DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Heather Stevanka, RN	Chairperson
David Edwards, RPN	Member
George Rudanycz, RN	Member
Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JESSICA LATIMER for
	)	College of Nurses of Ontario
- and -	)	
	)	
JEMMEL MARCANO	)	NO REPRESENTATION for
Registration No. JG679194	)	Jemmel Marcano
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: January 9, 2020

AMENDED DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on January 9, 2020 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(h), 2(h), 2(i) and 3(h) of the Notice of Hearing dated December 17, 2019. The Panel granted this request. The remaining allegations against Jemmel Marcano (the "Member") are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at North York General Hospital (the "Facility"), in Toronto,

Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

a. on or about February 16, 2015, you failed to complete a proper assessment of [Patient A]; and/or

b. on or about May 8, 2015, you failed to complete a proper assessment of [Patient B]; and/or

c. on or about May 8, 2015, you failed to provide a full report to the Nurse Practitioner to ensure proper transfer of care in relation to [Patient B]; and/or

d. on or about June 8, 2015, you failed to provide appropriate care to [Patient C] by not completing a proper assessment, not reporting [the patient's] condition to the Most Responsible Physician, *and/or not assessing [the patient's] blood pressure in accordance with an order;* and/or

e. on or about June 8, 2015, you failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment and findings rather than your own; and/or

f. on or about June 8, 2015, you failed to provide appropriate care to [Patient D] by not completing a proper assessment, not reporting [the patient's] condition to the Most Responsible Physician, and/or not assessing [the patient's] blood pressure in accordance with an order; and/or

g. on or about June 8, 2015, you failed to provide appropriate care to [Patient E] by not assessing [the patient's] blood pressure in accordance with an order, not notifying the Most Responsible Physician of [the patient's] vitals*, and/or not managing [the patient's] pain including completing a thorough pain assessment;* and/or

h. [withdrawn]; and/or

i. on or about August 24-25, 2015, you failed to provide appropriate care to [Patient F] by administering Metformin to [the patient] post-IV CT contract, contrary to the physician's orders to withhold Metformin for 48 hours post-CT, if IV contrast was administered, and/or by failing to read the [patient] chart to hold medication; and/or

j. on or about August 25, 2015, you failed to provide appropriate care to [Patient G] by not completing a proper assessment of [the patient], not initiating the physician's order to transfuse [the patient] post paracentesis, and/or not documenting the amount of fluid withdrawn from [the patient]; 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(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at the Facility, you failed to keep records as required, and in particular:

a. on or about February 16, 2015, you failed to complete a proper assessment of [Patient A]; and/or

b. on or about May 8, 2015, you failed to complete a proper assessment of [Patient B]; and/or

c. on or about June 8, 2015, you failed to complete a proper assessment of [Patient C]; and/or

d. on or about June 8, 2015, you failed to fully and accurately document with respect to [Patient C], including in the Patient Care Handoff and/or when the Most Responsible Physician was notified of [the patient's] condition; and/or

e. on or about June 8, 2015, you failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment and findings rather than your own; and/or

f. on or about June 8, 2015, you failed to complete a proper assessment of [Patient D]; and/or

g. on or about June 8, 2015, you failed to fully and accurately document with respect to [Patient D], including in the Patient Care Handoff and/or when the Most Responsible Physician was notified of [the patient's] condition; and/or

h. [withdrawn]; and/or

i. [withdrawn]; and/or

j. on or about August 25, 2015, you failed to complete a proper assessment of [Patient G] and/or failed to document the amount of fluid withdrawn from [the patient]; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while employed as a Registered Practical Nurse at the Facility, 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 of the profession as disgraceful, dishonourable or unprofessional, and in particular:

a. on or about February 16, 2015, you failed to complete a proper assessment of [Patient A]; and/or

b. on or about May 8, 2015, you failed to complete a proper assessment of [Patient B]; and/or

c. on or about May 8, 2015, you failed to provide a full report to the Nurse Practitioner to ensure proper transfer of care in relation to [Patient B]; and/or

d. on or about June 8, 2015, you failed to provide appropriate care to [Patient C] by not completing a proper assessment, not reporting [the patient's] condition to the Most

Responsible Physician, *and/or not assessing [the patient's] blood pressure in accordance with an order;* and/or

e. on or about June 8, 2015, you failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment and findings rather than your own; and/or

f. on or about June 8, 2015, you failed to provide appropriate care to [Patient D] by not completing a proper assessment, not reporting [the patient's] condition to the Most Responsible Physician, and/or not assessing [the patient's] blood pressure in accordance with an order; and/or

g. on or about June 8, 2015, you failed to provide appropriate care to [Patient E] by not assessing [the patient's] blood pressure in accordance with an order, not notifying the Most Responsible Physician of [the patient's] vitals, *and/or not managing [the patient's] pain including completing a thorough pain assessment;* and/or

h. [withdrawn]; and/or

i. on or about August 24-25, 2015, you failed to provide appropriate care to [Patient F] by administering Metformin to [the patient] post-IV CT contract, contrary to the physician's orders to withhold Metformin for 48 hours post-CT, if IV contrast was administered, and/or by failing to read [the patient] chart to hold medication; and/or

j. or about August 25, 2015, you failed to provide appropriate care to [Patient G] by not completing a proper assessment of [the patient], not initiating the physician's order to transfuse [the patient] post paracentesis, and/or not documenting the amount of fluid withdrawn from [the patient].

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Jemmel Marcano (the "Member") obtained a diploma in nursing from George Brown College in 2006.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse on March 9, 2007.

3. The Member was employed at North York General Hospital (the "Hospital") from February 2, 2009 to October 20, 2015, when her employment was terminated as a result of the incidents set out below.

4. During the time period at issue, the Member had recently returned to work following an injury. She was on modified duties as a result.

THE HOSPITAL

5. The Hospital is located in Toronto, Ontario.

6. The Member worked on the Acute Care Unit as a part-time staff nurse on day and evening shifts.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

[Patient A]

7. On February 16, 2015, the Member worked the evening shift and was assigned to [Patient A], who was 90 years old, palliative and was admitted with community-acquired pneumonia.

8. During her shift, the Member was responsible for conducting an assessment of [Patient A]. Her documented assessment was inadequate in light of [Patient A's] condition and circumstances, as it was missing the following important elements: nail bed assessment to check for capillary refill, cardiovascular (pulses), respiratory assessment, oxygen delivery device to patient and integumentary assessment.

9. If the Member were to testify, she would state that she did not perform these assessments because [Patient A] was palliative and under a "comfort measures only" order at the time. However, the Member acknowledges that the physician had not discontinued these assessments, and therefore she should have performed them.

10. The Member acknowledges that she failed to complete a proper assessment of [Patient A]. The Member further recognizes, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below with respect to [Patient A].

[Patient B]

11. On May 8, 2015, the Member worked the day shift, from 0730 to 1530 hrs. She was assigned to [Patient B], who was elderly and had been admitted following a stroke. [Patient B] was experiencing residual effects of the stroke, including being combative and resistant to care.

12. A Nurse Practitioner ("NP") was also involved in [Patient B's] care. The NP asked the Member how [Patient B] had been during the night, and the Member responded that he was "the same," rather than providing more detailed information, such as an update on how he slept and his behaviour. The Member's response was not fulsome and did not ensure proper transfer of care.

13. The Member was responsible for conducting an assessment of [Patient B] on her shift. There was an order in place to complete a focussed neurological assessment. The Member's documented assessment of [Patient B], did not include a focussed neurological assessment or a head to toe assessment, despite [Patient B's] condition and as required by the Hospital.

14. The Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below, with respect to [Patient B].

[Patient C]

15. On June 8, 2015, the Member worked the day shift, from 0730 to 1530 hrs. She was assigned to [Patient C], who had been admitted approximately two weeks earlier with a lower GI bleed. [Patient C] was scheduled for surgery to correct the lower GI bleed later that day.

16. The Member documented that [Patient C] had five frank bloody stools, but she did not communicate this fact to the physician. The Hospital's expectation was that the Member would complete a communication form to the physician in [Patient C's] patient record, which she did not do. The information about the bloody stools was also not included in the Transfer of Accountability portion of the record, which was used to share information between nurses coming on/off shift, and there was no follow up by the Member on [Patient C's] condition noted in the record.

17. The Member was responsible for conducting assessments of [Patient C]. The Member did not complete a GI assessment module, even though [Patient C] was admitted with GI conditions.

18. The Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below, with respect to [Patient C].

[Patient D]

19. On June 8, 2015, the Member worked the day shift, from 0730 to 1530 hrs, and was assigned to [Patient D], who had been admitted three days earlier with chronic obstructive pulmonary disease ("COPD").

20. There was an order in place that [Patient D's] blood pressure be assessed every four hours. The Member checked [Patient D's] blood pressure at 0800 hrs, but not again for the rest of her shift, as required.

21. There was also a physician's order that oxygen saturation be kept at 88-92%. The Member charted oxygen saturation at 96% (on June 8) and 95% (on June 9), and did not titrate the oxygen to a lower flow. She also did not report any issue to [Patient D's] physician.

22. The Member was responsible for conducting assessments of [Patient D]. The Member's documentation of [Patient D's] assessment was inadequate in light of the patient's condition of COPD as it was missing the following important elements: a focused respiratory assessment, follow-up pain assessment, re-check of oxygen saturation and reassessment of breath sounds. The Member charted "diminished all lobes" in her general assessment, but she did not complete a focused respiratory assessment, or reassess the patient, as would have been expected by the Hospital in these circumstances.

23. The Member also documented that [Patient D] had subcutaneous emphysema, as a result of something she read in x-ray results, but she did not take any steps to independently verify this diagnosis, and instead relied on another healthcare provider's assessment. As well, the Member did not communicate this issue to [Patient D's] physician. The patient did not, in fact, have subcutaneous emphysema – the Member misunderstood a note in the patient's x-ray results stating "severe emphysematous changes seen in the lung apices similar to previous".

24. Additionally, on the Transfer of Accountability document, the Member noted that [Patient D's] chest was clear, but her respiratory assessment in the patient record indicated "diminished all lobes." She did not leave any communication notes for the physician regarding diminished air entry or explain this discrepancy.

25. If the Member were to testify, she would say that, at the time, she believed that the nursing student and clinical instructor who were present would complete the charting in relation to this patient's condition. However, she acknowledges that she now realizes she was accountable for completing assessments and documentation in respect of [Patient D].

26. The Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below, with respect to [Patient D].

[Patient E]

27. On June 8, 2015, the Member was also assigned to [Patient E], who had been admitted just over a week earlier with a diagnosis of shock. There was an order in place that the patient's blood pressure be assessed every six hours. The Member failed to check [Patient E's] blood pressure at 1400 hrs, as required.

28. On June 9, 2015, the Member was working the day shift, from 0730 to 1530 hrs, and was assigned to [Patient E]. The Member documented [Patient E's] vitals in the morning, including blood pressure of 96/54. She notified the physician and indicated that she would continue to monitor [Patient E], but she did not document in the patient record that she rechecked the blood pressure for the remainder of her shift.

29. The Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below, with respect to [Patient E]. The Member acknowledges that she should have followed the physician's order to check blood pressure.

[Patient F]

30. On August 25, 2015, the Member worked a day shift, from 0730 to 1530 hrs, and provided care to [Patient F].

31. [Patient F] underwent an abdominal CT with contrast, and then returned to the unit, during the course of the Member's shift.

32. The Hospital's policy is to hold the administration of Metformin for any patient who is post-IV CT contrast. As a result, there was a hold in [Patient F's] Medication Administration Record, as well as flags in other areas of [Patient F's] chart. Despite this, the Member administered Metformin to [Patient F] on August 25, 2015.

33. The Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards*, *Documentation* and *Medication* standards, as set out below, with respect to [Patient F].

[Patient G]

34. On August 25, 2015, the Member was assigned to [Patient G] post paracentesis procedure. She had been given notice that [Patient G] would need an immediate blood transfusion when he returned to the unit. Upon his return, the Member was provided with a report indicating that [Patient G's] vital signs were dropping (blood pressure of 90/52) and that he was dehydrated, hypotensive and required albumin transfusion in a timely manner.

35. Despite the report, the Member fed [Patient G] first, instead of initializing the blood transfusion. The Member also did not document that she did a thorough assessment of [Patient G], including not documenting the amount of fluid withdrawn from [Patient G] or vital signs. This failure to document, with respect to the amount of fluid, meant that the nurse relieving the Member and who needed to do the blood transfusion did not know how many units of albumin to transfuse. This nurse had to take the time to seek this information by calling the physician.

36. If the Member were to testify, she would say that she made the decision to give [Patient G] food prior to the transfusion because, when she checked [Patient G's] blood pressure, it was stable, and he was asymptomatic and alert. She would also state that [Patient G's] family were present and requested that he be fed. Nevertheless, the Member acknowledges, and the parties agree, that she breached CNO's *Professional Standards* and *Documentation* standard, as set out below, with respect to [Patient G].

CNO STANDARDS

Professional Standards

37. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of practice of the profession. A nurse demonstrates this standard by actions such as:

    a. providing, facilitating, advocating and promoting the best possible care for [patients];

    b. assessing/describing the [patient] situation using a theory, framework or evidence-based tool;

    c. identifying/recognizing abnormal or unexpected [patient] responses and taking action appropriately;

    d. advocating on behalf of [patients];

    e. seeking assistance appropriately and in a timely manner;

    f. taking action in situations in which [patient] safety and well-being are compromised; and

    g. evaluating/describing the outcomes of specific interventions and modifying the plan/approach.

Documentation

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

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

39. The *Documentation* standard provides that nurses are accountable for ensuring their documentation of [patient] care is "accurate, timely and complete." The standard further

clarifies that a nurse meets the standard by documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event.

40. The *Documentation* standard also requires that nurses communicate effectively and specifically states:

> Nurses ensure that documentation presents an accurate, clear and comprehensive picture of the [patient's] needs, the nurse's intervention and the [patient's] outcome.

41. A nurse also meets the standard by ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation. In relation to assessments, this method of communicating important information to other health team members "demonstrates the nurse's commitment to providing safe, effective and ethical care by showing accountability for professional practice and the care the [patient] receives, transferring knowledge about the [patient's] health history" and demonstrates that the nurse has applied within the therapeutic nurse-client relationship the "nursing knowledge, skill and judgment required".

Medication

42. CNO's *Medication* standard describes nurses' accountabilities when engaging in medication practices. Among other things, nurses are to follow medication orders or explain any deviation from an order.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

43. The Member admits that she committed the acts of professional misconduct as described in paragraphs 7 to 42 above, in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as alleged in the Notice of Hearing, as follows:

- 1(a) in that, on or about February 16, 2015, she failed to complete a proper assessment of [Patient A].
- 1(b) in that, on or about May 8, 2015, she failed to complete a proper assessment of [Patient B].
- 1(c) in that, on or about May 8, 2015, she failed to provide a full report to the NP to ensure proper transfer of care in relation to [Patient B].
- 1(d) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient C] by not completing a proper assessment and not reporting the patient's condition to the most responsible physician.

- 1(e) in that, on or about June 8, 2015, she failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment, rather than her own.

- 1(f) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient D] by not completing a proper assessment, not reporting the patient's condition to the most responsible physician and not assessing the patient's blood pressure in accordance with an order.

- 1(g) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient E] by not assessing the patient's blood pressure in accordance with an order and not notifying the most responsible physician of the patient's vitals.

- 1(i) in that, on or around August 25, 2015, she failed to provide appropriate care to [Patient F] by administering Metformin to the patient post-IV CT contrast, contrary to a physician's order to withhold Metformin for 48 hours post-CT and by failing to read the patient's chart where it was noted the medication should be held.

- 1(j) in that, on or about August 25, 2015, she failed to provide appropriate care to [Patient G] by not completing a proper assessment of the patient, not initiating the physician's order to transfuse the patient post paracentesis, and not documenting the amount of fluid withdrawn from the patient.

44. The Member admits that she committed the acts of professional misconduct as described in paragraphs 7 to 36 above, in that she failed to keep records as required, as alleged in the Notice of Hearing, as follows:

- 2(a) in that, on or about February 16, 2015, she failed to complete a proper assessment of [Patient A].

- 2(b) in that, on or about May 8, 2015, she failed to complete a proper assessment of [Patient B].

- 2(c) in that, on or about June 8, 2015, she failed to complete a proper assessment of [Patient C].

- 2(d) in that, on or about June 8, 2015, she failed to fully and accurately document with respect to [Patient C].

- 2(e) in that on or about June 8, 2015, she failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by

documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment, rather than her own.

- 2(f) in that, on or about June 8, 2015, she failed to complete a proper assessment of [Patient D].

- 2(g) in that, on or about June 8, 2015, she failed to fully and accurately document with respect to [Patient D].

- 2(j) in that, on or about August 25, 2015, she failed to complete a proper assessment of [Patient G] and failed to document the amount of fluid withdrawn from the patient.

45. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3 (a), (b), (c), (d), (e), (f), (g), (i) and (j) of the Notice of Hearing, and in particular, her conduct was unprofessional, as described in paragraphs 7-36 above.

OTHER

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

- 1(h)
- 2(i)
- 2(h)
- 3(h)

Decision

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged *in the following paragraphs of the Notice of Hearing:*

- *1(a) in that, on or about February 16, 2015, she failed to complete a proper assessment of [Patient A].*

- *1(b) in that, on or about May 8, 2015, she failed to complete a proper assessment of [Patient B].*

- *1(c) in that, on or about May 8, 2015, she failed to provide a full report to the NP to ensure proper transfer of care in relation to [Patient B].*

- *1(d) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient C] by not completing a proper assessment and not reporting the patient's condition to the most responsible physician.*

- *1(e) in that, on or about June 8, 2015, she failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment, rather than her own.*

- *1(f) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient D] by not completing a proper assessment, not reporting the patient's condition to the most responsible physician and not assessing the patient's blood pressure in accordance with an order.*

- *1(g) in that, on or about June 8, 2015, she failed to provide appropriate care to [Patient E] by not assessing the patient's blood pressure in accordance with an order and not notifying the most responsible physician of the patient's vitals.*

- *1(i) in that, on or around August 25, 2015, she failed to provide appropriate care to [Patient F] by administering Metformin to the patient post-IV CT contrast, contrary to a physician's order to withhold Metformin for 48 hours post-CT and by failing to read the patient's chart where it was noted the medication should be held.*

- *1(j) in that, on or about August 25, 2015, she failed to provide appropriate care to [Patient G] by not completing a proper assessment of the patient, not initiating the physician's order to transfuse the patient post paracentesis, and not documenting the amount of fluid withdrawn from the patient.*

- *2(a) in that, on or about February 16, 2015, she failed to complete a proper assessment of [Patient A].*

- *2(b) in that, on or about May 8, 2015, she failed to complete a proper assessment of [Patient B].*

- *2(c) in that, on or about June 8, 2015, she failed to complete a proper assessment of [Patient C].*

- *2(d) in that, on or about June 8, 2015, she failed to fully and accurately document with respect to [Patient C].*

- *2(e) in that on or about June 8, 2015, she failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment, rather than her own.*

- *2(f) in that, on or about June 8, 2015, she failed to complete a proper assessment of [Patient D].*

- *2(g) in that, on or about June 8, 2015, she failed to fully and accurately document with respect to [Patient D].*

- *2(j) in that, on or about August 25, 2015, she failed to complete a proper assessment of [Patient G] and failed to document the amount of fluid withdrawn from the patient.*

As to Allegations #3(a), (b), (c), (d), (e), (f), (g), (i) and (j), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be unprofessional *with respect to the following allegations:*

- *3(a) on or about February 16, 2015, she failed to complete a proper assessment of [Patient A].*

- *3(b) on or about May 8, 2015, she failed to complete a proper assessment of [Patient B].*

- *3(c) on or about May 8, 2015, she failed to provide a full report to the Nurse Practitioner to ensure proper transfer of care in relation to [Patient B].*

- *3(d) on or about June 8, 2015, she failed to provide appropriate care to [Patient C] by not completing a proper assessment, not reporting [the patient's] condition to the Most Responsible Physician.*

- *3(e) on or about June 8, 2015, she failed to provide accurate and factual documentation based on assessment findings in relation to [Patient D] by documenting in the patient record "subcutaneous emphysema" in reliance on someone else's assessment, rather than her own.*

- *3(f) on or about June 8, 2015, she failed to provide appropriate care to [Patient D] by not completing a proper assessment, not reporting [the patient's] condition to the Most Responsible Physician, and not assessing [the patient's] blood pressure in accordance with an order.*

- *3(g) on or about June 8, 2015, she failed to provide appropriate care to [Patient E] by not assessing [the patient's] blood pressure in accordance with an order and not notifying the Most Responsible Physician of [the patient's] vitals.*

- *3(i) on or about August 25, 2015, she failed to provide appropriate care to [Patient F] by administering Metformin to [the patient] post-IV CT contract, contrary to a physician's orders to withhold Metformin for 48 hours post-CT and by failing to read the [patient] chart where it was noted the medication should be held.*

- *3(j) or about August 25, 2015, she failed to provide appropriate care to [Patient G] by not completing a proper assessment of [the patient], not initiating the physician's order to transfuse [the patient] post paracentesis, and not documenting the amount of fluid withdrawn from [the patient].*

Reasons for Decision

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

Allegation #1 in the Notice of Hearing is supported by paragraphs 8-43 in the Agreed Statement of Facts. These paragraphs show that the Member failed to meet a variety of professional standards by failing to properly assess a number of [patients], failing to accurately document assessment findings and failing to provide appropriate care to multiple [patients].

Allegation #2 in the Notice of Hearing is supported by paragraphs 8-13, 15-17, 19-25, 27-32, 34-36 and 44 in the Agreed Statement of Facts. The Member failed, on multiple occasions, to keep appropriate documentation in relation to [patient] assessments including failing to communicate important [patient] condition changes to the Physician.

With respect to Allegation #3, the Panel finds that the Member's conduct in failing to complete proper assessments, failing to provide full reports, failing to provide accurate documentation and failing to provide appropriate care was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

Penalty

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

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

Penalty Submissions

Submissions were made by College Counsel stating that the Member has signed an Undertaking with the College in which she undertakes as follows:

1. to permanently resign as a member of the College, effective from the date the College accepted this Undertaking; and

2. to not apply for membership with the College at any time in the future.

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

3. The public portion of the Register maintained by the College will indefinitely reflect that the Member entered into an Undertaking with the Executive Director to permanently resign as a member of the College as part of an agreed resolution of allegations of professional misconduct heard by a Panel of the Discipline Committee.

4. The College is authorized to and may, in its sole discretion, provide a copy of this Undertaking and/or its terms to a governing body that regulated nursing in Canada or elsewhere in response to any inquiry.

College Counsel submitted that this Undertaking and Joint Submission on Order had been agreed to by the parties. College Counsel submitted that the reprimand in conjunction with the Undertaking align with the public interest.

College Counsel submitted that the mitigating factors considered were that the Member had no previous disciplinary history with the College, that she has cooperated with the College by coming to an agreement on the facts in this case, she has taken responsibility for her conduct; and has avoided the need for a contested hearing.

College Counsel submitted that the aggravating factors in this case were the seriousness of the Member's conduct, the fact that the conduct was repeated over time, and the potential harm that can result from the conduct including patients receiving inadequate care and possible discredit to the entire nursing profession.

College Counsel submitted that due to the seriousness and repeated occurrence of the conduct, a strong regulatory response was required. With the agreed Undertaking, the proposed penalty supports specific and general deterrence as well as keeping the protection of the public a priority.

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

CNO v. Thomas, 2013

In this case, the member failed on multiple occasions to meet the standards of practice of the profession by failing to keep proper documentation and failing to complete assessment. These allegations were uncontested and proceeded by way of Agreed Statement of Fact. The panel found that the member had commitment acts of professional misconduct and after hearing penalty submissions ordered a verbal reprimand, a three month suspension and a variety of terms, conditions and limitations on the member's certificate of registration.

CNO v. Simeone, 2017

In this case, the member failed on numerous occasions to meet the standards of practice of the profession by failing to provide adequate care, failing to document accurately and failing to provide proper assessments. Proceeding by way of Agreed Statement of Fact, the panel found that the member had committed acts of professional misconduct and that the member engaged in unprofessional conduct. Subsequently, the panel accepted a Joint Submission on Order and ordered an oral reprimand, a five month suspension, and numerous terms, conditions and limitations on the member's certificate of registration.

CNO v. Doey, 2019

In this case, the member's conduct was vastly different in that it dealt with the use of profanity and derogatory statements. Similarly though, the case proceeded by way of Agreed Statement of Fact and the panel found the member had committed acts of professional misconduct. The member agreed to an Undertaking to permanently resign as a member of the College and to not apply for membership with the College at any time in the future. A Joint Submission on Order was also agreed upon by the parties to request an oral reprimand. In light of the member's undertaking, the panel agreed to accept the Joint Submission on Order.

Penalty Decision

The Panel accepts the Joint Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty, in combination with the Undertaking whereby the Member will permanently resign as a member of the College, satisfies the principles of specific and general deterrence, and public protection.

With respect to remediation, the Panel determined the Undertaking eliminated the necessity of this principle as the Member agreed to permanently resign from the profession.

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

I, Heather Stevanka, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.