DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Terry Holland, RPN	Chairperson
	Sylvia Douglas	Public Member
	Jennifer Farah, RPN	Member
	Karen Goldenberg	Public Member
	Sherry Szucsko-Bedard, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
SUSANNE I. SEGUIN	)	NO REPRESENTATION for
Registration No. JB08124	)	Susanne I. Seguin
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: March 15-16, 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") commencing on March 15, 2021, via videoconference.

As Susanne I. Seguin (the "Member") was not present, the hearing recessed for 15 minutes to allow time for the Member to appear. Upon reconvening, the Panel noted that the Member was not in attendance.

College Counsel provided the Panel with evidence, by way of an affidavit from [College Staff Member], Prosecutions Clerk, dated December 18, 2020, that the Member had been sent the Notice of Hearing. In her affidavit, [College Staff Member] affirms that she sent correspondence, which included the Notice of Hearing, on December 3, 2020 to the Member's last known address on the College Register.

The Panel was satisfied that the Member had received adequate notice of the time, place and purpose of the hearing and of the fact that if she did not participate in the hearing, it may proceed without her participation. Accordingly, the Panel decided to proceed with the hearing in the Member's absence.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, *1991*, for an order preventing the public disclosure and banning the publication or broadcasting of the name, or any information that could disclose the identity, of the patient referred to orally or in any documents presented in the Discipline hearing of the Member.

The Panel considered the submissions of College Counsel and decided that there be an order preventing the public disclosure and banning the publication or broadcasting of the name, or any information that could disclose the identity, of the patient referred to orally or in any documents presented in the Discipline hearing of the Member.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated December 2, 2020 are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while you were employed as a Registered Practical Nurse at Woodland Villa in Long Sault, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that on or around December 2, 2018 you engaged in an improper and/or unnecessary verbal and physical altercation with [the Patient], when you:

    a. pointed a finger at [the Patient]'s face and spoke very firmly to her;
    b. aggressively pulled on [the Patient]'s arm;
    c. scratched [the Patient]'s forearm;
    d. slapped [the Patient] across the face; and/or
    e. said to [the Patient], "well, that's what happens", or words to that effect; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation 799/93*, in that while you were employed as a Registered Practical Nurse at the Facility, you abused [the Patient], verbally, physically, and/or emotionally on or around December 2, 2018 when you:

    a. pointed a finger at [the Patient]'s face and spoke very firmly to her;
    b. aggressively pulled on [the Patient]'s arm;
    c. scratched [the Patient]'s forearm;

d. slapped [the Patient] across the face; and/or
e. said to [the Patient], "well, that's what happens", or words to that effect; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while you were employed as a Registered Practical Nurse at the Facility, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that on or around December 2, 2018 you engaged in an improper and/or unnecessary verbal and physical altercation with [the Patient], when you:

a. pointed a finger at [the Patient]'s face and spoke very firmly to her;
b. aggressively pulled on [the Patient]'s arm;
c. scratched [the Patient]'s forearm;
d. slapped [the Patient] across the face; and/or
e. said to [the Patient], "well, that's what happens", or words to that effect.

Member's Plea

Given that the Member was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member first registered with the College as a Registered Practical Nurse ("RPN") in October 2002. She practiced as an RPN from October 2002 until April 10, 2008 when she was suspended until April 19, 2011 for non-payment of fees. The College's Register Report (Exhibit 3) documents that the Member had an active certificate of registration with the College from April 19, 2011 until July 2, 2019 when the Member's certificate of registration was suspended by the Inquiries, Complaints and Reports Committee ("ICRC").

The Member was hired by Woodland Villa (the "Facility") in Long Sault, Ontario on September 1, 2018. On December 2, 2018 while a registered Member of the College and working as an RPN at the Facility the Member pointed her finger at the Patient's face and spoke very firmly to her, aggressively pulled the Patient's arm, scratched the Patient's forearm, slapped the Patient across the face and made the comment "well, that's what happens", or words to that effect. A witness who was in the room at the time immediately reported what they saw to the nurse in charge at the Facility and an investigation was initiated. The Member was initially put on administrative leave until the investigation was complete which led to the Member being terminated from her position.

The Panel heard evidence from two fact witnesses and one expert witness. It also received 19 exhibits to consider. Having considered the evidence and the onus and standard of proof, the Panel found that the Member committed acts of professional misconduct as alleged in paragraphs

1(a), (b), (c), (d), (e), 2(a), (b), (c), (d), (e), 3(a), (b), (c), (d) and (e) in the Notice of Hearing. With respect to allegations 2(a) and (e), the Panel found that the Member verbally and emotionally abused the Patient. With respect to allegations 2(b), (c) and (d), the Panel found that the Member physically and emotionally abused the Patient.

With respect to allegations 3(a), (b), (c), (d) and (e), the Panel found that the Member engaged in conduct that would reasonably be regarded by members of the profession as dishonourable, disgraceful and unprofessional.

The Evidence

The Panel received 19 exhibits from the College and heard testimony from two fact witnesses and one expert witness.

The two fact witnesses the Panel heard from were the facility's current Director of Care, as well as an RPN, who at the time of the incident, was a Personal Support Worker ("PSW"). The evidence provided by both witnesses was consistent, credible, logical, and supported by their actions and exhibits contemporaneous with the allegations.

[Witness 1] ("Witness 1")

Witness 1 is a Registered Nurse ("RN") and the Director of Care at the Facility. Witness 1 had originally been hired by the Facility in 2014 as an RN and transitioned into the Director of Care position in March 2017. The Director of Care position at this Facility works with an Assistant Director of Care regarding hiring, training, and disciplining of RNs, RPNs and PSWs.

Witness 1 described the Facility as being one floor, having 111 beds, with 4 units. The staff of the Facility are scheduled for three shifts which consist of days (0630-1430 hours), evenings (1430-2230 hours), and nights (2230-0630 hours). The staff working the three shifts are one Charge Nurse who was a RN, as well as RPNs and PSWs.

College Counsel asked if Witness 1 recalled the Member. Witness 1 testified that she did, and that the Member started at the Facility as an RPN on September 1, 2018.

Witness 1 identified two policies that were in place at the time of the incident. One was the Abuse/Neglect of Residents by Staff (Exhibit 4) which addresses the Facility's expectation of how residents are to be treated and the second policy was the Zero Tolerance of Abuse and Neglect of Residents (Exhibit 5) which addresses all forms of abuse, when to report, who to report to and the investigative procedure to follow. Both Exhibits 4 and 5 were in place at the time of the alleged incidents. Witness 1 gave evidence that the Member received training and education on these policies while on orientation and received hard copies as well to take home.

Witness 1 described the Care Plan (Exhibit 6) as well as provided a description of the Patient involved in the allegations. The Patient was a female with Down Syndrome with behavioural and verbal deficits. As the Care Plan's effective date was documented as March 3, 2019, Witness 1 confirmed the diagnosis was the same for the Patient in 2018 during the alleged incident. Care Plans are updated quarterly. Witness 1 went on to describe that the Care Plan is used for staff to

understand how care is to be provided to the individual patients at the Facility. Each patient would have their own Care Plan. Witness 1 confirmed that the Member would have been familiar with the Care Plan and would have been able to review it at any time as it is electronic and available. Staff caring for the Patient could revise the individual Care Plans at any time as it was deemed necessary. Witness 1 was taken to page 7 of the Care Plan of the Patient and reported what was written in regard to the expectations of the staff when the Patient was acting out with verbally and physically abusive behaviours. The Care Plan directed the staff to leave the Patient alone to allow her to calm down and speak in a calm, gentle and reassuring manner at all times.

Witness 1 was not working on December 2, 2018 but did receive a call from the Assistant Director of Care on call as documented in Witness 1's handwritten notes (Exhibit 7). Witness 1 documented her daily activities from December 2-7 and December 17, 2018 in Exhibit 7 which reported step by step what was done in follow-up to the allegations from the time the Member was removed from the Facility on December 2, 2018 up to the Member's termination on December 7, 2018, including reporting the incident to the Ontario Provincial Police. On December 3, 2018 the Member provided a written account to Witness 1 of the incident via email (Exhibit 8) where she admitted to "lightly tapping" the Patient. Final documentation on December 17, 2018 included follow up with the Patient and the final report from the Ontario Provincial Police. Witness 1 described the Member as being stone-faced when she was informed her employment was terminated and that the Member made no attempt to respond even though she had the opportunity.

Witness 1 explained the Facility's Mandatory Report Checklist (Exhibit 9) as a report that is completed when allegations of abuse occur with a patient. The report was initiated by the Charge Nurse who was working the evening of December 2, 2018 when the allegations were brought to her attention. The report documented physical and verbal abuse as well as a scratch on the Patient's right inner forearm. Witness 1 said this checklist identifies the steps that need to take place when abuse allegations occur within the Facility.

[Witness 2] ("Witness 2")

Witness 2 has worked at the Facility since March 2017. She initially started at the Facility as a PSW and then in December 2020 registered with the College as an RPN. At the time of the alleged incident Witness 2 was a PSW at the Facility. Witness 2 testified that her duties entailed giving baths, getting patients ready for bed as well as getting them up in the morning, assisting with mealtimes, assisting patients in the bathroom and transferring. Witness 2 went on to testify that normally there are 3 PSWs down each wing per shift at the Facility, but on December 2, 2018 there were only 2. Witness 2 was asked if she recalled the Member and she responded yes, and that the Member was an RPN at the time.

Witness 2 was asked to describe the Patient involved in the alleged incident and she went on to say that the Patient had Down's Syndrome and needed one to one assistance with all her care. Witness 2 described the care she provided the Patient on December 2, 2018 which entailed assisting her with washing, putting on her pajamas and allowing her to decide if she was going to bed or going to stay up a little longer. Witness 2 went on to say that she needed to approach the

Patient with a gentle persuasion method as sometimes the Patient was strong in her wishes and Witness 2 would need to gently redirect her to be able to provide care.

On December 2, 2018 Witness 2 was providing evening care when the Patient refused to go into the bathroom. Witness 2 testified that the Member came into the room when she noted her struggling to get the Patient into the bathroom. When Witness 2 was asked what happened when the Member came into the room, she testified that the Member held up her finger, pointing it into the Patient's face while she moved back and forth in the doorway to keep her from leaving the room. Witness 2 went on to say that the Member spoke firmly to the Patient and grabbed her arm and pulled her into the bathroom. The Patient was pulling away from the Member and it was at that time the Patient received the scratch on her arm that broke skin. The Patient then said "look what you did" and slapped the Member across the face. Witness 2 then testified that the Member slapped the Patient to the extent it made a clapping sound. The Patient's jaw dropped, and she appeared surprised according to Witness 2. It was at this time that Witness 2 heard the Member say "that is what happens when you don't listen". Witness 2 was questioned on the length of time of the interaction explained above and she testified that it was approximately 5 minutes and confirmed that she was in the room the entire time getting the Patient's pajamas ready. It was at this time that Witness 2 left the room and immediately spoke with a colleague who instructed her to report the incident to the Charge Nurse.

Witness 2 completed a handwritten note (Exhibit 12) before she left her shift that evening documenting the details of the interaction she witnessed between the Member and the Patient. Witness 2 testified that she and the Charge Nurse went back in to assess the Patient and found a scratch on her arm that they covered with a band aid. Witness 2 reviewed her note before the Panel and confirmed that it was her handwriting but reported that the "27 Dec" on the top right-hand corner was not her writing.

<u>Expert Witness - Dr. Ruth Gallop ("Dr. Gallop")</u>

Dr. Gallop is a Professor Emeritus at the University of Toronto for the Faculty of Nursing and the Department of Psychiatry. Dr. Gallop has done extensive nursing research into the challenges of working with difficult clients, including impulsive, unpredictable and difficult clients with a focus on how to maintain a professional role while providing nursing care. She was tendered by the College as an expert to provide an opinion on whether the Member met the *Professional Standards*, *Therapeutic Nurse-Client Relationship* (Exhibit 14) and whether the Member abused the Patient. Dr. Gallop confirmed the opinion she would provide would be nonpartisan and objective. Dr. Gallop provided her curriculum vitae (Exhibit 13) which outlined a long nursing career that started as a staff nurse on a Psychiatric Unit, then into an academic career where she was an Educator, Researcher and had numerous publications involving psychiatric nursing and nurse-client relationships. Dr. Gallop reported she has been asked by the College to testify at over 40 hearings which have concerned mostly boundary violations including physical, emotional, sexual, and financial circumstances. The Panel qualified Dr. Gallop as an expert in nursing in the areas of the Therapeutic Nurse-Client Relationships and Standard of Care.

Dr. Gallop was asked by College Counsel to explain the *Professional Standards* and the *Therapeutic Nurse-Client Relationship* (Exhibits 17 and 18). Dr. Gallop testified that the

Professional Standards set out nurses' responsibilities. The *Professional Standards* apply to all nurses, any member who is registered with the College and practicing, regardless of the setting. Dr. Gallop took the Panel to page 11 of Exhibit 17 and highlighted the therapeutic nurse-client relationship section where the nurse needs to maintain boundaries and have respect, empathy and be honest while working with clients and their families. Dr. Gallop called attention to the *Therapeutic Nurse-Client Relationship* Standard (Exhibit 18) where she testified it expands on the aspects of relationships but also provides definitions of abusive behaviours.

College Counsel asked Dr. Gallop if the two Facility policies (Exhibits 4 and 5) align with the College Standards to which Dr. Gallop responded that they are consistent with the way a nurse should treat a client and have consistent definitions.

College Counsel provided Dr. Gallop with a hypothetical scenario to review and provide her expert opinion. The scenario (Exhibit 15) detailed approximately what had happened between the Member and the Patient without going into specific details. Dr. Gallop reviewed this scenario and discussed how challenging the client in the scenario was, and that this situation is not about the nurse. Dr. Gallop went on to say nurses are to be gentle, soothing, and the nurse's care should be guided by the care plan documented for the patient.

Dr. Gallop then went through each allegation in the Notice of Hearing to respond to College Counsel's question, "Did the Member contravene the standards of practice?"

1. Pointing a finger at the Patient's face and speaking firmly to her:

   Dr. Gallop opined that the Member did not meet the *Professional Standards* as the Member was using intimidation and not treating the Patient with respect. Exhibit 18 page 16 documents that pointing a finger is considered intimidation/threatening.

2. Aggressively pulling the Patient's arm:

   Dr. Gallop opined that this act was a breach of the Standards as it was a threatening, abusive act with no therapeutic reason. Dr. Gallop testified that the Member should have been following the care plan and giving the Patient space to allow her to calm down and speaking quietly and gently to her.

3. Scratching the Patient's forearm:

   Dr. Gallop opined that this met the criteria for physical abuse.

4. Slapping the Patient across the face:

   Dr. Gallop opined that this was a serious situation, an absolute violation and physical abuse. Dr. Gallop testified that she would expect a member to stand back, give the Patient space and restrain if necessary but to do it with gentleness.

5. Saying "well, that's what happens" or words to that effect:

Dr. Gallop opined that this statement sounds unprofessional, but out of context she is not sure what the Member meant. College Counsel provided context that this came right after the slap across the face. Dr. Gallop testified that in that context, comment was inappropriate and would be verbal abuse and boundary crossing.

The Panel requested that Dr. Gallop identify which *Professional Standards* and *Therapeutic Nurse-Client Relationship* Standards were not met by the Member. Dr. Gallop testified that the Relationship Practice Standard in the *Professional Standards* was not met as the Member failed to demonstrate empathy and respect; failed to maintain boundaries; failed to ensure the clients' needs remained the focus of the nurse-client relationship and failed to recognize the potential for client abuse. Within the *Therapeutic Nurse-Client Relationship* Standards Dr. Gallop opined that the Member failed to meet the Therapeutic communication practice standard; failed to meet the Client-centred care practice standard; failed to meet the Maintaining boundaries practice standard; and failed to meet the Protecting the client from abuse practice standard.

The Panel also requested Dr. Gallop to opine on whether she considered the care the Member provided to be emotional abuse, to which Dr. Gallop responded that all the allegations made against the Member would be emotional abuse as all five actions would have been distressing to the Patient.

Final Submissions

College Counsel stated that the Member's conduct constituted professional misconduct, a breach of the standards of practice, verbal, physical and emotional abuse, and should be considered dishonourable, disgraceful, and unprofessional conduct. This conclusion comes after hearing the evidence from two fact and one expert witness. College Counsel said the witnesses were consistent in their evidence, forthright, sincere, and their testimony was consistent with what they had documented at the time of the incident. The College urged the Panel to find the witnesses and their testimony credible.

College Counsel submitted that Dr. Gallop, the expert witness, testified that the Member breached the standards of practice in each allegation in the Notice of Hearing as follows:

With respect to allegations 1(a) and 2(a) in the Notice of Hearing the Member breached the *Professional Standards* and the *Therapeutic Nurse-Client Relationship* Standard when she pointed her finger at the Patient's face and spoke firmly to her. This behaviour is intimidating, agitating and not consistent with the Care Plan documented for this Patient which outlined using a gentle approach. In the *Therapeutic Nurse-Client Relationship* Standard this action by the Member is considered verbal and emotional abuse as outlined in the definitions in Appendix A.

With respect to allegations 1(b) and 2(b) in the Notice of Hearing the Member breached the *Professional Standards* and *Therapeutic Nurse-Client Relationship* Standard when she aggressively pulled the arm of the Patient. This behaviour is agitating, threatening, non-therapeutic and not consistent with the Care Plan documented for this Patient which outlined using a gentle approach or to leave the Patient alone to allow her to calm down. The Member

escalated the situation with her actions towards the Patient which is defined as physical and emotional abuse as outlined in the *Therapeutic Nurse-Client Relationship* Standard.

With respect to allegations 1(c) and 2(c) in the Notice of Hearing the Member breached the *Professional Standards* and *Therapeutic Nurse-Client Relationship* Standard when the Member scratched the Patient's forearm which is a boundary violation and was threatening and caused the Patient to become agitated. This action by the Member caused physical and emotional harm to the Patient.

With respect to allegations 1(d) and 2(d) in the Notice of Hearing the Member breached the *Professional Standards* and *Therapeutic Nurse-Client Relationship* Standard when the Member slapped the Patient across the face. Dr. Gallop testified that there is no situation where slapping a patient is therapeutic. This behaviour is considered both physical and emotional abuse as outlined in the definitions in Appendix A of the *Therapeutic Nurse-Client Relationship* Standard.

With respect to allegations 1(e) and 2(e) in the Notice of Hearing the Member breached the *Professional Standards* and *Therapeutic Nurse-Client Relationship* Standard when the Member said to the Patient "well, that's what happens", or words to that effect. This type of communication is unprofessional, dismissive and shows a lack of respect and empathy for the Patient. Dr. Gallop testified initially that it is hard to provide an opinion without understanding the context these words were said in. College Counsel further provided the facts around this comment and Dr. Gallop opined that this behaviour constitutes emotional and verbal abuse.

With respect to allegations 3(a), (b), (c), (d) and (e) in the Notice of Hearing College Counsel submitted that the actions of the Member all constitute dishonourable, disgraceful and unprofessional conduct. College Counsel set out that the Member's actions related to nursing as all occurred while the Member was working, that the Member belittled a patient with cognitive impairment, abused the Patient while she was in distress, was disrespectful in the treatment of the Patient and that these actions all show a serious disregard for her professional obligations. College Counsel requested that the Panel make findings on all five allegations.

College Counsel provided the Panel with two previous cases of the Discipline Committee to demonstrate how similar cases concluded there was a breach of the *Professional Standards*, physical, emotional and verbal abuse along with findings of unprofessional, dishonourable and disgraceful conduct.

CNO v. Cook (Discipline Committee, 2018). In this case, the member did not participate and was therefore deemed to have denied all allegations in the Notice of Hearing. The allegations were similar to the current case as the member made inappropriate comments to the client; punched the client; and threw paper towels at the client's face. The panel in this case found that the member breached the standards of practice, verbally, physically, and emotionally abused the client and found that her conduct was considered disgraceful, dishonourable and unprofessional.

CNO v. Agustin (Discipline Committee, 2019). In this case, the member participated in the hearing and an Agreed Statement of Facts was presented to the panel. The member was caring for an elderly client with dementia when she spoke in an angry tone, made inappropriate

comments and struck him with his slipper. The member was found to have committed professional misconduct as she failed to meet the standards of practice; verbally, emotionally and physically abused the client; and her actions were found to be unprofessional and dishonourable.

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), 2(a), (b), (c), (d), (e), 3(a), (b), (c), (d) and (e) in the Notice of Hearing. With respect to allegations 2(a) and (e), the Panel finds that the Member verbally and emotionally abused the Patient. With respect to allegations 2(b), (c) and (d), the Panel finds that the Member physically and emotionally abused the Patient. As to allegations 3(a), (b), (c), (d) and (e), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession as dishonourable, disgraceful and unprofessional.

Reasons for Decision

The Panel considered the recollection and consistency of testimony of the two witnesses, where one was in the room during the incident. The Panel determined that the evidence provided by the witnesses was clear, cogent and convincing.

Witness 2 was able to describe the entire interaction between the Member and the Patient as she was present in the room as she was initially preparing the Patient for bed at the time of the incident. Witness 2 reported the interaction between the Member and the Patient included the Member pointing her finger into the face of the Patient and speaking firmly, aggressively pulling the Patient's arm, scratching the Patient's forearm and slapping the Patient across the face. Witness 2's verbal evidence accurately represented what was in her handwritten note.

Witness 1 was the Director of Care at the Facility that provided the Panel with written policies (Exhibits 4 and 5) of how patients at the Facility were to be treated and the expectations of all staff. Witness 1 testified that the Member was aware of the policies and had copies of these policies for her own review which were provided to her during her orientation. The Panel received written care expectations for the Patient that all staff at the Facility were to follow as documented in the Care Plan (Exhibit 6).

Both Witness 1 and 2 stated that the Member provided the opposite of the Care Plan expectations when she pointed her finger into the Member's face and spoke firmly, aggressively pulling the Patient's arm, scratching the Patient's forearm, slapping the Patient and communicating in a disrespectful manner.

Dr. Gallop, the expert witness, was qualified by the Panel as an expert in nursing in the areas of the Therapeutic Nurse-Client Relationships and Standards of Care. Dr. Gallop called attention to the Relationship Practice Standard in the *Professional Standards* and the *Therapeutic Nurse-*

Client Relationship Standard that document the expectations for all registered members at the College to comply with. The Relationship Practice Standard documents that the nurse is to demonstrate respect and empathy and ensure the clients' needs remain the focus of the nurse-client relationship. The Member breached this standard in all allegations in the Notice of Hearing as she did not show empathy towards the Patient nor made the Patient's needs the focus of the relationship. Dr. Gallop highlighted the *Therapeutic Nurse-Client Relationship* Standard that addresses communication with the client, client-centred care, boundaries and protecting the client from abuse. The Member's actions in all allegations in the Notice of Hearing breached the expectations set out in the *Therapeutic Nurse-Client Relationship* Standard. Dr. Gallop went on to take the Panel to Appendix A in the *Therapeutic Nurse-Client Relationship* Standard that defines what verbal, emotional and physical abuse is in a nurse-client relationship. Dr. Gallop stated that pointing a finger into a patient's face, speaking in a firm tone and saying "well, that's what happens" when referring to slapping a patient constitutes verbal and emotional abuse. Aggressively pulling a patient's arm, scratching a patient and slapping them across the face all constitutes physical and emotional abuse.

Dr. Gallop's opinion was objective, reasonable and impartial. It was substantiated by the factual evidence accepted by the Panel. The Panel found her to be credible and accepted and relied on her opinion evidence to find that the Member's conduct constituted a breach of the *Professional Standards* and the *Therapeutic Nurse-Client Relationship* Standard.

With respect to allegations 3(a), (b), (c), (d) and (e) in the Notice of Hearing, the Panel found that the Member's conduct would be regarded by members of the profession as dishonourable, disgraceful and unprofessional. The Member's failure to meet the standards expected of her shows a serious disregard for her professional responsibility. The Member's dishonourable conduct was displayed when she provided inaccurate written information (Exhibit 8) to the Director of Care of the Facility when asked to provide information on the incident. This was dishonourable as it showed an element of deceit, dishonesty and demonstrated moral failing. The Member's conduct was also disgraceful as her actions shamed her, and the profession. She should have known that slapping the Patient, and her belittling and demeaning behaviour towards the Patient was wrong. As a professional, she should have taken steps to remove herself from the situation and to protect the vulnerable Patient in her care from verbal, emotional and physical abuse.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, it should make an Order as follows:

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 6 months. This suspension shall take effect from the date that the Member obtains

an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of 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. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director in advance of the meetings;

        ii. At least 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, and
            3. if available, a copy of the Panel's Decision and Reasons;

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

            1. *Code of Conduct,*
            2. *Professional Standards,* and
            3. *Therapeutic Nurse-Patient Relationship;*

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

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

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

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

viii. If the Member does not comply with any 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 obtains an active certificate of registration and returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

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

c) The Member shall not practice independently in the community for a period of 18 months from the date the Member obtains an active certificate of registration and returns to the practice of nursing.

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

College Counsel submitted that there are multiple factors to consider with respect to the penalty. Protection of the public is first and foremost the main duty of the College, as well as maintaining public confidence and the ability of the College to self-regulate. General deterrence to other members of the College and specific deterrence to the Member are all considerations for the Panel when making a penalty decision, as is rehabilitation and remediation where appropriate.

The aggravating factors in this case were:

- The Member's conduct was very serious;
- The incident involved a vulnerable patient;
- The Member's conduct was intentional and caused physical and emotional harm;
- The Member showed a lack of respect towards the Patient;
- The Member demonstrated poor judgement in her actions;
- The Member intentionally chose to ignore the Care Plan in place for the Patient;
- The Member's conduct showed a serious disregard for the Patient;
- The Member's conduct showed questionable moral fitness;
- The Member's conduct brought discredit and shame to the profession.

As the Member did not attend the hearing, the Panel has no information to consider regarding the mitigating circumstances other than the Member has no prior discipline history with the College.

College Counsel submitted that the penalty that it is seeking is consistent with that found in other cases, protects the public, and meets all of the requirements of a self-regulating body.

College Counsel submitted the same cases as earlier provided to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee. Both cases contain similar aspects to the case before this Panel.

CNO v. Cook (Discipline Committee, 2018). In this case, the member did not participate. As described previously, the allegations were similar to the current case. The member was given an oral reprimand, received a 6-month suspension, had to attend two meetings with a Regulatory Expert and had 18 months of employer notification.

CNO v. Agustin (Discipline Committee, 2019). In this case, the member participated in the hearing and an Agreed Statement of Facts was presented to the panel. As described previously, the allegations were similar to the current case. The member was given an oral reprimand,

received a 4-month suspension, had to attend two meetings with a Nursing Expert and had 18 months of employer notification.

College Counsel stated that the penalty submitted meets the interest of the public, the profession and the Member and demonstrated that there are serious consequences for this type of conduct. General deterrence is achieved as the penalty sends a message to members of the profession that they cannot engage in this type of conduct without consequences and penalty. Specific deterrence is met through the oral reprimand and lengthy suspension. Remediation and rehabilitation are achieved through the meetings with the Regulatory Expert, giving the Member the opportunity to learn and improve her practice should she wish to continue to be a nurse. Public protection is met through the six-month suspension, meetings with the Regulatory Expert, 18 months of employer notification and the restriction on independent practice. The Member will be closely monitored if she returns to practice.

Penalty Decision

The Panel accepts the College's Submission on Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within 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 6 months. This suspension shall take effect from the date that the Member obtains an active certificate of registration and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of 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. If the Expert determines that a greater number of session are required, the Expert will advise the Director, Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director in advance of the meetings;

        ii. At least 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, and

3. if available, a copy of the Panel's Decision and Reasons;

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

1. *Code of Conduct,*
2. *Professional Standards,* and
3. *Therapeutic Nurse-Patient Relationship;*

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

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

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

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's patients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

viii. If the Member does not comply with any 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 obtains an active certificate of registration and returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

1. the Panel's Order,
2. the Notice of Hearing, and
3. a copy of the Panel's Decision and Reasons, once available;

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

c) The Member shall not practice independently in the community for a period of 18 months from the date the Member obtains an active certificate of registration and returns to the practice of nursing.

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

Reasons for Penalty Decision

The Panel deliberated and unanimously accepted the College's proposed order on penalty as presented.

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 found that the terms of the order set out by the College met all of the principles required of the penalty.

The Panel recognizes the seriousness of the Member's actions and that this behaviour is not in keeping with the values of the College. The suspension of six months, two meetings with a Regulatory Expert, the 18-month employer notification requirement and the 18-month period that the Member cannot practice independently in the community will protect the public by ensuring that the Member will be closely monitored and that she is not given the chance to harm the public any further when she returns to practice.

The oral reprimand and suspension provide a specific deterrent to the Member, as well as a general deterrence to the membership, indicating that the profession will not tolerate this type of behaviour and that there are serious consequences for this kind of behaviour.

Finally, considering remediation and rehabilitation of the Member, the minimum 2 meetings with the Regulatory Expert will require the Member to reflect and complete education that will provide her the opportunity to learn from her mistakes and ensure they are not repeated.

The penalty is also consistent with previous decisions of this Committee for similar circumstances. While the two precedent cases do not have a restriction on independent practice included in those penalty orders, the Panel takes notice that a restriction on independent practice is not an uncommon component of orders on penalty made by the Discipline Committee.

I, Terry Holland, 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.