DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Carly Gilchrist, RPN	Chairperson
	Grace Fox, NP	Member
	Mary MacNeil, RN	Member
	Devinder Walia	Public Member
	Christopher Woodbury	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JESSICA LATIMER for
	)	College of Nurses of Ontario
	)	
- and -	)	
	)	
	)	
MONIKA DI RUSCIO	)	NO REPRESENTATION for
Registration No.: JH708044	)	Monika Di Ruscio
	)	
	)	
	)	
	)	PATRICIA HARPER &
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: October 17 – 18, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") beginning on October 17, 2019 at the College of Nurses of Ontario (the "College") at Toronto.

As Monika Di Ruscio (the "Member") was not present at the scheduled time of 0930 for the commencement of the hearing, the hearing was recessed for 15 minutes to allow time for the Member to appear. Upon reconvening the Panel noted that the Member was still not in attendance.

College Counsel introduced as Exhibit 2 the Affidavit of [College Staff Member A] which provided evidence that the Notice of Hearing in this matter was sent to the Member by regular mail on June 21, 2019 at the last known address for the Member in the College's records. The Panel was satisfied that the Member had received adequate notice of this hearing and proceeded with the hearing in the Member's absence.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated June 21, 2019, 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(14) of *Ontario Regulation 799/93*, in November 2017, while working for Right at Home Canada, in that you falsified records relating to your practice, and in particular, you indicated in patient records that you were a registered practical nurse and/or a nurse, when your certificate of registration was suspended.

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(16) of *Ontario Regulation 799/93*, in or around November 2017, while working for Right at Home Canada, in that you inappropriately used a term, title or designation in respect of your practice, and in particular, you indicated in patient records that you were a registered practical nurse and/or a nurse, and/or held yourself out to clients and your employer as a registered practical nurse and/or a nurse, when your certificate of registration was suspended.

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(17) of *Ontario Regulation 799/93*, in November 2017, while working for Right at Home Canada, in that you used a name other than your name, as set out in the register, in the course of providing or offering to provide services within the scope of practice of the profession except where the use of another name is necessary for personal safety and provided the employer and the College have been made aware of the pseudonym and the pseudonym is distinctive, and in particular you identified yourself as Monika Barylski to clients and/or your employer when your name as set out in the College register was Monika Di Ruscio.

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(18) of *Ontario Regulation 799/93*, in November 2017 while working for Right at Home Canada, in that you contravened a term, condition or limitation on your certificate of registration, and in particular, you practiced nursing when your certificate of registration was suspended.

5. 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(19) of *Ontario Regulation 799/93*, in November 2017, while working for Right at Home Canada, in that you contravened a provision of the *Nursing Act, 1991*, the *Regulated Health Professions Act, 1991* or the regulations under

either of those Acts, and in particular, you contravened subsections 11(1) and 11(5) of the *Nursing Act, 1991*, by using the title registered practical nurse and/or nurse, or a variation thereof, and by holding yourself out as a person who is qualified to practice in Ontario as a registered practical nurse and/or nurse, when your certificate of registration was suspended.

6. 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 or around November 2017, while working for Right at Home Canada, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in particular,

    a. you practised nursing when your certificate of registration was suspended;

    b. you indicated in patient records that you were a registered practical nurse and/or a nurse when your certificate of registration was suspended;

    c. you held yourself out to clients and your employer as a registered practical nurse and/or a nurse when your certificate of registration was suspended;

    d. you asked a client to provide you with saline syringes and/or needles; and/or

    e. you took saline syringes from a client.

Member's Plea

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

Overview

The Member was a Registered Practical Nurse (RPN) who was not entitled to practise from November 17, 2016 to February 27, 2018 as a result of an interim Order by the Inquiries, Complaints and Reports Committee ("ICRC") dated November 17, 2016 directing the Executive Director to suspend the Member's Certificate of Registration. During this time, the Member was hired by Right at Home Canada to provide nursing services to clients. Both "patient" and "client" are specified in the Notice of Hearing. For consistency, throughout the Decision and Reasons, the word client shall be used in reference to both client and patient. The Notice of Hearing contained 6 allegations against the Member. All of the alleged conduct took place when her certificate of registration was suspended. However, in accordance with s. 14(1) of the *Health Professions Procedural Code*, the Member continued to be subject to the jurisdiction of the College for professional misconduct referable to the time when the Member was suspended.

The allegations against the Member are that: she indicated in client records that she was a nurse while she was suspended, she inappropriately used the title of "RPN" with her clients and employer

while suspended, she used a different name than what was registered at the College, she contravened the terms, conditions and limitations of her certificate of registration while suspended, and held herself out as a nurse while suspended contrary to the *Nursing Act, 1991*, the *Regulated Heath Professions Act, 1991* and the *Health Professions Procedural Code, 1991*.

College Counsel led evidence consisting of 14 exhibits and 3 witnesses. The witnesses were:

[Witness A], College Monitoring Team Lead who reviewed the College's records of the Member's registration status, name and address records and the ICRC letter of suspension to the Member.

[Witness B], the System Support Manager for Right at Home Canada, the nursing agency where the Member was employed, during the time when all of her misconduct was alleged to have occurred. [Witness B] testified that the Member applied to Right at Home Canada and worked as an RPN, holding herself out as a practising RPN under the name Monika Barylski. Evidence in the form of the Member's resume and certificate of registration with the College in the name of Monika Barylski, both as submitted to Right at Home Canada, were entered into evidence.

[Witness C] is the husband of [the client], the client who was unable to attend the hearing due to her poor health. He was present during the nursing care provided by the Member. He also uncovered the fact that the Member was not registered and made the initial complaint to the College. He testified that the Member provided nursing care to his wife in their home and, in addition, requested vials of normal saline, which he provided, and needles, which he was not able to provide.

The Panel found that there was sufficient evidence to support Allegations #1 through #5 and as to Allegations #6(a), (b) and (c), the Panel found that the Member's conduct would reasonably be regarded by members of the profession as disgraceful, dishonourable and unprofessional. As to Allegations #6(d) and (e) the Panel found that there was insufficient evidence to support the allegations and therefore dismissed these allegations.

The penalty proposed by the College was tempered by the mitigating circumstances of the Member.

College Counsel submitted that the Panel should make its decision on penalty having taken into account that it is not unreasonable to suspect that there is a connection between the basis of the Member's suspension by the Fitness to Practise Committee and the facts underlying this case and that as a result the imposition of a penalty short of revocation would be appropriate in this particular case.

The Evidence

College Counsel gave a review of the relevant legislation related to the allegations:

While section 13(2) of the *Health Professions Procedural Code* ("*Code*") states that "a person whose certificate of registration is suspended is not a member", section 14(2) of the *Code* states that "A person whose certificate of registration is suspended continues to be subject to the jurisdiction of the College for incapacity and for professional misconduct or incompetence referable to the time when the person was a member or to the period of the suspension and may be investigated under section 75".

The *Nursing Act, 1991* also provides so far as is relevant

(i) in section 11(1), that "no person other than a member shall use the title "nurse"…" [or]"registered practical nurse", a variation or abbreviation or an equivalent in another language" and

(ii) in section 11(5), that "no person other than a member shall hold himself or herself out as a person who is qualified to practise in Ontario as a nurse…[or] practical nurse…".

Accordingly, pursuant to section 13(2) of the *Code* referred to above, a suspended member of the College is not a "member" for the purposes of section 11 of the *Nursing Act, 1991*. Although not a member for the purpose of Section 11 of the *Nursing Act* this document will refer to Monika Di Ruscio as the "Member" for ease of reference and consistency throughout the Decision and Reasons.

Witness #1 [Witness A]

[Witness A] is the College Monitoring Team Lead. She has been employed at the College since November 2013. She has held positions within the organization initially as Investigations Assistant, giving administrative support to investigators, then as Administrative Assistant to Professional Conduct which led to her current role beginning in January 2015. Her role is to oversee, monitor and administer orders of and undertakings accepted by committees, including monitoring timelines and deadlines. She responds to inquiries regarding orders and assists in providing information to members on how to comply and submit the documents required for those Orders/Undertakings and collects compliance information from employers and health care agencies. She also maintains the public register for the College.

College Counsel presented as evidence a copy of the public register report (Exhibit #3) of the Member. This showed that the Member is an RPN currently suspended since December 3, 2018. There is also a suspension noted from November 17, 2016 to February 27, 2018 pursuant to an order of the ICRC dated November 17, 2016. [Witness A] identified a letter dated November 18, 2016 from the College to the Member informing her of the Order made by the ICRC on November 17, 2016 to direct the Executive Director to suspend the Member's certificate of registration (Exhibit #4). A copy of that Order was enclosed with the letter. [Witness A] stated she was not the person who sent the letter to the Member but confirmed that the letter was sent. The address to which it is addressed came from the Member's information with the College. [Witness A] stated that the public register was updated to reflect the suspension and that the Member's stated employers were notified as per normal practice.

A written summary of a voicemail message left for the Member on November 18, 2016 at the telephone number for the Member according to the College's records by [College Staff Member B], formerly a monitoring administrator with the College, was introduced into evidence (Exhibit #5). The note indicated that the message left for the Member was that the call was being made to the Member concerning new information on the public register and advising her to review that new information on the Member's profile.

College Counsel reviewed the 2 data tracking systems that have been in place at the College with [Witness A] who testified that FLO was the previous system which was replaced with the Pulse system in July 2017. A printout of the Member's profile shows the Member's address and postal code is the same as those used on the letter from the ICRC. The effective date of the entry was April 29, 2016. Printouts of the Member's profile from both systems show that the Member's address and postal code according to the College's records were the ones used to send the letter to the Member notifying her of the ICRC's decision concerning her suspension dated November 18, 2016. Those printouts also show that the Member's address according to the College's records has remained unchanged since April 29, 2016 (Exhibit #6). A screen shot of the FLO system's profile of the Member was presented which showed the Member's home address as unchanged and the phone number documented being the same as the one used to leave a message for the Member regarding the status of her Find a Nurse profile. The FLO screenshot also shows a previous address under history which was changed by the Member on April 28, 2016 (Exhibit #7). A copy of the FLO system name change screen was also presented into evidence which shows the member changed her name on October 12, 2010 (Exhibit #9).

[Witness A] reviewed the College records indicating that until October 12, 2010, the Member's name, as provided to the College, was Monika Barylski. On October 12, 2010, her name was changed with the College to Monika Di Ruscio (Exhibit #8). The records indicate that the Member provided the College with a copy of her marriage certificate to support her change of name.

Witness #2 [Witness B]

[Witness B] is the System Support Manager for Right at Home Canada and has held this position for the past 5 years in St. Catharines, Ontario. Right at Home Canada is a private in-home care company which employs nurses and personal support workers to provide visiting, personal and homecare support, as well as nursing.

[Witness B] identified a document entitled the Regulated Health Professional ("RHP") Job Description for the company effective October 2014 (Exhibit #10). The first 3 duties listed on Exhibit #10 were: to conduct nursing assessments of clients, perform tasks that are permitted within the scope of practice according to the skills lists as dictated by the respective governing college or body, abide by the "Controlled Acts" of respective provinces, and administer medication to clients and provide medication reminders. [Witness B] stated that it was a requirement in 2017, for anyone working for Right at Home Canada as a nurse in Ontario, to have a valid certificate of registration with the College. A resume submitted to Right at Home Canada in the autumn of 2017 was presented under the name of Monika Barylski which [Witness B] stated was the name under which the Member was hired. College Counsel noted that the most recent employment listed on the resume (Exhibit #11) was with Source Momentum Healthcare in Niagara and the resume indicates that the Member was still employed there at the time of preparation of the resume. A Certificate of Registration with the College was presented by the Member to Right at Home Canada dated December 29, 2008 under the name Monika Barylski (Exhibit #11). [Witness B] stated that the Member presented this as her confirmation of registration with the College and on that basis was hired.

College Counsel presented a Payroll Report for Right at Home Canada of Monika Barylski (Exhibit #12) showing the caregiver category as RPN and the dates that the Member actively worked in that

role. The dates and client named under the role of RPN are those noted in the allegations. The Member also worked at times as a personal support worker for Right at Home Canada but the time entries for that work were redacted from the report.

[Witness B] stated that she received a call and was made aware of the client's concerns about the registration status of the Member on November 25, 2017. [Witness B] then called the Member and told her she was unable to work in the RPN role with Right at Home Canada.

Right at Home Canada provides nurses with medical supplies as well as some equipment. It is not uncommon for [clients] to have their own stock of supplies. [Witness B] was asked if a nurse would or should ask one client for supplies to use for another client and she confirmed that no such request should be made.

Witness #3 [Witness C]

[Witness C] is married to [ ], the client referred to in the Notice of Hearing. The client has continuing health issues and was unable to attend the hearing. [The client]'s husband attended the hearing in her place and testified as to his knowledge of [the client]'s health, her clinical needs and interactions with the Member. [Witness C] reviewed [the client]'s previous medical history related to her diagnosis at the time of the alleged conduct of the Member. She was being treated by an oncologist in St. Catharines following a lengthy hospital stay.

During her first round of chemotherapy the client developed immune deficiency and contracted pneumonia leading to intubation and admission to intensive care. Once discharged she required 5 chemotherapy sessions, "blood thinners" and "blood boosters" in a time sensitive daily regimen. In collaboration with her physician a nursing-care plan was put together whereby an RN would attend to give injections. [Witness C] testified that he was not comfortable administering the injections himself. This was covered by their insurance plan and so he sought out Right at Home Canada to provide the services required in their home.

College Counsel presented [the client]'s client record which was completed by Right at Home Canada staff and included [the client]'s personal journal of diet and symptoms, as well as pharmacy receipts. A copy of the Insurance Plan (Chamber of Commerce) form filled out by the physician was presented and noted the level of care provider as RPN. The type of medication and how it was to be administered and recorded on the form, was reviewed. [Witness C] stated that the Neutrophil stimulator was time sensitive and required that it be given within an hour of the 24 hour frequency. Under the "exact duties" it does not state injections but this is assumed and stated above on the form. [Witness C] stated that a nurse was required as [the client] required monitoring for febrile neutropenia (contributed to her previous pneumonia) and stasis ulcer care.

Right at Home Canada's services were started September 2017. There was initially a challenge with timing and continuity of care and it was decided that one contact would be more consistent and decrease exposure to any pathogens. The Member was presented as the nurse most able to provide continuity of care and started November 2017. [Witness C] was present when care was provided to [the client] by the Member. The Member used the name Monika Barylski verbally and in written notes on the client's chart. The Member completed; the ordered injections, general care,

assessments including vital signs, wound care, PICC line checks, and occasionally giving [the client] a bath and assisting with getting [the client] out of bed.

The client record was kept in the home. The Medication Administration Record of Right at Home was presented. It showed the initials M.B. were used to sign for the medication given. There was a note at the top of the record stating "Non-licensed personnel may not administer medication". A Signature Record sheet signed by Monika Barylski with the same initials was used for comparison. M.B. signed with the designation of RPN. A vital signs record was presented to the Panel. It was initialled by M.B. and a nursing note dated November 19, 2017 stating that both medications were given was signed by M.B. The second entry in the nursing note dated November 22, 2017 was not signed.

College Counsel asked [Witness C] to review the time when the Member requested syringes. [Witness C] stated that the PICC line care kit was provided by the Local Health Integration Network ("LHIN") and [the client] was provided with vials of normal saline. This kit and normal saline were kept in another room within the house as they were not used daily. On one occasion the Member asked if she could take 2 vials of normal saline to use for her next client and [Witness C] gave them to her. The next evening the Member stated that she did not pick up any normal saline from the office and asked [Witness C] for more vials and, in addition, asked whether [Witness C] had any needles. The injections came in prefilled syringes with needles that were self-closing so [Witness C] did not have any needles but provided the Member with 2 more vials of normal saline.

[Witness C] and his wife became concerned on the evening of the Member's last visit. The injections were given and [the client] requested assistance with her bath. [Witness C] prepared the bath and took his wife upstairs. The Member was left alone in the living room for a short period of time. [The client]'s Dilaudid (pain medication) for breakthrough pain was on the table. The bath was completed and [the client] was assisted to bed. About 1.5 hours later [the client] developed severe pain and [Witness C] went to the medication box to retrieve the Dilaudid. [Witness C] states that his wife is very organized and meticulous. The emergency (breakthrough) Dilaudid was missing. [The client] remembered that she had 3 doses left. [The client] was able to use her scheduled Dilaudid which was a higher dose. This aroused suspicion and [the client] called her sister who was a retired nurse. She was told to look up the Member on line on the "Find a Nurse" website. [Witness C] could find no reference to Monika Barylski and was alarmed. [The client] found the name Monika Barylski on Instagram and that she also went by Monika Di Ruscio. [Witness C] found the Member, listed as Monika Di Ruscio, on the "Find a Nurse" website and noted that her registration was suspended. He then called the emergency number of the agency since it was a Sunday evening and cancelled the Member for the next visit and requested a call from a manager at the agency as soon as possible. The agency sent a different nurse for the evening visit. In the morning after 1000 hours, [Witness C] called the agency as he had not heard back from them, and the person he spoke to was deeply apologetic but no action was taken. He then called St. Elizabeth to change service providers and had to complete the entire care plan once again. He then contacted the College with his concerns as the reason for the Member's suspension was non-specific and he did not know what risk the Member might pose to public safety.

[Witness C] stated that the events made him feel very gullible. He testified that he had invited someone into his home to take care of the most precious thing he had, and he failed. He stated that he had trust in a nurse as much as a doctor and when this trust is broken one feels "had". He had not

verified that the Member was a nurse. There was no badge or picture. He assumed that due diligence had been done and feels misled.

Final Submissions

College Counsel reviewed the evidence related to each of the allegations and submitted that the evidence established that all of the alleged incidents of misconduct had been made out.

Allegation #1

College Counsel submitted that the evidence showed that the Member had falsified client records by indicating that she was an RPN or a nurse at times when her certificate of registration was suspended. College records show that the span of the relevant suspension was from November 17, 2016 to February 27, 2018. The relevant events took place during this period, in November 2017. The Member had been notified of her suspension by a letter from the ICRC dated November 18, 2016.

Specifically, College Counsel submitted that the Member indicated, as Monika Barylski in the signature record sheet, that she was an RPN. She then signed or initialled various client records, including the Medication Administration Record containing the notation "Non-licensed personnel may not administer medication" as Monika Barylski or "M.B.". College Counsel submitted that, based on the foregoing, every signature or initialing by the Member on the client records should be taken as indicating that she was an RPN.

Allegation #2

College Counsel submitted that the evidence shows that the Member had held herself out to clients and to Right at Home Canada, her employer, as an RPN or nurse while suspended. With regard to clients, [Witness C]'s evidence was that the Member had presented herself to him and [the client] as a nurse in November 2017. With regard to Right at Home Canada, [Witness B]'s evidence was that the Member's resume and job application in that same month described her as an RPN. The evidence also shows that, during this period, the Member was suspended and that the Member had been notified of her suspension.

Allegation #3

College Counsel submitted that the evidence shows that the Member used a name (Monika Barylski) other than her name as set out in the College's records (Monika Di Ruscio). The College's records show that, since October 2010 the Member's name in the College records was Monika Di Ruscio. The evidence shows that she applied for a job with the name Monika Barylski, and was hired by Right at Home Canada, as Monika Barylski. [Witness C] also testified that the Member identified herself to him as Monika Barylski.

Using the name of Monika Barylski allowed the Member to use her initial registration certificate from the College for employment and made it difficult to find her registration status on the College's website. It was by chance that [Witness C] and [the client] were able to find the Member through other means through an internet search.

Allegation #4

College Counsel submitted that the evidence shows that the Member contravened a term, condition or limitation on her certificate of registration by practising nursing while suspended. College Counsel referred to section 3 of the *Nursing Act, 1991* which defines the practice of nursing and to section 4 of that Act which sets out various acts which only a nurse is authorized to perform, one of which is administering a substance by injection or inhalation. College Counsel submitted that the evidence shows that, while she was suspended, the Member was hired by Right at Home Canada as a nurse and that both the evidence of [Witness C] and the client records for [the client] initialled by "M.B." demonstrate that the Member did administer injections to [the client] during the period when she was suspended.

Allegation #5

College Counsel further submitted that the evidence shows that the Member contravened section 11(1) of the *Nursing Act, 1991*, which provides that no person other than a member of the College (with a suspended member not constituting a "member" for this purpose) shall use the title "nurse" or "registered practical nurse" or any variation or abbreviation thereof, and section 11(5) of the same Act, which provides that no person other than a member of the College who is not suspended shall hold himself or herself out as a person qualified to practise in Ontario as a nurse or practical nurse. College Counsel referred to the ICRC's suspension of the Member in effect from November 17, 2016 to February 27, 2018 and the evidence that during that time period she had applied to Right at Home Canada for employment as an RPN and, according to [Witness C]'s testimony, had presented herself to him and his wife as a nurse.

Allegation #6

College Counsel submitted that Allegations #6(a), (b) and (c) constitute disgraceful, dishonourable, and unprofessional conduct as the Member practised nursing while suspended, held herself out as a nurse and documented as a nurse. Members are required to practice legally and within the scope of terms, conditions and limitations on their certificate of registration. By not abiding by the suspension and holding herself out and working as a nurse she contravened the *Nursing Act, 1991*. This was an act of deception, as the Member was able to apply for employment using an old certificate of registration under a former name as if this was still current. This made it difficult to find her actual registration status. She showed a disregard for her professional obligations and the allegations cast serious doubt on her moral fitness and her ability to discharge the higher obligations that the public and the College expect of nurses. [Witness C] gave testimony on the effect the events had on his trust in nurses.

Allegations #6(d) and #6(e) relate to asking for and taking items from clients.

College Counsel referred to the *Therapeutic Nurse-Client Relationship* Standard (2006) (Exhibit #14) which states that a nurse meets this standard by abstaining from accepting individual gifts except in the rare circumstances enumerated, none of which is applicable here. College Counsel submitted that what is alleged to have occurred here does not clearly meet the definition of a gift but submitted that it is clear that nurses are not supposed to take things from clients or to ask for them and that doing so is unprofessional.

College Counsel submitted that this is also disgraceful and dishonourable as [Witness B] stated that nurses are not expected to ask for supplies from one client to give to another client. This was a false reason and a deceitful way of getting things, which shows a moral failing as well.

The Panel requested submissions addressing the fact that Allegation #6(d) in the Notice of Hearing alleged that the Member had asked a client for "saline syringes" and Allegation #6(e) alleged that she had taken "saline syringes" from a client while the evidence of [Witness C] was that the Member had asked for "vials of saline" and that he had given her "vials of saline". College Counsel submitted that syringes and vials are the same thing and that a lay person could use these terms interchangeably. Normal saline syringes were part of the PICC line care kit and were kept separate from the other medications and therefore the terms used were not at issue. College Counsel submitted that the Panel should look at the totality of the evidence when making a decision and accept that the evidence establishes that Allegations #6(d) and (e) had been established.

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 to 5 in the Notice of Hearing. The Member: indicated in client records that she was a registered practical nurse and/or a nurse when her certificate of registration was suspended, held herself out to clients and her employer as a registered practical nurse and/or a nurse when she was suspended, used a name (Monika Barylski) other than the name set out in the College register (Monika Di Ruscio) in the course of providing or offering to provide services within the scope of the practice of nursing, contravened a term, condition or limitation on her certificate of registration by practising nursing while suspended and contravened sections 11(1) and 11(5) of the *Nursing Act, 1991* by using the title "nurse" and/or "registered practical nurse" and holding herself out as a person qualified to practise nursing in Ontario while her certificate was suspended.

With respect to Allegation #6, the Panel finds that the allegations, as described in paragraphs (a), (b) and (c) are established and that the misconduct alleged was relevant to the practice of nursing and would reasonably be regarded by members as disgraceful, dishonourable and unprofessional.

The Panel dismissed Allegations #6(d) and (e).

Reasons for Decision

The Panel found that all 3 of the witnesses seemed honest, made accurate and complete observations, had good memories of the events and were internally consistent in their testimony. [Witness A] and [Witness B] were supported by the evidence presented in the documents that were marked as Exhibits and had no interest in the outcome. [Witness C] was very consistent, articulate and deliberate in his explanations. He was present during his wife's care as the treatment held high importance to him and his wife was at high risk during the relevant time. He was forthright as he wants justice for his wife and to decrease the risk to others in a similar situation.

Allegation #1: The evidence showed that the Member indicated in client records that she was a registered practical nurse when her certificate was suspended and when she was not authorized to do so. This is evidenced by the ICRC letter to the Member notifying her of the suspension of her Certificate of Registration. The span of the suspension was established by the evidence to run from November 17, 2016 to February 27, 2018. The allegations occurred within the suspension period. The Member indicated in the client notes, signature record sheet, assessment record and medication administration record that she was an RPN. The Panel found that the signature sheet supports the initialled documentation as being those of the Member who signed the signature sheet with the designation of RPN.

Allegation #2: The evidence shows that the Member held herself out to [the client] and the client's husband [Witness C] and to her employer (Right at Home Canada) as a registered practical nurse and/or nurse when she was suspended. [Witness C]'s evidence was that he and [the client] believed the Member was a nurse and [Witness B]'s evidence established that the Member applied to Right at Home Canada for employment by submitting a resume describing herself as working as an RPN and providing a copy of her certificate of registration from the College in 2008 under a former name which stated that she was a registered practical nurse. The Member's actions all occurred during the time her certificate was suspended by the College.

Allegation #3: The Member used a name other than the name used on the College's register. The Panel is satisfied that, on the basis of the evidence before it, the Member known by the name Monika Di Ruscio on the College's records and the person known as Monika Barylski, who applied for employment with and was hired by Right at Home Canada and provided nursing services to [the client], are one and the same person. The Panel was satisfied with the evidence in the form of a copy of the College's Public Register for the Member as well as exhibits illustrating her name change history. Records show that since October 2010 the Member has been registered with the College as Monika Di Ruscio. The Member's resume and College registration document submitted by the Member at the time or her hiring by Right at Home Canada in 2017 used the name Monika Barylski.

The Panel agrees with College Counsel's submission that by using the name "Monika Barylski" the Member was able to use her initial registration certificate from the College for employment and made it difficult to find her registration status on the College's website. It was only by chance that [the client] was able to identify the Member through other means on an internet search.

Allegation #4: The evidence established that the Member contravened a term, condition or limitation on her certificate of registration by practising nursing when her certificate was suspended. Section 3 of the *Nursing Act, 1991* defines the practice of nursing as: "the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function." Section 4 of the same Act provides that in the course of engaging in the practice of nursing, a member who is not suspended may administer a substance by, among other things, injection. Right at Home Canada's registered health professional job description and the Member's payroll report show that the Member was hired by Right at Home Canada as an RPN and worked as a nurse attending to [the client]. The evidence further showed that the Member administered injections to [the client] during the course of her duties as well as providing assessments and general nursing care of [the client]. The Member did all of this when, according to the evidence, her

certificate of registration was suspended. Accordingly, the Panel is satisfied that, on this basis, the Member did contravene a term, condition or limitation on her certificate of registration.

Allegation #5: The evidence establishes that the Member use the title "nurse" and "registered practical nurse" or "RPN" and held herself out as a person qualified to practise in Ontario as a nurse, both while her certificate of registration was suspended and that by doing so, she contravened sections 11(1) and 11(5) of the *Nursing Act, 1991*. The Member held herself out as a person qualified to practise nursing in Ontario when she applied for employment with Right at Home Canada and when she presented herself to [Witness C] and [the client]. Further, she documented in [the client]'s chart in various ways that she was an RPN. All of these actions on the part of the Member occurred while her certificate of registration was suspended.

Allegation #6: The Panel accepts that Allegations #6(a), (b) and (c) have been established and that the conduct alleged constitutes disgraceful, dishonourable and unprofessional conduct on the part of the Member who practised nursing, indicated in client records that she was an RPN and held herself out to [Witness C] and [the client] as well as to Right at Home Canada as an RPN, all at times when her certificate of registration was suspended. Finally, the Panel concludes that all of these acts on the part of the Member were relevant to the practice of nursing. Members are required to practice legally and within the scope of terms, conditions and limitations on their certificate of registration. By not abiding by the suspension and holding herself out as a nurse she contravened the *Nursing Act, 1991*. This was a deception as the Member was able to apply for employment using an old certificate of registration under a former name as if this was still current. This made it difficult to find her registration status. She showed a disregard for her professional obligations and the allegations cast serious doubt on her moral fitness and inherent ability to discharge the higher obligations that the public and the College expects of nurses. [Witness C] gave testimony on the effect the events had on his trust in nurses.

Allegations #6(d) and #6(e) were related to asking for and taking items from clients.

These allegations contend that the Member asked a client to provide her with "saline syringes and/or needles" and that she took "saline syringes" from a client. The evidence of [Witness C] was that the Member asked him for and received from him "vials of saline". Having listened to College Counsel's submissions on the point, the Panel cannot accept that "syringes" and "vials" are terms that are interchangeable or that [Witness C] was using the term "vials" in an inexact way. [Witness C]'s evidence on all points was very clear and precise. The Panel does not consider that he would have used the term "vials" if he meant "syringes". Accordingly, the Panel finds that Allegations #6(d) and #6(e) have not been established and must be dismissed.

Penalty

<u>Penalty Submissions</u>

College Counsel submitted that the Panel should make the following order:

1. Requiring the Member to appear before the Panel to be reprimanded within 3 months from the date the Member obtains an active certificate of registration.

2. Directing the Executive Director to suspend the Member's certificate of registration for 12 months. This suspension shall take effect from the date the Member obtains an active certificate of registration 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director, 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, and
            3. 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. *Code of Conduct,*
            2. *Professional Standards*,

        iv. 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;

        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 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 18 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, and
3. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of 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

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

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.

College Counsel then reviewed the components of penalties and the objectives of general and specific deterrence to the membership and the Member, the protection of the public, and rehabilitation and remediation of the Member where appropriate. The objectives of general and specific deterrence are met by the proposed Order with the oral reprimand to the Member and the lengthy suspension of 12 months. The public is protected by the proposed Order, terms, conditions and limitations, the suspension, employer notification and the restriction on independent practice.

Rehabilitation and remediation of the Member is achieved under the proposed Order with the terms, conditions and limitations on her certificate of registration and the facilitated review with a Nursing Expert. College Counsel further submitted that, in this case, the Member's particular circumstances should be considered when determining the appropriate penalty.

Aggravating factors include:

- Unlicensed practice is taken very seriously by the College and the public;
- The use of a name different than that posted on the College Register leads to both clients and employers having difficulty in obtaining information on practice restrictions;
- This conduct was repeated over a month and had the client and husband not been suspicious, the conduct would not have been found;
- This is a breach of trust and is dishonest, for personal gain and to the detriment of a vulnerable client;
- There was potential for significant harm to the client;
- The actions of the Member shook [Witness C]'s trust in nurses and brought discredit to the profession.

As a result of the Member's non-participation in this hearing, College Counsel submitted that the Panel was left with little information to consider about the Member's particular situation and circumstances. Nevertheless, College Counsel indicated that the College was aware of two potentially mitigating factors which should be brought to the Panel's attention. The mitigating factors include:

- The Member has no prior record of discipline with the College;
- The Member's personal circumstances. The Member is currently suspended as a result of an Order by the Fitness to Practise Committee made in December 2018.

College Counsel noted that, as the evidence before the Panel demonstrated, between November 17, 2016 and February 27, 2018 the Member's certificate was suspended as a result of an Order of the ICRC. The letter from that Committee to the Member dated November 18, 2016 which the Panel had before it, giving notice to the Member of her suspension, indicated that the suspension Order was made because of her failure to attend for a health assessment directed by the Committee.

College Counsel further submitted that it was not unreasonable to suspect that there was a connection between the Fitness to Practise Committee's decision to suspend the Member and the conduct that occurred in this case.

College Counsel considered recommending revocation of the Member's certificate as the appropriate penalty as that is an Order which has been imposed in similar cases. However, taking into account the current suspension by the Fitness to Practise Committee and that the basis of that decision may have been related to the circumstances in this case, this aspect of the Member's personal circumstances was the only reason the College was proposing a penalty less than revocation of the Member's certificate of registration.

Further, the proposed Order with its reprimand, suspension and terms, conditions and limitations as well as terms on independent practice only starts once the Member becomes an active Member with the College.

College Counsel submitted a case which references 2 other cases to demonstrate the scope of previous penalties which involved circumstances that were somewhat similar to the present case.

CNO v. Vanderzwaag (Discipline Committee, 2014) was a revocation decision. The member, an RPN, was under a suspension decision of the Fitness to Practise Committee from May 2012 but practised without a licence from 2014 to 2017. This illustrates that there was no apparent connection between the member's Fitness to Practise suspension in that case and the period of practising without a licence, given the approximately two years between the two events. The practice setting was similar in Vanderzwaag to the present case but Vanderzwaag proceeded by way of a Joint Submission on Order for revocation. Two other decisions referred to in this decision, *CNO v. Nicole Kruczek* (Discipline Committee, 2014) and *CNO v. Hunter* (Discipline Committee, 2014) ordered revocation of their certificate of registration. Neither had any Fitness to Practise issues related to their cases.

College Counsel noted that she was not aware of any previous decision from the Discipline Committee in which conduct like that in the present case had not resulted in revocation. Nonetheless College Counsel submitted that the Panel should make its decision on penalty having taken into account that it is not unreasonable to suspect that there is a connection between the basis of the Member's suspension by the Fitness to Practise Committee and the facts underlying this case and that as a result the imposition of a penalty short of revocation would be appropriate, in the College's submission.

Penalty Decision

The Panel makes the following order as to penalty:

1. The Member is required to appear before the Panel to be reprimanded within 3 months from the date the Member obtains an active certificate of registration.

2. The Executive Director is directed to suspend the Member's certificate of registration for 12 months. This suspension shall take effect from the date the Member obtains an active certificate of registration 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director, 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, and
    3. 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. *Code of Conduct,*
    2. *Professional Standards*,

iv. 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;

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 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 18 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, and
3. a copy of the Panel's Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of 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

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

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 concluded that the penalty proposed by the College is reasonable and in the public interest in the particular circumstances of this case. The relevant comparison cases presented by College Counsel led to revocation of the member's certificate of registration. The Member in this case has an active Fitness to Practise suspension which the College has indicated it is reasonable to suspect is related to the circumstances leading to this matter and therefore this mitigating factor was taken into account. The Panel is comforted by the fact that the Member's 12 months suspension will not take effect until the Member obtains an active certificate of registration which will not occur until the Member has fulfilled any conditions imposed by the Fitness to Practise Committee. Further, the requirement that the Member inform all employers of this decision for 18 months will not start to run until the date she returns to the practice of nursing.

Given all these factors and the College's submission that, in the specific circumstances of this case, a penalty short of revocation is appropriate, the Order proposed by the College adequately takes

into account all of the relevant principles to be considered when imposing a penalty and is the penalty that should be imposed in this case.

I, Carly Gilchrist, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.