DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Tanya Dion, RN	Chairperson
	Spencer Dickson, RN	Member
	Mary MacMillan-Gilkinson	Public Member
	Ashleigh Molloy	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
CARLA L. RING	)	ANDREA WOBICK for
Reg. No: 8322869	)	Carla L. Ring
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: JANUARY 30, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on January 30, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

The Allegations

Counsel for the College advised the panel that the College was requesting leave to withdraw the allegation set out in paragraph 2 of the Notice of Hearing dated November 17, 2017. The panel granted this request. The remaining allegations against Carla Ring (the "Member") 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 as Registered Nurse at the North Bay Regional Health Centre in North Bay, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to misappropriating funds totalling approximately $36,500 from the

clients listed in Schedule A, and/or failing to document or otherwise account for the withdrawal of funds from the accounts of these clients, in or about April 2009-February 2012.

2. {*Withdrawn*}

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93,* in that while employed as Registered Nurse at the North Bay Regional Health Centre in North Bay, 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 of the profession as disgraceful, dishonourable or unprofessional with respect to misappropriating funds totalling approximately $36,500 from the clients listed in Schedule A, and/or failing to document or otherwise account for the withdrawal of funds from the accounts of these clients, in or about April 2009-February 2012.

Member's Plea

The Member admitted the allegations set out in paragraphs 1 and 3 in the Notice of Hearing specifically that she failed to document or otherwise account for the withdrawal of funds from the accounts of clients in or about April 2009-February 2012 and that this conduct would reasonably be regarded by members to be unprofessional. 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

Counsel for the College and the Member advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads as follows.

THE MEMBER

1. Carla L. Ring (the "Member") obtained a diploma in nursing from Durham College in 1982.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on January 1, 1983.

3. The Member was employed at North Bay Regional Health Centre (the "Hospital") from May 16, 1983 to April 16, 2012, when her employment was terminated as a result of the incidents below.

THE HOSPITAL

4. The Hospital had two sites. The College site was located in North Bay, Ontario and the Kirkwood site was located in Sudbury, Ontario.

5. At the relevant times, the Member was the Nursing Manager of Mental Health. In that role, she had responsibility for two programs at the North Bay site – Maple and Birch Lodges. One program dealt with complex rehabilitation and the other program was for those with dual diagnoses. Both programs involved clients with mental illnesses and cognitive/developmental issues.

6. Prior to her approximately eight years working as the Nurse Manager, the Member worked as a Nurse Facilitator in the same unit.

7. In January 2011, a number of the mental health beds at the North Bay site were moved to the Kirkwood site in Sudbury. The Member was not directly responsible for the Kirkwood site. However, some of her direct reports did shifts in both locations, and the Member was involved in meetings and communications regarding the management of the clients moved to the Kirkwood site.

8. In January 2012, the Hospital did an organizational restructure and elimination of positions, including the Member's position. The Member was unsuccessful in obtaining a management role in the new structure. She was in the process of determining whether she would have a role in the Hospital's new structure when the incidents below came to light.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

The Pin Money System

9. The Hospital maintained trust accounts for all mental health clients. A $5,000 float was available at all times. This was called the Pin Money System. Both the North Bay and Kirkwood site used the Pin Money System.

10. Separate Pin accounts were set up for each client. In many cases, money was deposited into client accounts by the Public Guardian and Trustee or the Ontario Disability Support Program.

11. Clients made two primary types of withdrawals: 1) canteen (i.e. snacks and cigarettes), or; 2) personal needs (clothing etc.). Withdrawals were also made for recreational outings.

12. The Pin Money Clerk maintained an authorization list that contained the names of staff who were able to access money for clients who were not financially competent. All nurses and social workers at the Hospital had access to client accounts at both sites.

13. The Hospital did not have a written policy or procedure for accessing funds on behalf of clients or maintaining documentation of purchases or change given.

14. To access funds, the client (or staff on the client's behalf) typically filled out a Pin Money Requisition Form. The Pin Money Requisition Form would be dated and signed by the staff member who prepared it (the "preparer") and approved by a different staff member (the "approver"). It was then presented to the Pin Money Clerk at the vault. The individual receiving the funds would sign the form as evidence of receipt. The client (if capable), preparer or approver could receive the funds.

15. If change was returned to the Pin Money Clerk, a valuable sheet was completed by the staff, which was kept at the Pin Money office, and the client/staff retained a copy. If the client opted to keep the change, the clerk would document that fact on the valuable sheet.

16. If any clothing was purchased, it was to be documented on the client clothing list (and sent down to the laundry for the client's name and unit number), which was in the client's chart.

17. At the end of each day, the Pin Money Clerk would add up the Pin Money Requisition Forms and balance the totals with the amount of money he or she handed out. The slips were then sent to the finance department to be retained.

18. On a monthly basis, the Pin Money Clerk received a list from each ward detailing which clients could withdraw funds on a daily basis. Copies of the requisitions were made and the Client would sign when/if money was withdrawn from the vault.

Hospital Policy

19. The Hospital had a policy called "Receipt/Inventory of Money And Valuables And Operation Of Patient's Valuables Drop-Off Box." Its purpose was to "maintain a record of money and valuables and provide a method of safekeeping for patient's valuables," and it was typically used when staff received valuables for newly-admitted client after hours. According to the Hospital, when valuables were held for clients, the Pin Money Clerk was accountable for verifying that the valuables presented were recorded correctly on the Receipt/Inventory of Money and Valuables Form. The Clerk would then sign all three copies and place an original in the client's file in the PIN money office.

20. According to [the Manager of Finance], who was the Hospital's Manager of Finance at the relevant time, there was a verbal policy that required that a copy of the Pin Money Requisition Form (carbon copy), and receipts for any purchases, to be kept in the client's file (when the funds were not received by the client directly). As well, the purchases were to be documented on the client's valuables sheet, which was also in the client's file in the Pin money office.

The Member's Use of the PIN Money System

21. The Member was authorized to obtain funds for clients through the Pin money system. Typically social workers and/or nurses would perform this task for clients. However, while this duty was not a normal aspect of the Member's position as a manager, it had formed part of her duties as a Nurse Facilitator, and she continued to do so as a Manager when employees in the unit were unwilling or unable to perform the duty.

22. In March 2012, a social worker at the Kirkwood site in Sudbury noticed some discrepancies in a client's account. She also noted that the Member continued to access funds for clients who had been moved to the Kirkwood site from the Member's units at the North Bay site. The social worker was concerned that items of clothing and furniture that were documented as purchased by nursing staff in North Bay for clients in Sudbury were not in the possession of the clients in Sudbury.

23. The Hospital conducted an investigation of the Member's accesses to client funds.

24. The Hospital retained KPMG to conduct an audit of client trust funds between April 2009 and July 2012. The audit concluded that the Member received cash totalling $36,460.47 for 19 different clients, for which there were no supporting receipts. There was an additional $1,111.78 the Member received during the same time period where supporting receipts were available.

25. After the Member's employment at the Hospital was terminated, she was charged criminally on two counts of fraud over $5,000, theft over $5,000 and criminal breach of trust with respect to client funds.

26. On April 28, 2017, the charges against the Member were withdrawn by the Crown during the course of the trial.

27. If the Member were to testify, she would say that she made purchases for clients at the Kirkwood site in Sudbury at the request of staff from that site. She would further testify that she would send the purchased items from North Bay to the Kirkwood site using the Hospital's courier. The Member admits that she failed to document the names of the individuals from the Kirkwood site who made the requests and she failed to document having sent items via the Hospital's courier service. The Member accepts responsibility for her failure to document these interactions. The Member recognizes that others might reasonably perceive that she misappropriated funds from clients, in the circumstances, even if she had not done so.

28. In terms of not having receipts for many of the purchases she made, the Member would testify that, as a result of not having a management position after the 2012 restructure, she had to move out of her office. In the course of cleaning out her office, she shredded many of the relevant receipts. The Member acknowledges that it was her responsibility to keep a copy of the receipts in the client file, and that her failure to do so was a breach of the Hospital's unwritten Pin Money policy and the College's standards of practice.

29. The Member further acknowledges that it was not in the clients' interests that she failed to document or keep receipts for purchases she made with respect to the 19 clients.

COLLEGE STANDARDS

30. The College's *Documentation* standard says that nurses "are accountable for ensuring their documentation of client care is accurate, timely and complete." One of the ways nurses can demonstrate accountability for their documentation is by advocating "for clear documentation policies and procedures that are consistent with the College's standards."

31. The College's *Professional Standards* provide that the nurse has an obligation to create environments to promote effective and ethical practices in dealing with clients. The College's *Therapeutic Nurse-Client Relationship* standard stipulates that nurses do not engage in behaviours that might reasonably be perceived as exploitative or that could result in monetary loss for the client.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

32. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, as described in paragraphs 9 to 29 above, in that she failed to document or otherwise account for the withdrawal of funds from the accounts of the 19 clients listed in Schedule A.

33. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 3 of the Notice of Hearing, in that she failed to document or otherwise account for the withdrawal of funds from the accounts of the 19 clients listed in Schedule A, and in particular that her conduct was unprofessional, as described in paragraphs 9 to 29 above.

34. With leave of the Discipline Committee, the College withdraws the allegation in paragraph 2 of the Notice of Hearing.

Decision

The panel finds that the Member committed acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing. Specifically that she failed to document or otherwise account for the withdrawal of funds from the accounts of clients in or about April 2009-February 2012.

As to allegation #3, the panel finds that the Member's failure to document or otherwise account for the withdrawal of funds from the accounts of clients in or about April 2009-February 2012 was conduct that would reasonably be considered by members to be 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.

Allegation #1 in the Notice of Hearing is supported by paragraphs 24, 27, 28, 29, 30, and 31 in the Agreed Statement of Facts. The Member failed to maintain records related to the names of the individuals who made purchase requests nor documentation related to delivery of those purchases. The Member's actions were in breach of the Hospital's PIN Money Policy as well as a breach of the College's *Documentation* and *Professional Standards*.

With respect to Allegation #3, the panel finds that the Member's conduct in failing to document or otherwise account for the withdrawal of funds from the accounts of clients set-out in Schedule A to the

Notice of Hearing in or about April 2009-February 2012 was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

Penalty

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

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

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

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

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

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

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

            1. the Panel's Order,
            2. the Notice of Hearing,
            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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

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

iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's 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 the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

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

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

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

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

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

1. the Panel's Order,
2. the Notice of Hearing,
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;

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

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

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

Penalty Submissions

Submissions were made by College Counsel and the Member's Counsel.

College Counsel stated that this is a case of failure to document. The seriousness of the lack of documentation led to allegations of misappropriation.

A mitigating factor in this case was that the Member admitted to her misconduct.

The proposed penalty provides for both specific and general deterrence through the reprimand and the one month suspension. Remediation of the Member's practice is supported through the meetings with the nursing expert and the employer notification, as the employer will be in a position to monitor the Member's practice to assist in avoiding future incidents.

Counsel for the Member stated that the mitigating factors included both the Member's admissions of misconduct as well as her having no previous disciplinary history with the College.

Specific deterrence is achieved through the suspension and employer notification while general deterrence is achieved through the overall penalty in that this type of misconduct is taken very seriously

Rehabilitation of the Member is supported through the meetings with the Nursing Expert.

Public protection is achieved though the Member meeting with the Nursing Expert as well as the employer notification of the hearing outcome.

Counsel submitted a case to the panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO vs Townend-Kolodziej (Discipline Committee, Aug., 2017)

This was a case involving a failure to maintain appropriate documentation related to narcotic medication administration. The parties stated that this was a documentation standards case with the difference being the level of significance of the impact between the two cases. In this case, the findings related to a failure to document related to a fundamental component of nursing practice, the

administration and management of narcotic medications. This was deemed a significant differentiator between the two cases and basis of why the parties proposed a lesser penalty in the current case.

Penalty Decision

The panel accepts the Joint Submission as to Order and accordingly orders:

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

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

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

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

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

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

            1. the Panel's Order,
            2. the Notice of Hearing,
            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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

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

        iv. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires and online participation forms;

        v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's 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 the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

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

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

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

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

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

1. the Panel's Order,
2. the Notice of Hearing,
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;

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

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

2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and

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

Reasons for Penalty Decision

The panel 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 suspension and reprimand will impress upon both the Member and members of the profession the seriousness of this misconduct. The meetings with the nursing expert will promote the remediation of the Member's practice and the employer notification will provide oversight for a period of time to ensure the Member is supported in her remediation.

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

I, Tanya Dion, RN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.

_____ _____

Chairperson Date