DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Mary MacNeil, RN	Chairperson
	Andrea Arkell	Public Member
	Tim Crowder	Public Member
	Sue Roger, RN	Member
	Jane Walker, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	HAILEY BRUCKNER for
	)	College of Nurses of Ontario
- and -	)	
	)	
AMIE MOORE	)	MICHAEL MANDARINO for
Registration No. 0455824	)	Amie Moore
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: September 21, 2021

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 September 21, 2021, via videoconference.

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 name of the patient, or any information that could disclose the identity of the patient referred to orally or in any documents presented in the Discipline hearing of Amie Moore.

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 name of the patient, or any information that could disclose the identity of the patient referred to orally or in any documents presented in the Discipline hearing of Amie Moore.

The Allegations

The allegations against Amie Moore (the "Member") as stated in the Notice of Hearing dated August 11, 2021, 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 working as a Registered Nurse ("RN") at Extendicare Kirkland Lake in Kirkland Lake, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that on or about April 29, 2018:

    a) you spoke to [the Patient] in an inappropriate tone of voice and/or you yelled at [the Patient];
    b) you attempted to put shoes on [the Patient] in a manner that caused [the Patient] pain; and/or
    c) you threw [the Patient]'s shoes into a closet and/or slammed the closet door in the presence of [the Patient];

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 RN at the Facility, you abused a patient verbally, physically, and/or emotionally, and in particular:

    a) you spoke to [the Patient] in an inappropriate tone of voice and/or you yelled at [the Patient];
    b) you attempted to put shoes on [the Patient] in a manner that caused [the Patient] pain; and/or
    c) you threw [the Patient]'s shoes into a closet and/or slammed the closet door in the presence of [the Patient];

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 RN 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:

    a) you spoke to [the Patient] in an inappropriate tone of voice and/or you yelled at [the Patient];

b) you attempted to put shoes on [the Patient], in a manner that caused [the Patient] pain; and/or
c) you threw [the Patient]'s shoes into a closet and/or slammed the closet door in the presence of [the Patient].

Member's Plea

The Member admitted the allegations set out in paragraphs #1(a), (b), (c), #2(a), (b), (c) and #3(a), (b) and (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's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

THE MEMBER

1. Amie Moore (the "Member") obtained a diploma in nursing from Northern College – Kirkland Lake Campus, in 2004.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on April 6, 2008.

3. The Member was employed as a RN at Extendicare Kirkland Lake (the "Facility") from July 20, 2004 until May 4, 2018, when her employment was terminated. She had previously worked at the Facility as a Personal Support Worker ("PSW") from 1998 until 2004.

PRIOR HISTORY

4. The Member has no prior disciplinary findings with CNO.

THE FACILITY

5. The Facility is located in in Kirkland Lake, Ontario.

6. The Facility is a long-term care home with approximately 100 residents on two floors in private, semi-private, and ward rooms.

7. When the Facility is fully staffed, a Charge RN oversees care for all residents, and is

supported by teams comprised of one Registered Practical Nurse ("RPN") and five or six PSWs per floor.

8. The Member was the Charge RN during her day shift on April 29, 2018.

9. One of the two RPNs scheduled to work during the day shift on April 29, 2018, called in sick and the Facility was not able to find a replacement.

FACILITY POLICIES

10. The Facility has a policy entitled "Zero Tolerance Residence Abuse and Neglect Program" (the "Abuse Policy") which all employees are required to read. All Facility employees are also required to complete training and education on the Abuse Policy.

11. Under the Abuse Policy, emotional abuse can include threatening, insulting, intimidating or humiliating gestures, actions, behavior or remarks.

12. The Abuse Policy defines verbal abuse as "any form of verbal communication of a threatening or intimidating nature or any form of verbal communication of a belittling or degrading nature which diminishes a resident's sense of well-being, dignity or self-worth."

THE PATIENT

13. The Patient, [ ], was approximately 80 years old at the time of the incident.

14. At the time of the incident, [the Patient] was a resident of the Facility on Respite Care. She later became a permanent long-term resident.

15. Respite Care involves a short-term stay at the Facility for a period of 30 – 90-days (i.e. when family members are out of town and unable to care for the resident).

16. In or around January 2018, [the Patient] suffered a right hip fracture and received a hip replacement. While on Respite Care at the Facility, [the Patient] had ongoing chronic pain, joint, and swelling issues in her right hip and legs. She was being closely monitored to determine if there was a hardware failure in her hip.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

17. On or around April 11, 2018, members of [the Patient]'s family attended the Facility and brought her a pair of tension socks to assist with the swelling in her leg and foot. As they did not fit, the socks were returned.

18. On April 29, 2018, the Member was called to [the Patient]'s room to assist with a transfer of [the Patient] from her bed to the washroom. [The Patient]'s care plan required the use of a pivot disc to transfer her to a wheelchair, although [the Patient] refused to use the pivot disc on that date.

19. When the Member entered [the Patient]'s room, [ ], PSW, was already present.

20. The Member first asked [the Patient] to put on tension socks because her feet were swollen. [The Patient] informed the Member that the tension socks had been returned because they did not fit.

21. The Member became frustrated and in an inappropriate tone, told [the Patient] that she needed to put on shoes with a proper grip to attend the washroom.

22. [The Patient] had three pairs of shoes with her at the Facility and advised the Member that none of the three pairs fit her feet due to the swelling.

23. The Member tried to put two different pairs of shoes on [the Patient]: a pair of slip-on shoes and a pair of Velcro shoes that open completely. The shoes would not fit on [the Patient]'s feet due to the swelling.

24. When the Member attempted to put the two different pairs of shoes on [the Patient]'s feet, the Member observed [the Patient] grimace from pain as her hip was jostled, although the Member was not forceful in attempting to put the shoes on her feet.

25. [The Patient] became visibly upset and cried while the Member tried to put the shoes on [the Patient].

26. When the shoes would not fit on [the Patient]'s feet, the Member then threw [the Patient]'s shoes into the closet in [the Patient]'s room and the closet door slammed shut. If the Member were to testify, she would state that the hinges on the closet door were loose and that she had not intended to slam the door. Nevertheless, the Member acknowledges that [the Patient] perceived the Member as having slammed the closet door.

27. With a raised voice, the Member told [the Patient] that her son had to bring new shoes to [the Patient] no later than the following day.

28. The Member then left [the Patient]'s room while [the PSW] remained with [the Patient]. [The Patient] urinated on herself because she did not make it to the washroom in time. [The Patient] later requested that a witness be present whenever the Member was in her room.

29. If the Member were to testify, she would say that her conduct with [the Patient] was due to the stress and pressure she was experiencing that day because of staffing and workload issues, and because she was frustrated that [the PSW] had not completed [the Patient]'s transfer without the Member's assistance. She would further state that she had no intention of harming [the Patient] and was attempting to minimize the risk of a fall and deterioration of [the Patient]'s condition.

30. The Member admits and acknowledges that the tone and manner she adopted when interacting with [the Patient] was not an appropriate way to respond to the situation and communicate with a resident of the Facility. The Member would further testify that she has gained insight into the way her serious tone and manner may be perceived negatively by others.

CNO STANDARDS

31. 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.

32. 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.

33. 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 nurse-patient relationship is based on trust, respect, empathy and professional intimacy, and requires the appropriate use of power inherent in the care provider's role.

34. 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:

    a. being aware of her/his verbal and non-verbal communication style and how [patients] might perceive it;

    b. modifying communication style, as necessary, to meet the needs of the [patient]; and

c. recognizing that all behaviour has meaning and seeking to understand the cause of a [patient's] unusual comment, attitude or behaviour.

35. 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:

a. 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

b. 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.

36. In addition, the *TNCR Standard* provides examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, threatening gestures, teasing or taunting, insensitivity to the patient's preferences and an inappropriate tone of voice, such as one expressing impatience.

37. The Member admits and acknowledges that her comments and gestures directed at [the Patient] 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], including throwing the Patient's shoes into the closet and the door slamming shut, amounted to verbal and emotional abuse.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

38. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), 1(b) and 1(c) of the Notice of Hearing in that she contravened the standards of practice of the profession, as described in paragraphs 5 to 37 above.

39. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a), 2(b), and 2(c) of the Notice of Hearing, in that she verbally and emotionally abused the Patient, as described in paragraphs 5 to 37 above.

40. The Member admits that she committed acts of professional misconduct as alleged in paragraphs 3(a), 3(b), and 3(c) of the Notice of Hearing, and in particular, her conduct was dishonourable and unprofessional, as described in paragraphs 5 to 37 above.

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), #2(a), (b), (c) as it relates to verbal and emotional abuse, #3(a), (b) and (c) of the Notice of Hearing. As to allegations #3(a), (b) and (c), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession 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.

Allegations #1(a), (b) and (c) in the Notice of Hearing are supported by paragraphs 5 to 38 in the Agreed Statement of Facts. The Member admitted that she failed to meet the standards of practice when she made abusive comments and gestures that were perceived as threatening to the patient. The Member agrees that she spoke to the patient with an inappropriate tone and threw the patient's shoes into a closet and the closet door slammed shut. The Member acknowledges that the patient perceived her as having slammed the closet door. The patient was so concerned that she requested that a witness be present whenever the Member was in her room. The College's *Professional Standards* provides that nurses are responsible for ensuring that their conduct meets legislative requirements and the standards of practice of the profession. A nurse demonstrates this standard by providing and promoting the best possible care for patients. Further the College's *Professional Standard* requires that each nurse establish and maintain respectful, collaborative, therapeutic and professional relationships by demonstrating respect and empathy for patients. The College's *Therapeutic Nurse-Client Relationship Standard* ("*TNCR Standard*") places responsibility on nurses to be aware of her/his verbal and non-verbal communication style and how it might be perceived. The Member, by her admission, did not meet these standards.

Allegations #2(a), (b) and (c) in the Notice of Hearing are supported by paragraphs 5 to 37 and 39 in the Agreed Statement of Facts. The Member admits that she verbally and emotionally abused the patient. The *Professional Standards* required the Member to be respectful, therapeutic and show empathy and respect for patients. Using an inappropriate tone and/or yelling at a frail and elderly patient did not meet this standard. Throwing the patient's shoes in a closet followed by demanding in a raised voice that the patient's son needed to bring new shoes the following day was also a threatening and abusive act that created mistrust for the patient. The actions of the Member were a clear violation of the *TNCR Standard*. The Panel accepted that the Member was not physically forceful in attempting to put shoes on the

patient's feet and therefore made its decision based on the evidence of verbal and emotional abuse.

With respect to allegations #3(a), (b) and (c), the Panel finds that the Member's conduct, consisting of upsetting comments and gestures that were made towards a vulnerable patient and were perceived as threatening, was unprofessional and dishonourable as it demonstrated a serious disregard for her professional obligations. The conduct arose during the course of treatment of a vulnerable, elderly patient and therefore is relevant to the practice of nursing. Patients expect nurses to be respectful, empathetic and foster a therapeutic relationship despite the hardships of the work environment. The Member was under considerable work stress and unfortunately, allowed this to impact care to the patient. She was abusive in her conduct and created a mistrustful relationship with the patient. The Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

College Counsel and the Member's 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 three 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 November 22, 2021 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date 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, and 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 this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended) 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 seriousness of the Member's conduct which warrants a significant regulatory response;
- There were deficits in the Member's conduct and comments to a vulnerable and elderly patient causing patient upset and breach of trust between the Member and her patient to a point that the patient felt unsafe;

- The Member showed poor leadership and role modelling to her colleagues.

The mitigating factors in this case were:

- The Member has attended this hearing and has come to a mutual agreement on the facts of this hearing;
- The Member has accepted responsibility for her actions and has cooperated with the College by agreeing to the Agreed Statement of Facts and the Joint Submission on Order;
- The Member has no prior disciplinary history with the College.

The proposed penalty provides for general deterrence through the two month suspension of the Member's certificate of registration. This sends a clear message to the membership that these actions fall well below the acceptable standards of nursing practice and are a reminder of the consequences of such substandard practice.

The proposed penalty provides for specific deterrence through a two month suspension and an oral reprimand.

The proposed penalty provides for remediation and rehabilitation through attendance and participation in two meetings with a Regulatory Expert, completion of Reflective Questionnaires and completion of learning modules.

Overall, the public is protected by the two month suspension of the Member's certificate of registration and the requirement of employer notification of this decision for a period of 9 months.

College Counsel submitted that the request to delay the suspension for 60 days until November 21, 2021 was to allow the Member's current employer, in the circumstances of the current COVID-19 pandemic, sufficient time to secure an appropriate replacement for the period of the Member's suspension.

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. Fu (Discipline Committee, 2020): This case was similar in that a member treated an elderly patient in a belittling manner and used inappropriate, unprofessional gestures while communicating with this patient. In this case, the member also bent the patient's thumb when she forced the patient's hands onto a stand lift. The member did not follow the patient's plan of care when transferring the patient. This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member's penalty included an oral reprimand, a 2 month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert and 9 months of employer notification.

CNO v. Blum (Discipline Committee, 2019): This case included an additional allegation and one incident of the member slapping a patient. This case included the member's conduct with two patients. This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The penalty included an oral reprimand, a three month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert and 12 months of employer notification.

The Member's Counsel submitted that the Member had accepted responsibility, expresses her apology and is remorseful. She has learned, gained insight and has reflected on her oversights and will act in accordance with the standards. She is currently working as an RN without any issues.

In terms of mitigation, the Member has cooperated, admitted her misconduct, is remorseful and has apologized.

The Joint Submission on Order will protect the public interest and sends a message of general deterrence.

Penalty Decision

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

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

2. The Executive Director is directed to suspend the Member's certificate of registration for 2 months. This suspension shall take effect from November 22, 2021 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date 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, and 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 this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended) 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 and is proportionate to the misconduct. The reprimand reinforces to the Member the seriousness of this misconduct and the suspension sends a clear message to the Member and the membership that professional misconduct of this nature will result in significant sanctions. The terms, conditions and limitations balance the interest of remediation of the Member with the need to ensure that public interest and protection are maintained.

The penalty is consistent with what has been ordered in prior decisions.

I, Mary MacNeil, 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.