DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Carly Gilchrist, RPN	Chairperson
	Sylvia Douglas	Public Member
	Lalitha Poonasamy	Public Member
	Sherry Szucsko-Bedard, RN	Member
	Jane Walker, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
CHING WAN FU	)	NO REPRESENTATION for
Registration No. JG685766	)	Ching Wan Fu
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 24, 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") on July 24, 2020, via videoconference. Ching Wan Fu (the "Member") attended the hearing via telephone.

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 the public disclosure of the identities of the patients in the Discipline hearing of the Member or any information that could disclose the patients' identities, including a ban on the publication or broadcasting of this information.

The Panel considered the submissions of the Parties and decided that there be an order preventing the public disclosure of the identities of the patients in the Discipline hearing of the Member or any information that could disclose the patients' identities, including a ban on the publication or broadcasting of this information.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(b)(i), 2(a)(i) and 3(b)(i) in the Notice of Hearing dated July 8, 2020. The Panel granted this request. The remaining allegations against the Member are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while practicing as a Registered Practical Nurse at Extendicare Rouge Valley in Toronto, Ontario (the "Facility"), you contravened a standard of practice of the profession, or failed to meet the standards of practice of the profession, in that on or about August 26, 2018:

    (a) you disregarded [the Patient]'s plan of care with respect to transfer of [the Patient];

    (b) you made inappropriate and/or unprofessional comments and/or gestures directed at [the Patient], including but not limited to the following:

        i. [*Withdrawn*];
        ii. you held your finger close to [the Patient]'s face;
        iii. you used words to the effect of "why can't we just tranquilize her"; and/or
        iv. you used words to the effect that [the Patient] should be a boxer; and/or

    (c) you bent [the Patient]'s thumb and/or forced her hands into the stand lift.

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 while practicing as a Registered Practical Nurse at the Facility, you verbally, physically, or emotionally abused [the Patient], in that on or about August 26, 2018:

    (a) you made inappropriate and/or unprofessional comments and/or gestures directed at [the Patient], including but not limited to the following:

        i. [*Withdrawn*];
        ii. you held your finger close to [the Patient]'s face;
        iii. you used words to the effect of "why can't we just tranquilize her;" and/or
        iv. you used words to the effect that [the Patient] should be a boxer; and/or

    (b) you bent [the Patient]'s thumb and/or forced her hands into the stand lift.

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

practicing as a Registered Practical Nurse at the Facility, you engaged in conduct relevant to the practice of nursing that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that on or about August 26, 2018:

(a) you disregarded [the Patient]'s plan of care with respect to transfer of [the Patient];

(b) you made inappropriate and/or unprofessional comments and/or gestures directed at [the Patient], including but not limited to the following:

i. [*Withdrawn*];
ii. you held your finger close to [the Patient]'s face;
iii. you used words to the effect of "why can't we just tranquilize her;" and/or
iv. you used words to the effect that [the Patient] should be a boxer; and/or

(c) you bent [the Patient]'s thumb and/or forced her hands into the stand lift.

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Ching Wan Fu (the "Member") obtained a diploma in nursing from George Brown College in 2007.

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

3. The Member was employed at Extendicare Rouge Valley (the "Facility") from October 2007 until November 2018, when her employment was terminated following the incident described below.

THE PATIENT

4. [The Patient] was an 88-year-old female with Alzheimer's disease and unspecified dementia.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

5. On August 26, 2018, the Member was working with [Personal Support Worker A] to change the Patient. Throughout the interaction, the Patient was agitated and yelling at the Member and [Personal Support Worker A].

6. When [Personal Support Worker A] and the Member entered the Patient's room with the Patient, the Member made a statement to the effect of "why can't we just tranquilize her, then we can change her."

7. [Personal Support Worker A] indicated that in the past she had transferred the Patient with another staff. The Member suggested that they use a stand lift and commented to [Personal Support Worker A] that this was "taking the path of least resistance."

8. The Member and [Personal Support Worker A] changed the Patient by lifting her into a stand lift and then cleaned her. During the process, the Member bent the Patient's thumb and forced her hands onto the stand lift. If the Member were to testify, she would say that she grabbed the Patient's thumb after the Patient was grabbing at the Member's arm, and that the Member was trying to secure her in the stand lift.

9. The transfer did not align with the Patient's plan of care, which required that two staff provide some physical assistance when transferring the Patient. The Patient was rocking the stand lift while on it and the Patient was screaming "I'm going to fall" during the transfer.

10. During the interaction, the Member also repeatedly said "shh" to the Patient and she similarly held her finger close to the Patient's face, apparently to communicate to the Patient that she should stop making noise. In addition, the Member told the Patient she should be a boxer, apparently in reference to the fact that the Patient would punch.

11. Once [Personal Support Worker A] and Member finished changing the Patient, the Member commented to [Personal Support Worker A] they should "work smart not hard."

CNO STANDARDS

12. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets legislative requirements and the standards of practice of the profession. A nurse demonstrates this standard by providing, facilitating, advocating and promoting the best possible care for patients.

13. CNO's *Professional Standards* further provides, in relation to the *Relationships* standard, that each nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships and a nurse demonstrates this standard by demonstrating respect and empathy for, and interest in patients.

14. CNO's *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard")* places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship

on the nurse. The *TNCR Standard* further provides that the relationship is based on trust, respect, empathy and professional intimacy, and requires the appropriate use of power inherent in the care provider's role.

15. The *TNCR Standard* provides that nurses use a wide range of effective communication strategies and interpersonal skills to appropriately establish, maintain, re-establish and terminate the nurse-patient relationship. A nurse meets the standard by:

    - being aware of her/his verbal and non-verbal communication style and how [patients] might perceive it;
    - modifying communication style, as necessary, to meet the needs of the [patient]; and
    - recognizing that all behaviour has meaning and seeking to understand the cause of a [patient's] unusual comment, attitude or behaviour.

16. The *TNCR Standard* also requires nurses to protect the patient from harm by ensuring that abuse is prevented or stopped and reported. With respect to protecting the patient from abuse, a nurse demonstrates having met the standard by:

    - not engaging in behaviours toward a [patient] that may be perceived by the [patient] and/or others to be violent, threatening or intending to inflict physical harm; and
    - not exhibiting physical, verbal and non-verbal behaviours toward a [patient] that demonstrate disrespect for the client and/or are perceived by the [patient] and/or others as abusive.

17. In addition, the *TNCR Standard* provides examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, intimidation including threatening gestures, teasing or taunting, insensitivity to the patient's preferences and an inappropriate tone of voice, such as one expressing impatience. Physical abuse includes using force and handling a patient in a rough manner.

18. The Member admits and acknowledges that her disregard for the Patient's plan of care with respect to the transfer of the Patient, her comments and gestures directed at the Patient as well as her bending of the Patient's thumb and forcing the Patient's hands onto the lift, were a breach of the standards of practice of the profession. The Member further admits and acknowledges that her comments and gestures directed at the Patient and her bending of the Patient's thumb and forcing the Patient's hands onto the lift and amounted to verbal, physical and emotional abuse.

19. If the Member were to testify, she would say she is remorseful, and she has taken steps to prevent such conduct from ever recurring. The Member would further testify that she has engaged in proactive remediation by reviewing and reflecting on CNO standards.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

20. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), 1(b) ii. to iv. and 1(c) of the Notice of Hearing in that she contravened a standard of practice of the profession, or failed to meet the standards of practice of the profession, as described in paragraphs 5 to 18 above.

21. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a) ii. to iv. and 2(b) of the Notice of Hearing in that she verbally, physically and emotionally abused the Patient, as described in paragraphs 5 to 18 above.

22. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a), 3(b) ii. to iv. and 3(c) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 5 to 18 above.

OTHER

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

    - 1(b) i.
    - 2(a) 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 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), 1(b)(ii), (iii), (iv), 1(c), 2(a)(ii), (iii), (iv) and 2(b) of the Notice of Hearing. As to allegation #3(a), (b)(ii), (iii), (iv) and 3(c), 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) in the Notice of Hearing is supported by paragraphs 7-9, 11, 12, 18 and 20 in the Agreed Statement of Facts. The Member admitted that she failed to meet the standards of practice when she did not follow the plan of care when transferring the Patient. A nurse meets the College's *Professional Standards* by providing, facilitating, advocating and promoting the best possible care for patients.

Allegations #1(b)(ii) and (iv) in the Notice of Hearing are supported by paragraphs 10,14,15 and 20 in the Agreed Statement of Facts. The Member admitted that she held her finger close to the Patient's face, repeatedly and said "shhh" to communicate to the Patient so she should stop making noises. The Member also made the comment to the Patient that she should be a boxer in reference to the Patient punching out at times.

Allegation #1(b)(iii) in the Notice of Hearing is supported by paragraphs 6, 12-16 and 20 in the Agreed Statement of Facts. While lifting the Patient into a stand lift the Member admitted that she failed to meet the standards of practice when she made the comment "why can't we just tranquilize her, then we can change her". The *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard*") places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse, and a nurse is to be aware of their verbal and non-verbal communication style and how it may be perceived. A nurse meets the College's *Professional Standards* by providing, facilitating, advocating and promoting the best possible care for patients.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs 8 and 20 in the Agreed Statement of Facts. The Member admitted that she failed to meet the standards of practice when she forced the Patient's hands onto the stand lift. The use of force demonstrates disrespect.

The *TNCR Standard* documents examples of verbal or emotional abusive behaviour to be threatening gestures, teasing, taunting and insensitivity, while physical abuse is using force and handling a patient in a rough manner. The *TNCR Standard* sets out a wide range of effective communication strategies that include both verbal and non-verbal styles to establish a therapeutic nurse-patient relationship based on respect, trust and empathy.

Allegation #2(a)(ii) and (iv) in the Notice of Hearing are supported by paragraphs 10 and 21 in the Agreed Statement of Facts. The Member verbally, and emotionally abused the Patient when she put her finger in the Patient's face, and made the comment that the Patient should be a boxer.

Allegation #2(a)(iii) in the Notice of Hearing is supported by paragraphs 6 and 21 in the Agreed Statement of Facts as the Member made a comment that could be considered threatening when saying "why can't we tranquilize her". The Member's actions are considered to be verbal and emotional abuse.

Allegation #2(b) in the Notice of Hearing is supported by paragraphs 8 and 21 in the Agreed Statement of Facts. The Member physically abused the Patient when she bent the Patient's thumb and/or forced her hands into the stand lift.

Allegations #3(a), 3(b)(ii), (iii), (iv) and 3(c) are supported by paragraphs 5 to 18 and 32 in the Agreed Statement of Facts. The Panel finds that the Member's conduct was dishonourable and unprofessional when she made demeaning comments towards the Patient, made an aggressive gesture towards the Patient when she put her finger in the Patient's face and blatantly did not follow the plan of care when transferring the Patient. This conduct demonstrated a serious and persistent disregard for her professional obligations and the Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

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

1. Requiring the Member to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 2 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 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. 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 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            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 CNO 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,* and
            3. *Code of Conduct;*

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

v. At least 7 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 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;

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 9 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.

4. All documents delivered by the Member to the CNO, 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.

The aggravating factors in this case were:

- The Member admitted to serious abusive behaviour over a short time frame;
- The Member disregarded a care plan;
- The Member ignored a colleague's suggestions when caring for the Patient;
- The Member showed poor role modeling and leadership when working with a Personal Support Worker;
- The Patient was elderly and highly vulnerable.

The mitigating factors in this case were:

- The Member has no prior history with the disciplinary committee;
- The Member accepted responsibility for her actions early in the investigation;
- The Member showed insight into her behaviour and was proactive as she started remedial work prior to the hearing;
- There was no evidence of harm or injury to the Patient.

The proposed penalty provides for general deterrence through:

- The oral reprimand;
- The 2 month suspension.

This penalty will send a strong signal to the profession and the public that the College will not tolerate this behaviour.

The proposed penalty provides for specific deterrence through:

- The oral reprimand;
- The 2 month suspension.

The proposed penalty provides for remediation and rehabilitation through:

- The terms, conditions and limitations placed on the Member's certificate of registration, including two meetings with a Regulatory Expert which will allow the Member to reflect on her professional standards and requirements.

Overall, the public is protected by:

- The proposed Joint Submission on Order, which in its totality, is geared toward public protection. The order sends a message to nurses that there are consequences for their behaviour, and to the public of the profession's ability to self-regulate;
- In particular, the 9 month employer notification will protect the public because of the increased employer awareness and understanding of the Member's past actions.

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

CNO v. Gibson (Discipline Committee, February 2014): The member was self-represented. The member in this case failed to meet the standards of practice when she raised her voice inappropriately to a client and handled the client roughly. The client was an elderly person with dementia, Parkinson's and osteoporosis. The member was given a penalty including an oral reprimand, 3 month suspension, 3 meetings with an Expert, spot audits and a 12 month employer notification.

CNO v. Agustin (Discipline Committee, January 2019): The member in this case failed to meet the standards of practice when she raised her voice with an angry undertone and commented "oh there is shit everywhere" when the client soiled themselves as well as struck the client with a slipper on and around the client's face. The client was an elderly person with dementia. The member was given a penalty including an oral reprimand, a 4 month suspension, 2 meetings with an Expert and an 18 month employer notification.

CNO v. Klein (Discipline Committee, September 2019): The member in this case failed to meet the standards of practice when he raised his voice with a patient and commented "you are a very bad girl", as well as leaving the patient naked crying on her bed, and telling the patient to dress herself. The Klein case was more serious than the current case presented as the abuse involved 3 patients and went over years documenting a pattern. The patients involved were vulnerable. The member was given a penalty including an oral reprimand, a 5 month suspension, 2 meetings with an Expert and an 18 month employer notification.

The Member advised the Panel that she had no comments to add.

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 3 months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 2 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 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. 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 7 days before the first meeting, the Member provides the Expert with a copy of:

      1. the Panel's Order,
      2. the Notice of Hearing,
      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 CNO 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,* and
      3. *Code of Conduct;*

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

   v. At least 7 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 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;

   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 9 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.

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted

responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The suspension of two months followed by a period of employer notification addresses the principle of public protection. Members of the profession will be reminded that use of unprofessional language directed to patients and physical and emotional abuse will not be tolerated. The penalty is in line with what has been ordered in previous cases.

I, Carly Gilchrist sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.