DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Catherine Egerton, Chairperson	Public Member
Laura Caravaggio, RPN	Member
Terry Holland, RPN	Member
Heather Stevanka, RN	Member
Margaret Tuomi	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for College of Nurses of Ontario
- and -	)	
MELISSA VISCA REGISTRATION #AC875826	)	NO REPRESENTATION for Melissa Visca
	)	ANDREA GONSALVES Independent Legal Counsel
	)	Heard: November 23-24, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on November 23 and 24, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

As Melissa Visca (the "Member") was not present, the hearing recessed for 15 minutes to allow time for the Member or her representative to appear. Upon reconvening the Panel noted that the Member was not in attendance, nor was anyone present on her behalf.

Counsel for the College provided the Panel with evidence that the Member had been sent the Notice of Hearing on November 7, 2017 via regular mail and email. The Panel was satisfied that the Member had received adequate notice and therefore proceeded with the hearing in the Member's absence.

Publication Ban

At the request of College counsel, the Panel ordered a ban of the publication and broadcasting outside of the hearing room of the names of the clients referred to in the Discipline Hearing of the Member or any information that could reasonably disclose the clients' identities, including any reference to clients' names contained in the allegations in the Notice of Hearing and in any exhibits filed with the Panel.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated October 19, 2017, are as follows.

IT IS ALLEGED THAT:

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

    (a) on or about January 10, 2016, you misappropriated $40 in cash and two bottles of narcotics from a client, [Client A], while providing care to [Client A] in her home; and/or

    (b) on or about January 27, 2016, you misappropriated approximately $20-30 dollars in cash from a client, [Client B]; 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 paragraph 1(8) of *Ontario Regulation 799/93*, in that, while employed by Care Partners as a Registered Practical Nurse, you misappropriated property, in particular,

    (a) on or about January 10, 2016, you misappropriated $40 in cash and two bottles of narcotics from a client, [Client A], while providing care to [Client A] in her home; and/or

    (b) on or about January 27, 2016, you misappropriated approximately $20-30 dollars in cash from a client, [Client B]; and/or

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as

amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, while employed by Care Partners as a Registered Practical Nurse, in that 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 of the profession as disgraceful, dishonourable or unprofessional in that you:

(a) on or about January 10, 2016, you misappropriated $40 in cash and two bottles of narcotics from a client, [Client A], while providing care to [Client A] in her home; and/or

(b) on or about January 27, 2016, you misappropriated approximately $20-30 dollars in cash from a client, [Client B].

Member's Plea

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

Overview

The Member was registered as a Registered Practical Nurse ("RPN") in July 2013 until March 2016 when her Certificate of Registration expired for nonpayment of fees. At the time of the incidents in question, she worked for Care Partners ("the Facility") in St. Catharines as a Registered Practical Nurse, providing in-home nursing care to vulnerable clients.

There were two incidents reported to the Facility, while the Member was working or had been the nurse providing care.

The first incident occurred on January 9 and/or 10, 2016 when the Member was providing care to patient [Client A], who had just been released from the hospital on January 8, 2016 after having major abdominal surgery. The client alleged that the Member misappropriated $40.00 in cash and two bottles of narcotics from her walker and her dresser, while providing wound care in the client's home.

The second incident occurred on January 27, 2016 when the Member was alleged to have misappropriated $20.00 to $30.00 cash from [Client B], for whom she was not currently providing care, but who was a client of the Facility and for whom the Member had provided nursing care at some point in the past. This client was a vulnerable elderly client, who has since passed away.

With respect to the allegations relating to [Client A], the Panel had to determine whether the Member misappropriated drugs and/or money from [Client A], as alleged. With respect to client [Client B], however, there was no issue with respect to the conduct as the Member had already pleaded guilty to the theft in criminal proceedings. With regard to both alleged incidents, the Panel had to determine if the conduct contravened a standard of the profession, amounted to misappropriation and would constitute disgraceful, dishonourable and or unprofessional conduct.

The Panel heard from one witness, received and reviewed 12 exhibits and a book of authorities containing past legal cases, excerpts from the *Evidence Act*, and other similar Discipline Committee decisions and reasons. The exhibits included the Member's work schedule, wound assessment flow sheets, progress notes, video surveillance still photographs, an affidavit from [Client A], court documents and documentation of Care Partners internal investigation.

The Panel made no finding on allegations 1(a), 2(a) and 3(a). With respect to allegations 1(b), 2(b) and 3(b), the Panel found the Member committed acts of profession misconduct in that she breached the standards of practice of the profession and misappropriated cash from [Client B]. In the case of 3(b), the Panel found the Member's actions would reasonably be regarded as disgraceful, dishonourable and unprofessional by members of the profession.

The Evidence

Oral and Documentary Evidence

College counsel presented one witness: Kim Syvret, a former Nurse Manager at Care Partners. Ms. Syvret was the Nurse Manager at the time of the incidents. She had worked for Care Partners for 12 years, from 2004 to 2016 in various positions. She described her position, the expectations of the staff, their roles and duties, the assignment process and timing of visits. Staff provided care for clients in their own homes. The Member was hired in January 2013 and had met all of the required qualifications and reported directly to Ms. Syvret.

The witness stated that the Member was a reliable worker until the end of 2015, when several incidents caused concern including work absenteeism, borrowing money from the office and reported practice gaps. Ms. Syvret went on to testify to the incidents that lead to the dismissal of the Member from Care Partners and to the criminal charges laid in connection with the incident involving client, [Client B]. The witness described that the Member was charged and ultimately pleaded guilty to the theft.

On January 10, 2016, Ms. Syvret testified that she received a phone call from [Client A] complaining that she thought the Member took [Client A's] 2 bottles of medication, $40.00 and her bank card, as they were missing. Ms. Syvret advised the client to report it to the police, which she did in Ms. Syvret's presence. On January 27, 2016, Ms. Syvret received a call from the Niagara Regional Police, requesting an offsite meeting to discuss an alleged theft from another client, [Client B]. [Client B] was an elderly gentleman who lived alone. He used the services of Care Partners but had not been receiving care from the Member. The client [Client B], with assistance from his personal support worker, video recorded the Member in his apartment, when he was out in the afternoon. The Member was identified, arrested and charged by the police. The witness testified that [Client B] told her he had noticed his stein of coins went missing and so he decided to set up video surveillance of his new jar of coins. His nurses and care providers all knew he left the back door open as he had neighbours that brought him food and for his care providers to have easy access. The subsequent video surveillance was viewed, the Member was identified, arrested and charged by the police.

Through Ms. Syvret, the College introduced a number of documents, including Care Partners Internal Investigation Notes, wound assessment flow sheet for [Client A] and IV flow sheet for [Client B], showing the Member had treated both clients at one time. The Panel also reviewed the Member's Schedule for January 9, 10, 2016 and November 17, 2015, showing she had been assigned to both clients but had not been assigned to [Client B] since November 17, 2015, Progress notes for [Client B] dated November 4 and 17, 2015 confirmed that the Member had seen the client and still photographs of surveillance video for January 27, 2016 showed the Member in the client's apartment, when she was not scheduled to be there. The witness identified the photo as the Member and testified that the Member was not assigned to this client on January 27, 2016.

As a result of the information gathered and reviewed by Ms. Syvret, a termination meeting was held with the Member on February 13, 2016 and the Member was terminated.

The Panel found the witness to be forthright and credible. She had direct knowledge of the events in question and her testimony was consistent with the documents presented. Having no professional or personal relationship with the Member, she had nothing to gain by misleading the Panel. She clearly attempted to provide the Panel with her best recollection of the events. Her evidence made sense in light of her position with the Facility and her role in investigating and ultimately terminating the Member for the alleged conduct.

With respect to the theft involving [Client B], the College counsel presented the Panel with documents establishing that the Member, had been charged, pleaded guilty and was found guilty of stealing money of a value not exceeding five thousand dollars, contrary to section 334, clause (b) of the *Criminal Code of Canada*. The Panel accepted these exhibits as evidence.

Affidavit Evidence

College counsel presented the Panel with a sworn affidavit from [Client A] and asked the Panel to allow it to be admitted as evidence for the truth of its content. The client was unable to leave home to give live, video or other evidence because of the state of her health. The document was sworn before a Commissioner of Oaths on November 10, 2017.

After hearing submissions and receiving advice on the issue, the Panel decided to admit the sworn affidavit of [Client A] into evidence. The Panel relied on the previous cases cited, the *Evidence Act* and advice from independent legal counsel to allow the affidavit to be admitted.

The affidavit of [Client A], sworn November 10th, 2017, reads in part as follows:

4. *Since 2005, I have been prescribed pain medication due to my illness. I began using a walker in 2005 and have used one ever since.*

5. *I keep a number of items in my walker, including cigarettes, a pouch in which I keep my bank cards and personal identification, my pain medications, and other medications that I need to take every three or four hours.*

6. *In January 2016, my pain medication included two different medications: Oxycodone and Percocet. My Oxycodone comes in yellow pills with a 'p' on one side and '40' on the other. My Percocet comes in a big white bottle. My practice is to count out my estimated daily number of Oxycodone pills, and take those pills from the larger bottle I receive from my pharmacist, and place them into a smaller bottle. Then I take the pills from there. This helps me keep track of how many pills I have taken. I keep the small bottle of Oxycodone and the big bottle of Percocet in my walker. I take approximately 8 Percocets per day (they are prescribed every 4-6 hours as needed), and two Oxycodone (as prescribed).*

7. *Given my health, I have been under the care of Personal Support Workers ("PSW") and nurses from CarePartners since 2005. My care is co-ordinated through the Community Care Access Centres ("CCAC").*

8. *On January 8, 2016, I was discharged from the Greater Niagara Hospital where I had major abdominal surgery. I was prescribed heavy pain medication while in the hospital, but I was not given any pain medication for use upon my release, as I already had prescription pain medication.*

9. *My health was very poor when I returned home from the hospital. I was in pain and suffering from recurring leg ulcers. I was bedridden and required care from a PSW and a nurse on a daily basis. The PSW was responsible for cleaning my stomach, legs, and feet and bathing me. Before my operation, I had only needed a nurse once or twice a week. CarePartners was to send a nurse to clean my surgical wounds.*

10. *When I returned home from the hospital on January 8, 2016, my son put my usual medications in my walker (the small bottle of Oxycodone and the big bottle of Percocet), and the bottle of the remaining Oxycodone on the dresser in my bedroom.*

11. *My bedroom was arranged with a bed and dresser. The bed is closer to the door, and the dresser is on the opposite side of the bed from the door to the room. The bed and dresser are a few feet apart; I could not reach the dresser from my bed. I kept my walker beside my bed in front of my dresser. There was no space between the dresser and the walker.*

12. *I met Melissa Visca for the first time on Saturday, January 9, 2016 when she was the nurse CarePartners sent to care for me. I had never met her before that day. That afternoon, Ms. Visca visited me in my bedroom.*

13. *Ms. Visca introduced herself and mentioned that we were related through the marriage of a cousin. She said she would take extra good care of me because of our familial connection. Ms. Visca also commented on my walker. Ms. Visca flipped up the flap that concealed the compartment in my walker where I kept my money and medications and looked inside the compartment. She was impressed that I could "keep stuff" in my walker. While she provided care, she sat on my walker, facing the bed and the door to the room, with the dresser to her left.*

14. *Ms. Visca provided me with wound care, although her care was unusual. She told me that I had to wear a belt around my waist, over my incision. I did not think the belt was required because I did not have to wear it during my hospital stay. However, Ms. Visca insisted that I needed to wear the belt. Then Ms. Visca said she needed to turn me over to the right, so that I was facing away from Ms. Visca, my walker, and my dresser, while she adjusted the belt because the buckle was in the back.*

15. *Ms. Visca removed and replaced the sterile wound pad covering my wound. She also turned me over to hook and unhook the belt. This process seemed to take a long time, and Ms. Visca seemed to forgot (sic) what she had done, and had to double-check her care. This made the process much slower and irritated me.*

16. *During Ms. Visca's visit on January 9, 2016, my daughter [Client A's Daughter], brought us each a coffee and we had a cigarette. [Client A's Daughter] was worried because Ms. Visca was fidgety and hyper. She asked me if there was "something wrong with the nurse". At that time, I thought Ms. Visca was just nervous because she was new. I told [Client A's Daughter] that everything was okay.*

17. *I did not take any of my prescribed pain medication on January 9, 2016, as I was still medicated from my stay at the hospital.*

18. *On Sunday, January 10, 2016, I was expecting a nurse named "Jen". I had not met Jen before but CarePartners told me that she was scheduled to care for me that day. However, Ms. Visca showed up around 2:30 or 3:00 pm that afternoon. She told me that she had called Jen and advised her that it would be better if she cared for me instead of Jen since I was "family". I thought that was odd.*

19. *My husband and children were home during Ms. Visca's visit on Sunday, January 10, 2016. [Client A's Daughter] checked in on me to see if I needed anything while Ms. Visca was in my room. [Client A's Daughter] later told me that she noted again that Ms. Visca was very fidgety, which I noticed as well. [Client A's daughter] was also concerned that Ms. Visca sat on my walker during her visits.*

20. *On January 10, 2016, Ms. Visca provided me with the same care as the day before. She again turned me over to the right, so that I was facing away from her, my walker, and my dresser, while she adjusted the belt because the buckle was in the back. I felt Ms. Visca left me on my side, facing away from her, for a long time. It was not a good side to be on. Staying in that position really hurt my hip. I had to tell Ms. Visca that she needed to move me because she was hurting me. When Ms. Visca rolled me back for the first time, on Saturday, there was a Kleenex box on my walker that did not belong to me. Ms. Visca referred to the Kleenex box as "her stuff".*

21. *Ms. Visca rolled me over twice on Sunday, January 10, 2016 because the belt came unhooked and needed to be re-hooked.*

22. *Ms. Visca did not provide me with any care in addition to putting the belt on me and cleaning my wound. She did not administer any medications and we did not discuss the medications I was taking, although I assume she would have known I was taking strong pain medications following my surgery. Ms. Visca was in my home for about forty-five minutes to an hour on each day.*

23. *I did not take my prescribed pain medication on January 10, 2016.*

24. *On Monday, January 11, 2016, I went to retrieve my usual pain medications for the first time since my return from the hospital and discovered that my medications were no longer on my dresser. My son, [Client A's Son], was at home with me. I told him that the bottle on the dresser and the bottles in my walker were both gone and asked him for my pills. [Client A's Son] searched everywhere in my bedroom, and in my walker, but he could not find my pills.*

25. *Each of my pill bottles was nearly full at that time as I had refilled my medications just before being admitted to the hospital on January 2, 2016. My copy of my Patient Medical History from my pharmacist is attached as* ***Exhibit A***.

26. *In addition to the medications that were missing, [Client A's Son] and I soon discovered that I was also missing $40.00 in cash and my debit card, both of which had been in my walker. I know that I had $40.00 in cash in my walker because I had placed $40.00 in cash in my walker on January 10, before Ms. Visca arrived, to pay a lab technician who was scheduled to visit my home and complete some blood work for me on Monday, January 11, 2016. I did not speak to Ms. Visca about the $40.00 when she visited. There is no reason she would have known what the money was for.*

27. *When we discovered the pills were missing, [Client A's Son] removed everything from my walker. We found my debit card, which it had slipped out of my pouch but was still present in my walker. The pills and $40.00 were never found. When the lab technician arrived at 9:00 am to complete my blood work [Client A's Son] had to pay for her services because my $40.00 had gone missing.*

28. *I do not believe that my children or my husband would have removed my pills from my bedroom. Ms. Visca was the only other person in my bedroom on January 9 and 10, 2016, other than my PSW. Ms. Visca was the only person who had me turn away from my dresser and walker, where the missing items were kept, during that period. I believe Ms. Visca stole my medication and money*.

In her affidavit, [Client A] described that once she noticed that the drugs and money were missing, she called Ms. Syvret at CarePartners, who advised her to file an incident report with the police, which she did on January 12, 2016.

Final Submissions

College counsel reminded the Panel that the College bears the onus of satisfying the Panel, on a balance of probabilities, that the Member is guilty of the professional misconduct as alleged. Counsel submitted that the documents, the evidence from the witness and the affidavit evidence clearly established that it was more probable than not that the Member committed the acts as alleged. With respect to the theft involving [Client B], the court documents were incontrovertible. The Member was charged criminally, admitted her guilt and was found guilty in criminal court. The court documents filed provide the Panel with sufficient evidence to make a finding of misconduct with respect to the theft involving [Client B].

With respect to the theft involving [Client A], College counsel submitted that the affidavit evidence was necessary and reliable. [Client A] swore the affidavit, understanding her obligation to tell the truth. [Client A's] description of her interaction with the Member on January 9 and 10, 2016 provides the Panel with sufficient evidence to make a finding that the Member took [Client A's] missing pills and money.

College counsel reminded the Panel that while it cannot penalize the Member for not appearing at the hearing, because of her absence there is no evidence available to contradict the evidence filed by the College.

Counsel also stated the evidence presented is internally consistent, reliable and credible. College counsel made reference to the standard of practice and in particular the need for trust, honesty and respect in the profession: "Trust is one of the cornerstones of the nurse-client relationship. Honesty is an essential ingredient in ensuring that client trust is maintained and that the client's vulnerable position is not abused. Dishonesty will destroy the nurse-client relationship regardless of the level of knowledge, skill and judgement of the nurse."

College counsel went on to submit that a nurse misappropriating money and drugs is clearly dishonest behaviour that is unprofessional and disgraceful, Clients expect that their property will be safe in their home when they invite a nurse in to provide care.

Independent Legal Counsel ("ILC") advised the Panel to review the affidavit of [Client A] carefully and in particular to note internal consistency, as well as areas of hearsay. Hearsay is presumptively inadmissible and lacks the features our legal system relies on. Seeing live evidence allows the panel to assess credibility and allows cross examination of evidence. ILC further stated that the pillars of admissibility are necessity and reliability. One must consider if there are any reasons to question the affidavit or suspect it may not be trustworthy. An affidavit made under oath increases the witness's understanding of the importance of being truthful. At the same time, one cannot assess demeanour or cross examine the evidence. The Panel has discretion as to the weight of the affidavit. The Panel was tasked with considering was it reasonably probable or were there opportunities for others to have taken [Client A's] property?

With respect to the allegations relating to client [Client B], ILC reminded the Panel that it has the court transcripts, the Member's admission of guilt and a photograph of the Member in the client's

home when she was not scheduled to be there. The Panel should look at each case separately and the evidence of each incident, as they are not related. The Panel was advised not to accept a version of events as true simply because it finds the facts relating to the other incident as true. The Panel must look at the standard of practice and consider if there is a breach of trust. Did the College prove based on the evidence and on a balance of probabilities that the Member misappropriate drugs and money from two clients? With respect to how this conduct would be viewed by others in the profession, ILC reminded the Panel members to consider how each of them view the conduct.

Decision

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(b), 2(b) and 3(b) in the Notice of Hearing. In particular, the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional by misappropriating money from an elderly, vulnerable client in his own home, when the Member was not even there to provide care.

The Panel makes no findings with respect to allegations 1(a), 2(a) and 3(a) in the Notice of Hearing.

Reasons for Decision

The Case of [Client A] (allegations 1(a), 2(a), 3(a))

In the case of [Client A] the Panel reviewed the wound assessment flow sheet for [Client A], Care Partners Schedule for January 9 & 10, 2016, the affidavit of [Client A] (Exh 10) and Care Partners internal investigation notes very carefully. The Panel was satisfied based on the documents that the Member did care for [Client A] on January 9 & 10, 2016 in her home. Unfortunately, upon review of the affidavit of [Client A] and the patient medical history, the Panel found a number of inconsistencies that it was unable to reconcile. The client was on a significant amount of narcotics for pain control (8 Percocet per day and 2 Oxycodone per day), according to the medical history. Based on this history, the Panel did not accept that the client did not require any medication for pain between January 8th and January 11th. This was entirely inconsistent with her pain management needs up to that point. Additionally the Panel reviewed the pharmaceutical record and found that [Client A] had filled her prescriptions for 240 Percocet on December 25, 2015 and Oxycodone on December 15, 2015. After the theft she filled her prescription for Percocet on January 13, 2016 and January 20, 2016 (both for 1 week). She did not refill her prescription for Oxycodone until January 21, 2016. The Panel found the fact that the client went without her pain medication for 5 days for the Percocet and 13 days for the Oxycodone questionable as it was inconsistent with her past medication regime.

In addition, while [Client A] concluded that her money and pills had been stolen by the Member given her opportunity to do so, she acknowledged in the affidavit that a PSW and her family

members were also present in her bedroom during the two days at issue. The Member was not the only person with access to the client's bedroom, walker or dresser.

Finally, the Panel noted that at paragraph 30 of her affidavit, the client indicated that when she called the police to file a report on January 12, 2016, the police told her that the Member had been caught on camera stealing from another client and that he was interested in pressing charges. The Panel assumes this is in reference to the [Client B] theft, which did not occur until January 27, 2016, some 15-days after [Client A] called the police. This inaccuracy cast doubt on the credibility of the affidavit and on [Client A's] ability to accurately recall the events. As a result of the inconsistencies in the affidavit evidence, the Panel was not satisfied on a balance of probabilities that the Member was guilty of the allegations as they relate to the client, [Client A].

The Case of [Client B] (allegations 1(b), 2(b) and 3(b))

The evidence of the Member's criminal charges and conviction for theft under in relation to the client [Client B] provided ample evidence to support the findings of misconduct in that regard. In addition, the photograph evidence clearly established that the Member was present in the client's home on a day and time that she was not scheduled to be there. The Panel is satisfied that she attended the client's home and misappropriated the client's property as alleged.

This conduct is clearly a gross violation of a nurse's obligations to her clients and is in breach of the Standards of Practice. Trust and honesty are at the heart of the Standards. The Member behaved in a dishonest and untrustworthy manner. The theft of the client's cash is obviously misappropriation of property as defined in the Regulations. Finally, the conduct would reasonably be regarded as disgraceful, dishonourable and unprofessional. The Member displayed a moral failing and a complete disregard for her professional obligations. Taking advantage of a vulnerable client is an anathema to what it means to be a nurse.

Penalty

Counsel for the College submitted that the Panel should make an Order as follows:

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

2. Directing the Executive Director to suspend Ms. Visca's certificate of registration for five months. This suspension shall take effect from the date Ms. Visca obtains an active certificate of registration and shall continue to run without interruption as long as Ms. Visca remains in the practising class.

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

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

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

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

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

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

    1. *Professional Standards*,
    2. *Therapeutic Nurse-Client Relationship.*

iv. At least seven days before the first meeting, Ms. Visca 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 Ms. Visca was found to have committed professional misconduct,
    2. the potential consequences of the misconduct to Ms. Visca's clients, colleagues, profession and self,
    3. strategies for preventing the misconduct from recurring,
    4. the publications, questionnaires and modules set out above, and
    5. the development of a learning plan in collaboration with the Expert;

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

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

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

b) For a period of 24 months from the date Ms. Visca returns to the practice of nursing, Ms. Visca will notify her employers of the decision. To comply, Ms. Visca is required to:

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

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

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

   iii. Ensure that within 14 days of the commencement or resumption of Ms. Visca'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 Ms. Visca has breached the standards of practice of the profession; and

c) Ms. Visca shall not practise independently in the community for a period of 18 months from the date Ms. Visca returns to the practice of nursing.

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

Penalty Submissions

College counsel presented the Panel with a submission on order requesting a reprimand, five months suspension, and terms, conditions and limitations. Counsel stated the seriousness of the findings warranted a penalty that would tell the Member and the profession these actions will not be accepted.

The penalty addresses general and specific deterrence through the five-month suspension, the reprimand, employer notification and meetings with the expert. Remediation and rehabilitation are met through the requirement that the Member meet with the nursing expert, as well as the 24-month employer notification. The public is protected by the suspension, the employer notification and the prohibition on independent practice.

College counsel submitted the mitigating factor is the Member had no prior history with the College. The aggravating factors were the client was an elderly and vulnerable patient who opened

his home to nurses, as he required their assistance. Theft and dishonesty are a breach of trust and should not be tolerated. Honesty is the corner stone of the profession. The Member preferred her own interests over that of her client. The Member entered into a client's home when he was out, which shows an element of planning and deception.

The Panel was provided with three previous cases, which in some aspects were comparable but none were identical.

CNO vs Burton February 25, 2013
In this case the member did not attend the hearing and was found guilty of theft for misappropriation of money. The panel made a finding of disgraceful, dishonourable and unprofessional. The penalty was four months suspension, a reprimand, terms, conditions and limitations and eight months employer notification.

CNO vs Hore September 30, 2010
The member was present and admitted to the charges of theft over a period of time from several clients, a more serious case. The member received a reprimand, eight months suspension, terms, conditions and limitations and 24 months of no independent practice.

CNO vs Reaume March 5, 2012
This matter involved theft of $1005.00. The member did not attend the hearing. The penalty was a reprimand, six months suspension, two sessions with an expert, and 24 months employer notification.

Penalty Decision

The Panel makes the following order as to penalty:

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

2. The Executive Director is directed to suspend Ms. Visca's certificate of registration for five months. This suspension shall take effect from the date Ms. Visca obtains an active certificate of registration and shall continue to run without interruption as long as Ms. Visca remains in the practising class.

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

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

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

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

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

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

    1. *Professional Standards,*
    2. *Therapeutic Nurse-Client Relationship.*

iv. At least seven days before the first meeting, Ms. Visca 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 Ms. Visca was found to have committed professional misconduct,
    2. the potential consequences of the misconduct to Ms. Visca's clients, colleagues, profession and self,
    3. strategies for preventing the misconduct from recurring,
    4. the publications, questionnaires and modules set out above, and
    5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after Ms. Visca has completed the last session, Ms. Visca will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:
    1. the dates Ms. Visca attended the sessions,
    2. that the Expert received the required documents from Ms. Visca,
    3. that the Expert reviewed the required documents and subjects with Ms. Visca, and
    4. the Expert's assessment of Ms. Visca's insight into her behaviour;

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

b. For a period of 24 months from the date Ms. Visca returns to the practice of nursing, Ms. Visca will notify her employers of the decision. To comply, Ms. Visca is required to:

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

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

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

iii. Ensure that within 14 days of the commencement or resumption of Ms. Visca'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 Ms. Visca has breached the standards of practice of the profession; and

c. Ms. Visca shall not practise independently in the community for a period of 18 months from the date Ms. Visca returns to the practice of nursing.

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

Reasons for Penalty Decision

The Panel considered the fact that public protection is paramount to any penalty and that this penalty provided for this while making a statement to the membership at large that this behaviour will not be tolerated. This penalty, including the suspension, terms, conditions and limitations, has all the required elements needed to deter members from such actions in the future.

Dishonest behaviour is clearly unprofessional and contrary to the expectations of clients, employers and the public. Deceptive behaviour is disgraceful and dishonourable and shames the Member and the profession, particularly in the home care environment. Vulnerable clients welcome nurses into their home expecting to be safeguarded by them.

The Panel finds the penalty is proportional to the allegations and findings. The penalty should deter the Member from ever repeating this type of behaviour through the reprimand, suspension and meeting with the nursing expert, 24 month employer reporting and 18 month restriction on independent practice. The terms, conditions and limitations should give the Member the tools to rehabilitate and improve her practice if she chooses to do so.

I, Catherine Egerton, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of this Discipline Panel.

Chairperson	Date