DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Margaret Tuomi	Chairperson
	Karen Laforet, RN	Member
	Laura Sanderson, RPN	Member
	George Rudanycz, RN	Member
	Chuck Williams	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	MEGAN SHORTREED for
	)	College of Nurses of Ontario
- and -	)	
	)	
JOSEPH JOHN ANDREW	)	ROBERT STEPHENSON for
Registration No. 9318189	)	Joseph John Andrew
	)	
	)	
	)	
	)	
	)	Heard: January 12, 2016

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on January 12, 2016 at the College of Nurses of Ontario (the "College") at Toronto.

The Allegations

The allegations against Joseph John Andrew (the "Member") as stated in the Notice of Hearing dated November 5, 2015, are as follows.

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 during your employment as a Registered Nurse for [the Agency] in [ ] Ontario, you contravened a standard or practice of the profession or failed to meet the standards of practice of the profession as follows:

    a. between May and August 2013, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Client]; and/or

b. between May and August 2013, you made an inappropriate comment to [the Client], stating that "NCP" means "nice cute pussy;" and/or

c. between May and August 2013, you failed to properly document your interactions, provisions of care and/or treatment interventions with [the Client]; and/or

d. in August 2013, you improperly removed [the Client]'s chart from her home; and/or

e. in August 2013, while you knew you were under investigation by your employer and no longer providing nursing services to [the Client], you made entries on [the Client]'s chart that were not noted as late entries; and/or

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(13) of *Ontario Regulation 799/93*, in that during your employment as a Registered Nurse for the Agency in Ontario, you failed to keep records as required, as follows:

   a. between May and August 2013, you failed to properly document your interactions, provisions of care and/or treatment interventions with [the Client]; and/or

   b. in August 2013, you improperly removed [the Client]'s chart from her home; and/or

   c. in August 2013, while you knew you were under investigation by your employer and no longer providing nursing services to [the Client], you made entries on [the Client]'s chart that were not noted as late entries; and/or

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(37) of *Ontario Regulation 799/93*, in that during your employment as a Registered Nurse for the Agency 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, as follows:

   a. between May and August 2013, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Client]; and/or

   b. between May and August 2013, you made an inappropriate comment to [the Client], stating that "NCP" means "nice cute pussy"; and/or

   c. between May and August 2013, you failed to properly document your interactions, provisions of care and/or treatment interventions with [the Client]; and/or

   d. in August 2013, you improperly removed [the Client]'s chart from her home; and/or

   e. in August 2013, while you knew you were under investigation by your employer and no longer providing nursing services to [the Client], you made entries on [the Client]'s chart that were not noted as late entries.

Counsel for the College advised the panel that the College was not calling any evidence with respect to the allegations set out in paragraphs 1(e), 2(c) and 3(e) of the Notice of Hearing.

Member's Plea

The Member admitted the allegations set out in paragraphs numbered 1(a), (b), (c), (d), 2(a), (b) and 3(a), (b), (c), (d) 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 advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts which provided as follows:

THE MEMBER

1. Joseph John Andrew (the "Member") obtained a diploma in nursing [ ] in 1993. He registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on June 9, 1993.

2. At the relevant time, the Member was employed as a full-time RN for [the Agency], providing homecare to clients. His employment was terminated on August 15, 2013, as a result of the incidents described below.

3. The Member has no history of discipline with the College.

THE CLIENT

4. The Client [ ] was referred to [the Agency] by the Community Care Access Centre ("CCAC") for diabetic foot wound care.

5. She was initially referred on May 17, 2013 for dressing changes for a foot ulcer. On May 22, 2013, she was admitted to hospital with a 6-week history of progressive left foot ulceration and increased pain, despite a trial of antibiotics and wound care. On June 3, 2013, following three lateral toe amputations on May 29, 2013, CCAC referred her for further foot wound care.

6. The Client signed a Consent to Service on May 19, 2013, prepared by the Member. In it, she consented to nursing services for "wound care; PICC line/CADD pump care." The Member completed extensive initial care planning documents, including physician's orders, all of which related to the treatment of the Client's foot wound and were silent as to any assessment or treatment for a rash elsewhere on the Client's body. A history of alcoholism was noted in the Client's record.

7. The Member was the primary and only visiting nurse for the Client until August 3, 2013. He provided wound care and dressing services to [the Client] several times per week between May and early August 2013.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

8. On August 7, 2013, [the Agency] received information from [the Client] about her interaction with the Member, and investigated. During the course of the investigation, the Member admitted that:

    a. he gave [the Client] his personal cell phone number, contrary to [the Agency]'s policy,

    b. he had conversations with [the Client] that were not work related,

    c. he failed to report that [the Client] called the Member's personal call phone many times in the evening,

    d. he failed to report concerns when [the Client] made sexual comments to him, tried to kiss or hug him, invited him to dinner, and suggested they should live together,

    e. he gave [the Client] a plant as a birthday gift, and

    f. he spoke to [the Client] about a personal call with a friend.

9. With respect to point (a) above, if the Member were to testify, he would say that he provided the Client with his home phone number for use in emergencies only. This Client was aware of his number because she would not accept calls unless the caller, including the Member, unblocked their phone number. However, the Member acknowledges he could have entered [the Agency]'s general number.

10. With respect to point (f) above, the Member took a personal phone call from a friend while performing nursing services for [the Client]. The Client overheard him use the term "NCP". The Client asked what it meant and the Member told her it meant "nice cute pussy". The Member admits that this language was inappropriate to use in the presence of a client, regardless of [the Client] making an inquiry.

11. If the Member were to testify, he would say that the Client repeatedly made inappropriate comments and physical advances of a sexual nature toward him. The Member would also state that the Client seemed to call him when she had been drinking. The Member would further say that he gave the Client an orchid flower for her birthday because he felt sorry for her.

12. The Member did not document any of the above interactions, or report or seek guidance about them from [the Agency] or CCAC.

13. The Member admits that he failed to maintain the boundaries of the therapeutic nurse-client relationship, and in particular, that he failed to follow the principles set out in the *Therapeutic Nurse-Client Relationship* standard, attached, including:

    a. recognizing that there may be an increased need for vigilance in maintaining professionalism and boundaries when care is provided in a client's home;

b. abstaining from self-disclosure unless it meets an articulated therapeutic client need;

c. acknowledging difficulty establishing a therapeutic relationship with a client, and requesting a therapeutic transfer of care when the relationship is not evolving therapeutically;

d. continually clarifying his role in the therapeutic relationship, especially in situations in which the client was unclear about the boundaries;

e. consulting with colleagues and/or the manager in a situation in which the Client's behavior crossed the boundary of the therapeutic relationship;

f. documenting client-specific information in the client's records regarding instances in which it was necessary to consult with a colleague/manager about an uncertain situation;

g. not engaging in making remarks that may reasonably be perceived by other nurses and/or others to be sexually suggestive; and

h. giving gifts to clients only as a group of nurses from the agency, after determining that it does not change the dynamics of the therapeutic relationship.

14. The Member also told the Agency that, on July 25, 2013, he lifted the Client's breast to assess her rash, and may have applied cream to her body. He made one note in the Client's health record on July 25, 2013 at 16:30, which states, "Client confirms rash is almost all over her body – with Client's consent nurse observed body. Attempted to apply cream but client indicated she will try to do it herself."

15. If the Member were to testify, he would say that he examined the Client's entire body, in response to a complaint by the Client that she had a rash all over her body, and did so with the Client's consent. The Member offered to apply cream for her rash but the Client elected to do so herself.

16. The Member did not adequately document this care in the Client's chart. The Member did not chart that he assessed the Client's upper body, or that he lifted her breast to assess her rash. The Member did not properly document or report to the CCAC concerns that [the Client] had other health care issues, including his observation that she had a rash and that he examined her upper body, including lifting her breast. His progress note was inadequate for the standard of charting expected when a homecare client requests treatment outside the treatment plan.

17. The Member admits that he failed to properly document his interactions with [the Client] in respect of personal calls and comments to him, and that he failed to properly document his provisions of care and/or treatment interventions with [the Client] respecting his assessment and treatment of her rash.

18. The Member removed the Client's chart from her home on or after his last visit on August 3, 2013, contrary to [the Agency's] policy which specifically required that client charts be maintained in the home for reasons of privacy, security and continuity of care. He did not return the chart until after the investigation was underway, on August 13, 2013. He told [the Agency] that the Client agreed he could remove the chart for documentation to save time and because her home was "not tidy enough", and would repeat these reasons if he were to testify. He also said that he removed the chart from the Client's home for the purpose of "fixing up the chart".

19. The Member acknowledges that his removal of the Client's chart from her home was in breach of [the Agency's] policies and improper.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

20. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 1(a), (b), (c) and (d) of the Notice of Hearing, as described in paragraphs 8 to 19 above, in that he contravened a standard of practice of the profession or failed to meet the standards of practice of the profession relating to the therapeutic nurse-client relationship, appropriate communication, documentation and maintenance of health care records.

21. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 2(a) and (b) of the Notice of Hearing, as described in paragraphs 8 to 19 above, in that he failed to keep records as required.

22. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3(a), (b), (c) and (d) of the Notice of Hearing, and in particular that his conduct was unprofessional, as described in paragraphs 8 to 19 above.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support findings of professional misconduct. In particular, the panel finds that the Member committed an act of professional misconduct as alleged in paragraphs 1(a), (b), (c), (d), 2(a), (b) and 3(a), (b), (c), and (d) of the Notice of Hearing. The Member failed to maintain a professional therapeutic nurse-client relationship (1 (a) and 3 (a)); made an inappropriate comment to a client (1(b), 3(b)); failed to properly document his client's condition and treatment, and client comments and behaviour (1(c),2(a), and 3(c)). The Member removed the client's medical chart from the client's home against agency policy and the standards of practice of the profession (1(d), 2(b), and 3(d)).

As to allegations 1(e), 2(c) and 3(e), College Counsel advised that she was not calling any evidence in respect of these allegations. Accordingly, the panel dismisses allegations 1(e), 2(c) and 3(e) in the Notice of Hearing.

Reasons for Decision

All allegations other than 1(e), 2(c) and 3 (e) were supported by the Agreed Statement of Facts.

As to allegations 3 (a), (b), (c) and (d), the panel found the Member's actions to be unprofessional as they showed a disregard to his professional boundaries in regards to the therapeutic nurse-client relationship.

Penalty

The parties submitted jointly that the panel should make an order that requires as follows.

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

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

3. 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 from the date that this Order becomes final. 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 and online participation forms (where applicable):

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

        iv. Before the first meeting, the Member reviews and completes the College's self-directed learning package, *One is One Too Many*, at his own expense, including the self-directed *Nurses' Workbook*;

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

vi. 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;

vii. 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;

viii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his certificate of registration;

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

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

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

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

iii. 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

College Counsel submitted, and both parties agreed, that the mitigating factors were:

1. This was the Member's first time before the College.

2. There was only one client involved.

3. The Member admitted misconduct to the College and to his employer.

4. The Member had a long unblemished career.

The aggravating factors were:

1. The Member committed a series of errors in judgment.

2. The Member did not report, document, or seek guidance while experiencing a difficult nurse-client relationship.

3. The Member made an inappropriate comment.

4. The Member removed the client's chart/record, from the client's home, contravening the agency's policy.

College Counsel stated that the proposed penalty provides specific deterrence to the Member with a two-month suspension of the Member's certificate and an oral reprimand.

The two-month suspension also provides a general deterrent to the profession and shows that this type of boundary violation will not be tolerated.

The terms, conditions, and limitations on the Member's certificate provide the opportunity to focus on rehabilitation, remediation, and a return to the nursing profession.

The Member's Counsel concurred with the comments of the College Counsel.

Penalty Decision

In view of the facts and admissions set out in the Agreed Statement of Facts and the findings of professional misconduct, the panel accepts the joint submission as to order and accordingly orders that:

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 two months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practising class.

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at his own expense and within six months from the date that this Order becomes final. 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, online learning modules and online participation forms (where applicable):

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

        iv. Before the first meeting, the Member reviews and completes the College's self-directed learning package, *One is One Too Many*, at his own expense, including the self-directed *Nurses' Workbook*;

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

vi. 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;

vii. 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;

viii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on his certificate of registration;

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

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

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

1. the Panel's Order,
2. the Notice of Hearing,
3. the Agreed Statement of Facts,
4. 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, Margaret Tuomi, Public Member, 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:

Karen Laforet, RN
Laura Sanderson, RPN
George Rudanycz, RN
Chuck Williams, Public Member