DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Dawn Cutler, RN	Chairperson
	Sylvia Douglas	Public Member
	Lalitha Poonasamy	Public Member
	Sherry Szucsko-Bedard, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
DENNIS SOPHA	)	MICHAEL MANDARINO for
Registration No. 0421412	)	Dennis Sopha
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: June 12, 2020

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 June 12, 2020, via teleconference.

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 publication or broadcasting of the names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Dennis Sopha.

The Panel considered the submissions of the Parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the names, or any information that could disclose the identities, of the patients referred to orally or in any documents presented in the Discipline hearing of Dennis Sopha.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(a)(v), 1(a)(vi), 3(e), 3(f), 4(e) and 4(f) in the Notice of Hearing dated March 2, 2020. The Panel granted this request. The remaining allegations against Dennis Sopha (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 a Registered Nurse at the North East Local Health Integration Network (the "Agency"), in [ ], Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that:

    a. you failed to maintain the appropriate boundaries of the therapeutic nurse-client relationship with [the Patient], including but not limited to:

        i. you engaged in a financial transaction unrelated to the provision of care with [the Patient] on or about June 13, 2016;

        ii. you provided [the Patient] with assistance and services unrelated to the provision of care between approximately May 2016 and May 2017;

        iii. you accepted the position(s) of power of attorney for personal care and/or property in relation to [the Patient];

        iv. you assisted with [the Patient]'s financial affairs;

        v. [withdrawn]; and/or

        vi. [withdrawn].

2. You have committed an act of professional misconduct as provided by sub-section 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 employed as a Registered Nurse at the Agency, you abused [the Patient] verbally, physically or emotionally, in that you assisted with [the Patient]'s financial affairs.

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(26) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at the Agency, you practiced the profession while in a conflict of interest in relation to [the Patient] in that:

a. you engaged in a transaction unrelated to the provision of care with [the Patient] on or about June 13, 2016;

b. you provided [the Patient] with assistance and services unrelated to the provision of care between approximately April 2016 and August 2017;

c. you accepted the position(s) of power of attorney for personal care and/or property in relation to [the Patient];

d. you assisted with [the Patient]'s financial affairs;

e. [withdrawn]; and/or

f. [withdrawn].

4. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that while employed as a Registered Nurse at the Agency, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that:

   a. you engaged in a transaction unrelated to the provision of care with [the Patient] on or about June 13, 2016;

   b. you provided [the Patient] with assistance and services unrelated to the provision of care between approximately May 2016 and May 2017;

   c. you accepted the position(s) of power of attorney for personal care and/or property in relation to [the Patient];

   d. you assisted with [the Patient]'s financial affairs;

   e. [withdrawn]; and/or

   f. [withdrawn].

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i), (ii), (iii), (iv), 2, 3(a), (b), (c), (d) and 4(a), (b), (c), (d) in the Notice of Hearing. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Dennis Sopha (the "Member") obtained a diploma in nursing from St. Lawrence College in 2004.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse on July 21, 2004.

3. The Member was employed by the North East Local Health Integration Network (the "NE LHIN") as a Care Coordinator between August 2015 and August 2017.

THE NE LHIN

4. As a Care Coordinator, the Member's role was to visit each of his assigned patients in their home and create a service plan for community homecare based on each patient's needs. The Member would then conduct ongoing assessments with his assigned patients and their caregivers.

5. The Member worked in a satellite office in [ ] for the NE LHIN which had its main office in [ ], Ontario. [ ] is a rural community in northern Ontario.

6. The Member's employment was terminated for cause following the NE LHIN's investigation into the incidents described below.

THE PATIENT

7. [ ] (the "Patient") was a 90-year-old woman who received homecare services through the NE LHIN. The Member was also the Patient's husband's Care Coordinator through the NE LHIN from April 15, 2015 until his death on May 16, 2016.

8. If the Member were to testify, he would state that the Member and the Patient's husband had developed a close personal friendship in the years before he began providing the Patient with care. During this period, the Member assisted the Patient and her husband with errands and tasks around the house. The Member would further testify that prior to the Patient's husband's death, the Patient's husband asked the Member to take care of and "look out for" the Patient once he died.

9. The Member was assigned to be the Patient's Care Coordinator as of May 2, 2016. According to the Member's manager, the Member requested to be assigned as the Patient's Care Coordinator. If the Member were to testify, he would say that he had notified his managers of his personal relationship with the Patient and the Patient's husband. He would testify that he was advised that he could provide the Patient with

nursing care despite the personal relationship, given that they lived in a small rural community, there was a lack of available nursing resources, and a Personal Support Worker would be providing the Patient with direct care. The Member did not, however, document these concerns or any such discussion with his manager in the Patient's records.

10. The Member was in a therapeutic nurse-patient relationship with the Patient at all relevant times.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Purchase of the Patient's Home and Possessions

11. Following the Patient's husband's death, the Member began to provide the Patient with services unrelated to his responsibilities as Care Coordinator, including grocery shopping, assisting her with tasks around the house, and running errands. If the Member were to testify, he would say the reason he did this was because of his promise to the Patient's husband to take care of the Patient.

12. On or about June 13, 2016, approximately six weeks after the Patient's husband died, the Patient, through her lawyer, approached the Member and asked him if he wanted to purchase her home as she was going to move into a retirement residence. If the Member were to testify, he would state that the Patient insisted on the purchase price of $20,000 because that was the amount her husband advised her to ask for, given the home's condition and the cost of the necessary renovations.

13. If the Member were to testify, he would say that he advised the Patient's lawyer that he did not know if he could enter into the transaction because he provided care to the Patient. The Member would further testify that he obtained legal advice and was advised that it was not a conflict to purchase the home if it was addressed in the Purchase and Sale Agreement.

14. The Agreement of Purchase and Sale Agreement included the following language:

> The [Patient] acknowledges that the [Member] has been responsible for co-ordinating care for her and for her late husband, and both parties wish to address the issue of whether or not a conflict of interest may exist. By her signature of this agreement, the [Patient] acknowledges that:
>
> A. She and her late husband approached the [Member] requesting his assistance in finding a purchaser for her home;
>
> B. The [Member] has made it clear that he is the one purchasing the property, and no one else;

C. The purchase price of $20,000 reflects the amount of repair required to upgrade the home to appropriate standards, and the fact that it is being sold on an as is basis;

D. The [Patient] has received independent legal advice as to the acceptance of this offer.

15. The Member purchased the Patient's home. The transaction also included the contents of the home, the Patient's car and a four-wheel drive ATV. The total purchase price the Member paid for the assets was $20,000. A subsequent investigation estimated the assets' value at more than $70,000. If the Member were to testify, he would say the $70,000 value did not take into account the condition of the home and the extent of construction it required.

16. The Member did not disclose the financial transaction to the NE LHIN.

17. After the NE LHIN learned of the financial transaction in or around May 2017, it conducted an investigation. As part of the investigation, the Patient advised that she set the purchase price for the assets, and she was the one who approached the Member to inquire about his interest in purchasing her home.

18. The Member admits and acknowledges that regardless of whether the Patient approached the Member with respect to the transaction, it was inappropriate for him to engage in a financial transaction with the Patient at a time when he was in a nurse-patient relationship with her, and that he put himself in a situation where his personal interests could improperly influence his professional judgment, or conflict with this duty to act in the best interests of the Patient. He also acknowledges that the provision in the Agreement of Purchase and Sale acknowledging the conflict of interest does not relieve him of his professional obligations, and that the legal advice he received did not address his professional obligations.

19. The Member further admits and acknowledges that his actions were contrary to the *Therapeutic Nurse-Client Relationship* Standard ("*TNCR Standard*") which prohibits nurses from engaging in financial transactions unrelated to the provision of care, and engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse, or result in monetary or personal loss for the patient.

20. The Member admits and acknowledges that his actions were contrary to NE LHIN's Conflict of Interest Policy which prohibits employees from engaging in any business or transaction, or having a financial or other personal interest, that is incompatible with their duties or responsibilities.

Management of and Assistance with Personal and Financial Affairs

21. After the sale of her home, the Patient moved into a retirement home. The Member continued to be assigned to provide the Patient with Care Coordinator services after she

moved to the retirement home. He also continued to assist the Patient in his personal capacity including visiting her socially, paying her bills, and running errands for her. If the Member were to testify, he would say that the Patient requested he complete these tasks.

22. If the Member were to testify he would state that he had initially paid for the Patient's personal items himself and she subsequently insisted that she pay for her own groceries, and prescriptions. He would say that it was on this basis that on January 26, 2017, the Member was issued a bank card that provided him access to the Patient's bank account.

23. The Patient formally appointed the Member to be her power of attorney for personal care, her power of attorney for property, and her power of attorney for financial affairs. The Member accepted these positions.

24. If the Member were to testify he would state that he advised the NE LHIN that he was assisting the Patient with personal errands, but that he did not advise that he had accepted and was using her ATM card. The Member acknowledges that he did not document any such discussion with the NE LHIN about the assistance he was providing the Patient, nor did he otherwise document that he was assisting the Patient as described in this Agreed Statement of Facts.

25. The Member admits and acknowledges that in accepting these positions as the Patient's power of attorney for personal care, her power of attorney for property, and her power of attorney for financial affairs, and in assisting the Patient with her personal affairs, he put himself in a situation where his personal interests could improperly influence his professional judgment, or conflict with his duty to act in the best interests of the Patient. In addition, the Member admits and acknowledges that he did not notify the NE LHIN that he accepted the power of attorney positions, or that he was assisting the Patient with her financial affairs.

26. The Member further admits and acknowledges that his conduct crossed the boundaries of the professional and therapeutic relationship with the Patient.

27. In addition, the Member admits and acknowledges he also engaged in financial abuse, as defined in the *TNCR Standard*, insofar as he had power of attorney over the Patient's financial affairs, and that he assisted with the Patient's financial affairs without the healthcare team's knowledge.

Revisions to the Patient's Will

28. On November 9, 2016, the Patient revised her last will and testament to name the Member as an alternative trustee and the beneficiary of 95% of her estate, which is estimated to be worth over $800,000. In two places in her will, the Patient described the Member as "my friend, Dennis Sopha". If the Member were to testify, he would say he

understood the Patient revised her will as her husband had requested, prior to his death. There has been no challenge to the validity of the will or the Patient's capacity.

29. If the Member were to testify, he would state that he was not aware that he was named as beneficiary and alternative trustee at the time the Patient executed the revised will. However, the Member admits and acknowledges that the fact the Patient named him as a beneficiary and alternative trustee exceeds the boundaries of the therapeutic nurse-patient relationship.

30. As of the date of this Agreed Statement of Facts, the Member continues to have a personal relationship with the Patient.

CNO STANDARDS

31. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets legislative requirements and the standards of practice of the profession.

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

- identifying ethical issues and communicating them to the healthcare team; and
- identifying personal values and ensuring they do not conflict with professional practice.

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

34. CNO's *TNCR Standard* places the responsibility for establishing and maintaining the limits and boundaries in the therapeutic nurse-patient relationship on the nurse. The *TNCR Standard* provides that:

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

35. With respect to maintaining boundaries, a nurse demonstrates having met the *TNCR Standard* by actions such as:

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

- ensuring that any approach or activity that could be perceived as a boundary crossing is included in the care plan developed by the health care team;

- recognizing that there may be an increased need for vigilance in maintaining professionalism and boundaries in certain practice settings, such as a [patient's] home;

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

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

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

- documenting [patient]-specific information in the [patient's] record regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation.

36. CNO's *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, a nurse demonstrates having met the *TNCR Standard* by actions such as:

- not entering a friendship, or a romantic, sexual or other personal relationship with a [patient] when a therapeutic relationship exists;

- not engaging in activities that could result in monetary, personal or other material benefit, gain or profit for the nurse (other than the appropriate renumeration for nursing care or services), the nurse's family and/or the nurse's friends, or result in monetary or personal loss for the [patient]; and

- not accepting the position of power of attorney for personal care or property for anyone who is or has been a [patient], with the exception of those [patients] who are direct family members of the nurse.

37. In addition, the *TNCR Standard* further provides that financial abuse includes having financial trusteeship, power of attorney or guardianship, and assisting with the financial affairs of a patient without the health care team's knowledge.

38. The Member acknowledges and admits that his actions breached the *TNCR Standard*.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

39. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a)(i) to (iv) 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 11 to 38 above.

40. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing in that he abused the Patient verbally, physically or emotionally in that he assisted with the Patient's financial affairs, as described in paragraphs 21 to 27 and 36 to 38 above.

41. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a) to (d) of the Notice of Hearing in that he practiced the professionwhile in a conflict of interest in relation to the Patient, as described in paragraphs 11 to 30 above.

42. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 4(a) to (d) of the Notice of Hearing, and in particular his conduct was dishonourable and unprofessional, as described in paragraphs 11 to 30 above.

OTHER

43. With leave of the Panel of the Discipline Committee, CNO withdraws the remaining allegations in the Notice of Hearing, which are as follows:

- 1(a)(v);
- 1(a)(vi);
- 3(e);
- 3(f);
- 4(e); and
- 4(f).

Decision

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

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i), (ii), (iii), (iv), 2 and 3(a), (b), (c), (d) of the Notice of Hearing. As to Allegations #4(a), (b), (c) and (d), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional.

As for Allegation #2 the Panel makes the finding of only emotional abuse.

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)(i), (ii), (iii) and (iv) in the Notice of Hearing are supported by paragraphs 11-39 in the Agreed Statement of Facts. The Member failed to maintain the standard of practice of the profession, namely the *Therapeutic Nurse-Client Relationship* Standard (the "*TNCR Standard*") when he engaged in a financial transaction with the Patient, unrelated to the provision of care and services. The *TNCR Standard* states that "nurses are responsible for effectively establishing and maintaining the limits or boundaries in the therapeutic nurse-client relationship". The *TNCR Standard* bans nurses from engaging in financial transactions unrelated to the provision of care and any activity that could result in monetary or personal gain. The Member admitted to engaging in activities that led to the Member purchasing the Patient's home, car and four-wheel drive ATV for a price below their value.

Allegation #2 in the Notice of Hearing is supported by paragraphs 21-27, 36-38 and 40 in the Agreed Statement of Facts. The Panel made the finding of emotional abuse of the Patient by the Member as he assisted with the Patient's financial affairs and on the basis of the evidence that the Member took advantage of an elderly, vulnerable woman after the death of her spouse. The Member accepted the position of power of attorney for personal care and/or property during the time care was actively being provided to the Patient. The *TNCR Standard* provides that financial abuse includes having financial trusteeship, power of attorney or guardianship, and assisting with the financial affairs of a patient without the health care team's knowledge. The Member's employer was not aware the Member was involved in the Patient's financial affairs until May 2017 when an investigation was conducted. The *TNCR Standard* requires nurses to protect the patient from harm by ensuring that abuse is prevented or stopped and reported and this includes not engaging in activities that could result in monetary, personal or material benefit, gain or profit for the nurse (other than remuneration for nursing care or services). By being involved in and the beneficiary of the Patient's house sale transaction, the Member failed to meet this standard.

Allegations #3(a), (b), (c) and (d) in the Notice of Hearing are supported by paragraphs 11-30 and 41 in the Agreed Statement of Facts. The Member admitted in paragraph 41 that he committed the acts of professional misconduct as alleged in paragraphs 3(a), (b), (c) and (d) of the Notice of Hearing in that he practiced while in a conflict of interest in relation to the Patient. The College's *Professional Standards* provide that ethical nursing includes acting with integrity, honesty and professionalism in all dealings with the Patient and other health care team members by identifying personal values and ensuring they do not conflict with professional practice. The Member admits in paragraph 18 of the Agreed Statement of Facts that it was inappropriate for him to engage in a financial transaction regardless of who initiated it while he was in a nurse-patient relationship with the Patient.

With respect to Allegations #4(a), (b), (c) and (d), the Panel finds that the Member's conduct would reasonably be regarded by members of the profession as unprofessional and dishonourable. The Member's conduct was unprofessional in that he demonstrated a serious disregard for his professional obligations. The Member's conduct showed a lack of good judgement when he entered into financial arrangements with the Patient. The Panel also finds the Member's conduct to be dishonourable. The Member demonstrated an element of dishonesty when he used his position as a nurse in the relationship

for financial gain. The Member did not advise his Employer that he was using the Patient's ATM card, or that he accepted the power of attorney for the Patient's personal and financial affairs. The Member ought to have known, that due to the nurse-client relationship, and the Patient's age she would have been trusting and vulnerable. The Member knew or ought to have known that his conduct was unacceptable and fell below the standards of the profession.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 8 months. This 8 month suspension shall take effect from September 1, 2020 and shall continue to run without interruption as long as the Member remains in the 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 his 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 the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date 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 the Director of Professional Conduct (the "Director") in advance of the meetings;

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

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

        iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires,

online learning modules, decision tools and online participation forms (where applicable):

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

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

v. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms and Nurses' Workbook;

vi. 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;

vii. 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 his behaviour;

viii. 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 his certificate of registration;

b) For a period of 18 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including

the period during which the Member's certificate of registration is suspended), the Member will notify his 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 his 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.

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member benefited financially from his inappropriate relationship with the Patient;
- The Patient was elderly and vulnerable;
- The Member has had a long standing relationship with the Patient where boundaries had not been respected;
- The Member's conduct was done in full knowledge and intent for his own personal gain;
- There was a need for vigilance, particularly given the relationship the Member had with the Patient's husband.

The mitigating factors in this case were:

- The Member has no prior disciplinary record;
- The Member has been cooperative;
- The Member did not contest the hearing, and has accepted accountability for his actions by agreeing to the Agreed Statement of Facts and the Joint Submission on Order;

- The Member did seek legal advice prior to the purchase of the Patient's property.

The proposed penalty provides for general and specific deterrence through:

- The eight month suspension;
- The oral reprimand.

The proposed penalty provides for remediation and rehabilitation through:

- The terms, conditions and limitations placed on the Member's certificate of registration, including two meetings with a Nursing Expert which will allow the Member to reflect on his professional standards and requirements.

Overall, the public is protected because:

- The proposed Joint Submission on Order, in its totality, is geared toward public protection. The order sends a message to nurses that there are consequences for their behaviour, and to the public of the profession's ability to self-regulate.
- In particular, the 18 month employer notification will protect the public because of the increased employer awareness and understanding of the Member's past actions.

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

CNO v. Steen (Discipline Committee, November 2018): The member failed to maintain the boundaries of the therapeutic nurse-client relationship and engaged in a financial transaction unrelated to the provision of care and services with the client. The member was given a penalty of an oral reprimand and her certificate of registration was revoked due to the significant financial amount involved in the transactions.

CNO v. Eno (Discipline Committee, January 2016): The member failed to maintain appropriate therapeutic boundaries with the spouse of the client by accepting money from the vulnerable client's spouse as well as entering into a personal relationship with the client's spouse. The member signed an undertaking resigning her certificate of registration.

CNO v. O'Connell (Discipline Committee, March 2019): The member failed to maintain the boundaries of the therapeutic nurse-client relationship and engaged in a personal relationship with the client. The member was given a penalty including an oral reprimand, a five month suspension, and two meetings with a Nursing Expert.

CNO v. MacDonald (Discipline Committee, November 2017): The member failed to maintain the boundaries of the therapeutic nurse-client relationship; entered into financial arrangements as a personal relationship with a former client; and practiced the profession while in conflict of interest. The member was given a penalty including an oral reprimand, a four month suspension, and two meetings with a Nursing Expert.

The Member's Counsel submitted that the proposed penalty sends a message to the Member and the profession that such conduct will have serious consequences and thereby addresses general and specific

deterrence. The terms, conditions and limitations on the Member's certificate will address rehabilitation and remediation of the Member and the public is protected by the 18 month employer notification.

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 8 months. This 8 month suspension shall take effect from September 1, 2020 and shall continue to run without interruption as long as the Member remains in the 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 his 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 the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date 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 the Director of Professional Conduct (the "Director") in advance of the meetings;

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

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

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

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

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

v. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms and Nurses' Workbook;

vi. 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;

vii. 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 his behaviour;

viii. 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 his certificate of registration;

b) For a period of 18 months from the date this Order becomes final during which the Member is engaged continuously in the practice of nursing (i.e. not including the period during which the Member's certificate of registration is suspended), the Member will notify his 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 his 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.

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The Panel recognized the seriousness of the Member's conduct. The Member repeatedly made decisions that involved an elderly, vulnerable patient for his own financial gain. Members of the profession will be reminded that failing to maintain the appropriate boundaries of the therapeutic nurse-client relationship will not be tolerated.

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

I, Dawn Cutler, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.