DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Terry Holland, RPN	Chairperson
Grace Fox, NP	Member
Carolyn Kargiannakis, RN	Member
Devinder Walia	Public Member
Christopher Woodbury	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
	)	
- and -	)	
	)	
	)	
LISE LABROSSE	)	NO REPRESENTATION for
Registration No.: II06082	)	Lise Labrosse
	)	
	)	
	)	CHRISTOPHER WIRTH (October 7-9,
	)	2019) and
	)	
	)	PATRICIA HARPER (November 8, 2019)
	)	Independent Legal Counsel
	)	
	)	Heard: October 7-9, 2019
		and November 8, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on October 7, 2019 at the College of Nurses of Ontario (the "College") at Toronto. Due to ongoing construction at the College, the hearing continued at Victory Verbatim at 222 Bay St., Toronto, on October 8-9, 2019.

As Lise Labrosse (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 not in attendance.

College Counsel submitted as Exhibit #2 the Affidavit of [ ], Prosecutions Clerk for the College, which affirms that the Member had been sent the Notice of Hearing on July 4, 2019 by regular mail. The Notice of Hearing was mailed to the last known address of the Member from the College Register. The Panel was satisfied that the Member had received adequate notice of this hearing and therefore proceeded with the hearing in the Member's absence.

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 banning the disclosure, including the publication and broadcasting of the names of the patients or any information that could disclose the patients' identities referred to in the Discipline Hearing of Lise Labrosse due to the privacy interests of the patients.

The Panel considered the submissions of the College and decided that there be an order prohibiting disclosure including a ban of the publication and broadcasting of the names of the patients or any information that could disclose the patients' identities referred to in the Discipline Hearing of Lise Labrosse.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated July 4, 2019, are as follows:

IT IS ALLEGED THAT:

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

    a. on or about July 18, 2016, you failed to complete the admission information for [Patient A], including transcribing the patient's list of medications into her Hospital chart;

    b. on or about July 22, 2016, you failed to document the administration of medication, namely Percocet, for [Patient B], including the date of administration, in an appropriate manner;

    c. on or about November 29, 2016, you failed to document in a timely manner the administration of medication, namely Percocet, for [Patient C], that you withdrew from the Hospital's medication dispensing system at 1732;

d. between approximately November 29, 2016 and December 8, 2016, you altered the documentation in the medical record of [Patient C], in that you obscured your colleague's notation that you had failed to administer medication on November 29, 2016 and inserted the date and time of your administration;

e. on or about June 3, 2017, you withdrew tablets of Oxycodone IR 5mg from the Hospital's medication dispensing system at 0945, 1319, and/or 1707 for [Patient D], which you did not administer;

f. on or about June 3, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0945, 1330, and/or 1715 to [Patient D], when you had not administered them;

g. on or about June 4, 2017, you withdrew tablets of Oxycodone IR 5mg from the Hospital's medication dispensing system at 0709, 1115, 1517 and/or 1837 for [Patient D], which you did not administer;

h. on or about June 4, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0705, 1145, 1515, and/or 1850, to [Patient D] when you had not administered them;

i. on or about October 8, 2017, you withdrew two tablets of Percocet from the Hospital's medication dispensing system at 1621 for [Patient E],

   i. which you did not administer; and/or
   ii. which administration you did not document;

j. on or about October 8, 2017, you administered two tablets of Percocet at 1850 for [Patient E], less than three hours after the last administration of Percocet, contrary to the medication order;

k. on or about November 18, 2017, you withdrew tablets of Percocet from the Hospital's medication administration dispensing system at 0907 and 1334 for [Patient F], which you did not administer; and/or

l. between approximately February 2015 to December 2017, you misappropriated medication, namely Percocet, from the Hospital that was prescribed to patients, for your personal use; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(8) of *Ontario Regulation 799/93*, in that while employed as a Registered Practical Nurse at the Hospital in North Bay, Ontario, you misappropriated property from your workplace, in that:

a. on or about June 3, 2017, you withdrew tablets of Oxycodone IR 5mg from the Hospital's medication dispensing system at 0945, 1319, and/or 1707 for [Patient D], and did not administer them or properly dispose of them;

b. on or about June 4, 2017, you withdrew tablets of Oxycodone IR 5mg at 0709, 1115, 1517 and/or 1837 from the Hospital's medication dispensing system for [Patient D] and did not administer them or properly dispose of them;

c. on or about October 8, 2017, you withdrew two tablets of Percocet from the Hospital's medication dispensing system at 1621 for [Patient E], and did not administer them or properly dispose of them; and/or

d. on or about November 18, 2017, you withdrew tablets of Percocet from the Hospital's medication dispensing system at 0907 and 1334 for [Patient F], and did not administer or properly dispose of them; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(14) of *Ontario Regulation 799/93,* in that while employed as a Registered Practical Nurse at the Hospital in North Bay, Ontario, you falsified a record relating to your practice, in that:

   a. on or about June 3, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0945, 1330, and/or 1715 to [Patient D], which you have not administered; and/or

   b. on or about June 4, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0705, 1145, 1515, and 1850 to [Patient D], which you have not administered; 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 during your employment as a Registered Practical Nurse for the Hospital in North Bay, 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:

   a. on or about July 18, 2016, you failed to complete the admission information for [Patient A], including transcribing the patient's list of medications into her Hospital chart;

   b. on or about July 22, 2016, you failed to document the administration of medication, namely Percocet, for [Patient B], including the date of administration, in an appropriate manner;

c. on or about November 29, 2016, you failed to document in a timely manner the administration of medication, namely Percocet, for [Patient C], that you withdrew from the Hospital's medication dispensing system at 1732;

d. between approximately November 29, 2016 and December 8, 2016, you altered the documentation in the medical record of [Patient C], in that you obscured your colleague's notation that you had failed to administer medication on November 29, 2016 and inserted the date and time of your administration;

e. on or about June 3, 2017, you withdrew tablets of Oxycodone IR 5mg from the Hospital's medication dispensing system at 0945, 1319, and/or 1707 for [Patient D], which you did not administer;

f. on or about June 3, 2017, you misappropriated tablets of Oxycodone IR 5mg that you withdrew from the Hospital's medication dispensing system at 0945, 1319, and/or 1707 for [Patient D];

g. on or about June 3, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0945, 1330, and/or 1715 to [Patient D], when you had not administered them;

h. on or about June 4, 2017, you withdrew tablets of Oxycodone IR 5mg from the Hospital's medication dispensing system at 0709, 1115, 1517 and/or 1837 for [Patient D], which you did not administer;

i. on or about June 4, 2017, you misappropriated tablets of Oxycodone IR 5mg that you withdrew from the Hospital's medication dispensing system at 0709, 1115, 1517 and/or 1837 for [Patient D];

j. on or about June 4, 2017, you documented that you administered tablets of Oxycodone IR 5mg at 0705, 1145, 1515, and/or 1850 to [Patient D], when you had not administered them;

k. on or about October 8, 2017, you administered two tablets of Percocet at 1850 for [Patient E], less than three hours after the last administration of Percocet, contrary to the medication order;

l. on or about October 8, 2017, you withdrew two tablets of Percocet from the Hospital's medication dispensing system at 1621 for [Patient E],

   i. which you did not administer;
   ii. which you misappropriated; and/or
   iii. which administration you did not document;

m. on or about November 18, 2017, you withdrew tablets of Percocet from the Hospital's medication administration dispensing system at 0907 and 1334 for [Patient F], which you did not administer; and/or

n. between approximately February 2015 to December 2017, you misappropriated medication, namely Percocet, from the Hospital that was prescribed to patients, for your personal use.

Member's Plea

Given that the Member was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member was initially registered as a Registered Practical Nurse with the College in February 1999. At the time the various events forming the basis of the allegations in the Notice of Hearing were alleged to have occurred (July 2016 to December 2017), the Member worked as a staff nurse on a medical/surgical unit of the North Bay Regional Health Centre ("NBRHC").

The Member has not been employed at NBRHC since a meeting with her manager, union and human resources representatives on December 8, 2017. Subsequently, her College registration was suspended on August 22, 2018 following her failure to comply with an order of the Investigations, Complaints and Reports Committee of the College ("ICRC") to submit to a health examination. (Exhibits #3 and #4)

The Notice of Hearing alleged that the Member had, in various instances:

(i) Withdrawn narcotics for patients, with or without documentation, but did not administer them;

(ii) Documented in patient records that she had administered narcotics when she had not;

(iii) Failed to complete admission information for a patient, including the patient's list of home medications;

(iv) Altered the documentation of a colleague; and

(v) Misappropriated property (i.e. narcotics withdrawn but not administered) from the workplace for her own personal use.

It was alleged that, as a result, the Member had breached the standards of practice of the profession, committed an act of professional misconduct by misappropriating property from NBRHC, falsified a record relating to her practice, and engaged in conduct relevant to the practice of nursing that would reasonably be regarded as disgraceful, dishonourable or unprofessional.

The Evidence

Much of the evidence concerned four patients with alleged medication discrepancies.

College Counsel called as witnesses six former work colleagues of the Member at NBRHC, one of the patients with an alleged medication discrepancy and an expert witness concerning the relevant standards of practice as they relate to surgical units.

Witness #1 [ ]

[Witness 1] has been a Registered Nurse ("RN") for 30 years and has worked at NBRHC for the past 10 years. She is currently the Clinical Nurse Educator ("CNE") for the inpatient surgery units and has been in this role for the past 8 years. Her duties are threefold: to provide inpatient services and orientation education, both formal and informal, to staff; development of curriculum for the interdisciplinary team, and to monitor both new and senior staff.

Exhibit #9, a July 18, 2016 email from [Witness 1] to the Member regarding her failure to complete the Kardex for [Patient A] as required was presented. The Kardex of [Patient A] was presented (Exhibit #27) to illustrate the lack of documentation. The NBRHC Best Possible Medication History instructions were presented (Exhibit #28). [Witness 1] stated that this lack of documentation could lead to a missed dose or delay in the patient receiving the appropriate medications.

An email of July 27, 2016 (Exhibit #10) from [Witness 1] to the Member was submitted as evidence, which [Witness 1] confirmed she wrote. This email was to address the knowledge gap identified which involved inappropriate documentation on the Medication Administration Record ("MAR") on the night shift of July 21, 2016. She confirmed that the Member was assigned to the patient on this shift. The MAR (Exhibit # 29) was reviewed. The medication documentation completed by the Member was entered in the margin of the MAR, which was inappropriate and posed a safety risk if other nurses did not notice the entry. [Witness 1] stated that when the MAR's dates are full, a new sheet should be initiated with the new date and 6 days post.

[Witness 1] testified that she raised the issue of improper documentation in the MAR, as part of her role was to work with the Pain Management Service. When she was reviewing the MAR pain medications, she noted an entry in the right margin and that it was not documented appropriately. The standard of practice was that medications need to be identified as to the date and time they were administered. A NBRHC Medication Administration Policy (Exhibit #28) was presented as an exhibit. [Witness 1] testified that she had a face to face meeting with the Member following the email and that the Member stated that it was a very busy shift, that she should have started a new MAR sheet and that she did not fully complete the patient care plan in question. The Member blamed heavy workload for this omission.

Witness #2 [ ]

[Witness 2] has been registered with the College as an RN since 2010 and has worked at NBRHC as a staff nurse on the inpatient surgery unit since July 6, 2010. She was a co-worker with the Member beginning January 2011. [Witness 2] was the nurse assigned to [Patient C] on November

29, 2016 on the night shift. The Member was assigned to the patient on the previous shift. [Witness 2] had no discussion at shift change with the Member, which was common as the unit utilized written report sheets. [Patient C] was a patient on the unit who had suffered a fractured ankle requiring surgery. At the commencement of [Witness 2]'s shift, [Patient C]'s surgery had been completed and he had been on the floor for a couple of hours.

College Counsel presented the MAR and the Post Anaesthetic Record from the chart of [Patient C] (Exhibit #11, p. 149). [Witness 2] stated that patients stay in the Post Anaesthetic Care Unit (PACU) usually around one hour, depending on the surgery and patient co-morbidities. [Patient C] was in the PACU from 1628 to 1710 and then transferred to the surgical unit. [Patient C] was given Fentanyl for pain in the PACU as noted in the patient record.

At the beginning of her shift, [Witness 2] discussed with [Patient C] his level of pain. [Patient C] indicated that he was sore and had not received any medications yet, since arriving on the surgical unit from PACU. [Witness 2] checked the MAR which indicated that no medications had been given (Exhibit #11, p.135).

When [Witness 2]'s shift had started there were no notations on the MAR, which implied no medication had been given. The Immediate Post-Operative Record was presented (Exhibit #11, p. 172) and showed documentation by the Member of Percocet 2 tablets given to [Patient C] at 1732. [Witness 2] went to the medication cabinet to retrieve an analgesic and found that there was a dose taken out at 1732. A print out of the Automatic Drug Dispensing Cabinet ("ADC") report was presented (Exhibit #12) as evidence confirming that this had occurred. The witness stated that when selecting a medication, the machine tells you the last time medication has been removed and by whom. She then went back to [Patient C] to confirm he had received medication. The patient was certain he had not received any medication. [Witness 2] then approached the unit leader regarding what course of action she should take, as it was only about 2000 hours. The next dose was not due until 2030, assuming the last dose had been administered at 1730. The patient was fully cognitive and she trusted [Patient C]'s statement that he had received no medications since leaving PACU.

[Witness 2] withdrew 2 Percocet tablets at 2100 hours and administered them to the patient. [Witness 2] then documented the alleged missed dose, noted on the MAR as "not signed", and followed up with a focus note online (Exhibit #11, p. 164). [Witness 2] went on to document the dose she had administered. At 0700 the following morning there was no documentation on the MAR from the Member (Exhibit #11, p. 135). College Counsel presented a signature sheet from the chart to compare signatures and initials of staff (Exhibit #11, p. 162)

Witness #3 [ ]

[Witness 3] has been a RN registered with the College since 1993 and has worked at NBRHC since that time. He has been the Program Manager of the inpatient surgical unit since 2013. Prior to this position he was the unit leader for approximately 8 years after being a staff nurse. The unit has 64 beds, 40 of which are classified as surgical and the remaining 24 are medical overflow and alternative level of care ("ALC"). The unit staff provide some preoperative care, but primarily postoperative care. College Counsel presented the NBRHC Human Resources job description for Registered Practical Nurse (Exhibit #5). The RPN role involves; dressing changes, intravenous

("IV") starts, basic morning care and activities of daily living, preparing patients for diagnostic tests, discharge teaching, and work with other members of the interdisciplinary team.

On a patient's admission to the unit, the physician order sheets must be transcribed including the best possible medication history ("BPMH") and, if not, reported to the next shift. College Counsel presented, and [Witness 3] reviewed, the RPN job description for documentation which states "Documents accurately, clearly, concisely, legibly in the patient's permanent health record". The documentation method is charting by exception, and abnormal findings are documented under patient care notes.

College Counsel reviewed the chart of [Patient C] (Exhibit #11) with [Witness 3], the Immediate Post-Operative Assessment Flow Record kept in the chart, the written documentation record and the Hospital's Medication Administration Policy. PRN (i.e. as needed) medications must be written to communicate the reason for administering the medication and its effectiveness. The policy stipulates that if the medication is not administered or is removed in error, a second registered staff is required to witness and sign for the discarding of the narcotic (Exhibit #4). It defines specifics in regard to narcotic removal from the ADC, a computerized system that provides records of withdrawals including the medication name, the time and the person removing the medication.

As a manager [Witness 3] stated that he could request old records of the ADC through the pharmacy by date and staff member.

[Witness 3] stated that he had a professional relationship with the Member. She worked as an RPN on the unit when [Witness 3] was a staff member, unit leader and then her manager. The Member started to work on the unit in 2005 and ceased in December 2017. Her role was a full time RPN scheduled for 12 hour day and night shifts. College Counsel presented the Member's shift schedule from the period of time during when the events described in the Notice of Hearing were alleged to have occurred and the witness confirmed the schedule. [Witness 3] confirmed being copied on an email sent from nurse educator [Witness 1] to the Member, dated July 18, 2016, regarding the fact that the Member did not transcribe [Patient A]'s medications onto the Kardex on admission. Consequently, the day nurse was not able to check the medications against the MAR and the covering physician was not able to gather any medication information that was needed for this patient on admission.

The email from [Witness 1] to the Member dated July 18, 2016 (Exhibit #9) and cc'd to [Witness 3] regarding the transcription of medications to the Kardex was reviewed. [Witness 3] confirmed that he is normally copied on emails from the educator so that he is able to keep current on issues, educational needs and any necessary support for the Member and other staff. He stated that he met with the Member, reviewed the issues and concerns with her and developed a plan with [Witness 1] which eventually led to audits. A second email from [Witness 1] to the Member dated July 27, 2016 (Exhibit #10) regarding improper documentation on the MAR, which was also cc'd to [Witness 3] was reviewed. [Witness 3] stated that [Witness 1] started auditing the Member's MAR sheets at this time.

[Witness 3] stated that he reviewed [Patient C]'s health record and remembers the incident. College Counsel presented the ADC record of [Patient C] (Exhibit #12). The Member stated to [Witness 3] that she had given the patient the medication and documented later. He spoke to her about properly

documenting medications. He also spoke to [Patient C] sometime between November 30, 2016 and December 8, 2016, as the patient was still in hospital, to clarify that the patient received the medication. Initially [Patient C] was sure he had not received the medication but following a change in the patient's status (ICU admission), upon further questioning, the patient was unclear. [Witness 3] stated that the Member should not have scratched out [Witness 2]'s entry and should have also completed a note. He stated that the first time he viewed the MAR it was more clear. It was not signed and [Witness 2]'s notation was not scratched out. When he reviewed the document on December 8, 2016, it was signed and [Witness 2]'s notation was scratched out. [Witness 3] stated that the Member told him that the patient was confused. [Witness 3] also stated that he believed the Member had gone back to [Patient C] and discussed with him the issue of whether he had received his medication.

[Witness 3] stated that the initial monitoring of documentation, concerning the Member's medication administration practice completed by [Witness 1], showed no issues and that only the Member's attendance continued to be a concern. [Witness 3] stated he received a June 5, 2017 email (Exhibit #13), presented by College Counsel, from [Witness 6] (Witness # 5) an RN on the floor regarding [Patient D] not receiving her Oxycodone signed out of the ADC. [Witness 3] states that he spoke with [Patient D] who was an 85 year old patient on the unit. His impression the following day was that she was clear, concise and believable. [Patient D] had stated that she had not received any medication and would not have needed so much. She was an RN and manager during her career. The chart of [Patient D] was presented into evidence (Exhibit #15) including the unit report sheets, MAR (scheduled and prn), administrative graphic sheet and signature sheet. The signature sheet was reviewed for an example of the Member's initials. [Witness 3] confirmed that these were the Member's initials. The post-operative pain service scheduled medication sheet and the prn medication sheet were reviewed and showed that Oxycodone and Celebrex were not ordered on the scheduled medication list (p. 236) and Tramacet was discontinued on June 3, 2017 and Tylenol started. On the prn medication list (p. 234) Oxycodone was signed for by the Member 3 times on June 3, 2017 and 4 times on June 4, 2017. There is no accompanying assessment or evaluation noted in any notes. College Counsel presented the Member's work schedule (Exhibit #8) and copies of the ADC reports from both cabinets on the unit for comparison which showed that the Member was present and withdrew medications for [Patient D]. [Witness 3] confirmed the Tramacet dose of June 3, 2017 was wasted and witnessed. [Patient D] stated that she did not require or receive any Oxycodone on those dates.

[Witness 3] stated that he had a discussion with the NBRHC human resources department and the College in order to seek direction. He met with the Member in his office with union representation on the next scheduled night shift. He brought up concerns that [Patient D] did not receive the medications documented. The Member stated that the patient was mistaken. At this meeting, [Witness 3] told the Member that her charts would be audited after each shift going forward.

An email (Exhibit #14) dated June 9, 2017 from [Colleague A], an RN on the unit, to [Witness 3] was presented by College Counsel. This email was a result of a conversation [Colleague A] had with [Witness 3], regarding [Patient D]'s medications and his observations. In his email, [Colleague A] confirmed for [Witness 3] that when he had given [Patient D] some oxycodone on the night shift of June 3, 2017, indicating that it was the same medication she had received previously from the

Member, [Patient D] had responded that she had not received any Oxycodone previously. This email supported the evidence that [Patient D] was consistent in not receiving any Oxycodone.

An email dated October 9, 2017 from [Colleague B] an RN on the Unit, to [Colleague C] the after-hours manager and copied to [Witness 3] regarding a potential discrepancy in pain medication was presented by College Counsel (Exhibit #17). According to [Colleague B], the patient ("[Patient E]") had no recollection of receiving any pills other than her morning pills on the morning of October 8, 2017. The chart of [Patient E] was presented and reviewed with [Witness 3] (Exhibit #18). The Adult Pain Management Orders for prn medications illustrated the dates and times Tramacet and Percocet were recorded as administered to [Patient E] and the initials of the Member in connection with those notations were confirmed. There was a concern that the recorded 0930 dose of Percocet was not administered on October 8, 2017. A review of the ADC (Omnicell Report) (Exhibit #19) showed a Percocet withdrawal for 0920 on that date. [Witness 3] met with the patient who was not clear that she had received the Percocet. There was no nursing documentation regarding the prn dose. A review of the frequency of Percocet was completed.

[Witness 3] stated that he spoke with [Patient E] on October 9, 2017 by phone regarding a number of issues including medications. [Witness 3] stated that a Human Resources specialist was consulted over the concerns regarding medication administration by the Member. The medication sheets and ADC records of [Patient E] were reviewed. It was decided that there was not enough evidence at that time to report the Member. [Witness 3] spoke with the Member on Friday, October 13, 2017, at which time the Member stated that she gave the medication to [Patient E]. Human Resources spoke with the Member and a learning plan, including an audit, was to be completed with the assistance of nurse educator [Witness 1].

College Counsel also presented an email dated November 19, 2017 from after-hours manager [Colleague C] to [Witness 3] regarding concerns of possible misappropriation of Percocet (Exhibit #20). An email from [Witness 5] an RN on the Unit (Witness #6) to [Witness 3] was presented as an exhibit (Exhibit #21). The email concerned [Patient F] and outlined concerns about medication administration during [Witness 5]'s break. [Witness 3] confirmed that he found a sealed envelope with a copy of the email under his office door the following day. The Member was not involved in the care of [Patient F]. Nurse [Witness 5] was the primary nurse for [Patient F] and [Witness 6] (Witness #7) was her relief for breaks. The concern expressed by [Witness 5] was that the Member had, according to the records, withdrawn Percocets for [Patient F] at 9:07 am and 1:34 pm but there was no record of these medications being administered and, according to [Witness 6], [Patient F] asserted that he had not received those medications. Yet, the Member had told [Witness 6] that she had administered the Percocets but had forgotten to sign the MAR. [Witness 3] stated that he reviewed the MAR, physician orders and then spoke with the patient. [Witness 3] pointed out the Member to [Patient F] when the Member walked by the patient's room. [Patient F] was very clear that he did not receive any medication from the Member. [Witness 3] confirmed that the ADC (Exhibit #24) and MAR (Exhibit #23) show medications taken out under and signed for [Patient F] but no further documentation was noted. [Witness 3] stated that there now appeared to be a credible pattern of medication discrepancies involving the Member.

An email from [Colleague D], an RN on the Unit, to [Witness 3] dated November 20, 2017 was presented (Exhibit #22). [Colleague D] expressed concerns with the Member's conduct regarding administration of narcotics and not reporting to [Patient F]'s primary nurse the fact that she had

administered medications to [Patient F]. [Witness 3] stated that he met with the Member hoping for an explanation, but the Member stated that the patient must be mixed up as she had given the medications she had withdrawn for [Patient F].

Human Resources, [Witness 3], a Hospital Quality Assurance representative, the union president and the Member were present for a meeting on December 18, 2017 to address concerns about the Member's conduct. [Witness 3] stated that initially the Member's response was quiet and denying but became more emotional once [Patient F]'s allegations were presented. The union president requested a private conversation with the Member. On return [Witness 3] stated that the Member admitted to diverting medications in each case, writing over the times on the MAR and was overworked and therefore did not document properly in the MAR and did not transcribe the BPMH to the Kardex.

A copy of the Practice Review Report (dated December 19, 2017) summarizing the discussion at the meeting, was entered into evidence (Exhibit #25). The Member indicated that she was less certain of diversion with [Patient E]. The Member stated that she had been self-medicating with Percocet since an accident in 2015. [Witness 3] testified that the Member stated that she would take medications from patients who were confused or would not realize they had missed them. At this point the meeting was stopped by the union president and the Member was escorted to the Occupational Health and Safety department. She has not returned to nursing at NBRHC since that time.

College Counsel reviewed with [Witness 3] his testimony regarding what the Member had said about each of the patients at the meeting. In regard to [Patient C] the Member initially denied the allegation but admitted it by the end of the meeting. The Member admitted diverting narcotics from [Patient D]. In regard to [Patient E], the Member could not remember the patient well and stated that she may have diverted narcotics. As to [Patient F] the Member stated that she had not given [Patient F] any of his narcotics and had diverted them. [Witness 3] stated that these were the only 4 patients reviewed.

Witness #4 [Patient D]

[Patient D] is a retired College member with 30 years of full-time nursing experience. She stated that she was admitted to hospital for emergency surgery and transferred to the surgical unit on May 31, 2017 to June 5, 2017. There was pain medication prescribed for her when she arrived on the unit. She was administered pain medication with a pain pump initially and it was removed on the third day. After being taken off the pain pump she does not recall requesting any pain medications as she was very comfortable. She remembers the Member who provided care to her for 2 days prior to discharge. She had a different nurse on her discharge day. [Patient D] request something to get a good night sleep on the night prior to discharge. It was early in the shift as her son was still visiting. [Patient D] was told by the night shift nurse that she had just had pain medication at 1845. She denied receiving any medication and her son who was present at the stated time concurred. She remembers speaking to the Member at 1845 as she had asked her if she was working late and was told it was only 1845. She remembered the discussion with the night shift nurse regarding the 1845 medications reportedly given. She knew the medication and what it looked like and knew that she had not taken any Oxycodone.

Witness #5 [ ]

[Witness 5] is an RN registered with the College since 2012. She is employed at NBRHC and worked on the surgical unit from 2012 to 2018. She was acquainted with the Member as a co-worker. [Witness 5] confirmed that she was the person who sent the email, dealing with a possible medication error involving [Patient D] (Exhibit #13), to [Witness 3], the manager on June 5, 2017 as referred to in the evidence of [Witness 3] above. She was the primary nurse for [Patient D] on the night shift of June 4, 2017. She stated that she also left [Witness 3] a voice mail regarding her concerns. [Witness 5] stated that the Member was on the day shift and [Witness 5] was on the next shift (nights). Common practice on the unit was to provide a written report at change of shift, depending on the nurses' preference.

On June 5, 2017 at the start of [Witness 5]'s shift, [Patient D]'s son was visiting [Patient D] and [Patient D] was doing well. [Witness 5] recalls [Patient D]'s stated level of pain was 2 to 3 out of a score of 10. The documentation on the MAR showed that [Patient D] had been taking Oxycodone 10mg during the shift (Exhibit #15, p 234, 236). The patient had received Oxycodone 5mg the evening prior, had slept well and wished to have the same that night. [Witness 5] noted that [Patient D] already had 4 doses during the day shift and was not due for another dose until 2250. She reviewed this with [Patient D]. [Witness 5] further indicated that [Patient D] recalled the Member checked on her but did not give any pills. This prompted [Witness 5] to ask if any other medications had been given on the prior shift and [Patient D] stated that none had. She then decided to complete an assessment for confusion by reviewing the date, time and patient's orientation. [Patient D] passed easily. She then compared the MAR to the ADC machine. The ADC's report showed that the Oxycodone was removed at 1850 (Exhibit #16). In questioning [Patient D] [Witness 5] stated that [Patient D] "clued into" the concern. [Patient D] stated to [Witness 5] that she knew what the medication looked like, what colour it was and that she had remembered having it the night before. [Witness 5] then gave [Patient D] the regularly scheduled Tylenol ordered at 2200 and Oxycodone 5 mg at 2250, as this was the earliest time she could give it according to the ADC and MAR record. College Counsel reviewed the medication documentation records in [Patient D]'s chart. [Witness 5] stated that she sent the email to [Witness 3] because "things did not add up, something was not right".

Witness #6 [ ]

[Witness 6] is an RN registered with the College since 1996 and has been employed by NBRHC since August of 2007. She has worked on the inpatient medical/surgical unit for more than 10 years. She was acquainted with the Member as a co-worker. College Counsel presented the email of November 19, 2017 to [Witness 3] (Exhibit #21) and the witness confirmed that she sent it as addressed by [Witness 3] in his evidence summarized above. She stated that she was working November 18, 2017 on the day shift and [Patient F] was a patient assigned to her. Her break partner was [ ] (Witness #7). [Witness 6] was whistle tipping a patient (manual bladder irrigation for clots) which usually took 2 to 4 hours to complete and requires 100 percent of one's attention. While she was whistle tipping and then starting continuous bladder irrigation, her buddy [Witness 7], would oversee her patients until she was able to. [Witness 6] stated that she had no interactions with the Member on that shift prior to the incident. [Patient F] was not the patient who required whistle

tipping. [Witness 6] recalled [Witness 7] asking her if she ([Witness 7]) could give [Patient F] pain medications and she said yes. [Witness 7] returned from the ADC machine and stated that pain medications had been withdrawn for [Patient F] and it was sooner than the allotted time for the next dose. [Witness 6] went to see [Patient F] and assessed his pain score and asked him when he last received any pain medication. The patient stated that he needed the Percocet and had not received any since 0640 that morning. The MAR (Exhibit #23, p. 298) and ADC report (Exhibit #24) were reviewed and 2 doses of Percocet had been withdrawn by the Member, according to the ADC report and were not documented in the MAR. [ ] (Witness #5) had given her shift report and at that time 0640 was the only notation in the MAR. College Counsel presented [Patient F]'s prn Medication sheet for review. According to the ADC it was only 2.5 hours since the last dose of pain medication had been withdrawn for this patient, therefore it appeared to be too early to administer the next dose. [Witness 6] spoke with [Patient F] and wanted to confirm that the patient did not have any cognitive issues and found that the patient was very clear and coherent. She spoke to the patient a third time and found that patient to have very good memory. The decision was made following a discussion with the unit leader and another nurse on duty to give [Patient F] a dose of Percocet at 1520. [Witness 6] and [Witness 7] co-signed for the Percocet.

[Witness 6] stated that she spoke with the Member and asked her if she had given [Patient F] Percocet. The Member stated that she had and was surprised that she had not documented the administration in the MAR. This made [Witness 6] suspicious as not signing for narcotics or writing a note in the chart was not common or acceptable. [Witness 6] then printed off the ADC report and had a discussion regarding the course of action with 3 colleagues. She waited until the end of the shift to complete the email to [Witness 3] as it was a busy shift. [Witness 6] stated that the Member did not take any steps to correct the MAR.

Witness # 7 [ ]

[Witness 7] is an RN registered with the College for the past 2 years. She is employed at NBRHC and worked on the surgical unit from April 2017 to September 2019. She was acquainted with the Member as a co-worker on the same surgical unit. She stated that she remembered [Patient F] and working the day shift on November 18, 2017. [Witness 6] was assigned to [Patient F] and [Witness 7] was her break partner (buddy). She recalled it being a busy day.

[Witness 7] recalled answering a call from [Patient F] around 1330 as [Witness 6] was busy with another patient. He was a post-operative patient and requested something for pain. [Witness 7] reviewed the MAR for [Patient F]. (Exhibit #23, p. 298) to see what was ordered and when it was last given. [Witness 7] noted [Patient F] was ordered Percocet for pain every four hours and nothing had been documented as given on her shift. The last notation was by [Witness 5] at 0640. [Witness 7] then went to the ADC. She also clarified with the assigned nurse [Witness 6] if it could be given. The ADC report stated that 2 Percocet had been removed at 1334 but not signed for in the MAR. The ADC report (Exhibit #24) was presented by College Counsel and reviewed by [Witness 7]. The Member had signed for 2 Percocet at 0907 and 1334. [Witness 7] thought it peculiar that the Member would remove pain medication for [Witness 6]'s patient. She returned to [Patient F] and he confirmed that he had not taken any Percocet since 0640. She then spoke to [Witness 6] and they both looked at the ADC. Following further discussion, it was decided to give [Patient F] a dose of Percocet at 1522. [Witness 7] stated that she and [Witness 6] both signed for it in the MAR as

reviewed by College Counsel. [Witness 7] stated that [Witness 6] printed the ADC report and said she would take it up with the manager.

Expert Witness – Melissa Berquist ("M.B.")

M.B. was presented by College Counsel as an expert in the Standards of Practice for inpatients on surgical units. M.B.'s recent Curriculum Vitae ("CV") was provided to the Panel.

The Panel reviewed the CV of M.B. and qualified her as an expert on the Standards of Practice of nursing, as they relate to patients on medical/surgical units. An acknowledgement of the expert's duty, signed by M.B., was presented (Exhibit #31) and she confirmed her understanding of her duty at the hearing. The questions and hypothetical case considered by the expert, on September 8, 2019 were presented by College Counsel, (Exhibits #32 and #33). College Counsel noted an error of date of the Member's registration with the College in the Hypothetical (Exhibit #33). M.B. stated that this did not alter her opinion. She stated that she was able to form an opinion on each of the questions using the College Standards.

Question #1 Patient A: The nurse contravened a standard of practice by failing to record a patient's list of medications in the patient care plan during the patient's admission.

M.B. stated that the Standard of Practice related to this question was the *Documentation Standard* (Revised 2008) which sets out that nurses must document clearly, completely and accurately, which would include the patient medication list. Complete and accurate documentation, shared with the interdisciplinary team, ensures that the patient receives the appropriate medications. The risk in not completing the task is that the patient may not receive their appropriate medications, and, further, this omission results in the nurse on the next shift having to complete the task.

The indicators in the Standard most appropriate to the scenario are:

- *Communication*: ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process; and
- *Accountability*: Nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.

The result of the nurse's contravention of the standard is that the nurse on the next shift had to complete the patient's list of medications.

Question #2 Patient B: The nurse contravened or failed to meet a Standard of Practice by failing to input medication details within the columns of Patient B's MAR and inserting times into the side margin of the document.

M.B. stated that the Member failed to meet the *Documentation Standard, (*Revised 2008). The medication should have been signed off in the correct date column with an appropriate time so that it is clear for anyone reviewing the MAR to know when the last dose was given and to be in a position to give the next dose at the appropriate interval. As in Question #1, this is a failure in the *Communication* accountability indicator. The oncoming nurse might miss a notation in the margin that medication had been given.

Question #3 a) Patient C: The nurse failed to document that she withdrew medication from the ADC.

M.B. stated that *Documentation Standard, Revised 2008* was breached as there is an appropriate medication process for prn medications. A nurse should assess the patient's pain as to severity, timeframe and location. Then the nurse should go to the MAR and check what type of pain medications have been ordered and determine if the patient is able to have any, based on when the last dose was given. The nurse can then proceed to the ADC and withdraw the medication, administer it to the patient, document and a short while later assess the effectiveness. The documentation of the medication must be timely, preferably immediately. The effectiveness of the prn medication should also be documented.

Medications withdrawn from the ADC are to be given to the patient and if the patient cannot take it or it is not required it should be wasted. In the case of narcotics wasting, this involves putting the medication back into the ADC, something that should be witnessed by another nurse. It is important to document controlled substances to ensure that no diversion occurs. A nurse must document to ensure the record is up to date. If a nurse withdraws and administers medications but does not document these actions, a different nurse may administer more medications in too short a time. On the other hand, if a nurse does not administer medications withdrawn but documents that he or she has, another nurse may delay administering medication based on the faulty documentation which may cause the patient to be in pain and to delay or slow down the patient's recovery.

Question #3 b): The nurse altered the documentation of another nurse.

M.B. stated that Standards of Practice were breached, as once the nurse withdrew the narcotic, she should have administered it to the patient and document that she had. Nurses are not permitted to change another nurse's documentation. There are processes in place to correct a record if necessary. A nurse needs to ensure that the original is still visible. This is supported by the *Documentation, Revised 2008* under the Accountability Indicator: f) correcting errors while ensuring the original information remains visible/retrievable and g) never deleting, altering or modifying anyone else's documentation.

Question #4 Patient D: The nurse contravened/failed to meet the Standard of Practice when she withdrew narcotics that she did not administer, documented that she had administered narcotics when she did not, and documented that she had administered them when she did not.

M.B. stated that if the nurse withdrew and did not give the medication, but documented that she had without a reason, there was a breach of the *Professional Standards,* (Revised 2002) as this is not ethical care. The nurse documented care provided that was not done. This was also a breach of the *Therapeutic Nurse-Client Relationship Standard, (*Revised 2006) as the nurse failed to provide care, thus a form of neglect. If the case is assumed to be a diversion of narcotics, the *Medication Standard* (Revised 2015) was breached under the Safety indicator: failing to prevent controlled substances from diversion. College Counsel asked if the patient did not have a pain pump in place would this change her opinion? M.B. stated "no".

Question #5 a) Patient E: The nurse contravened/failed to meet the Standard of Practice when she withdrew Percocet from the ADC which she did not document and/or administer.

M.B. stated that the breach relates to the *Documentation Standard,* Revised 2008. Withdrawal of narcotic medications and not administering the said medication is a breach of the *Medication Standard,* Revised 2015 and the *Professional Standards,* Revised 2002. Withdrawal of medication and no administration of it and no documentation is a breach of both the *Medication Standard,* Revised 2015 and the *Professional Standards,* Revised 2002 and the *Documentation Standard,* Revised 2008.

Question #5 b) The nurse contravened/failed to meet the Standard of Practice when she administered Percocet to a patient less than 3 hours after the last administration, contrary to the medication order.

M.B. stated that by giving the medication less than 3 hours after the last medication was withdrawn, the nurse is not honouring the frequency that the medication was prescribed for. The nurse therefore failed to follow the order. A nurse does not have the authority to change an order. If the Member did not administer the 1621 hours dose and withdrew a[t] 1850 hours, dose it would constitute a breach of the *Medication Standard,* Revised 2015 and the *Professional Standards,* Revised 2002 for the missed 1621 hour dose.

Question #6 Patient F: M.B. testified that the nurse contravened/failed to meet the Standard when she withdrew medications which she did not administer, especially related to paragraph 49 of the Standard where the patient was not assigned to the nurse. The nurse withdrew the 0907 hours and 1334 hours doses and did not administer the doses. The nurse breached the *Medication Standard,* Revised 2015 and the *Professional Standards,* Revised 2002, as she withdrew medications that she did not administer.

Question #7 M.B. testified that the nurse contravened/failed to meet the *Medication Standard,* Revised 2015, by diverting medications intended for the patient. The Member further breached the *Professional Standards,* Revised 2002, resulting in a failure to provide ethical care.

Final Submissions

College Counsel submitted that the evidence in the form of 7 fact witnesses and a Nursing Expert on the College's Standards of Practice, as well as the 36 exhibits, gave the Panel sufficient evidence to make findings of professional misconduct that the Member:

(a) Breached the Standards of Practice;
(b) Misappropriated property from the Member's employer;
(c) Falsified records; and
(d) Engaged in disgraceful, dishonourable and unprofessional conduct.

College Counsel first addressed the issue of the Panel's continuing jurisdiction to hear this matter despite the fact that the Member's certificate of registration is currently suspended. She relied on s. 14 of the *Health Professions Procedural Code* which makes it clear that a suspended member continues to be subject to the jurisdiction of the College for professional misconduct when the acts

of alleged misconduct occurred when the person was either an active member or one whose certificate of registration was suspended. All of the events referred to in the Notice of Hearing and constituting alleged acts of misconduct occurred while the Member had an active certificate of registration with the result that she remains subject to the Panel's jurisdiction to make findings in respect of the allegations against her.

College Counsel acknowledged that the burden of proving the allegations rests with the College. Although the Member elected not to participate in the discipline process and was deemed to have denied the allegations, the College must still prove on a balance of probabilities that the member committed the acts set out in the Notice of Hearing.

The Panel must assess the evidence presented to determine its admissibility, reliability and credibility.

College Counsel submitted further that the 36 exhibits, including the health record excerpts of patients and the testimony of [Witness 1] and [Witness 3] who identified the health records as those from the patients' hospital records, should be accepted by the Panel as accurately reflecting the care provided to the patients concerned, except where there is evidence to suggest that information in a health record is not accurate.

College Counsel noted that there were a number of witnesses who provided context and described the ADC reports. [Witness 3]'s testimony included evidence of the ADC system report which provided a trail of the medication withdrawals. College Counsel's position was that the Panel should accept the accuracy of the ADC reports and information contained therein (names, dates, times and names of drugs) as the ADC records are the most reliable records about what happened with regard to medication withdrawals as the ADC system automatically records medication withdrawals. The witnesses' testimony gave context to the documents presented and provided their observation of events.

College Counsel addressed the issues of credibility and reliability of particular witnesses. College Counsel asserted that reliability is about a witness' powers of perception and ability to observe the events in question while credibility is based on reliability plus honesty. She also referred the Panel to the factors to be considered in assessing credibility as laid out in *Pitts v Ontario (Ministry of Community and Social Services, Director of Family Benefits Branch)*. College Counsel also urged the Panel not to expect perfection when dealing with the details of a witness' evidence as the events in issue occurred several years ago.

College Counsel submitted that the Panel needs to be careful to distinguish between evidence witnesses have given based on their own observations (direct evidence) and evidence of what they have heard others say (hearsay evidence). Hearsay evidence is generally not admissible in discipline hearings for the truth of what was said. However, as an exception to this general rule, when the Member makes a statement against her interests outside the hearing room, hearsay evidence in the hearing about what she said is admissible and can be relied on for the truth of what the Member said. College Counsel submitted that evidence of several such statements made by the Member against her interest were before the Panel in this hearing and that they can be relied on by the Panel for the truth of what the Member said.

College Counsel then made submissions about what the College urged the Panel to find in regard to the various individual allegations in the Notice of Hearing, including the basis in the evidence for those submissions.

Allegations 1(a) and 4(a)

Allegations 1(a) and 4(a) relate to the Member's failure to transcribe a list of medications into a patient's chart. The Notice of Hearing alleged that this was a breach of the Standards of Practice (Allegation 1(a)) and conduct that would be regarded as unprofessional, dishonourable and/or disgraceful (Allegation 4(a)). College Counsel referred to [Witness 1]'s evidence that the Member had failed to complete all required parts of the patient care plan, in particular, the list of medications being taken, when the patient in question was admitted, something she was required to do as the night nurse when a new patient is admitted. [Witness 1]'s evidence was that the Member had admitted to her that she did not complete the patient care plan in question fully and blamed heavy work load for the omission. [Witness 1] also testified that it is important to have all medications listed on a patient care plan to ensure that the patient will receive all appropriate medications.

M.B. (Nursing Expert) testified that Allegation 1(a) was a breach of the *Documentation Standard, Revised 2008* and was unprofessional. As to Allegation 4(a), there were no repercussions to the patient, but the Member should have been aware of her professional obligations and failure to complete the required information which shifted the task to the oncoming staff and is therefore both unprofessional and dishonourable in the College's submission. The College made no submissions about whether the actions of the Member referred to in Allegation 4(a) were disgraceful.

Allegations 1(b) and 4(b)

[Witness 1] testified to the documentation provided in the MAR of [Patient B]. She also gave evidence of the institution's policy and practice in the NBRHC BPMH document. Nursing Expert M.B. gave evidence of the professional standards related to these allegations. Documenting medication administration beyond the date of the MAR is a breach of the *Documentation Standard, Revised 2008.* The expectation is that a nurse will make a new MAR sheet and chart the date and time of administration. Both witnesses testified that it was inappropriate to document in the margins and could have le[]d to the oncoming nurse giving an additional dose within the time frame ordered. College Counsel submitted that the failure to meet the standard was unprofessional. The breach was a basic and fundamental component of nursing practice and put the patient at risk as well as increasing the workload of the oncoming nurse.

Allegations 1(c), 1(d), 4(c) and 4(d) relate to [Patient C] on November 29, 2016. With respect to Allegation 1(c) [Witness 2] gave evidence that she had cared for that patient and he had returned from surgery earlier that day. [Patient C]'s health record and ADC report for November 29, 2016 were presented as factual evidence. [Witness 2] gave clear evidence that during her shift she checked [Patient C]'s MAR and it contained no notation for Percocet for November 29, 2016 (direct evidence). [Patient C] told her that he had not received any pain medication.

By contrast, the ADC for [Patient C] showed a withdrawal of Percocet by the Member at 5:32 pm on November 29, 2016. This showed an inconsistency between the MAR and ADC. [Witness 2]

testified that she gave Percocet to [Patient C] at 2100 hours and made a notation in the MAR and a progress note in the chart to reflect the 1730 withdrawal noted in the ADC.

In connection with Allegation 1(c), College Counsel submitted that the Panel is not required to make a finding as to whether or not the Member actually administered Percocet around 1730 because the allegation concerns an alleged documentation issue only, not an administration error. M.B. had stated in her testimony that when a nurse withdraws from the ADC she must administer the medication or waste it, and must document accordingly. A failure to do so is a breach of the *Documentation Standard, Revised 2008.*

Allegation 4(c)

The Member's actions and the resulting inconsistency between the ADC report and the MAR lead to ambiguity. College Counsel submitted that this was a breach of the standard of practice and so could be regarded as unprofessional. The Member should have known that she was engaging in improper conduct.

Allegations 1(d) and 4(d)

These allegations allege that the Member altered the documentation record concerning the administration of medications for patient [Patient C]. College Counsel submitted that nurse [Witness 2]'s evidence was, that she had inserted the date and time of the possible 1730 administration of Percocet to [Patient C], including a notation "not signed" in an attempt to show when and how [Patient C] had received medication. Sometime later, the Member entered her own initials on [Witness 2]'s entry and scratched out the "not signed" note. Nursing expert M.B. testified that the alteration of a colleague's entry is a breach of the standards. College Counsel submitted that the Member's action made the MAR less clear as a historical record concerning when [Patient C] received medications and that she knew or ought to have known that it was improper to amend documentation in this manner. College Counsel submitted that the Member's actions established professional misconduct on her part for the purposes of Allegation 1(d) and conduct that would be regarded as dishonourable and unprofessional for the purposes of Allegation 4(d).

Allegations 1(e), 1(f), 1(g), 1(h), 2(a), 2(b), 3, 4(e), 4(f), 4(g), 4(h), 4(i) and 4(j) relate to the patient [Patient D].

Allegations 1(e) through (h) relate to a breach in the Standards of Practice. In particular 1(e) and 1(g) relate to withdrawal of tablets not administered. 1(f) and 1(h) relate to documentation of the administration of tablets for [Patient D] that were not administered to [Patient D].

Allegations 2(a) and 2(b) relate to alleged misappropriation of tablets that were withdrawn for [Patient D].

Allegation 3 is regarding the falsification of records in the documentation of medications that were not administered to [Patient D].
Allegations 4(e) through 4(j) relate to the withdrawal of medications, failure to document and misappropriation of property in connection with medications intended for [Patient D]. College Counsel submitted that [Patient D] presented as an impressive cognitively intact person for her age.

She was able to provide clear and cogent evidence. [Patient D] had been an RN for many years and had an understanding of nursing Standards of Practice and medication documentation practices. She was clear that the Member did not give her any Oxycodone on June 3 or 4, 2017. She was able to recall a conversation she had with the Member on June 4, 2017, including the time of that conversation. She was clear that she did not request any pain medication or receive any from the Member at that time. College Counsel acknowledged that [Patient D] was not able to say what other medications she received or to confirm minor details. College Counsel submitted that with the passage of time memories fade with regards to points not crystalized into the patient's mind. Nurse [Witness 5] and manager [Witness 3]'s testimony concerning their interviews with [Patient D] were that she was able to convey a clear memory about any pain medications given. Her testimony at the hearing and in previous interviews remained consistent. College Counsel submits that [Patient D] and nurse [Witness 5] are credible and the Panel should accept their evidence. Manager [Witness 3] testified that the Member admitted in December 2017 that she had taken Oxycodone meant for [Patient D]. Taking medications that were not administered but documenting that she administered them is an obvious breach of the Standards of Practice. M.B. testified that it was also a breach of the: *Professional Standards,* Revised 2002 with respect to ethical nursing care, *Medication Standard,* Revised 2015 in that nurses should employ strategies to avoid diversion, and a breach of the *Documentation Standard,* Revised 2008 as nurses are to document when narcotics are not given. College Counsel submitted that the Panel could infer that the Member misappropriated the medications as there is evidence to support the allegations. If the Panel finds that the Member did not administer the medication but documented she had, this supports a finding of falsification of records and is related to Standards of Practice.

As to disgraceful, dishonourable and unprofessional conduct, College Counsel submitted that giving medications to patients as ordered and documenting the administration is a duty of nurses. Controlled acts are acts which nurses have the privilege of performing. The conduct of stealing medications and falsely documenting to cover the fact is inconsistent with the core duty of nursing, shames the Member and the entire profession. Therefore, the Member's conduct is all of disgraceful, dishonourable and unprofessional conduct.

Allegations 1(i), 1(j), 2(c), 4(k) and 4(l) relate to [Patient E].

All of these allegations concern whether the Member withdrew Percocets at 1621 on October 8, 2017 for [Patient E] and then either administered them to [Patient E] without documenting that administration or, alternatively, did not administer the medications to [Patient E].

College Counsel submitted that the 1621 withdrawal of Percocets by the Member is documented in the ADC report but the MAR for [Patient E] does not include any corresponding record of administration of these Percocets to [Patient E]. College Counsel also pointed to the evidence of [Witness 3] to the effect that, in November 2017, the Member admitted to him that she may have diverted some medications from [Patient E] but could not remember [Patient E] well.

College Counsel asked the Panel to make the inference based on the evidence that the Member did not administer the Percocets she withdrew at 1621 to [Patient E] because any administration shortly after 1621 would have been inconsistent with all the documentation and less than three hours before

the next documented administration of Percocets to [Patient E] at 1850, contrary to the medication order for [Patient E].

With respect to Allegation 1(i), College Counsel confirmed that Allegations 1(i) (i) and (ii) are in the alternative, depending on whether the Panel concludes that the Member administered the Percocets or not.

College Counsel next addressed Allegation 1(j), alleging that the Member administered Percocets to [Patient E] at 1850 (a documented administration) less than three hours after the last administration. College Counsel confirmed that this allegation proceeded on the basis that the Panel concludes that the Member did administer the Percocets to [Patient E] at 1621, contrary to the College's submission. If the Panel concludes that the Member did not administer Percocets to [Patient E] at 1621, College Counsel accepted that Allegation 1(j) falls away (along with Allegation 4(k)).

Similarly, College Counsel acknowledged that Allegation 2(c), alleging misappropriation of property, is based on the Panel concluding that the Member did not administer Percocets to [Patient E] at 1621 but diverted them improperly.

College Counsel also referred to nursing expert M.B.'s evidence to the effect that, whether a member withdrew the Percocets but did not administer them or did administer them without documenting that fact, there would be a breach of a standard in either case: a breach of the *Medication Standard* in the first case and a breach of the *Documentation Standard* in the latter case.

Finally, College Counsel also submitted that, for the purposes of Allegations 4(k) and 4(l), the Member's conduct would reasonably be regarded as unprofessional, dishonourable or disgraceful, whatever decision the Panel reaches on the issue of whether she administered Percocets at 1621.

Allegations 1(k), 2(d), 4(m) relate to [Patient F].

These allegations allege that the Member withdrew Percocets for [Patient F] at 0907 and 1334 on November 18, 2017 which she did not administer to him.

In her submissions, College Counsel pointed to the fact that the ADC showed that the Member withdrew Percocets for [Patient F] at both 0907 and 1334. She also referred to the clear admission by the Member at the meeting with, among others, manager [Witness 3] that the Member remembered [Patient F] and that she had taken the Percocets rather than administering them to [Patient F].

College Counsel submitted that the Member's taking of these medications was a breach of the Professional and Medication Standards and was unprofessional, dishonourable or disgraceful for the same reasons outlined in respect of other allegations.

Allegations 1(l) and 4(n)

These allegations are general allegations that, between February 2015 and December 2017 the Member misappropriated Percocets, that were prescribed for patients, for her personal use from NBRHC.

College Counsel submitted that the Member had admitted to manager [Witness 3] that she had misappropriated the medications. [Witness 3]'s evidence was that the Member admitted that she had been self-medicating and that her taking of medications had not been limited to the four patients identified in this hearing ([Patient C], [Patient D], [Patient E] and [Patient F]).

College Counsel took the position that the Panel could find that these allegations were established even though there were no details of the alleged misappropriations, based simply on the Member's admission and that her actions as alleged were both a breach of the standards and unprofessional, dishonourable or disgraceful conduct.

Decision

As a preliminary matter, the Panel finds that it has jurisdiction to hear this matter despite the Member being currently suspended.

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, the Panel found that the College established Allegations 1(a), 1(b), 1(d), 1(e), 1(f), 1(g) 1(h), 1(i) i, and 1(k), 2(a), 2(b), 2(c) and 2(d), 3(a) and 3(b) in the Notice of Hearing.

As to Allegation 4(a) the Panel found the Member's conduct to be unprofessional. With respect to Allegations 4(b) and 4(d), the Panel found the Member's conduct to be unprofessional and dishonourable. As to Allegations 4(e) through 4(j), 4(l) (i), 4(l) (ii) and 4(m) the Panel found the Member's conduct to be disgraceful, dishonourable and unprofessional.

The Panel found that allegations 1(c), 1(i) ii, 1(j), 1(l), 4(c), 4(k), 4(l) iii and 4(n) were not established with the result that they have been dismissed.

Reasons for Decision

With respect to the preliminary matter, the Panel finds that it has jurisdiction pursuant to s. 14 of the *Health Professions Procedural Code* to hear this matter and to make determinations in respect of each of the allegations set out in the Notice of Hearing despite the fact that the Member is currently suspended. In that regard, the Panel accepts the submissions of College Counsel on this issue as summarized above.

The Panel heard evidence from 7 fact witnesses and one expert witness and used the criteria set out in *Pitts v Ontario (Ministry of Community and Social Services, Director of Family Benefits Branch)* to assess their credibility.

The Panel found that nurses [Witness 1], [Witness 2], [Witness 5], [Witness 6] and [Witness 7] were honest, gave accurate and complete observations and had good memories of the events that they had the opportunity to see and the conversations they had the opportunity to hear or participate in. Their testimony was reasonable and consistent both internally and externally. They appeared to have no interest in the outcome of the hearing and were very professional.

Manager [Witness 3] seemed honest and gave accurate and complete observations. His memory was reasonable and relied on the factual evidence presented. Inconsistencies in his testimony, although minor, were clarified. He appeared to have no personal interest in the outcome.

M.B. (Nursing Expert) was professional, honest, accurate and complete in her assessment of the hypothetical case. There were no inconsistencies in her testimony nor any apparent personal interest in the outcome. The Panel accepted and relied upon M.B.'s evidence.

[Patient D] the patient, was very clear, forthright and had good recall of her interactions with the Member and whether she had received medications from the Member on June 3 and 4, 2017. While her recall of other, less significant events was less clear, the Panel found her to be very credible on the subject of the Member giving her medications or not. Her account was accurate and complete on that subject. Her testimony was reasonable and consistent internally. The Panel found that she had no personal interest in the outcome of the hearing.

The Panel relied on the 37 exhibits and the witnesses' testimonies in arriving at its decision.

What follows are the Panel's reasons for its decisions concerning the various allegations in the Notice of Hearing.

Allegations 1(a) and 4(a)

The evidence establishes that the Member failed to complete all admission information for [Patient A] and, in particular, that the Member failed to enter [Patient A]'s list of medications into her chart upon [Patient A]'s admission on July 18, 2016 as required.

The Kardex (Patient Care Plan) for [Patient A], entered as Exhibit # 27 shows as blank the section for [Patient A]'s medications. In addition, [Witness 1]'s evidence was that when she met with the Member to discuss this issue, the Member admitted that she had failed to complete the medications list, blaming a busy shift and a lack of time. M.B.'s evidence was that this sort of failure by the Member would result in a breach of the *Documentation Standard,* Revised 2008.

This evidence is sufficient to establish Allegation 1(a).

Allegation 4(a) relies on the same alleged failure of the Member to complete [Patient A]'s list of medication into her NBRHC chart upon admission as does Allegation 1(a). For the reasons given in respect of Allegation 1(a) above, the factual basis for Allegation 4(a) is also established.

For the purpose of Allegation 4(a), the Panel considers that the Member's conduct in failing to complete the list of medications as alleged was clearly relevant to the practice of nursing, as are all of the actions on the part of the Member forming the basis for the various allegations in Allegation 4. The Panel further considers that the Member's failure represented a serious disregard for the

Member's professional obligation to ensure that [Patient A]'s chart was complete upon admission. Accordingly, the Panel concludes that the Member's conduct in this respect would reasonably be regarded by members of the College as unprofessional although the Panel does not consider that the misconduct was in this respect sufficiently serious to properly be described as dishonourable or disgraceful.

Allegations 1(b) and 4(b)

The evidence establishes that the Member documented the administration of medication to [Patient B] on July 22, 2016 in the margin of [Patient B]'s MAR rather than on a new MAR, in a column dedicated to that particular date. [Patient B]'s MAR, showing the Member's documentation in the margin was entered as an exhibit.

Further, nurse educator [Witness 1]'s evidence was that documenting in this fashion was contrary to NBRHC's policies. Nursing expert M.B., for her part, testified that a member documenting the administration of medication in this fashion would fail to meet the requirements of the *Documentation Standard*, Revised 2008.

Finally, [Witness 1]'s evidence was that when she discussed this issue with the Member, the Member admitted that she had documented in the margin but should have rewritten it in a new MAR in a column dedicated to July 22, 2016 but did not do so as it had been a busy shift.

This evidence is sufficient to establish Allegation 1(b).

With respect to Allegation 4(b), it relies on the same alleged documentation failure by the Member as Allegation 1(b) with the result that the factual basis for Allegation 4(b) is also established.

The Panel considers that the Member's conduct in documenting the administration of medication to [Patient B] in the margin represented a serious disregard on the Member's part for her professional obligations and that the Member would have known or ought to have known that her choice to document in this manner was unacceptable and fell well below the standards of a professional. Proper documentation is a fundamental part of nursing practice which the Member chose to ignore, thereby exposing the patient to potential risk of a medication error.

Accordingly, the Panel concludes that the Member's conduct in this respect would reasonably be regarded by members of the College as unprofessional and dishonourable, but the Panel does not consider that it rises to the level of being disgraceful.

Allegations 1(c), 1(d), 4(c) and 4(d)

These allegations all concern alleged documentation errors made by the Member in connection with her administration of Percocet to [Patient C] on November 29, 2016.

Allegations 1(c) and 4(c) rely on the alleged failure of the Member to document appropriately the administration of Percocet to [Patient C] at 1732 on November 29, 2016.

Allegations 1(d) and 4(d) rely on the Member's alleged alteration of [Patient C]'s medical record by obscuring a colleague's notation that the Member had failed to document the administration of medication to [Patient C], thereby altering the colleague's notation.

The Panel dismisses Allegations 1(c) and 4(c) on the basis that, on the balance of probabilities, it is more likely that the Member did not in fact administer the Percocet in question to [Patient C]. While the medication was shown as being withdrawn by the ADC records, [Patient C]'s MAR did not initially show any administration of the medication to [Patient C]. If, as the Panel finds, the Member did not administer that medication, she cannot be found to have failed to document its administration as alleged.

In connection with Allegations 1(d) and 4(d), the Panel accepts the evidence of nurse [Witness 2] about the state of [Patient C]'s chart when she first looked at it, what she entered on that chart in an attempt to reflect the possible administration of medication which the ADC report suggested (but [Patient C]'s MAR did not) and the subsequent change to [Witness 2]'s notation on [Patient C]'s chart.

The evidence also establishes that, at the meeting on November 22, 2017, the Member admitted that she had altered [Witness 2]'s notation on [Patient C]'s MAR.

Nursing expert M.B.'s evidence was that a member altering a colleague's notation on a chart would fail to meet the requirements of the *Documentation Standard*, Revised 2008 which requires any original note to remain visible and precludes one member from altering another's documentation.

This evidence is sufficient to establish Allegation 1(d).

With respect to Allegation 4(d), as it relies on the same alleged conduct by the Member as Allegation 1(d), its factual basis is also established.

For the same reasons set out above in respect of Allegation 4(b), the Panel concludes that the Member's conduct in this respect would reasonably be regarded by members of the College as unprofessional and dishonourable but the Panel does not consider that it reaches the level of being disgraceful.

<u>Allegations 1(e), 1(f), 1(g), 1(h), 2(a), 2(b), 3(a), 3(b), 4(e), 4(f), 4(g), 4(h), 4(i) and 4(j)</u>

All of these allegations concern the alleged withdrawal by the Member of Oxycodone for [Patient D] at various times as alleged on June 3, 2017 and June 4, 2017 followed by the Member's alleged failure to administer the medications withdrawn and the Member's falsification of [Patient D]'s patient records to show that she had in fact administered the Oxycodone to [Patient D]. Allegations 2(a) and 2(b) further allege that the Member misappropriated the Oxycodone withdrawn.

The ADC records for [Patient D] entered as exhibits show that the Member withdrew Oxycodone for [Patient D] at the various times alleged on June 3, 2017 and June 4, 2017 and [Patient D]'s MAR contains documentation by the Member that she administered Oxycodone to [Patient D] at the times alleged on June 3, 2017 and June 4, 2017.

The Panel accepts that the ADC record for [Patient D] is accurate. The main factual issue is whether [Patient D]'s MAR is also accurate or whether it was falsified by the Member.

The Panel accepts [Patient D]'s forthright testimony that she was certain that the Member had not given her any Oxycodone on June 3, 2017 or June 4, 2017. [Patient D] was a very impressive factual witness with excellent recall of her interactions with the Member. Accordingly, on the balance of probabilities, it is established that the Member did not in fact administer any Oxycodone to [Patient D] on June 3, 2017 or June 4, 2017.

It follows from that determination, that [Patient D]'s MAR is inaccurate in documenting that the Member did administer Oxycodone to [Patient D] at the various times in question.

The remaining factual issues are (i) whether the Member "falsified" the MAR as alleged or whether there is a more innocent reason for the MAR's inaccuracy and (ii) whether the Member misappropriated the Oxycodone not administered to [Patient D], as alleged.

Since the Member did not attend the hearing, the Panel has not had the opportunity to hear any explanation from her of the inaccurate documentation on [Patient D]'s MAR. Given the number of instances of documentation showing the administration of Oxycodone to [Patient D]. which the Panel has found did not in fact occur, it is difficult to conclude that those documentation inaccuracies were mere errors. Accordingly, the Panel finds on the balance of probabilities that these documentation errors were the result of an intentional effort by the Member to falsify [Patient D]'s MAR.

The Panel further finds on the balance of probabilities that the Member misappropriated the Oxycodone not administered to [Patient D], as alleged. In November 2017, at the meeting with, among others, [Witness 3], The Member admitted to [Witness 3] that she had taken at least some of the medication intended for [Patient D]. Further, it is difficult to conceive of any purpose on the Member's part for withdrawing and not administering the medication other than in order to misappropriate it.

M.B.'s evidence was that a member who withdrew but did not administer medication and then falsely documented the administration would be in breach of several professional standards, namely the Professional Standards requiring ethical nursing, the *Medication Standard*, Revised 2015 and the *Documentation Standard*, Revised 2008.

This evidence is sufficient to establish Allegations 1(e), 1(f), 1(g), 1(h), 2(a), 2(b), 3(a) and 3(b).

With respect to Allegations 4(e), 4(f), 4(g), 4(h), 4(i) and 4(j), as these allegations rely on the same alleged conduct as Allegations 1(e), 1(f), 1(g), 1(h), 2(a), 2(b), 3(a) and 3(b), the factual basis for them is also established.

The Panel considers that the Member's conduct in withdrawing Oxycodone for [Patient D], falsely documenting its administration on [Patient D]'s MAR and misappropriating the Oxycodone, all on multiple occasions, represented a serious and, given the number of instances of misconduct, persistent disregard for her professional obligations. The Member's conduct in this respect also showed an element of moral failing and casts doubt on the Member's moral fitness to discharge her obligations as a nurse because of the dishonesty and deceit involved in her actions. The Member

would have known, or ought to have known, that her conduct was unacceptable and fell well below the standards of a professional. Further, the Member's dishonest conduct had the effect of shaming both the Member and the profession.

Accordingly, the Panel concludes that the Member's conduct in this respect would reasonably be regarded by members of the College as unprofessional, dishonourable and disgraceful.

Allegations 1(i) (i), 1(j), 2(c), 4(k) and 4(l)

These allegations relate to the Member's interactions with [Patient E]. As College Counsel acknowledged, The College's position is made in the alternative in respect of these Allegations.

The College's primary position is that the Member withdrew Percocets for [Patient E] at 1621 on October 8, 2017 but did not administer them to [Patient E] and instead misappropriated them. In the alternative, if the Panel finds that the Member did administer the Percocets withdrawn at 1621 to [Patient E], the College's position is that the Member did not document that administration and that she then administered another dose of Percocet to [Patient E] at 1850 on October 8, 2017, less than three hours after the last administration, contrary to the medication order.

The ADC records for [Patient E] entered as an exhibit make it clear that the Member withdrew Percocets for [Patient E] at 1621 and 1846 on October 8, 2017. [Patient E]'s MAR contains no documentation corresponding to the withdrawal at 1621 but does contain documentation by the Member that she administered Percocets to [Patient E] at 1850 on October 8, 2017.

The Panel accepts that the ADC for [Patient E] is accurate. The principal factual issue, therefore, is whether the Member administered the Percocets withdrawn at 1621 to [Patient E] and did not document that administration or whether she instead did not administer the medication. If the latter is determined to have occurred, the further question of whether the Member misappropriated the Percocets arises.

The Member made a form of admission to [Witness 3] in November 2017 that she may have taken some medication intended for [Patient E] but could not remember [Patient E] well. The Panel declines to place any weight on this equivocal statement by the Member.

However, the NBRHC's records are clear and contain no documentation that the Percocets withdrawn by the Member at 1621 on October 8, 2017 were ever administered to [Patient E]. The Panel finds it difficult, in these circumstances, to identify any basis for inferring, given the evidentiary record in this matter as a whole, that the administration occurred but was not documented. Rather, it is more likely that the Member did not administer these medications to [Patient E].

Accordingly, the Panel finds on the balance of probabilities that the Member did not administer the Percocets she withdrew at 1621 to [Patient E].

M.B.'s evidence was that a member who withdrew but did not administer medication would be in breach of both the *Professional Standards*, Revised 2008 and the *Medication Standard*, Revised 2015.

The remaining factual issue is whether the Member misappropriated the Percocets which the Panel has found that she withdrew for [Patient E] but did not administer. As outlined above in connection with the allegations against the Member involving [Patient D], the Panel finds it difficult to conceive of any purpose the Member might have had to withdraw and not administer these Percocets other than to misappropriate them. No evidence of any such purpose was before the Panel.

Accordingly, the Panel finds, on the balance of probabilities, that the Member misappropriated the Percocets she withdrew at 1621 on October 8, 2017 for [Patient E].

The evidence is, therefore, sufficient to establish Allegations 1(i) (i) and 2(c). Since Allegations 1(i) (ii), 1(j), 4(k) and 4(l) (iii) are all predicated on a finding that the Member did in fact administer the Percocets withdrawn at 1621 to [Patient E] but did not document that administration, it follows from the Panel's finding to the contrary, that all of those allegations must be dismissed.

With respect to Allegations 4(l) (i) and 4(l) (ii), the factual basis for these allegations is established given the Panel's factual findings above.

For many of the same reasons outlined above in connection with the Allegations involving the Member's conduct with [Patient D], the Panel finds that the Member's conduct in this respect would reasonably be regarded by members of the College as unprofessional, dishonourable and disgraceful. In summary, the Member's conduct showed a disregard for her professional obligations as well as an element of moral failing given the dishonesty involved. The Member's conduct shamed herself and the profession.

<u>Allegations 1(k), 2(d) and 4(m)</u>

These allegations all allege that the Member withdrew Percocets for [Patient F] at 0907 and 1334 on November 18, 2017 which she did not administer. Allegation 2(d) alleges in addition that the Member misappropriated the medications withdrawn.

The ADC records for [Patient F] entered as an exhibit make it clear that the Member withdrew Percocets for [Patient F] at 0907 and 1334 on November 18, 2017. [Patient F]'s MAR contains no documentation that those medications were administered to [Patient F]. The Member was not assigned to care for [Patient F] on November 18, 2017.

Later in November 2017, the Member made a clear admission to [Witness 3] that she had taken these Percocets that she had withdrawn for [Patient F].

The Panel accepts that the ADC for [Patient F] is accurate. In addition, the Member's clear admission that she took these Percocets withdrawn for [Patient F], combined with the lack of any documentation in the MAR for [Patient F] indicating that these medications had been administered to him, constitute a sufficient evidentiary basis for the Panel to find, as it does, that, on the balance of probabilities, the Member did not administer the Percocets withdrawn for [Patient F] on November 18, 2017, as alleged.

As to whether the Member misappropriated these Percocets, the Panel finds, on the balance of probabilities, that the Member misappropriated them generally for the same reasons the Panel

determined above that the Member had misappropriated medications withdrawn for [Patient D] and [Patient E]. In addition, in this instance, the Panel relies on the Member's clear admission that she had taken these Percocets.

M.B.'s evidence was that a member who withdrew medication which he or she did not administer would be in breach of the Professional Standards and the *Medication Standard*, Revised 2015.

This evidence is sufficient to establish Allegations 1(k) and 2(d). Since Allegation 4(m) relies on the same alleged conduct as Allegations 1(k) and 2(d), its factual basis is also established.

As with various other similar allegations against the Member addressed above, the Panel concludes, in connection with Allegation 4(m) that the Member's conduct in withdrawing medication for [Patient F] (who was not her patient) and then not administering it but misappropriating it instead would reasonably be regarded by members of the College as unprofessional, dishonourable and disgraceful.

The Panel's reasons in connection with its decisions in respect of other factually similar allegations involving the withdrawal and non-administration of medications apply equally here with any necessary amendments required given the slight changes in the circumstances."

Allegations 1(l) and 4(n)

Both of these very general allegations allege that the Member, between approximately February 2015 and December 2017, misappropriated for her personal use Percocets from NBRHC that were prescribed to patients. The allegations contain no specifics about what the dates of the alleged misappropriations were or who the patients in question were.

The evidence presented at the hearing did not address either of those issues. There was no specific evidence presented about any particular misappropriation of medication, other than that presented in respect of one or more of the many specific allegations contained in the Notice of Hearing affecting specific patients identified in that Notice of Hearing.

The only evidence relied on by the College to establish these general allegations consisted of [Witness 3]'s evidence that, at the November 2017 meeting, the Member admitted that she had, since a motor vehicle accident in 2015, been self-medicating. According to [Witness 3], the Member further indicated that she would obtain medications from ADC's intended for patients who were confused or would not realize they had missed their medications. [Witness 3]'s evidence did not specifically include an admission by the Member that the medications she was referring to were Percocets, as alleged.

Given this very limited and general evidence, the Panel is unable to conclude that the required factual basis for Allegations 1(l) and 4(n) has been established on the balance of probabilities. In the absence of any specifics about when any of the alleged misappropriations occurred, what medications were involved, who the relevant patients were and in the absence of more compelling evidence that these unspecified misappropriations were, in fact, for the Member's personal use, the Panel has concluded that these Allegations must be dismissed.

In the interests of clarity, the Panel adds that it is not prepared to rely on any of the evidence introduced by the College to support any of the specific allegations of misappropriation by the Member contained in Allegation 2 or Allegations 4(f), 4(i) or 4(l) (ii) of the Notice of Hearing to establish either of the general allegations contained in Allegations 1(l) or 4(n). It should also be noted in fairness that College Counsel did not submit that the Panel should do so.

Penalty Submissions

College Counsel submitted that the Panel should make the following penalty order:

1. Requiring the Member to appear before the Panel to be reprimanded within 3 months of the date that the Member obtains an active certificate of registration.

2. Directing the Executive Director to suspend the Member's certificate of registration for 8 months. This suspension shall take effect from the date that the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

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

    a) The Member will attend a minimum of 2 meetings with a Nursing Expert (the "Expert") at her own expense and within 6 months from the date that the Member obtains an active certificate of registration. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

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

        ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. if available, a copy of the Panel's Decision and Reasons;

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

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

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

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

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

v. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

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

b) For a period of 24 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

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

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

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.

College Counsel further submitted that this proposed penalty was reasonable and in the public interest as it meets the goals of penalty.

College Counsel submitted that the only mitigating factor was that the Member has no past discipline history with the College.

The Member did not attend the hearing, therefore there were no other mitigating factors identified.

The aggravating factors are:

- The seriousness of the allegations;
- The vulnerability of the post surgical patient population who required pain control;
- The Member failed to ensure that her patients received pain medications;
- This conduct left her colleagues and patients in confusion as to when the patients could receive more pain medication;
- False documentation of medication documentation is deceitful and shameful in that the Member had not administered the medication and, in fact, misappropriated the medication;
- The conduct undermined the trust of patients and colleagues, when the Member misappropriated medication, falsely documented and was untruthful when she was confronted;
- The conduct occurred over a period of time and with a number of patients.

College Counsel submitted to the Panel that general deterrence is met through the proposed penalty and will send a message to the profession that this type of behaviour will not be tolerated. College Counsel submitted that there was no evidence of remorse, responsibility or accountability or other kinds of explanations provided by the Member. The Member did not attend or participate in the hearing, nor provide any mitigating factors.

Specific deterrence to the Member will be achieved in the reprimand, suspension and terms, conditions and limitations on her certificate of registration. All these aspects of the proposed penalty will assist in ensuring the Member understands the seriousness of her conduct so as to avoid it in the future. As to remediation and rehabilitation, College Counsel submitted that the Panel does not have evidence that the Member is on the road to rehabilitation at this time, but she will have an opportunity to meet with a nursing expert for reflection and insight once the Member's certificate of registration becomes active.

The ultimate goal of penalty is public protection. The public is protected by all the components but especially the period of employer notification which will provide extra oversight of the Member. Prohibition of independent practice for a period of 24 months will ensure that the Member will practise in an environment that will provide this oversight and supervision.

College Counsel presented the Panel with three similar cases to illustrate that the proposed penalty was within a reasonable range.

CNO v Genereaux (2018)
The member misappropriated narcotics from a patient on 3 occasions. The member as in this case did not attend the hearing and therefore there were no mitigating factors from the member's perspective. She was also found guilty of break and entering and failed to report this to the College. She was a care supervisor in a retirement home and caught on video camera misappropriating the medication. The member received; a reprimand, a 7 months suspension, 2 meetings with a nursing expert, 24 months employer notification, and 18 months prohibition on independent practice. College Counsel submitted that this misconduct was a discrete act of misappropriation on only 3 occasions from the same patient and accordingly less serious than the Member's conduct as found by the Panel as no falsification of records or breach of the Standards of Practice were involved.

CNO v Reinhart (2018)
Counsel submitted that this case proceeded by way of an Agreed Statement of Facts and Joint Submission on Order. The member misappropriated narcotics and falsified documentation. The member suffered from an unspecified medical condition. The member agreed to: a reprimand, a 5 month suspension, 2 meetings with a nursing expert, 18 months employer notification, and 18 months of prohibition on independent practice. College Counsel submitted that the *Reinhart* case required a less significant regulatory response than the present one both because there was less serious misconduct involved and because there was the mitigating factor of an Agreed Statement of Facts and Joint Submission on Order.

CNO v Wardlaw (2018)
The member was a homecare nurse to a 13 year old patient with terminal brain cancer. The member was found to be impaired leaving the patient's home. The member took and used medications from the patient for herself. The hearing was completed by way of an Agreed Statement of Facts and Joint Submission on Order. The member received a reprimand and revocation. The member had a history with the Fitness to Practice Committee and had failed several attempts at remediation. In order to ensure public protection, revocation was ordered.

Penalty Decision

The panel makes the following order as to penalty:

1. The Member is required to appear before the Panel to be reprimanded within 3 months of the date that the Member obtains an active certificate of registration.

2. The Executive Director is directed to suspend the Member's certificate of registration for 8 months. This suspension shall take effect from the date that the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in the practising class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:
    a) The Member will attend a minimum of 2 meetings with a Nursing Expert (the "Expert") at her own expense and within 6 months from the date that the Member obtains an active certificate of registration. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date that the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

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

        ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. if available, a copy of the Panel's Decision and Reasons;

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

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

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

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

v. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

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

b) For a period of 24 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of:

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member's employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:

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

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

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 general deterrence, specific deterrence and, where appropriate, rehabilitation and remediation. The penalty is in line with what has been ordered in previous cases.

The Panel has concluded that the Order proposed is reasonable and in the public interest. It satisfies the principles of general and specific deterrence by the reprimand and the length of the suspension, which addresses the seriousness of the misconduct. Misappropriation of narcotics ordered and meant for patients and the falsification of records, which put patients at risk during their recovery is a serious breach of the Standards of Practice which nurses are expected to follow.

The penalty also allows the Member to return to the profession once she has an opportunity to reflect on and gain insight into the reasons for her misconduct. The Member will then be monitored and supported for a full twenty-four months to protect the public on her return to active practice.

I, Terry Holland, 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.