DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Michael Hogard, RPN	Chairperson
	Tim Crowder	Public Member
	Andrea Norgate, RN	Member
	Lalitha Poonasamy	Public Member
	Michael Schroder, NP	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
SEAN EVERETT WARD	)	BEN MILLARD for
Registration No. 09377168	)	Sean Everett Ward
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: February 3, 2023

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 February 3, 2023, via videoconference.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act*, *1991*, for an order preventing public disclosure and banning the publication or broadcasting of the names of the family members of patients, or any information that could disclose their identities, referred to orally or in any documents presented at the Discipline hearing of Sean Everett Ward.

The Panel considered the submissions of College Counsel and the Member's Counsel and decided that there be an order preventing public disclosure and banning the publication or broadcasting of the names of the family members of patients, or any information that could disclose their identities, referred to orally or in any documents presented at the Discipline hearing of Sean Everett Ward.

The Allegations

The allegations against Sean Everett Ward (the "Member") as stated in the Notice of Hearing dated December 14, 2022 are as follows:

IT IS ALLEGED THAT:

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

    (a) in or about 2017 to 2019, you engaged in inappropriate interactions with colleagues in the workplace, in that:

        (i) you showed a co-worker a partially-obscured picture of a tattoo located in your groin area; and/or

        (ii) you told your co-worker(s) about your sex life with your partner and/or others;

    (b) you failed to maintain the boundaries of the therapeutic nurse-patient relationship with patients in that:

        (i) during your employment at the Facility, you provided your telephone number to a male patient and/or communicated by text with that patient about matters unrelated to his care;

        (ii) in or about 2017 to 2019, you purchased a blanket from the daughter of a patient; and/or

        (iii) in or about 2017 to 2019, you engaged in a personal relationship with [Person A], the family member of a patient, including but not limited to providing your phone number to [Person A], and/or going for coffee with her; and/or

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, employed at London Health Sciences in London, Ontario (the "Facility"), you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that:

    (a) in or about 2017 to 2019, you engaged in inappropriate interactions with colleagues in the workplace, in that:

(i) you showed a co-worker a partially-obscured picture of a tattoo located in your groin area; and/or

(ii) you told your co-worker(s) about your sex life with your partner and/or others;

(b) you failed to maintain the boundaries of the therapeutic nurse-patient relationship with patients in that:

(i) during your employment at the Facility, you provided your telephone number to a male patient and/or communicated by text with that patient about matters unrelated to his care;

(ii) in or about 2017 to 2019, you purchased a blanket from the daughter of a patient; and/or

(iii) in or about 2017 to 2019, you engaged in a personal relationship with [Person A], the family member of a patient, including but not limited to providing your phone number to [Person A], and/or going for coffee with her.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(ii), 1(b)(i), 1(b)(ii), 1(b)(iii), 2(a)(ii), 2(b)(i), 2(b)(ii) and 2(b)(iii) in the Notice of Hearing. The Member denied the allegations set out in paragraphs 1(a)(i) and 2(a)(i) 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's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

THE MEMBER

1. Sean Everett Ward (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") in the Temporary Class on May 5, 2009 and in the General Class on August 27, 2009.

2. The Member was employed at London Health Sciences Centre in London, Ontario (the "Facility") on the Dialysis Unit from May 2009 until June 30, 2020, when he was terminated as a result of the incidents described below.

3. In settings where ongoing care is provided, such as a Dialysis Unit, nurses may have contact with patients and their family members for months or years given the nature of the treatment provided.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Tattoo Incident

4. In or around early August 2019, the Member had an interaction with his co-worker, [ ] ("Co-worker [A]"), regarding a tattoo in his groin area. Co-worker [A] was uncomfortable with the interaction.

5. If Co-Worker [A] were to testify, she would state that the Member showed her part of a photo of a tattoo of a boat, located just above the Member's penis in the groin area which was shaved in the photo. Co-worker [A] would further testify that the Member's hand was covering part of the photo, obscuring his penis, but it was apparent where the tattoo was. Co-worker [A] would also testify that the Member told her that the tattoo was a reminder of his Dad and was a "boat of them fishing".

6. The Member denies that he showed a co-worker a photo of a tattoo in his groin area. If the Member were to testify, the Member would state that no such photo exists, that he only discussed his plans to get a tattoo in the groin area, and that he meant no offence by describing his planned tattoo. However, the Member admits and acknowledges that having a discussion with a co-worker regarding a tattoo on his groin area was inappropriate.

7. CNO does not call other evidence in respect of the tattoo incident.

Sex Life Discussions

8. In early 2019, the Member told his co-workers [ ] ("Co-worker [B]") and [ ] ("Co-worker [C]") information about his sex life relating to observing his ex-wife and other partners having sex with other people and/or his satisfaction with his sex life with his current partner. The Member's disclosure of this information was uninvited by Co-worker [B] and Co-worker [C]. In addition, these conversations occurred in areas of the Facility where they could have been overhead by patients.

9. If the Member were to testify, he would state that his co-workers on the unit sometimes discussed their personal lives with each other, including their personal and sex lives. The Member would further testify that he believed the discussions were mutual and he meant no offence to his co-workers. However, the Member admits and acknowledges that it was inappropriate to have discussions regarding his sex life in the workplace.

Blanket Purchase

10. During the Member's employment at the Facility, he purchased a blanket from a patient's daughter. The Member texted the patient's daughter to make arrangements to pick up and pay for the blanket and he met with her outside of the Facility to pick up the blanket.

Interactions with Male Patient

11. During the Member's employment at the Facility, the Member provide his cell phone number to a male patient for the purpose of communicating with him by text about matters unrelated to the patient's care.

12. If the Member were to testify, he would state that he is a former mechanic, the patient was interested in cars, and he provided his cell phone number to the patient to discuss cars and auto parts.

13. The Member denies that he communicated by text or otherwise with the patient outside the Facility after providing the patient with his cell phone number.

Personal Relationship

14. During the Member's employment at the Facility, he engaged in a personal relationship with [Person A], who was the daughter of a patient and the patient's power of attorney.

15. In 2019, while [Person A]'s mother was the Member's patient, the Member provided [Person A] with his phone number to discuss her mother and matters not related to her mother's care. The Member and [Person A] commenced a friendship.

16. The Member and [Person A] did not have any romantic or sexual relationship. However, other co-workers and patients observed them interacting in the Facility in a manner they perceived as flirtatious, including standing close together and whispering to each other. On one occasion, a patient observing the Member and [Person A] told them to "get a room".

17. During the course of their interactions, the Member made inconsistent statements to [Person A] about whether he was in a relationship. The Member and [Person A] texted occasionally, primarily but not exclusively about [Person A]'s mother. The Member and [Person A] met for coffee on more than one occasion. In addition, on one occasion, the Member ran into [Person A] at a local mall while he was with his mother and stepfather and [Person A] sat with them.

18. The Facility became aware of the Member and [Person A]'s non-therapeutic interactions when the Member advised the Facility that [Person A] had reported to him that she had received a phone call on June 13, 2019 from an unknown caller telling her to "stay away" from the Member. The Member asserted that there had been a breach of confidentiality when someone from the Facility contacted [Person A] without her permission.

Facility Response

19. In respect of his interactions with [Person A], the purchase of the blanket from the daughter of a patient and providing his cell phone number to the male patient, the Facility concluded that the Member failed to comply with CNO's *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard*") and the Member was issued a verbal warning on September 25, 2019. He was required to review the *TNCR Standard* and meet with a Facility representative.

20. As part of the subsequent investigation about inappropriate interactions with co-workers in the workplace, several staff referenced the Member's conduct with daughters of patients.

21. On June 30, 2020, the Facility terminated the Member's employment.

CNO STANDARDS

Code of Conduct

22. CNO's *Code of Conduct* is a standard of practice describing the accountabilities all Ontario nurses have to the public. The *Code of Conduct* consist of six principles including:

    - Nurses respect the dignity of patients and treat them as individuals;
    - Nurses work together to promote patient well-being;
    - Nurses maintain patients' trust by providing safe and competent care;
    - Nurses work respectfully with colleagues to best meet patients' needs;
    - Nurses act with integrity to maintain patients' trust; and
    - Nurses maintain public confidence in the nursing profession.

23. With respect to the principle requiring nurses to work respectfully with colleagues to best meet patients' needs, CNO's *Code of Conduct* provides that:

    - Nurses are professional with colleagues and treat them with respect, including on social media; and
    - Nurses collaborate and communicate with colleagues in a clear, effective, professional and timely way.

24. Regarding the principle requiring nurses to act with integrity to maintain patients' trust, CNO's *Code of Conduct* provides that nurses maintain professional boundaries with patients. In addition, CNO's *Code of Conduct* defines boundaries as:

> The points when a relationship changes from professional and therapeutic to unprofessional and personal. Therapeutic nurse-patient relationships put patients' needs first. Crossing a boundary means a nurse is misusing their power and trust in the relationship to meet personal needs, or behaving in an unprofessional manner with the patient. Crossing a boundary can be intentional or unintentional

Professional Standards

25. CNO's *Professional Standards* provides an overall framework for the practice of nursing and a link with other standards, guidelines and competencies developed by CNO. It includes seven broad standard statements pertaining to accountability, continuing competence, ethics, knowledge, knowledge application, leadership and relationships.

26. CNO's *Professional Standards* provides, in relation to the accountability standard, that nurses are accountable to the public and responsible for ensuring their 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 as well as for conducting themselves in ways that promote respect for the profession. Nurses demonstrate this standard by actions such as ensuring their practice is consistent with CNO's standards of practice and guidelines as well as legislation.

27. CNO's *Professional Standards* further provides, in relation to the ethics standard, that ethical nursing includes acting with integrity, honesty and professionalism in all dealings with the patient and other health care team members. A nurse demonstrates having met this standard by actions such as identifying ethical issues and communicating them to the healthcare team.

28. CNO's *Professional Standards* provides, in relation to the relationship standard and the therapeutic nurse-patient relationship, that a nurse demonstrates this standard by:

    - Maintaining boundaries between professional therapeutic relationships and non-professional personal relationships;
    - Ensuring [patients'] needs remain the focus of nurse-[patient] relationships; and
    - Ensuring his or her personal needs are met outside of the therapeutic nurse-[patient] relationships.

29. CNO's *Professional Standards* also provides, in relation to the relationship standard and professional relationships, that a nurse demonstrates this standard by:

- Role-modelling positive collegial relationships; and

- Using a wide range of communication and interpersonal skills to effectively establish and maintain collegial relationships.

30. In addition, CNO's *Professional Standards* further provides, in relation to the leadership standard, that a nurse demonstrates leadership by actions such as role-modelling professional values, beliefs and attributes.

Therapeutic Nurse-Client Relationship Standard

31. CNO's *TNCR Standard* contains four standard statements which describe nurses' accountabilities with respect to therapeutic communication, patient-centred care, maintaining boundaries and protecting the patient from abuse. The *TNCR Standard* provides that the nurse-patient relationship is built on trust, respect, empathy, professional intimacy and requires the appropriate use of power inherent in the care provider's role. The power inherent in the nurse-patient relationship can extend to the relationship between a nurse and the family members of a patient.

32. CNO's *TNCR Standard* defines a boundary in the nurse-patient relationship as "the point at which the relationship changes from professional and therapeutic to unprofessional and personal." CNO's *TNCR Standard* places the responsibility for establishing and maintaining the limits and boundaries in the therapeutic relationship with patients and their families on the nurse. CNO's *TNCR Standard* provides that:

> Crossing a boundary means that the care provider is misusing the power in the relationship to meet his/her personal needs, rather than the needs of the [patient], or behaving in an unprofessional manner with the [patient].

33. CNO's *TNCR Standard* provides, in relation to maintaining boundaries, that nurses meet this standard by:

- Setting and maintaining the appropriate boundaries within the relationship, and helping [patients] understand when their requests are beyond the limits of the therapeutic relationship;

- Ensuring that the nurse-[patient] relationship and nursing strategies are developed for the purpose of promoting the health and well-being of the [patient] and not to meet the needs of the nurse, especially when considering self-disclosure, giving a gift to or accepting a gift from a [patient];

- Continually clarifying her/his role in the therapeutic relationship, especially in situations in which the [patient] may become unclear about the boundaries and limits of the relationship;

- Abstaining from disclosing personal information, unless it meets an articulated therapeutic need of the [patient];

- Abstaining from engaging in financial transactions unrelated to the provision of care and services with the [patient] or the [patient's] family/significant other;

- Consulting with colleagues and/or the manager in any situation in which it is unclear whether a behaviour may cross a boundary of the therapeutic relationship; and

- Documenting [patient]-specific information in the [patient's] record regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation (non-[patient] related information, such as a letter of summary or incident report, should be documented on the appropriate confidential form).

34. The Member admits and acknowledges that he contravened *Professional Standards* and the *Code of Conduct* when he told co-workers about his sex life with his partner and/or others.

35. The Member admits and acknowledges that he contravened *Professional Standards*, the *Code of Conduct* and the *TNCR Standard* when he provided his telephone number to a male patient, purchased a blanket from the daughter of a patient and engaged in a personal relationship with [Person A], the family member of a patient, including but not limited to providing his phone number to [Person A] and going for coffee with her. The Member further admits and acknowledges that in these cases, he was required to establish and maintain appropriate professional boundaries with patients and their family members and he failed to do so. For clarity and as set out in paragraph 13 above, the Member does not admit that he texted or communicated with the male patient after he gave the patient his phone number, and the Member does not make any admissions with respect to the allegation that he did so.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

36. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a)(ii), 1(b)(i), 1(b)(ii) and 1(b)(iii) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 8 to 18 and 34 to 35 above. In respect of paragraph 1(b)(i), the Member admits that during his employment at the Facility he failed to maintain the boundaries of the therapeutic nurse-patient relationship when he provided his telephone number to a male patient unrelated to the patient's care.

37. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2(a)(ii), 2(b)(i), 2(b)(ii) and 2(b)(iii) of the Notice of Hearing, and in particular his

conduct was dishonourable and unprofessional, as described in paragraphs 8 to 18 and 34 to 35 above. In respect of paragraph 2(b)(i), the Member admits that during his employment at the Facility he failed to maintain the boundaries of the therapeutic nurse-patient relationship when he provided his telephone number to a male patient unrelated to the patient's care.

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)(ii), 1(b)(i) with respect to the Member providing his telephone number to a male patient, 1(b)(ii), 1(b)(iii), 2(a)(ii), 2(b)(i) with respect to the Member providing his telephone number to a male patient, 2(b)(ii) and 2(b)(iii) of the Notice of Hearing. As to allegations #2(a)(ii), #2(b)(i) with respect to the Member providing his telephone number to a male patient, #2(b)(ii) and #2(b)(iii), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be dishonourable and unprofessional. With regard to allegations #1(a)(i) and #2(a)(i), the Panel did not find sufficient evidence to support these allegations and they were therefore dismissed.

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 allegations 1(a)(ii), 1(b)(i), 1(b)(ii), 1(b)(iii), 2(a)(ii), 2(b)(i), 2(b)(ii) and 2(b)(iii) in the Notice of Hearing.

Allegations #1(a)(i) and #2(a)(i) in the Notice of Hearing are partially supported by paragraphs 4-7 in the Agreed Statement of Facts. The Member admitted that while employed as a Registered Nurse ("RN") at London Health Sciences Centre (the "Facility") he had an interaction with Co-worker [A] regarding a tattoo in his groin area. If Co-worker [A] were to testify, she would have stated that the Member showed her a photo of a tattoo of a boat located above the Member's penis which made her uncomfortable. If the Member were to testify, he would have stated that no such photo exists and that he merely discussed his plan to get a tattoo in his groin area. Given that there is no agreement with respect to the Member having showed Co-worker [A] a picture of a tattoo above his penis, the Panel finds that there is insufficient evidence to prove allegations #1(a)(i) and 2(a)(i), on a balance of probabilities, and accordingly dismissed them.

Allegation #1(a)(ii) in the Notice of Hearing is supported by paragraphs 8-9, 22-30, 34 and 36 in the Agreed Statement of Facts. In early 2019, the Member admitted to having uninvited discussions of a personal nature with Co-worker [B] and Co-worker [C] regarding his sex life. The College's *Professional Standards,* in relation to the relationship standard and professional relationships, states that a nurse demonstrates the standard by "role-modelling positive collegial relationships". Given that Co-worker [B] and Co-worker [C] were uncomfortable with the discussion about the Member's sex life, the

Member breached the College's *Professional Standards.* The College's *Code of Conduct* in relation to the principle requiring nurses to work respectfully with colleagues, provides that "Nurses are professional with colleagues and treat them with respect". The Member demonstrated a lack of respect for his colleagues, Co-worker [B] and Co-worker [C], by engaging in an unsolicited discussion about his sex life. The Member admitted that he committed acts of professional misconduct as alleged in paragraph 1(a)(ii) in the Notice of Hearing by breaching the College's *Code of Conduct* and the *Professional Standards.*

Allegation #1(b)(i) in the Notice of Hearing is supported by paragraphs 11-13, 31-33 and 35-36 in the Agreed Statement of Facts. Although the Member denies actually communicating with a male patient outside the Facility by text or otherwise, the Member admitted that he provided his personal cell phone number to a male patient with the intention of discussing cars and auto parts with him. The College's *Therapeutic Nurse-Client Relationship Standard* ("*TNCR* Standard") defines a boundary in the nurse-patient relationship as "the point at which the relationship changes from professional and therapeutic to unprofessional and personal". The Member attempted to initiate a non-therapeutic, personal relationship with the male patient given the Member's intention to discuss a hobby with the male patient outside the Facility. This blurs the line between a therapeutic-nurse client relationship and is for the purpose of meeting the Member's own needs rather than the patient's. The Member also contravened the College's *Professional Standards* through not maintaining boundaries between professional therapeutic relationships and non-professional personal relationships. The Member admitted that he committed acts of professional misconduct as alleged in paragraph 1(b)(i) in the Notice of Hearing through breaching the *TNCR* Standard and the *Professional Standards.*

Allegation #1(b)(ii) in the Notice of Hearing is supported by paragraphs 10, 31-33 and 35-36 in the Agreed Statement of Facts. During the Member's employment at the Facility, the Member met with a patient's daughter outside the Facility to purchase a blanket from her. The College's *TNCR* Standard, in relation to maintaining boundaries, states that nurses meet the standard by "abstaining from engaging in financial transactions unrelated to the provision of care and services with the client or the client's family/significant other". The Member contravened the *TNCR* Standard through transacting with a patient's daughter to purchase a blanket which was unrelated to the provision of the patient's care. The Member admitted that he committed acts of professional misconduct by failing to maintain the boundaries of the therapeutic nurse-client relationship as outlined in the *Code of Conduct* and the *TNCR* Standard.

Allegation #1(b)(iii) in the Notice of Hearing is supported by paragraphs 14-18, 31-33 and 35-36 in the Agreed Statement of Facts. The Member developed a friendship with [Person A], the daughter of a patient. The Member provided [Person A] with his phone number in which they texted. The Member was witnessed being flirtatious with [Person A]. The Member met with [Person A] on more than one occasion for coffee. The Member breached the College's *Code of Conduct* and *TNCR* Standard as he misused the power in the nurse-patient relationship to engage in a personal relationship with the daughter of a patient. The Member admitted that he committed acts of professional misconduct by failing to maintain the boundaries of the therapeutic nurse-client relationship as outlined in the *Code of Conduct* and the *TNCR* Standard.

Allegations #2(a)(ii), #2(b)(i), #2(b)(ii) and #2(b)(iii) in the Notice of Hearing are supported by paragraphs 8-18, 22-35 and 37 in the Agreed Statement of Facts. The Panel finds that the Member's conduct was unprofessional. The Member knew or ought to have known that having uninvited discussions of a personal nature with co-workers about his sex life, providing his telephone number to a male patient, engaging in a financial transaction with a patient's family member and establishing and maintaining a personal relationship and flirting with a patient's daughter was unacceptable. The Panel finds that the Member's conduct was clearly relevant to the practice of nursing and was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations as set out in the standards of practice of the profession.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty through attempting to meet the Member's own personal needs at the cost of potential compromised patient care through the blurring of boundaries of the therapeutic nurse-client relationship. The Member also knew or ought to have known that his conduct was unacceptable and fell below the standards of a professional.

Penalty

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

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

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

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

    a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at the Member's own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO 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 that this Order becomes final. To comply, the Member is required to ensure that:

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

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

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

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

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

iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

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 their report to CNO, in which the Expert will confirm:

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

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in

the Member breaching a term, condition or limitation on the Member's 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 the Member's employers of the decision. To comply, the Member is required to:

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

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

iii. Provide the Member's 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;

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

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

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member has an established pattern of not maintaining professional boundaries with patients, patient's families and co-workers.

The mitigating factors in this case were:

- The Member has taken accountability and responsibility through his admissions and by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College, the Member has avoided the need for a contested hearing; and
- The Member has no past discipline history with the College.

The proposed penalty provides for general deterrence through the 3 month suspension of the Member's certificate of registration, which will send a clear message to the profession that failing to maintain professionalism with co-workers and failing to maintain boundaries with patients and patient's families will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3 month suspension of the Member's certificate of registration, which will deter the Member from repeating similar misconduct.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert and the opportunity for the Member to review and reflect upon the standards.

Overall, the public is protected through the 18 months of employer notification as there will be employer oversight on the Member's return to practice.

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

CNO v. De Cesare (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. This case involved allegations that the member engaged in a personal relationship with one patient over a period of time. The relationship consisted of texting, socializing in person, accepting gifts and the member making personal disclosure about her life. The panel found that the member had engaged in disgraceful, dishonourable and unprofessional conduct. The penalty included an oral reprimand, a 4 month suspension of the member's certificate of registration, a minimum of 1 meeting with a Regulatory Expert and 18 months of employer notification. This case is different from the case before this Panel as it involves long-term interactions with one patient compared to several inappropriate short-term interactions with one patient, two patient's family members, and two co-workers.

The College submitted that the Member purchasing a blanket from a patient's family member and providing a cell phone number to a patient are breaches of boundaries, however, they are not as significant as the more persistent interactions and the personal relationship with [Person A], a patient's daughter.

Submissions were made by the Member's Counsel:

The Member's Counsel submitted that the mitigating factors in this case were:

- The Member has had a long and successful career as a nurse;

- The Member registered with the College in 2009;
- Prior to these issues arising, the Member had no discipline issues at work;
- The Member has no discipline history with the College;
- The Member has taken the allegations seriously;
- The Member has treated these incidents as a learning opportunity;
- The are no allegations concerning his mistreatment or care of patients;
- The Member agreed to plead guilty to the allegations at the onset of the proceeding;
- The Member took the earliest opportunity to take responsibility and seek a joint resolution;
- The parties were spared the costs of a pre-hearing and a contested hearing; and
- The penalty is substantial and demonstrates that the Member has taken ownership for his conduct.

The Member's Counsel submitted that the Joint Submission on Order is fair and proportionate to the allegations.

College Counsel submitted that she agreed with the Member's Counsel with respect to the Member being registered as an RN in 2009 and having no discipline history with the College. With respect to the Member's Counsel's submission regarding an absence of prior discipline with the Member's employer, College Counsel submitted that the Panel has no evidence in that regard one way or the other. College Counsel submitted that the Panel should only rely on the facts for which there is evidence. College Counsel confirmed the Member's Counsel's submission that the Member and the Member's Counsel worked quickly, promptly and early in the process to achieve a resolution.

Penalty Decision

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

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

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

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

    a) The Member will attend a minimum of 2 meetings with a Regulatory Expert (the "Expert") at the Member's own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions are required, the Expert will advise CNO 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 that this Order becomes final. To comply, the Member is required to ensure that:

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

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

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

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

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

iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

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 their report to CNO, in which the Expert will confirm:

    1. the dates the Member attended the sessions,
    2. that the Expert received the required documents from the Member,

3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into the Member's behaviour;

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

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

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

iii. Provide the Member's 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;

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

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

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. 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. Specific deterrence is achieved through the oral reprimand and the 3 month suspension of the Member's certificate of registration, which will deter the Member from repeating similar misconduct in his future practice. General deterrence is met through the 3 month suspension of the Member's certificate of registration, which will demonstrate to the membership that there are serious consequences for therapeutic nurse-patient boundary violations. Rehabilitation and remediation are met through a minimum of 2 meetings with a Regulatory Expert and the review of the College's publications, which will allow the Member an opportunity to reflect on necessary changes to ensure his future nursing practice is consistent with the standards. The public is protected through the 18 months of employer notification, which will provide a heightened level of employer oversight on the Member's return to nursing practice.

This penalty illustrates that there are serious consequences for violations of the boundaries of the therapeutic-nurse-patient relationship.

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

I, Michael Hogard, 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.