DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Terry Holland, RPN	Chairperson
	Carolyn Kargiannakis, RN	Member
	Ian McKinnon	Public Member
	Linda Marie Pacheco, RN	Member
	Lalitha Poonasamy	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
PHYLLIS E. JACKSON	)	NO REPRESENTATION for
Registration No. 6635395	)	Phyllis E. Jackson
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 25-26, 2021 &
	)	February 25, 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 January 25, 2021, via videoconference.

As Phyllis E. Jackson (the "Member") was not present, the hearing recessed for fifteen 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 that the Member had been sent the Notice of Hearing on October 15, 2020, by way of an affidavit from [ ], Prosecutions Clerk, dated October 16, 2020, confirming that [the Prosecutions Clerk] sent correspondence, which included the Notice of Hearing, on October 15, 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 names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Phyllis E. Jackson.

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 names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Phyllis E. Jackson.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated October 14, 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 Nurse at Comfort Residential Group Home in Toronto, Ontario ("Comfort"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to one or more of the following incidents:

    (a) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to keep adequate records regarding [the Patient], including but not limited to, a care plan or equivalent and contact information for the patient's Power of Attorney for Personal Care;

    (b) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that unregulated staff were aware of [the Patient]'s heath care needs in relation to her diagnoses, and that she required monitoring with respect to taking medication and eating meals;

(c) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient] was provided with adequate meals;

(d) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient] was taking her daily medication and/or failed to report medication compliance concerns to her Power of Attorney for Personal Care;

(e) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient]'s medications were sufficiently stocked, and/or failed to ensure [the Patient]'s medications were refilled by the pharmacy as needed;

(f) on or around April 24, 2017, you misrepresented to [the Patient] and [the Patient]'s daughter, that:

(i) [the Patient] would receive 3 meals and 2 snacks per day;

(ii) [the Patient] would be adequately monitored and/or assisted with medication administration and eating; and/or

(iii) [the Patient]'s medications would be sufficiently stocked, including refills obtained by the pharmacy as needed;

(g) at various times between, on, or around May 2017 to June 2017, you failed to provide sanitary conditions for [the Patient]; and/or

(h) at various times between, on, or around June 2017 to July 2017, you failed to ensure patients were provided with adequate meals; 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 Nurse at Comfort, you abused patient(s) verbally, physically and/or emotionally with respect to the following incidents:

(a) at various times between, on, or around April 24, 2017 to June 26, 2017, you neglected [the Patient] by failing to ensure that she was provided with adequate meals;

(b) at various times between, on, or around April 24, 2017 to June 26, 2017, you neglected [the Patient] when you failed to ensure her medications were sufficiently stocked and/or failed to refill her prescriptions with the pharmacy;

(c) at various times between, on, or around May 2017 to June 2017, you neglected [the Patient] by failing to ensure sanitary conditions; and/or

(d) between, on, or around June 2017 to July 2017, you neglected patients by failing to ensure they were provided with adequate meals; 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(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Comfort, between, on or around April 24, 2017 to June 26, 2017, you failed to keep records as required for [the Patient], including but not limited to, a care plan or equivalent and contact information for [the Patient]'s Power of Attorney for Personal Care;

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 while you were employed as a Registered Nurse at Comfort, 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 as disgraceful, dishonourable or unprofessional with respect to the following incidents:

   (a) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to keep adequate records regarding [the Patient], including but not limited to, a care plan or equivalent and contact information for the patient's Power of Attorney for Personal Care;

   (b) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that unregulated staff were aware of [the Patient]'s heath care needs in relation to her diagnoses, and that she required monitoring with respect to taking medication and eating meals;

   (c) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient] was provided with adequate meals;

   (d) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient] was taking her daily medication and/or failed to report medication compliance concerns to her Power of Attorney for Personal Care;

   (e) at various times between, on, or around April 24, 2017 to June 26, 2017, you failed to ensure that [the Patient]'s medications were sufficiently stocked, and/or failed to ensure [the Patient]'s medications were refilled by the pharmacy as needed;

   (f) on or around April 24, 2017, you misrepresented to [the Patient] and [the Patient]'s daughter, that:

(i) [the Patient] would receive 3 meals and 2 snacks per day;

(ii) [the Patient] would be adequately monitored and/or assisted with medication administration and eating; and/or

(iii) [the Patient]'s medications would be sufficiently stocked, including refills obtained by the pharmacy as needed;

(g) at various times between, on, or around May 2017 to June 2017, you failed to provide sanitary conditions for [the Patient]; and/or

(h) between, on, or around June 2017 to July 2017, you failed to ensure patients were provided with adequate meals; and/or

5. 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 Nurse at Paradise Retirement Home in Toronto, Ontario ("Paradise"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to the following incidents:

(a) between, on, or around October 24, 2017 to November 21, 2017, you failed to ensure [the Patient] attended her follow-up appointment at the fracture clinic and/or failed to promptly reschedule the appointment; and/or

(b) between, on, or around October 2017 to January 2018, you failed to ensure [the Patient] had sanitary living conditions; and/or

6. 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 Nurse at Paradise, you abused [the Patient] verbally, physically and/or emotionally, when you neglected to ensure sanitary conditions; and/or

7. 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 Nurse at Paradise, 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 as disgraceful, dishonourable or unprofessional with respect to the following incidents:

(a) between, on, or around October 24, 2017 to November 21, 2017, you failed to ensure [the Patient] attended her follow-up appointment at the fracture clinic and/or failed to promptly reschedule the appointment; and/or

(b) between, on, or around October 2017 to January 2018, you failed to ensure [the Patient] had sanitary living conditions.

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 was employed as a Registered Nurse ("RN") at Comfort Residential Group Home ("Comfort") in Toronto, Ontario and, subsequently, at the Paradise Retirement Home ("Paradise") in Toronto, Ontario. The Member had a supervisory role at both facilities. The allegations involved care to a Patient that resided first at Comfort (April - July 2017) and then at Paradise (October 2017 - January 2018). It is alleged that the Member, while working at Comfort, failed to keep adequate records including a care plan for the Patient and contact information for the Patient's Power of Attorney for Personal Care ("POA"); failed to ensure unregulated care providers were aware of the Patient's health care needs and that the Patient required monitoring with respect to taking medications and eating meals; failed to ensure the Patient received adequate meals and had sanitary living conditions; failed to ensure the Patient was taking her daily medication, failed to ensure medications were stocked or refilled, and failed to report medication compliance concerns to the Patient's POA.

Furthermore, the Member was alleged to have misrepresented to the Patient and her POA that the Patient would receive adequate meals, would be sufficiently monitored and/or assisted with eating and with medication administration, and that medications would be stocked or refilled as needed.

It was further alleged that, during June and July 2017, the Member, while working at Comfort, additionally failed to ensure other patients were provided with adequate meals. The Patient was later transferred to Paradise. While working as an RN at Paradise, the Member allegedly neglected the same Patient when she failed to ensure the Patient attended her medical appointment and failed to ensure the Patient had sanitary living conditions.

The Panel heard evidence from three witnesses and received 24 exhibits.

The Panel found that the Member committed professional misconduct by failing to meet the standards of practice, abusing the Patient physically and emotionally, failing to keep records as required, and engaging in conduct that would be regarded by members of the profession to be

disgraceful, dishonourable, and unprofessional. All the evidence presented supported the allegations as set out in the Notice of Hearing.

The Evidence

Witness 1: [ ], POA

This matter came to the attention of the College as a result of a complaint from [Witness 1], [the Patient]'s daughter. [Witness 1] confirmed that [the Patient] is her mother and that she is her mother's POA for care and finances. [Witness 1] stated that her mother has epilepsy, cirrhosis, type 2 diabetes, and stages of dementia. Her mother had some mobility limitations (she walked with a walker) and memory issues, and required oversight related to her medications. [The Patient] was relatively independent and lived with [Witness 1] for a period of time until the Patient decided that she wanted to move to the Scarborough area. Upon researching extremely limited living options for her mother, [Witness 1] chose Comfort. [Witness 1] and her mother both visited the home and found it suitable. They were met by the Member who introduced herself as an RN and were given a tour of the home by her.

The Member told the Patient and [Witness 1] that the monthly rent would include the living area, cooking, cleaning, three meals and two snacks daily, and medication oversight. She assured them that the Patient would be monitored every day. [Witness 1] stated that she emphasized to the Member that the Patient's medications needed to be monitored daily as she was not always compliant. [Witness 1] spent time with the Member explaining the Patient's personality and the Member assured [Witness 1] that there would be 24/7 coverage and that the Member would be there daily, as well as someone always being on site. [Witness 1] stated that when the Member told her that she was an RN, this gave peace of mind as the Member was a health professional able to keep an eye on the Patient's diagnosis and medical needs. [Witness 1] provided the Member with her contact information.

[Witness 1] received an update from the Member a couple of times the first week and was pleased that her mother was doing well, eating, and taking her medications. There was no phone at Comfort and although the Patient had a cell phone, she had difficulty managing it, thus it was challenging for [Witness 1] to talk to the Patient. As a result, the Member was the only source of information.

After a couple of weeks at the home, [Witness 1] received a call from "[Comfort Employee]", who worked at the home who was gravely concerned about the Patient. [Comfort Employee] told her that the Patient was not eating or taking her medications and was spending a great deal of time outside of the home. [Witness 1] explained to [Comfort Employee] that the Member had told her the Patient was doing well and [Comfort Employee] responded that this was not true. Additionally, as [Comfort Employee] was not aware of the Patient's epilepsy or medical condition, [Witness 1] gave her a full report on her mother's health conditions.

[Witness 1] stated that she lived out of town and visited her mom monthly at Comfort. She noticed several things that were safety risks when she visited: there was no handle in the bathtub and a railing that only went partway down the outdoor steps, the house was very dirty, and the Patient complained of there being cockroaches inside. [Witness 1] sent emails complaining about the safety concerns and living conditions to the Member and the owner of the home (Exhibit 6), and further complained to the City of Toronto concerning the insect infestation (Exhibit 5). [Comfort Employee] further told [Witness 1] that the Patient was unhappy with the food in the home. As well, hotdogs were served regularly, the meals were not nutritious, and the refrigerator was locked, meaning the Patient could not have milk, which she loved.

When [Witness 1] was questioned concerning whether she communicated her concerns to the Member, [Witness 1] said that the Member was very difficult to contact and felt that she had become evasive. Her voicemails and occasional text messages to the Member went unanswered. On June 5, 2017, [Witness 1] sent a summary of her concerns to the owner of the home, including her complaints about the Member, whom she subsequently learned was the owner's wife. On June 8, 2017, the owner of the home told [Witness 1] that the Patient would be transferred to another home.

On June 9, 2017, [Witness 1] received a call from [Witness 2], a new staff member at Comfort, telling her that the Patient "had an episode". [Witness 2] told [Witness 1] that she had called an ambulance and the Patient had been sent to the hospital. [Witness 1] shared with [Witness 2] that the Patient had epilepsy. [Witness 2] was unaware of this and did not recognize the seizure. [Witness 2] also stated that she had struggled to find the POA's number as this information had not been kept on file. She also told [Witness 1] that she had informed the Member of the episode earlier that morning but that the Member had neglected to contact or inform [Witness 1]. [Witness 1] was genuinely concerned that staff had changed in the home and that they were not provided with any information about the Patient. The Patient spent a couple of weeks in the hospital recovering from a number of health issues. As the Patient was unable to be discharged to a different group home, she was released back to the Member's care at Comfort.

The Member told [Witness 1] that she would pick up the Patient from the hospital but when she did so, the medications were not sent along with the Patient. The Member told [Witness 1] that the hospital did not have the Patient's medications, so [Witness 1] called the pharmacy for the medications and Ensure. When [Witness 1] spoke with [Witness 2] at Comfort four days after the Patient was discharged from the hospital, the Member had still not picked up the Patient's medications and allegedly refused to purchase Ensure for her. [Witness 1] stated that she spoke with the Patient that day and found her very distraught, barely able to speak, could not locate her dentures, nor get the help that she needed. In addition, [Witness 1] called the hospital and was told that the Patient's medications had been readily available since the day of discharge. It

appeared that the Member never attempted to retrieve the medications, nor did she call the pharmacy to arrange for pick-up of the medications.

[Witness 1] stated that she was comfortable with the Patient being transferred to a different home as she had lost trust in Comfort, particularly when staff had changed and there was no transfer of information about the Patient. She felt the Patient was frail and malnourished and had suffered a serious decline in her health while at Comfort. The wait for long-term-care was greater than a year, and again, there were limited options. The Patient was transferred to Paradise. Upon admission to Paradise, [Witness 1] spoke with [Comfort Employee], who now worked at Paradise and was relieved to hear that Paradise was a better home and [Comfort Employee] would look after the Patient, as she did before.

On June 27, 2017, [Witness 1] sent an email to [Paradise Employee] who worked at Paradise, with a summary of the Patient's needs, indicating that the Patient required a great deal of care and appealing to [Paradise Employee] to keep the Patient at the home (Exhibit 9). The Patient was able to stay at Paradise and regained her health, becoming more independent. In October 2017, [Witness 1] received notice that day-to-day operations at Paradise would be transferred to the owner of Comfort. The Member then started working at Paradise and assumed oversight at that home. [Witness 1] visited Paradise before and after the management and staff change and saw the state of cleanliness and state of the home decline, along with care and oversight of the Patient. [Witness 1] testified that she found the Patient's bed linens at Paradise were often soiled and smelled dirty. She further noted that there were occasions where there was no soap, hand towels or paper in the washrooms; furthermore, the toilet seat was broken.

[Witness 1] received a telephone call from a resident in the home who informed her that the Patient had fallen, had gone to the hospital and had a cast applied on her wrist. The Patient was to return to the fracture clinic for a follow-up appointment; however, the Member said she was unable to take the patient and she would reschedule the appointment. [Witness 1] arranged the new appointment and sent the details to the Member (Exhibit 8) who confirmed that she would take the Patient to the appointment. The morning of the appointment, the Member refused to take the Patient to the appointment, subsequently the Patient had the cast on her wrist for one month longer than intended.

[Witness 1] continued to look for housing options for the Patient elsewhere. Eventually the Patient was assessed to require assistive living and was fast-tracked into a long-term-care home.

Witness 2: [ ], worker at Comfort

[Witness 2] held various administrative health positions and health care jobs since 2012. She worked with the elderly and provided personal care support to long-term-care and privately. [Witness 2] explained that her role at Comfort was to assist the clients, clean the rooms, change

bedding, and do the job of a personal support worker; she also cooked and prepared meals. The witness explained that the Member and owner of the home (the Member's husband) were responsible for purchasing the food for Comfort and that the witness was uncomfortable with the quality of the food, and that it was often expired. [Witness 2] further explained that the Member told her nothing about the Patient's medications. [Witness 2] provided oversight for the Patient's medications, and any information she received, was passed on by a previous staff member.

[Witness 2] moved into the home a few days after being hired. She stated that the Member told her that the Member would do the documentation. [Witness 2] was unaware that the Member was a nurse; the Member did not provide any information to her about the Patient's diagnosis, including the fact that the Patient was diabetic and epileptic, or concerning the Patient's medications. [Witness 2] stated that she took it upon herself to watch over the Patient's medications, and that this was not based on any instruction or guidance from the Member. It was [Witness 2] that discovered the Patient having the seizure. [Witness 2] explained that she put the Patient into shock position, called the ambulance and when the ambulance arrived, the paramedics asked questions about the Patient which [Witness 2] could not answer. [Witness 2] stated that she informed the Member immediately that the Patient had a seizure and told the Member that she required more information on the clients living in the home. In addition, [Witness 2] had to go through the Patient's personal belongings to find the contact information for the Patient's daughter to inform her of the incident as the Member had not provided it to her.

After this event, [Witness 2], on her own initiative, created "cue cards," containing patient information for each patient. [Witness 2] stated that the Member rarely visited the home and when she did attend, that it was to drop off clean laundry or groceries, but that the Member most often did not come into the home. When the Member covered for [Witness 2]'s days off, [Witness 2] did not receive a report at all from the Member upon return.

Following the seizure, [Witness 2] spoke to [Witness 1] about the Patient's overall health, and told her that the Patient was not eating, was not taking her medications, and was leaving the home and staying out. [Witness 1] told [Witness 2] that she wanted the Patient to have Ensure, a meal-replacement, since the Patient was not eating; however, the Member refused to provide this.

[Witness 2] discussed the overall state of Comfort. She indicated that Comfort was not clean; there were insects in the rooms and mice in the kitchen. [Witness 2] used bleach to rid the residents' rooms of cockroaches. [Witness 2] contacted the owner of the home to address the issue, but the problem persisted.

With respect to medications, [Witness 2] indicated that she had sent the Patient's medications with the Patient to the hospital when the seizure occurred. When the Patient returned to Comfort, following her hospitalization after the seizure, the Patient's medications were not returned with her. The Member told [Witness 2] that she went to the hospital and the hospital could not locate the Patient's medications and that the Member would try to get refills for them. [Witness 2] then explained that [Witness 1] called the hospital and discovered that the medications were still there.

Expert Witness: Helen McGee ("Ms. McGee")

Ms. McGee has been an RN with the College since 1974 and has worked at the Centre for Addiction and Mental Health ("CAMH") since that time. She has held several leadership positions, including nurse educator and advance practice nurse. Ms. McGee supports interprofessional teams that work in group homes by attending weekly clinical team reviews where discussions occur based on care plans, including getting patients to doctor appointments, medication assessments and safety concerns. Ms. McGee explained that there is often concurrent illness with substance use in the community, such as diabetes or schizophrenia. Ms. McGee's role includes suggesting care strategies for challenging situations, and she would assess if the person required a higher level of support. The College tendered Ms. McGee as an expert to provide an expert opinion on providing care in a group home setting including the applicable standards in this care environment. The Panel accepted Ms. McGee as an expert witness.

Ms. McGee reviewed the relevant College standards and noted that standards are written to protect the public and are intended to apply to all nurses regardless of the practice setting. Ms. McGee was provided with a hypothetical situation (Exhibit 18) on which to give her opinion.

Professional Standards

A nurse in an administrator role must ensure the appropriate use, education, and supervision of staff, and must advocate for a quality practice setting that supports safe, effective, and ethical care. A nurse in an administrator role must also create environments that support safe and effective practice. A nurse is required to explain to unregulated care providers ("UCPs") about a patient's health status and managing health conditions. A nurse should not assume the UCP has any background knowledge or competence related to medications or assessing POA. Ms. McGee stated that the onus is on the nurse to model the expectations of care and that the UCP and family member are part of the health care team.

***Documentation* Standard**

The *Documentation* Standard applies to all nurses in all settings, including group homes, and nurses are required to document a care plan. It is important that nurses communicate with team members and to document the patient's progress and what was done with the patient. Ms. McGee noted that, if there is not a documentation system in place, then it is the nurse's responsibility to implement one.

***Medication* Standard**

Ms. McGee highlighted that nurses possess competencies of medication administration. When a patient is administering their own medications, such as in a group home, it is important that the nurse is responsible for ensuring the patient has the medications, is taking them as prescribed, is monitoring for side effects, and considering if the intended effect of the medication is being achieved. Ms. McGee stated that she would expect a nurse in a group home to see if the medication supply is current and to have a contact information sheet with details of how to reach the pharmacy, physician and POA in case of questions. If the nurse has delegated this task to UCPs, it is critical that the nurse provide this information to make it easier and safer for the UCP.

***Therapeutic Nurse-Client Relationship* Standard ("*TNCR* Standard")**

The *TNCR* Standard is important to consider when the patient is disclosing personal health information. The nurse needs to be trustworthy and needs to follow through with commitments to care. Ms. McGee stated that this standard is the cornerstone for psychiatric nurses but also every nurse in every practice setting. A nurse needs to demonstrate empathy in knowing the patient and understanding their challenges. Lacking empathy and not going to see the patient could be considered neglectful. Empathy also applies when considering a safe, clean environment in which to live. It also applies with respect to medications – i.e., knowing if they are working and if there are side effects.

Working with Unregulated Care Providers ("UCP") Practice Guideline

Ms. McGee stated that the purpose of this Standard is to support UCPs, who may not have the background to care for people with illnesses. UCPs require supervision and nurses should not make assumptions. Nurses should teach and supervise in order to ensure care is provided in a safe manner. Ms. McGee noted the Patient in this case had epilepsy and was cooperative for the most part but was sometimes resistant to care. It is important to work as a team and to demonstrate empathy with team members as well.

Ms. McGee spoke to the hypothetical situation, noting this was a vulnerable population, and people are in group homes because they may have had difficulty providing for themselves and thus require a level of care. She noted that some patients may have little disposable income and may not be organized enough to take care of their own needs, including medications. Their

conditions may impair their ability for their own personal care, and many require some form of assistance in their day-to-day functions of daily life. In the case of this Patient, there were multiple complex health conditions, and the nurse should have taken on an advocacy role within the team.

Hypothetical Scenario

Ms. McGee spoke to the hypothetical scenario (Exhibit 18) and provided an opinion based on the allegations. The Hypothetical did not identify the name of the Member, the Patient, or the Patient's daughter/POA.

Ms. McGee addressed the issues in the Hypothetical that were reflective of the Member's alleged conduct while the Patient was a resident at Comfort:

- Ms. McGee stated that the Member breached the *Documentation* Standard when she failed to keep records, including a documented care plan, the Patient's health conditions and medications. The POA informed the Member of the Patient's significant health conditions, yet nothing was documented or made accessible to the UCP who was part of the team. If the Member was asking the UCP to supervise the Patient, the Member should have a plan to know what the UCP is doing to monitor the Patient, and if the UCP were able to identify if/when medications were missed as well as a process for documentation.
- The Member told the Patient and the POA that she was a nurse, thus highlighting her accountability. She also gave an undertaking that she would provide nutritious meal services when she met with the POA. The Patient was diabetic and therefore healthy food and snacks were important. Some medications cause dizziness which placed the Patient at higher risk for falling. There was no contact information for the POA when the Patient had a seizure. The expert stated she would have expected the nurse to list each Patient's diagnosis, treatment, including medications, to tell the UCP how to monitor these conditions and who to report to. The fact that there was no information shared by the Member is a breach of the standards unless the Member was going to provide the care herself, which she did not do.
- Ms. McGee opined that the Member's failure to provide sufficient or quality food would constitute neglect, according to the College's *TNCR Standard*. This is a vulnerable population. The residents in a group home are dependent on adequate food, including nutritious meals and snacks. The Patient was diabetic and should have had monitored food intake. The Member had assured the Patient and the POA that the Member was responsible for purchasing food and undertaking to provide the food according to a set menu, however there was no evidence to support that this occurred.
- The Member did not monitor compliance with medications, directly or indirectly by getting reports from the UCP. Again, the nurse told the Patient and POA that she would do so. As a supervisor, the Member should have ensured that report with the UCP took place, and if there were concerns about medication compliance, this information should

have been reported to the POA, at which point the POA has the information to make an informed treatment decision.

- During the tour at Comfort, the Member informed the POA that Comfort would provide several services including medication administration monitoring and ordering or picking up medication refills. When the Patient returned from the hospital, the medications did not accompany her. The Member failed to ensure the medications were returned or that they were replaced. A nurse should ensure, at hospital discharge, that medication reconciliation had occurred, as the medications may have changed. Failure to have the medications restocked could constitute neglect in the *TNCR Standard*. The Patient went to the hospital because of a seizure. Not taking the medications could indeed increase the risk of another seizure. The Member did not follow through with those things that she had promised. Ms. McGee stated that there are components in the *TNCR Standard* that relate to misrepresentation, including trust, respect, and empathy. There were no supports in place to minimize safety risks for the Patient. The POA provided advocacy for the Patient. Ms. McGee stated she would have expected the Member to respect the POA for her advocacy for the Patient.
- Ms. McGee also testified as to respect and empathy when she reviewed the Member's representation to the Patient and the POA, that she would provide sanitary living conditions and adequate meals to the patients. The Patient had a disability that required both a clean living arrangement and nutrition. By denying these services, the Patient was at risk. If there is an insect infestation in the kitchen, this would pose a food safety risk. The Patient was weak and unable to provide for herself. Providing sanitary living conditions is considered standard and would be important for all the residents at the group home. Neglecting to provide this, especially for a vulnerable population, would be considered neglect.

Ms. McGee next addressed the issues identified while the Patient was a resident at Paradise.

- The Patient, while at Paradise, experienced a fall, was taken to the hospital, and had a cast applied to her wrist. The Patient was supposed to attend a follow-up appointment at the fracture clinic a few days later, however, it did not occur. The Member did not take the Patient to her appointment, nor make arrangements to reschedule the appointment. It was the Member's obligation to ensure the Patient attended the appointment. Eventually the POA rescheduled the appointment and when she did so, was advised by the clinic that no one else had called to reschedule it. Ms. McGee stated that this would be a breach of the College's TNCR and Professional Standards.
- The POA was in favour of having the Patient moved to Paradise, a different group home. However, soon after, the same owner of Comfort took over management at Paradise and the Member then became responsible for care at Paradise. In closing, Ms. McGee testified that the Member, in both settings, should have ensured sanitary living conditions, and her failure to do so constitutes neglect and abuse under the *TNCR Standard*.

This concluded the evidence from Ms. McGee, nursing expert.

Final Submissions

College Counsel stated that the Member's conduct resulted in a breach of the College's *Professional Standards, Medication*, *Documentation*, and the *Therapeutic Nurse-Client Relationship Standards* and that some of the Member's conduct constitutes abuse, failing to keep records as required and would reasonably be considered by members of the profession to be disgraceful, dishonourable, and unprofessional.

College Counsel submitted that the over-arching issue in this case was whether the Member was acting as a nurse in her work at Comfort and Paradise. College Counsel reminded the Panel of the evidence from [Witness 1], daughter and POA for the Patient, who met with the Member prior to the Patient going to Comfort and was told by the Member that she was an RN and would visit the home daily, ensure the Patient was taking meals, and provide oversight for the patient's medications. The POA relied on this information from the Member, and it was important to her knowing that there was a nurse involved with the Patient's care which gave her assurance to move the Patient into the home.

College Counsel stated that the nursing expert expressed that, in making representation to the POA and Patient, it meant that the Member was holding herself out as a nurse and providing a nursing role in the home, and therefore is required to provide care based on the College Standards. College Counsel referred to a prior decision, *CNO v Bowles* (2019), a case in which a registered practical nurse was working in a personal support worker (PSW) role. In the *Bowles* case the panel found that this member breached the documentation standard and concluded that, regardless of the role, a nurse with an active license is accountable to the College and must abide by the regulatory standards.

College Counsel provided a summary of the allegations and evidence and stated that the witnesses were all forthright and sincere in their recollection of the incidents. College Counsel asked the Panel to find that the Member committed professional misconduct in all allegations in the Notice of Hearing.

College Counsel submitted two additional cases with similar scenarios to the Panel for its consideration.

CNO v. Tennant (Discipline Committee, 2011): In this case, the member worked at a retirement home and failed to properly document, maintain proper sanitation, or provide training to UCPs; the member was frequently absent from the home and failed to provide supervision at the home. The evidence in the case before this Panel was significantly more serious than this case. The panel found that the member's conduct was disgraceful, dishonourable, and unprofessional.

CNO v. Hill (Discipline Committee, 2006): In this case, the member was the owner and co-operator at a private seniors' home. This member was the only nurse at the facility and hired

UCPs for daily care at the home and neglected to train them for medication administration or documentation, which was their role at the facility. The member admitted that she had provided misleading information. That panel found the member's conduct 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 and based upon clear, cogent, and convincing evidence. Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs:#1(a), (b), (c), (d), (e), (f)(i), (ii), (iii), (g), (h); #2(a), (b), (c), (d) insofar as it relates to physical and emotional abuse; #3; #4(a), (b), (c), (d), (e), (f)(i), (ii), (iii), (g), (h); #5(a), (b); #6 insofar as it relates to physical and emotional abuse; #7(a) and (b) in the Notice of Hearing. With respect to allegations #4(a), (b), (c), (d), (e), (f)(i), (ii), (iii), (g), (h), #7(a) and (b), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable, and unprofessional.

Reasons for Decision

The credibility of each witness was assessed by the Panel using the criteria set out in *Pitts v Ontario (Ministry of Social and Community Services)* (1985). The Panel determined that the evidence provided by [Witness 1] and [Witness 2] was clear, cogent, and convincing as their testimony was consistent and aligned with the multiple documentary exhibits. As such, the Panel found the witnesses to be credible and evidence reliable such that it satisfied the burden of proof.

Ms. McGee, the expert witness, was qualified by the Panel as an expert in nursing practice, with a focus on community settings including group homes. Her testimony was objective, reasonable and impartial. The Panel found her to be credible and accepted and relied on her opinion evidence.

With respect to allegations #1 and #5, incidents of breach of College Standards involving the same patient and POA, in two different homes, Comfort and Paradise: The Panel found that the Member breached several of the College Standards when she failed to keep adequate records or ensure that unregulated staff were informed of the Patient's health condition; failed to provide adequate meals; failed to ensure the Patient was taking her daily medications and did not report concerns of medication compliance to [Witness 1]; failed to ensure medications were restocked; and finally, failed to provide sanitary living conditions. Furthermore, the Member misrepresented to the Patient and [Witness 1] that these things would be in place at Comfort, which they were not. After the Patient fell and broke her wrist while at Paradise, the Member failed to ensure the Patient attended her follow-up appointment at the fracture clinic, nor did the Member promptly reschedule the appointment. Also, while at Paradise, the Member failed to ensure the Patient had sanitary living conditions.

The Member's conduct was a breach of the *Documentation Standard*. The Member should have maintained health records for the Patient and ensured documentation took place as a means to share information with others that worked in the home. As it was, [Witness 2] was entirely unaware of the Patient's diagnosis, which included epilepsy and diabetes, which posed a significant risk to the Patient.

The Member's failure to keep any type of medication record at Comfort was a breach of the *Medication Standard*. This record may not have been as formal as it would be in a more acute setting, however it was important to have some sort of monitoring system in place. It was also important that the Member ensure the Patient's medications were available and refilled as necessary, particularly due to the Patient's medical conditions.

The Member's conduct at Comfort was also a breach of the *Professional Standards* and the College's Practice Guideline, Working with Unregulated Care Providers. [Witness 2] received no information about the Patient. It was only after the seizure that the Member provided any information with respect to the Patient to [Witness 2], nor did she identify herself to [Witness 2] as an RN. Under the *Professional Standards*, the Member should have demonstrated leadership by working with UCPs as a team and providing necessary support and education. The Member made it impossible for the UCP to carry out important tasks and made no attempt to provide the care or monitor the Patient herself.

The Member, while employed at Comfort, further breached the *TNCR Standard* when she failed to ensure the Patient and other patients received adequate meals or sanitary living conditions. The Member refused to provide a meal-replacement (Ensure) at the request of [Witness 1] when the Patient was not eating her meals. The Member purchased expired or poor-quality food which demonstrated a lack of empathy and respect for the Patient. These principles are foundational to the *TNCR Standard*. [Witness 1] spoke with the Member a few days after the Patient was admitted and was assured that things were going well with the Patient, however, a week later [Witness 1] spoke with the UCP and received an entirely different account. This demonstrated dishonesty on the Member's part. Furthermore, the Member did not contact [Witness 1] on her own initiative; it was always [Witness 1] that sought out information. There developed a lack of trust in the Member when the Member did not retrieve the Patient's medications from the hospital on discharge, nor arrange to have the medications refilled.

The Member, while employed at Paradise, breached the *TNCR Standard* when she failed to follow through on her commitment to ensure the Patient, while at Paradise, attended her follow-up appointment at the fracture clinic. [Witness 1] testified that she called the clinic herself and was told that no one had called to reschedule the Patient's appointment. The result of this incident was that the Patient had the cast on her wrist for significantly longer than necessary. Trust is critical in the nurse-client relationship. The Patient was in a very vulnerable position and both the Patient and [Witness 1] were counting on the Member to do as she had

promised. The Member further demonstrated a lack of respect when she failed to fulfil this commitment. While at Paradise, [Witness 1] found the Patient's bed sheets soiled, and no soap or toilet tissue. Failing to provide clean sanitary conditions would pose risk for diabetic patients and does not align with infection control protocols. The Member demonstrated a lack of empathy when she knew the Patient could not physically tend to these things herself.

With respect to allegations #2 and #6, Abuse of the patient, at Comfort and at Paradise: The Panel found that the Member's failure to provide adequate food and meals to the Patient and other patients constituted physical and emotional abuse as described in the *TNCR Standard*. The Patient and others at these homes were vulnerable, with little disposable income and unable to provide for themselves in many circumstances. Food was included in the monthly rent. The Member was responsible for purchasing the food and this should have meant something. Failure to ensure medications were monitored and stocked or refilled is also considered abuse and neglect. The Patient and [Witness 1] were counting on the Member to fulfill her duties and ensure these important care requirements were monitored. Finally, failing to provide sanitary living conditions is also considered neglect under the *TNCR Standard*. The Panel found these examples to be physical and emotional abuse due to the Patient's vulnerability and trust in the Member.

With respect to allegation #3, both [Witness 1] and the UCP confirmed that there was no documentation system in place at Comfort. Indeed, the UCP took it upon herself to create cards for each patient in efforts to organize information, identify diagnoses and care requirements. The Member should have documented a care plan for the Patient and identified the POA contact. It may have looked different in the group home setting versus in a hospital or long-term-care environment, but it was nonetheless important that one be prepared by the Member.

With respect to allegations #4 and #7, disgraceful, dishonourable, and unprofessional conduct at Comfort and at Paradise: The Panel found that the Member's conduct was relevant to the practice of nursing as the Member was functioning as an RN at Comfort and Paradise, and would reasonably be regarded as disgraceful, dishonourable, and unprofessional. The Member demonstrated disregard for her professional obligations while the Patient was at both Comfort and Paradise. She was dishonest on a number of occasions with the Patient and [Witness 1] regarding services that she would provide in the interest of the Patient's well-being, by failing to ensure the Patient had follow-up care, and by failing to provide sanitary living conditions. This conduct is profoundly serious and unbecoming of a nurse. It is disgraceful and dishonourable to abuse a vulnerable Patient who was relying on her for basic necessities of life, and disrespectful to both the Patient and the nursing profession at large. The Member's conduct casts serious doubt on her moral fitness and ability to discharge the higher obligations the public expects of nurses.

Penalty

Penalty Submissions

College Counsel submitted that, in view of the Panel's findings of professional misconduct, the Panel 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 immediately revoke the Member's certificate of registration.

Penalty Submissions

College Counsel made submissions on the appropriate penalty for the Member. College Counsel submitted that there was a disturbing pattern of breach of standards, abuse, failing to keep records and conduct that was all of disgraceful, dishonourable, and unprofessional toward the most vulnerable patients in society, and therefore required an extremely significant penalty. The Member has demonstrated that she is unwilling to be accountable for her conduct by not attending or participating in the discipline process. Her absence leaves the Panel with no mitigating factors or information to consider with respect to her personal circumstances.

The aggravating factors were:

- The nature of the Member's conduct was very serious;
- The Member breached the most basic standards of practice;
- The Member's conduct was not isolated and was a prolonged pattern of abuse;
- The Member's conduct involved one Patient at one facility and multiple patients at the second facility;
- The Member's conduct demonstrated a pattern of dishonesty and breach of trust and brought serious discredit and shame to the profession.

College Counsel submitted that the Member's conduct demonstrated dishonesty and a significant breach of trust on a number of occasions. Abusive behaviour toward an extremely vulnerable Patient shows a lack of respect and empathy. The conduct resulted in harm to the Patient when the Patient suffered a significant decline in health under the Member's oversight.

College Counsel submitted that there is no evidence before the Panel to show that the Member could be remediated or rehabilitated. There is no evidence of remorse, insight, responsibility or willingness to improve. College Counsel submitted that the Member has disregarded the College's process, which raises concerns of the Member's governability. The focus of the penalty should be on public protection and to preserve confidence in the College's regulatory process

and revocation will send a clear message to the public and the profession that this type of conduct is not tolerated.

College Counsel also submitted the same two cases as earlier provided to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO v. Tennant (Discipline Committee, 2011): This was a case in which the member did not participate. The member worked at a retirement home and her conduct was remarkably similar to the matter at hand, in terms of failing to document, maintain sanitation, provide quality food, and provide support to the team. There was no evidence of mitigating factors, remorse, or a desire to remediate. The penalty was an oral reprimand and revocation of the member's certificate of registration.

CNO v. Hill (Discipline Committee, 2006): This was a case whereby the member admitted some allegations and denied others. The member was co-owner and operator of a private seniors' home and failed to provide adequate training for staff, ensure patients medications were given, and gave misleading and untruthful information to others. The member used her professional status to convince people to come to the home and misrepresented the services the home would provide. In this case, the member benefitted financially, and the quality of care suffered. The member's conduct was deemed to be disgraceful, dishonourable, and unprofessional. In the interest of public protection, and in the absence of evidence from the member, the penalty was revocation of the member's certificate of registration.

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 immediately revoke the Member's certificate of registration.

Reasons for Penalty Decision

The Panel's greatest concern was for protection of the public. The findings of professional misconduct were numerous in this case. The Member's misconduct caused harm and broke the trust between the public and the Member. The Member's breach of the standards were multiple and are thoroughly contrary to the values of the nursing profession which holds public trust, honesty, respect, and integrity as cornerstones of the profession.

There were no mitigating factors to consider. The Member's lack of remorse or willingness to remediate as evidenced by her failure to attend the hearing demonstrate the Member to be ungovernable.

In the interest of maintaining public confidence in the self-regulatory process of the College, the Panel concludes that this order demonstrates to the public that this profession can govern itself in the public interest. The oral reprimand and revocation of the Member's certificate of registration satisfies the principles of specific deterrence and public protection as the Member will no longer be permitted to practice. The penalty will provide general deterrence to the nursing membership, sending the message that this type of conduct will not be tolerated. As the Member's conduct was such that it required that her certificate of registration be revoked, the goals of remediation and rehabilitation are not applicable.

The penalty is also consistent with previous decisions of this Committee for similar circumstances.

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.