DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN,	Chairperson
	Sylvia Douglas	Public Member
	Mary MacNeil, RN	Member
	Ian McKinnon	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
DEBBIE CYNTRA PANGOWISH	)	NO REPRESENTATION for
Registration No. HH11937	)	Debbie Cyntra Pangowish
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: December 14-16, 2020

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") commencing on December 14, 2020, via videoconference.

As Debbie Cyntra Pangowish (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.

By way of an affidavit from [College Staff Member], Prosecutions Clerk, dated November 3, 2020, College Counsel provided the Panel with evidence that the Member had been sent the Notice of Hearing. In her affidavit, [College Staff Member] confirms that on October 27, 2020 she sent correspondence, which included the Notice of Hearing, to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if she did not participate in the hearing, it may proceed without her participation. Accordingly, the Panel decided to proceed 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 preventing public disclosure and banning publication or broadcasting of the names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of the Member.

The Panel considered the submissions of the parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of the Member.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated October 27, 2020 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 the Ottawa Inner City Health Inc. – Targeted Engagement and Diversion Program (the "Facility") in Ottawa, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, in that:

    a. between on or about October 27, 2017 and January 20, 2018, you failed to adequately document admissions, assessments and/or nursing notes for any of the [patients] admitted to the Facility and/or under your care at the Facility;

    b. on or about December 30 or 31, 2017, you failed to assist your colleague with the assessment and care of [Patient A], and/or provide assessment and care to the [patient] who was in medical distress;

    c. on or about December 30 or 31, 2017, you failed to respond promptly to a radio call from your colleague;

    d. on or about December 30 or 31, 2017, you failed to secure the medication cart at the Facility;

    e. on or about December 30 or 31, 2017, on one or more occasions, you failed to respond promptly to a code situation where a [patient] of the Facility was overdosing;

    f. on or about December 30 or 31, 2017, you watched videos and/or played on your phone while you were on shift at the Facility;

g. on or about January 20, 2018, you failed to complete hourly checks on [patients] of the Facility;

h. on or about January 20, 2018, you failed to take steps to advise yourself of the arrival and admission of [Patient B], in the Facility; and/or

i. on or about January 20, 2018, you failed to assess [Patient B], when he arrived at the Facility, and/or you failed to complete 15-minute checks on the [patient] and/or ensure that your colleagues had done so, and/or you failed to assess and provide care to [Patient B] at any time after his admission; 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, in that:

a. between on or about October 27, 2017 and January 20, 2018, you failed to document admissions, assessments and/or nursing notes for any of the [patients] admitted to the Facility and/or under your care at the Facility; 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 as disgraceful, dishonourable or unprofessional, in that:

a. between on or about October 27, 2017 and January 20, 2018, you failed to adequately document admissions, assessments and/or nursing notes for any of the [patients] admitted to the Facility and/or under your care at the Facility;

b. on or about December 30 or 31, 2017, you failed to assist your colleague with the assessment and care of [Patient A], and/or provide assessment and care to the [patient] who was in medical distress;

c. on or about December 30 or 31, 2017, you failed to respond promptly to a radio call from your colleague;

d. on or about December 30 or 31, 2017, you failed to secure the medication cart at the Facility;

e. on or about December 30 or 31, 2017, on one or more occasions, you failed to respond promptly to a code situation where a [patient] of the Facility was overdosing;

f. on or about December 30 or 31, 2017, you watched videos and/or played on your phone while you were on shift at the Facility;

g. on or about January 20, 2018, you failed to complete hourly checks on [patients] of the Facility;

h. on or about January 20, 2018, you failed to take steps to advise yourself of the arrival and admission of [Patient B], in the Facility; and/or

i. on or about January 20, 2018, you failed to assess [Patient B], when he arrived at the Facility, and/or you failed to complete 15-minute checks on the [patient] and/or ensure that your colleagues had done so, and/or you failed to assess and provide care to [Patient B] at any time after his admission.

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 is a Registered Practical Nurse ("RPN") who registered with the College in 2000. She worked part-time as a staff RPN from September 2017 to February 2018 at Ottawa Inner City Health Inc. (the "Facility") in their Targeted Engagement and Diversion Program ("TED Program" or "Program").

The TED Program is a specialized mental health and addictions service in Ottawa to support members of the homeless community who experience issues with substance abuse. It is an alternative service meant to divert [patients] from police, paramedic and hospital emergency rooms to the Program where medically supervised withdrawal care can be provided. The Program aims to ensure care is appropriate, safe, reduces illness and prevents death for a very vulnerable population. The Program is physically located in the Shepherds of Good Hope Homeless Shelter (the "Shelter") and is staffed by nurses, unregulated Client Care Workers ("CCW") within the Program, as well as unregulated staff from the Shelter. The Shelter also includes a safe injection site, housed in a trailer outside the Shelter. Program staff are expected to respond and help Shelter staff working in the trailer when there is a patient experiencing an overdose.

Following the alleged incidents, the Member was on Administrative Suspension with the College beginning February 20, 2019.

During her period of employment at the Facility, and specifically between October 27, 2017 and January 20, 2018, it was alleged that the Member failed to adequately document admissions,

assessments and/or nursing notes for any of the [patients] admitted to the Facility and/or under her care at the Facility. It is also alleged that on or about December 30 or 31, 2017, the Member failed to assist her colleague with the assessment and care of [Patient A] and/or provide assessment and care to the [patient] who was in medical distress, failed to respond promptly to a radio call from a colleague, failed to secure the medication cart, failed to respond promptly to a code situation where a [patient] was overdosing and watched videos and/or played on her phone while on shift. It is also alleged that on or about January 20, 2018, the Member failed to complete hourly checks on [patients] at the Facility, failed to take steps to advise herself of the arrival and admission of [Patient B] to the Facility, failed to assess [Patient B] when he arrived at the Facility, failed to complete 15-minute checks on [Patient B] and/or ensure that her colleagues had done so and failed to assess and provide care to [Patient B] at any time after his admission.

The Panel considered the following issues:

(a) Did the Member commit professional misconduct by contravening the standards of practice of the profession with her conduct as alleged between on or about October 27, 2017 and January 20, 2018?

(b) Did the Member fail to adequately document admissions, assessments and/or nursing notes for [patients] admitted to the Facility and/or under her care in the Program between on or about October 27, 2017 and January 20, 2018?

(c) Did the Member engage in conduct that would be considered by members of the profession to be disgraceful, dishonourable and/or unprofessional?

The Panel found that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), (b), (c), (d), (e), (f), (g), (h), (i), 2(a), 3(a), (b), (c), (d), (e), (f), (g), (h) and (i) of the Notice of Hearing. With respect to allegations #3(a), (b), (c), (d), (e), (f), (g), (h) and (i), the Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

The Evidence

The Panel heard from 2 witnesses who worked with the Member and 1 expert witness. Fifty exhibits were presented. Twenty-one of the fifty exhibits were fifteen-minute video recordings of activity in the facility on January 20, 2018 from 1715 until 2215 with the exception of there being no available video for January 20, 2018 from 2030-2045. College Counsel explained the format of the videos prohibited providing them in any other format than fifteen-minute segments.

[ ] (“Witness #1”)

Witness #1 is a Registered Nurse and the Nurse Coordinator and RPN Supervisor for the Program, She was the direct supervisor for the Member and has worked at the Facility for 19 years. Her responsibilities include supervision of the RPNs in various programs at the Facility, as well as staff training and follow-up. Witness #1 reviewed the history and goals of the Program and reported that the Program admits on average 15-20 [patients] per shift.

- Witness #1 explained staffing, orientation and responsibilities of RPNs in the Program:

    - Staffing in the Program consists of 1 RPN, 1 CCW and 1 Shelter staff. The CCW and the Shelter staff are unregulated care providers;
    - TED Training and Orientation content (Exhibit 6) was reviewed with the Member or was to be reviewed by the Member. The content included information on documentation, policy and procedures, program description and how to respond to emergencies, etc.;
    - The Member was provided a USB with power point presentations on the TED Program (Exhibit 10) and the RPN Orientation (Exhibit 11). The content included information on the Program, RPN responsibilities, admission procedure, documentation tools and how to respond to emergencies, etc. The presentations were also available on the office computer. It was the Member's responsibility to review them;
    - RPN responsibilities were reviewed in the interview and were provided to the Member (Exhibit 5). The RPN is the most responsible person in the Program. [Patients] may be assessed by CCW or Shelter staff. However, it is the RPN's responsibility to know the vital signs, decide on stability of the [patient] and appropriate location for further assessment and management, including diversion to a hospital if warranted. The RPN is also responsible to do hourly rounding on the [patients], document assessments and care and also address any overdose in or around the building;
    - Off hours support for the RPN is available from an RN and/or Physician who is on call (i.e. not on site);
    - The employer for staff in the Program is the Facility. Carefor is a third party hired to schedule staff. Exhibit 15 is an email from the scheduler at Carefor to a human resource employee at the Facility. The email shows the shifts the Member worked since being hired, including December 30 and 31, 2017, 0700-1500 and January 20, 2018, 0700-2300.

- Witness #1 explained that the Program admission process is guided by the TED Service Admission Form (Exhibit 7) which, based on [patient] presentation, helps to determine appropriate treatment and room assignment.

    - The TED Service Admission Form is completed by either the CCW or the RPN when a [patient] is admitted to the Program. If the CCW completes the admission, the form is reviewed with the RPN. Documentation takes place in the Program's electronic health record.

- Witness #1 explained the indications for using a regular [patient] room and an observation room in the Program and responsibilities of the RPN on shift vis-à-vis the [patient] rooms.
    - A regular [patient] room is used for [patients] who are stable: i.e., [patients] that can verbalize, ambulate alone or with staff support. Vital signs are done on admission. [Patients] are monitored every thirty minutes by Program or Shelter staff for color, breathing and position changes in response to stimuli. Hourly vital signs are not part of the hourly assessments;

- Two observation rooms are located on either side of the Program office; each room contains two stretchers. There is a large window between the office and the observation rooms to help view and monitor the [patients]. [Patients] who are admitted to these rooms are not stable; they may not be able to protect their airway and their vital signs are unstable. Vital signs are done on admission and every thirty minutes for two to three hours until stable. Monitoring of color, breathing and position changes in response to stimuli are also done every fifteen minutes by Program or Shelter staff;
- The RPN is directly responsible for care provided to the [patients] in the regular [patient] room and the observation room. RPNs do the initial rounding on [patients] and then alternate along with the CCW and/or Shelter staff for remaining rounds throughout the shift.

- Witness #1 testified to other documentation tools that were reviewed with the Member during training and which are used in the Program:

    - TED Rounds Sheet (Exhibit 8), a two-page form that shows rounds have been completed. There is one form per shift, per [patient]. RPNs, including the Member, are expected to round on [patients] at the start of the shift. CCW, Shelter staff and the RPN alternate subsequent rounds. Documentation can be done on the Rounds Sheet by either the CCW or RPN but it is the RPN's responsibility to ensure the documentation is completed;
    - TED Care Plan (Exhibit 9) is a [patient] specific reference tool that helps RPNs, including the Member, care for the [patient], especially for medication administrations. Completion of the Care Plan in 2017 would have been done by Witness #1;
    - TED Admitting List (Exhibit 13) provides the names of all [patients] in the Program that the RPN is responsible for during the shift;
    - TED Shift Notes (Exhibit 14) is a Microsoft Word document completed by the CCW to communicate highlights from the shift to colleagues. TED Shift Notes are not part of the electronic health record.

- Witness #1 explained the documentation process in the Program:

    - Log in to the electronic record is a 2 tier log in. Each RPN and CCW have unique usernames and log ins;
    - Documentation on the TED Service Admission Form, Round Sheets, Care Plan and Shift notes is done on one of two computers in the main office;
    - Staff access into the electronic record is archived and can be tracked. Once logged in, if there is no activity for 10 minutes, the user gets locked out of the system and needs to log in again.

- Witness #1 explained the overdose protocol, called a Code Abby, and the role of the RPN during a Code Abby (Exhibit 12):

    - A Code Abby is a life and death situation. Time is of the essence;
    - Nurses in the Program, including RPNs are to respond to any Code Abby in or outside the Shelter. All staff carry walkie-talkies which are used to communicate a Code Abby.

The Member received specific training on this protocol. It was also on the USB and the Program office computer;
    - In a Code Abby, the RPN has the greatest responsibility for ensuring that care is being provided as required. All other staff attending the Code Abby are unregulated care providers;
    - During a Code Abby, the RPN grabs a 'Go-Bag' that contains rescue equipment that includes Narcan, portable oxygen and an oxygen monitor. Narcan is an opioid reversal agent that is administered either nasally or by injection. The 'Go-Bag' contains three pre-filled syringes of Narcan. All staff in the Program and at the Shelter are trained to recognize the signs of overdose and how to administer Narcan. The RPNs are also called to oversee and manage the overdose;
    - Narcan can be administered every 30-60 seconds. On average 8-11 doses are required before a [patient] is revived;
    - Code Abby's are a daily occurrence averaging two overdoses a shift and up to five or six overdoses a day. An incident report is filed after a Code Abby indicating the location, vital signs of the [patient], doses of Narcan administered and staff who responded;
    - Training on the Code Abby response would have been specifically covered during the six clinical training shifts the Member received following her hire.

- Witness #1 testified to concerns from staff:

    - Exhibit 16 is a letter from Witness #1 to the Member, dated January 12, 2018. The letter outlines concern from the Member's colleagues regarding lack of support from the Member, and specifically: the Member ignoring a call for the TED RPN; ignoring or having a delayed response to a Code Abby; not properly securing the medication cart; poor team work; and use of personal cell phone, including a reminder to not use her phone to watch videos. The Member received this letter but did not respond to Witness #1, her supervisor.

- Witness #1 testified to documentation concerns:

    - Exhibit 17 is a Shelter Admission list of [patients] in the Program for January 20, 2018. The list includes their location and a log of highlights from the shifts. An admission form and rounds sheet should be available for all [patients] on the Shelter Admission List. The list should also match the TED Admission List (Exhibit 13). Witness #1 noted names on the Shelter Admission list do not match names on the TED Admission List.

- Witness #1 testified to the status of [Patient B] when brought to the facility by OC Transpo Constables on January 20, 2018:

    - Exhibit 20 video surveillance shows [Patient B] arriving by wheelchair, he was slouched in the wheelchair with his head lagging to the side, his feet were dragging on the floor, his eyes were closed and he was not holding his head or body upright.

- Witness #1 testified to the video surveillance from January 20, 2018:

- Exhibit 21 video surveillance shows the Member in the TED Office when [Patient B] passed in front of her on his arrival to the Program. Witness #1 reported that the clinical presentation of [Patient B] (i.e. he was unable to mobilize or speak and he could not hold his head up) should have been obvious to the Member and the Program staff. They should have also concluded that he required an observation room per the Admission protocol. When asked by College Counsel, if Witness #1 thought the Member did an assessment of [Patient B] before being admitted to a regular [patient] room, Witness #1 responded "Not at all";
- [Patient B] was admitted by a CCW into a regular [patient] room (Exhibit 22 video surveillance);
- Exhibit 23-39 video surveillance from January 20, 2018, 1745-2200 shows that the Member and the Program staff did not complete rounds that evening nor did they check on [Patient B]. Witness #1 stated that she believes the gap in video surveillance between 2030-2045 is an administrative error. There is no documentation to support that rounds were done in that period. Shelter staff checked on [Patient B] at approximately 2200 where he was found unresponsive.

- A meeting between Witness #1 and the Member took place on January 26, 2018, before the video surveillance had been reviewed. Witness #1 stated that the Member was nonchalant and vague in her recollection of her shifts on January 20, 2018 stating that she had worked a double shift and was tired. Witness #1 said the Member had no recollection of [Patient B] arriving. Contrary to the video surveillance, the Member stated she was not present for [Patient B's] arrival as she was outside in the Shelter trailer. The Member spoke about poor communication with the CCW working with her on January 20, 2018. Witness #1 stated the Member said she had asked the CCW to do more rounds as she was tired and her legs were sore. Witness #1 reported extra shifts are accepted at the staff's discretion. Notes from the meeting are contained in Exhibit 18.

- Following a review of the video surveillance, the Facility conducted an investigation that revealed that the Member had not logged into the electronic health record since her training on September 26, 2017 (Exhibit 40). Exhibit 41 indicated that the Member had also not documented any care in the electronic medical record since being hired. Witness #1 reported she concluded the Member was not documenting in the legal record but rather the Member was putting [patient] information in the TED Shift Notes document, which is a document that was not part of the permanent legal record.

- In a meeting with the Member on February 1, 2018, Witness #1 said that the Member had no explanation for the discrepancy in the video footage and her whereabouts when [Patient B] arrived to the Program. The Member also stated that she wrote [patient] information in a word document and thought the CCW would document it in the electronic health record. Following this meeting the Facility terminated the Member's employment and a report was issued to the College. Notes from the meeting are contained in Exhibit 42.

[ ] ("Witness #2")

Witness #2 was educated as a Developmental Social Service Worker and employed by Carefor Community Health Services to work as a CCW in various community programs, including the

Program. Witness #2 was working on December 30-31, 2017 with the Women's Special Care Unit ("WSCU") at the Shelter. During her testimony, she reviewed the role of the CCW, which is to assess [patients], do vital sign checks, and work with the nurses and Shelter staff to check on [patients]. She confirmed that CCWs always report back to the nurses for any admissions and that documentation of admissions is done by the nurses. Responsibility for rounds rests with the nurses. Shelter staff also do rounds. Documentation of rounds is done by the staff, nurses or the CCW who completes the rounds.

Witness #2 reviewed multiple concerns from the shift she worked with the Member on or about December 30-31, 2017:

- Witness #2 testified that the Member failed to assess and monitor a [patient] when asked. She also failed to assist Witness #2 when Witness #2 asked for help. Witness #2 further explained:
    - The doors of the WSCU and the Program are shared and often left open. Witness #2 had worked in the Program and was familiar with the Program procedures. Witness #2 noticed rounds were not taking place in the Program. She was concerned and checked on [Patient A] who was in the Program. She found [Patient A] on the floor, grey, sweaty and not responding to verbal communication. Witness #2 got the vital sign machine and spoke to the Member about her concern. The Member continued with her meal. The vital signs showed [Patient A] had oxygen saturation in the 70's. Witness #2 reported oxygen saturation of 89-92% was considered 'stable'. [Patient A's] pulse was elevated and color was poor. Witness #2 applied oxygen. Witness #2 reported that the Member finished her meal, peeked in and saw [Patient A] was being attended to by Witness #2 and a Shelter staff. The Member did not ask for or conduct an assessment although Witness #2 told the Member that [Patient A] had low oxygen and she thought [Patient A] was detoxing. The detoxing protocol at the Program requires staff to call Emergency Medical Services ("EMS") or the nurse on call for direction. Despite this, Witness #2 stated that the Member provided no assistance. Recognizing her limitations and realizing she needed help, Witness #2 called EMS.

- Witness #2 testified that the Member ignored radio calls for help:
    - In a separate situation that weekend, a call went out on the radio for the Program nurse. The Member was the nurse working that shift but she did not respond. According to Witness #2, the Member told a Shelter staff she was working with, "If they really need me, they will call back. I'm busy." At the time, the Member was eating at the desk and on her phone. Witness #2 reported a more appropriate response would be to ask for details on the assistance needed, confirm the emergency and determine if it could wait. Witness #2 was unaware if the Member responded to the call.

- Witness #2 testified that the Member failed to lock and secure the medication cart:
    - The medication cart is located in the office and kept locked except when dispensing medications. The door to the office is locked when the office is empty or when staff are in the office, providing double security for the medications. Witness #2 reported that she saw the door to the office was open with no one inside. Opioids were in plain view and

the medication cart was not locked. Witness #2 secured the medications and then located the Member in the kitchen, eating and on her phone. Witness #2 reminded the Member of the importance of medication security and the risk to staff and [patients]. The Member "shrugged it off" saying to Witness #2 "You are not my Supervisor."

- Witness #2 testified that the Member failed to respond to two overdose situations in a timely manner.
    - The Member was called to assist during a Code Abby in the Shelter trailer. The call was overheard by other staff in the office. The Member was on her phone and did not respond. Witness #2, wearing just a T-shirt, grabbed the 'Go-Bag' and went to the trailer. The [patient] needing help in the trailer had already received a Narcan injection. Injections are usually given three minutes apart. On arrival, Witness #2 administered two more injections before the Member arrived, fully dressed for the winter wearing her coat, hat, boots, mitts and scarf. Witness #2 stated injections need to be given quickly to bring [patients] back and without a timely response, [patients] can die.
    - A second Code Abby happened with the same [patient] later in the shift. Witness #2 was on break and had crossed the street to buy a coffee. The coffee shop was approximately 100m from the Shelter. While at the coffee shop, Witness #2 heard a Code Abby called on her radio. Witness #2 ran to the Shelter trailer. The Member was not present. Three intramuscular and one intranasal injection of Narcan were administered before the Member arrived to the trailer, again wearing her coat, hat, boots, mitts and scarf.

- The Witness saw the Member watch YouTube videos and be on her phone while on shift. Witness #2 said personal phone use is not permitted while on shift. Downtime should be spent getting to know the [patients] to better support them.

- Witness #2 also expressed these concerns to her Carefor supervisor in an email dated January 5, 2018 (Exhibit #43).

Expert Witness - Sara Ling ("Witness #3")

Witness #3 was presented by College Counsel as an expert in nursing standards for [patients] with addiction and in a withdrawal and diversion program. Witness #3's Curriculum Vitae ("CV") (Exhibit 44) was presented and reviewed.

A retainer letter (Exhibit 45), a hypothetical case (Exhibit 46) and a signed Acknowledgment of Expert's Duty (Exhibit 47) was presented. The College's *Professional Standards*, Revised 2002 (Exhibit 48), *Documentation* Standard, Revised 2008 (Exhibit 49) and the *Medication* Standard (Exhibit 50) were also presented. Witness #3 briefly reviewed the purpose of the *Professional Standards* and *Documentation* Standard. She also satisfied the Panel that she understood the [patient] population. The Panel accepted Witness #3 as an expert in the Standards of Care in nursing for patients with addiction and in a withdrawal and diversion program.

College Counsel referred Witness #3 to paragraphs 48-54 in the Hypothetical and asked her opinion on whether the Member met the Standards when she declined to attend to the [patient].

Witness #3 stated that the Member contravened the *Professional Standards* related to accountability and leadership. The RPN role was to consult and oversee medication needs. Not responding to the CCW is concerning as the Member is not sharing nursing knowledge nor responding in a timely manner. When [patients] are intoxicated or experiencing withdrawal, their condition can escalate quickly and a timely response is important for safety.

Witness #3 was asked to opine on Witness #1's report that no documentation was available between on or about October 27, 2017 and January 20, 2018 and if the failure to document admissions, assessments and/or nursing notes for [patients] in the Program contravened the standards.

Witness #3 stated that the *Documentation* Standard clearly states that nurses are required to keep records and to do so in a timely fashion. Additionally, a [patient] requiring emergency medical services indicates an acute event is happening and therefore, appropriate documentation is required.

With reference to paragraphs 55-61 in the Hypothetical, Witness #3 was asked to provide her opinion whether the lack of response to the radio call was a breach of standards.

Witness #3 stated that this was a failure to meet the *Professional Standards*. In a leadership role the Member had a responsibility to support the unregulated care providers. The RPN job description also indicated that the nurse was to respond promptly. It was not appropriate to say "If it is important, they will call back." since the radio is used to request a prompt response. The Member could have relayed that she was busy attending another [patient], provided a timeline to respond, or requested additional information. Failure to respond was a breach of the standard.

With reference to paragraphs 62-64 of the Hypothetical, Witness #3 was asked if the failure to secure the medication cart was a breach of standards.

Witness #3 stated that the *Medication* Standard indicates nurses are to ensure medications are secure. Witness #3 referenced the *Medication* Standard, page 3, 'Safety'. Witness #3 stated medications used in withdrawal treatment programs are benzodiazepines which are controlled substances that need to be managed for safety. The nurse on duty would be responsible to secure the medication in the cart and keep the office door closed to reduce access to the cart. Failure to secure the medication cart would be a breach of the *Medication* Standard.

College Counsel referenced paragraphs 65-70 of the Hypothetical, and asked Witness #3 if the failure to respond to a Code Abby was a breach of standards.

Witness #3 stated that failure to respond was a breach of the *Professional Standards* of accountability and leadership. [Patients] experiencing an overdose have low to absent respirations and therefore require a timely response and Narcan administration to avoid brain injury or death. It does not appear that the Member arrived promptly since the [patient] received up to three doses of

Narcan while the Member took the time to dress for the outdoors before presenting herself. Failure to respond in a timely manner to a Code Abby would be a breach of the *Professional Standards*.

With reference to paragraph 71 of the Hypothetical, College Counsel sought Witness #3's opinion on whether using YouTube on shift was a breach of standards.

Witness #3 stated that the Member could not and did not meet the *Professional Standards* and provide care if she spent time on her phone watching videos.

With reference to paragraphs 76-88, Witness #3 was asked if the events surrounding [Patient B] were a breach of standards.

Witness #3 stated that based on her review of the video surveillance she believes that the Member saw [Patient B] when he was admitted as [Patient B's] wheelchair paused in front of the Member while she was standing in the door of the office. It was the Member's responsibility to assess [Patient B] on admission. She should have realized his presentation (i.e. slumped over in a wheelchair, appearing not alert and not conscious) warranted admission to an observation room. The Member also had oversight of any admissions processed by the CCW. Even if the CCW did not alert the Member to [Patient B'] condition, the Member should have become aware of his condition if she had done regular rounds during the shift. The Member should have then performed and documented her assessment.

Witness #3 stated the lack of rounding and the lack of assessment and care was a breach of the *Professional Standards*. The Member was responsible for ensuring observation of [patients] in the Program were completed and that the [patients'] needs were met. In the 'Accountability' section of the *Professional Standards*, "A nurse demonstrates the standard by: providing, facilitating, advocating and promoting the best possible care for [patients]; sharing nursing knowledge and expertise with others to meet [patient] needs; taking action in situations in which [patient] safety and well-being are compromised". The Member did not meet these standards.

Witness #3 stated that the lack of documentation is a breach of the *Documentation* Standard. In the *Documentation* Standard, it states on Page 4 "Nurses are required to make and keep records of their professional practice". The Member did not complete any documentation for any [patient] following her orientation at the Facility. The impact of no documentation is that care and status of [patients] is unknown. The Member did not meet the standard.

Final Submissions

College Counsel submitted that the evidence from the two witnesses and the expert witness provided sufficient evidence for findings of professional misconduct and breaches of the *Professional Standards*, *Documentation* Standard and the *Medication* Standard. College Counsel submitted the evidence proves that the Member's conduct was disgraceful, dishonourable and unprofessional.

College Counsel acknowledged that the burden of proving the allegations rests with the College. There is a presumption that the Member is innocent and the College must displace that presumption through evidence and prove on the balance of probabilities that the Member participated in the allegations. College Counsel also reminded the Panel that witnesses must be assessed for their reliability and credibility. College Counsel reviewed for the Panel various factors that are important in assessing witnesses.

College Counsel submitted there are important facts to consider for the two nurse witnesses. Both nurse witnesses were consistent about the RPN's role in the Program and the leadership role of the RPN as the only regulated provider working on the dates where the allegations occurred. Both nurse witnesses were also consistent about expectations of RPNs during an overdose situation. Testimony of Witness #2 was consistent with the concerns she expressed in a January 5, 2018 letter to her supervisor (Exhibit 43).

College Counsel submitted a review of each allegation and the evidence proving the allegation. A summary is provided below.

Allegations 1(a) and 2(a): College Counsel submitted that Exhibits 40 and 41 proved the Member did not log into the electronic record system which was the only place for documenting in the [patient's] personal health record. The Expert Witness also testified that documentation is of fundamental importance and critical to patient care. Lack of documentation was a flagrant breach of the *Professional Standards* and the *Documentation* Standard and was a failure to keep records for patients.

Allegation 1(b): College Counsel submitted that Witness #2 was familiar with protocols in the Program and also familiar with [Patient A]. When she found [Patient A] in distress and reported her concern to the Member, the Member did nothing. She continued eating. She did not assess or provide medication to [Patient A], nor did she share her nursing knowledge with Witness #2 who was an unregulated care provider. Witness #2 recognized her limitations and called EMS for help. Witness #1 confirmed this incident, including the responsibilities of the Member and the limitations of Witness #2, an unregulated care provider. The Member's inaction and lack of timely response put the [patient] at risk. The *Professional Standards* which are clear on nursing accountability were not met.

Allegation 1(c): College Counsel submitted that Witness #2 testified that the Member ignored a call for help. The Expert Witness also testified that failure to respond was a breach of the *Professional Standards*. A colleague was seeking her expertise and the Member dismissed this request.

Allegation 1(d): College Counsel submitted that Witness #2 testified to seeing an unattended medication cart. Witness #2 also testified to the Member's disregard for Witness #2's concern. The Member did not care or seem to understand the problem. The Expert Witness testified that according to the *Medication* Standard, nurses are responsible to keep medications secure, especially in a managed withdrawal setting where drug seeking [patients] are present. The Member's actions were a breach of the *Medication* Standard.

Allegation 1(e): College Counsel submitted that Witness #2 testified to a delayed response from the Member for a [patient] experiencing an overdose. Twice on one shift, the Member took her time responding to the scene of an overdose. She arrived fully dressed for the winter and only long after multiple doses of Narcan had already been given. The timely administration of Narcan is essential to help resume breathing and avoid brain damage or death and every moment matters. The Member's lack of timely response was reckless, dangerous and a breach of nursing standards.

Allegation 1(f): College Counsel submitted that Witness #2 testified that she witnessed the Member watching videos on her personal device. This event took place on New Year's Eve weekend and the Program was busy with many [patients]. The Expert Witness testified that being on her phone meant the Member was likely not providing care to [patients] and therefore breaching the *Professional Standards*.

Allegations 1(h) and (i): College Counsel submitted that Witness #1 testified that neither the Member nor the CCW completed an admission form for [Patient B]. However, video surveillance showed [Patient B] passed right in front of the Member on his arrival to the Program. The Member was responsible to assess and admit him to an observation room based on his condition. Instead, [Patient B] was admitted to a regular [patient] room. The Member also missed opportunities to assess and provide care to [Patient B] by not conducting rounds. This had a catastrophic outcome for [Patient B] as the Shelter staff found him unresponsive later in the evening. Failure to document these events were also a breach of standards.

Allegation 3: College Counsel submitted that the threshold for a finding of disgraceful, dishonourable and unprofessional conduct is met when others in the profession acting reasonably would come to the same conclusion upon reviewing the evidence. College Counsel submitted that the Member's conduct was so obviously lacking that there is no need for an expert opinion in determining that the Member's behaviour was disgraceful, dishonourable and unprofessional. Breaching the standards as well as not documenting at all in the electronic record is sufficient for a finding of professional misconduct. The Member showed serious disregard for fundamental aspects of the profession. Her failure to provide care, document, secure medications, support colleagues, conduct rounds was disgraceful and dishonourable. The Member breached trust and her neglectful actions put the [patients] and colleagues at risk. She shamed the profession and showed a lack of moral fitness and ability to discharge her professional responsibilities.

College Counsel submitted the following cases to assist the Panel in their review:

CNO v. Hearty (Discipline Committee, 2012). Between 2005 and 2008, the member provided insufficient and neglectful care to a [patient] with a complete lack of documentation. This conduct was determined to be disgraceful, dishonourable and unprofessional and a breach of standards.

CNO v. Nkwelle (Discipline Committee, 2018). The member worked in an Emergency Assessment Unit in a mental health and addictions service facility. The member failed to conduct fifteen-minute

checks and during this lapse a patient in the facility committed suicide. The member also documented that he performed fifteen-minute checks when he had not. This conduct was determined to be disgraceful and unprofessional, a breach of standards and a failure to document.

CNO v. Williams (Discipline Committee, 2014). The member failed to provide appropriate assessment, care and treatment of a [patient] in a mental health facility. The member did not follow a physician's order and did not follow the proper process when he disagreed with the physician's order. The member also failed to document. This conduct was determined to be unprofessional, a breach of standards and a failure to keep records.

Decision

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), (b), (c), (d), (e), (f), (g), (h), (i), 2(a), 3(a), (b), (c), (d), (e), (f), (g), (h) and (i) of the Notice of Hearing. With respect to allegations #3(a), (b), (c), (d), (e), (f), (g), (h) and (i) the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the evidence as well as the credibility of the witnesses and found that the evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

In assessing the witness credibility, the Panel found that the Member's Supervisor, Witness #1, was credible in knowing the training and responsibilities of the RPN's in the Program, the RPN documentation requirements for admission and [patient] care and the Code Abby protocols. Her answers were appropriate, consistent and backed up with exhibits. She was deemed to be credible and the Panel accepted her evidence.

Witness #2 worked with the Member and her testimony was a report of her direct observations from December 30-31, 2017. Witness #2 answered questions succinctly and completely. She was familiar with her role as a CCW as well as the RPN role. She was thoughtful and deliberate in outlining the concerns she had during the shifts on December 30-31, 2017. Her testimony demonstrated a sense of responsibility and caring for the [patients] she worked with. Her testimony was also consistent with concerns she raised in an email to her supervisor (Exhibit 43). She was also deemed to be a credible witness by the Panel which accepted her evidence.

The Panel also accepted the testimony of Witness #3, the Expert Witness.

With respect to allegations #1(a), (b), (c), (d), (e), (f), (g), (h) and (i), the Panel found that the Member committed acts of professional misconduct when she contravened multiple standards of

practice. Witness #1's review of orientation and training indicated that the Member should have known her responsibilities within the Program. The audit done by the Facility (Exhibits 40 and 41) showed that the Member did not document her admissions, assessments and/or nursing notes between on or about October 27, 2017 and January 20, 2018. She did not document anything in the electronic record during this time. The Panel heard from Witness #2 that rounds were not being done in the Program on or about December 30 or 31, 2017. As a result, Witness #2 took responsibility to conduct rounds on the [patients] and found [Patient A] in distress. The Member did not assist Witness #2 in caring for [Patient A]. Instead, she peeked into [Patient A's] room and returned to the office despite a request by Witness #2 to stay with the [patient]. The Member also failed to acknowledge a call for help on or about December 30 or 31, 2017, dismissing it with a suggestion "if they really needed me, they will call back. I'm busy". That same weekend, the Member delayed her response for two overdose events. While the Member took time to put on her scarf, hat and mitts to avoid the cold, unregulated providers were caring for and administering multiple injections of Narcan to a [patient] experiencing an overdose. She continued with careless and neglectful actions that weekend leaving the medication cart unattended and spending time on her phone and watching videos.

For the events that took place on January 20, 2018, the Panel saw video of [Patient B] passing right in front of the Member as he was brought into the Facility. The Member was in a position to observe [Patient B] with her own eyes but she did not assess him or document his admission. She also failed to do rounds on [Patient B]. Had rounds been done the outcome for [Patient B] might have been different.

In summary, the evidence showed the Member ignored the professional expectations the public has for nurses. As part of the *Professional Standards*, the Member was accountable to provide, facilitate, advocate and promote the best possible care for [patients]. She failed to do so. She was also accountable to share her nursing knowledge and expertise and take appropriate action when [patients] in her care were compromised. She also failed to meet this expectation. The *Documentation* Standard states that nurses document care to promote continuity of care and communicate to other providers their assessment and interventions. Nursing documentation is an integral component of interprofessional documentation within the [patient] record. The Member's complete lack of documentation for any [patients] in her care on the dates alleged is appalling. Particularly applicable to the Program, the *Medication* Standard also states that nurses need to minimize the risk of drug misuse or diversion. Failing to secure the medication cart was a blatant breach of this standard.

With respect to allegation #2(a), the Panel reviewed the dates worked by the Member (Exhibit 15) as well as the audit by the Facility (Exhibits 40 and 41) and found that the Member committed acts of professional misconduct when she failed to document admissions, assessments and/or nursing notes as required and which was also contrary to the *Documentation* Standard.

With respect to allegations #3(a), (b), (c), (d), (e), (f), (g), (h) and (i), the Panel found that these allegations are supported by the evidence. The Member's conduct was unprofessional as her lack of

any documentation for almost three months of part time work, her careless and indifferent response when colleagues needed help and her lack of concern regarding an unattended medication cart in a withdrawal treatment program showed a persistent disregard for her professional obligations. The Member's conduct was also dishonourable as it had an element of moral failing and showed her inability to meet the higher obligations the public expects nurses to meet. She ignored [patients], she ignored her obligation to round on them for safety, she had no sense of urgency in responding to Code Abby's. The Member's conduct was also disgraceful as her overall lack of care, compassion and team work was deplorable. One of her [patients] potentially paid the ultimate price for her despicable conduct. Her conduct shamed herself and by extension the nursing profession. Accordingly, the Panel finds that the Member committed acts of professional misconduct and engaged in behaviour that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should 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 seven months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of two meetings with a Nursing Expert (the "Expert") at her own expense and within six months from the date 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 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 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, 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. *Code of Conduct,*
2. *Professional Standards*,
3. *Documentation*, and
4. *Therapeutic Nurse-Client Relationship*;

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

v. 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;

vi. 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;

vii. 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 obtains an active certificate of registration and 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, that will confirm the following:

      1. the employer received a copy of the required documents, and
      2. the employer agrees to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
      3. the employer agrees to perform six random spot audits of the Member's documentation at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

         a. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,
         b. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,
         c. the third audit shall take place within nine months from the date the Member begins or resume employment with the employer,
         d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer,
         e. the fifth audit shall take place within 15 months from the date the Member begins or resumes employment with the employer, and
         f. the sixth audit shall take place within 18 months from the date the Member begins or resumes employment with the employer;

   iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 10 of the Member's charts to ensure that they meet both CNO and employer standards, and
2. discussing (by telephone or in person), with at least three of the Member's patients, to ensure that the Member provided the necessary and/or required care to the patient and that her documentation accurately reflects the care provided.

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 led the Panel through a review of aggravating factors in considering penalty. An aggravating factor is the seriousness of the Member's conduct and flagrant breach and disregard of multiple professional standards. The Member's conduct potentially led to the death of a [patient] and brought serious shame and discredit to the profession. The Member also has a history of prior discipline with the College. The College's Register Report (Exhibit 3) shows that the Inquiries, Complaints and Reports Committee ("ICRC") issued a caution to the Member with respect to the *Professional Standards* and *Medication* Standard, similar to the breaches of standards being considered in this case. College Counsel submitted that there were no mitigating factors considering the Member's lack of attendance in the proceedings.

College Counsel submitted that the proposed order supports the goals of penalty, including specific and general deterrence, protection of the public's interest and maintains the public's confidence in the ability of the nursing profession to self-regulate. The proposed order meets general deterrence as it sends a clear message to the profession that conduct of this nature will not be tolerated. Members of the profession will learn from this penalty ensuring similar mistakes are not repeated. Specific deterrence is met through the oral reprimand and suspension. The proposed order also has a rehabilitative benefit as it provides an opportunity for the Member to learn and understand her mistakes and improve her practice should she return to the profession.

College Counsel also submitted the same cases as earlier provided to the Panel along with one additional case, to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO v. Hearty (Discipline Committee, 2012). Between 2005 and 2008, the member provided insufficient and neglectful care to a [patient] with a complete lack of documentation. This conduct was determined to be disgraceful, dishonourable and unprofessional. The member entered into an undertaking with the College to permanently resign her certificate of registration. In view of the undertaking, the panel accepted the Joint Submission on Order and ordered the member to appear before the panel to receive an oral reprimand.

CNO v. Nkwelle (Discipline Committee, 2018). The member worked in an Emergency Assessment Unit in a mental health and addictions service facility. The member failed to conduct fifteen-minute

checks and during this lapse a patient in the facility committed suicide. The member also documented that he performed fifteen-minute checks when he had not. This conduct was determined to be disgraceful and unprofessional. The panel accepted a Joint Submission on Order that included an oral reprimand, a three-month suspension, two meetings with a Nursing Expert and 12-month employer notification. In this case, the member participated in the proceedings, showed remorse and there were also mitigating factors to consider, including the transgressions transpired over one shift versus multiple incidents over multiple months.

CNO v. Williams (Discipline Committee, 2014). The member failed to provide appropriate assessment, care and treatment of a [patient] in a mental health facility. The member did not follow a physician's order and did not follow the proper process when he disagreed with the physician's order. The member also failed to document. This conduct was determined to be unprofessional. The penalty issued was an oral reprimand, a two-month suspension, three meetings with a Nursing Expert and 24 months employer notification. The incident was a one-time incident with no evidence of a pattern. Mitigating factors were present. The member also showed remorse.

CNO v. Simeone (Discipline Committee, 2017). The member breached standards of the profession in multiple repeat incidents over a two-year period. The member failed to provide care or delivered improper care and had documentation omissions. This conduct was also determined to be disgraceful, dishonourable and unprofessional. The panel accepted a Joint Submission on Order that included an oral reprimand, a five month suspension, two meetings with a Nursing Expert, an 18 month employer notification, chart audits and discussions with three [patients] about the care the member provided. The member was also ordered to not practice independently for 18 months after returning to practice. The member attended the hearing, admitted to the allegations, did not have any discipline history with the College and cooperated with the College.

Penalty Decision

The Panel accepts the College's 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 seven months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of two meetings with a Nursing Expert (the "Expert") at her own expense and within six months from the date 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 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 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, 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. *Code of Conduct,*
    2. *Professional Standards*,
    3. *Documentation*, and
    4. *Therapeutic Nurse-Client Relationship*;

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

v. 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;

vi. 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;

vii. 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 obtains an active certificate of registration and 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, that will confirm the following:

1. the employer received a copy of the required documents, and
2. the employer agrees to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
3. the employer agrees to perform six random spot audits of the Member's documentation at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

1. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,
2. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,
3. the third audit shall take place within nine months from the date the Member begins or resume employment with the employer,
4. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer,
5. the fifth audit shall take place within 15 months from the date the Member begins or resumes employment with the employer, and
6. the sixth audit shall take place within 18 months from the date the Member begins or resumes employment with the employer;

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 10 of the Member's charts to ensure that they meet both CNO and employer standards, and
2. discussing (by telephone or in person), with at least three of the Member's patients, to ensure that the Member provided the necessary and/or required care to the patient and that her documentation accurately reflects the care provided.

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. The Panel concluded that the proposed penalty is reasonable and in the public interest. Public protection is achieved through the terms, conditions and limitations on her registration that includes additional suspension, meetings with a Nurse Expert, employer notification for 24 months and audits of her documentation. The oral reprimand and suspension also satisfy the principle of specific deterrence. General deterrence is accomplished by sending a message to the profession that failure to follow employer policies and/or College Standards can lead to serious and tragic consequences and will not be tolerated. The penalty also allows for rehabilitation and remediation through meetings with a Nursing Expert and follow up chart audits, should the Member choose to participate.

The penalty is also consistent with previous decisions of this Committee for similar circumstances.

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