DISCIPLINE COMMITTEE OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Andrea Arkell	Public Member
	Sylvia Douglas	Public Member
	Carly Gilchrist, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	GLYNNIS HAWE for
	)	College of Nurses of Ontario
- and -	)	
	)	
ANDREA PARKER	)	NO REPRESENTATION for
Registration No. JF675476	)	Andrea Parker
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 14, 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 January 14, 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 prohibiting public disclosure and banning the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented in the Discipline hearing of Andrea Parker.

The Panel considered the submissions of College Counsel and the Member and decided that there be an order prohibiting public disclosure and banning the publication or broadcasting of the names of the patients, or any information that could disclose their identities, referred to orally or in any documents presented in the Discipline hearing of Andrea Parker.

The Allegations

The allegations against Andrea Parker (the "Member") as stated in the Notice of Hearing dated November 16, 2021 are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while you were employed as a Registered Practical Nurse ("RPN") at the Village at University Gates in Waterloo, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that:

    a) on or about April 8, 2019:

        i. you failed to administer Trimethoprim 100mg to Patient [1] at 20:00, as ordered; and/or

        ii. you documented that you administered Trimethoprim 100mg to Patient [1] at 20:00, when you had not;

    b) on or about July 31, 2019:

        i. you failed to administer Tacrolimus 1mg to Patient [2] at 08:00, as ordered; and/or

        ii. you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

    c) on or about August 6, 2019:

        i. you failed to administer Tacrolimus 1mg to Patient [2] at 08:00, as ordered; and/or

        ii. you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

    d) on or about September 26, 2019:

        i. you failed to administer Famotidine 20mg to Patient [3] at 08:00, as ordered; and/or

        ii. you documented that you administered Famotidine 20mg to Patient [3] at 08:00, when you had not;

    e) on or about May 12, 2020:

        i. you failed to administer the following medications to Patient [4] at 08:00, as ordered:

1. Duloxotine 60mg;
2. Hydromorph Contin 9mg;
3. Furosemide 40 mg; and/or
4. Allopurinol 100 mg;

ii. you documented that you administered the following medications to Patient [4] at 08:00, when you had not:

1. Duloxotine 60mg;
2. Hydromorph Contin 9mg;
3. Furosemide 40 mg; and/or
4. Allopurinol 100 mg;

iii. you failed to change a dressing on Patient [4]'s left foot at 11:00, as ordered; and/or

iv. you documented that you changed a dressing on Patient [4]'s left foot at 11:00, when you had not;

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 paragraph 1(13) of *Ontario Regulation 799/93*, in that, while employed as a RPN at the Facility, you failed to keep records as required, in that:

a) on or about April 8, 2019, you documented that you administered Trimethoprim 100mg to Patient [1] at 20:00, when you had not;

b) on or about July 31, 2019, you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

c) on or about August 6, 2019, you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

d) on or about September 26, 2019, you documented that you administered Famotidine 20mg to Patient [3] at 08:00, when you had not;

e) on or about May 12, 2020:

i. you documented that you administered the following medications to Patient [4] at 08:00, when you had not:

1. Duloxotine 60mg;
2. Hydromorph Contin 9mg;
3. Furosemide 40 mg; and/or
4. Allopurinol 100 mg; and/or

ii. you documented that you changed a dressing on Patient [4]'s left foot at 11:00, when you had not;

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 RPN at the Facility, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that:

a) on or about April 8, 2019:

i. you failed to administer Trimethoprim 100mg to Patient [1] at 20:00, as ordered; and/or

ii. you documented that you administered Trimethoprim 100mg to Patient [1] at 20:00, when you had not;

b) on or about July 31, 2019:

i. you failed to administer Tacrolimus 1mg to Patient [2] at 08:00, as ordered; and/or

ii. you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

c) on or about August 6, 2019:

i. you failed to administer Tacrolimus 1mg to Patient [2] at 08:00, as ordered; and/or

ii. you documented that you administered Tacrolimus 1mg to Patient [2] at 08:00, when you had not;

d) on or about September 26, 2019:

i. you failed to administer Famotidine 20mg to Patient [3] at 08:00, as ordered; and/or

ii. you documented that you administered Famotidine 20mg to Patient [3] at 08:00, when you had not;

e) on or about May 12, 2020:

i. you failed to administer the following medications to Patient [4] at 08:00, as ordered:

1. Duloxotine 60mg;

2. Hydromorph Contin 9mg;

3. Furosemide 40 mg; and/or

4. Allopurinol 100 mg;

ii. you documented that you administered the following medications to Patient [4] at 08:00, when you had not:

1. Duloxotine 60mg;

2. Hydromorph Contin 9mg;

3. Furosemide 40 mg; and/or

4. Allopurinol 100 mg;

iii. you failed to change a dressing on Patient [4]'s left foot at 11:00, as ordered; and/or

iv. you documented that you changed a dressing on Patient [4]'s left foot at 11:00, when you had not.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii), (e)(iv), 2(a), (b), (c), (d), (e)(i) 1, 2, 3, 4, (e)(ii), 3(a)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii) and (e)(iv) 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

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

THE MEMBER

1. Andrea Parker (the "Member") obtained a diploma in nursing from Fanshawe College in London, Ontario in 2006.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on December 5, 2006.

3. The Member resigned her certificate of registration on December 20, 2021. She is not currently entitled to practice nursing in Ontario.

THE FACILITY

4. The Member was employed part-time at the Village at University Gates (the "Facility"), a long-term care home in Waterloo, Ontario, from April 6, 2017 to May 28, 2020, when her employment was terminated as a result of the incidents described below.

PRIOR HISTORY

5. In 2016, the Member was found to have committed professional misconduct for failing to cooperate with the Quality Assurance Committee after being selected for practice assessment. The Discipline Committee ordered the Member to receive an oral reprimand, suspended her certificate of registration for one month, and imposed various terms, conditions, and limitations on the Member's certificate of registration, including a requirement for the Member to attend expert meetings and participate in the 2017 Quality Assurance program (the "2016 Discipline Committee Order").

6. The Member completed the terms of the 2016 Discipline Committee Order to the satisfaction of CNO as of February 16, 2018.

INTERIM ORDER

7. On October 8, 2019, the Facility reported four instances in which it was alleged the Member failed to administer medications to patients, but documented that she had done so. On March 23, 2020, after the Facility's initial report, the Facility reported a further instance of a similar medication error by the Member that occurred in March 2020. These reports form the basis of the allegations of professional misconduct in the Notice of Hearing.

8. The Facility's reports were considered by a panel of the Inquiries, Complaints and Reports Committee (the "Panel"). The Panel expressed concern that the Member's reported conduct exposed or was likely to expose patients to harm or injury. The Member did not provide a response to the Panel.

9. As a result, on August 12, 2020, the Panel made an interim order directing the Executive Director to impose the following terms, conditions or limitations on her certificate of registration pursuant to s. 25.4 of the *Health Professions Procedural Code*:

    a) the Member must practice under the supervision of another member of the CNO;
    b) the Member must inform her employer of the reported concerns and that her conduct was under investigation by the CNO;

c) within 14 days of commencing or continuing employment in a nursing position, the Member must provide the Director, Professional Conduct, with the following:
    i. written notification of the name, address and telephone number of the employer; and
    ii. a signed statement from the employer confirming that the employer:
        1. has been informed that a report of concerns has been sent to CNO and that CNO is investigating these concerns; and
        2. agrees to immediately notify the Director upon receipt of reasonable information that the Member has breached he standards of practice of the profession.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

<u>April 2019 – Patient [1]</u>

10. Patient [1] was a 91-year old resident of the Facility. Patient [1] was diagnosed with Type 2 diabetes, and Alzheimer's disease, among other comorbidities.

11. At 20:00 on April 8, 2019, the Member documented that she had administered a scheduled dose of Trimethoprim 100mg to Patient [1]. However, later that evening, an RPN colleague discovered Patient [1]'s 20:00 dose intact in its medication strip, in the med room drawer.

12. No patient harm resulted from this incident.

13. Following the incident, the Member was asked to complete a written practice reflection and review CNO's *Medication* standard.

14. The Member admits that she failed to administer the Trimethoprim 100mg to Patient [1] on April 8, 2019, despite having documented doing so.

<u>July and August 2019 – Patient [2]</u>

15. Patient [2] was a 74-year old resident of the Facility. Patient [2] was diagnosed with renal failure, among other comorbidities.

16. At 08:00 on July 31, 2019, the Member documented that she had administered a scheduled dose of four capsules of Tacrolimus 1mg to Patient [2]. However, on the following shift, a RPN discovered the July 31, 2019 08:00 dose of Tacrolimus for

Patient [2] intact in its blister pack in the med cart, despite the Member having documented that it was administered.

17. No patient harm resulted from this incident.

18. After this incident, the Member was asked again by the Facility to submit a written practice reflection and review the CNO *Medication* standard. The Member ultimately did not submit a practice reflection.

19. At 08:00 on August 6, 2019, the Member documented that she had administered a scheduled dose of four capsules of Tacrolimus 1mg to Patient [2]. However, the RPN colleague working the day shift the following day, August 7, 2019, discovered Patient [2]'s August 6, 2019 Tacrolimus dose intact in the package, despite the Member having documented that it was administered.

20. After this incident, the Member was asked again by the Facility to review the CNO *Medication* standard, as well as the Facility's medication policies.

21. The Member admits that she failed to administer Tacrolimus to Patient [2] on each of July 31 and August 6, 2019, despite having documented doing so.

<u>September 2019 – Patient [3]</u>

22. Patient [3] was an 89-year old resident of the Facility. Patient [3] was diagnosed with Parkinson's disease, along with other comorbidities.

23. At 08:00 on September 26, 2019, the Member documented that she had administered a scheduled dose of Famotidine 20mg to Patient [3]. However, during the evening shift that same day, a RPN colleague discovered Patient [3]'s 08:00 Famotidine dose in an intact medication pouch in the med cart disposal bin.

24. The Member was asked to complete a practice reflection after this incident and received a one-shift suspension from the Facility.

25. The Member admits that she failed to administer Famotidine to Patient [3] on September 26, 2019, despite having documented doing so.

<u>May 2020 – Patient [4]</u>

26. Patient [4] was a 66-year old resident of the Facility. Patient [4] had a number of medical and behavioural diagnoses stemming from long-term alcohol abuse, including renal failure, in addition to diagnoses of heart failure and chronic obstructive pulmonary disease, among others.

27. At the time of the incident, Patient [4] also had an open wound on the toes of his left foot for which a dressing change was ordered twice a day, at 11:00 and 16:00.

28. At 08:00 on May 12, 2020, the Member documented administering the following medications to Patient [4]:
    a) Duloxotine 60 mg (2 capsules);
    b) Hydromorph Contin 9mg;
    c) Furosemide 40 mg (2 tablets); and
    d) Allopurinol 100mg.

29. At 11:00, the Member also documented changing the dressing on [Patient 4]'s left foot, as ordered.

30. On the following shift, a RPN colleague entered Patient [4]'s room and discovered a number of pills on the floor. The RPN reviewed the Patient's chart and the medication packs for the Patient in the medication cart and verified that the pills on the floor were medications that the Member documented having administered to Patient [4] at 08:00 that morning.

31. If Patient [4] were to testify, he would state that the Member left the medications in a plastic cup by his bedside on the morning of May 12, 2020, before leaving the room. At some point, Patient [4] knocked the medications on to the floor, where they were later discovered by the RPN.

32. If Patient [4] were to testify, he would also state that when the Member was in his room that morning, he advised her that he required a dressing change on his left foot. The Member refused, stating that she did not have time and that a nurse on the incoming shift would handle it.

33. The Member admits that on May 12, 2020, she documented administering medications to Patient [4] and changing Patient [4]'s dressing, which she did not do.

34. If the Member were to testify, she would state that she takes full responsibility for her conduct and that she understands that her conduct posed a serious risk to patient safety. The Member would also state that her personal circumstances at the time of the incidents interfered with her ability to concentrate on her nursing practice. Nevertheless, the Member unreservedly apologizes for any harm that her actions may have caused.

CNO STANDARDS

35. CNO's *Documentation* standard provides that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. The standard further clarifies that a nurse meets the standard by:

a) Ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;

b) Documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; and

c) Ensuring that relevant [patient] care information is captured in a permanent record.

36. CNO's *Medication* standard provides that administering, recommending and/or prescribing medication requires knowledge, technical skills and judgment.

37. The *Medication* standard further provides that a nurse meets the standard by:

a) Assessing her or his own knowledge, skill and judgment to competently carry out medication administration, use medication equipment and intervene during an adverse reaction;

b) Preparing and administering the medication according to an evidence-based rationale, including, scheduling dosing times for a medication, taking into consideration the effect of food intake or medication absorption, contraindications, required interventions before, during and after administration, and [patient] choice and preference; and

c) Documenting, during and/or after medication administration, in the [patient's] record according to documentation standards.

38. The *Medication* standard also provides that safe medication practice includes reporting all errors and near misses using formal practice-setting communication mechanisms.

39. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standards of the profession. Nurses are responsible for their actions and the consequences of those actions. A nurse demonstrates accountability by actions such as:

a) Providing, facilitating, advocating and promoting the best possible care for [patients];

b) Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation; and

c) Taking responsibility for errors when they occur and taking appropriate action to maintain [patient] safety.

40. In addition, CNO's *Professional Standards* provides that each nurse continually improves the application of professional knowledge and demonstrates knowledge application by actions such as identifying and addressing practice-related issues.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

41. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 1(c), 1(d), 1(e) of the Notice of Hearing in that she contravened a standard of practice of the profession, as described in paragraphs 10-34 above.

42. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a), 2(b), 2(c), 2(d), and 2(e) of the Notice of Hearing in that she failed to keep records as required, as described in paragraphs 10-34 above.

43. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a), 3(b), 3(c), 3(d), 3(e) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 10-34 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)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii), (e)(iv), 2(a), (b), (c), (d), (e)(i) 1, 2, 3, 4, (e)(ii), 3(a)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii) and (e)(iv) of the Notice of Hearing. As to allegations 3(a)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii) and (e)(iv), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be dishonourable and unprofessional.

Reasons for Decision

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

Patient [1]

Allegations #1(a)(i) and (ii) in the Notice of Hearing are supported by paragraphs 10-14 and 35-41 in the Agreed Statement of Facts. On or about April 8, 2019, the Member failed to administer and documented that she administered Trimethoprim 100mg at 20:00 hours to Patient [1]. However, a Registered Practical Nurse ("RPN") colleague discovered Patient [1]'s 20:00 hours dose of Trimethoprim 100mg still intact in its medication strip in the medication drawer. The Member admitted that she did not administer the prescribed medication.

Patient [2]

Allegations #1(b)(i) and (ii) in the Notice of Hearing are supported by paragraphs 15-21 and 35-41 in the Agreed Statement of Facts. On or about July, 31, 2019, the Member failed to administer and documented that she administered a scheduled dose of four capsules of Tacrolimus 1mg to Patient [2]. However, the following shift, an RPN discovered the dose of Tacrolimus intact in its blister pack in the medication drawer. The Member admitted that she did not administer the prescribed medication.

Allegations #1(c)(i) and (ii) in the Notice of Hearing are supported by paragraphs 15-21 and 35-41 in the Agreed Statement of Facts. On or about August 6, 2019, at 08:00 hours the Member had documented that she had administered a scheduled dose of four capsules of Tacrolimus 1mg to Patient [2]. However, an RPN colleague working the day shift the following day on August 7, 2019, discovered Patient [2]'s August 6, 2019, Tacrolimus dose still intact in the package despite the Member having documented that it was administered. The Member admitted that she did not administer the prescribed medication.

Patient [3]

Allegations #1(d)(i) and (ii) in the Notice of Hearing are supported by paragraphs 22-25 and 35-41 in the Agreed Statement of Facts. On or about September 26, 2019, the Member documented that she administered a 08:00 hour scheduled dose of Famotidine 20mg to Patient [3]. However, during the evening shift that same day, an RPN colleague discovered Patient [3]'s 08:00 hour Famotidine in an intact medication pouch in a medication cart disposal bin. The Member admitted that she did not administer the prescribed medication.

Patient [4]

Allegations #1€(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii) a€(e)(iv) in the Notice of Hearing are supported by paragraphs 26-34 and 35-41 in the Agreed Statement of Facts. On or about May 12, 2020, the Member documented that she administered a 08:00 hour scheduled dose of Duloxotine 60mg (two capsules), Hydromorph Contin 9mg, Furosemide 40mg (two tablets) and Allopurinol 100mg. On the following shift, an RPN colleague entered into Patient [4]'s room and discovered a number of pills on the floor. The RPN reviewed Patient [4]'s chart and medication packs for Patient [4] in the medication drawer and verified that the medication on the floor was the medication that the Member documented having administered to Patient [4]. If Patient [4]

were to testify, he would state that the Member left the medications in a plastic cup by his bedside on the morning of May 12, 2020, before leaving the room. At some point, Patient [4] knocked the medications on to the floor, where they were later discovered by the RPN. The Member admitted that she did not administer the prescribed medication.

At 11:00 hours, the Member documented changing the dressing on Patient [4]'s left foot as ordered. If Patient [4] were to testify, he would state that when the Member was in his room the morning of May 12, 2020, he advised the Member that he required a dressing change on his left foot. The Member refused, stating that she did not have time and that a nurse from the incoming shift would handle it. The Member admits to documenting the completion of the dressing change despite not doing so.

The Panel finds that the Member contravened the standards of practice of the profession when she did not administer medication to multiple Patients and documented that she had done so and when she did not change the dressing on Patient [4]'s foot but documented that she had done so.

In this regard, the College's *Documentation* Standard provides that nurses are accountable for ensuring their documentation of patient care is accurate, timely and complete. The *Medication* Standard provides that administering, recommending and/or prescribing medication requires knowledge, technical skills and judgment. The *Medication* Standard further provides that a nurse meets the standard by assessing his or her own knowledge, skill and judgment to competently carry out medication administration. A nurse must prepare and administer medication according to an evidence-based rationale. Documenting, during and/or after medication administration, in the patient's record according to the *Documentation* Standard is important. The College's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring his or her practice and conduct meets the legislative requirements and the standards of the profession. A nurse is responsible for his or her actions and the consequences of those actions. A nurse demonstrates accountability by actions such as providing, facilitating, advocating and promoting the best possible care for patients. A nurse must take responsibility for errors when they occur and take appropriate action to maintain patient safety.

Further, the College's *Documentation* Standard provides that nurses are accountable for ensuring that their documentation of patient care is accurate, timely and complete. The standard further clarifies that a nurse meets this standard by a) ensuring documentation is a complete record of nursing care provided; b) documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; c) ensuring that relevant patient care information is captured in a permanent record.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 10-14, 35-38 and 42 in the Agreed Statement of Facts. The Member documented on or about April 8, 2019, that she administered a 20:00 hour dose of Trimethoprim and failed to do so. An RPN colleague discovered the 20:00 hour dose intact in its medication strip in the medication room drawer.

Allegation #2(b) in the Notice of Hearing is supported by paragraphs 15-21, 35-38 and 42 in the Agreed Statement of Facts. The Member documented on or about July, 31, 2019, that she administered a 08:00 hour dose of Tacrolimus and failed to do so. An RPN colleague discovered the dose of Tacrolimus intact in its blister pack in the medication drawer.

Allegation #2(c) in the Notice of Hearing is supported by paragraphs 15-21, 35-38 and 42 in the Agreed Statement of Facts. The Member documented on or about August 6, 2019, that she administered a 08:00 hour does of Tacrolimus and failed to do so. An RPN colleague working on August 7, 2019, discovered Patient [2]'s August 6, 2019, Tacrolimus dose still intact in the package.

Allegation #2(d) in the Notice of Hearing is supported by paragraphs 22-25, 35-38 and 42 in the Agreed Statement of Facts. The Member documented on or about September 26, 2019, that she administered a 08:00 hour dose of Famotidine 20mg and failed to do so. During an evening shift the same day, an RPN colleague discovered Patient [3]'s 08:00 hour Famotidine 20mg dose in an intact medication pouch in the medication cart disposal bin.

Allegations #2(e)(i) 1, 2, 3, 4 and (e)(ii) in the Notice of Hearing are supported by paragraphs 26-38 and 42 in the Agreed Statement of Facts. The Member documented on or about May 12, 2020, that she administered 08:00 hour dose of Duloxotine 60 mg, Hydromorph Contin 9mg, Furosemide 40 mg, Allopurinol 100mg and failed to do so. The Member also documented that she completed a dressing change on Patient [4]'s left foot and failed to do so. An RPN colleague found the medication on Patient [4]'s floor in his bedroom. Upon reviewing Patient [4]'s chart and medication packs it was verified that the pills on the floor was the medication that the Member had documented as administered. If Patient [4] were to testify, he would indicate that the medication was left on his bedside table, and he knocked the medication onto the floor. In regard to the incomplete dressing change, if Patient [4] were to testify, he would indicate that he reminded the Member that he required a dressing change to his left foot and the Member refused. The Member reported that she did not have time and that a nurse from the oncoming shift would handle it. Despite not changing the bandage, the Member documented that she had done so.

The evidence supporting allegations 2 (a) - 2(e), inclusive, establishes that the Member did not keep records as required.

With respect to allegations #3(a)(i), (ii), (b)(i), (ii), (c)(i), (ii), (d)(i), (ii), (e)(i) 1, 2, 3, 4, (e)(ii) 1, 2, 3, 4, (e)(iii) and (e)(iv), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. The Member was repeatedly asked to engage in remediation and reflection activities by her employer and she knew or ought to have known that her medication practices did not meet the standard required of the profession.

The Panel also finds that the Member's conduct was dishonourable in that there is an element of moral failing. The Member knew or ought to have known that her conduct was unacceptable and was repeated on a number of occasions and after being directly asked to remedy these errors the Member was unable to do so. Further, the Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

College Counsel and the Member 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 4 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration in a practicing class. To comply, the Member is required to ensure that:

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

        ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            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. *Professional Standards*,
2. *Medication*,
3. *Documentation*, and
4. *Code of Conduct*;

iv. At least 7 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 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;

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 her behaviour; and

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 her certificate of registration.

b) For a period of 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), 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,
      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; and

   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.

   iv. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

      1. that they received a copy of the required documents,
      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
      3. that they agree to perform 3 random spot audits of the Member's documentation at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

a. the first audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
b. the second audit shall take place within 12 months from the date the Member begins or resumes employment with the employer, and
c. the third audit shall take place within 18 months from the date the Member begins or resumes employment with the employer.

v. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of at least 3 of the Member's charts to ensure they meet both CNO and employer documentation and care plan standards, and
2. discussing (by telephone or in person), with at least 3 of the Member's patients, the care provided by the Member and the quality of the Member's interactions with the patients to ensure that the Member provided necessary and/or required care to the patients and that the Member's documentation accurately reflects the care provided.

c) The Member shall not practice independently in the community for a period of 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended).

4. All documents delivered by the Member to the 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. College Counsel submitted that the proposed penalty is appropriate. It is a product of negotiations between the College and the Member. College Counsel reinforced that it is generally expected of the Panel to accept the Joint Submission on Order unless doing so is contrary to public interest or would bring the administration of justice into disrepute.

College Counsel indicated that she had three submissions on the proposed penalty, namely that it (1) reflects the mitigating and aggravating factors in this case; (2) appropriately meets the goals of penalty; and (3) is consistent with prior discipline decisions.

The aggravating factors in this case were:

- There were a number of incidents over an extended period of time and after each incident the Member was provided an opportunity to remediate her conduct;
- The patients were in a Long-Term Care Home and were vulnerable;
- The Member's failure to administer medication and falsifying documentation poses a particular risk of harm to patients as the care team does not have a complete and accurate clinical picture of the care that is being provided;
- The Member has a prior discipline history with the College.

The mitigating factors in this case were:

- The Member has taken full responsibility for her actions;
- The Member has cooperated with the College by entering into an Agreed Statement of Facts and a Joint Submission on Order;
- The Member has expressed genuine remorse for her conduct.

The proposed penalty meets the goals of penalty. There are three objectives to a penalty: (1) specific deterrence; (2) general deterrence; and (3) rehabilitation and remediation.

The proposed penalty provides for specific deterrence through the oral reprimand and the 4 month suspension of the Member's certificate of registration, which will deter the Member from engaging in this misconduct again.

The proposed penalty provides for general deterrence through the 4 month suspension of the Member's certificate of registration, which serves to warn members of the profession that engaging in such conduct is serious and will not be tolerated.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert, which is designed to provide guidance to the Member and offer an opportunity to learn, reflect and prevent future mistakes.

Further, the public is protected through the 3 random spot audits of the Member's documentation, 12 months of employer notification and the restriction on independent practice in the community for a period of 12 months.

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

CNO v. Nugent (Discipline Committee, 2015): The allegations in this case are similar to the case before this Panel. The member documented the completion of wound dressing changes and administration of medication, however failed to do so. The member had a discipline history; there were three complaints about the member's clinical practice. The member did not appear before the Discipline Committee, and so there were no mitigating factors to consider in regard to the penalty. College Counsel stated that the conduct in the *Nugent* case was more serious as the member had been previously cautioned in regard to three separate complaints with similar

clinical concerns. The penalty included an oral reprimand, a six-month suspension of the member's certificate of registration, two meetings with a Nursing Expert, 18 months of employer notification and three random spot audits over 12 months.

CNO v. Simeone (Discipline Committee, 2017): There are similarities in this case. The member was alleged to have failed to provide home care, failed to document relevant conversations with family members and failed to provide proper wound care. There were also additional allegations of improper delegation of nursing tasks to others. College Counsel stated that there was a similar risk of harm to patients by the member's conduct in the *Simeone* case. Although the member did not have a discipline history, the member's conduct was over a longer period of time and a number of incidents occurred. The member appeared before the Discipline Committee and cooperated and took responsibility for her conduct. The penalty included an oral reprimand, a five-month suspension of the member's certificate of registration, two meetings with a Nursing Expert, 18 months of employer notification, no independent practice for 18 months and four spot audits over 12 months.

The Member made no submissions on penalty.

Penalty Decision

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

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 4 months. This suspension shall take effect from the date the Member obtains an active certificate of registration in a practicing class and shall continue to run without interruption as long as the Member remains in a practicing class.

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

    a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date the Member obtains an active certificate of registration in a practicing class. If the Expert determines that a greater number of sessions are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member obtains an active certificate of registration in a practicing class. To comply, the Member is required to ensure that:

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

ii. At least 7 days before the first meeting, the Member provides the Expert with a copy of:

    1. the Panel's Order,
    2. the Notice of Hearing,
    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. *Professional Standards*,
    2. *Medication*,
    3. *Documentation*, and
    4. *Code of Conduct*;

iv. At least 7 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 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;

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 her behaviour; and

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 her certificate of registration.

b) For a period of 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), 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,
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; and

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.

iv. Only practice nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

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

3. that they agree to perform 3 random spot audits of the Member's documentation at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

    a. the first audit shall take place within 6 months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within 12 months from the date the Member begins or resumes employment with the employer, and
    c. the third audit shall take place within 18 months from the date the Member begins or resumes employment with the employer.

v. The audits shall, on each occasion, involve the following:

    1. reviewing a random selection of at least 3 of the Member's charts to ensure they meet both CNO and employer documentation and care plan standards, and
    2. discussing (by telephone or in person), with at least 3 of the Member's patients, the care provided by the Member and the quality of the Member's interactions with the patients to ensure that the Member provided necessary and/or required care to the patients and that the Member's documentation accurately reflects the care provided.

c) The Member shall not practice independently in the community for a period of 12 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended).

4. All documents delivered by the Member to the 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. 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.

The proposed penalty provides for general deterrence through the 4 month suspension of the Member's certificate of registration. This will signal to fellow practicing nurses that this on going example of poor judgment is conduct that is considered serious in nature and will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 4 month suspension of the Member's certificate of registration. The oral reprimand allows the Member to understand how her conduct is viewed by her peers as well as the public. The suspension of the Member's certificate of registration allows the Member the time to complete her remedial activities and to learn and gain insight into her actions with the hope of preventing future misconduct.

The proposed penalty provides for remediation and rehabilitation through a minimum of two meetings with a Regulatory Expert. This allows the Member to gain insight into her actions allowing her the opportunity to grow as a nurse.

Overall, the public is protected through the 3 random spot audits of the Member's documentation, 12 months of employer notification and the restriction on independent practice in the community for a period of 12 months which allows the Member to gain insight into her professional misconduct, learn from her mistakes through reviewing relevant College Standards and seeking guidance from a Regulatory Expert. The 4 month suspension allows the Member to step away from her practice and gain awareness of her wrong doings and the potential harm she could have inflicted on others if her professional misconduct continued.

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

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.