DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	DAWN CUTLER, RN	Chairperson
	LAURA CARAVAGGIO, RPN	Member
	RENATE DAVIDSON	Public Member
	MARY MACMILLAN-GILKINSON	Public Member
	SUSAN ROGER, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
JUDE NZUONKWELLE NKWELLE	)	SHEILA RIDDELL for
Registration No. 08366564	)	Jude Nzuonkwelle Nkwelle
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: FEBRUARY 13, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on February 13, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

Counsel for the College asked for additional time to continue to pursue a negotiated agreement. The Panel granted this request and commenced the hearing at 11:15 a.m.

The Allegations

The allegations against Jude Nzuonkwelle Nkwelle ("the Member") as stated in the Notice of Hearing dated December 5, 2017 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, as a Registered Nurse employed at the Centre for Addiction and Mental Health in Toronto, Ontario, 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 regarding the client, [the Client], on or about February 12, 2016:

a. you failed to complete and/or ensure other staff completed the close observation (Q15) checks on the client as required between approximately 0445 hours and 0645 hours;

b. you documented that you had completed close observation (Q15) checks on the client that you had not actually performed between approximately 0445 hours and 0615 hours; and/or

c. you napped while on duty between approximately 0445 hours and 0600 hours.

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(14) of *Ontario Regulation 799/93*, in that, as a Registered Nurse employed at the Centre for Addiction and Mental Health in Toronto, Ontario, you falsified a record relating to your practice with respect to documenting that you had completed close observation (Q15) checks on the client, [the Client], that you had not actually performed between approximately 0445 hours and 0615 hours on or about February 12, 2016.

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, as a Registered Nurse employed at the Centre for Addiction and Mental Health in Toronto, Ontario, 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 with respect to following incidents regarding the client, [the Client], on or about February 12, 2016:

a. you failed to complete and/or ensure other staff completed the close observation (Q15) checks on the client as required between approximately 0445 hours and 0645 hours;

b. you documented that you had completed close observation (Q15) checks on the client that you had not actually performed between approximately 0445 hours and 0615 hours; and/or

c. you napped while on duty between approximately 0445 hours and 0600 hours.

Member's Plea

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

Agreed Statement of Facts

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

THE MEMBER

1. Jude Nzuonkwelle Nkwelle (the "Member") obtained a degree in nursing from the University of Toronto in 2008. The Member obtained his Nurse Practitioner designation from York University in 2015.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on September 29, 2008. The Member has been registered in the Extended Class since December 2, 2015.

3. The Member was employed at the Centre for Addiction and Mental Health ("the Hospital") from January 19, 2009 to March 7, 2016, when his employment was terminated as a result of the incidents below. The Member grieved his termination and that grievance was resolved through a settlement.

THE HOSPITAL

4. The Hospital is located in Toronto, Ontario. It is a mental health and addictions services facility.

5. The Member worked in the Emergency Department (the "Unit") as a part-time staff nurse on the day, evening and night shift.

6. The Unit had two sections: the acute area, which was in the front, and the Emergency Assessment Unit ("EAU"), which was in the back. The nursing station was in the middle. Clients entered the Unit at the front and were assessed by a RN and a psychiatrist. If the client required medical assistance, they were transferred to the EAU, another unit at the Hospital or another hospital.

7. Staffing on the Unit (front and back), at the time of the incident, was as follows: four RNs and two Program Assistants ("PA") were scheduled from 0730 to 1930 and from 1930 to 0730. Normally, three RNs and one PA would be scheduled on the front of the Unit, with two RNs and one PA on the back, but this balance could change, depending on the acuity of the patients on a particular shift. An extra RN also worked a swing shift from 1130 to 2330 and would cover both the front and back of the Unit.

Hospital Policies

8. The Close Observation Protocol in the Unit required the PAs to conduct checks of all clients every 15 minutes ("Q15"). The checks were recorded on the Close Observation

Form, which included space for the initials of the PA who observed the client and the location of the client. The Form was pre-marked with 15 minute intervals.

9. If the PAs were both temporarily unavailable to perform the Q15 checks, for example if they were on a break, RNs were expected to fill in. There was no doctor's order for the checks, but it was considered part of the routine care in the EAU.

THE CLIENT

10. [the Client] (the "Client") was 41 years old at the time of the incident. She was admitted to the Hospital on February 10, 2016. When assessed, the Client was described as psychotic and disturbed. She expressed suicidal ideation, specifically that she would hang herself if released from the Hospital. The Client was admitted to the EAU.

11. On February 11, 2016, the Client was assessed again. She was determined not to be an acute risk to herself or others. Nevertheless, the Client was held overnight on a Form 1 because her mother was unable to take her home.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Events of February 11-12, 2016

12. On February 11-12, 2016, the Member worked the night shift from 1930 to 0730 in the EAU. The Member was not originally scheduled to work, but he was called in to work, and he agreed.

13. If the Member were to testify, he would say that, a few days earlier, his friend and colleague passed away. The Member was therefore distraught and not sleeping well. He acknowledges that he is responsible for accepting the shift, despite how he was feeling.

14. The Member was not assigned to provide care to the Client. [Co-worker #1], RN, was the Client's assigned nurse but [Co-worker #1] spent most of her shift in the front of the Unit.

15. [Co-worker #2] was the Program Assistant ("PA") on shift with the Member in the EAU. She was responsible for performing Q15 checks for clients in the EAU.

16. The Member and [Co-worker #3]., RN, were not assigned specifically by a supervisor to conduct the Q15 checks in [Co-worker #2]'s absence.

17. Around 0200 on February 12, 2016, the Client became agitated when another client was put in her room. She dragged her personal belongings into the hallway.

18. Around 0242, [Co-worker #1] moved the Client to the family room, which was a space used when clients were not able or willing to share a room. The Client was permitted to bring her personal belongings with her, including a blanket. There was a video camera in the family room, but it did not show the entire room.

19. [Co-worker #2] charted that she had performed Q15 checks from 1930 until she went on break around 0430. However, the video evidence indicates that not all of the Q15 checks charted by [Co-worker #2]were performed by her or other staff.

20. The Member returned from his break around 0430, shortly before [Co-worker #2]left on break. By that time, [Co-worker #3] was already on break so the Member was the only RN present in the back of the Unit. [Co-worker #1]was also assigned to the client but, as noted above, she spent most of her shift at the front of the Unit).

21. If she testified, [Co-worker #2]would state that, before going on break, she confirmed with the Member that he would conduct the checks in her absence. According to [Co-worker #2], the Member said he would.

22. If he testified, the Member would state that he was not told by [Co-worker #2]that he was responsible for the Q15 checks. However, the Member admits that he was aware he was the only staff in the back of the EAU who could conduct the Q15 checks at that time.

23. [Co-worker #2]then left the EAU for her break. She was gone for approximately two and a half hours.

24. The Nursing Station video showed the following:

    - 0442 – the Member is sitting at the nursing station, wrapped in linens, with his head down
    - 0445 – check is missed
    - 0500 – check is missed
    - 0522 – the Member conducts a check
    - 0530 – check is missed
    - 0543 – [Co-worker #3]returns from break
    - 0545 – check is missed
    - 0600 – check is missed
    - 0611 – the Member conducts a check.

25. The Member charted that he conducted Q15 checks at 0445, 0500, 0515, 0530, 0545, 0600 and 0615. The Member actually performed checks at only 0522 and 0611.

26. Additional Q15 checks were scheduled for 0630 and 0645 and no one performed these checks.

27. If the Member testified, he would state that at 0456 he began working on an online learning module about emergency protocol, which his supervisor had directed him to complete by the end of his shift. The Member would further testify that he was not sleeping at the nursing station and that he was only wrapped in linens because he was cold. Nevertheless, the Member acknowledges that from 0430 to 0450, he was resting at the desk and was not working.

28. If he testified, the Member would also state that after he performed the Q15 check at 0611, he backdated the entries on the Close Observation Form because he had checked all the clients at 0611 and therefore he thought he could assume they had been okay at the earlier times as well. The Member would testify that documenting Q15s the way he did was a common practice at the Hospital, but he acknowledges that it was a breach of the Hospital's Close Observation Protocol and the College's *Documentation* standard.

29. At approximately 0615, the Member attempted to pass on responsibility for the Q15 checks to [Co-worker #3], who had returned from her break. However, she refused because she said she had done the Q15 checks earlier in the shift and believed it was [Co-worker #1]'s responsibility.

30. If the Member were to testify, he would say that he thought [Co-worker #3]had taken over the Q15 checks because she took the clip board with the Close Observations Form and placed it on the counter at the nursing station in front of her. However, the Member accepts that it was his responsibility to ensure either that [Co-worker #3] had accepted the delegation of the task, particularly since she said she would not, or to continue performing the Q15 checks himself.

31. [Co-worker #2] returned from break, shortly before 0700, approximately half an hour later than expected. She passed the family room, looked in through the window and noticed that the Client was not on the couch. She looked up and saw that the Client had used her blanket to hang herself. [Co-worker #2]. pressed her personal panic alarm, unlocked the door and called for assistance.

32. The Family Room video shows the following:

    - 0611 – the Member checks in through the window
    - 0639 – the Client walks out of camera to back of room
    - 0640 – the Client is beginning to pace, in and out of camera view
    - 0642 – the Client is pacing, wearing a blanket, grabs a chair and takes it out of camera view
    - 0653 – a chair juts out with force
    - 0705 – [Co-worker #2] presses the panic button.

33. The Client could not be revived. She was transferred by EMS to Mount Sinai Hospital where her pulse was restored on life support. However, life support was ultimately withdrawn and the Client died on February 18, 2016.

34. The Member acknowledges that he falsely charted certain Q15 checks prior to 0615. The Member would testify that his intention with his charting was not to be deceptive or cover up misconduct that led to a tragic outcome; instead, his intention was to complete an incomplete record, something he now understands was a violation of the *Documentation* standard and resulted in a false record.

COLLEGE STANDARDS

35. The College'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 clients." As well, each nurse is expected to continually improve the application of professional knowledge. A nurse demonstrates this standard by "using best-practice guidelines to address client concerns and needs." Furthermore, a nurse is required to maintain professional relationships with other care providers based on trust and respect. To demonstrate this standard, a nurse is expected to role-model "positive collegial relationships."

36. The College's *Documentation* standard states that:

> Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the client health record. Documentation — whether paper, electronic, audio or visual — is used to monitor a client's progress and communicate with other care providers. It also reflects the nursing care that is provided to a client.

37. The standard goes on to say that a nurse meets the standard by "ensuring their documentation of client care is accurate, timely and complete."

ADMISSIONS OF PROFESSIONAL MISCONDUCT

38. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a), (b) and (c) of the Notice of Hearing, as described in paragraphs 12-34 above, in that he:

- (a) failed to complete and/or ensure other staff completed all of the close observation (Q15) checks on the Client as required between approximately 0445 and 0645;
- (b) documented that he had completed certain close observation (Q15) checks on the Client that had not actually been done between approximately 0445 and 0615;
- (c) withdrew himself from service when he rested while on duty between approximately 0430 to 0450.

39. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, as described in paragraphs 12-34 above, in that he falsified a record relating to his practice when he documented that he completed certain close observation (Q15) checks on the Client that he had not actually performed, between approximately 0445 and 0615.

40. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a), (b) and (c) of the Notice of Hearing, as described in paragraphs 12-34 above, in that he:

- (a) failed to complete and/or ensure other staff completed all of the close observation (Q15) checks on the Client as required between approximately 0445 and 0645;

- (b) documented that he had completed certain close observation (Q15) checks on the Client that had not actually been done between approximately 0445 and 0615;

- (c) withdrew himself from service when he rested while on duty between approximately 0430 to 0450.

41. With respect to the allegations of professional misconduct in paragraphs 3(a), (b) and (c) of the Notice of Hearing, the Member admits that his conduct was dishonourable and unprofessional.

Decision

The Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 1(c), 2 and 3(a), 3(b) and 3(c) of the Notice of Hearing. As to allegation #3, the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

Reasons for Decision

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

Allegation #1 in the Notice of Hearing is supported by paragraphs 12 – 34 in the Agreed Statement of Facts. The Member admits he was the only staff member on duty on the Emergency Assessment Unit ("EAU") between 0443 and 0645. He acknowledges that he was the only one available to do the Q15 checks and complete the corresponding documentation. The Nursing Station video captured the Member resting at the desk between 0430 and 0450 and not working. The Member acknowledges that he started to work on an on-line module at 0456 that was supposed to be finished by the end of his shift. The Member only completed two of the required Q15 checks and they were not done at the specified times. The Member back-dated the Q15 entries that he had missed on the Close Observation Form in the mistaken belief that if clients are okay at the present time, he could make the assumption that they were okay at the previous times as well.

[The Client] was a vulnerable mental health client whom the Member assumed responsibility for while his colleagues were working elsewhere and on break. [The Client] was found hanging at approximately 0705 by another staff member. She later died. The Member's actions and inactions are clear violations of the standards of the profession, which state that it is the requirement of a nurse to provide, facilitate, advocate and promote the best possible care for patients. The Member did not take this standard into consideration when he chose to rest for a period of time during his shift and then work on his on-line training instead of doing the scheduled and required Q15 checks on [the Client] The Member was also derelict in his duties when he failed to ensure that another staff member did the checks in his absence. Unfortunately, this conduct contributed to the tragic suicide of [the Client]

Allegation #2 in the Notice of Hearing is supported by paragraphs 12-34 in the Agreed Statement of Facts. The Member acknowledged that, although it was common practice at the Hospital to back-date entries on the Close Observation Form, it was in fact an actual breach of the Hospital's Close Observation Protocol. It was also a breach of the College's *Documentation* standard which states the importance of "accurate, timely and complete" documentation. Documentation, in all its forms, is purposeful as it is used to monitor a client's progress and communicate with other care providers. The Member neglected his professional duty to regularly monitor [the Client]and then falsified what he had actually done by backdating the Q15 observations. This demonstrates serious misconduct.

With respect to Allegation #3 (a), 3(b) and 3 (c), the Panel finds that the Member's conduct would reasonably be regarded by members of the profession as dishonourable and unprofessional. This is supported by paragraphs 12 - 34 in the Agreed Statement of Facts. The Member's conduct was unprofessional when he demonstrated a serious and persistent disregard for his professional obligations by missing several of the Q15 checks on [the Client] This shows a lack of good judgement and responsibility. The Member's conduct was also dishonourable. He ought to have known that he was being dishonest when he backdated observations that he had not completed. This conduct falls well below the standards expected of a professional.

Penalty

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

JOINT SUBMISSION ON ORDER

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

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

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at his own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

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

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

    1. *Professional Standards*,
    2. *Documentation*.

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

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

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

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

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

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his 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 his employers of the decision. To comply, the Member is required to:

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

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

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

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

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

4. All documents delivered by the Member to the College, 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 and the Member's Counsel.

The parties agreed that the mitigating factors in this case included the following:

- The Member has no disciplinary history with the College.
- The Member has taken continuing education to better himself. This includes acquiring his Nurse Practitioner designation.
- He has done on-line training to further his knowledge of suicidal patients.
- He has fully accepted responsibility and acknowledged his misconduct.
- A contested hearing was avoided thus saving time and resources.
- The Member did not try to cover up his actions in the 45 minutes before [the Client] was found hanging.
- The Member has deep regret and remorse regarding the tragic outcome of his actions.
- He has made a commitment to not allow a situation such as this to happen again.
- The Member's life has been altered.

The aggravating factor in this case is the Member's serious neglect of his professional duties which contributed to = [the Client]'s death. No Q15 checks were done at 0630 or at 0645. The Member did not do the checks himself nor did he ensure another staff member did them. It is possible that the [the Client]'s increased agitation could have been detected and staff could have intervened had these checks been completed. A tragic outcome might have been averted.

The proposed penalty provides for general deterrence through a three month suspension. This sends a clear message to the profession that the failure to meet one's professional obligations can result in serious disciplinary sanctions. The terms, conditions and limitations on the Member's certificate indicate to the membership, and the public, that this type of behaviour is taken very seriously by the College and by this Discipline Committee. It also sends a strong message that this is a profession that is capable of governing itself.

The proposed penalty provides for specific deterrence through the three month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of how his actions are perceived by both the profession and the public. The terms, conditions and limitations will provide monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert, the review of the College's publications and the completion of the Reflective Questionnaires and on-line participation forms. These requirements will help to deepen the Member's understanding of his 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 his practice. This will inform his practice in the future. The 12 month employer notification will ensure that the Member's practice is monitored for a significant time when he returns to nursing after the suspension.

The College submitted two cases to the Panel to demonstrate that the proposed penalty is consistent with prior disciplinary decisions and that it falls within the range of appropriate outcomes. Counsel acknowledged that the two cases were not similar in facts but did illustrate the range of similar misconduct.

The College submitted the case of *CNO v. Cristina Victoria Stefanescu* (Discipline Committee, 2015). The member was not in attendance and had resigned. She had previously been suspended for non-payment of fines but was still working as a charge nurse when the incidents occurred. It was alleged that the Member documented hourly round checks that she had not personally done, that her documentation was illegible on two occasions and that she failed to provide appropriate measures to a client who had vital signs absent. The Member was given a two-month suspension, which was to take effect from the date the Member obtained an active certificate of registration. The panel ordered a reprimand. The documentation irregularities in allegations the Stefanescu case were less serious as the hourly checks had actually been completed even if they weren't done by the Member. In this case, the Member left a record which indicated that the Q15 checks had actually been done when they were not.

The College submitted the case of *CNO v. Sandra Lewis* (Discipline Committee, 2013). This case represented a wider range of misconduct including physical and emotional abuse. One allegation was that the member documented Q15 observations that she did not perform. She pre-signed the Q15 record, left her shift early and then left the facility. The Member was given a 6 month suspension, 3 meetings with a Nursing Expert and a 24 month employer notification requirement. The College acknowledged that the Sandra Lewis case was not a direct comparison as it included additional serious allegations. As a result, it attracted a more serious penalty.

Counsel for the Defence submitted the case of *CNO v. Lancelot E. Williams* (Discipline Committee, 2014). The Member was an RPN. A physician ordered "constant observation" on a client who had anxiety attacks. The Member disagreed with the order but did not raise his concerns with a supervisor. Although the Member did not provide "constant observation" to the client, he did do Q15 and hourly checks on the client. Contrary to the Unit's policy and College standards, another staff member documented them. The client was found with vital signs absent. The Member did not immediately initiate CPR or a Code Blue. The client was pronounced dead. The Member was suspended for two months, required to attend two meetings with a Nursing Expert and was given a 24 month employer notification requirement. Counsel for the Defence submitted that this case is closest to the situation involving the Member.

Independent Legal Counsel reminded the Panel that the primary goal of its penalty decision is not to punish but rather to protect the public, and to maintain high professional standards and preserve public confidence in the nursing profession and its disciplinary process. He reiterated that the Panel should accept this carefully negotiated Joint Submission on Order unless to do so would bring the administration of justice into disrepute or be contrary to the public interest. If we had such concerns or questions, in this rare circumstance, the Panel should notify both Counsels so that they would have an opportunity to respond.

Penalty Decision

The Panel accepts the Joint Submission as to Order and accordingly orders:

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

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

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at his own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

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

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

    1. *Professional Standards*,
    2. *Documentation*.

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

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

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

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

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

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his 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 his employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. Members of the profession will be reminded that there can be serious, tragic and irreversible consequences when hospital policies and College standards are not followed.

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

_____	_____
Chairperson	Date