she testified, described a situation in the Facility where there could be confusion regarding medication administration. She said that, at times, nurses may have signed the MAR as if they had administered the medication, but in actuality, they may have handed over the medication to another nurse to administer. The Member reiterated her concern regarding staff shortages. A Medication System Improvement Report was not completed by the Member.

The Facility's Final Response to these Incidents

[The Manager] testified that, after the last medication errors, he was concerned. He felt that his efforts to help the Member had not yielded the results he had hoped for. He was worried that the Member's conduct might continue into the future. [The Manager] consulted with Corporate Health Care. He felt that it would be irresponsible to assume that the Member would provide competent care. He stated that he asked the Member to come to his office. The Member had representation. He had a suspension letter ready to give the Member but he was hopeful that she would realize the severity of her conduct and would show remorse. He hoped that she would help him to understand some mitigating factors of what transpired. [The Manager] stated that he tried to draw attention, not to the fact that the errors happened, but what the Member did after the errors. He stated "Errors happen but, when discovered, they must be managed" and that "it is not an option not to assess someone especially after a serious error involving a controlled drug. The manager stated that he had other concerns in this meeting, including the member's response when told that one of the inmates had to be transferred to the hospital, at which point the member laughed and replied "As if!". He

testified that he was shocked to the core and this reinforced his fear and if he did nothing it would be very irresponsible on his part. He testified that, "The meeting did not go as planned." According to [the Manager], the Member threatened to go to Human Rights because she said that she would be the first nurse dismissed because of medication errors. [The Manager] recalls that she stepped out of the meeting several times and finally did not return. He had given her the suspension letter.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based on clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel found that the Member committed acts of professional misconduct as alleged in paragraphs 1 (a) (ii) (iii), (b) (i) (ii), (c) (i) (ii), (d) (i) (ii), (e) (i) (ii) (iii), (f) (i) (ii) (iii) (iv), (g) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix), 2 (a), (b), 3, 4 (b) (i) (ii), (c) (i) (ii),

As to Allegation 5, the Panel finds that the Member engaged in conduct that would be reasonably regarded by members to be:

- Unprofessional in allegations (a) (ii) (iii), (d) (i) (ii), (e) (i) (ii), (f) (i) (ii) (iii), (g) (ii) (iii) (iv) (v)
- Dishonourable and Unprofessional in allegations (b) (i), (c) (iii), (e) (iii), (f) (iv), (g) (i) (vi) (vii)
- Disgraceful, Dishonourable and Unprofessional in allegations (b) (ii), (c) (i) (ii), (g) (viii) (ix) and (h)

Reasons for Decision

During the hearing, the Panel received 51 exhibits and received oral testimony from 3 witnesses as well as the Member. [The Manager], Health Care Manager at the Facility was the first witness. He was the Member's direct supervisor. He had knowledge of the majority of the allegations and, at times was the recipient of some of the Member's angry, profane and disrespectful comments as well as her non-compliance. He attempted to remediate the Member through discussions and the implementation of a Learning Plan but in the end, he felt that he had no choice other than to terminate her employment. [The Manager] spoke clearly and answered each question articulately and with composure. He was well versed in the College Standards and MCCS policies. He was internally consistent within his testimony and was externally consistent with other evidence.

[The Correctional Officer] was the second witness. He is a correctional officer in the Facility. He testified to the Member's demeaning and threatening communications with two inmates whose behaviour had the potential to escalate as a result of the Member's particular interactions with them. He also observed the Member lightly kick a colleague, another correctional officer, in the leg and swear at him. [The Correctional Officer] was quite confident in his recollections once he reviewed

the Occurrence Report that he wrote after the incidents occurred. He testified that he had never seen such behaviour from a nurse.

The third witness was [the Investigator]. She is an investigator with the College. She documented and retained all communications, both verbal and written, with the Member. The Member was told that all communications would be saved. [The Investigator] described how both she, and the College, became a target of the Member's anger and outrage. [The Investigator] was a reliable witness who had several pieces of documentary evidence to support the Member's unprofessional and concerning conduct.

The Member testified in her own defence. She admitted the majority of the allegations. It seemed to the Panel, however, that she attributed many of her medication and documentation errors/omissions to the fact that the workload was high and the Facility was understaffed. The Panel did observe the Member during the hearing and noted that, at times, she was using non-verbal communication to show her objection to what was being said by [the Manager]. At one point, she was cautioned about what was considered disrespectful, behaviour in the hearing. The Member, however, seemed honest in her testimony. Even three of the allegations which she denied were based on the fact that she did not use those precise profane words, or, that she did say those things but it was to a different inmate. The Member did not bring any character witnesses to testify in her defence nor did she provide any letters of support. In her concluding remarks, the Member acknowledged that she had been "totally disrespectful" and that she had been suffering from "exhaustion".

In regards to allegations 1 (a) (ii) and (iii). [The Manager] confirmed that [Client A] shared her cell with two other inmates and that [Client A's] health record was retrieved from that cell. The College's Professional Standard and Confidentiality Standard states the importance of promoting client well-being by ensuring their privacy and their confidentiality. Although the Member denied the allegation in 1 (a) (iii), she did not take the time to retrace her steps and look for the record in the cell. She wrote that she only would have been worried if she thought [Client A's] file was not in the HCU. This shows a lack of awareness of College Standards, MCCS policy and PHIPA legislation as well as the possible consequences to the Client, and to the Facility, of a misplaced file.

In regards to allegations 1 (b) (i) and (ii), the Member admitted that she refused to do the narcotic count. She testified that she had refused because she believed [the Manager] had changed the method for counting narcotics. This "new method" was going to take longer and she had to leave the Facility because she had an appointment. [The Manager] denied that there ever was a different way of counting medication except counting the pills one by one. The Member should have realized the importance of an accurate medication count and complied with her manager's request. Although the Member denied allegation 1 (b) (ii), she did admit in her testimony that she was quite upset and could not attest to what she may have said. The College's Professional Standards Revised 2002 document states the importance of role-modelling positive collegial relationships and demonstrating "effective conflict resolution skills." The Panel accepted [the Manager's] testimony as accurate.in regards to allegations 1 (c) (i) and (ii). The Member denied that she said those words to [Client B] and [Client C]. She believed that she did say those things but to different inmates. She testified that she apologized to one of them. However, [the Correctional Officer] was unequivocally confident in the identities of the Clients. The Panel accepted [the Correctional Officer's] testimony. The Member testified that the word "dummy" was not used in malice. The Member should have realized the potency of the words she used, particularly with the prison clientele and the potential they may

have had to cause disruption in the Facility. The College's Professional Standards Revised 2002 states that nurses should "demonstrate respect and empathy …. for clients."

In regards to allegation 1 (d) (i) the Member admitted that she refused to attend a morning group meeting because she was exhausted and feeling overwhelmed. She denied saying those specific words in allegation 1 (d) (ii) but did admit in her testimony that she did say something profane as she was signing out of the Facility. In effect, the Member admitted to 1 (d) (ii) as well. MCCS policy states that employees are expected to "Undertake the duties associated with a designated role fully " and to fulfill their duties in a "diligent, competent and courteous manner."

In regards to allegations 1 (e) (i) (ii) and (iii), the Member admitted the allegations. The Clients' MARS reflect that no medications were given the evening of June 22, 2015. In her Occurrence Report, the Member wrote that she believed that she had a 24 hour window and that methadone could be missed and resumed the next day. The Member also told her manager that she did not administer the methadone because of the volume of work and staff shortages. These statements from the Member indicate that she does not fully understand the purpose of methadone and the symptoms that can occur when it is not administered on a regular prescribed basis. She does not understand the importance of following a doctor's orders, and the steps to take following a medication error, especially a controlled drug, which is a high-risk medication. The Member also failed to understand that staff shortages can never be used as an excuse for not fulfilling one's professional obligations and minimizing the risk of harm to all clients.

In regards to allegations 1 (f) (i) (ii) (ii) and (iv), the Member admitted that she did not consult the MAR when she administered an incorrect dose of methadone to the wrong client. She also did not follow proper methadone protocol when she administered it. In her Occurrence Report, she wrote that a "staff shortage" led to this event occurring. The Member denied that she failed to document the administration of methadone to [Client K], yet, the Panel received [Client K's] MAR into evidence and it was clear there was no entry by the Member. The Member did do an Occurrence Report relating to the [Client K] incident but there was no evidence found to show that she had completed the Medication System Improvement Report as mandated by MCCS.

In regards to allegations 1 (g) (i) (ii) (iii) (iv) (v) (vi) (vii) (viii) (ix) the Member admitted all these allegations.

In regards to allegation 1 (g) (i), the Member clearly did not identify the Client before administering the methadone. This is a breach of the standards of the profession which states that it is a nurse's responsibility to "take appropriate action to resolve or minimize the risk of harm to a client from a medication error or adverse reaction." This is also contrary to MCCS' policy which states the steps to follow when administering methadone.

In regards to allegation 1 (g) (ii) the Member admitted that she gave [Client N] 22mg of methadone on top of the 22mg he had received earlier.

In regards to allegation 1 (g) (iii), the Member admitted that she failed to consult the MAR and that this resulted in medication administration errors for both [Client N] and [Client M].

In regards to allegation 1 (g) (iv), the Member admitted that she failed to document the administration of medication for [Client M] and [Client N] in their MARs.

In regards to allegation 1 (g) (v), the Member admitted that she failed to document her medication errors.

In regards to allegation 1 (g) (vi), the Member admitted that she failed to report her medication errors relating to [Client M] and [Client N] to the on-call doctor. This is contrary to MCCS' Methadone Treatment policy which states that a doctor has to be called immediately and/or as soon as possible if it involves a medication such as methadone that depresses the central nervous system.

In regards to allegation (g) (vii), the Member admitted that she struck through another nurse's entry in [Client M's] MAR. [The Manager] testified that nurses do not correct another's record. The College's Documentation standard clearly states that a nurse should never delete or modify anyone else's documentation.

In regards to allegation (g) (viii) the Member admitted that she failed to monitor and assess [Client M] after his overdose. The expectation is that when an overdose occurs, a nurse is to advise the inmate, move the client so he/she can be closely monitored and a doctor should be notified immediately. [Client M] received an additional 70 mg in addition to his 110 mg dose. This incident occurred after the Member had received remediation 6 months previously for her medication errors regarding [Client K].

In regards to allegation (g) (ix) the Member admitted that she failed to appropriately monitor and assess. [Client N] after his overdose. The Member did ask a correctional officer to monitor [Client N] but that is not in his scope of practice. [Client N] eventually was hospitalized with symptoms of an overdose.

In regards to allegation 2, the Member denied the allegation that she verbally and/or emotionally abused clients [Client B] and [Client C]. In the College's Practice Standard: Therapeutic Nurse-Client Relationship, Revised 2006 it states that nurses should not engage in conduct that may be perceived neglectful. Neglect is a form of abuse. Nurses have to be continually mindful of their behaviour and careful of their comments and "recognize the potential for client abuse." The Panel determined that the Member committed abuse that was both verbal and emotional.

In regards to allegation 3, the Member admitted that she falsified a record when she struck through a nurse's entry which had documented [Client M's] 1430 dose of methadone.

In regards to allegation 4 (b) (i), the Member denied that she failed to keep records for [Client K] as required yet the MAR showed no evidence of an entry.

In regards to allegation 4 (b) (ii) the Member did not complete MCCS' requirement that a Medication System Improvement Report be completed.

In regards to allegations *4 (c) (i) and (ii)*, the Member admitted that she did not keep records as required.

In regards to Allegation 5, the Panel finds that having regard to all the circumstances the Member engaged in conduct which would reasonably be regarded by members of the profession as unprofessional and showed a serious and persistent disregard for her professional obligations when she:

- Left [Client A's] health care record in the cell that she shared with two other inmates. The Member failed to show good judgement and responsibility when she neglected to take the misplaced file seriously. She failed to immediately inform the inmate as well as her supervisor. She failed to take the time to retrace her steps. She failed to live up to the standards expected of her. (Allegation 5 (a) (ii) and (iii))

- Refused to attend a mandated morning briefing and used profane language to decline her attendance. This demonstrates a lack of professional integrity and responsibility. (Allegation 5 (d) (i) and (ii))

- Neglected to administer methadone/or suboxone to six clients because she had the mistaken notion that she did not have to follow a doctor's orders and that there was a 24 hour window in which these particular medications could be given. This demonstrates a lack of good judgement and common sense. It shows a disregard for the Member's professional obligations. (Allegation 5 (e) (i) and (ii))

- Administered an incorrect methadone dose to [Client K] because she did not check his MAR and because she did not follow proper MCCS policies. She also did not document the administration of [Client K's] methadone in his MAR. Through her actions, the Member demonstrated that she was not living up to the standards expected of nurses. (Allegation 5 (f) (i) (ii) (iii))

- Administered incorrect methadone doses to [Client M] and [Client N] because she did not check their MARS and because she did not follow proper MCCS policies regarding the administration of their methadone. The Member's medication errors are persistent and extremely serious as they have the potential to adversely affect the Clients. The Member is showing a lack of good judgement and is demonstrating difficulty with self-reflection and learning from her mistakes.(Allegation 5 (g) (ii) (iii) (iv))

- Failed to document her administration of methadone to [Client M] and [Client N] in their MARS. This documentation is a requirement of all nurses and the Member ought to have known this. (Allegation 5 (g) (v))

The Panel also finds that the Member engaged in conduct that having regard to all the circumstances would reasonably be regarded by members of the profession as dishonourable and unprofessional that falls well below the standards expected of a professional when she:

- Refused to complete a narcotic count as requested by her manager. She ought to have been very familiar with this and her non-compliance falls well below the conduct of a nurse who is expected to comply with legislation including the Controlled Drugs and Substances Act and, furthermore, to be professional in all her interactions. (Allegation 5 (b) (i))

- Used profanities when she spoke to a correctional officer and then kicked him on the knee when he questioned her choice of language. The frequent use of profanities by the Member and the ease in which they are spoken demonstrate an element of moral failing. (Allegation 5 (c) (iii))

- Failed to advise medical staff that six Clients they had not received their daily dose of methadone. Medical staff, when notified, can access the Clients and monitor them for signs of withdrawal. By not notifying medical staff, the Member put these six Clients at risk. This conduct is indicative of a moral failing as the Member failed to realize the seriousness of her error.(Allegation 5 (e) (iii))

- Failed to complete the Medication System Improvement Report in regards to [Client K] as mandated by MCCS. The Member ought to have known that this is an organizational requirement. (Allegation 5 (f) (iv))

- Struck through another nurse's entry in [Client M's] MAR. The Member ought to have known that this is unacceptable by College standards. There is also a possible element of deceit involved as it created the perception that the Member may have been trying to cover her error. (Allegation 5 (g) (i))

- Failed to complete the Medication System Improvement Report in relation to clients [Client M] and/or [Client N]. The Member ought to have known that an Occurrence Report is not the only requirement when a medication error has occurred. The Medication System Improvement Report is an MCCS requirement whose purpose is to develop a culture of safety through the reflective input and participation of its staff. (Allegation 5 (g) (vi))

- Failed to report the medication errors in relation to clients [Client M] and/or [Client N] to the on-call physician. The Member ought to have known the risks, to her Clients, of not relaying such important information to the on-call doctor. This conduct falls well below the standards expected of a professional. It is also in violation of MCCS' policy on Methadone Medication Errors which the Member should have known. (Allegation 5 (g) (vii))

The Panel finds that the Member engaged in conduct that having regard to all the circumstances would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional behaviour when she:

- Spoke disrespectfully to her manager when she refused to do the narcotic count one pill at a time. The Member questioned the knowledge and authority of her manager. She was dismissive of the workplace and used profanity when she described it. This conduct is extreme and unacceptable. It demonstrates behaviour that has a moral failing. (Allegation 5 (b) (ii))

- Called [Client B] a "big fucking dummy". These words are disrespectful, derogatory and inflammatory and can potentially trigger an escalation of problematic behaviour in the inmate. These words spoken by the Member cast serious doubt on her moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.(Allegation 5 (c) (i))

- Threatened [Client C] that she would withhold his medications if he did not clean his cell by the next day. The Member ought to have known that this could be perceived negatively by the inmate. The Member ought to have known that making vague threats that she professionally, can't/shouldn't, follow through on can create additional agitation and uncertainty in an inmate who is already feeling compromised. (Allegation 5 (c) (ii))

- Failed to appropriately monitor, assess and/or treat [Client M] for symptoms of an overdose. Without closely monitoring [Client M], the Member would have had no knowledge if his condition worsened and/or if he would need medical intervention. She put the health of [Client M] at risk. This conduct is serious and has the effect of shaming the Member and, by extension, the profession. (Allegation 5 (g) (viii))

- Failed to appropriately monitor, assess and/or treat [Client N] for symptoms of an overdose. The Member left a correctional officer to oversee [Client N] The correctional officer, however, did not have the knowledge, skills or judgement to effectively evaluate [Client N]. [Client N] ended up being hospitalized as they could not effectively deal with his medical issues in the Facility. This was a serious situation that the Member fails to recognize. This conduct casts serious doubt on the Member's moral fitness and her inherent ability to discharge the higher obligations the public expects professionals to meet. (Allegation 5 (g) (ix))

- Engaged in unprofessional written and/or verbal communication with the College on several occasions. The Member ought to have known the serious consequences of such disrespectful conduct. This is behaviour that has the effect of shaming the Member and, by extension, the profession. The Member's words speak to an individual who has no sense of boundary or comportment and who has difficulty showing restraint even when it is with her professional regulator. (Allegation 5 (h))

Penalty

Penalty Submissions

Submissions were made by College Counsel. The Member was not present. She was not planning to attend. The Member's sister, Deirdre Parks, and son, Maxwell Freyer, who had attended all the hearing dates, were granted permission by the Panel to speak on her behalf regarding penalty submissions.

College Counsel asked that the Panel accept into evidence the Affidavit of [Prosecutions Associate] dated May 25, 2018. College Counsel stated that the affidavit was necessary because the Member is not present and it speaks to the communications between the Member and the College. The Member is the only person who could cross-examine [Prosecutions Associate] and she is absent. It is reliable, College Counsel stated because it was affirmed. College Counsel stated that she believed that courts would likely agree to enter it as evidence *under Rule 53.02 of the Rules of Civil Procedure, such that it could be admitted in accordance with s. 49 of the Code.* Ms. Parks did not comment. The Panel agreed to enter it as Exhibit 52.

The Affidavit, according to College Counsel, speaks to the challenges the College had in contacting the Member and sending her the disclosure materials. The Member's address was incorrect and when it was correct, it included a typo. Attempts were made to arrange a pre-hearing in December 2017 but to no avail. It wasn't until Thursday, May 17, 2018 that the Member finally contacted the College and left a message to call her back. The Member said that she would attend. The College attempted to call the Member back but there was no response.

College Counsel stated that the College is seeking an order revoking the Member's license on the basis that she is ungovernable and a reprimand.

The College submitted the case of the *Law Society of Upper Canada.v. Robin Douglas Scott* (Law Society Hearing Panel, 2005). This is a seminal case regarding factors that are relevant to governability. It states that when a member has subjected themselves to regulation, it would negate ungovernability. College Counsel said that it is relevant that the Member is not in attendance for the last day of the hearing. She has a responsibility to attend and this, too, relates to her governability. She has done herself a "disservice by not attending."

The College submitted the case of *The Discipline Committee of the College of Optometrists of Ontario v. Dr. A. John Metzger* (Discipline Committee, 2017). It states "Due to Dr. Metzger's failure to participate in the hearing, the Panel has no information whatsoever about his state of mind in terms of likelihood of future misconduct…..The Panel cannot give him the benefit of the doubt in this matter." He chose not to attend, and did not take the opportunity this could have provided to express remorse for his conduct." The Panel concluded that Dr. Metzger had "demonstrated ungovernability."

The panel was also provided with an excerpt from "A Complete Guide to the Regulated Health Professions Act" by Richard Steinecke, which stated that ungovernability "suggests a pattern of conduct that demonstrates that a member is unprepared to recognize his or her professional obligations and the regulator's role."

College Counsel submitted that if the Member has expressed remorse, it is always followed by an excuse or a justification for her conduct. By not attending this part of the hearing, there is no way to understand her state of mind and if there is any likelihood of remediation. Without this knowledge, College Counsel submits that revocation is the only option.

The College also submitted the case of *CNO v. Mike Gillette* (Discipline, 2015). College Counsel submitted that this case is very different from the Member's. The member in this case worked in a mental health facility. He provoked two clients so that he could use force against them. The member did not attend the hearing and did not appreciate the impact of his conduct. The panel revoked his license.

The College submitted that the Member did not show deceit or obstruction yet the totality of the evidence indicates that she is not governable. Her failure to attend the hearing on the last day is only one factor. College Counsel submitted that the multiple and serious findings of misconduct are indications that the public would be put at risk if she were to practice. Revocation would ensure the safety of the public. Members of the profession would receive a clear message that there are severe and lasting consequences when there is serious and repetitive misconduct. The public would be confident that the College is able to regulate itself.

College Counsel acknowledged that it is appropriate, when considering a possible order of revocation, for the Panel to consider the effect that the order would have on the Member, her emotional state and her life in general.

College Counsel related the many aggravating factors which included:

- That much of the misconduct related to basic nursing principles such as documentation, patient rights, reporting errors etc.
- The Member's conduct which was either a result of a basic lack of knowledge or laziness or a combination of both.
- The Member's mishandling of methadone and suboxone administration.
- The failure to report, and file reports on medication errors. The process of reporting an error necessitates an analysis of what occurred. The result is additional insight and a deeper understanding of how to prevent errors in the future.
- The Member was not amenable to remediation as evidenced by the fact that, even after completing her Learning Plan, she continued to make medication and related errors.
- Many of the Member's actions jeopardized patient safety.
- The Member's problematic attitude in dealing with clients, colleagues, her manager and the College.
- The Member's tendency to use profanity in her workplace.
- The Member's insubordination was not just unprofessional and rude; it demonstrated that she did not want to subject herself to authority. She thought she knew better.
- The Member did not show remorse. Instead she offered a string of excuses. Her Occurrence Reports are evidence of this.
- The Member's voice messages and emails to the College in which she expressed her disdain for the process and called it a "witch hunt". She did not just have one bad day. The College received sarcastic and angry communications on different occasions.
- The Member has difficulty conducting herself in a respectful manner in different situations and with different people.

The Member's family members were given an opportunity to make submissions on the Member's behalf.

The Member's son, Max Freyer, acknowledged that there was no possible way to contest the allegations. He stated that his mother's unprofessional conduct came from insecurity and fear – not malice. He said that his mother had devoted her life to her profession. He stated that OCDC was the only institution where his mother had demonstrated this type of conduct. He asked that the Panel take a therapeutic approach to his mother as they would do with a patient. He stated that he has never seen his mother physically aggressive except in a joking manner. The word "dummy" is used by his mother as a "term of endearment" not for mockery. He asked the Panel not to revoke his mother's nursing license as it wouldn't serve her as a person. He acknowledges that his mother is not deceitful. Her conduct he speculates is as a result of his mother reaching her maximum level of emotional fortitude. He said that he could not defend his mother's threats to the College but stated that they are uncharacteristic of her. The Member's sister, Deirdre Parks, then spoke. She stated that her sister is quite remorseful and that she knows that what she has done is wrong. Her sister is willing to send a letter of apology to the College and [The Investigator]. Ms. Parks asked the Panel to consider a suspension with the additional requirement that she take remediation courses. Ms. Parks said that her sister is "very kind and giving." She said her sister was fond of the inmates and brought them gifts such as books, eye glasses and sandwiches. She confirmed that the term "dummy" has been a part of their family's lexicon for a long time.

Independent Legal Counsel reminded the Panel that the appropriate order is based on protecting the public and preserving the high standards of the profession. ILC advised the Panel that they could also consider the following as mitigating factors:

- The Member has lost her job and has been subject to an interim suspension since August 2017.
- The Member has had no prior disciplinary issues with the College.
- The Member did admit to some of the allegations.

Penalty Decision

The Panel deliberated thoughtfully and took into account all the submissions relating to penalty. The Panel is aware of the impact of revocation but concluded that that it is the appropriate order in this case. Accordingly, the Panel directs the Executive Director to immediately revoke the Member's Certificate of Registration. As well, the Member is required to appear before a Panel of the Discipline Committee to be reprimanded within three months of this Order becoming final.

Reasons for Penalty Decision

The Panel was presented with a preponderance of documentary evidence relating to the many serious allegations against the Member. The College's witnesses were credible and confirmed the unprofessional conduct of the Member. The Member's participation in the hearing was uncertain until the very last minute when she arrived. It seemed to the Panel that the Member had initially hoped to use the proceedings as a soapbox for her continued discontent and frustration with the Facility and perhaps even her regulator. In fact, the Member stated that she hoped that the process would be cathartic for her. After so many months of being suspended, it was disappointing to see that she had not gained the necessary insight into her actions.

It seemed from the communications with the College that the Member was becoming increasingly angry and less remorseful as time went on. To her credit the Member did admit the majority of the allegations but it was extremely unfortunate that she did not help the Panel see and understand the woman and the nurse who her son and sister described.

The evidence clearly showed that the Member was ungovernable through the repetitive nature of the allegations and her inability to be remediated while in the workplace. The Member was also seen to be ungovernable when she was inaccessible and unresponsive during the College's many attempts to contact her. The Panel's mandate is the protection of the public and preserving the public's confidence in the nursing profession which holds its integrity and public confidence as cornerstones of the profession. As the Member did not demonstrate remorse or insight and only limited cooperation, the Panel felt confident that revocation was the appropriate order.

I, Dawn Cutler, RN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.

Chairperson	Date