DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Terry Holland, RPN	Chairperson
Laura Caravaggio, RPN	Member
Deborah Graystone, NP	Member
Mary MacMillan-Gilkinson	Public Member
Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for College of Nurses of Ontario
- and -	)	
SHARON COOK Registration No. JB01087	)	NO REPRESENTATION for Sharon Cook
	)	CHRIS WIRTH Independent Legal Counsel
	)	Heard: October 15-16, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on October 15, 2018 at the College of Nurses of Ontario (the "College") at Toronto.

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

College Counsel submitted an affidavit from [ ], Prosecutions Clerk, that confirmed that the Member had been contacted about the hearing, served with the Notice of Hearing and received all relevant documents prior to the hearing. The Panel was satisfied that the Member had received adequate notice of the time, place, date and nature of the hearing and therefore proceeded with the hearing in the Member's absence.

Publication and Broadcasting Ban

At the request of the College, the Panel made an order pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991 banning the disclosure, including the publication and broadcasting, of the identity of the Client referred to in the Discipline Hearing of Sharon Cook or any information that could disclose the Client's identity, including any reference to the Client's name contained in the allegations in the Notice of Hearing and in any exhibits filed with the Panel.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated August 17, 2018, 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 practising as a Registered Practical Nurse at Providence Care – Kingston, 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 June 21, 2016:

    (a) you made rude and inappropriate comments about [the Client], including:

        a) referring to the size of his penis;

        b) using words to the effect of "mangina";

        c) using words to the effect of "fat boy"; and/or

        d) using words to the effect of "dirty pig"; and/or

    (b) you punched [the Client] in or around his face; and/or

    (c) you threw bunched up paper towel(s) at [the Client's] face.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation* 799/93, in that while practicing as a Registered Practical Nurse at Providence Care – Kingston, you verbally, physically, or emotionally abused [the Client], in that on or about June 21, 2016:

    (a) you made rude and inappropriate comments about [the Client], including:

        a) referring to the size of his penis;

b) using words to the effect of “mangina”;

c) using words to the effect of “fat boy”; and/or

d) using words to the effect of “dirty pig”; and/or

(b) you punched [the Client] in or around his face; and/or

(c) you threw bunched up paper towel(s) at [the Client’s] face.

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 practising as a Registered Practical Nurse at Providence Care – Kingston, you engaged in conduct relevant to the practice of nursing that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, in that on or about June 21, 2016:

(a) you made rude and inappropriate comments about [the Client], including:

a) referring to the size of his penis;

b) using words to the effect of “mangina”;

c) using words to the effect of “fat boy”; and/or

d) using words to the effect of “dirty pig”; and/or

(b) you punched [the Client] in or around his face; and/or

(c) you threw bunched up paper towel(s) at [the Client’s] face.

Member’s Plea

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

Overview

The Member first registered with the College as a Registered Practical Nurse (“RPN”) in December 2001. She practiced as a RPN from December 2001 until August 2, 2017, when she was suspended by the Inquiries, Complaints and Reports Committee until April 18, 2018 at which point her membership returned to active status.

On June 21, 2016 while a registered Member of the College and working as a RPN at the Facility, the Member made rude and inappropriate comments towards a Client, punched the Client in or around the face and threw bunched up paper towels at the Client. The Client spat on the Member during the incident. The Member filed a report with the facility but did not include details of her own actions in the report. Once witnesses came forward at the Facility, an investigation was initiated, which culminated in the Member being terminated from her position.

The panel identified the following issues for it to consider:

a) Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she made the inappropriate comments in reference to the Client?

b) Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she punched the Client in or around the face?

c) Did the Member contravene a standard of practice of the profession or fail to meet the standard of practice of the profession when she threw bunched up paper towels at the Client?

d) Did the Member abuse the Client verbally, physically or emotionally when she made the inappropriate comments about the Client?

e) Did the Member abuse the Client verbally, physically or emotionally when she punched the Client in or around the face?

f) Did the Member abuse the Client verbally, physically or emotionally when she threw bunched up paper towels at the Client?

g) Did the Member engage in conduct relevant to the practice of nursing that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional?

The Panel heard evidence from four fact witnesses and one expert witness, and received 19 exhibits to review. Having considered the evidence and the onus and standard of proof, the Panel found that the Member committed acts of professional misconduct as alleged in the Notice of Hearing in paragraphs: 1(a), 1(b), 1(c), 2(a), 2(b), 2(c), 3(a), 3(b) and 3(c).

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

The Evidence

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

Witness 1- [ ], RN

[Witness 1] is the manager of the [Unit] at Providence Care, Kingston (the "Facility"). [Witness 1] became unit manager in 2013 and was familiar with the Member. The Member started working on the Unit in 2002.

[Witness 1] described the client base of the Unit, and the type of care provided. The Unit is an inpatient behavioural unit that has clients whose behaviours cannot be managed in the community or other settings, such as long term care. The clients will often display verbal or physical aggression, and would sometimes stay on the Unit for extended periods until such time that other suitable placements were found.

[Witness 1] identified several policies in place at the time of the incident, including the Code of Conduct for Providence Care which addressed the facility's expectations for a respectful environment. [Witness 1] spoke about the Facility's Abuse Free Environment policy which addresses all forms of abuse, when to report, who to report to and the procedure to follow during an investigation, and finally the Administrative Manual on Incident Reporting and Management, all of which were in place at the time of the incident which is the subject of the hearing. [Witness 1] confirmed and gave evidence that unit staff, including the Member, received training and education on these policies.

[Witness 1] described the clinical training the nurses received which included the Gentle Persuasive Approach ("GPA"), a program which teaches strategies to approach and gently persuade a client to accept care. Training also included the P.I.E.C.E.S Program which involves physical, intellectual, emotional, capabilities, environmental and social health: a training program for nurses caring for clients with dementia. Further training included Non-Violence Crisis Intervention ("NVCI") where caregivers learn to safely manage disruptive and assaultive behaviour. There were also weekly behavioural rounds on the Unit with the interdisciplinary team, in order to develop a specific behavioural care plan for clients.

[Witness 1] described the routine of the Unit, and stated that the staff practiced in a team model. Team members on the Unit most often worked together to provide toileting and incontinence care, in order to ensure safety of both clients and staff. [Witness 1] confirmed that the Member worked the day shift on the day of the incident which was corroborated by a copy of the staff schedule. Staff assignments for [the Client] were often rotated as the Client was known to be challenging. [Witness 1] testified that the Client, with whom the alleged incident took place, arrived on the Unit in early 2016. He had a diagnosis of dementia and a history of responsive behaviours which included verbal and physical outbursts. The Client was known to yell frequently, cry out for help; his voice was loud enough that it could be heard throughout the building and outside in the parking lot. The Client would sometimes become physical with the staff and strike out at them. He was confined to a wheelchair and required assistance with transfer during toileting and to/from bed or chair. [Witness 1] reported that transfers with the Client were unpredictable. The Client was a large person, and transfers required the use of a SARA lift (identified in Exhibit 13) for staff and Client safety. [Witness 1] stated that the Client was frequently discussed at behavioural rounds in attempts for staff to collaborate and strategize around ways to assist with the aggressive behaviour.

[Witness 1] was working on June 21, 2016, the day of the alleged incident. She received a report from staff that day, outlining the Client's behaviour and noted that there was nothing unusual about the report. [Witness 1] identified Exhibit 11 as the progress note entered by [Nurse A], the nurse responsible for the Client on the day of the incident. The progress note did not include anything unusual happening during the shift. In retrospect she recalls an informal conversation in the hallway with [Nurse A] regarding the Client, in relation to pain the Client was experiencing in his shoulder.

[Witness 1] identified an Incident Report completed on June 21, 2016 by the Member. The report noted that there was an incident that occurred between the Member and the Client. It noted the Client was cursing at staff, spat in the writer's face, and hit another nurse on the arm. The Charge Nurse was notified about the incident and the report, as was Human Resources and Occupational Health. [Witness 1] stated that she had received the report and had done a first level review and noted that medical and psychiatric management of the Client was ongoing.

[Witness 1] reported that on the Thursday evening following the alleged incident, she received a text message from another nurse [(Witness 3)], stating that there had been an incident and that [Witness 3] wished to come in and speak to the manager about it. A meeting was arranged the following day, where [Witness 3] reported that, during the incident the Member was heard calling the Client names, and punched the Client in the side of the head. [Witness 1] asked [Witness 3] to document everything that had occurred, and the Human Resources department started an investigation. The Member was excused from work at that time, until the investigation took place. The Client had been assessed the same day of the incident by two nurses on the Unit and was found to have no visible marks on his face. [Witness 1] attempted to interview the Client, but due to the Client's condition, was unable to obtain any details. The Member's employment was terminated the next time she came into the facility.

[Witness 1] received a phone call from nurse [(Witness 2)] the same day as the meeting between [Witness 1] and [Witness 3]. [Witness 2] was upset and told a story similar to [Witness 3's]. She was asked to document what she could recall. Another nurse, [(Witness 4)] arrived to work the night shift on the following Friday and sent an email to [Witness 1] detailing her recollection of the incident.

<u>Witness 2- [ ], RPN</u>

[Witness 2] has worked on the [ ] [U]nit for several years. [Witness 2] was familiar with the Client, and his behaviours. She confirmed that the Client used a wheelchair and required incontinence care. [Witness 2] also confirmed that the Client was regularly discussed during rounds, to try to find ways to manage his behaviour.

[Witness 2] described a typical day on the Unit including meal times and toileting routines. She was not assigned to the Client but did assist with providing incontinence care as part of the team. While [Witness 2] was assisting another nurse, [Witness 4], in an alternate bathroom, she heard yelling coming from the bathroom in use for the Client. [Witness 2] and [Witness 4] went in to offer assistance and came upon the Member, [Witness 3], [Nurse A] and the Client in the bathroom. The Client was positioned in the SARA lift and was yelling about pain in his right shoulder. The Client needed to void and wanted to void in the sink, which was impossible to accommodate. The

nurses in the room attempted to explain this to the Client. [Witness 2] reports that she heard the Member yelling about how small the Client's genitals were, calling it a "mangina" and using the term "fat boy" to describe the Client. The Client then spat on the Member. [Witness 2] recalls the Member saying "he spit on me", and then the Member walked up to the Client and using a closed fist, punched the Client on the left side of the face under the eye. This witness recalls the Member's hand was facing palm inwards with a closed fist when she struck the Client. The Client reportedly said, "that lady punched me in the face", after the care was completed. After the strike, the Client started yelling, spitting and hit [Witness 2] in the arm. The Member proceeded to wash her face in the sink, used paper towels to dry off her face and then bunched them up and threw them at the Client. [Witness 2] nudged the Member and said "stop" but the Member reportedly did not stop right away. The Witness assisted the other nurses to finish providing care to the Client after the incident.

Witness 3- [ ], RPN

[Witness 3] has worked on the Unit at the Facility for 3 years. She knew the Client and reiterated that the Client's challenges were well known to staff on the Unit. Thus care was always provided with two people. [Witness 3] identified Exhibit 13 as a photograph of the SARA lift used on the Unit. [Witness 3] stated that she was assisting with the incontinence care for the Client that day, as part of the team. She was on the left side of the Client, helping to get the sling in place to use the lift. The Member was standing directly in front of the lift using the controls. She recalled the Client was yelling during the transfer, calling the staff foul names not directed at anyone specifically, which was typical behaviour for the Client.

[Witness 3] recalled that there was a lot of noise and activity in the bathroom at the time, which could have agitated the Client. She states that the Client spit on the Member but she is not sure why. [Witness 3] recalls the Member was a few feet away from the Client and that she used her right hand closed fist and struck the Client on the left side of his face around his cheek. She states the Member struck the Client hard enough that the Client's head turned from the force, though she observed no physical markings on the Client after. The Client appeared quite shocked and just stared at the Member. [Witness 3] recalls the Member rinsing her face and throwing the paper towels at the Client. The towels rolled down the Client's chest and hit the floor. The Member picked them back up and threw them forcefully at the Client, several times again. The Member was yelling at the Client in an angry tone of voice, saying things along the lines of "fat dirty pig".

Witness 4- [ ], RN

[Witness 4] has worked at the Facility for several years. The Witness knew of the Client and his challenges. [Witness 4] testified that during the incident she was in one of the bathrooms on the Unit, assisting other clients. Once finished she went into the bathroom where the Client was, to assist with care. When she entered the bathroom of the Client accompanied by [Witness 2], she saw [Witness 3], [Nurse A], the Client, and the Member in there. All of the nurses were getting the Client up on the lift to provide personal care after toileting. The Client was upset and complaining of shoulder pain. [Witness 4] was not looking at the Client when she heard the Member say "oh my God he spit on me". [Witness 4] turned and saw the Member walk to the sink to wash her face. She next observed the Member grab the paper towel and throw it at the Client, quite forcefully. The

team worked together to finish the care and then dispersed. [Witness 4] took the Client back to his room.

Expert Witness- Susan Ash RN ("Ms. Ash")

Ms. Ash, a Certified Administrator in Long Term Care, is an expert in the area of nursing standards in long term care. She was tendered by the College to provide opinions on whether the Member met the standards of practice and whether the Member abused the Client. Ms. Ash provided her curriculum vitae which outlined education focused on long-term-care, quality assurance and Ontario not-for-profit homes for senior services. Ms. Ash explained her background managing a long-term-care home that has a special behavioural unit which is a transitional unit that specializes in residents with dementia and responsive behaviours. Ms. Ash stated that she is also on the College of Nurses of Ontario Long-Term-Care Advisory Committee and is often approached by different organizations for her opinions on care of patients with responsive behaviours. The Panel qualified Ms. Ash as an expert in nursing practice in the areas of dementia care and responsive behaviours.

College Counsel provided Ms. Ash with a hypothetical scenario to review and give her expert opinion. The scenario detailed approximately what had happened between the Member and the Client without going into specific details. Ms. Ash reviewed this scenario and discussed expectations within the College's standards, including the *Professional Standards* and the *Therapeutic Nurse Client Relationship Standard*, as well as the Facility's policies. She further reviewed her own practice and her expectations for her own staff at the facility in which she works.

Ms. Ash highlighted the language in the *Therapeutic Nurse Client Relationship Standard*, and described the boundaries, and focus on client needs and patient centered care. This standard addresses abuse of a client, the prevention of abuse and neglect and summarizes the details related to interactions between a nurse and a client. The Standard speaks to communicating with the client, treating them with dignity and respect, taking the required time to do the care and modifying as needed. The Standard talks about abusive behaviours, including verbal, emotional and physical abuse.

Ms. Ash testified that the Member's actions in this case contravened and failed to meet the standards of practice of the profession.

In the hypothetical scenario, Ms. Ash described best practices when dealing with a challenging client. These strategies include taking a step back, allow time to de-escalate, re-approach later, don't argue, give space, understand where the client is coming from, and give the client time to respond.

Ms. Ash referred to the *Professional Standards*, a guideline for all nurses to ensure they are providing the best possible care and their practice is in accordance with those standards.

Ms. Ash further reviewed the expectations within the *Therapeutic Nurse Client Relationship Standard* related to dignity, respect and reading cues, both verbal and non-verbal. She noted that nurses must modify their communications to meet the needs of the client.

Ms. Ash stated that the words used by the Member, such as “fat boy” and “mangina”, are taunting and demeaning and are considered verbal and emotional abuse. These words, and the inappropriate tone used, can cause an emotional impact to the Client.

Furthermore, using physical force of any kind and handling the Client in a rough manner constitutes physical abuse.

Ms. Ash noted that, when caring for clients with responsive behaviours, nurses need to learn to go where the client’s reality is. They must create a care plan for the patient that helps the client de-escalate from behaviour that may be happening. She stated that behaviours that this Client displayed are not unusual in this setting and nurses must respond professionally and respectfully at all costs. There was no indication that the Member considered that pain may have contributed to the Client’s behaviour. The witness posited that there should have been a pain assessment prior or during the intervention. She indicated there was no evidence of this in the health record.

Finally, Ms. Ash confirmed a breach in leadership qualities. The Member should have managed the situation and, at the very least, removed herself from the situation when she became out of control. She stated that nurses should display leadership qualities, regardless of their role on the team.

Final Submissions

College Counsel stated that the Member’s conduct constitutes professional misconduct, a breach of the Standards of Practice, verbal, physical and emotional abuse, and should be considered dishonourable, disgraceful and unprofessional conduct. This conclusion flows from the clear and cogent evidence provided which made it more likely than not that this conduct occurred, and that the Panel should be able to make findings based on the evidence. The College submitted that it had met the required onus and standard of proof.

In terms of credibility of the witnesses, the College submitted that all of the witnesses were forthright and sincere in their evidence. The evidence of the three fact witnesses who saw the events was consistent in the key events, including the verbal and physical assaults. While there were some inconsistencies, they were not about the key evidence. Rather, taking into account what else was happening in the room with five nurses and an upset Client, they were about some of the minor details in the incident. The College urged the Panel to find the witnesses and their testimonies credible.

For allegations 1(a), 2(a), and 3(a) in the Notice of Hearing, the statements from the witnesses show that the Member made rude and inappropriate comments to the Client as alleged. [Witness 2] reported the Member making comments about the size of the Client’s penis, and using the word “mangina”. [Witness 2] and [Witness 3] both reported the Member making comments such as “fat boy” and “dirty pig”. According to Ms. Ash those comments were a breach of the Standards of Practice, and constituted verbal and emotional abuse. This conduct falls well below the standards of practice in other respects as well. The Member failed to show leadership, and failed to engage with the Client’s needs. The College submitted that based on the evidence provided, this conduct is dishonourable, disgraceful and unprofessional. It shows a lack of integrity, an abuse of power, and

the disregard for a client under the Member's care. This conduct cannot be accepted or tolerated by others in the profession.

For allegations 1(b), 2(b), and 3(b) in the Notice of Hearing, Counsel for the College submitted that there is ample evidence to make a finding that the Member punched the Client. Both [Witness 2] and [Witness 3] reported observing the Member punching the Client with a closed fist, using force. Ms. Ash clearly stated that punching a client is physical abuse and also emotional abuse. The conduct was a breach of standards, including leadership and considering client needs. This action shows a serious disregard for the Member's moral obligations, shows a lack of empathy and casts serious doubt on the moral fitness and ability to discharge obligations and the public's expectations of the conduct of nurses. Counsel for the College submitted that the actions of the Member all constitute dishonourable, disgraceful and unprofessional conduct and requested that the Panel make findings on all three.

For allegations 1(c), 2(c), and 3 (c) in the Notice of Hearing, College Counsel submitted that there is evidence to make a finding that the Member threw bunched up paper towels at the Client. Three eye witnesses reported seeing the incident and described the Member using force to throw the paper towels at the Client. Ms. Ash stated that this conduct is both physical and emotional abuse to the Client. It is also a breach of standards and a failure to show leadership and communication skills with the Client. The College submitted that this conduct is dishonourable, disgraceful and unprofessional, as the Client was vulnerable in the SARA lift, without the ability to use his hands to protect himself. The Member's actions show a disregard for obligations and a lack of empathy. The College asked the Panel to make findings of professional misconduct on all three allegations.

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), 1(b), 1(c), 2(a), 2(b), 2(c), 3(a), 3(b) and 3(c) in the Notice of Hearing. In particular, with respect to allegations 3(a), 3(b) and 3(c), the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional by: (a) making rude and inappropriate comments about the Client; (b) punching the Client in or around his face; and (c) throwing bunched up paper towels at the Client.

Reasons for Decision

The credibility of each witness was assessed by the Panel based on the criteria laid out in *Pitts and Director of Family Benefits Branch of the Ministry of Community & Social Services* (1985), 51 O.R. (2d) 302.

The Panel considered the recollection and consistency of testimony of all three witnesses who were in the room during the incident. The Panel determined that the evidence provided by the witnesses was clear, cogent and convincing. They were able to describe the Member throwing paper towels at the Client in anger. [Witness 2] and [Witness 3] both described the Member punching the Client in the face, and also using terms such as "fat boy", and "fat dirty pig". The similarity of the witnesses'

descriptions of the Member's actions and attitude during the incident, and the details that they provided were used by the panel in making the final decision that the Member verbally, emotionally and physically abused the Client.

Ms. Ash, the expert witness was qualified by the Panel as an expert in nursing practice in the areas of dementia care and responsive behaviours.

Ms. Ash highlighted the *Therapeutic Nurse Client Relationship Standard* that addresses abuse of a client, the prevention of abuse and neglect and also speaks to communicating with the client, treating them with dignity and respect, taking the required time to do the care and modifying as needed. The Member's actions, by physically hitting the Client, throwing paper towels at the Client, and the words and tone of voice used towards the Client all breached the expectations set out in the Standard.

Ms. Ash stated that the words and inappropriate tone used by the Member are considered verbal and emotional abuse. The comments are taunting and demeaning. Finally, using physical force of any kind, such as throwing objects and punching or handling the Client in a rough manner, constitutes physical abuse.

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

With regard to all the allegations in section 3 of the Notice of Hearing, the Panel found the Member's conduct would be considered by members of the profession as disgraceful, dishonourable and unprofessional. The Member's words and actions showed a serious disregard for her professional obligations. Her failure to live up to the standards expected of her is unprofessional. The Member left out her own actions from her incident report on what occurred. This was dishonourable as it showed an element of deceit, dishonesty and demonstrated a moral failing. The Member's conduct was also disgraceful as her actions shamed her, and also the profession. Her conduct towards the Client, and afterwards through the inaccurate incident report cast's serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects the profession to meet. She should have known that her actions and words were wrong, and as a professional should have taken steps to safely remove herself from the situation and protect the vulnerable Client in her care.

Penalty

The College 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 three months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 6 months. This suspension shall take effect from the date that 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 Regulatory Expert (the "Expert"), at her 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, and
            3. 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 (where applicable):

            1. *Professional Standards*,
            2. *Therapeutic-Nurse Client Relationship*,
            3. *Conflict Prevention and Management*,

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

        v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, 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 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;

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

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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

Counsel for the College submitted that there are multiple factors to consider with respect to the penalty. Protection of the public is first and foremost the main duty of the College, as well as maintaining public confidence and the effectiveness of the College to self-regulate. Specific

deterrence to the Member and general deterrence to the other members of the College are all considerations for the Panel when making a penalty decision.

College Counsel submitted that the aggravating factors in this case are:

- The conduct was very serious.
- There was verbal, physical and emotional abuse, committed towards a vulnerable client.
- This was a breach of client trust.
- As the conduct was intentional, the potential harm to the Client was very real.
- The Member's conduct demonstrated poor judgement and questionable moral fitness.
- It showed a serious disregard for her obligations to the Client.
- It brought serious discredit to the profession.

As the Member did not attend the hearing, the Panel has no information to consider regarding the Member's mitigating circumstances.

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

College Counsel provided three cases previous cases of the Discipline Committee for the Panel to consider. All three cases contain some similar aspects to the case before this Panel. The penalties ordered in the precedent cases are consistent with what the College is asking for in this case.

CNO v. Hayden (2018)
In this case, the member was helping restrain a resistant client and he punched the client three times. The member participated in the hearing and displayed remorse and shame. The member was given a reprimand, received a four month suspension, had to attend two meetings with a nursing expert and had 12 months of employer notification.

CNO v. Rowe (2017)
This case involved a pattern of disrespectful communication and abusive behaviours to vulnerable clients. The member took responsibility, participated in the hearing and admitted to the allegations. The member was given a reprimand, a six month suspension, had to attend two meetings with a nursing expert and had 18 months of employer notification.

CNO v. Lento (2017)
The case involved a pattern of verbal abuse. The member participated in the hearing and admitted to the allegations. The member received a reprimand, a five month suspension, had to attend two meetings with a nursing expert and had 24 months of employer notification.

Penalty Decision

The Panel makes the following order as to penalty:

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 6 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 Regulatory Expert (the "Expert"), at her 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, and
            3. 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 (where applicable):

            1. *Professional Standards*,
            2. *Therapeutic-Nurse Client Relationship*,
            3. *Conflict Prevention and Management*,

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

        v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, 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 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;

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

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

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

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

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

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 deliberated and accepted the College's proposed order on penalty as presented. The Panel found that the terms of the order set out by the College met all of the principles required of a penalty.

The suspension of six months, the meetings with a regulatory expert and the 18 month employer notification requirement will protect the public by ensuring that the Member will be closely monitored and that she is not given the chance to harm the public any further. The requirements provide the Member with the opportunity to remediate while showing that the College takes such misconduct seriously.

The oral reprimand and suspension act as specific deterrents to this Member. They also act as general deterrents to other members of the College by sending a message that there are serious consequences for this kind of behaviour. Other members will realize that abusive behaviour is never tolerated and will have the opportunity to learn from this Member's mistakes and ensure that they are not repeated in their own practices.

Finally, considering remediation and rehabilitation of the Member, the reprimand, education, reporting and suspension will ensure that the Member is aware of why the conduct was wrong. The requirements will provide her with the skills and lessons necessary to ensure that she makes the best decisions for the public and herself going forward. Requiring the Member to meet with a nursing expert demonstrates to the public that this penalty is consistent with the mandate of public interest and safety. An 18 month period of employer notification also demonstrates future considerations of public confidence and protection.

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.

Chairperson