DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Lalitha Poonasamy	Public Member
	Ingrid Wiltshire-Stoby, NP	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
AMBER-LEE JOHNSTON	)	DANIELLE BISNAR AND SYDNEY LANG for
Registration No. 0186809	)	Amber-Lee Johnston
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: March 17, 2022

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on March 17, 2022, via videoconference.

Publication Ban

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

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

The Allegations

The allegations against Amber-Lee Johnston (the "Member") as stated in the Notice of Hearing dated January 10, 2022 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 employed as a Registered Nurse at Orillia Soldiers Memorial Hospital in Orillia, Ontario (the "Hospital"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that on or about April 6, 2019, you:

    (a) failed to remove yourself from a situation in which you were not able to practice nursing in accordance with the standards of practice;

    (b) used improper techniques and/or excessive force when placing a shoulder restraint on [the Patient]; and/or

    (c) dismissed security guards' concerns that [the Patient]'s shoulder restraint was applied inappropriately;

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, while employed as a Registered Nurse at the Hospital, you verbally, physically or emotionally abused [a patient] in that on or about April 6, 2019 you used improper techniques and/or excessive force when placing a shoulder restraint on [the Patient]; 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 employed as a Registered Nurse at the Hospital, 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 about April 6, 2019, you:

    (a) failed to remove yourself from a situation in which you were not able to practice nursing in accordance with the standards of practice;

    (b) used improper techniques and/or excessive force when placing a shoulder restraint on [the Patient]; and/or

(c) dismissed security guards' concerns that [the Patient]'s shoulder restraint was applied inappropriately.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), (b), (c), 2, 3(a), (b) and (c) in the Notice of Hearing. The Panel conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Amber-Lee Johnston (the "Member") obtained a diploma in nursing from Seneca College in 2001.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on November 1, 2001. She subsequently completed a Diploma in Social Work, also at Seneca College.

3. The Member has worked primarily in mental health nursing in various settings, including Southlake Regional Health Centre, Royal Victoria Hospital, and Orillia Soldiers Memorial Hospital (the "Hospital") in Orillia, Ontario.

4. Over the course of her career as a mental health nurse, the Member experienced several incidents of physical abuse and injury from patients, including a severe physical assault in 2014 leading to a concussion, trauma and several months off work.

5. The Member was employed at the Hospital on the Inpatient Mental Health unit (the "Unit") as a full-time nurse from May 14, 2007 to July 29, 2019, when her employment was terminated as a result of the incident described below.

6. Shortly after the incident described below, the Member sought medical treatment and was diagnosed with Post Traumatic Stress Disorder (PTSD) as result of the 2014 patient assault.

7. The Member is currently employed in non-psychiatric settings with Paramed Health Services and Veterans Affairs Canada. No other issues have been raised regarding her nursing care with these subsequent employers.

PRIOR HISTORY

8. The Member has no prior disciplinary findings with CNO and has cooperated with CNO throughout the investigation and discipline processes. In addition, she has fully participated in the Nurses' Health Program ("NHP"), with no restrictions on her nursing practice being recommended by the NHP or her health care providers.

HOSPITAL POLICIES

9. The Hospital's *Least Restraint Policy* indicates that restraints are to be viewed as last resorts in circumstances where there exists imminent risk of harm to the patient or others. In all cases, when a restraint is required, only the least restrictive restraint shall be used. Use of restraints is temporary and should be discontinued as soon as possible. The application of restraints is carried out with the minimal use of force as is necessary while maintaining dignity and respect for the patient.

10. Appendix C to the *Least Restraint Policy* provides a framework for making decisions on when a restraint is needed and whether the regulated health professional responding to the situation has the resources needed to manage the situation safely. It indicates that de-escalation techniques are to be employed throughout the process, even once restraints have been applied. The framework also provides that the patient is to be monitored closely and states that restraints ought to be discontinued as soon as they are no longer deemed necessary.

THE PATIENT

11. [ ] (the "Patient") was 20 years old at the time of the incident.

12. The Patient was admitted to the Unit on April 5, 2019, after his mother called police to attend the family home as the Patient was threatening suicide.

13. The Member was familiar with the Patient as he had been admitted to the Unit on prior occasions within the two months preceding his admission in April 2019.

14. The Patient's diagnosis at the time of his April 2019 admission was psychosis, polysubstance use disorder and suicidal ideation. The diagnosis was subsequently revised to include bipolar mood disorder, as well as attention deficient hyperactivity disorder (ADHD).

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

15. On April 6, 2019, the Member was assigned to the Extra Care Area (ECA). The ECA is reserved for higher acuity patients who benefit from lower nurse to patient ratios. The Patient was located in the ECA on the day in question.

16. When the Member arrived at the Patient's bedside, he was yelling, spitting, and thrashing in his bed, while already in 5-point restraints. If the Member were to testify, she would say she was concerned that there was a risk of the Patient flipping the bed.

17. At approximately 0820hrs on April 6, 2019, security was called to the Unit to assist with the Patient.

18. On arrival, nursing staff advised the three security staff members that the Patient was not following direction and was thrashing in his bed.

19. The nursing staff wanted to administer a medication by injection and required assistance to restrain the Patient to do so.

20. None of the security staff observed the Patient physically move the bed and did not identify a risk of the bed flipping over, noting that this was unlikely based on their observation of the Patient's size and weight. The security staff characterized the level of resistance demonstrated by the Patient as relatively minimal.

21. The Patient spat in the Member's face and attempted to bite her while she was restraining his head. The Member adjusted her head control technique and kept her composure. Moments later, one of the security staff, [A], took over restraining the Patient's head so the Member could assist with the placing of the shoulder restraint.

22. If the Member were to testify, she would state that during this interaction she experienced physiological effects of fear, including a racing heart, a sense of being on the verge of tears and sweating profusely. The Member would testify that she was assisted by a float nurse who had minimal experience on the ECA and was unfamiliar with applying shoulder restraints. The Member would testify that she felt that she lacked sufficient support from other experienced nurses in addressing this dynamic and safety-sensitive situation. Nevertheless, she did not leave the room or advise her colleagues that she was unable to safely provide care to the Patient.

23. As video footage of the incident confirms, at 0826 hours, the Member placed her foot against the bed while tightening the shoulder restraint. The Member completed applying the restraint at 0827 hours and all staff left the room shortly thereafter.

24. Once the restraint was applied by the Member, discolouration of the Patient's arm is visible on the video indicating that circulation to the Patient's arm was restricted. The Patient can also be seen looking at his arm out of concern and/or pain.

25. Another security guard, [B], observed that the shoulder restraint was digging into the Patient's shoulder. She also heard the Patient comment that it was tight and request that it be loosened.

26. After the restraint had been placed and staff left the room, [Security Staff A] spoke to the Member and informed her that he thought the restraint needed to be loosened for the safety of the Patient. According to [Security Staff A], the Member responded defensively, stating "well you can stay up here to deal with him" or words to that effect. If the Member were to testify, she would say that she does not recall stating words to that effect and was still experiencing physiological effects of fear at that time. The Member did not object to the suggestion that the restraint be loosened.

27. Security and nursing staff, including the Member, re-entered the room and security loosened the shoulder strap at 0834 and then completely removed it and re-applied it at 0835, thereby indicating that its previous placement by the Member was not correct.

28. Shortly after the incident, [Security Staff A] brought forward a concern to the Hospital that the Member used excessive force when applying the shoulder restraint and that the restraint was excessively tight to the point that it was evident that the Patient's circulation was restricted. [Security Staff A] acknowledged that the Patient may have been difficult, but in his view, the Patient was not uncontrollable and restraints were not necessary.

29. The Member admits that she put her foot on the bed while tightening the shoulder restraint. If the Member were to testify, she would state that she did this to stabilize herself, so she did not fall over while she tightened the restraint. Nevertheless, she acknowledges that this was contrary to the Hospital's protocol and CNO's standards of practice.

30. If the Member was having difficulty placing the shoulder restraint, Hospital protocol would have been to remove it and start over rather than trying to pull harder on it and forcing it into place. Alternatively, the Member could have sought support from her colleagues rather than continuing on her own, causing harm to the Patient.

31. The Member also acknowledges that she used more force than necessary while applying the restraint.

32. The Member deeply regrets her actions in the circumstances described above and is remorseful for any harm caused to the client. In hindsight and in light of her subsequent diagnosis of PTSD she recognizes she ought to have removed herself from the situation. Since her employment ended with the Hospital, and her diagnosis of PTSD, the Member has changed her focus to work in nursing contexts outside of mental health nursing. The Member does not intend to return to psychiatric nursing because she now has insight into the impact this nursing context has on her own health and her ability to perform her duties in accordance with her professional obligations.

CNO STANDARDS

33. CNO's *Professional Standards* provide that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets legislative requirements and the standards of practice of the profession. A nurse demonstrates this standard by providing, facilitating, advocating and promoting the best possible care for patients.

34. CNO's *Professional Standards* further provide, in relation to the *Relationships* standard, that each nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships and a nurse demonstrates this standard by demonstrating respect and empathy for, and interest in patients.

35. CNO's *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard")* places the responsibility for establishing and maintaining the therapeutic nurse-patient relationship on the nurse. The *TNCR Standard* further provides that the relationship is based on trust, respect, empathy, and professional intimacy, and requires the appropriate use of power inherent in the care provider's role.

36. Abuse is defined as the misuse of the power imbalance intrinsic to the nurse-client relationship. Abuse may be verbal, emotional, physical, sexual, financial or take the form of neglect. Physical abuse includes but is not limited to: using force; and handling a client in a rough manner. The intent of the nurse does not justify a misuse of power within the nurse-client relationship.

37. Nurses protect clients from harm by ensuring that abuse is prevented or stopped and reported. A nurse meets this expectation by not engaging in behaviours toward a client that may be perceived by the client and/or others to be violent, threatening, or intending to inflict physical harm.

38. Nurses are also expected to have sufficient knowledge, skill and judgment to determine the appropriateness of performing a particular procedure at a given time for a particular client considering the client's overall condition, risks and benefits, and available resources to support the performance of the procedure and manage outcomes.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

39. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1 (a) (b) and (c) of the Notice of Hearing, as described in paragraphs 15-31 and 33-38 above.

40. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, and in particular that she physically abused the Patient when she used improper techniques and excessive force when placing a restraint on the Patient, as described in paragraphs 15-31 and 33-38 above.

41. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3 (a), (b) and (c) of the Notice of Hearing, and in particular her conduct was unprofessional, as described in paragraphs 15-31 and 33-38 above.

Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs #1(a), (b), (c), #2, #3(a), (b) and (c) of the Notice of Hearing. With respect to allegation #2, the Panel finds that the Member physically abused the patient. As to allegations #3(a), (b) and (c), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be unprofessional.

Reasons for Decision

The Panel considered the Agreed Statement of Facts, which it accepts, and the Member's plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegations #1(a), (b) and (c) in the Notice of Hearing are supported by paragraphs 15-31, 33-38 and 39 in the Agreed Statement of Facts. When [the Patient] spat in her face and attempted to bite her while she was restraining his head, the Member experienced physiological effects of fear, including a racing heart, a sense of being on the verge of tears and sweating profusely. Even though she lacked sufficient support from other experienced nurses in addressing this dynamic and safety-sensitive situation, the Member did not leave the room or advise her colleagues that she was unable to safely provide care to [the Patient]. The Member acknowledged that she used more force than necessary while applying the restraint. Once the restraint was applied by the Member, discolouration of [the Patient]'s arm was visible on the video indicating that circulation to [the Patient]'s arm was restricted. The shoulder restraint

was observed to be digging into [the Patient]'s shoulder and he was overheard commenting that it was tight and requested that it be loosened. When a suggestion was made by a security officer that the restraints be loosened for the safety of [the Patient], the Member responded defensively, stating "well you can stay up here to deal with him" or words to that effect. Security and nursing staff, including the Member, re-entered the room and security loosened the shoulder strap at 0834 and then completely removed it and re-applied it at 0835, thereby indicating that its previous placement by the Member was not correct.

The Member's conduct as described above was a failure to meet the *Professional Standards* and breached the *Therapeutic Nurse–Client Relationship* Standard ("*TNCR* Standard"). The *Professional Standards* provide that a nurse demonstrates this standard by providing, facilitating, advocating and promoting the best possible care for patients. It further provides that nurses must demonstrate respect and empathy for and interest in patients. The *TNCR* Standard sets out the expectation that nurses have sufficient knowledge, skill and judgment to determine the appropriateness of performing a particular procedure at a given time for a particular client considering the client's overall condition, risks and benefits, and available resources to support the performance of the procedure and manage outcomes. The Member's conduct is inconsistent with the fundamental professional obligations of a nurse.

Allegation #2 in the Notice of Hearing is supported by paragraphs 15-31, 33-38 and 40 in the Agreed Statement of Facts. The Panel finds that the Member physically abused [the Patient]. Video footage of the incident confirms, at 0826 hours, the Member placed her foot against the bed while tightening the shoulder restraint. The Member also acknowledged that she used more force than necessary while applying the restraint and once the restraint was applied by the Member, discolouration of [the Patient]'s arm was visible on the video indicating that circulation to [the Patient]'s arm was restricted. The Member behaved in a manner that jeopardized the Patients' safety by using excessive force. This constitutes an abuse of authority and power over the Patient. The *TNCR* Standard defines abuse as the misuse of the power imbalance intrinsic to the nurse-client relationship. It further defines physical abuse as including but not limited to: using force; and handling a client in a rough manner. The intent of the nurse does not justify a misuse of power within the nurse-client relationship.

Allegations #3(a), (b) and (c), in the Notice of Hearing are supported by paragraphs 15-31, 33-38 and 41 in the Agreed Statement of Facts. The Panel finds that the Member's conduct was unprofessional. It demonstrated a serious and persistent disregard for her professional obligations. The Member failed to remove herself from a situation thereby compromising the safety of a client. She used more force than necessary while incorrectly applying and securing the restraints. The use of excessive force amounts to physical abuse and constitutes an abuse of authority and power over the Patient.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 3 months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

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

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

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

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

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

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

v. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and *Nurses' Workbook*;

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

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

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, in which the Expert will confirm:

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

viii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were that the Member showed a serious disregard for her obligations to maintain [the Patient]'s safety. [The Patient] was a member of a vulnerable population and was harmed by the seriousness of the offence.

The mitigating factors in this case were that the Member has no prior discipline history with the College, she demonstrated remorse and has taken responsibility and accountability for her conduct. The Member does have a mental health diagnosis that was triggered by [the Patient]'s behaviour. The Member has shown insight by limiting her practice outside of mental health nursing. The Member has saved the College time and resources by entering into an Agreed Statement of Facts and a Joint Submission on Order. The Member has agreed to engage in education and reflection to improve her clinical practice.

The proposed penalty provides for general deterrence through the 3 month suspension of the Member's certificate of registration as it sends a clear message to the profession that failure to meet one's professional obligations can result in serious disciplinary sanctions.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3 month suspension of the Member's certificate of registration as it demonstrates the seriousness of her conduct to the Member.

The proposed penalty provides for remediation and rehabilitation through the 2 meetings with a Regulatory Expert. The Member will also review the College's publications and complete Reflective Questionnaires, online learning modules, decision tools and online participation forms, including *One is One Too Many* learning package. These requirements will help to facilitate the Member's understanding of her misconduct and will help to ensure that this conduct is not repeated.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. This will inform her future practice. The public is also protected through the 12 months of employer notification requirements whereby the Member is required to notify her employers of the Panel's decision. This penalty sends a message to the public about the profession's ability to self-regulate and to ensure this conduct is not repeated.

College Counsel submitted the following cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee:

CNO v. Hayden (Discipline Committee, 2018): In this case, the hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. Similarities to the case before this Panel include the client spitting in the member's face while being placed in restraints for aggressive behavior. That member responded by punching the client several times. The penalty included an oral reprimand, a four month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification. The difference in the case before this Panel is that the Member maintained her composure and did not respond in an aggressive manner to being spat at by [the Patient].

CNO v. Wreaks (Discipline Committee, 2017): In this case, the hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. Similarities to the case before this Panel include aspects of physical and emotional abuse of a client, however the client was not restrained. The client was vulnerable and initially on an involuntary admission to a psychiatric facility. In this case the member struck the client several times while attempting to prevent the client from leaving the unit. The penalty included an oral reprimand, a four month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification. The Member in the case before this Panel maintained her composure and did not respond to [the Patient] in an aggressive manner.

CNO v. Agustin (Discipline Committee, 2019): In this case, the hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. Similarities to the case before this Panel include aspects of physical and emotional abuse of a client, however this client was not restrained but was a member of a vulnerable population. The member responded to the client in a raised tone and/or angry tone and struck the client on or around the face with the client's shoe. The penalty included an oral reprimand, a four month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 18 months of employer notification.

Submissions were made by the Member's Counsel.

The Member's Counsel submitted that on the whole she agreed with the submissions of College Counsel. The Member's Counsel submitted that the Member was deeply remorseful and accepted the Joint Submission on Order.

The aggravating factors in this case were that the Member showed a serious disregard for her professional responsibilities, her actions did compromise patient's safety. [The Patient] was a member of a vulnerable population and was harmed by the seriousness of the offence.

The mitigating factors in this case were that the Member has a 20+ year membership with the College and a 12 year employment history with the hospital, with no prior discipline history with either. This was an isolated incident that involved a single patient, on a single shift and involved a triggering event to her mental health illness. The Member has sought out remediation of her own accord, has taken accountability and has modified her practice to areas outside mental health.

The oral reprimand meets the goals of specific deterrence, general deterrence and rehabilitation and remediation and will provide an opportunity for the Member to hear from fellow members of the profession and public members about the seriousness of her conduct. It is a meaningful opportunity for the member to receive insight about the expectations of the College and members of the public.

The meetings with the Regulatory Expert will meet the goals of rehabilitation and remediation and public protection.

The 3 month suspension will have a strong deterrent effect by sending an important message to the Member reflecting the seriousness of the misconduct and to members of the profession that this type of misconduct is not acceptable.

The 12 month employer notification will protect the public through ensuring the Member's employer is aware of the misconduct. The employer will be afforded an opportunity to be vigilant in monitoring the Member's practice on her return to the profession.

Penalty Decision

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

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

2. The Executive Director is directed to suspend the Member's certificate of registration for 3 months. This suspension shall take effect from the date that this Order becomes final

and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

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

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of:

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

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

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

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

        v. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires, online participation forms and *Nurses' Workbook*;

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

            1. the acts or omissions for which the Member was found to have committed professional misconduct,

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

vii. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards their report to CNO, in which the Expert will confirm:

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

viii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

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

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel concluded that the proposed penalty is reasonable and in the public interest. It sends a strong message to the Member and the membership as a whole that conduct such as this will not be tolerated. Members will be reminded that they are accountable for meeting the standards of care as outlined in the College's standards of practice. The oral reprimand and suspension provide specific deterrence to the Member. The 3 month suspension sends a clear message to the membership that such conduct will attract a severe penalty. The public is protected by the fact that the Member has accepted responsibility for her actions and will be rehabilitated by the *One is One Too Many* learning package and the 2 meetings with a Regulatory Expert. The 12 months of employer notification will ensure that when the Member returns to practice, she has appropriate supervision. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public interest.

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

I, Lalitha Poonasamy, Public Member, sign this decision and reasons for the decision on behalf of the Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.