DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL: Tammy Hedge, RPN Chairperson
Grace Fox, NP Member
Andrea Vidovic, RN Member
Renate Davidson Public Member
Chuck Williams Public Member

BETWEEN:
COLLEGE OF NURSES OF ONTARIO ) JEAN-CLAUDE KILLEY for
- and - ) College of Nurses of Ontario
DARREN SMITH ) NO REPRESENTATION for
Registration No. 10428726 ) Darren Smith
) Heard: June 13, 2014

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on June 13, 2014, at the College of Nurses of Ontario (“the College”) at Toronto.

The Allegations

The allegations against Darren Smith (the “Member”) as stated in the Notice of Hearing dated January 29, 2014, are as follows.

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(a) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, in that you were found guilty of an offence that is relevant to your suitability to practise, and in particular, on or about December 7, 2012, you were found guilty of the offence of knowingly acting upon a forged document as if it were genuine, contrary to s. 368(1) of the Criminal Code of Canada.

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(1) of Ontario Regulation 799/93, in that, while employed as a Registered Nurse at [the Facility] in [ ] Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

(a) on or about December 26, 2011, you failed to respond appropriately when you knew that a piece of a urinary catheter remained inside a client’s urethra;

(b) on or about December 26, 2011, you documented receiving a verbal order for medication related to [Client A], when you had not received a verbal order;

(c) on or about December 26, 2011, you administered medication to [Client A] without proper authorization;

(d) on or about December 26, 2011, you failed to document appropriately and/or as required the administration of medication to [Client A];

(e) on or about December 23, 2011, you documented receiving a verbal order for medication related to [Client B], when you had not received a verbal order;

(f) on or about December 23, 2011, you administered medication to [Client B] without proper authorization;

(g) on or about December 23, 2011, you failed to document appropriately and/or as required the administration of medication to [Client B];

(h) on or about December 23, 2011, you documented receiving a verbal order for medication related to [Client C], when you had not received a verbal order;

(i) on or about December 23, 2011, you administered medication to [Client C] without proper authorization;

(j) on or about September 29, 2011, you documented receiving a verbal order for medication related to [Client D], when you had not received a verbal order;

(k) on or about September 29, 2011, you administered medication to [Client D] without proper authorization;

(l) on or about September 29, 2011, you failed to document appropriately and/or as required the administration of medication to [Client D];

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(9) of Ontario Regulation 799/93, in that, while employed as a Registered Nurse at [the Facility] in [ ] Ontario, you did something to a client for a therapeutic, preventative, palliative, diagnostic, cosmetic or other health related purpose in a situation in which a consent is required by law, without such a consent, and in particular:

(a) on or about December 26, 2011, you administered medication to [Client A] without consent;
(b) on or about December 23, 2011, you administered medication to [Client B] without consent;

(c) on or about December 23, 2011, you administered medication to [Client C] without consent;

(d) on or about September 29, 2011, you administered medication to [Client D] without consent;

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(14) of Ontario Regulation 799/93, in that, while employed as a Registered Nurse at [the Facility] in [ ] Ontario, you falsified records relating to your practice, and in particular:

(a) on or about December 26, 2011, you falsified an order for medication related to [Client A];

(b) on or about December 23, 2011, you falsified an order for medication related to [Client B];

(c) on or about December 23, 2011, you falsified an order for medication related to [Client C];

(d) on or about September 29, 2011, you falsified an order for medication related to [Client D];

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 (the “Act”), and defined in subsection 1(19) of Ontario Regulation 799/93, in that, while employed as a Registered Nurse at [the Facility] in [ ] Ontario, you contravened a provision of the Nursing Act, 1991, the Regulated Health Professions Act, 1991, S.O. 1991, c. 18, as amended (the “RHPA”), or the regulations under either of those Acts, and in particular, you contravened section 27(1) of the RHPA by performing a controlled act, namely, prescribing a drug, when not authorized to do so, as follows:

(a) to [Client A] on or about December 26, 2011;

(b) to [Client B] on or about December 23, 2011;

(c) to [Client C] on or about December 23, 2011;

(d) to [Client D] on or about September 29, 2011;

6. You have committed an act of professional misconduct as provided 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 (the “Act”), and defined in subsection 1(19) of Ontario Regulation 799/93, and as provided by subsection 5(2) of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, in that, while employed as a Registered Nurse at [the Facility] in [ ] Ontario, you administered a substance by injection without being permitted to do so by
the regulations and/or without an order or other appropriate authorization, contrary to s. 5(1) of the *Nursing Act, 1991*, and in particular:

(a) to [Client A] on or about December 26, 2011;
(b) to [Client B] on or about December 23, 2011;
(c) to [Client C] on or about December 23, 2011;
(d) to [Client D] on or about September 29, 2011;

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

(a) on or about December 26, 2011, you failed to respond appropriately when you knew that a piece of a urinary catheter remained inside a client’s urethra;
(b) on or about December 26, 2011, you documented receiving a verbal order for medication related to [Client A], when you did not receive a verbal order;
(c) on or about December 26, 2011, you administered medication to [Client A] without proper authorization;
(d) on or about December 26, 2011, you failed to document appropriately and/or as required the administration of medication to [Client A];
(e) on or about December 23, 2011, you documented receiving a verbal order for medication related to [Client B], when you did not receive a verbal order;
(f) on or about December 23, 2011, you administered medication to [Client B] without proper authorization;
(g) on or about December 23, 2011, you failed to document appropriately and/or as required the administration of medication to [Client B];
(h) on or about December 23, 2011, you documented receiving a verbal order for medication related to [Client C], when you did not receive a verbal order;
(i) on or about December 23, 2011, you administered medication to [Client C] without proper authorization;
(j) on or about September 29, 2011, you documented receiving a verbal order for medication related to [Client D], when you did not receive a verbal order;
(k) on or about September 29, 2011, you administered medication to [Client D] without proper authorization;
on or about September 29, 2011, you failed to document appropriately and/or as required the administration of medication to [Client D].

**Member’s Plea**

The Member admitted the allegations set out in paragraphs 1 through 7 inclusive 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. Darren Smith (the “Member”) obtained a nursing degree [ ] in 2010.

2. The Member registered with the College of Nurses of Ontario (the “College”) as a Registered Nurse (“RN”) on August 19, 2010.

3. The Member was employed at [the Facility] from November 17, 2010, to January 9, 2012.

**THE FACILITY**

4. The Facility is located in [ ] Ontario.

5. The Facility is a long-term care home that has [ ] long-term care beds and [ ] respite beds.

6. The Member worked at the Facility as a full-time staff nurse on evening, night and weekend shifts.

**INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

**[Client E]’s Catheter**

7. On December 26-27, 2011, the Member was providing care to [Client E] on the night shift.

8. While assessing [Client E], the Member discovered a cut piece of catheter in [Client E]’s room. The Member investigated and determined that a piece of catheter remained in [Client E]’s urethra.

9. The Member charted the following in the progress notes:
Staff found piece of catheter. Catheter appears to be cut off by resident. Catheter cut at ¼. Resident returned to bed. Catheter tube cut off at tip of penis. Unable to remove reminder [sic] of catheter. No blood. Denies pain.

Staff looked for sharp object. None found in bathrooms, closet, resident’s room, hallway or floors. Resident remains pleasantly confused. No new S+S.

10. The Member did not do anything further about the piece of catheter remaining inside the client’s urethra, although he knew that it did in fact remain in the client’s urethra.

11. Approximately thirty minutes later, at the end of his shift, the Member informed the oncoming nurse about [Client E] having cut his catheter. He did not specify that a piece of the catheter remained inside the client’s urethra, although the Member knew this was still the case.

12. The oncoming nurse only understood this to be the case when, later on in her shift, she reviewed the progress notes and saw that the Member had been “unable to remove” the cut piece of catheter. The oncoming nurse sent [Client E] to the hospital, where the remaining piece of catheter was surgically removed.

Incidents Related to Medication Administration

13. On December 27, 2011, the Facility’s Director of Nursing (“DON”) was reviewing Point Click Care progress notes (i.e. electronic progress notes) from her home. She noticed that the Member had documented contacting the physician by phone and receiving a verbal order for Haldol for [Client A] at 01:00 on December 26, 2011, then administering Haldol twice overnight, at 01:00 and 03:00.

14. The DON was concerned, upon reading this progress note, that Haldol had not been discussed with [Client A]’s substitute decision makers, and that the Member had therefore not obtained appropriate consent for the new medication administration. Furthermore, the Member had not documented on the client’s Medication Administration Record that he had administered this medication.

15. The DON investigated and determined that the doctor who was listed as having given the Haldol order was not on call on the night in question. The physician also told the DON that he would not have ordered Haldol for [Client A].

16. As a result of this information, the DON conducted a detailed review of progress notes made by the Member, and identified three more suspicious instances of medication administration, as follows:

a. On December 23, 2011, the Member administered Haldol to [Client B] without consent and without a corresponding physician’s order. The Member nevertheless documented receiving an order for Haldol for [Client B] verbally over the phone and documented administering the medication in
the progress notes. He did not, however, document in the client’s Medication Administration Record that he had administered the medication. The physician to whom the Member attributed the order was not in fact on call that night.

b. On the same day, the Member also administered Trazodone to [Client C] without consent and without a corresponding physician’s order. He documented receiving a verbal order from the physician at 23:30 and documented having administered Trazodone to [Client C] in the client’s progress notes and Medication Administration Record. The physician to whom the Member attributed the order was not in fact on call that night.

c. On September 29, 2011, the Member administered Haldol to [Client D] without consent and without a corresponding physician’s order, and without documenting at all that he administered the medication.

17. In each of these four instances, the Member forged an order for the medication at issue. The Member admits that this amounts to prescribing medication, a controlled act which he was not authorized to perform in those circumstances. He also administered the medication at issue, without having any authorization to do so.

18. The Member did not obtain consent from the clients or from their substitute decision makers to administer the medication in question in any of these four instances.

19. The Member admits that this conduct was in breach of the standards of practice of the profession, and was disgraceful, dishonourable and unprofessional.

Criminal Convictions

20. As a result of the incidents described above in which the Member forged physicians’ orders before administering medication without authorization, on December 7, 2012, the Member was found guilty of knowingly acting on a forged document as if it were genuine (namely, the forged physicians’ orders), contrary to s. 368(1) of the Criminal Code of Canada.

21. The Member pled guilty and was sentenced to a conditional sentence of three months and probation for 21 months. As a term of his probation, the Member was prohibited from practising nursing for the first 15 months of the probation period. The term will expire on June 7, 2014.

22. The Member admits that this offence is relevant to his suitability to practise nursing.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

23. The Member admits that he committed the acts of professional misconduct as alleged, as described in paragraphs 7 to 22 above, and as set out in the Notice of Hearing in the following paragraphs:
Decision

The panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1, 2, 3, 4, 5, 6, and 7 of the Notice of Hearing.

As to allegation # 7, the panel finds that the Member engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional, and in particular:

(a) on or about December 26, 2011, he failed to respond appropriately when he knew that a piece of a urinary catheter remained inside a client’s urethra;

(b) on or about December 26, 2011, he documented receiving a verbal order for medication related to [Client A], when he did not receive a verbal order;

(c) on or about December 26, 2011, he administered medication to [Client A] without proper authorization;

(d) on or about December 26, 2011, he failed to document appropriately and/or as required the administration of medication to [Client A];

(e) on or about December 23, 2011, he documented receiving a verbal order for medication related to [Client B], when he did not receive a verbal order;

(f) on or about December 23, 2011, he administered medication to [Client B] without proper authorization;

(g) on or about December 23, 2011, he failed to document appropriately and/or as required the administration of medication to [Client B];

(h) on or about December 23, 2011, he documented receiving a verbal order for medication related to [Client C], when he did not receive a verbal order;

(i) on or about December 23, 2011, he administered medication to [Client C] without proper authorization;

(j) on or about September 29, 2011, he documented receiving a verbal order for medication related to [Client D], when he did not receive a verbal order;

(k) on or about September 29, 2011, he administered medication to [Client D] without proper authorization;
on or about September 29, 2011, he failed to document appropriately and/or as
required the administration of medication to [Client D].

Reasons for Decision

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

Allegation # 1 in the Notice of Hearing is supported by paragraphs 17, 20, 21, and 22 in the
Agreed Statement of Facts.

Allegation # 2a in the Notice of Hearing is supported by paragraphs 8, 9, 10, 11, 12 in the
Agreed Statement of Facts.

Allegations # 2b, c and d in the Notice of Hearing is supported by paragraphs 13, 14, and 15 in
the Agreed Statement of Facts.

Allegations # 2h and i in the Notice of Hearing is supported by paragraph 16b in the Agreed
Statement of Facts.

Allegations # 2e, f and g in the Notice of Hearing is supported by paragraph 16a in the Agreed
Statement of Facts.

Allegations # 2j, k, and l in the Notice of Hearing is supported by paragraph 16c in the Agreed
Statement of Facts.

Allegation # 3a in the Notice of Hearing is supported by paragraphs 13, 14, 17, and 18 in the
Agreed Statement of Facts.

Allegation # 3b in the Notice of Hearing is supported by paragraphs 16a, 17, and 18 in the
Agreed Statement of Facts.

Allegation # 3c in the Notice of Hearing is supported by paragraphs 16b, 17, and 18 in the
Agreed Statement of Facts.

Allegation # 3d in the Notice of Hearing is supported by paragraphs 16c, 17, and 18 in the
Agreed Statement of Facts.

Allegation # 4a in the Notice of Hearing is supported by paragraphs 13, 15, and 17 in the Agreed
Statement of Facts.

Allegation # 4b in the Notice of Hearing is supported by paragraphs 16a and 17 in the Agreed
Statement of Facts.
Allegation # 4c in the Notice of Hearing is supported by paragraphs 16b and 17 in the Agreed Statement of Facts.

Allegation # 4d in the Notice of Hearing is supported by paragraphs 16c and 17 in the Agreed Statement of Facts.

Allegation # 5a in the Notice of Hearing is supported by paragraphs 13 and 18 in the Agreed Statement of Facts.

Allegation # 5b in the Notice of Hearing is supported by paragraphs 16a and 18 in the Agreed Statement of Facts.

Allegation # 5c in the Notice of Hearing is supported by paragraphs 16b and 18 in the Agreed Statement of Facts.

Allegation # 5d in the Notice of Hearing is supported by paragraphs 16c and 18 in the Agreed Statement of Facts.

Allegation # 6a in the Notice of Hearing is supported by paragraph 13 in the Agreed Statement of Facts.

Allegation # 6b in the Notice of Hearing is supported by paragraph 16a in the Agreed Statement of Facts.

Allegation #6c in the Notice of Hearing is supported by paragraph 16b in the Agreed Statement of Facts.

Allegation # 6d in the Notice of Hearing is supported by paragraph 16c in the Agreed Statement of Facts.

Allegation # 7a in the Notice of Hearing is supported by paragraphs 7, 8, 9, 10, 11, 12, and 19 in the Agreed Statement of Facts.

Allegation # 7b in the Notice of Hearing is supported by paragraphs 13, 14, 15, and 19 in the Agreed Statement of Facts.

Allegation # 7c in the Notice of Hearing is supported by paragraphs 13, 14, 15, 18, and 19 in the Agreed Statement of Facts.

Allegation # 7d in the Notice of Hearing is supported by paragraphs 13, 14, and 19 in the Agreed Statement of Facts.

Allegation # 7e in the Notice of Hearing is supported by paragraphs 16a, 17, and 19 in the Agreed Statement of Facts.
Allegation #7f in the Notice of Hearing is supported by paragraphs 16a and 19 in the Agreed Statement of Facts.

Allegation #7g in the Notice of Hearing is supported by paragraphs 16a, 17, and 19 in the Agreed Statement of Facts.

Allegation #7h in the Notice of Hearing is supported by paragraphs 16b and 19 in the Agreed Statement of Facts.

Allegation #7i in the Notice of Hearing is supported by paragraphs 16b, 17, and 19 in the Agreed Statement of Facts.

Allegation #7j in the Notice of Hearing is supported by paragraphs 16c and 19 in the Agreed Statement of Facts.

Allegation #7k in the Notice of Hearing is supported by paragraphs 16c, 17, and 19 in the Agreed Statement of Facts.

Allegation #7l in the Notice of Hearing is supported by paragraphs 16c and 19 in the Agreed Statement of Facts.

As to allegation #1, the Member was found guilty on December 7, 2012 of knowingly acting on a forged document as if it were genuine (namely, the forged physicians’ orders), contrary to s. 368(1) of the Criminal Code of Canada. This is clearly relevant to the Member’s suitability to practice.

As to allegation #2, the Member breached three standards of practice of the profession, as follows.

1. Professional Standards, Revised 2002

   The Member failed to meet the accountability, ethics, knowledge and knowledge application standards in at least four ways.

   a) Accountability: The Member did not take action or seek assistance when the catheter tip remained in the [client]’s urethra and thus the client’s safety and wellbeing was compromised. He administered a medication without authorization and therefore failed to ensure his practice was consistent with the standards of practice, guidelines and legislation.

   b) Ethics: The Member’s forgery of medication orders and deception illustrates a lack of integrity, honesty and professionalism

   c) Knowledge: The prescribing and administration of medications without authorization shows a lack of understanding of the scope of practice of nursing
d) Knowledge Application: The Member failed to recognize the limits of practice and consult appropriately in relation to the catheter incident. The Member also failed to evaluate and modify the plan of action when not able to retrieve the catheter tip.

2. Documentation, Revised 2008

The Member failed to ensure that documentation was complete. The documentation did not reflect all aspects of the nursing process

3. Medication, Revised 2008

The Member failed to meet this standard by forging an order for a medication, then administering the medication without verifying informed consent from the client or the client’s substitute decision-maker.

With respect to Allegation # 7, the panel finds that the Member’s conduct in failing to report that a piece of a urinary catheter remained in a client, forging a physician’s order, documenting receipt of a verbal order when the Member did not receive such direction, failing to document appropriately, and administering a medication without proper authorization, was in total dishonourable, disgraceful and unprofessional, as it demonstrated a serious and persistent disregard for his professional obligations. The Member was dishonest. The panel finds that the Member’s conduct shames the Member and, by extension, the profession. The conduct casts serious doubt on the Member’s moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

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 six 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 his 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. Documentation,
   3. Medication,

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;

viii. Requiring the Member, at his own expense, to successfully complete, with a minimum passing grade of 65%, within 24 months from the date of this Order, or at such further time as pre-approved by the Director, in writing, a course in pharmacology, approved by the Director.

ix. Requiring the Member, at his own expense, to successfully complete, with a minimum passing grade of 65%, within 24 months from the date of this Order, or at such further time as pre-approved by the Director, in writing, a course in medication administration, approved by the Director.

b) For a period of 18 months from the date the Member returns to clinical nursing practice, the Member will notify his employers of the decision. To comply, the Member is required to:

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

ii. Provide his employer(s) with a copy of:
   1. the Panel’s Order,
   2. the Notice of Hearing,
   3. the Agreed Statement of Facts,
   4. this Joint Submission on Order, and
   5. a copy of the Panel’s Decision and Reasons, once available;

iii. Ensure that within 14 days of the commencement or resumption of the Member’s employment in any nursing position, the employer(s) forward(s) a report to the Director, in which it will confirm:
   1. that they received a copy of the required documents, and
   2. that they agree to notify the Director immediately upon receipt of any information that the Member has breached the standards of practice of the profession; and
4. All documents delivered by the Member to the College, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

**Penalty Submissions**

Submissions were made by College Counsel. The Member indicated that he agreed with those submissions.

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

a) there was no harm to the clients,

b) the Member has accepted responsibility for his actions, and

c) the Member is willing to participate in rehabilitation

The aggravating factors in this case were:

a) the allegations are serious in nature,

b) the allegations were deliberate and repetitive, and

c) the events pose a high risk to public safety.

The proposed penalty provides for general deterrence as the suspension of six months is a significant length of time. The members of the profession will also realize that the Member pled guilty to a criminal charge and was sentenced to three months incarceration plus probation for 21 months. As a term of his probation, the Member was prohibited from practising nursing for the first 15 months of the probation period.

The proposed penalty provides for specific deterrence aimed at the Member and rehabilitation. Employer notification will increase awareness of the Member’s prior misconduct and is intended to maintain public confidence in the profession. The meetings with a Nursing Expert will promote personal reflection. Courses in medication and pharmacy will allow the Member to demonstrate his knowledge of the Standards of Practice, namely the Medication Standard and the Documentation Standard.

The proposed penalty provides for remediation and rehabilitation through the reprimand, the suspension, meetings with an expert witness, two courses to illustrate the Member’s understanding of the Medication and Documentation Standards of Practice, and the period of employer notification

Overall, the public is protected because the suspension sends a strong, clear message to the profession that such behaviour will not be tolerated. The penalty includes both educational and remedial components, and addresses the need for public protection by ensuring the Member’s employer(s) will be aware of his conduct for a period of 18 months following his suspension.
Counsel submitted cases to the panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee and other similar committees.


   Although the facts of this case are not similar, this case is useful in that it expresses the principle that penalties should address the guiding principles of protection of the public, disapproval and denunciation of wrongful conduct, maintenance of public confidence in the integrity and self-regulation capacity of the profession, specific and general deterrence, and the rehabilitative needs of the member. The case law is clear that discipline committees should accept a joint submission, unless to do so would be contrary to the public interest and would bring the administration of justice into disrepute.

2. *CNO v. Peters* (Discipline Committee, 2009)

   In the case of Peters the member administered medications early, falsified administration numerous times, and falsified the narcotic sheet. The member did not attend the hearing. The member was suspended for six months and was ordered to complete courses in pharmacy and medications. The member was to also meet with a Practice consultant, and employer notification was for twelve months. The allegations were not as serious as in the present case and did not lead to criminal charges.

3. *CNO v. Stromme* (Discipline Committee, 2009)

   In Stromme the member forged a physician’s order leading to a finding that the member acted in a manner that was disgraceful, dishonourable and unprofessional. The member was suspended for three months, ordered to meet with the Director of Investigations and Hearings, and was subjected to an employer notification period of 12 months following the member’s return to work. The penalty in Stromme was lighter than the proposed penalty for the present case as the conduct was narrower in scope.

**Penalty Decision**

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

1. The Member shall 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 six 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 his 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. *Documentation*,
          3. *Medication*,

      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;

viii. Requiring the Member, at his own expense, to successfully complete, with a
    minimum passing grade of 65%, within 24 months from the date of this
    Order, or at such further time as pre-approved by the Director, in writing, a
    course in pharmacology, approved by the Director.

ix. Requiring the Member, at his own expense, to successfully complete, with a
    minimum passing grade of 65%, within 24 months from the date of this
    Order, or at such further time as pre-approved by the Director, in writing, a
    course in medication administration, approved by the Director.

b) For a period of 18 months from the date the Member returns to clinical nursing
   practice, 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. [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, 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 cooperated 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.

I, Tammy Hedge, 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 as listed below:

____________________  ______________
Chairperson  Date

**Panel Members:**

Grace Fox, NP
Andrea Vidovic, RN
Renate Davidson, Public Member
Chuck Williams, Public Member