DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Carly Gilchrist, RPN	Chairperson
	Sylvia Douglas	Public Member
	Karen Goldenberg	Public Member
	Sherry Szucsko-Bedard, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	GLYNNIS HAWE for
	)	College of Nurses of Ontario
- and -	)	
	)	
LYNNE TANGUAY	)	NO REPRESENTATION for
Registration No. JD00192	)	Lynne Tanguay
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: September 8, 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 8, 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 the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented in the Discipline hearing of Lynne Tanguay.

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

The Allegations

The allegations against Lynne Tanguay (the "Member") as stated in the Notice of Hearing dated July 28, 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 Practical Nurse ("RPN") at the Teck Pioneer Residence 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:

    a) you failed to administer sliding scale Insulin at 11:00 hrs to [Patient A] as ordered, and/or to confirm or clarify the order with a physician, on one or more of the occasions listed in Appendix "A";

    b) on or about September 20, 24, and/or 25, 2018, you documented that you administered sliding scale Insulin at 16:00 hrs and at 17:00hrs to [Patient A], contrary to the physician's order;

    c) on or about September 24, 2018, you improperly delegated a nursing task, applying a topical steroidal cream, to a non-registered staff member;

    d) on or about September 24 and/or 25, 2018, you requested a report regarding a patient's personal health information from a non-registered staff member in a public area of the Facility;

    e) on or about September 25, 2018, you left [Patient B]'s medications in the Facility's dining room, unsupervised;

    f) on or about September 25, 2018, you instructed a non-healthcare professional, the family member of another patient, to administer medication to [Patient D];

    g) on or about September 25, 2018, you repeatedly said "my shift is over, I don't have time for this", or words to that effect, while assisting [Patient E] following a fall; and/or

    h) on or about September 29, 2018, you failed to adequately assess [Patient D];

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(37) of *Ontario Regulation 799/93*, in that while employed as a RPN 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) you failed to administer sliding scale Insulin at 11:00 hrs to [Patient A], as ordered, and/or to confirm or clarify the order with a physician, on one or more of the occasions listed in Appendix "A";

b) on or about September 20, 24, and/or 25, 2018, you documented that you administered sliding scale Insulin at 16:00 hrs and at 17:00hrs to [Patient A], contrary to the physician's order;

c) on or about September 24, 2018, you improperly delegated a nursing task, applying a topical steroidal cream, to a non-registered staff member;

d) on or about September 24 and/or 25, 2018, you requested a report regarding a patient's personal health information from a non-registered staff member in a public area of the Facility;

e) on or about September 25, 2018, you left [Patient B]'s medications in the Facility's dining room, unsupervised;

f) on or about September 25, 2018, you instructed a non-healthcare professional, the family member of another patient, to administer medication to [Patient D];

g) on or about September 25, 2018, you repeatedly said "my shift is over, I don't have time for this", or words to that effect, while assisting [Patient E] following a fall; and/or

h) on or about September 29, 2018, you failed to adequately assess [Patient D]

APPENDIX A

	Date (on or about)
i.	December 20, 2017
ii.	December 23, 2017
iii.	December 24, 2017
iv.	December 25, 2017
v.	December 26, 2017
vi.	January 3, 2018
vii.	January 6, 2018
viii.	January 7, 2018
ix.	January 8, 2018
x.	January 9, 2018
xi.	January 29, 2018
xii.	January 30, 2018
xiii.	February 2, 2018
	Date (on or about)
xiv.	February 3, 2018
xv.	February 4, 2018

xvi.	February 7, 2018
xvii.	February 8, 2018
xviii.	February 12, 2018
xix.	February 17, 2018
xx.	February 18, 2018
xxi.	February 21, 2018
xxii.	February 22, 2018
xxiii.	February 26, 2018
xxiv.	February 27, 2018
xxv.	March 2, 2018
xxvi.	March 3, 2018
xxvii.	March 4, 2018
xxviii.	March 7, 2018
xxix.	March 8, 2018
xxx.	March 12, 2018
xxxi.	March 17, 2018
xxxii.	March 21, 2018
xxxiii.	March 27, 2018
xxxiv.	March 30, 2018
xxxv.	March 31, 2018
xxxvi.	April 1, 2018
xxxvii.	April 4, 2018
xxxviii.	April 5, 2018
xxxix.	April 9, 2018
xl.	April 14, 2018
xli.	April 15, 2018
xlii.	April 18, 2018
xliii.	April 19, 2018
xliv.	April 24, 2018
xlv.	April 27, 2018
xlvi.	April 28, 2018
xlvii.	April 29, 2018
xlviii.	May 2, 2018
xlix.	May 3, 2018
	Date (on or about)
l.	May 7, 2018
li.	May 21, 2018

lii.	May 22, 2018
liii.	May 25, 2018
liv.	May 26, 2018
lv.	May 27, 2018
lvi.	May 30, 2018
lvii.	May 31, 2018
lviii.	June 4, 2018
lix.	June 5, 2018
lx.	June 9, 2018
lxi.	June 10, 2018
lxii.	June 13, 2018
lxiii.	June 14, 2018
lxiv.	June 18, 2018
lxv.	June 19, 2018
lxvi.	June 27, 2018
lxvii.	June 28, 2018
lxviii.	July 2, 2018
lxix.	July 3, 2018
lxx.	July 7, 2018
lxxi.	July 8, 2018
lxxii.	July 11, 2018
lxxiii.	July 12, 2018
lxxiv.	July 16, 2018
lxxv.	July 17, 2018
lxxvi.	August 8, 2018
lxxvii.	August 9, 2018
lxxviii.	August 13, 2018
lxxix.	August 14, 2018
lxxx.	August 17, 2018
lxxxi.	August 22, 2018
lxxxii.	August 23, 2018

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Lynne Tanguay, (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on December 31, 2003. The Member resigned her certificate of registration on November 16, 2020.

2. The Member was employed at Teck Pioneer Residence in Kirkland Lake, Ontario (the "Facility") as an RPN from August 11, 2008 to October 4, 2018, when her employment was terminated as a result of the incidents described below. At the time of her termination by the Facility, the Member was working full-time in the Facility's general unit, which had 32 patients.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Patient [A]

Insulin Administration Incidents

3. [Patient A] is diabetic and was ordered to receive multiple types of insulin including:

    - Regular Insulin Human-100 subcutaneously at "lunch";
    - Lantus Insulin at "bedtime"; and
    - Novorapid Insulin four times a day, at 0700, 1100, 1600, and 2000 hrs.

4. [Patient A]'s Novorapid was ordered on a sliding scale as follows:

    - for blood glucose of 10mmol/L or less, no units of insulin were to be administered;
    - for blood glucose of 10.1-15mmol/L, 14 units of insulin were to be administered;
    - for blood glucose of 15.1-17mmol/L, 17 units of insulin were to be administered;
    - for blood glucose of 17.1-20mmol/L, 20 units of insulin were to be administered; and
    - for blood glucose above 25mmol/L, a physician was to be called.

5. [Patient A]'s blood glucose was also to be tested four times per day, at the same time as the sliding scale Novorapid administrations.

6. [Patient A]'s medication orders were reviewed and continued by his physician, [Doctor A], on February 20, 2018, February 28, 2018, May 29, 2018, May 30, 2018, and June 5, 2018. In each case, [Doctor A] continued the 1100 hrs sliding scale Novorapid order.

7. On June 5, 2018, [Doctor A] replaced [Patient A]'s lunchtime order for Regular Insulin Human-100 with 10 units of 30/70 Human Insulin subcutaneously, also at lunchtime. The 1100 hrs sliding scale Novorapid order was continued.

8. On 82 dates between December 20, 2017 to August 24, 2018, the Member withheld [Patient A]'s 1100 hrs administration of Novorapid insulin despite [Patient A]'s blood glucometer readings indicating that insulin should have been administered in some quantity.

9. The 82 dates included:
    - December 20, 23, 24, 25, and 26, 2017;
    - January 3, 6, 7, 8, 9, 29, and 30, 2018;
    - February 2, 3, 4, 7, 8, 12, 17, 18, 21, 22, 26, and 27, 2018;
    - March 2, 3, 4, 7, 8, 12, 17, 21, 27, 30, and 31, 2018;
    - April 1, 4, 5, 9, 14, 15, 18, 19, 24, 27, 28, and 29, 2018;
    - May 2, 3, 7, 21, 22, 25, 26, 27, 30, and 31, 2018;
    - June 4, 5, 9, 10, 13, 14, 18, 19, 27, and 28, 2018;
    - July 2, 3, 7, 8, 11, 12, 16, and 17, 2018; and
    - August 8, 9, 13, 14, 17, 22, and 23, 2018.

10. The Member was not authorized to independently decide to withhold medication from [Patient A], and the Member did not make any attempt to clarify the medication order with [Patient A]'s physician before withholding the medication.

11. On or around September 20, 2018, the Facility's pharmacy failed to remove a discontinued order for sliding scale insulin at 1700hrs from [Patient A]'s MAR. The Member failed to recognize the error and on September 20, 24, and 25, 2018, she signed as having administered sliding scale insulin at both 1600hrs and 1700hrs to Patient [A], without recognizing that the 1700hrs order was no longer valid, and despite not having administered doses of insulin at the times signed for.

Steroidal Cream Incident

12. On September 24, 2018, the Member asked a Personal Support Worker ("PSW"), [ ], to apply Betamethasone Valerate 0.1%, a steroidal cream, to [Patient A]. [The

Personal Support Worker] refused because it was not within the scope of her responsibilities.

13. PSWs are permitted by the Facility's *Transfer of Function* Policy to apply some topical creams, including non-steroidal prescription topical medications. The *Transfer of Function* Policy does not permit PSWs to apply steroidal creams. The Facility's *Medication Administration* Policy does permit PSWs to apply topicals they are "not otherwise permitted to administer" if: they have been trained by a registered staff member to administer topicals, the registered staff member who is permitting the administration is satisfied that the unregistered staff can safely administer the topical, and the unregistered staff member administers the topical cream under the supervision of the registered nursing staff. The Member's attempted delegation did not meet these criteria.

Personal Health Information Incidents

14. Also, on September 24, 2018, the Member asked [the Personal Support Worker] during meal service in the dining room for a report on whether Patient [A] had a bowel movement. [The Personal Support Worker] refused to provide a report because it would involve breaching Patient [A]'s privacy.

15. The following day, on September 25, 2018, the Member again asked [the Personal Support Worker] to provide her a report on Patient [A] in the dining room. [The Personal Support Worker] again refused to provide a report because it would involve breaching Patient [A]'s privacy.

<u>Patient [B]</u>

16. On or about September 25, 2018, Patient [B] was seated in the Facility's dining room at breakfast time. The Member approached Patient [B] and left a cup of pills at the table beside her. The Member then left the room.

17. Patient [B] had dozed off and, as such, was not aware that the medications were left beside her. Shortly thereafter, a male patient, Patient [C], attempted to grab the cup of medication.

18. A housekeeper at the Facility, [ ], intervened and prevented Patient [C] from taking Patient [B]'s medication cup. [The Housekeeper] then notified [the Personal Support Worker] of the incident.

19. There was no harm to Patient [B] or Patient [C] as a result of the incident.

<u>Patient [D]</u>

Medication Administration Incident

20. On September 25, 2018, Patient [D] was agitated and yelling.

21. Patient [D] was yelling the name "[Visitor A]", which referred to [Visitor A], the son of another patient. [Visitor A] and Patient [D] had known each other for many years.

22. The Member approached [Visitor A] and asked him to try and calm Patient [D] down and to give him medication. The Member then handed a cup of apple sauce with medication in it to [Visitor A].

23. [Visitor A] spoke with Patient [D] for approximately half a minute before Patient [D] started yelling at him. [Visitor A] attempted to calm Patient [D] and give Patient [D] his medication, but he was unsuccessful.

24. The Member documented in Patient [D]'s progress notes that he was very agitated and swearing at staff. The Member also documented that Patient [D] grabbed the Member by the wrist and squeezed and grabbed another individual by the throat. In addition, the Member documented that she "tried everything", including asking Patient [D]'s daughter to attempt to calm him down, which was unsuccessful. The Member also documented that a Registered Nurse ("RN") called the physician and the physician ordered 5mg of Haldol. Five staff members were required to administer the Haldol by injection.

25. The Member did not document asking [Visitor A] to assist or attempt to administer medication to Patient [D].

26. The Facility's *Medication Administration: Preparation and General Guidelines* Policy governs the administration of medications. According to the policy, no person shall administer a drug to a patient unless that person is a RN or a RPN.

Failure to Assess Patient [D]

27. On September 29, 2018, [the Housekeeper] and [the Personal Support Worker] reported to the Member that there was something wrong with Patient [D], and that he did not seem himself as he wasn't eating and was lethargic. The Member replied that it was due to Patient [D]'s new medication.

28. Later that day, the Member documented in Patient [D]'s chart that he was very quiet and lethargic and more confused than usual. The Member did not document conducting any further assessment of Patient [D] at that time, which was inadequate in the circumstances.

29. On September 30, 2018, [the Personal Support Worker] raised the issue with another nurse, who ordered the Member to assess Patient [D] and check his urine.

30. At or around 18:10 on September 30, 2018, the Member conducted an assessment as directed, and discovered that Patient [D] had a urinary tract infection.

Patient [E]

31. Patient [E] was confined to a wheelchair. On September 25, 2018, Patient [E] was allowed outside the Facility by another patient. Patient [E] then fell off the curb in her wheelchair and sustained a broken thumb, broken ribs and some bruising.

32. After Patient [E] fell, the Member, three PSWs, and the oncoming shift charge nurse went outside to assist. While the PSWs tended to Patient [E], the Member stated approximately four times, "my shift is over, I don't have time for this." The individuals present could hear the Member make this statement, including Patient [E].

33. The Member ultimately remained with Patient [E] until the ambulance arrived, approximately 10 minutes later.

CNO STANDARDS

Professional Standards

34. CNO's *Professional Standards* provides an overall framework for the practice of nursing and a link with other standards, guidelines and competencies developed by CNO. It includes seven broad standard statements pertaining to accountability, continuing competence, ethics, knowledge, knowledge application, leadership and relationships.

35. CNO's *Professional Standards* provides, in relation to the accountability standard, that nurses are accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of the profession. Nurses are responsible for their actions and the consequences of those actions as well as for conducting themselves in ways that promote respect for the profession. Nurses demonstrate this standard by actions such as:

    - providing, facilitating, advocating and promoting the best possible care for [patients];
    - seeking assistance appropriately and in a timely manner;
    - ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;

- taking action in situations in which [patient] safety and well-being are compromised; and
- taking responsibility for errors when they occur and taking appropriate action to maintain [patient] safety.

36. In relation to the ethics standard, CNO's *Professional Standards* provides, among other things, that ethical nursing means promoting the values of patient well-being, respecting patient choice, as well as assuring privacy and confidentiality.

37. In addition, CNO's *Professional Standards* provides, in relation to the knowledge application standard, that nurses continually improve the application of professional knowledge. Nurses demonstrate this standard by actions such as:

    - assessing/describing the [patient] situation using a theory, framework or evidence-based tool;
    - identifying/recognizing abnormal or unexpected [patient] responses and taking action appropriately;
    - recognizing limits of practice and consulting appropriately; and
    - identifying and addressing practice-related issues.

38. CNO's *Professional Standards* further provides, in relation to the leadership standard, that nurses demonstrate leadership by providing, facilitating and promoting the best possible care/service to the public. Nurses demonstrate this standard by actions such as role-modelling professional values, beliefs and attributes.

Medication

39. CNO's *Medication* standard ("*Medication Standard*") describes nurses' accountabilities when engaging in medication practices. CNO's *Medication Standard* provides that three principles outline the expectations related to medication practices that promote public protection including authority, competence and safety.

40. CNO's *Medication Standard* provides, in relation to authority, that nurses must have the necessary authority to perform medication practices. It further provides that RNs and RPNs require an order for medication practices when a controlled act is involved, they are administering a prescription medication, or it is required by legislation that applies to a practice setting. Nurses are to accept orders that are clear, complete and appropriate. If nurses receives an order that is unclear, incomplete or inappropriate, they are not to perform the medication practice and instead must follow-up with a prescriber in a timely manner.

41. CNO's *Medication Standard* provides, in relation to competence, that nurses ensure they have the knowledge, skill and judgment needed to perform medication practices safely. It further provides that nurses:

    - ensure their medication practices are evidence-informed;
    - assess the appropriateness of the medication practice by considering the [patient], the medication and the environment;
    - know the limits of their knowledge, skill and judgment and get help as needed; and
    - do not perform medication practices that they are not competent to perform.

42. CNO's *Medication Standard* provides, in relation to safety, that nurses promote safe care, and contribute to a culture of safety within their practice environments, when involved in medication practices. It further provides that nurses take appropriate action to resolve or minimize the risk of harm to a patient from a medication error or adverse reaction and they report medication errors, near misses or adverse reactions in a timely manner.

Therapeutic Nurse-Patient Relationship

43. 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* provides that the nurse-patient relationship is built on trust, respect, empathy, professional intimacy and requires the appropriate use of power.

44. The *TNCR Standard* further 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];
    - recognizing that all behaviour has meaning and seeking to understand the cause of a [patient's] unusual comment, attitude or behaviour; and
    - reflecting on interactions with a [patient] and the health care team, and investing time and effort to continually improve communication skills.

45. The *TNCR Standard* also requires nurses to protect the patient from harm. In this respect, a nurse demonstrates having met the standard by not exhibiting physical,

verbal and non-verbal behaviours toward a patient that demonstrate disrespect for the patient and/or are perceived by the patient and/or others as abusive.

Working with Unregulated Care Providers

46. CNO's *Working with Unregulated Care Providers Guideline* ("*UCP Guideline*") clarifies the roles and responsibilities of nurses in relation to Unregulated Care Providers ("UCP") and identifies expectations for nurses when UCPs are part of the healthcare team. CNO's *UCP Guideline* provides that nurses who work with UCPs have certain accountabilities related to teaching, delegating, assigning and supervising depending on the nature of their role.

47. Nurses who assign duties to or supervise UCPs must know the UCP is competent to perform the particular procedure or activity safely for the [patient] in the given circumstances. A nurse who assigns or supervises is expected to verify that the UCP's competence has been determined.

48. With respect to [Patient A], the Member admits and acknowledges that she contravened CNO's *Professional Standards*, *Medication Standard* and *UCP Guideline* when she failed to administer sliding scale insulin to Patient [A] as ordered and failed to confirm or clarify the order with a physician; documented that she administered sliding scale insulin at 1600 hrs and at 1700 hrs to Patient [A], contrary to the physician's order; improperly delegated the nursing task of applying a topical steroidal cream to a non-registered staff member; and requested a report regarding a patient's personal health information from a non-registered staff member in a public area of the Facility.

49. With respect to Patient [B], the Member admits and acknowledges that she contravened CNO's *Professional Standards* and *Medication Standard* when she left Patient [B]'s medications in the Facility's dining room, unsupervised.

50. With respect to Patient [D], the Member admits and acknowledges that she contravened CNO's *Professional Standards* and *Medication Standard* when she instructed a non-healthcare professional, the family member of another patient, to administer medication to Patient R.M; and when she failed to adequately assess Patient [D].

51. With respect to Patient [E], the Member admits and acknowledges that she contravened CNO's *Professional Standards* and *TNCR Standard* when she said "my shift is over, I don't have time for this" while assisting Patient [E] following a fall.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

52. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1 (a), (b), (c), (d), (e), (f), (g) and (h) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as described in paragraphs 3 to 51 above.

53. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2 (a), (b), (c), (d), (e), (f), (g) and (h) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 3 to 51 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), (d), (e), (f), (g), (h), 2(a), (b), (c), (d), (e), (f), (g) and (h) of the Notice of Hearing. As to allegations #2(a), (b), (c), (d), (e), (f), (g) and (h), 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.

Allegation #1(a) in the Notice of Hearing is supported by paragraphs 3-10, 39, 40-42 and 52 in the Agreed Statement of Facts. The Member admitted that she committed professional misconduct when she failed to administer subcutaneous insulin 82 times while caring for [Patient A] as ordered. The College's *Medication Standard* documents a nurse must follow up with a prescriber in a timely manner if an order is unclear, but also needs to demonstrate the knowledge, skill and judgement to perform medication practices safely. Missing 82 doses of insulin administration demonstrates lack of knowledge. Furthermore, the Member did not inquire or ask for assistance if she did not understand the written order.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 3-11, 39, 40-42 and 52 in the Agreed Statement of Facts. The Member failed to identify that the 17:00 hours insulin order from [Patient A]'s medication administration record was no longer valid and went on to sign as if she administered the insulin at 17:00 hours for the dates of September 20, 24 and 25, 2018 even though she had also signed she administered the insulin at 1600 hours as well on the same days. The Member failed to meet the College's *Medication Standard* when she signed as if she administered insulin at both 1600 hours and 1700 hours when she did not.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs 12-13, 39, 40-42, 46-48 and 52 in the Agreed Statement of Facts. The Member asked a Personal Support Worker ("PSW") to apply steroidal cream on a patient. The College's *Working with Unregulated Care Providers* guideline ("*UCP Guideline*") states a nurse must know that the Unregulated Care Providers ("UCP") is competent to provide the care being asked of them. The Facility's *Transfer of Function* Policy clearly stated that PSWs cannot administer steroidal creams. The College's *Medication Standard* documents that nurses must take appropriate action to minimize risk of harm from a medication error.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs 14, 15, 36, 48 and 52 in the Agreed Statement of Facts. While in the Facility's dining room the Member asked the PSW if [Patient A] had a bowel movement as well as requested a report on [Patient A]. By discussing and requesting personal health information in an open space the Member failed to meet the College's *Ethics Standard* as she breached [Patient A]'s privacy and confidentiality.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 16-19, 26, 35, 39-42, 49 and 52 in the Agreed Statement of Facts. The Member left [Patient B]'s medication on the dining room table beside her. The Member did not stay to ensure [Patient B] took her medication, as she left the dining room. [Patient B] dozed off and at that time a staff member witnessed another patient attempting to take [Patient B]'s medication from the table. Even though it was fortunate the medication was not taken by another patient the Member failed to meet both the *Professional Standards* and the *Medication Standard* when she left [Patient B]'s medication unsupervised.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs 20-26, 39-42, 50 and 52 in the Agreed Statement of Facts. The Member requested a visitor who was visiting another patient in the Facility to administer medication to [Patient D] who was agitated at the time. The Member provided applesauce for the visitor to use to assist in the administration of the medication. The Member failed to document this request of the visitor in [Patient D]'s health record. The Facility where the Member was working at the time had a *Medication Administration: Preparation and General Guidelines* Policy that specifically stated no person shall administer a drug to a patient unless that person is a RN or a RPN. By her actions, the Member contravened the College's *Professional Standards* and *Medication Standard*.

Allegation #1(g) in the Notice of Hearing is supported by paragraphs 31-33, 35, 43-45, 51-52 in the Agreed Statement of Facts. The Member failed to meet the College's *Professional Standards* and the *Therapeutic Nurse-Patient Relationship Standard* ("*TNCR Standard*") when she stated "approximately" four times "my shift is over, I don't have time for this" when she was outside the Facility assisting her colleagues when [Patient E] fell out of her wheelchair. Nurses need to be aware of both their verbal and non-verbal communication when caring for patients. The

Member speaking this way demonstrated disrespect and an uncaring attitude towards [Patient E].

Allegation #1(h) in the Notice of Hearing is supported by paragraphs 27-30, 35, 50 and 52 in the Agreed Statement of Facts. The Member was alerted by a colleague that [Patient D] did not seem himself and was lethargic and not eating. The Member did document this information in [Patient D]'s chart but did not conduct any further assessment of [Patient D] at that time. A day later when a full assessment was completed on [Patient D] it was discovered that he had a urinary tract infection. The College's *Professional Standards* establish that it is expected that a nurse will facilitate and promote the best care for patients. The Member failed to promote the best care for [Patient D] when there was a delay in the assessment after she was alerted to a change in his condition.

With respect to allegations #2(a), (b), (c), (d), (e), (f), (g) and (h), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations including but not limited to, by incorrectly administering subcutaneous insulin on numerous occasions, by not assessing [Patient D] when she was informed of a change of condition and making inappropriate comments while providing patient care.

The Panel also finds that the Member's conduct was dishonourable as she knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional. The Member demonstrated persistent and ongoing breaches of the standards while caring for vulnerable patients. The Member demonstrated an element of moral failing by leaving medication unattended and by making inappropriate comments to the patient she was caring for. This has the potential to put the patient and many other patients at risk. The Member ought to have known better.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 4 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class 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 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of 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 in a practicing class. 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 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. *Medication*,
        3. *Therapeutic Nurse-Client Relationship*,
        4. *Working with Unregulated Care Providers*, and
        5. *Code of Conduct*;

    iv. 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;

    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 one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:
   i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

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

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

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

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

c) The Member shall not practice independently in the community for a period of 18 months from the date the Member returns to the practice of nursing.

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.

College Counsel submitted that the Member has not been practicing nursing since November 2020, but if she decided to reapply the penalty would be initiated at that time.

The aggravating factors in this case were:

- The substantial number of repeated incidents, the frequency of incidents, and the extended length of time over which the incidents occurred;
- The Member was responsible for caring for vulnerable and elderly patients with many health issues;
- Due to the numerous incidents, there was an increased risk of harm that could have occurred to any patient the Member was caring for.

The mitigating factors in this case were:

- The Member was present at the hearing;
- The Member cooperated with the College;
- The Member has taken full responsibility for her actions by agreeing to the Agreed Statement of Facts and the Joint Submission on Order;
- The Member has no prior discipline history with the College.

The proposed penalty provides for general deterrence through:

- The 4 month suspension.

The proposed penalty provides for specific deterrence through:

- The oral reprimand; and
- The 4 month suspension.

The proposed penalty provides for remediation and rehabilitation through:

- The two meetings, at minimum, with a Regulatory Expert which will allow the Member to reflect on her professional standards and requirements;

- The terms, conditions and limitations placed on the Member's certificate of registration.

Overall, the public is protected because this process will assist the Member in gaining insight and knowledge into her practice. The 18 month employer notification will ensure that the Member's practice is monitored for a significant time if she returns to nursing.

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. Popo (Discipline Committee, 2020): The hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member failed to monitor, initiate appropriate interventions and falsified documentation. The member received an oral reprimand, a three month suspension and terms, conditions and limitations on her certificate of registration, including a minimum of two meetings with a Regulatory Expert and eighteen months of employer notification.

CNO v. Russon (Discipline Committee, 2018): The member was not present at the hearing. In this case, the member administered controlled substances without a prescribed order, failed to ensure patients were assessed and failed to document. The member received an oral reprimand, a four month suspension and terms, conditions and limitations on her certificate of registration, including two meetings with a Regulatory Expert and twenty-four months of employer notification. This case has a similar number of allegations as the case before this Panel.

CNO v. Fernandez (Discipline Committee, 2021): The hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member failed to maintain an active glucometer barcode, failed to administer medication properly, failed to flush a catheter properly, failed to assess patients and document patient care. The member received an oral reprimand, a four month suspension and terms, conditions and limitations on her certificate of registration, including a minimum of two meetings with a Regulatory Expert, nursing courses, twelve months of employer notification, meetings with a mentor for at least 8 months and no longer than 12 months and no independent practice for 12 months.

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 4 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class 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 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of 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 in a practicing class. 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 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. *Medication*,
            3. *Therapeutic Nurse-Client Relationship*,
            4. *Working with Unregulated Care Providers*, and
            5. *Code of Conduct*;

        iv. 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;

        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 one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

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

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

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

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

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

1. that they received a copy of the required documents, and

2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession.

c) The Member shall not practice independently in the community for a period of 18 months from the date the Member returns to the practice of nursing.

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 Member resigned from the College in November 2020 and will need to meet re-entry requirements before obtaining a certificate of registration at which time this penalty will take effect. The 18 months of employer notification and no independent practice for 18 months from the date the Member returns to the practice of nursing, will ensure public safety if the Member returns to her nursing practice. The penalty sends a strong message to the Member and the membership as a whole, that there will be serious consequences when Facility policies and College standards are not followed.

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

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