DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Zahir Hirji, RN  Chairperson
Patrick Chiu, RN  Member
Sarah Corkey, RN  Member
Mary MacMillan-Gilkinson  Public Member
Chuck Williams  Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO ) SHANE SMITH for
) College of Nurses of Ontario
- and - )
) ALLISON RUSSELL ) DANIELLE BISNAR for
Registration No. 0185967 ) Allison Russell
) )
) )
) )
) )
) ) Heard: February 7, 2014

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on February 7, 2014, at the College of Nurses of Ontario (“the College”) at Toronto.

The Allegations

At the outset of the hearing, College Counsel requested leave of the panel to withdraw certain allegations. The panel allowed it. The remaining allegations against Allison Russell (the “Member”), as stated in the Notice of Hearing dated January 6, 2014, are as follows.

IT IS ALLEGED THAT:

1. You have committed an act or acts 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 1.1 of Ontario Regulation 799/93 in that you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession in that, on or about November 24 and 25, 2010, and in subsequent investigations into the events occurring on those days in respect of [the Client], you:
a. [withdrawn];
b. [withdrawn];
c. [withdrawn];
d. [withdrawn];
e. [withdrawn]; and/or
f. failed to intervene to protect the health and well-being of [the Client] when she was being abused by [Nurse C].

2. [withdrawn]

3. You have committed an act or acts 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 1.37 of Ontario Regulation 799/93 in that, on or about November 24 and 25, 2010, you engaged in conduct or performed acts that, having regard to all of the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional and, in particular:

a. [withdrawn];
b. [withdrawn];
c. [withdrawn];
d. [withdrawn];
e. [withdrawn]; and/or
f. failed to intervene to protect the health and well-being of [the Client] when she was being abused by [Nurse C].

Member’s Plea

The Member admitted the allegations set out in paragraphs 1(f) and 3(f) in the Notice of Hearing. The panel received a written plea inquiry which was signed by the Member. The panel also conducted an oral plea inquiry and was satisfied that the Member’s admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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. Allison Russell (the “Member”) obtained a diploma in nursing [ ] in 2001.

2. The Member registered with the College of Nurses of Ontario (the “College”) as a Registered Nurse (“RN”) on May 16, 2001. The Member previously registered with the College as a Registered Practical Nurse (“RPN”) on June 10, 1998, but she resigned her certificate of registration on February 1, 2013.
3. The Member has been employed at [the Facility] since May 7, 2001.

PRIOR HISTORY

4. The Member has no prior disciplinary findings with the College or any disciplinary issues at work.

[THE FACILITY]

5. [The Facility] is located in [ ] Ontario.

6. The Member worked in the Emergency Department as a full-time staff nurse on day, night and weekend shifts.

THE CLIENT

7. [The Client] was 17 years old at the time of the incident.

8. At approximately 23:58 on November 24, 2010, city police and paramedics brought [the Client] to the Emergency Department at the [Facility]. [The Client] had been found at a [coffee shop] with a decreased level of consciousness, due to alcohol and drug consumption, and was also bleeding from her wrists.

9. [The Client] did not have any identifying information with her and was not willing to provide her name to [Facility] staff, despite several attempts to gather this information.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

10. On the night of November 24-25, 2010, the Member was working in the role of triage nurse. Her responsibilities included triaging clients.

11. The Member did not see [the Client] when she was brought into the emergency department by ambulance.

12. [The Client] was initially assigned to [RN A], who was assisted by [RN B]. [RN A] performed a light sternal rub because [the Client] was not responding to voice or touch. [The Client] responded by wincing and moving her shoulders and arms, which indicated she was not unconscious. [RN A] stopped applying the sternal rub.

13. [The Client] was conscious and interacting with staff, but was non-verbal, when [RN A] went on her break around 02:30. [The Client] had not provided her name to staff, despite being asked on a number of occasions.

14. Shortly after 03:00, another nurse, [Nurse C], approached the Member and asked her to assist with rousing an unconscious client, (who was [the Client]), in order to obtain her name.
15. In order to rouse [the Client], the Member flicked her on the cheeks and forehead with her fingers and also rubbed [the Client]’s sternum.

16. If the Member were to testify, she would say that she conducted a brief neurological assessment to measure [the Client]'s level of consciousness. She did this by first calling to [the Client] and gently shaking her. When there was no response, the Member would say moved to the next stage of a neurological assessment, which was providing a painful stimulus in the form of a sternal rub.

17. If the Member were to testify, she would say that [the Client] did not respond to the initial sternal rub, so the Member did a second sternal rub and [the Client] responded by moving her hands. When [the Client] responded, the Member would say she did not perform any further sternal rubs.

18. The Member would further testify that after [the Client] showed signs of consciousness, she asked [the Client] questions to try to elicit her name and information about her condition. [The Client] continued to keep her eyes close and not respond. [The Client] was crying softly on and off.

19. If the Member were to testify, she would also say that [Nurse C] was trying to prompt [the Client] to provide her name, and that she made a number of comments and suggestions to or in the presence of [the Client] that were not appropriate. These included:

   a. [Nurse C] suggesting she change the Attends [the Client] was wearing;
   b. [Nurse C] suggesting they insert a catheter;
   c. [Nurse C] suggesting they call the police; and
   d. [Nurse C] suggesting they cut [the Client]'s hair.

20. If [RN B] were to testify, he would say that when [the Client] continued to withhold her name, the Member and [Nurse C] pretended to leave the room to get the police. When the Member and [Nurse C] returned, [the Client] had turned so that her sternum could not be rubbed. [Nurse C] proceeded to take [the Client]’s left and right arms and hold her down. [the Client] was crying and asking the Member and [Nurse C] to stop.

21. During the time the Member and [Nurse C] were in [the Client]'s room, the cardiac monitor went off, indicating that [the Client]’s heart rate had exceeded 110 beats per minute.

22. When [RN A] returned from her break after approximately 40 minutes, [the Client]’s heart rate was over 130 beats per minute and she was crying and gasping and was so upset she could not catch her breath.

23. By shift change, between 06:30 and 07:00, a six-inch bruise was visible on [the Client]’s sternum.
24. [The Client] was transferred to the [child and adolescent mental health unit] on November 25, 2010. A physical assessment was conducted on [the Client]’s admission to the [mental health unit] and it was noted that her sternum was bruised and tender. The bruising was recorded into the progress notes of the chart as a late entry.

25. If the Member were to testify, she would say that she was not aware until after her interactions with [the Client] that [the Client] had previously been talking and responding to some degree. The Member would testify that if she had known [the Client] had been responsive, she would have approached the situation differently and would not have performed a sternal rub.

26. In any case, the Member acknowledges that she should have intervened to protect [the Client] when she realized [Nurse C] was acting inappropriately towards her.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

27. The Member admits that she committed the act of professional misconduct as alleged in paragraph 1 (f) of the Notice of Hearing, as described in paragraphs 10 to 26 above.

28. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(f) of the Notice of Hearing, in that she engaged in conduct or performed an act, relevant to the practice of nursing, that would reasonably be regarded by members of the profession as unprofessional, as described in paragraphs 10 to 26 above.

Decision

The panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(f) and 3(f) of the Notice of Hearing. As to allegation #3(f), the panel finds that the Member engaged in conduct that would reasonably be considered by members to be unprofessional.

Reasons for Decision

The panel considered the Agreed Statement of Facts and the Member’s plea and finds that this evidence supports findings of professional misconduct as alleged in the Notice of Hearing.

Allegation #1 (f) in the Notice of Hearing is supported by paragraphs 19, 20, 21, 22, 23 and 26 in the Agreed Statement of Facts.

Allegation #3(f) in the Notice of Hearing is supported by paragraphs 27 and 28 in the Agreed Statement of Facts.

With respect to Allegation #3(f), the panel finds that the Member’s conduct, in failing to intervene to protect the health and wellbeing of a client when she was being abused by another nurse, was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.
Penalty

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

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

2. Directing the Executive Director to suspend the Member’s certificate of registration for two 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 two meetings with a Nursing Expert (the “Expert”), at her own expense and within six months of 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 and online learning modules:

         1. Professional Standards,
         2. Therapeutic Nurse-Client Relationship;

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

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

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

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

vii. If the Member does not comply with any 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 12 months from the date the Member’s suspension ends, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

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

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

1. that they received a copy of the required documents, and
2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
4. All documents delivered by the Member to the College, the Expert or the employer(s) will be [delivered] by verifiable method of delivery, the proof of which the Member will retain.

Penalty Submissions

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

The parties agreed that the mitigating factors in this case were:

1. The Member did not have any prior discipline proceedings with the College nor any discipline proceeding with her employer; and
2. The Member cooperated with the College to address this matter, as seen in the Agreed Statement of Facts.

The aggravating factor in this case was the seriousness of the offense that occurred.

The proposed penalty provides for general deterrence through the two-month suspension; the terms, limitations and conditions on the Member’s certificate of registration; and the twelve-month employer notification period.

The proposed penalty provides for specific deterrence through the oral reprimand; the two-month suspension; the terms, limitations and conditions on the Member’s certificate of registration; the two meetings with the Nursing Expert; and the twelve-month employer notification.

The proposed penalty provides for remediation and rehabilitation through the two meetings with the Nursing Expert and the review of the Professional Standards and the Therapeutic Nurse-Client Relationship Standard, which will include a learning plan to be developed with the Nursing Expert.

Overall, the public is protected because of the initial suspension and the employer notification which will ensure awareness and attention of future employers.

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

1. CNO v. Clitheroe (Discipline Committee, 2008). This case involved a member who was present during an incident but failed to intervene. Penalty included an oral reprimand, a four-month suspension, terms, limitations and conditions on the certificate, meeting with a Nursing Expert, review of College professional standards, a learning plan, and a twelve-month employer notification provision.

2. CNO v. Guilbeau (Discipline Committee, 2010). This involved a member who physically abused a client. Penalty included an oral reprimand, a three-month suspension, terms, limitations and conditions on the certificate, three meetings with a Nursing Expert, review of
College professional standards, a learning plan, and a twelve-month employer notification term.

3. *CNO v. Lupp* (Discipline Committee, 2011). This involved a member who physically abused a client. Penalty included an oral reprimand, a four-month suspension, terms, limitations and conditions on the certificate, three meetings with a Nursing Expert, review of College professional standards, a learning plan, and a twelve-month employer notification.

Defence Counsel added the following cases for our consideration:

1. *R v. DeSousa*, 2012 ONCA 254 (CanLII). Defence counsel presented this case to remind the panel not to reject the joint submission unless the joint submission is contrary to the public interest and would bring the administration of justice into disrepute.

2. *CNO v. Allingham* (Discipline Committee, 2000). This involved a member who failed to intervene in a situation where two clients were barricaded in a special observation room. Penalty included an oral reprimand, no suspension, and terms, limitations and conditions on the certificate.

**Penalty Decision**

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

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

2. The Executive Director is directed to suspend the Member’s certificate of registration for two 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 two meetings with a Nursing Expert (the “Expert”), at her own expense and within six months of 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. [the] 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 and online learning modules:

   1. Professional Standards,
   2. Therapeutic Nurse-Client Relationship;

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

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

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

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

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

vii. If the Member does not comply with any 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 12 months from the date the Member’s suspension ends, the Member will notify her employers of the decision. To comply, the Member is required to:
i. Ensure that the Director is notified of the name, address, and telephone number of all employer(s) within 14 days of commencing or resuming employment in any nursing position;

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

1. the Panel’s Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. [the] Joint Submission on Order, and
5. a copy of the Panel’s Decision and Reasons, once available;

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

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

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be [delivered] by verifiable method of delivery, 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 two-month suspension and the terms, limitations and conditions on the Member’s certificate of registration, particularly the twelve-month employer notification, serve as general deterrence. The oral reprimand, the two-month suspension and the terms, limitations and conditions on the Member’s certificate of registration, particularly including the two meetings with the Nursing Expert and the twelve-month employer notification, serve as specific deterrence.
The two meetings with the Nursing Expert and the review of the *Professional Standards* and the *Therapeutic Nurse-Client Relationship Standard*, which will include a learning plan to be developed with the Nursing Expert, serve as remediation and rehabilitation.

In addition, protection of the public is served through the initial suspension and the employer notification, which will ensure awareness and attention of future employers.

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

I, Zahir Hirji, RN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

__________________________________________  ________________________________
Chairperson                                      Date

**Panel Members:**

Patrick Chiu, RN
Sarah Corkey, RN
Mary MacMillan-Gilkinson, Public Member
Chuck Williams, Public Member