DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Ingrid Wiltshire-Stoby, NP	Chairperson
	Carly Gilchrist, RPN	Member
	Michael Schroder, NP	Member
	Devinder Walia	Public Member
	Chuck Williams	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
FE AGUSTIN	)	MATTHEW FRIEDBERG for
Registration No. JJ08920	)	Fe Agustin
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 14, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on January 14, 2019 at the College of Nurses of Ontario ("the College") at Toronto.

The Allegations

Counsel for the College advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(b)(i), 2(a)(i), 2(b)(i) and 3(b)(i) of the Notice of Hearing dated December 7, 2018. The Panel granted this request. The remaining allegations against Fe Agustin ("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 you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, and in particular:

    (a) while practising as a Registered Practical Nurse at Sunnybrook Health Sciences Centre in Toronto, Ontario,

(i) on or about August 10, 2016, while assisting a client who had soiled himself, you spoke to the client in a raised voice and/or with an angry tone and/or used words to the effect of “oh there is shit everywhere”;

(ii) on or about August 29, 2016, you struck a client on or around the face with the client’s shoe and/or slipper;

(iii) on or about August 29, 2016, you failed to appropriately document and/or follow-up on your having struck a client on or around the face with the client’s shoe and/or slipper;

(b) (i) [*Withdrawn*]

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation 799/93*, in that you abused a client verbally, physically, or emotionally, and in particular:

(a) while practising as a Registered Practical Nurse at Sunnybrook Health Sciences Centre in Toronto, Ontario,

(i) [*Withdrawn*];

(ii) on or about August 29, 2016, you struck a client on or around the face with the client’s shoe and/or slipper;

(b) (i) [*Withdrawn*]

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 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) while practising as a Registered Practical Nurse at Sunnybrook Health Sciences Centre in Toronto, Ontario,

(i) on or about August 10, 2016, while assisting a client who had soiled himself, you spoke to the client in a raised voice and/or with an angry tone and/or used words to the effect of “oh there is shit everywhere”;

(ii) on or about August 29, 2016, you struck a client on or around the face with the client’s shoe and/or slipper;

(iii) on or about August 29, 2016, you failed to appropriately document and/or follow-up on your having struck a client on or around the face with the client’s shoe and/or slipper;

(b) (i) [*Withdrawn*]

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i)(ii)(iii), 2(a)(ii) and 3(a)(i)(ii)(iii) 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

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

THE MEMBER

1. Fe Agustin (the "Member") obtained a certificate in nursing from the Philippines in 1979.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") on June 22, 2000.

3. The Member was employed at Sunnybrook Health Sciences Centre (the "Hospital") from December 4, 2000 to September 26, 2016, when her employment was terminated as a result of the incidents below.

THE HOSPITAL

4. The Hospital is located in Toronto, Ontario.

5. The Member worked as a full-time staff nurse on the L Wing Second Street East Unit (the "Unit"), which is a 34-bed unit.

6. Clients on the Unit were diagnosed with moderate to severe dementia.

7. Registered staff worked eight hour shifts. The day shift was from 0730 to 1530, the evening shift was from 1530 to 2330 and the night shift was from 2330 to 0730. On the day shift, there were two Registered Nurses ("RN") and five RPNs. On the evening shift, there were two RNs and three RPNs on duty, each assigned to six or seven clients. On the night shift, there was one RN and one RPN on duty.

8. The Member worked on the evening shift.

THE CLIENT

9. [ ] (the "Client") was 96-97 years old at the time of the incidents (the incidents straddled his birthday, [ ]). He suffered from dementia but had some lucid moments. The Client also had issues with his memory.

10. The Client was admitted to the Unit on February 16, 2016.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incident on August 10, 2016

11. On August 10, 2016, the Member worked the evening shift. She was assigned to care for the Client.

12. The Client was in his wheelchair in the hallway. [The co-worker], an Environmental Service Worker, was in the hallway with an Activity Aid when they noticed that the Client had soiled himself and needed to be cleaned. The Activity Aid reported this to the Member.

13. The Member moved the Client in to his room. [The co-worker] could hear the Member yelling at the Client in an angry tone. She said words to the effect of, “oh there’s shit everywhere.”

14. When questioned by the Hospital, the Member admitted using profanity and raising her voice to the Client.

15. If the Member were to testify, she would say that she raised her voice to prevent the Client from putting his hands in the toilet bowl, which the Member says the Client was known to do. In any case, the Member acknowledges that she raised her voice and used inappropriate language towards the Client.

Incident on August 29, 2016

16. On August 29, 2016, the Member worked the evening shift. She was assigned to care for the Client.

17. Around 1700, the Member was getting the Client ready for dinner, but he was resistive. The Client was sitting on the bed, with his legs hanging down. The Member was standing in front of the Client getting ready to transfer him to his wheelchair. The Client’s slippers were on the floor in front of him.

18. [The co-worker] was working in the room next to the Client’s room when she overheard raised voices coming from the Client’s room. The Member said words to the effect of, “you pinched me” and the Client said words to the effect of, “get away from me.” [The co-worker] became concerned and went into the Client’s room to investigate.

19. When [the co-worker] entered the room, the Member was standing in front of the Client, whose slippers were off. The Client said, “Get her away from me, she hit me in the face,” or words to that effect.

20. [The co-worker] took over care of the Client and the Member left the room. When [the co-worker] checked on the Client towards the end of her shift, around 1800, she noticed redness on the Client’s face.

21. The Member did not document her interaction with the Client, and in particular, she did not document that she hit the Client with his slipper.

22. The following day, the assigned nurse charted in the Client's progress notes that there was "some redness and bruising to the right side of his eye. Resident unaware how he got it."

23. According to the Hospital's Patient Care Manager, the bruise was still visible more than two weeks later, on September 14, 2016.

24. When she was interviewed by the Hospital, the Member acknowledged that she hit the Client in the face with his slipper.

25. If the Member were to testify, she would say that the Client grabbed her hand and dug his nails in to her skin. The Member would further say she was holding the Client's slipper at the time, and she instinctively struck him with a slipper in the face. The Member acknowledges that she struck the Client with his slipper in the face, which caused the Client pain and which amounts to emotional and physical abuse.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

26. The Member admits that she committed the acts of professional misconduct as described in paragraphs 11 to 25 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)(i) in that she spoke to the Client in a raised voice and/or with an angry tone and/or used words to the effect of "oh there is shit everywhere" on August 10, 2016;

    - 1(a)(ii) in that she struck the Client on the face with the Client's slipper on August 29, 2016;

    - 1(a)(iii) in that she failed to document and/or follow up after she struck the Client on the face with the Client's slipper.

27. The Member admits that she committed the acts of professional misconduct as described in paragraphs 11 to 25 above and as alleged in the Notice of Hearing as follows:

    - 2(a)(ii) in that she abused the Client emotionally and physically when she struck the Client on the face with the Client's slipper on August 29, 2016.

28. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a)(i), 3(a)(ii) and 3(a)(iii) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 11 to 25 above.

29. With leave of the Discipline Committee, the College withdraws the following allegations from the Notice of Hearing:

- 1(b)(i)
- 2(a)(i)
- 2(b)(i)
- 3(b)(i)

Decision

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i)(ii)(iii), 2(a)(ii) and 3(a)(i)(ii)(iii) of the Notice of Hearing. As to allegation 3(a)(i)(ii)(iii), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

Reasons for Decision

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

Allegation 1(a)(i) in the Notice of Hearing is supported by paragraphs 12, 13, 14, 15 and 26 in the Agreed Statement of Facts. It was reported to the Member that the Client soiled himself and required care. The Member moved the Client into his room and [the co-worker] overheard the Member yelling to the Client in an angry tone "oh there's shit everywhere"

Allegation 1(a)(ii) in the Notice of Hearing is supported by paragraphs 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26 in the Agreed Statement of Facts. On August 29, 2016, the Member was getting the Client ready for dinner. His slippers were on the floor. The Client was resistive. [The co-worker] overheard the Client state "get away from me." [The co-worker] entered the room and the Client stated "get her away from me, she hit me in the face". The Member acknowledges that she struck the Client with his slipper in the face.

Allegation 1(a)(iii) in the Notice of Hearing is supported by paragraphs 21 and 26 in the Agreed Statements of Facts. The Member did not document her interaction with the Client on August 29, 2016, and in particular, she did not document that she hit the Client with his slipper.

Allegation 2(a)(ii) in the Notice of Hearing is supported by paragraphs 13, 14, 15, 24, 25 and 27 in the Agreed Statement of Facts. On August 10, 2016, [the co-worker] could hear the Member yelling at the Client in an angry tone. The Member said words to the effect of, "oh there's shit everywhere." When questioned by the Hospital, the Member admitted using profanity and raising her voice to the Client. On August 29, 2016, when [the co-worker] entered the Client's room, the Member was standing in front of the Client, whose slippers were off. The Client said, "Get her away from me, she hit me in the face," or words to that effect. When [the co-worker] checked on the Client towards the end of her shift, around 1800, she noticed redness on the Client's face. It was noted and documented in the Client's progress notes that there was "some redness and bruising to the right side of his eye". On September

14, 2016 the Hospital's Patient Care Manager noted that the bruise was still visible. The Member acknowledges that she physical and emotional abused the Client.

Allegation 3(a)(i)(ii)(iii) in the Notice of Hearing is supported by paragraphs 13, 14, 15, 21, 24, 25 and 28 in the Agreed Statements of Facts. The Member struck a vulnerable Client in the face with his slipper. During personal care, the Member raised her voice and used inappropriate language with this Client. Her conduct failed to meet and maintain a therapeutic nurse-client relationship and was physically and emotionally abusive. The Panel finds this conduct was dishonourable. The Member ought to have known that her actions were unacceptable and fell well below the standards expected of a nurse. The Member's conduct in failing to document her interaction with the Client and in particular that she had hit the Client with his slipper also fails to maintain the standards of practice and was found to be unprofessional. It demonstrated a serious and persistent disregard for the Member's professional obligations.

Penalty

Counsel for the College and the Member advised the panel that a Joint Submission on Order had been agreed upon. The Joint Submission 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.

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

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

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

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

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

1. *Professional Standards*,
2. *Therapeutic Nurse-Client Relationship*,

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

v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and Nurses' Workbook;

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

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

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

Penalty Submissions

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

College Counsel submitted to the Panel that the proposed penalty provides for both specific and general deterrence, as well as remediation and rehabilitation. The reprimand and suspension serves specific and general deterrence ensuring the Member does not re-offend in the same way and sends a signal to other members about what kind of penalty they can expect for this kind of conduct.

The terms, conditions and limitations add self and guided reflection with a Nursing Expert that will focus attention on the standards and reporting back to the College on how that went, along with employer notification, which aims at public confidence and protecting the public. The employer will be attuned to the issues arising from this case for some time.

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

College of Nurses of Ontario v. Joan Gibson. (Discipline Committee, February, 2014). In this case the member failed to maintain an appropriate Nurse-Client Relationship. The member roughly handled a client as well as was rude and/or raised her voice. The member also failed to respond to a client's assistance alarm. The member did not strike the Client. The panel found the member acted in an unprofessional, dishonourable and disgraceful manner. The penalty ordered was an oral reprimand, 3-

month suspension, 3 meetings with a Nursing expert and employer notification for a period of 12-months with terms, limitations and conditions.

College of Nurses of Ontario v. Marie Smith. (Discipline, Committee, March, 2017). In this case the member hit and/ or slapped a client and/or grabbed the client by the shoulders and/or blouse and/or shook her on one or more occasion(s), failed to maintain appropriate documentation as well as crossed professional boundaries. The panel found the member acted in an unprofessional, dishonourable and disgraceful manner. The penalty ordered was an oral reprimand as the member had signed an undertaking with the College to permanently resign as a member and not to re-apply for membership as a Registered Nurse in the future.

College of Nurses of Ontario v. Cheryl Yvonne Rowe. (Discipline Committee, November, 2017). In this case the member had numerous allegations (over nine) from multiple clients. The member failed to maintain an appropriate Nurse-Client Relationship. The Member hit and pulled on clients. She left clients in an unsafe environment, failed to monitor and attend to her clients' care needs and follow the clients' care plans. The panel found the member acted in an unprofessional and dishonourable manner. The penalty was an oral reprimand, 6-month suspension, 2 meetings with a Nursing expert and employer notification for a period of 18-months with terms, limitations and conditions.

Member's Counsel indicated that the mitigating factors in this case were:

- The Member's plea is a significant sign of remorse.
- She understands she made a few mistakes and is willing to take responsibility for those
- She has saved the College time and expense
- The Member is 63 years old

Member's Counsel provided the Panel with a package of reference letters (Exhibit #5) to demonstrate that the Member, is a sensitive, caring, kind, good nurse who devoted her life to helping and caring for other people but who made mistakes and wants to take responsibility.

Member's Counsel further submitted that he agreed with College Counsel that this is a fit and fair penalty consistent with case law. A lot of time and consideration and negotiation has been put into this. The four month suspension is tremendous and will be very difficult on the Member. The penalty also addresses rehabilitation.

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.

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

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

   a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

      i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

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

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

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

         1. *Professional Standards*,
         2. *Therapeutic Nurse-Client Relationship*,

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

      v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and Nurses' Workbook;

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

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

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. She has avoided the need for a lengthy and contested hearing. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. Members of the profession will be reminded that use of unprofessional language directed to clients and physical and emotional abuse will not be tolerated. The penalty is in line with what has been ordered in previous cases.

I, Ingrid Wiltshire-Stoby, NP, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline Panel.

Chairperson