DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Jay Armitage	Public Member
	Carly Gilchrist, RPN	Member
	Carly Hourigan	Public Member
	Andrea Norgate, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
STEPHEN HARPER	)	ANNA LICHTY for
Registration No. 9706607	)	Stephen Harper
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: February 9, 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 February 9, 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 the identities of the patients, referred to orally or in any documents presented in the Discipline hearing of Stephen Harper.

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 the identities of the patients, referred to orally or in any documents presented in the Discipline hearing of Stephen Harper.

The Allegations

The allegations against Stephen Harper (the "Member") as stated in the Notice of Hearing dated January 4, 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 you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

    (a) while practicing as a Registered Nurse at Brockville Mental Health Centre in Brockville, Ontario, on or about February 18, 2019, and/or in or around May or June 2017, and/or on at least one occasion between about June 2017 and February 2019, you told an offensive and/or inappropriate story about yourself in the presence of at least one patient, in which you recounted having said to a prison inmate, while practicing nursing at the prison, words to the effect of "listen here you nigger, I look forward to knowing you'll never be able to eat watermelon and fried chicken again";

    (b) while practicing as a Registered Nurse at Cornwall Hospice in Cornwall, Ontario,

        i) on or about February 17-18, 2017, you attempted a 1-person transfer of [Patient A] when a 2-person transfer was required;

        ii) on or about February 17-18, 2017, you failed to document unsuccessfully attempting a 1-person transfer of [Patient A];

        iii) on or about February 12-13, 2017, you failed to document that [Patient B] had fallen;

        iv) on or about February 12-13, 2017, you administered Buscopan to [Patient B] without authorization;

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 Nurse at Brockville Mental Health Centre in Brockville, Ontario, you abused a client verbally, physically or emotionally, and in particular:

    (a) on or about February 18, 2019, and/or in or around May or June 2017, and/or on at least one occasion between about June 2017 and February 2019, you told an offensive and/or inappropriate story about yourself in the presence of at least one patient, in which you recounted having said to a prison inmate, while practicing nursing at the prison, words to the effect of "listen here you nigger, I look forward to knowing you'll never be able to eat watermelon and fried chicken again";

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(13) of *Ontario Regulation 799/93*, in that, while practicing as a Registered Nurse at Cornwall Hospice in Cornwall, Ontario, you failed to keep records as required, and in particular:

(a) on or about February 17-18, 2017, you failed to document unsuccessfully attempting a 1-person transfer of [Patient A];

(b) on or about February 12-13, 2017, you failed to document that [Patient B] had fallen;

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in particular:

(a) while practicing as a Registered Nurse at Brockville Mental Health Centre in Brockville, Ontario, on or about February 18, 2019, and/or in or around May or June 2017, and/or on at least one occasion between about June 2017 and February 2019, you told an offensive and/or inappropriate story about yourself in the presence of at least one patient, in which you recounted having said to a prison inmate, while practicing nursing at the prison, words to the effect of "listen here you nigger, I look forward to knowing you'll never be able to eat watermelon and fried chicken again";

(b) while practicing as a Registered Nurse at Cornwall Hospice in Cornwall, Ontario,

i) on or about February 17-18, 2017, you attempted a 1-person transfer of [Patient A] when a 2-person transfer was required;

ii) on or about February 17-18, 2017, you failed to document unsuccessfully attempting a 1-person transfer of [Patient A];

iii) on or about February 12-13, 2017, you failed to document that [Patient B] had fallen;

iv) on or about February 12-13, 2017, you administered Buscopan to [Patient B] without authorization.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b)(i), (ii), (iii), (iv), 2(a), 3(a), 3(b), 4(a), 4(b)(i), (ii), (iii) and (iv) 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 as amended reads, unedited, as follows:

THE MEMBER

1. Stephen Harper (the "Member") obtained a diploma in nursing from the School of Health Sciences at St. Lawrence College in 1994.

2. The Member is a Registered Nurse ("RN") with the North Carolina Board of Nursing. He has maintained active registration since January 31, 1997. He has no prior discipline history in that jurisdiction.

3. The Member registered with the College of Nurses of Ontario ("CNO") as an RN on November 20, 1996. He has no prior disciplinary findings with CNO.

4. The Member was employed as a full-time staff nurse at Hospice Cornwall (the "Hospice") in Cornwall, Ontario from November 1, 2015 until April 30, 2017.

5. The Member is currently employed as a full-time staff nurse at the Brockville Mental Health Centre (the "Mental Health Centre") in Brockville, Ontario. The Member has worked in the Forensic Assessment Unit since May 11, 2017. The nurse-patient ratio is 3:1 given the range of patient diagnoses.

THE PATIENTS

6. [Patient B] was a female patient at the Hospice, receiving care for pancreatic cancer as well as other comorbidities and general mobility challenges.

7. [Patient A] was a female patient at the Hospice, receiving care for advanced ALS, as well as other comorbidities and general mobility challenges.

8. The Member was in a nurse-patient relationship with both patients.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Mental Health Centre Incident

Repeatedly Telling Offensive and/or Inappropriate Story Infront of Patients

9. On February 18, 2019, at approximately 2100 hours, the Member was sitting with between four and 10 patients in the dining room for snack time. Security was present in the hallway. The Member was the supervising nurse on duty.

10. The Member was asked by a patient to tell them stories about his time as a nurse in the American prison system.

11. The Member began recounting a story about his last day working in a North Carolina prison in front of patients in the dining hall.

12. The Member said that he told an inmate who was indefinitely imprisoned, “Listen here you nigger, I look forward to knowing you’ll never be able to eat watermelon and fried chicken again.”

13. The Member made follow-up remarks about the association between African American men and fried chicken.

14. Shortly following the snack time, one of the patients reported the incident to another RN at the Mental Health Centre. On or around the morning of February 19, 2019, two patients also reported the incident to the Ministry of Health and Long-term Care’s Psychiatric Patient Advocate Office.

15. If the patients were to testify, they would state that they were emotionally upset and affected by the incident. They would further say that they felt offended and disrespected during their interaction with the Member because one patient was African American and the other patient’s partner and child are racialized persons.

16. On or around February 28, 2019, the Manager of Patient Care Services interviewed the RN about the incident. The RN stated that, although she had not witnessed the February 18, 2019 incident in the dining room, she personally witnessed the Member tell a similar story and use racial slurs on two separate occasions.

17. When interviewed by the Manager of Patient Care Services at the Mental Health Centre, the Member admitted that he told the prison story in front of patients on February 18, 2019. The Member also admitted to telling a similar story on at least two other occasions in front of staff in or around May or June 2017 and between June 2017 and February 2019.

18. If the Member were to testify, he would state that he deeply regrets using a racial slur and that offensive language has no place in the profession. He would further state that he recognizes the impact of his comments on patients and colleagues, and that he will be more self-aware and never repeat this story in the presence of patients or colleagues in future.

Incidents of Professional Misconduct Relating to [Patient B]

Unauthorized Medication Administration

19. While working the night shift on or around February 12-13, 2017, the Member administered 10 mg of Buscopan to [Patient B] for gastrointestinal discomfort, without a physician’s order.

20. The Member charted his administration of the Buscopan, but admits that he administrated the medication without authorization, which fell outside the scope of his duties. The Member acknowledges that, even though he was trying to alleviate [Patient B’s] distress and did not mean to cause her harm, he should have contacted the ordering physician before proceeding with an unauthorized administration.

Failure to Document Patient Fall

21. During the same night shift on or around February 12-13, 2017, [Patient B] fell from her bed and hit her head.

22. The Member did not document that [Patient B] had fallen from her bed, nor did he enter any notes regarding the extent of her injury or evidence of an assessment.

23. On February 13, 2017, the Member told [Patient B's] daughter that her mother had fallen out of bed the previous night, "was tired, scared and vomited 3L of blood. We were in a room gowned up."

24. On February 14, 2017, [Patient B's] family submitted a Client Concerns and Complaints Form to the Hospice regarding the Member's conduct. As a result of this incident and their interactions with the Member, [Patient B's] spouse and daughter requested that the Member no longer be involved with her care.

Incidents of Professional Misconduct Relating to [Patient A]

Unsuccessful Patient Transfer and Failure to Document Unsuccessful Transfer

25. While working the night shift on or around February 17-18, 2017, the Member unsuccessfully attempted a 1-person transfer of [Patient A], contrary to the 2-person transfer method required by [Patient A's] physician and documented in [Patient A's] chart.

26. The Member attempted the inappropriate transfer despite the presence of a Personal Support Worker, who offered to assist with the two-person transfer.

27. The Member discontinued the transfer after an unsuccessful attempt.

28. The Member failed to document the unsuccessful 1-person transfer.

29. [Patient A] suffered spine and neck pain as a result of the Member's inappropriate transfer.

30. On February 18, 2017, [Patient A's] physician submitted a Client Incident Report to the Hospice detailing the incident. The physician affirmed that the Member's 1-person transfer was inappropriate and contrary to [Patient A's] care plan.

31. On February 20, 2017, two physicians who routinely provided care for [Patient A] submitted a Client Concerns and Complaint Form to the Hospice about the incident.

CNO STANDARDS

32. CNO publishes nursing standards to set out the expectations of practice for its members. CNO's standards inform nurses of their accountabilities and apply to all nurses, regardless of their position, job description or practice setting.

Professional Standards

33. CNO's *Professional Standards* provides that "[e]ach nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships. One way of doing so is by demonstrating respect and empathy for, and interest in, [patients]".

34. A nurse meets the standard by demonstrating the following:

    (a) Role-modelling positive collegial relationships,
    (b) Refraining from performing activities that he or she is not competent in carrying out;
    (c) Taking responsibility for errors when they occur and taking appropriate action to maintain patient safety;
    (d) Using a wide range of communication and interpersonal skills to effectively establish and maintain collegial relationships, and
    (e) Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation.

35. The Member contravened the standard of practice of the profession by repeatedly telling an inappropriate story involving racist language, initiating and failing to document an unsuccessful patient transfer, failing to document a patient fall, and administering a medication without a physician's order.

Documentation Standard

36. The *Documentation Standard* states that a nurse meets the standard by "ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process including assessment, planning, intervention (independent and collaborative) and evaluation." As such, the nexus between documentation and responsive care cannot be understated.

37. Documenting, charting and entering progress notes, to name a few examples, are integral components of interprofessional documentation expected of members across employment settings.

38. Maintaining accurate and timely records is not only necessary for developing care plans based on complete health histories. Rather, it is a practice that reflects the nurses' commitment to providing effective and ethical care by showing accountability for professional practice and the care the patient receives.

39. The Member failed to keep records, as required, for two incidents where patient safety was at risk. By not documenting the unsuccessful attempt at a 1-person transfer of [Patient A], as well as failing to document that [Patient B] had fallen, the Member breached the *Documentation Standard*.

Medication Standard

40. CNO's Medication Standard requires nurses to "prepare and administer medication(s) to [patients] in a safe, effective and ethical manner."

41. The standard further sets out the expectation that nurses will not administer medications that require direct orders in order to be carried out. If the nurse has any questions or concerns about the medication being administered or the order given, he or she must follow up with the prescriber in a timely manner.

42. By administering a medication for which he did not have a direct order from a physician, the Member breached the standard of practice by administering Buscopan to [Patient B] without authorization.

Therapeutic Nurse-Client Relationship Standard

43. Nurses are expected to use a variety of interpersonal skills in order to establish and maintain appropriate relationships with their patients and colleagues.

44. CNO's *Therapeutic Nurse-Client Relationship Standard* (the "TNCR") requires members to meet the standard by demonstrating the following, to name a few:

    (a) Contributing to the patient's health and overall well-being;
    (b) Promoting trust, respect, empathy and professional intimacy by recognizing the power inherent in the care provider's role and using it appropriately at all times;
    (c) Being aware of his or her verbal and non-verbal communication style and how patient might perceive it; and,
    (d) Listening to, understanding and respecting patients' values, opinions, needs and ethnocultural beliefs.

45. The TNCR also reinforces the importance of protecting patients from verbal, emotional and physical abuse.

46. Nurses are expected to meet the TNCR by understanding that emotional and verbal abuse can take many forms, including sarcasm, cultural or racial slurs and swearing. There is no place for patient abuse in any practice setting, under any circumstance.

47. The Member failed to meet the TNCR by telling an offensive and inappropriate story in the presence of at least one patient and repeating this story on more than one occasion despite being advised against doing so by a colleague and his employer.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

48. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a), 2(a) and 4(a) of the Notice of Hearing, as described in paragraphs 9-18 above, in that he committed verbal and emotional abuse by telling an offensive and/or

inappropriate story using racialized language on more than one occasion in the presence of at least one patient.

49. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(b)(i), 1(b)(ii), 3(a), 4(b)(i) and 4(b)(ii) of the Notice of Hearing, as described in paragraphs 25-31 above, in that he unsuccessfully attempted and failed to document a 1-person transfer of a patient when a 2-person transfer was required and clearly articulated in the patient's care plan.

50. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(b)(iii), 1(b)(iv), 3(b), 4(b)(iii) and 4(b)(iv) of the Notice of Hearing, as described in paragraphs 19-24 above, in that he failed to document that a patient had fallen and failed to document that he administered Buscopan to the patient without authorization.

51. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1-4 of the Notice of Hearing, as described in paragraphs 9-31, and that his conduct breached the standards of practice of the profession and was disgraceful, dishonourable and unprofessional.

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)(i), (ii), (iii), (iv), 2(a), 3(a) and 3(b) in the Notice of Hearing. With respect to allegation #2(a), the Panel finds that the Member verbally and emotionally abused a client. As to allegations #4(a), 4(b)(i), (ii), (iii) and (iv), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be disgraceful, dishonourable and unprofessional.

Reasons for Decision

The Panel considered the 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 9-18, 32-35 and 43-48 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. On February 18, 2019 the Member was sitting with between four and ten patients in the dinning room. The Member was asked by a patient to tell them stories about his time as a nurse in the American Prison System. The Member said he told an inmate who was indefinitely imprisoned, "Listen here you nigger, I look forward to knowing you'll never be able to eat watermelon and fried chicken again". The Member made follow-up remarks about the association between African American men and fried chicken. The Member was also noted to tell a similar story and use racial slurs on two separate occasions. This was a clear breach of the College's *Professional Standards* and *TNCR Standard*.

Allegation #1(b)(i) in the Notice of Hearing is supported by paragraphs 7, 25-35 and 49 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. [Patient A] was a female patient at the hospice receiving care for advanced ALS, as well as other comorbidities. While working the night shift, the Member unsuccessfully attempted a one-person transfer, contrary to the two-person transfer method required by [Patient A's] physician and documented in the patient chart. The Member completed the inappropriate transfer despite the presence of a personal support worker, who offered to assist with the two-person transfer. The Patient suffered spine and neck pain as a result of the Member's inappropriate transfer.

Allegation #1(b)(ii) in the Notice of Hearing is supported by paragraphs 7, 25-39 and 49 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. [Patient A] was a female patient at the hospice receiving care for advanced ALS, as well as other comorbidities. While working the night shift, the Member unsuccessfully attempted a one-person transfer, contrary to the two-person transfer method required by [Patient A's] physician and documented in the patient chart. The Member completed the inappropriate transfer despite the presence of a personal support worker, who offered to assist with the two-person transfer. The Patient suffered spine and neck pain as a result of the Member's inappropriate transfer. The Member failed to complete appropriate documentation about the above matter and breached the College's standards which it publishes to set out the expectations of practice for its members. The College's standards inform nurses of their accountabilities and apply to all nurses regardless of their position, job description or practice setting. The *Documentation Standard* states that a nurse meets the standard by "ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process".

Allegation #1(b)(iii) in the Notice of Hearing is supported by paragraphs 6, 21-24, 32-39 and 50 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. [Patient B] was a female patient at the hospice, receiving care for pancreatic cancer as well as other comorbidities and general mobility challenges. During the night shift of February 12-13, 2017, the Patient fell from her bed and hit her head. The Member did not document that the Patient had fallen from her bed, nor did he enter any notes regarding the extent of her injury or evidence of an assessment. Documenting, charting, and entering progress notes are integral components of the interprofessional documentation expected of members across the employment setting. Maintaining accurate and timely records is not only necessary, rather it reflects the nurses' commitment to providing effective and ethical care by showing accountability for professional practice and the care the patient receives. This was a clear breach of the *Documentation Standard*.

Allegation #1(b)(iv) in the Notice of Hearing is supported by paragraphs 6, 19, 20, 32-42 and 50 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. While working the night shift on or around February 12-13, 2017, the Member administered 10mg of Buscopan to [Patient B] for gastrointestinal discomfort, without a physician's order. The College's *Medication Standard* requires a nurse to "prepare and administer medication(s) to [patients] in a safe, effective and ethical manner." The standard further sets out the expectation that nurses will not administer medications that require direct orders in order to be carried out. By administering Buscopan to [Patient B] without a direct order from a physician, the Member breached the standard of practice.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 9-18, 32-35 and 43-48 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. On February 18, 2019 the Member was sitting with between four and ten patients in the dinning room. The

Member was asked by a patient to tell them stories about his time as a nurse in the American Prison System. The Member said he told an inmate who was indefinitely imprisoned, “Listen here you nigger, I look forward to knowing you’ll never be able to eat watermelon and fried chicken again”. The Member made follow-up remarks about the association between African American men and fried chicken. The Member was also noted to tell a similar story and use racial slurs on two separate occasions. If the patients were to testify, they would state that they were emotionally upset and affected by the incident. They would further say that they felt offended and disrespected during their interaction with the Member because one patient was African American and the other patient’s partner and child are racialized persons. The Panel finds that the Member verbally and emotionally abused a client.

Allegation #3(a) in the Notice of Hearing is supported by paragraphs 7, 25-39 and 49 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. [Patient A] was a female patient at the hospice receiving care for advanced ALS, as well as other comorbidities. While working the night shift, the Member unsuccessfully attempted a one-person transfer, contrary to the two-person transfer method required by [Patient A’s] physician and documented in the patient chart. The Member completed the inappropriate transfer despite the presence of a personal support worker, who offered to assist with the two-person transfer. The Patient suffered spine and neck pain as a result of the Member’s inappropriate transfer. The Member failed to complete appropriate documentation about the above incident. The College publishes nursing standards to set out the expectations of practice for its members. The College’s standards inform nurses of their accountabilities and apply to all nurses regardless of their position, job description or practice setting. The *Documentation Standard* states that a nurse meets the standard by “ensuring that documentation is a complete record of nursing care provided and reflects all aspects of the nursing process”. As such, the Member failed to keep records as required.

Allegation #3(b) in the Notice of Hearing is supported by paragraphs 6, 21-24, 32-39 and 50 in the Agreed Statement of Facts. The Member admits he committed acts of professional misconduct. [Patient B] was a female patient at the hospice, receiving care for pancreatic cancer as well as other comorbidities and general mobility challenges. During the night shift of February 12-13, 2017, the Patient fell from her bed and hit her head. The Member did not document that the Patient had fallen from her bed, nor did he enter any notes regarding the extent of her injury or evidence of an assessment. Documenting, charting, and entering progress notes are integral components of the interprofessional documentation expected of members across the employment setting. Maintaining accurate and timely records is not only necessary, rather it reflects the nurses’ commitment to providing effective and ethical care by showing accountability for professional practice and the care the patient receives. As such, the Member failed to keep records as required.

With respect to Allegation #4, the Panel finds that the Member’s conduct in using racial slurs, inappropriately transferring two patients and administering medication without a physician’s order as well as putting patients at risk was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations.

It was dishonourable as the Member knew or ought to have known that his conduct was unacceptable and fell below the standards of a professional and it demonstrated an element of dishonesty and deceit.

Finally, the Panel finds that the Member's conduct was disgraceful as it shames the Member and by extension the profession. The conduct casts serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

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 three 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 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 two meetings with a Regulatory Expert (the "Expert"), at his own expense and within six 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 seven days before the first meeting, the Member provides the Expert with a copy of:

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

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

            1. *Code of Conduct,*
            2. *Documentation,*
            3. *Medication,*
            4. *Professional Standards,* and
            5. *Therapeutic Nurse-Client Relationship;*

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

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

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

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's 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 his 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 his certificate of registration.

b) For a period of 18 months from the date this Order becomes final, the Member will notify his 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 his 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 Joint Submission on Order was appropriate as the proposed penalty provides for general deterrence through a three-month suspension and the reprimand which send a clear message to the profession that this conduct will not be tolerated. It will also discourage other members from repeating these actions. The terms, conditions and limitations on the Member's certificate will signal a message to the membership, as a whole, that this type of behaviour is significant and serious and falls well below professional standards.

The proposed penalty provides for specific deterrence through a suspension of three months which is lengthy and by the oral reprimand which will assist the Member in gaining a greater understanding of the impact of his conduct. The terms, conditions and limitations on his license will provide for monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through a combination of self-reflection, review of the College's standards, and a review of the *One is One Too Many* learning package, including two meetings with the Regulatory Expert. The meetings with the Regulatory Expert will help the Member to gain insight into his actions and to remediate his conduct.

The aggravating factors in this case were:

- The seriousness and nature of the Member's conduct.

The mitigating factors in this case were:

- The Member has cooperated with the College and that by agreeing to the Agreed Statement of Facts and Joint Submission on Order, the Member has accepted responsibility for his conduct;
- He has no prior history with the College;
- He voluntarily admitted the allegations;
- The Member is remorseful.

Overall, the public is protected because, after the suspension ends, the Member is required to notify his employers of this decision for 18 months.

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 Lento (Discipline Committee, 2017). In this case the member made inappropriate comments and displayed an inappropriate attitude towards a number of clients. The conduct amounted to verbal, physical and emotional abuse. The penalty was an oral reprimand, a 5-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and employer notification for 24-months.

CNO v Loughrey (Discipline Committee, 2019). In this case the member made inappropriate communication (racist overtone) towards clients, failed to assess one or more of his clients, provided inadequate care, failed to document, failed to administer medication and left early prior to the end of the member's shift. The member did not attend the hearing, and did not admit the allegations and the panel had no information as to the member's remorse or suitability for remediation and rehabilitation. The penalty was an oral reprimand and revocation of the member's certificate of registration.

The Member's Counsel submitted that the mitigating factors in this case, include that the Member has been registered with the College since November 1996, has also been registered with the North Carolina Board of Nursing since January 1997, and has no discipline history in either jurisdiction. The Member is remorseful and recognizes the impact of his actions and conduct on his patients and indicated that he will never repeat this conduct again.

The Panel requested that further submissions be made by College Counsel as well as the Member's Counsel in regards to what consideration was given to the Member's use of racial slurs when Counsel were drafting the proposed Joint Submission on Order. The Member's Counsel indicated that the use of racial slurs in today's society was considered when determining the penalty. The Member's Counsel reported College Counsel looked at cases that, although did not use the specific term at issue in this case, did reflect an appropriate penalty. College Counsel considered the mitigating factors, one of which was not contained within the Agreed Statement of Facts. The Member's Counsel divulged to the Panel that the Member suffered from a substance abuse problem and became sober in January 2019. The Member used those racial slurs during this time frame. He is attending alcohol anonymous meetings twice a week. The Member is remorseful and is committed to not doing it again. College Counsel submitted three other cases to the Panel. While they did not contain any racial slurs, counsel argued that these cases contained content similar in the level of inappropriateness.

CNO v McInnes (Discipline Committee, 2011). In this case the member handled an infant roughly, raised her voice at the infant and/or used inappropriate language towards infant client D, including words to the effect of "enough, enough", and/or "knock it off", and/or "shut the fuck up," and/or "if you were my baby I would kill you". The penalty in this case was an oral reprimand, a one-month suspension, two meetings with a Nursing Expert, self-directed learning and employer notification for twelve months.

CNO v Hewitt (Discipline Committee, 2010). In this case the member had a verbal and/or physical confrontation with a client, made false and/or disparaging entries in the client records, made disparaging comments about language skills, cultural background and/or place of origin, made angry and/or disparaging comments to various co-workers and made angry and/or threatening comments to various clients. The penalty in this case was an oral reprimand, a three-month suspension of the

member's certificate of registration, three sessions with a Nursing Expert and employer notification for twenty-four months.

CNO v Pottruff (Discipline Committee, 2006). In this case the member abused the client verbally, physically and/or emotionally by slapping him on an exposed thigh, shouting at the client and telling him to "let go of my wrist you fucking prick" or words to that effect. The penalty in this case was an oral reprimand, a two-month suspension on the member's certification of registration and employer notification for eighteen months.

College Counsel indicated that counsel may have been light in submitting cases to the Panel and the additional cases will inform the range of penalties that the College keeps in mind when it agreed to support this order. College Counsel argued that although the cases provided did not have any racial undertone, all of the cases provided involve inappropriate communication directed towards patients. The contextual factor here is the slight disconnect when communicating in racial language in the context of telling a story to two patients and not directing abuse towards a client. In all, the terms of the penalty ordered should be considered as a whole and not on their own. There is no partial formula that can lead to a specific roster of terms in any individual case. The orders of this Discipline Committee tend to comprise of similar elements case to case – reprimand and suspension. The length of suspension is one of the main variables of different orders in different cases which usually also include meetings with a Regulatory Expert and a term of employer notification. College Counsel argued the penalty ordered is a balance of factors that were urged to the Panel in earlier submissions, the consistency with precedence, deterrence - specific and general and individual circumstances balanced with the general message to the membership and the general message to the public. College Counsel maintained that it is an appropriate order and that the question would be does this order bring the administration of justice into disrepute and would it be contrary to public interest.

The Member's Counsel reinforced that the parties considered the mitigating factors, including that the Member has been a nurse for over 24 years without a discipline history, that he is extremely remorseful, during the time of the incident the Member was experiencing a family crisis and he became sober which has had an impact on his behaviour. He has accepted responsibility and has admitted to the facts and regrets what he has done.

Independent Legal Counsel provided his advice to the Panel. The Panel must accept the Joint Submission on Order and only reject it in circumstances where that which is proposed by way of the penalty is so disproportionate to the offence in question that to accept it would bring either the administration of justice into disrepute or be contrary to the public interest.

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 three 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 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 two meetings with a Regulatory Expert (the "Expert"), at his own expense and within six 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 seven days before the first meeting, the Member provides the Expert with a copy of:

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

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

            1. *Code of Conduct,*
            2. *Documentation,*
            3. *Medication,*
            4. *Professional Standards,* and
            5. *Therapeutic Nurse-Client Relationship;*

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

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

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

            1. the acts or omissions for which the Member was found to have committed professional misconduct,
            2. the potential consequences of the misconduct to the Member's 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 his 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 his certificate of registration.

b) For a period of 18 months from the date this Order becomes final, the Member will notify his 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 his 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 deliberated and had grave concerns with the Joint Submission on Order and questioned whether given the nature of the Member's conduct, did the penalty truly reflect the guiding principles of any penalty. 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.

Although the Panel believed that the Member's conduct warranted a longer suspension of his certificate of registration, it was mindful of the principle that a joint submission on penalty agreed to by the parties ought not to be interfered with lightly and acknowledges that the Panel ought not to impose a penalty different from that agreed to by the parties simply because the Panel may have come to a different conclusion on penalty had the parties not reached an agreement. Ultimately, the Panel cannot say the penalty set out in the Joint Submission on Order proposed by the parties was so disproportionate to the Member's professional misconduct that to accept it would bring the administration of justice into disrepute or that it was contrary to the public interest.

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

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