DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (“the Panel”) on February 5, 2019 at the College of Nurses of Ontario (“the College”) at Toronto.

Deanna Blum (“the Member”) was present but not represented by Counsel.

Publication Ban

At the request of Counsel for the College, the Panel made an order pursuant to s.45(3) of the Health Professions Procedural Code of the Nursing Act, 1991, preventing the public disclosure of the names of the Clients or any information that could identify them, referred to orally or in any documents presented in the Discipline Hearing of Deanna Blum, including a ban on the publication or broadcasting of this information.

The Allegations

The allegations against the Member as stated in the Notice of Hearing dated January 29, 2019 are as follows:
IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of Ontario Regulation 799/93, in that, while employed by Bluewater Health (the “Hospital”) as a Registered Practical Nurse, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that:

   (a) while assigned to your client, [Client A], on the evening of April 7, 2016, you failed to monitor, assess, intervene, and/or seek assistance and/or appropriately document your care of [Client A] including but not limited to
      
      i. failing to observe the client while he was in his locked room while he engaged in self-harm and/or rang his call bell;
      
      ii. failing to de-escalate his behaviour;
      
      iii. failing to assess the ongoing need for restraints; and/or
      
      iv. failing to document his self-harm in his chart and/or in an incident report;

   (b) on or about June 13, 2017, you swatted and/or slapped the hand or hands of your client, [Client B]; and/or

   (c) on or about June 13, 2017, you told your client, [Client B], “don’t hit me or I will not help you” and/or “stop pawing me” or words to that effect, in a rude and/or annoyed tone.

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(37) of Ontario Regulation 799/93, while employed by the Hospital as a Registered Practical Nurse, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in that you:

   (a) while assigned to your client, [Client A], on the evening of April 7, 2016, you failed to monitor, assess, intervene, and/or seek assistance and/or appropriately document your care of [Client A] including but not limited to
      
      i. failing to observe the client while he was in his locked room while he engaged in self-harm and/or rang his call bell;
      
      ii. failing to de-escalate his behaviour;
      
      iii. failing to assess the ongoing need for restraints; and/or
      
      iv. failing to document his self-harm in his chart and/or in an incident report;

   (b) on or about June 13, 2017, you swatted and/or slapped the hand or hands of your client, [Client B]; and/or
(c) on or about June 13, 2017, you told your client, [Client B], “don’t hit me or I will not help you” and “Stop pawing me” or words to that effect, in a rude and/or annoyed tone.

**Member’s Plea**

The Member admitted the allegations set out in paragraphs 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(b), 1(c), 2(a)(i), 2(a)(ii), 2(a)(iii), 2(a)(iv), 2(b) and 2(c) 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. Deanna Blum (the “Member”) obtained a diploma in practical nursing from St. Clair College in 2009.

2. The Member registered with the College of Nurses of Ontario (the “College”) as a Registered Practical Nurse (“RPN”) on August 4, 2009.

3. The Member was employed at Bluewater Health (the “Hospital”) from August 8, 2011 to June 21, 2017, when her employment was terminated as a result of the incidents below.

**THE FACILITY**

4. The Hospital is located in Sarnia, Ontario.

5. The Member worked as a full-time staff nurse at the Hospital in the Mental Health Unit (the “MH Unit”) and later in the Acute Care Unit (“AC Unit”).

6. The MH Unit has approximately 20 beds, with an Observation Area with four locked rooms with their own locked lounge area called the vestibule. The nursing station in the Observation Area (“Nursing Station”) has videos of each client room; as does the nursing station in the MH Unit outside the Observation Area, and nurses can speak remotely to clients in their rooms from these locations.

7. In addition to the video feeds from the four Observation Area rooms, the Observation Area had two cameras in the hallways.

8. Clients in the Observation Area are not on constant observation as a matter of course, but one nurse is required to be present in the area and to have “eyes and ears” on clients at all times.
9. The Hospital had an unwritten policy that only one client could be in the vestibule at any one time, and only one door could be unlocked at any one time.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

[Client A]

10. [Client A] (“Client A”) was a [ ] developmentally delayed client, with numerous past admissions for depression with psychotic features, paranoid/delusional thinking and suicidal ideation, among other things.

11. On April 3, 2016, he was admitted [ ], and had numerous outbursts in the Hospital from April 3-7, 2016, including head-banging. He was bedded in one of the four Observation Area rooms.

12. Client A did not like to be in his room and preferred to be in the vestibule area. On several occasions on April 4-6, 2016, he became agitated when he was placed in his room, and bit his arm, hit his door, and banged his head. In the early hours of April 7, 2016, he became agitated and engaged in similar behaviour. He received PRN medications to calm him on several occasions between April 4 and 7, 2016.

13. On April 7, 2016, the Member was scheduled to work the day shift from 0700 to 1900. She also worked from 1900 to 2300 to cover for a colleague who was off sick. On the evening shift, the Observation Area was staffed with two nurses – the Member and [Nurse A]. [Nurse B] was the Charge Nurse/Unit Lead on that day and evening.

14. In the evening, the Member was assigned to Client A and five other clients. Those other clients were bedded in the part of the MH Unit that is outside the Observation Area.

15. At 1811, the Member made a brief note in Client A’s chart (the first charting for Client A on her shift that started at 0700) that Client A had been received in the vestibule in the Observation Area. He was anxious and yelling, disruptive, and was “aggressive at times when asked to go back to his room.” She noted that he had spent most of the day sitting in the vestibule.

16. Client A entered his room at 1840. If the Member were to testify, she would say that Client A was escorted back to his room to clear the vestibule for an admission coming from the emergency department.

17. Between 1845 and 1934, Client A was in his room, banging his head, shouting, and ringing his call bell.

18. Around 1845, the Member began admitting a suicidal client from the emergency department. The video shows the new client entering the hallway at 1902 when the admission was complete.
19. From her location at another nursing station, [Nurse B], the Charge Nurse, heard Client A ringing his call bell repeatedly. [Nurse B] was unable to answer or turn off the call bell, because the call bell had been taken off the hook in the Observation Area. [Nurse B] went to Client A’s door and spoke to him at 1855, which calmed him briefly. She then advised [Nurse A] to tell the Member to release Client A from his room as soon as possible.

20. From 1854 to 1903, Client A banged his head on the door several times, shouted and used the call bell several times. While the Member was completing the admission, [Nurse A] was sitting at the Nursing Station. [Nurse A] told the Hospital that she was charting, but also frequently monitoring the video feeds. She spoke to Client A through the audio link several times while he was in his room but Client A persisted.

21. The Member returned to the Nursing Station in the Observation Area at 1906, sitting until 1910. During this time, Client A banged his head and used the call bell several times. [Nurse A] and the Member did not communicate with him. At 1910, the client being admitted was escorted through the hallway, having changed into a gown. From this point, the vestibule area was empty.

22. From 1910 to 1923, the Member was not present in the Nursing Station. When she returned, she is seen on the video speaking to several other people in the Nursing Station. It does not appear that anyone communicated with Client A during this time, despite him banging his head, banging on the door, and repeatedly using the call bell.

23. At 1934, the Member entered Client A’s room and administered a PRN injection. Client A was then relatively calm until 2015.

24. Between 2015 and 2107, Client A was in his room, ringing his call bell. Client A can be observed on video at 2027, banging the back of his head and smacking the wall between five and ten times. The Member was in the Nursing Station at that time but did not let Client A into the vestibule area. If the Member were to testify, she would state that she did not observe him banging his head. The Member exited the Nursing Station at 2040.

25. At 2042, Client A banged his head against the glass door and used the call bell. He repeatedly banged on the wall and door, and rang the call bell between 2053 and 2103, while no one was at the Nursing Station. At 2107, the Member allowed Client A to enter the vestibule area.

26. At 2112, the Member recorded that, at 1940, Client A was agitated and aggressive and that she administered Haldol and Cogentin IM at 1940 (which she also recorded in the MAR), and that the medication was not effective at this time. The Member did not chart anything else in Client A’s chart during her shift.

27. If the Member were to testify, she would state that Client A appeared uninjured when he exited his room at 2107.
28. [Nurse C] took over on the night shift at 2300. From 0239 to 0259, Client A engaged in significant head-banging and use of the call bell. Security spoke to Client A through his door at 0250, and had a physical altercation with him at 0257.

29. At 0406, [Nurse C] charted that Client A was bruised and swollen from banging his head. The following day, he had black eyes and swelling. He received a CT scan, which confirmed that he did not suffer any long-term damage. Following this incident, Client A had several more outbursts. On April 17, 2016, he was admitted to the Hospital’s medical unit with low sodium levels, an unsteady gait and drooling.

30. On April 27, 2016, the Hospital issued a three-day suspension to the Member for her failure to attend to Client A on the night of April 7, 2016. She was also required to complete a learning plan.

31. The Member moved to the AC Unit after this incident.

32. If the Member were to testify, she would say that that the MH Unit was under resourced when the incident occurred, and that she did her best to provide care to all of her clients, but she relied on [Nurse A] to monitor Client A while she was admitting the new client to the MH Unit. She would also state that Client A’s treating physician wanted Client A to get used to spending time alone in his room. The Member acknowledges that she did not observe Client A during her shift in a sufficiently close manner, given her other priorities on that shift.

33. Although she administered a PRN medication at approximately 1934, the Member admits that she did not take adequate steps to assess, intervene, seek assistance and/or de-escalate Client A’s behaviour, which included banging his head and body and using the call bell. She observed or could have observed Client A’s agitation and self-harming behaviour, especially when she was in the Nursing Station between 1906 and 1910, and also between 2015 and 2107. The vestibule was empty and available as early as 1910, and Client A could have been released from his room as early as 1910. She also failed to accurately and completely document Client A’s status during her shift.

34. The Member administered a chemical restraint at 1934, as set out above, but she acknowledges that she failed to assess the need for restraints throughout her shift and did not document the rationale for the administration of the chemical restraint at 1934. She acknowledges that she failed to complete an incident report, which is required when a client injures themselves.

35. The Member also acknowledges and admits that her conduct fell below the standards of practice.

[Client B]

36. [Client B] (“Client B”) was 94 years old at the time of the incident. She was in the AC Unit of the Hospital. She suffered from dementia and could not see or hear well. She often
reached out her hands to staff because of her limited sight and hearing. She had been a client in the AC Unit on numerous occasions in the past. She was occasionally rude to staff and had pinched and punched staff on occasion in the past.

37. The Member worked the day shift on June 13, 2017 and was assigned to provide care to Client B.

38. On June 13, 2017, at approximately 0715, a bed alarm alerted AC Unit staff that Client B had fallen out of her bed. She was found on the floor of her room.

39. [Nurse D], the Charge Nurse on shift and [Nurse E], another RN, assisted Client B back to bed after assessing her for a fracture. [Colleague A], a medical laboratory assistant, was also present. Client B thanked [Nurse D] and did not express a significant amount of pain, though she did state, “it hurts, it hurts.”

40. It was later determined that Client B had suffered a fracture.

41. [Nurse E] and [Nurse D] left Client B’s room. Client B was in bed talking to herself saying “help me, help me,” which was not uncommon for this client. [Colleague A] also left, attended to another client, with the intention to return to Client B’s room a few minutes later to complete her bloodwork.

42. As Client B’s assigned nurse, the Member was required to take her complete vitals, as required after a fall.

43. [Colleague A] returned to Client B’s room. As [Colleague A] was completing hand hygiene outside Client B’s room, she observed the Member in the room, standing on the right side of Client B’s bed. [Colleague A] moved to the doorway of the room. If [Colleague A] were to testify, she would state that she saw the Member swat or slap Client B’s right hand away and say, “Stop pawing at me or I will not help you,” in an annoyed tone of voice. She would further state that Client B was reaching her hand up and asking the Member to hold her hand, but was not flailing or grasping. If the Member were to testify, she would state that Client B was aggressive, due to pain, hitting the Member, and would further state that the Member was attempting de-escalate the client and that she held her hands up to defend herself against Client B’s actions.

44. If [Colleague A] were to testify, she would say she entered the room and held Client B’s hand. Client B indicated that she liked [Colleague A] and did not like the Member. The Member responded that “this was going to be a great day,” or words to that effect, in a sarcastic tone.

45. The Member acknowledges that she could have been more empathetic when she held up her hands. The Member further acknowledges that she swatted or lightly slapped the client’s hand away, which she would testify was to protect herself from Client B’s aggression. She also acknowledges she could have spoken to Client B in a tone that was more empathetic to the pain the client was experiencing or the situation she was in.
ADMISSIONS OF PROFESSIONAL MISCONDUCT

46. The Member admits that she committed the acts of professional misconduct as described in paragraphs 9 to 45 above, in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as alleged in the Notice of Hearing, as follows:

- 1(a) in that she failed to monitor, assess, intervene and/or seek assistance and/or appropriately document her care of Client A on April 7, 2016 as follows:
  - 1(a)(i) in that she failed to observe Client A while he was locked in his room and engaging in self-harm and/or ringing his call bell;
  - 1(a)(ii) in that she failed to de-escalate Client A’s behaviour;
  - 1(a)(iii) in that she failed to assess Client A’s ongoing need for restraints;
  - 1(a)(iv) in that she failed to document Client A’s self-harm in his chart and/or in an incident report.

- 1(b) in that she swatted Client B’s hand on June 13, 2017;

- 1(c) in that she said to Client B in a rude or annoyed tone, “don’t hit me or I will not help you” or/or “stop pawing at me,” or words to that effect.

47. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a) (i), (ii), (iii) and (iv), 2(b) and 2(c) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 9 to 45 above.

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 of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(b), 1(c), 2(a)(i), 2(a)(ii), 2(a)(iii), 2(a)(iv), 2(b), and 2(c). As to allegations 2(a)(i), 2(a)(ii), 2(a)(iii), 2(a)(iv) and 2(b) and 2(c), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be unprofessional and dishonorable.
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(a)(i) in the Notice of Hearing is supported by paragraph 8, in the Agreed Statement of Facts. Clients that are in the observation area are always required to have a nurse observing them. [Client A] had numerous past admissions to this unit. He was known to be developmentally delayed and suffering from depression, with history of psychotic features and paranoid/delusional thinking and suicidal ideation. The Member failed to provide the supervision as set out in the hospital’s policy.

Allegation 1(a)(ii) in the Notice of Hearing is supported by paragraphs 15, 21, 22, 24 to 26 and 28 to 34 in the Agreed Statement of Facts. The Member failed to provide de-escalation for Client A, the client was observed banging his head on the door, shouting out and he used his call bell several times. The Member failed to communicate, give support, reassurance or direction to Client A.

Allegation 1(a)(iii) in the Notice of Hearing is supported by paragraphs 21, 22, 24 to 26 and 28 to 34 in the Agreed Statement of Facts. The Member was observed on video giving support and direction to several other clients. The Member did not appear to communicate with Client A despite him banging his head, banging on the door and repeatedly using the call bell. The Member did not allow Client A into the vestibule area even though she was aware that Client A was usually calm while there. The vestibule had been empty since 1910. The Member could have moved Client A which would have reduced the client’s anxiety and self-harming behaviours. The Member failed to support an action that was known to de-escalate the client in the past.

Allegation 1(a)(iv) in the Notice of Hearing is supported by paragraphs 26, 33 to 35 in the Notice of Hearing. The Member administered Haldol andCogentin IM at 1934 hours. The medication was not effective. While the Member documented at 2112 that the medication on order was not effective at this time, she made no other entries in Client A’s chart during her shift. The Member admits that she did not observe Client A during her shift in a sufficiently close manner according to policy and practice on the unit. The Member could have de-escalated Client A’s behaviours if she had allowed him into the vestibule. The Member was aware that Client A did not like to be in his room and preferred to be in the vestibule area.

Allegations 1(b) and (c) in the Notice of Hearing are supported by paragraphs 43 to 46 in the Agreed Statement of Facts. The Member transferred to the Acute Care Unit (“AC Unit”) after her three day suspension from the psychiatric unit. The Member was caring for a 94-year-old client (“Client B”) who had dementia, and was hearing and visually impaired. Client B had been a client in the AC unit on numerous occasion in the past. Client B’s bed alarm alerted the unit staff and Client B was found on the floor of her room. Client B verbalized that “it hurts, it hurts.” The Member was observed by [Colleague A] swatting and slapping Client B’s right hand away and overheard saying in an annoyed tone of voice, “stop pawing at me or I will not help you.” This was an elderly vulnerable client. It was determined that Client B had suffered a fracture.
For allegations 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(b) and 1(c), the Panel was satisfied that the standards of practice of the profession as they concern the Member’s conduct are notorious and that the Member’s conduct breached those standards.

Allegations 2(a)(i), (ii), (iii), (iv) in the Notice of Hearing are supported by paragraphs 15, 21, 22, 26, 28 to 35 in the Notice of Hearing. The Member received Client A in the observation area at the beginning of her shift. Client A was anxious, yelling, disruptive and aggressive when asked to return to his room. The Member was seen on video speaking with several other clients on the unit, but she did not communicate or attempt to de-escalate Client A who continued to bang his head and use his call bell. The Member gave Client A medication and she reported that the medication was not effective. The Member made no other entries in Client A’s chart during her shift. The Member was issued a three-day suspension due to failure to attend to Client A’s needs. The Member was required to complete a learning plan. The Member moved to the Acute Care Unit (“AC Unit”) after this incident. The Panel was satisfied that this conduct by the Member was unprofessional and dishonourable.

With respect to allegations 2(b) and 2(c), they are supported by paragraphs 43 to 45 in the Agreed Statement of Facts. The Panel finds that the Member’s conduct was unprofessional and dishonorable as it demonstrated a serious and persistent disregard for her professional obligations. The Member slapped the hand of a 94-year-old client who suffered from dementia, poor hearing, poor eyesight and who had fallen out of her bed and in fact had a fracture as the result of the fall. The Member was heard by [Colleague A] telling Client B “stop pawing at me or I won’t help you” in an annoyed tone. The Member reported that Client B was in pain and hitting out. The Member claims she was defending herself. It was further reported by [Colleague A] that the Member made a comment “this is going to be a great day”, in a sarcastic tone of voice. The Member acknowledges that she should have been empathetic to Client B’s pain and situation.

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 three 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 Regulatory Expert (the “Expert”), at her own expense and within six months 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,

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 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 her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

   1. the Panel’s Order,
   2. the Notice of Hearing,
   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

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 specific and general deterrence, remediation and protection of the public.

Counsel for the College submitted that the mitigating factors in this case were:

- The Member has no prior discipline history with the College;
- The Member attended the hearing;
- The Member co-operated with the College and took responsibility for her actions;
- The Member did not contest the allegations;
- The Member agreed to the JSO;
- The Member in admitting to the allegations saved the College money by reducing the hearing time.
• The Member expressed remorse.

The aggravating factors in this case were:

• The Member caused harm to two vulnerable clients;
• The Member slapped and threatened to withhold care from a 94-year-old woman who had poor eyesight, hearing and a diagnosis of dementia;
• The Member failed to document the Client A’s care, treatment, and status throughout her shift;
• The Member failed to provide safe and appropriate care to the clients in her care;
• The Member did not take proper steps to protect Client A from self-harm; and
• The Member failed to provide documentation that was complete, concise and timely.

The proposed penalty provides for general deterrence through the oral reprimand which will discourage 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 three-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 two meetings with the Nursing Expert will provide the Member with opportunities to reflect on the incident and learn.

Overall, the public is protected because the Member will be required to notify her employer of this decision for a period of twelve months after the suspension ends. The proposed penalty also promotes public confidence in the ability of the nursing profession to regulate its members.

Counsel for the College submitted one case to the Panel, CNO v. Lancelot E. Williams to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee. This case proceeded with the member present and represented by counsel. In this case, the member failed to provide adequate care, observation, and documentation. The member failed to follow his agency’s policy for close observations, he failed to de-escalate the client who has a diagnosed mental illness and he failed to initiate a code blue. The member’s conduct was found to be unprofessional in that he failed to provide appropriate care or advocate for the client. This client died. The Member was given a two-month suspension, three meetings with a nursing expert and a twenty-four-month employer notification.

The Member had no submissions on the penalty.

In providing the Panel with advice, Independent Legal Counsel (“ILC”) 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 referenced the JSO and advised the Panel that it must accept it unless it decided that the proposed penalty was so disproportionate to the offence 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 three 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 Regulatory Expert (the “Expert”), at her own expense and within six months 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*,

      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 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 her certificate of registration;

b) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision. To comply, the Member is required to:

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

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

1. the Panel’s Order,
2. the Notice of Hearing,
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.
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. Conduct by nurses that demonstrates a lack of integrity, dishonesty, abuse of power and authority, or disregard for the welfare and safety of members of the public is conduct that cannot be tolerated by the nursing profession. Nurses are responsible for their actions and the consequences of these actions. Nurses are accountable for conducting themselves in ways that promote respect for the profession. A nurse must demonstrate ethical conduct by creating environments that promote and support safe, effective and ethical practice.

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.