DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Terry Holland, RPN	Chairperson
	Tania Perlin	Public Member
	Heather Stevanka, RN	Member
	Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
SUNDAY LADIPO	)	NO REPRESENTATION for
Registration No. 15077854	)	Sunday Ladipo
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: February 4, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on February 4, 2019 at the College of Nurses of Ontario (the "College") at Toronto.

Sunday Ladipo (the "Member") was present for the hearing and self-represented.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated December 19, 2018 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 Saint Elizabeth Health Care – Central East (Whitby), you contravened

a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

a) on or about February 10, 2017, you provided inadequate care to [Client A], and/or inadequately documented the care you provided to [Client A], including but not limited to the following:

i. you failed to maintain appropriate documentation with respect to the physician's order for [Client A], including:

1. you failed to verify and/or failed to document that the physician's order for [Client A] was incomplete;

2. you failed to verify and/or failed to document that you verified the physician's order for [Client A]; and/or

3. you failed to verify and/or failed to document the physician's verbal order for [Client A]; and/or

ii. you failed to maintain appropriate documentation with respect to [Client A's] response to the catheter procedure;

iii. you provided inadequate care in your insertion of a catheter into [Client A] , including:

1. you failed to properly insert the catheter into [Client A]; and/or

2. you failed to appropriately assess whether the continuation of the catheter procedure met [Client A] needs; and/or

iv. you failed to establish and maintain therapeutic communication with [Client A] and/or his family with respect to the catheter procedure; and/or

b) on or about February 27, 2017, you administered the incorrect amount of hydromorphone to [Client B]..

2. You have committed an act of professional misconduct, as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in paragraph 1(13) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at Saint Elizabeth Health Care – Central East (Whitby), you failed to keep records as required, and in particular, on or about February 10, 2017:

a) you failed to verify and/or failed to document that the physician's order for [Client A] was incomplete;

b) you failed to verify and/or failed to document that you verified the physician's order for [Client A];

c) you failed to verify and/or failed to document the physician's verbal order for [Client A]; and/or

d) you failed to document [Client A's] response to the catheter procedure.

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(18) of *Ontario Regulation 799/93*, in that while employed as a Registered Nurse at Saint Elizabeth Health Care – Central East (Whitby), you contravened a term, condition or limitation on your certificate of registration, as provided in subsection 1.5(1)1.(iii) of *O. Reg. 275/94*, in that you failed to provide the College with details of a proceeding for professional misconduct, incompetency or incapacity, and in particular, the investigation undertaken by the College of Registered Nurses of Manitoba into your practice and conduct as a registered nurse.

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 you engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

a) on or about February 10, 2017, you provided inadequate care to [Client A], and/or inadequately documented the care you provided to [Client A], including but not limited to the following:

i. you failed to maintain appropriate documentation with respect to the physician's order for [Client A], including:

1. you failed to verify and/or failed to document that the physician's order for [Client A] was incomplete;

2. you failed to verify and/or failed to document that you verified the physician's order for [Client A]; and/or

3. you failed to verify and/or failed to document the physician's verbal order for [Client A]; and/or

ii. you failed to maintain appropriate documentation with respect to [Client A's] response to the catheter procedure;

iii. you provided inadequate care in your insertion of a catheter into [Client A] , including:

1. you failed to properly insert the catheter into [Client A]; and/or

2. you failed to appropriately assess whether the continuation of the catheter procedure met [Client A's] needs; and/or

iv. you failed to establish and maintain therapeutic communication with [Client A] and/or his family with respect to the catheter procedure; and/or

b) on or about February 27, 2017, you administered the incorrect amount of hydromorphone to [Client B];

c) you failed to provide the College with the details of an investigation, inquiry and proceeding for professional misconduct in relation to your practice of nursing undertaken by the College of Registered Nurses of Manitoba; and/or

d) while employed as a Registered Nurse at Saint Elizabeth Health Care – Central East (Whitby) ("Saint Elizabeth"), you failed to provide Saint Elizabeth with:

(a) details of the investigation undertaken by the College of Registered Nurses of Manitoba into your practice and conduct as a registered nurse; and/or

(b) details of conditions on your registration with the College of Registered Nurses of Manitoba.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i)(1),(2),(3); 1(a)(ii); 1(a)(iii)(1),(2); 1(a)(iv); 1(b); 2(a),(b),(c),(d); 3; 4(a)(i)(1),(2),(3); 4(a)(ii); 4(a)(iii)(1),(2); 4(a)(iv); 4(b); 4(c); and 4(d)(a),(b).

The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Sunday Ladipo (the "Member") obtained a degree in nursing from Ryerson University in 2003.

2. The Member registered with the College of Nurses of Ontario ("College") as a Registered Nurse ("RN") on January 1, 2015. The Member registered with the College as a Registered Practical Nurse ("RPN") on February 25, 2015. The Member resigned his RPN certificate of registration on December 31, 2015.

3. The Member was employed at Saint Elizabeth Health Care — Central East (Whitby) (the "Agency") from June 27, 2016 to March 6, 2017.

THE AGENCY

4. The Agency is located in Whitby, Ontario.

5. The Member worked at the Agency as a full-time staff nurse on day, night and evening shifts, providing care to clients in facilities and at home.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incident on February 10, 2017

6. At the time of the incident on February 10, 2017, [Client A] was a 79-year-old palliative male. Client A resided in a retirement community in [ ], Ontario.

7. On February 10, 2017, the Member received a call from the Agency to provide care to Client A. The Member advised that it would be difficult for him to attend to Client A in a timely manner because he was 75 kilometres away from the retirement community, and the roads were slippery, but the Agency told the Member to get there when he could. The Member contacted Client A's daughter to let her know he would be late.

8. The Member arrived at Client A's residence around 20:15. Client A's spouse and his daughter, as well as a Personal Support Worker ("PSW"), [the PSW], were with Client A.

9. Client A's physician, [the Physician], had completed a written order for Client A but the order was incomplete. In particular, the box indicating that a catheter should be inserted was not checked, the box for the insertion of a subcutaneous lock was not checked, and the order for the administration of Midazolam had a frequency, but no dose.

10. The Member made a number of telephone calls after arriving at Client A's unit to confirm [the Physician's] order. The Member did not take any notes or otherwise document that he had confirmed [the Physician's] order to insert a catheter.

11. According to [the Physician], if a nurse calls to clarify an order, her clarification should become a verbal order and should be documented as such. The Agency's policies require nurses to document conversations with physicians arising out of concerns over a physician's orders.

12. The Member acknowledges that he should have documented that the physician's order was incomplete, and that he called [the Physician] to clarify and confirm her order. The Member also recognizes that he should have documented [the Physician's] clarification with respect to the insertion of the catheter as a verbal order.

13. Prior to inserting the catheter, the Member administered Client A's medication, some of which was administered subcutaneously.

14. The Member then proceeded to insert the catheter into Client A's penis. Client A screamed in pain. The Member continued with the procedure, despite Client A's obvious discomfort.

15. The Agency has a policy called "Insertion of Indwelling Urinary Catheter, Specimen Collection and Irrigation – Procedure." It states that nurses must: "Encourage the client/resident to verbalize, or provide visual cues of, pain experienced at any point during the procedure."

16. Nurses must also "[p]rovide time outs as needed and involve the client/resident in decision making regarding possible solutions to reduce the pain experienced in future procedures."

17. If [the PSW] were to testify, she would describe Client A's reaction by saying that she had "never heard screams like that before." She would also say that the Member kept inserting the catheter higher and higher, and Client A kept screaming. If Client A's daughter were to testify, she would describe the procedure as a "bloody scene" (though there was no actual blood).

18. The Member acknowledges that, given Client A's reaction, he failed to properly insert the catheter into Client A, and he should have re-assessed the situation to determine whether the procedure met Client A's therapeutic needs. If the Member were to testify, he would say that the catheterization was successful in that urine began to flow. The Member would further testify that Client A was noticeably uncomfortable during the procedure, but that in his experience, Client A's reaction was not uncommon during male catheterization.

19. The Member did not speak to Client A or his daughter during the insertion of the catheter, despite Client A's daughter expressing concerns about her father's pain. The Member acknowledges that he did not follow the Agency's policy with respect to communicating with the Client during the catheterization process, and that he should have maintained therapeutic communication with Client A and his family. If the Member were to testify, he would say he did not speak with Client A or his family in order to maintain the sterile field.

20. The Member's documentation from the visit does not include any reference to the difficulties he experienced inserting the catheter, or Client A's reaction. The Member acknowledges that he should have documented both the difficulties he experienced in inserting the catheter, and Client A's reaction.

21. Client A died on February 12, 2017 for reasons unrelated to the care the Member provided.

Incident on February 27, 2017

22. On February 27, 2017, the Member received an order from the Agency to provide care to [Client B] in his home. Client B was 73 years old at the time of the incident, and was palliative.

23. Client B had received a new order for Hydromorphone (a narcotic), to be administered at a concentration of 10mg/ml by a patient-controlled analgesia infusion. The Agency assigned the Member to attend at Client B's home to administer the new dose of medication.

24. After arriving at Client B's home, the Member called his supervisor, [the Supervisor], who read the Member the physician's order for the administration of hydromorphone over the phone. [The Supervisor] reminded the Member that the pump on the machine administering the medication would need to be reset for concentration, and that it did not automatically prompt to reset for concentration. [The Supervisor] reminded the Member to confirm the concentration setting with the Agency's Clinical Practice Leader, [the Clinical Practice Leader].

25. The Member spoke with the Clinical Practice Leader, [ ], on the phone so that she could perform an independent double check of the dosage. The Member did not confirm the change in concentration with her.

26. Despite [the Supervisor's] reminder that he manually reset the concentration setting on the pump, the Member did not do so, and he ultimately administered five times the ordered dose of hydromorphone to Client B.

27. The Member's error was noticed the following day during a nursing visit at 12:30. By that time, Client B had received an overdose of 152mg as a result of the pump infusing at an incorrect concentration. Client B was drowsier than normal, but otherwise fine. He was transported to the hospital for monitoring.

28. Client B died two weeks after the incident for reasons unrelated to the care the Member provided.

Failure to Report Proceeding in Manitoba

29. The Member was registered with the College of Registered Nurses of Manitoba ("Manitoba College") and began working as an RN in Manitoba beginning in July 2015.

30. In May 2016, the Manitoba College received an Employer Report indicating that the Member struggled in multiple areas, including assessment, skills, prioritizing, medication errors and communication. The Report also indicated that the Member failed to acknowledge his lack of experience or knowledge deficits in a timely fashion, or seek assistance as necessary.

31. The Executive Director of the Manitoba College referred the matter to its Investigation Committee on May 31, 2016, and notified the Member of the Employer Report the same day. On June 3, 2016, the Member was advised of a request to attend a meeting of the Manitoba College's Investigation Committee.

32. The Manitoba College's Investigation Committee met on June 9, 2016 to review the matter. The Member made verbal submissions and responded to questions from the Committee members. After receiving the Member's submissions, the Investigation Committee directed that the Manitoba College's Executive Director impose conditions on the Member's Manitoba RN license in June 2016, including that the Member not practice in an environment where he is the sole registered nurse on duty at any time, and requiring him to successfully complete certain remedial course work.

33. The Manitoba College's Investigations Committee directed these conditions to be imposed on the Member's registration pursuant to a statutory provision that permits the Committee to impose such conditions where there is a question that a member's conduct exposes or is likely to expose the public to serious risk.

34. On June 13, 2016, the Manitoba College wrote to the College of Nurses of Ontario advising of the Member's history with the Manitoba College, and the conditions imposed on the Member's registration to practice in that jurisdiction.

35. The Member did not report that he had conditions imposed on his Manitoba registration to the College until February 2018.

36. The Member did not disclose to the Agency at the time he was hired in June 2016, or at any time thereafter, that there were ongoing proceedings before the Manitoba College in relation to his nursing practice, and that there were conditions on his registration with the Manitoba College.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

37. The Member admits that he committed the acts of professional misconduct as described in paragraphs 6 to 21 above, and as alleged in the following paragraphs of the Notice of Hearing:

- 1(a) in that he provided inadequate care to Client A and/or inadequately documented the care he provided to Client A on February 10, 2017 when he:
    - (i) failed to appropriately document a physician's order for Client A, including:
        - 1. Failing to verify and/or failing to document that the physician's order for Client A was incomplete;
        - 2. Failing to verify and/or failing to document that he verified the physician's order for Client A;
        - 3. Failing to verify and/or failing to document the physician's verbal order for Client A;
    - (ii) failed to appropriately document Client A's response to the catheter procedure;
    - (iii) provided inadequate care during the insertion of Client A's catheter, including:
        - 1. Failing to properly insert Client A's catheter;
        - 2. Failing to properly assess whether the continuation of the catheter procedure met Client A's needs;
    - (iv) failed to establish and maintain therapeutic communication with Client A and his family with respect to the catheterization procedure;
- 1(b) in that he administered the incorrect amount of hydromorphone to Client B on February 27, 2017.

38. The Member admits that he committed the act of professional misconduct, as described in paragraphs 6 to 21 above, in that he failed to keep records as required, as alleged in the following paragraphs of the Notice of Hearing:

    - 2(a) in that he failed to verify and/or failed to document that the physician's order for Client A was incomplete;

    - 2(b) in that he failed to verify and/or failed to document that he verified the physician's order for Client A;

    - 2(c) in that he failed to verify and/or failed to document the physician's verbal order for Client A;

    - 2(d) in that he failed to appropriately document Client A's response to the catheter procedure.

39. The Member admits that he committed the acts of professional misconduct as alleged in paragraph 3 of the Notice of Hearing, as described in paragraphs 29 to 36 above, in that he contravened a term, condition or limitation on his certificate of registration when he failed to notify the College that he was the subject of an investigation by the College of Registered Nurses of Manitoba into his practice and conduct as a registered nurse.

40. The Member admits that he committed the acts of professional misconduct as described in paragraphs 6 to 36 above, and in particular that his conduct was disgraceful, dishonourable and unprofessional, as alleged in the following paragraphs of the Notice of Hearing:

    - 4(a)(i)(1),(2) and (3)
    - 4(a)(ii)
    - 4(a)(iii)(1) and (2)
    - 4(a)(iv)
    - 4(b)
    - 4(c)
    - 4(d)(a) and (b)

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)(1),(2),(3); 1(a)(ii); 1(a)(iii)(1),(2); 1(a)(iv); 1(b); 2(a),(b),(c),(d); 3; 4(a)(i)(1),(2),(3); 4(a)(ii); 4(a)(iii)(1),(2); 4(a)(iv); 4(b); 4(c); and 4(d)(a),(b) in the Notice of Hearing.

As to allegation #4 in its entirety, the Panel finds that the Member did not engage in disgraceful conduct but that, based on the evidence presented, the Member did engage in unprofessional and dishonorable conduct in the delivery of his nursing care to Client A and Client B.

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)(1); 1(a)(i)(2); 1(a)(i)(3) and 1(a)(ii) in the Notice of Hearing are supported by paragraphs 9-12 and 20 in the Agreed Statement of Facts. [The Physician] left an incomplete order on Client A's chart. The Member admitted that there should have been check marks in the boxes indicating an order for insertion of a catheter and insertion of a subcutaneous lock. There was an order for Midazolam which had a frequency but no dose. The Member admits that he did contact [the Physician] and obtained a verbal order for the insertion of the catheter, but the Member failed to document that he confirmed [the Physician's] order. The Member also failed to follow the Agency's policies which require nurses to document conversations with physicians arising out of concerns over a physician's order. The Member failed to document the difficulties he experienced inserting the catheter or the reaction Client A had to the procedure.

Allegation #1(a)(iii)(1) in the Notice of Hearing is supported by paragraphs 14 to 16 in the Agreed Statement of Facts. The Member inserted the catheter into [ ] Client A's penis even after the client was in obvious discomfort. The Agency has a policy called "Insertion of Indwelling Urinary Catheter, Specimen Collection and Irrigation Procedure." The policy states that nurses must: "encourage the client/resident to verbalize, to provide visual clues of pain experienced at any point during the procedure." Also, the Agency has a policy for "providing time outs as needed and involving the client in decision making regarding possible solutions to reduce the pain experienced in future procedures". The Member failed to comply with this policy.

Allegation #1(a)(iii)(2) in the Notice of Hearing is supported by paragraphs 14, 15, 16, 18 and 19 in the Agreed Statement of Facts. The Member acknowledges that he failed to properly insert the catheter into Client A, and that he should have re-assessed the situation to determine whether the procedure met Client A's therapeutic needs.

Allegation #1(a)(iv) in the Notice of Hearing is supported by paragraphs 15 to 20 in the Agreed Statement of Facts. The Member failed to speak to Client A's daughter during the procedure, when Client A's daughter expressed her concerns about her father's pain. The Member failed to follow the Agency's policy with respect to communicating with the Client during the catheterization. The Member's documentation did not include any reference to the difficulties he experienced inserting the catheter or Client A's reaction. The Member did not provide a time out for the client nor did the Member re-assess the situation.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 23 to 27 in the Agreed Statement of Facts. The Member failed to administer the proper dose of Hydromorphone to Client B. The Member received new orders for Hydromorphone (a narcotic) from his Supervisor. [The Supervisor] [ ] read the Member the physician's order for the administration of Hydromorphone over the phone. Client B was

to receive 10mg/ml by a patient-controlled analgesia pump. The Member was informed by [the Supervisor] that he would have to reset the concentration on the pump. The Member failed to reset the pump with the correct infusion rate, and he failed to confirm the change in concentration with the Agency's Clinical Practice Leader [ ] which resulted in Client B receiving 152 mg of Hydromorphone which is five times the ordered dose.

Allegation #2(a),(b),(c) in the Notice of Hearing is supported by paragraphs 9 to 12 in the Agreed Statement of Facts. The Member admits to not following the policy about clarifying the physician's orders and documenting not only the clarification but the verbal order. The Member failed to document that he clarified the catheter insertion, subcutaneous lock and the frequency of Midazolam for Client A. The Member also failed to document the confirmation of the order by [the Physician].

Allegation #2(d) in the Notice of Hearing is supported by paragraphs 14 to 18 and 20 in the Agreed Statement of Facts. If [the PSW] were to testify, she would describe Client A's reaction by saying that she had never heard screams like that before. She would say that the Member kept inserting the catheter higher and higher, and Client A kept screaming. The Member would testify that Client A was noticeably uncomfortable during the procedure but, that in his experience, Client A's reaction was common during male catheterization. The Member failed to document the difficulties he experienced inserting the catheter or the reaction Client A had to the procedure.

Allegation #3 in the Notice of Hearing is supported by paragraphs 29 to 36 in the Agreed Statement of Facts. The Member registered with the College of Registered Nurses of Manitoba ("Manitoba College") and began working in July 2015. In May 2016, the Manitoba College received an Employer Report indicating that the Member struggled in multiple areas, including assessment skills, prioritizing, medication errors and communication. The Employer Report indicated that the Member failed to acknowledge his lack of experience or knowledge deficits in a timely fashion or seek assistance as necessary. Subsequently, the matter was referred to the Manitoba College's Investigation Committee which in June 2016 imposed conditions on the Member's Manitoba RN licence but the Member did not report these conditions on his Manitoba registration to the College until February 2018.

Allegation #4(a)(i)(1),(2),(3) in the Notice of Hearing is supported by paragraphs 9 to 12 in the Agreed Statement of Facts. The Member failed to obtain clarification on three orders: First the catheter insertion for Client A, then the subcutaneous lock insertion, and lastly, the frequency of Midazolam. The Member failed to document that he confirmed [the Physician's] order. The Member did not document that he received a verbal order or that he had concerns about the incomplete orders, which is policy at the Agency.

Allegation #4(a)(ii),(iii)(1),(2) in the Notice of Hearing is supported by paragraphs 14 to 20 in the Agreed Statement of Facts. The Member proceeded to insert the catheter into Client A's penis even though Client A was screaming in pain. The Member continued with the procedure despite Client A's obvious discomfort. The Member failed to document the insertion of a catheter into Client A. The Member failed to offer comfort and time outs during this procedure.

Allegation # 4(a)(iv) in the Notice of Hearing is supported by paragraphs 14 to 19 in the Agreed Statement of Facts. The Member failed to communicate to Client A and his daughter as the Client yelled in pain.

Allegation #4(b) in the Notice of Hearing is supported by paragraphs 22 to 27 in the Agreed Statement of Facts. The Member failed to administer the proper dosage of medication to a 73 year old palliative client. Client B was to receive 10mg/ml of Hydromorphone which was a new dose for this Client. The Member did not confirm the changes with the Clinical Practice Leader, [ ], as instructed by his Supervisor, [ ]. The Member failed to reset the infusion pump and this resulted in Client B receiving 152mg of Hydromorphone which was five times the ordered dose.

With respect to Allegation #4(c) and 4(d)(a),(b) in the Notice of Hearing, the allegations are supported by paragraphs 29 to 36 in the Agreed Statement of Facts. The Member was registered with the Manitoba College. The Member worked as an RN in July 2015. In May 2016, the Manitoba College received an Employer Report indicating that the Member was struggling. The matter was referred to the Manitoba College's Investigation Committee on May 31, 2016, and the Member was notified of the Employer Report the same day. In June 2016, the Investigations Committee imposed conditions on the Member's RN license informing the Member not to practice in an environment where he is the sole registered nurse on duty at any time and requiring the Member to successfully complete certain remedial course work.

The College was advised by the Manitoba College on June 13, 2016 of the conditions imposed on the Member's registration to practice in that jurisdiction, however, the Member did not report the conditions imposed by the Manitoba College to the College until February 2018. The Member failed to disclose to the Agency at the time he was hired that there were ongoing proceedings before the Manitoba College in relation to his nursing practice and that there were conditions on his registration.

With regard to the entirety of Allegation #4, the Panel finds that the Member's conduct was unprofessional and dishonourable as it demonstrated a serious and persistent disregard for his professional obligations.

The Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations. Nurses are accountable for practicing in accordance with the *Professional Standards*, practise expectations, legislation, and regulations. The Member gave false and misleading information, which is dishonest and breaches the public's trust in the profession.

The Panel also finds that the Member's conduct was dishonourable as it demonstrated an element of dishonesty and deceit by failing to document important information in the case of Client A. If the Member documented the care given and the reaction to the care, the Health Care Team could have re-assessed and re-evaluate what would be in Client A's best interest and in turn decrease the trauma to the Client. The Member further did not follow the *Medication Standard [ ]*. The Member failed to document a verbal medication order and delivered a dose of medication to Client B that was five times the ordered dosage.

However, there was no finding by the Panel of disgraceful conduct, as there was no evidence supporting that the Member's actions or lack thereof fit the definition of disgraceful.

The Panel considered that "disgraceful" conduct has elements of moral failing. It is conduct that is more severe than that which is dishonourable, and it is conduct that has the effect of shaming the Member and, by extension, the profession. To be disgraceful, the conduct should cast serious doubt on the Member's moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet. In general, the more knowledge of the wrongfulness the Member has or ought to have had at the time of the conduct, the more it will tend to be "disgraceful" instead of merely "dishonourable."

The Panel deliberated and found that although the conduct of the Member showed a lack of professionalism, it did not indicate a moral failing on the part of the Member.

The Panel determined that to find the Member disgraceful in this case would be disproportionate to the offence the Member committed. It would also minimize the term and lessen its impact.

Although the conduct of the Member showed a lack of professionalism, the Panel decided that in fairness to the process, the term and understanding of disgraceful conduct does not apply in this case.

Penalty

Counsel for the College and the Member advised the Panel that a Joint Submission on Order ("JSO") had been agreed upon. The JSO requests that this Panel make an order as follows:

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

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

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

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

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

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

            1. the Panel's Order,

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

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

1. *Professional Standards*,
2. *Medication*,
3. *Documentation*,

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

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

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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

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

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his 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 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. Only practise nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

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

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

3. that they agree to perform six random spot audits of the Member's practice at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

a. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,

b. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,

c. the second audit shall take place within nine months from the date the Member begins or resumes employment with the employer,

d. the second audit shall take place within 12 months from the date the Member begins or resumes employment with the employer,

e. the second audit shall take place within 15 months from the date the Member begins or resumes employment with the employer,

f. the second audit shall take place within 18 months from the date the Member begins or resumes employment with the employer,

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of the Member's charts to ensure they meet both College and employer standards,

2. discussing (by telephone or in person), with at least three of the Member's clients, the care provided by the Member to ensure that the Member is meeting College and employer standards.

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

Penalty Submissions

Counsel for the College submitted that the JSO was negotiated carefully between the College and the Member and that it meets the goals of penalty, which are general and specific deterrence, remediation and protection of the public.

The mitigating factors in this case were:

- The Member attended the hearing;
- The Member co-operated with the College and has taken responsibility for his actions;
- The Member agreed to the JSO;
- The Member in admitting to the allegations saved the witnesses from having to testify; and
- The Member in admitting the allegations saved the College money by reducing the hearing time.

The aggravating factors in this case were:

- The Member had serious difficulties providing care to two clients in a very short period of time;
- The Member caused harm to both clients by failing to meet the clients' basic needs;
- The Member breached the trust and confidence of Client A and his daughter due to his poor care and poor communication skills;
- The Member failed to document verbal orders not only from [the Physician] but also failed to carry out orders given by his supervisor for Client B;
- The Member failed to document concerns regarding incomplete doctor's orders per the Agenc[y's] policy;
- The Member failed to correctly set Client B's infusion pump and this error caused the Client to be administered five times the ordered dose of Hydromorphone; and
- The Member failed to report to the College that he currently has conditions imposed on him by the Manitoba College where he held an RN certificate.

The proposed penalty provides for general deterrence through the suspension which will discourage other members of the profession from engaging in similar conduct by reminding them of the importance of their professional obligations.

The proposed penalty provides for specific deterrence through the five-month suspension which will discourage other members of the profession from engaging in similar conduct in the future.

The proposed penalty provides for remediation and rehabilitation through the reprimand and the terms, conditions and limitations. The meeting with the nursing expert provides the Member with opportunities to reflect on the incident and learn.

Overall, the public is protected because the penalty is in line with similar cases of professional misconduct and meets the tests for a proposed penalty. Counsel for the College submitted cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

The first case was *CNO v. Smith* (Discipline Committee, 2015).This case proceeded with the member present and represented. The member was subject to similar allegations in that the member was found to have committed acts of professional misconduct by the Board of Nursing from another jurisdiction. The member failed to comply with the stipulated agreement, consent agreement or board order. The member engaged in unprofessional conduct. The member negligently caused physical and or emotional injury and the member failed to follow policies and procedures of the employer, which were designed to safeguard the client. The member was given a three-month suspension, two meetings with a nursing expert and an eighteen-month employer notification once the suspension was completed.

The second case was *CNO v. Finnigan* (Discipline Committee, 2013). This case proceeded as a contested hearing in the absence of the member. The member was found to have committed acts of professional misconduct in another jurisdiction. The member had committed acts of professional misconduct when she forged a letter from her supervisor and explicitly denied her involvement in prior disciplinary actions. The member was given a five-month suspension, one meeting with a nursing expert and twenty-four-month employer notification once the suspension was completed.

The third case was *CNO v. John Thomas* (Discipline Committee, 2013). This case proceeded on the basis of two of the allegations being contested and the other allegations being accepted. This case is similar in that the member failed to contact the prescribing physician in response to a client's drug reaction. The member also failed to process a doctor's order in relation to a client. The member failed to adjust the medication as ordered. Finally, the member failed to correctly transcribe a physician's verbal order. The member was given a three-month suspension, two meetings with a nursing expert and twelve-month employer notification once the suspension was completed.

The fourth case was *CNO v. Jesse Powell* (Discipline Committee, 2011). The member was not present and not represented. This case is vastly different from the Ladipo case. The only similarity is the member demonstrated fundamental problems and deficiencies in his practice. In this case, it was deemed that the member could not be rehabilitated therefore his certificate of registration was revoked.

The Member advised that he accepted the JSO.

Independent Legal Counsel stated that "the primary goals of an order are to ensure the protection of the public and to maintain confidence in nursing and self-regulation". ILC also referenced the JSO and informed the Panel that we must accept the JSO unless we decide that the proposed penalty was so disproportionate to the offense that to accept it would not be in the public's interest or would bring the administration of justice into disrepute.

Penalty Decision

The Panel accepts the JSO and accordingly orders:

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

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

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

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

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

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

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

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

            1. *Professional Standards*,
            2. *Medication*,
            3. *Documentation*,

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

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

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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

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

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his 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 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. Only practise nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

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

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

3. that they agree to perform six random spot audits of the Member's practice at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

    a. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,

    b. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,

    c. the second audit shall take place within nine months from the date the Member begins or resumes employment with the employer,

    d. the second audit shall take place within 12 months from the date the Member begins or resumes employment with the employer,

    e. the second audit shall take place within 15 months from the date the Member begins or resumes employment with the employer,

    f. the second audit shall take place within 18 months from the date the Member begins or resumes employment with the employer,

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of the Member's charts to ensure they meet both College and employer standards,

2. discussing (by telephone or in person), with at least three of the Member's clients, the care provided by the Member to ensure that the Member is meeting College and employer standards.

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

Reasons for Penalty Decision

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

The Panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection. The penalty is in line with what has been ordered in previous cases.

I, Terry Holland, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.