DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Joanne Furletting, RN	Chairperson
	Lori McInerney, RN	Member
	Denise Dietrich, RPN	Member
	David Bishop	Public Member
	Catherine Genereux	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	LINDA ROTHSTEIN
	)	for College of Nurses of Ontario
	)	
- and -	)	
	)	
ANA GALILEA SORIANO	)	ELIZABETH MCINTYRE for
Registration No. 9882143	)	Ana Galilea Soriano
	)	
- and -	)	
	)	
RUTH DOERKSEN	)	MARLYS EDWARDH for
Registration No. 8502726	)	Ruth Doerksen
	)	
	)	
	)	BRIAN GOVER
	)	Independent Legal Counsel
	)	
	)	Heard: September 19, 2005

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on September 19, 2005 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

College Counsel informed the panel that allegations #2, #3 and #4 in the Notices of Hearing dated August 2, 2005 had been withdrawn. Consequently, Ruth Doerksen and Ana Galilea Soriano (the "Members") each faced the following, remaining allegation:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation* 799/93, in that, while employed as a Registered Nurse at [the Hospital], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular, on October 22, 1998 with respect to [the client] you:

    a) failed to adequately obtain information regarding [the client's] condition and prescribed care; and/or

    b) failed to adequately assess and/or monitor and/or provide nursing care; and/or

    c) failed to follow physician orders; and/or

    d) failed to adequately document her condition and care.

Members' Plea

Ruth Doerksen and Ana Galilea Soriano admitted the allegations set out in paragraph number 1 in the Notice of Hearing. The panel conducted plea inquiries and was satisfied that the Members' admissions were voluntary, informed and unequivocal. Signed responses to the plea inquiries were submitted.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts which provided as follows:

BACKGROUND – ANAGAILE SORIANO

1. Anagaile Soriano graduated with a BScN from [a university] in 1998 and became a member of the College of Nurses (the "College") the same year. While at [university], Ms. Soriano was on the Dean's list and received high academic grades.

2. She was hired as a full-time registered nurse by [the Hospital] in May of 1998 on [the Unit]; she completed her orientation in July of 1998.

3. Ms. Soriano was very active in continuing nursing education both through inservices at the Hospital and at academic institutions. Although she was a novice nurse, she was well regarded by her superiors and peers at [the Hospital] and has no prior disciplinary history.

BACKGROUND – RUTH DOERKSEN

4. Ruth Doerksen graduated from [a university] in 1984 with a Diploma in Nursing. She became a member of the College in 1985 and completed her BScN in 2003.

5. Ms. Doerksen initially worked for a nursing agency following graduation. In October 1984, she was hired as a full time registered nurse at [the Hospital] and worked in a variety of areas, [including the Unit].

6. Ms. Doerksen was very active in continuing nursing education both through inservices at [the Hospital] and at academic institutions. Ms. Doerksen has no prior disciplinary history and was well regarded by her peers and other health care professionals.

[THE UNIT]

7. [The Unit] was a surgical unit [ ]. It contained 20 single bed rooms and a 4 patient Constant Care Room where those requiring more frequent monitoring, including clients with airway problems and young babies, were placed.

8. The Constant Care Room was staffed with one nurse. Staffing for the rest of the Unit depended on the number of beds occupied. In general, each staff nurse was assigned 4 or 5 patients, depending on client needs.

9. Additionally, on the day shift, there was a Resource Nurse who did not have a patient assignment, a Clinical Educator, and a Unit Manager. As well a ward clerk was assigned to [the Unit] on days and evenings until 8pm to perform various clerical duties at the nursing station including the processing of orders, obtaining equipment and the paging and receipt of calls from physicians and others.

10. The staffing on the night shift consisted of staff nurses who had a client assignment. The night Resource Nurse carried a full client assignment as well as administrative duties.

11. On the evening of October 21/22, 1998, due to a lower than usual client census, there were three nurses assigned to [the Unit]. Ms. Doerksen was the Resource Nurse and, in addition, had an assignment of initially four and then five clients after the transfer of [the client]. [Nurse A] was assigned to the Constant Care Room, which required the presence of one nurse at all times. Ms. Soriano was assigned to care for four clients. During breaks, Ms. Soriano and then Ms. Doerksen cared for nine clients. Ms. Doerksen first covered the break for [nurse A] and then took her own break, while Ms. Soriano looked after both her clients and those of Ms. Doerksen. Subsequently, Ms. Doerksen covered the nine clients when Ms. Soriano took her break from approximately 0430 hours to 0600 hours.

PATIENT CONTROLLED ANESTHESIA ("PCA")

12. PCA is a method of administrating an analgesic, such as morphine, intravenously. A PCA machine allows a client to self-administer analgesia by pressing a hand-held button. When the button is pushed by the client, the pump delivers a pre-determined dose of analgesia as long as it is within pre-set limits.

13. [The Unit] was one of the units in the hospital approved for use of PCA pumps. Nurses on [the Unit] were trained to care for clients receiving morphine, including morphine administered via PCA pumps and were accustomed to monitoring such patients, particularly post surgical patients transferred to the unit from the post anesthetic recovery room.

14. PCA monitoring standards in effect at [the Hospital] at the time required the recording of a baseline heart rate, respiratory rate, blood pressure, sedation score and pain score and then hourly for four hours:

    a) on initiation of narcotic administration; and

    b) after any increase in drug dose or infusion rate.

    Thereafter, during the continuation of PCA narcotic administration, respiratory rate and sedation scale were to be taken every hour, and heart rate, blood pressure and pain score taken every four hours.

15. The nursing practice on [the Unit] at the time was to monitor most patients on a PCA with the assistance of a Corometric monitor.

16. The Corometric monitor in use on the unit at the time was designed for children under the age of two, particularly those at risk of SIDS (Sudden Infant Death Syndrome). It had a digital readout of both heart rate and respiratory rate. The monitor would normally be positioned toward the door so that the readouts would be readable by the nursing staff from the hallway. The monitor had a loud heart rate alarm that could be set to sound if it exceeded various parameters and could

not be deactivated. The monitor also had a loud apnea alarm that could be set to various settings including deactivation in which case.

17. There would still be a heart rate and respiratory rate readout but the apnea alarm would be deactivated. The Corometric monitor had a history of false apnea alarms particularly with older children. It is no longer in use at the hospital.

[THE CLIENT]

18. In 1998, [the client] was a 10-year-old physically active [child] who loved swimming, roller blading, biking, and playing with animals, [the client's] friends, and [the client's siblings]. [The client] suffered a spiral fracture to [the] right tibia on February 11, 1998, when playing in the school yard. [The client's] right leg was put in a cast at [another hospital]. [The client] subsequently began complaining of severe pain in [the] right leg and had [the] cast split at the ER of [the Hospital] on February 13 and replaced on February 17. [The client] was re-admitted to [the Hospital] on February 17, 1998 for management of increasing right leg pain, including a continuous lumbar epidural insertion of analgesic. [The client] was hospitalized at [the Hospital] on another occasion, and then at [another] Hospital. [The client] was diagnosed as having reflex sympathetic dystrophy ("RSD"), a complex regional pain syndrome. [The client] was prescribed a number of medications, including Gabapentin, an antiseizure medication and Amitriptyline, an antidepressant medication, to treat [the client's] RSD.

19. [The client] also continued to be seen by the pain clinic of [the Hospital] where, on or about September 9th 1998, [the client] was prescribed an additional anti-seizure medication, Carbamazepine, for [ ] RSD.

EVENTS OF OCTOBER 21-22, 1998

20. On October 21, 1998, [the client] was experiencing increased pain in [the] right leg. At approximately 2150 hours, [the client] was brought to [the Hospital] by [the client's] parents where [the client] was triaged by the nurse in the Emergency Department as a stable non-urgent patient.

21. [The client] was assessed in the Emergency Department by [Dr. A], who was a Fellow with [the Hospital's] anaesthesiology Pain Service ("Pain Service") at approximately 2350 hours.

22. Prior to coming to [the Hospital], [the client] was given [the client's] daily dose of 400 mg of Carbamazepine at 1900 hours. While in the Emergency Department,

[the client] was given [the client's] other usual medications by [the client's] mother with the approval of [Dr. A]. This included 1400 mg of Gabapentin at 2220 hours and 75 mg of Amitriptyline at 2300 hours.

23. Because Pain Service could not admit patients directly, (they had no admitting privileges), arrangements were made between Orthopaedics and Pain Service to admit [the client] as an orthopaedic patient but on the understanding that Pain Service would take responsibility for [the client's] care and that the orders would be written by Pain Service and not by orthopaedics. This arrangement was unusual.

24. [Dr. A] developed a plan of care for [the client]**.** [The client] would be admitted to the ortho service for pain control, [the client] would be put on a PCA , and [the client's] pain management would be decided upon by Anaesthesia Pain Service, including an assessment for an epidural in the morning. [The client] was to be cared for in the Emergency Department until [the client's] pain was under control (about 5 on a scale of 1 to 10) and then transferred to an inpatient unit.

25. [Dr A] ordered on the Doctor's Orders Sheet the following for pain control:

> 10 mg morphine
> Incremental doses 2 mg IV Until pain free (pain scale about 5)
> IV PCA device
> 50 mg morphine in 50 mg saline = 1 mg=1cc
> Bolus 1.5 mg, lockout interval 6 minutes, Total Dose= 20 mg in 2 hours

26. At approximately 2350 hours [the client] was given a stat dose of 2 milligrams of morphine IV. [The client's] vital signs recorded at that time were: pulse 88, respirations 16 and pain scale 8/10.

27. At approximately 0015 hours, [Dr. A], with the assistance of an emergency department nurse, set up the PCA . [The client] self-administered 10.5 mg of morphine via the PCA between 0040 hours and 0107 hours.

28. At approximately 0040 hours, [the client] was given a further dose of morphine 2 mg IV by the emergency room nursing staff. The vital signs recorded at this time were: pulse 90, respirations 14, blood pressure 106/84, pain scale 7.

29. The total amount of morphine administered to [the client] in the emergency department prior to [transferring to the Unit] was 14.5 mg morphine.

30. At approximately 0105 hours, the emergency department nurse recorded in the nursing notes that [the client] was up to bathroom, that [the client's] pain had increased to 8 and that [the client's] mother stated "[the client's] pain will never be 5 on a PCA pump. [The client] needs to be upstairs sleeping". At [the

mother's] request, the emergency department nurse paged [Dr. A], who agreed that [the client] could be transferred to the floor with a reported pain level of 8.

TRANSFER TO [THE UNIT]

31. At approximately 0105 hours, the emergency department nurse called [the Unit] and gave report to Ms. Soriano, who was working on the unit. She reported that the patient being transferred was a 10 year old [ ], admitted for pain management and that she had been given some Morphine in Emergency Department by way of bolus and was coming to the floor with a PCA pump. It was further reported that [the client] was a stable patient that was being transferred to [the Unit] to get some sleep and to have [ ] pain treated with an epidural the next day. Finally, it was reported that [the client] was being admitted through Orthopaedics but under the management of Pain Service.

32. At approximately 0145 hours, [the client] was transferred to [the Unit] by transport personnel and [the] mother. [The client] was received by Ms. Doerksen, her assigned nurse. Ms. Doerksen settled [the client] into a room for the night with the assistance of Ms. Soriano. Prior to the evening of October 21, 1998, neither Ms. Doerksen nor Ms. Soriano had any prior contact with or information about [the client].

33. While Ms. Doerksen attached [the client] to a Corometric monitor, she failed to ensure that the Corometric monitor was properly set and functioning.

34. Ms. Doerksen assessed and documented the following vital signs on the flow sheet (attached as Appendix 1) at 0145 hours:

    Temperature: 36

    Pulse: 72

    Respirations: 16

    Blood pressure: 90/60

    Ms. Doerksen checked the IV site and documented the total amount absorbed. She also checked the PCA pump and documented the number of demands and goods as well as the total amount of morphine absorbed.

35. At no time after [the] transfer to [the Unit] did [the client] make any further demands for morphine; all morphine received by [the client] was administered in the emergency department.

36. Ms. Doerksen recorded her observations in a progress note at 0150 hours:

> Admitted to 5A via emergency. PIV (peripheral intravenous) insitu and infusing well. PCA started and using appropriately. Child in no obvious pain when moving from stretcher to a bed. No voiced c/o (complaints) although mom states not to place blanket over right leg as [the client] can not tolerate it. Child asleep on stretcher and settled to sleep as soon as moved over to bed. Mom at bedside and staying overnight. Vital signs stable.

37. Ms. Doerksen recorded the following observations of [the client] on the hospital's computerized record keeping system at 0205 hrs.

> patient general description: -- chronic r hip pain
>
> Gabapentin, 400 400 600, TID
>
> Carbamazepine, 200, BID
>
> Amitriptyline, 75, QHS
>
> Apical Heart Rate: 72BPM
>
> Respiratory Rate: 16
>
> Temperature: 36.1, PO
>
> Weight/KG: 40
>
> Physical findings: Healthy looking ten year old [ ] with in no obvious distress. Holds R leg straight when moving about in bed

38. Ms. Doerksen relieved the nurse in the Constant Care Room at approximately 0215 hours and then took her break. Ms. Soriano assumed care for [the client] during Ms. Doerksen's absence. In addition to caring for [the client] during this time, Ms. Soriano attended to the care needs of eight other patients including assessments, observations, interventions, treatments, and medications.

39. Ms. Soriano assessed and documented the following vital sign at 0230 hours:

> Respirations: 14

Ms. Soriano checked the IV site and documented the total amount absorbed. She also checked the PCA pump and documented the number of demands and goods as well as the total amount of morphine absorbed.

40. Ms. Soriano assessed and documented the following vital sign at 0245 hours:

> Respirations: 12
>
> Ms. Soriano checked the IV site and documented the total amount absorbed. She also checked the PCA pump and documented the number of demands and goods as well as the total amount of morphine absorbed.

41. Ms. Soriano documented the following assessments and intervention at 0250 hours:

> Chest dry good a/e [air entry], took morphine PCA away
>
> Respirations: 8, 10

42. Following the removal of the morphine, Ms. Soriano paged [Dr. A] at 0250 hours and got no response to the page.

43. Ms. Soriano documented the following assessments at 0320 hours:

> Asleep
>
> Pulse: 120
>
> Respirations: 12

Ms. Soriano checked the IV site and documented the total amount absorbed.

44. Ms. Soriano assessed and documented the following vital signs at 0400 hours:

> Pulse: 130
>
> Respirations: 12
>
> Ms. Soriano checked the IV site and documented the total amount absorbed.

45. Ms. Soriano documented the following at 0405 hours after she paged and then spoke by telephone with [Dr. A]:

> very drowsy, pain service aware of RR [respiratory rate] and sedation
>
> Pulse: 120
>
> Respirations: 12

46. [Dr. A] did not return to the hospital to further assess [the client].

47. Ms. Soriano documented the following intervention and assessments at 0415 hours:

HOB [head of bed up]

Pulse: 134

Respirations: 10

Ms. Soriano checked the IV site and documented the total amount absorbed.

48. Ms. Soriano assessed and documented the following at 0420 hours:

Respirations: 16, 12

49. When Ms. Doerksen returned to the floor at approximately 0430 hours she received report from Ms. Soriano on the nine patients on the floor. In reporting on [the client], Ms. Soriano told Ms. Doerksen that she had earlier had a concern about [the client's] decreased respirations, and [ ] sedation level. She reported that she had spoken to [Dr. A] to make him aware of [the client's] status and that he had said to take away PCA access (which Ms. Soriano had already done) and to keep a close eye on [the client]. Ms. Soriano advised Ms. Doerksen that [the client's] respirations had recovered and were no longer a concern. She also told Ms. Doerksen that [the client] had not used the PCA at all since coming to the unit.

50. Ms. Doerksen documented the following assessments at 0500 hours:

Asleep

Temperature: 35.7 po [by mouth]

Pulse: 126

Respirations: 16

Ms. Doerksen checked the IV site and documented the total amount absorbed.

51. Ms. Doerksen documented the following assessments at 0600 hours:

Asleep

Pulse: 126

Respirations: 14

Ms. Doerksen checked the IV site and documented the total amount absorbed.

52. Both Ms. Soriano and Ms. Doerksen, if they testified, would have said that after 0405 hours, they made clinical observations about [the client] which they did not document and that satisfied them that [the client] was stable and sleeping.

53. Shortly after 0700 hours, Ms. Doerksen and a number of doctors entered [the client's] room. [the client's] vital signs were absent. A code was called, but [the client] could not be resuscitated and was pronounced dead.

54. Ms. Doerksen made the following progress note at 09:00 hours:

> Received pt. from ER @ 01:45 hr. PIV in situ and infusing well at 20 cc/hr PCA had been started in ER. Vital signs stable, Afebrile on arrival to unit PO36 - 72-16-BP 90/60. child moved from ER stretcher to bed with assistance, No complaint of pain when moving corometric monitor applied since arrival to unit and insitu throughout the night - child settled to sleep and was asleep all night except when woken by nurse for vital signs. Mom at bedside, settled to sleep. Nurse covering for writer at break, called pain service @ 04:05 as respirations (down symbol) to 8-10 min. Pain service advised to take button away which was done. Child has not used PCA since arrival to unit at 0:145 At 0:600 respiration 14, HR 126.
>
> Entered room at 0715 with physicians (orthopaedic service) child not breathing, code 25 called, CPR initiated - by orthopaedic resident ([Dr. B]). oxygen applied by RN while writer ran for narcan in med room when checked pt at 0600, monitor in situ (error Ruth Doerksen) on and functioning, Pt. sleeping, mom asleep in room.

55. Following [the client's] death, a post mortem examination disclosed no cause of death. Further, toxicology reports indicated that all medications received by [the client] were within therapeutic range, except for Gabapentin, which had higher levels.

56. Expert opinions from toxicologists and pathologists opined that death was caused by an unknown drug interaction precipitated by cardiac arrhythmia or an electrical conduction difficulty resulting in cardiac arrest. Prior to [the client's] death, there was no documented history of an interaction from the combination of drugs prescribed to [the client].

57. The College is not alleging that any omission or commission on the part of Ms. Doerksen or Ms. Soriano caused [the client's] death.

SORIANO ADMISSIONS

58. Ms. Soriano admits that she failed to maintain the standards of practice of the profession, as alleged in Allegation #1 of the Notice of Hearing dated November 5, 2001, in that:

    i) Having determined that there were indications that [the client] was experiencing respiratory depression at approximately 0250 hours she failed thereafter to:

        a) adequately assess [the client] including complete vital signs and pain and sedation scales;

        b) determine whether further assessments including oxygenation levels were necessary;

        c) determine whether further interventions were necessary.

    ii) Having not had a response to her initial page to the physician at approximately 0250 hours, she failed to ensure that she obtained timely advice with respect to the care of [the client] by either re-paging the physician prior to 0400 hours or asking assistance from another nurse on the unit.

    iii) She failed to adequately document [the client's] condition and care (vital signs, sedation scale, pain scale, respiratory status, assessments and interventions).

DOERKSEN ADMISSIONS

59. Ms. Doerksen admits that she failed to maintain the standards of practice of the profession, as alleged in Allegation #1 of the Notice of Hearing dated November 5, 2001, in that:

    i) After accepting responsibility for the admission of [the client]. to [the Unit] at approximately 0200 hours:

        a) she failed to adequately assess sedation scale and pain scale in the admission assessment;

        b) she failed to ensure that the Corometric monitor was properly set and functioning.

ii) Upon her return from break at approximately 0430 hours and upon learning that [the client] had shown earlier indications of respiratory depression, she failed thereafter to:

a) adequately assess [the client] including complete vital signs and sedation scale;

b) determine whether further assessments including oxygenation levels were necessary;

c) determine whether further interventions were necessary.

iii) She failed to adequately document [the client's] condition and care (vital signs, sedation scale, pain scale, respiratory status, assessments and interventions).

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support findings of professional misconduct. The panel finds that the Members failed to meet a standard of practice of the profession. Specifically, on October 22, 1998, with respect to [the client], Ms. Soriano failed to meet the standards of practice of the profession in the manner particularized in paragraph 58 of the Agreed Statement of Facts, and Ms. Doerksen failed to meet the standards of practice of the profession in the manner particularized in paragraph 59 of the Agreed Statement of Facts.

Reasons for Decision

The panel deliberated and in reviewing the Agreed Statement of Facts found that the facts supported Allegation #1, particulars 2 and 4. The panel found that there were no facts to support Allegation #1, particulars 1 and 3.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty had been agreed upon. The Joint Submission as to Penalty provides as follows:

Joint Submissions on Penalty

The College of Nurses and Ruth Doerksen ("Member") and Anagaile Soriano ("Member") jointly submit that in light of the admissions of professional misconduct set out in the Agreed Statement of Fact, the significant remedial education undertaken by the Members, and the events that have occurred since [the client's] death, the panel of the Discipline Committee make an Order for each Member:

1. Directing the Executive Director to suspend the Member's certificate of registration for one month with such suspension to be wholly suspended;

2. Requiring the Member to appear before the panel to be reprimanded.

The College and the Members jointly submit that the results of this discipline hearing should be published in the usual course in *The Standard*, and available on the public portion of the College's Register.

Counsel for the College submitted that the goals of any penalty should include general and specific deterrence, remediation and protection of the public. A discipline penalty differs from a criminal sentence, where punishment is key. Our emphasis should be on assessing the degree of risk in permitting nurses to hold themselves out as authorized to practice nursing. Discipline penalties are not intended as a redress for a wrong or to exact retribution.

In coming to the proposed penalty, the College considered various processes involving the Members which preceded this hearing. These included a coroner's inquest, the laying of criminal charges and the Members' discharge at the preliminary hearing. The inquest and the criminal proceedings have had a profound deterrent effect on both the Members and the membership as a whole.

The College's main concern when there is an isolated instance of failing of the standards of practice is that there is effective remediation. This ensures that safe, competent nursing care will be provided upon the Members' return to practice. Since the event in question, the Members have, on their own initiative, participated in extensive educational upgrading and remediation. Each Member has already completed extensive mentoring and reorientation and therefore, the College was not seeking monitoring and retraining as part of the penalty order. The degree of remediation already undertaken by the Members far exceeds what would have been expected by the College. The College is satisfied that both Members can and will provide safe and effective nursing care to their patients.

Counsel for the College further submitted that not every failure requires a discipline hearing and/or a finding of professional misconduct. This case involved a serious breach of the standards of practice, a failure to adequately assess and intervene. The College wants to send the message that, if in doubt, nurses must get the help they need to provide appropriate care.

However, this was an isolated case of misconduct. The Members' conduct was neither intentional nor dishonest. It did not involve a breach of trust, nor was it motivated by personal gain.

The focus of a discipline proceeding is the conduct of the nurses, not the consequences of their conduct. The College is not asserting, nor can it prove, that the Members caused the death of [the client]. Where conduct is not intentional and can be addressed by remediation, it is not appropriate to harshly penalize solely because the consequences were tragic.

Furthermore, the Members have been in "legal jeopardy" since October 1998.

Taking all of the above considerations into account, the College was able to support a one month suspended suspension.

Ms. McIntyre, counsel for Ana Galilea Soriano, urged the panel to consider the following as relevant to penalty:

- the breaches of the standards acknowledged by both Members
- the lack of aggravating factors and the presence of factors in mitigation, including the Members' proven good character
- the systemic issues present in the employment setting where the incidents arose, which provide a context to the admissions
- the exemplary remediation/rehabilitation undertaken by these Members with their employer
- the history of the legal proceedings which arose from the death of [the client] and which resulted in this case taking seven years to come before a Discipline panel
- the "penalty" already served by these members as a result of being at the centre of protracted legal proceedings.

Ms. McIntyre further pointed out that the College does not allege that any act of commission or omission on the part of either of the Members led to the death of [the client]. The death of [the client] is the reason for the legal proceedings, but, she submitted, it is not relevant to the panel's consideration on penalty in this case.

Ms. Edwardh, counsel for Ruth Doerksen, submitted that the extraordinary parallel proceedings that have occurred since 1998 provided both specific and general deterrence. Ms. Edwardh supported the penalty proposed by the College and noted that the panel can be sure that the Members do not and will not place any patients at risk.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly makes the following order in respect of each Member:

1. The Executive Director is directed to suspend the Member's certificate of registration for one month with such suspension to be wholly suspended;

2. The Member is required to appear before the panel to be reprimanded.

The panel further orders pursuant to subsection 23(5) of the *Health Professions Procedural Code* that the results of this discipline hearing should be published in the usual course in *The Standard*, and available on the public portion of the College's Register.

The panel concluded that the penalty is reasonable and in the public interest. The panel found that the penalty addresses both specific and general deterrence. The Members have participated in extensive remediation, education and monitoring on their own initiative. Therefore, the panel determined that further remediation was not necessary to protect the public. The Members have co-operated with the College and, by agreeing to the facts and a proposed penalty, have accepted responsibility for their failure to maintain the standards of practice of this profession.

The panel concluded that this case sends a strong message to the membership. Nurses are client advocates, and if they are in doubt, nurses need to get help to ensure that proper assessment and care are provided.

I, Joanne Furletti, 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:

David Bishop, Public Member
Denise Dietrich, RPN
Catherine Genereux, Public Member
Lori McInerney, RN