DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Andrea Arkell, Public Member	Chairperson
	Carly Gilchrist, RPN	Member
	Nazlin Hirji, RN	Member
	Carly Hourigan	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
RONALDO DACILLO CRUZ	)	NO REPRESENTATION for
Registration No. AD043082	)	Ronaldo Dacillo Cruz
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: February 13, 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 13, 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 name of the patient, or any information that could disclose the patient's identity, referred to orally or in any documents presented at the Discipline hearing of Ronaldo Dacillo Cruz.

The Panel considered the submissions of College Counsel and the Member and decided that there be an order preventing public disclosure and banning the publication or broadcasting of the name of the patient, or any information that could disclose the patient's identity, referred to orally or in any documents presented at the Discipline hearing of Ronaldo Dacillo Cruz.

The Allegations

The allegations against Ronaldo Dacillo Cruz (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 you were employed as a Registered Practical Nurse at Southlake Regional Health Centre in Newmarket, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession on or around December 20, 2020 when you:

    a. took a photograph using your personal cell phone of [the Patient], who was undressed and lying on the ground, without [the Patient]'s knowledge and/or consent; and/or

    b. posted the photograph of [the Patient] with a description of the patient on a departmental WhatsApp group chat;

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(7) of *Ontario Regulation 799/93*, in that while you were employed as a Registered Practical Nurse at Southlake Regional Health Centre in Newmarket, Ontario, you abused [the Patient] verbally, physically, and/or emotionally on or around December 20, 2020 when you:

    a. took a photograph using your personal cell phone of [the Patient], who was undressed and lying on the ground, without [the Patient]'s knowledge and/or consent; and/or

    b. posted the photograph of [the Patient] with a description of the patient on a departmental WhatsApp group chat; 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*, in that, while you were employed as a Registered Practical Nurse at Southlake Regional Health Centre in Newmarket, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, on or around December 20, 2020 when you:

    a. took a photograph using your personal cell phone of [the Patient], who was undressed and lying on the ground, without [the Patient]'s knowledge and/or consent; and/or

    b. posted the photograph of [the Patient] with a description of the patient on a departmental WhatsApp group chat.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b), 2(a), 2(b), 3(a) and 3(b) 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 reads, unedited, as follows:

THE MEMBER

1. Ronaldo Dacillo Cruz (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on January 17, 2014. The Member is also registered as a nurse in New York, United States and in the Philippines.

2. The Member was employed as a full-time RPN at Southlake Regional Health Centre (the "Facility") on the Restorative Care Unit (the "Unit"). The Member's employment at the Facility was terminated on January 12, 2021, as a result of the incident described below.

THE PATIENT

3. Patient [ ] (the "Patient") was 88 years old and was diagnosed with late-stage cancer at the time of the incident.

4. The Patient has since passed away.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

5. On December 20, 2020, [Nurse A], the Patient's primary nurse, asked the Member to assist her with a transfer of the Patient. When they got to the Patient's room, the Patient was on a geri chair. They noticed the Patient was soaked with loose bowel/stool.

6. The Member and [Nurse A] subsequently transferred the Patient to the floor because the Patient was slipping off the geri chair and was unable to stand or lift to be cleaned.

7. During the interaction, the Member took a photograph on his personal cell phone of the Patient while the Patient was lying on the ground. The Member took the photograph without the Patient's knowledge and/or consent. Later that day, the Member posted the photograph of the Patient to a departmental WhatsApp group chat amongst colleagues on the Unit.

8. The photograph showed the Patient lying on the ground, undressed and nude, in a vulnerable position.

9. Below the photograph, the Member wrote the following description:

> look at this guy ! [Nurse A]'s patient asking me to help her. terrible physio put him in geri chair when we try to put him back on bed using sara steady he is barely moves and he had a big explosive of loose BM.all over geri chair and floor 😳 when ever he moved from chair to sara he is also moving down we decided to put him in the floor for safety my back now is hurting for the first time 😡 we clean together in the floor and at the same time he urinates omg! he is to much abusing nurses! we transfer back using hoyer!! 😳😳😳

10. A number of colleagues responded to the photograph and message. Eventually one colleague expressed concern with sharing the photograph and the type of message on the group chat citing concerns with privacy and abuse. Colleagues on the group chat also brought the photograph and message to the attention of the Unit manager, [ ].

11. The Facility conducted an investigation, which included obtaining screen shots of the photograph and messages and interviewing the Member.

12. During the Member's interview with the Facility, he admitted to taking the photograph and sharing it on the WhatsApp group. The Member stated that he shared the photograph in order to advise other nurses on the Unit about issues with the Patient and for the benefit of patient safety; however, the Member admitted it was poor judgment to do so.

13. Following the investigation, the Facility terminated the Member's employment.

14. If the Member were to testify, he would state that the purpose of taking the photograph and sharing it with his colleagues was to express a concern about the Patient and nurse safety. The Member would further testify that he was under a significant amount of stress due to COVID and the long hours he had been working and made a momentary lapse of judgment.

CNO STANDARDS

Code of Conduct

15. 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.

16. With respect to the principle requiring nurses to respect the dignity of patients and treat them as individuals, CNO's *Code of Conduct* provides that:

    - Nurses treat patients with care and compassion; and
    - Nurses take steps to maintain patients' privacy and dignity in the physical space where they are receiving care.

17. Regarding the principle requiring nurses to act with integrity to maintain patients' trust, CNO's *Code of Conduct* provides that nurses protect the privacy and confidentiality of patients' personal health information.

Professional Standards

18. 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.

19. 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.

20. CNO's *Professional Standards* provides, in relation to the ethics standard, that ethical nursing care means promoting the values of patient well-being, respecting patient choice, assuring privacy and confidentiality, respecting the sanctity and quality of life, maintaining commitments, respecting truthfulness and ensuring fairness in the use of resources. It further provides that ethical nursing includes acting with integrity, honesty and professionalism in all dealings with the patient and other health care team members.

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

22. CNO's *Professional Standards* further provides, in relation to the relationship standard and the therapeutic nurse-patient relationship, that nurses demonstrate this standard by:

    - practising according to CNO's *Therapeutic Nurse-Client Relationship* practice standard ("*TNCR Standard*"); and

    - demonstrating respect and empathy for, and interest in [patients].

Therapeutic Nurse-Client Relationship

23. 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.

24. The *TNCR Standard* provides, in relation to patient-centred care, that a nurse meets the standard by:

    - recognizing that the [patient's] well-being is affected by the nurse's ability to effectively establish and maintain a therapeutic relationship; and

    - reflecting on how stress can affect the nurse-[patient] relationship, and appropriately managing the cause of the stress so the therapeutic relationship is not affected.

25. The *TNCR Standard* also requires nurses to protect the patient from harm by ensuring that abuse is prevented or stopped and reported. With respect to protecting the patient from abuse, nurses meet the standard by not exhibiting physical, verbal and non-verbal behaviours toward a patient that demonstrate disrespect for the patient and/or are perceived by the patient and/or others as abusive.

26. In addition, the *TNCR Standard* provides examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, intimidation including threatening gestures/actions, teasing or taunting, insensitivity to the patient's preferences, swearing and an inappropriate tone of voice, such as one expressing impatience.

Confidentiality and Privacy: Personal Health Information

27. CNO's *Confidentiality and Privacy: Personal Health Information* standard largely incorporates the *Personal Health Information Protection Act, 2004* and requires that personal health information be kept confidential and secure. The legislation recognizes that personal health information belongs to patients and is simply being housed in health care facilities. Patients have the right to give, refuse or withdraw their consent to the collection, use and disclosure of their personal health information. Nurses comply with this standard by actions such as:

    - seeking information about issues of privacy and confidentiality of personal health information;

    - collecting only information that is needed to provide care; and

    - maintaining confidentiality of [patients'] personal health information with members of the healthcare team, who are also required to maintain confidentiality, including information that is documented or stored electronically.

28. The Member admits and acknowledges that he contravened CNO's *Code of Conduct*, Professional *Standards*, *TNCR Standard* and *Confidentiality and Privacy: Personal Health Information* standard when he took a photograph using his personal cell phone of the Patient, who was undressed and lying on the ground, without the Patient's knowledge and/or consent and when he posted the photograph of the Patient, with a description of the Patient, on a departmental WhatsApp group chat.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

29. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1 (a) and (b) of the Notice of Hearing in that he contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as described in paragraphs 5 to 28 above.

30. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2 (a) and (b) of the Notice of Hearing in that he emotionally abused the Patient, as described in paragraphs 5 to 14 and 25 to 26 above.

31. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3 (a) and (b) of the Notice of Hearing, and in particular that his conduct was dishonourable and unprofessional, as described in paragraphs 5 to 28 above.

Submissions on liability were made by College Counsel.

College Counsel submitted that with respect to allegation #1, the Agreed Statement of Facts outlines the relevant standards for the Panel's consideration, which includes the *Code of Conduct*, the *Professional Standards*, the *Therapeutic Nurse-Client Relationship* Standard and the *Confidentiality*

and Privacy: Personal Health Information Standard. College Counsel submitted that taking a photograph of [the Patient] who was nude and in a compromising position without his knowledge or consent and sharing this photograph with a description of [the Patient] on a WhatsApp group chat with his colleagues is a clear breach of the standards of practice. It is also conduct that would amount to emotional abuse of [the Patient] as set out in allegation #2.

With respect to allegation #3, College Counsel reminded the Panel that first the Panel must satisfy itself that the Member's conduct is relevant to the act of nursing. College Counsel submitted that the conduct in this case is relevant to nursing practice as it arose from the context of providing care to [the Patient]. College Counsel submitted that the Panel also must be satisfied that the members of the profession would find the Member's conduct to be disgraceful, dishonourable or unprofessional. College Counsel submitted that it is a disjunctive term, meaning that the Panel only needs to find one to make a finding of professional misconduct and that the Panel does not need to specify which of disgraceful, dishonourable or unprofessional in order to make the finding. College Counsel submitted that the College and the Member, through his admissions of professional misconduct, agreed that it amounted to both dishonourable and unprofessional conduct. College Counsel submitted that the Member's conduct is unprofessional as it demonstrated a serious disregard for his professional obligations. College Counsel submitted that it is also dishonourable as the Member knew or ought to have known that his conduct fell below the standards of the profession and it included an element of moral failing by taking a photograph of a vulnerable nude patient and distributing it to his colleagues via text message.

College Counsel reviewed with the Panel prior discipline hearing cases that contained similar conduct.

CNO v. Brosso (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts. College Counsel submitted that there were a number of allegations but not all of them were similar to the allegations in the case before this Panel. However, one of the allegations involved the member photographing and videotaping a patient, lying on the patient's bed and making inappropriate jokes to the patient about "who was boss" and laughing as the patient talked about bowel movements. That panel found the conduct in taking the photograph and the video amounted to a breach of the standards of practice and emotional abuse of the patient. That panel also found the member's conduct to be dishonourable and unprofessional. College Counsel submitted that this case was more severe than the Member's conduct in the case before this Panel as it involved a number of different incidents and patients over a lengthy period of time; it was more severe conduct and persistent. The case before this Panel involved a one-time incident.

CNO v. Proulx (Discipline Committee, 2019): This case proceeded by way of an Agreed Statement of Facts. College Counsel submitted that one of the allegations in this case was that the member used her cellphone to take a video of the patient who was in a behavioural state and also took pictures of the patient's feces on the wall where the patient had pulled down part of the paneling. She shared that video and photograph with colleagues through Snapchat. College Counsel submitted that the panel found that this conduct amounted to a breach of the standards of practice was emotional abuse and that the member's conduct was dishonourable and unprofessional.

CNO v. Lauzon (Discipline Committee, 2013): This case proceeded by way of an Agreed Statement of Facts. College Counsel submitted that this case involved the member taking photographs on her cellphone of a patient. The member took a picture of herself with the patient in the background and a photograph of another patient lying in his hospital bed with his torso exposed and the patient appeared to be unconscious and on a ventilator. There was a caption associated with the photo "see the monster I have to deal with. Wtf". This photograph was sent to a colleague that was working in the ICU that night, who was also planning on sending the photograph to her boyfriend. The panel found that the conduct amounted to a breach of the standards of practice, emotional abuse of the patient and disgraceful, dishonourable and unprofessional conduct.

The Member made no submissions on liability.

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), 1(b), 2(a), 2(b), 3(a) and 3(b) of the Notice of Hearing. With respect to allegations #2(a) and #2(b), the Panel finds that the Member emotionally abused [the Patient]. As to allegations #3(a) and #3(b), 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.

Allegations #1(a) and #1(b) in the Notice of Hearing are supported by paragraphs 5-29 in the Agreed Statement of Facts. The Member admitted to these allegations. On December 20, 2020 while employed as a Registered Practical Nurse ("RPN") at Southlake Regional Health Centre (the "Facility") on the Restorative Care Unit (the "Unit"), [the Patient]'s primary nurse asked the Member to assist her with a transfer of [the Patient]. When they got to [the Patient]'s room, he was sitting on a geri chair and was soaked with loose stool. The Member and [the Patient]'s nurse transferred him to the floor because he was slipping off the geri chair and was unable to stand or lift to be cleaned. During the interaction, the Member took a photograph on his personal cell phone of [the Patient] while he was lying on the ground. The Member took the photograph without [the Patient]'s knowledge or consent. The photograph showed [the Patient] lying on the ground, undressed and nude and in a vulnerable position. Later that day, the Member posted the photograph of [the Patient] to a department WhatsApp group chat amongst colleagues on the Unit. The Member discussed in the group chat how he and his co-worker found [the Patient], including the amount and type of incontinence and transfer techniques utilized for his transfer.

The Panel finds that the Member failed to meet the College's *Code of Conduct* when he failed to respect the dignity of [the Patient] and failed to take steps to maintain [the Patient]'s privacy and dignity. The Member breached the *Professional Standards* by not promoting [the Patient]'s well-being and assuring privacy and confidentially of [the Patient]. The Member failed to meet the *Therapeutic Nurse-Client Relationship* Standard ("*TNCR* Standard") when he posted the photo of [the Patient] without clothing and in a vulnerable position. The *TNCR* Standard requires nurses to protect the patient from harm. The confidentiality and privacy of [the Patient] was breached when consent was not obtained when the photograph of [the Patient] was taken. Although the Member was responsible for collecting and relaying information to the health care team about [the Patient], the Member demonstrated unnecessary and inappropriate behaviour by posting the photo of [the Patient] in a vulnerable position to the WhatsApp group.

Allegations #2(a) and #2(b) in the Notice of Hearing are supported by paragraphs 5-14, 25, 26 and 30 in the Agreed Statement of Facts. The Member admitted to emotionally abusing [the Patient] when he took a photograph on his personal cell phone of [the Patient] without his knowledge or consent and while [the Patient] was lying on the ground, undressed and nude and in a vulnerable position and to posting the photograph to a department WhatsApp group chat amongst colleagues on the Unit. The Panel finds the Member emotionally abused [the Patient] through non-verbal behaviours, by posting a picture of [the Patient] in a vulnerable position. The Member disrespected [the Patient] further by discussing [the Patient]'s amount of incontinence which demonstrated insensitivity and by disregarding [the Patient]'s right to confidentiality.

Allegations #3(a) and 3(b) in the Notice of Hearing are supported by paragraphs 5-28 and 31 in the Agreed Statement of Facts. The Panel finds that the Member's conduct in posting and commenting on an inappropriate photo he took of [the Patient] to his colleagues WhatsApp chat 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 *Code of Conduct*, the *Professional Standards*, the *TNCR* Standard and the *Confidentiality and Privacy: Personal Health Information* Standard. Nurses are expected to uphold, demonstrate and maintain the standards of the profession.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of moral and ethical failing through posting an inappropriate picture of [the Patient] and then making comments to the health care team in the group chat. The Member 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 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 2 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*,
            3. *Therapeutic Nurse-Client Relationship*, and
            4. *Confidentiality and Privacy – Personal Health Information*;

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

v. Before the first meeting, the Member reviews *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

vi. 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 and *Nurses' Workbook;*

vii. 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;

viii. 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;

ix. 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 12 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.

College Counsel submitted that the proposed penalty is appropriate in light of the Panel's findings of misconduct. College Counsel reminded the Panel that the foremost duty when considering the appropriate penalty is a penalty that is intended to protect the public and enhance the public's confidence in the College's ability to self-regulate. College Counsel submitted that the Panel is obliged to accept the Joint Submission on Order unless doing so brings the administration of justice into disrepute.

College Counsel submitted that public protection is achieved through specific deterrence of the Member, general deterrence which includes the membership at large and where applicable rehabilitation and remediation of the Member. College Counsel submitted that when the Panel is trying to meet these objectives it needs to review the aggravating and mitigating circumstances of this case.

The aggravating factors in this case were:

- The serious nature of the conduct - it involved a vulnerable patient;
- The Member's conduct displayed a lack of dignity and respect for the vulnerable patient;

- The conduct amounted to emotional abuse; and
- The Member's conduct brings discredit to the profession.

The mitigating factors in this case were:

- As indicated in the Agreed Statement of Facts the Member had no intention of causing harm to this patient;
- The Member's intention in taking the photograph and sharing it amongst his colleagues was to raise a concern he had about the patient and nurse safety;
- This was an isolated incident and occurred on one occasion;
- The Member has no prior discipline history with the College;
- The Member immediately admitted to his wrong doing during the course of the investigation with his employer and has continued to cooperate and admit his wrong doing; and
- The Member has expressed his remorse and taken responsibility and accountability throughout the College's process by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College.

The proposed penalty provides for general deterrence through the 2-month suspension of the Member's certificate of registration, which will deter the membership at large, reinforcing that this type of conduct will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2-month suspension of the Member's certificate of registration, which will deter the Member from repeating this type of conduct.

The proposed penalty provides for remediation and rehabilitation through a minimum of 2 meetings with a Regulatory Expert, which will allow the Member to further reflect on his conduct and ensure that this conduct will not be repeated in the future.

Overall, the public is protected through the 12 months of employer notification as there will be employer oversight on the Member's return to practice.

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

CNO v. Brosso (Discipline Committee, 2021): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. There were a number of allegations which involved the member photographing and videotaping a patient, lying on the patient bed and making inappropriate jokes to the patient about "who was boss" and laughing as the patient talked about bowel movements. The panel found that the member's conduct breached the standards of practice, amounted to emotional abuse of the patient and was dishonourable and unprofessional. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, a minimum of 2 meetings with a Regulatory Expert and 12 months of employer notification. College

Counsel submitted that in this case the member appropriately received a lengthier suspension as there was multiple instances of breaches of the *Professional Standards* and abuse of patients.

CNO v. Proulx (Discipline Committee, 2019): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member used her cellphone to take a video of the patient who was in a behavioural state and also took pictures of the patient's feces on the wall where the patient had pulled down part of the paneling and shared that video and photograph with colleagues through Snapchat. There was also an allegation of falsifying records. The penalty included an oral reprimand, a 5-month suspension of the member's certificate of registration, two meetings with a Regulatory Expert and 18 months of employer notification. College Counsel submitted that in this case the member received a lengthier suspension and employer notification period, due to the serious nature of her conduct.

CNO v. Lauzon (Discipline Committee, 2013): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case the member took two photographs on her cellphone of a patient. The member took a picture of herself with the patient in the background and a photograph of another patient lying in his hospital bed with his torso exposed and the patient appeared to be unconscious and on a ventilator. There was a caption associated with the photo "see the monster I have to deal with. Wtf". This photograph was sent to a colleague. This case also involved another allegation of inappropriate communication with a patient's daughter. The penalty included an oral reprimand, a three-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification.

The Member made no submissions on penalty.

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 2 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*,
    3. *Therapeutic Nurse-Client Relationship*, and
    4. *Confidentiality and Privacy – Personal Health Information*;

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

v. Before the first meeting, the Member reviews *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

vi. 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 and *Nurses' Workbook*;

vii. 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;

viii. 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;

ix. 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 12 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.

The oral reprimand and the 3-month suspension of the Member's certificate of registration will provide specific deterrence.

The 3-month suspension of the Member's certificate of registration will provide general deterrence.

A minimum of 2 meetings with a Regulatory Expert will provide for rehabilitation and remediation. This will allow the Member the opportunity to review relevant College publications and complete the associated Reflective Questionnaires, online learning modules and decision tools and will allow the Member to reflect on his misconduct and ensure that this type of misconduct does not occur again.

The public is protected through the 12 months of employer notification which will allow for further oversight into the Member's practice ensuring that no other forms of misconduct occur in the future.

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

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