DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL: Catherine Egerton, PM Chairperson
Carly Gilchrist, RPN Member
George Rudanycz, RN Member
Terah White, RPN Member
Richard Woodfield Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO) ) DENISE COONEY for
) ) College of Nurses of Ontario
- and - )
) )
) ) NO REPRESENTATION for
) ) Steven Mymryk
) )
) ) CHRISTOPHER WIRTH
) ) Independent Legal Counsel
) )
) ) Heard: February 26, 2020

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the “Panel”) on February 26, 2020 at the College of Nurses of Ontario (the “College”) at Toronto.

Publication Ban

College Counsel brought a motion pursuant to s.45(3) of the Health Professions Procedural Code of the Nursing Act, 1991, for an order preventing the public disclosure of the names or information identifying the patients whose identities are disclosed in the Discipline hearing of Steven Mymryk or any information that could disclose the names, including a ban on the publication or broadcasting of this information.

The Panel considered the submissions of the Parties and decided that there be an order preventing the public disclosure of the names or information identifying the patients whose identities are disclosed in the Discipline hearing of Steven Mymryk or any information that could disclose the names, including a ban on the publication or broadcasting of this information.
The Allegations

The allegations against Steven Mymryk (the “Member”) as stated in the Notice of Hearing dated January 27, 2020 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 practicing as a Registered Practical Nurse at District of Kenora Home for the Aged – Pinecrest in Kenora Ontario (the “Facility”) you contravened a standard of practice of the profession, or failed to meet the standard of practice of the profession, in that:
   (a) on or about June 19, 2018, you spoke to [Patient 1] in an inappropriate tone of voice;
   (b) on or about June 19, 2018, you threw and/or spilled a glass of liquid and/or the contents of a glass of liquid at [Patient 1];
   (c) on or about September 10, 2018, you spoke to [Patient 2] in an inappropriate tone of voice;
   (d) on or about September 10, 2018, you made rude and/or inappropriate comments directed at [Patient 2], including but not limited to words to the effect of “suit yourself”, “don’t eat”, “doesn’t bother me none” and/or “if you want to die”;
   (e) on or about September 10, 2018, you yelled at [Patient 3];
   (f) on or about September 10, 2018, you hit and/or struck [Patient 3];
   (g) on or about September 11, 2018, you pushed [Patient 3]’s wheelchair using inappropriate force;
   (h) on or about September 11, 2018, you failed to take appropriate steps to ensure [Patient 3] received appropriate care, including but not limited to ensuring her soiled pants were changed;
   (i) on or about September 11, 2018, you made rude and inappropriate comments directed at [Patient 4], including but not limited to words to the effect of “wake up”, “do you want to eat or not”; and/or
   (j) on or about September 11, 2018, you forced and/or attempted to force [Patient 4] to eat.

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(7) of Ontario Regulation 799/93, in that while practicing as a Registered Practical Nurse at the Facility, you abused a patient verbally, physically, and/or emotionally, and in particular:
   (a) on or about June 19, 2018, you spoke to [Patient 1] in an inappropriate tone of voice;
   (b) on or about June 19, 2018, you threw and/or spilled a glass of liquid and/or the contents of a glass of liquid at [Patient 1];
on or about September 10, 2018, you spoke to [Patient 2] in an inappropriate tone of voice;

on or about September 10, 2018, you made rude and/or inappropriate comments directed at [Patient 2], including but not limited to words to the effect of “suit yourself”, “don’t eat”, “doesn’t bother me none” and/or “if you want to die”;

on or about September 10, 2018, you yelled at [Patient 2];

on or about September 10, 2018, you hit and/or struck [Patient 3];

on or about September 11, 2018, you pushed [Patient 3]’s wheelchair using inappropriate force; and/or

on or about September 11, 2018, you failed to take appropriate steps to ensure [Patient 3]’s soiled pants were changed.

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 while practicing as a Registered Practical Nurse at the Facility you engaged in conduct relevant to the practice of nursing that would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, in that:

on or about June 19, 2018, you spoke to [Patient 1] in an inappropriate tone of voice;

on or about June 19, 2018, you threw and/or spilled a glass of liquid and/or the contents of a glass of liquid at [Patient 1];

on or about September 10, 2018, you spoke to [Patient 2] in an inappropriate tone of voice;

on or about September 10, 2018, you made rude and/or inappropriate comments directed at [Patient 2], including but not limited to words to the effect of “suit yourself”, “don’t eat”, “doesn’t bother me none” and/or “if you want to die”;

on or about September 10, 2018, you yelled at [Patient 3];

on or about September 10, 2018, you hit and/or struck [Patient 3];

on or about September 11, 2018, you pushed [Patient 3]’s wheelchair using inappropriate force;

on or about September 11, 2018, you failed to take appropriate steps to ensure [Patient 3] received appropriate care, including but not limited to ensuring her soiled pants were changed;

on or about September 11, 2018, you made rude and inappropriate comments directed at [Patient 4], including but not limited to words to the effect of “wake up”, “do you want to eat or not”; and/or

on or about September 11, 2018, you forced and/or attempted to force [Patient 4] to eat.
**Member’s Plea**

The Member admitted to the allegations set out in paragraphs 1(a), (b), (c), (d), (e), (f), (g), (h), (i) and (j), 2(a), (b), (c), (d), (e), (f), (g) and (h) and 3(a), (b), (c), (d), (e), (f), (g), (h), (i) and (j) 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**

College Counsel and the Member advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

**THE MEMBER**

1. Steven Mymryk (the “Member”) obtained a diploma in nursing from Confederation College in 2010.

2. The Member registered with the College of Nurses of Ontario (“CNO”) as a Registered Practical Nurse (“RPN”) on July 7, 2010.

3. The Member was employed at the District of Kenora Home for the Aged - Pinecrest (the “Facility”) between October 21, 2010 and October 1, 2018. His employment was terminated following the incidents described below.

4. The Facility is a long-term care facility. At the time of the incidents, the Member worked on a unit for patients with cognitive impairments.

**INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

**Patient 1**

5. (“Patient 1”) had cognitive impairments. On June 19, 2018, the Member was sitting with Patient 1 to assist him with taking his evening medications. The Member was having difficulty administering the medications and spoke to Patient 1 in a tone that a dietary aide described as “harsh” and “mean”. The Member then stood up suddenly, took the glass filled with liquid, and threw its contents at Patient 1. The Member walked away, leaving Patient 1 in wet clothing. The dietary aide described Patient 1’s face as “pure bewilderment”.

**Patient 2**

6. On September 10, 2018, the Member was feeding (“Patient 2”), who had dementia and often takes longer to eat. The Member made comments to Patient 2 to the effect of, “suit yourself if you want to die”, “fine then don’t eat if you don’t want to. Doesn’t bother me none” in a tone which was described by a Personal Support Worker (“PSW”) as “stern” and “agitated”.

**Patient 3**

7. On September 10, 2018, the Member was transferring [ ] (“Patient 3”), who was very ill, to her bed with a PSW. The Member loudly, and in a stern voice, asked Patient 3 to take off her oxygen. When Patient 3 started to fall asleep before taking off her oxygen, the Member used the palm of his hand to strike or slap Patient 3’s right shoulder. The contact startled Patient 3, waking her. The Member then yelled at the patient to take off her oxygen and took off her oxygen.

8. The following day, September 11, 2018, Patient 3 needed assistance to be changed after urinating in her pants. The Member refused to change Patient 3 and did not use the call bell to request assistance. The Member brought Patient 3 to the nursing station and pushed her wheelchair with force down the hall. He then walked away with his hands in the air. The Member had told the Patient to “yell at one of you guys” (referring to one of the other staff at the Facility).

**Patient 4**

9. On September 11, 2018, the Member became frustrated while feeding [ ] (“Patient 4”), who was unwell and very sleepy. The Member became agitated and aggressive with Patient 4. The Member then began “force feeding” Patient 4, by shoving the utensil into Patient 4’s mouth before she was ready to eat. The Member said words to the effect of, “wake up [Patient 4]” and “do you want to eat or not.” When Patient 4 reached for the glass or her plate, the Member said, “What are you doing? Stop that.” Patient 4 started crying during the interaction.

**CNO STANDARDS**

10. CNO has published nursing standards to set out the expectations for the practice of nursing. CNO’s standards inform nurses of their accountabilities and apply to all nurses regardless of their role, job description, or area of practice.

**Therapeutic Nurse-Client [or Patient] Relationship Standard**

11. CNO’s *Therapeutic Nurse-Client Relationship Standard* (“TNCR Standard”) provides guidance to nurses on establishing and maintaining appropriate relationships with patients. The TNCR Standard notes that the therapeutic relationship with patients is at the core of the practice of nursing.

12. The TNCR Standard specifies that the nurse is responsible for establishing and maintaining the therapeutic nurse-patient relationship. Therapeutic nursing services “contribute to the [patient’s] health and well-being” and the relationship is based on “trust, respect, empathy and professional intimacy, and requires the appropriate use of power inherent in the care provider’s role.”
13. The TNCR Standard specifies that nurses meet the standard for “therapeutic communication” through “effective communication strategies and interpersonal skills”. In addition, a nurse meets the standard by:

a. …being aware of her/his verbal and non-verbal communication style and how [patients] might perceive it;

b. modifying communication style, as necessary, to meet the needs of the [patient] (for example, to accommodate a different language, literacy level, developmental stage or cognitive status); …

c. listening to, understanding and respecting the [patient’s] values, opinions, needs and ethnocultural beliefs and integrating these elements into the care plan with the [patient’s] help; …

d. recognizing that all behaviour has meaning and seeking to understand the cause of a [patient’s] unusual comment, attitude or behaviour…

e. reflecting on interactions with a [patient] and the health care team, and investing time and effort to continually improve communication skills…

14. Nurses are responsible for ensuring that all professional behaviours and actions meet the therapeutic needs of the patient.

15. The TNCR Standard defines “abuse” as:

The misuse of the power imbalance intrinsic in the nurse-[patient] relationship. It can also mean the nurse betraying the [patient’s] trust, or violating the respect or professional intimacy inherent in the relationship, when the nurse knew, or ought to have known, the action could cause, or could be reasonably expected to cause physical, emotional or spiritual harm to the [patient]. Abuse may be verbal, emotional, physical, sexual, financial or take the form of neglect. The intent of the nurse does not justify a misuse of power within the nurse-[patient] relationship.

16. The TNCR Standard includes examples of abusive behaviours. Verbal and emotional abuse includes sarcasm, retaliation or revenge, teasing or taunting, and an inappropriate tone of voice, such as one expressing impatience. Physical abuse includes hitting, pushing, using force, and handling a patient in a rough manner.

17. Nurses are required to protect patients from abuse. The TNCR Standard sets out indicators by which the nurse meets this standard:

a. …not engaging in behaviours toward a [patient] that may be perceived by the [patient] and/or others to be violent, threatening or intended to inflict physical harm; …

b. not exhibiting physical, verbal and non-verbal behaviours toward a [patient] that demonstrate disrespect for the [patient] and/or are perceived by the [patient] and/or others as abusive…

c. not neglecting a [patient] by failing to meet or withholding his/her basic assessed needs…
18. The Member admits that he contravened the TNCR Standard through his conduct as described in paragraphs 5-9, above.

Professional Standards

19. CNO’s Professional Standards (“Professional Standards”) provides that “[e]ach nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships.” One way of doing so is “demonstrating respect and empathy for, and interest in [patients].”

20. In terms of accountability, the standard sets out indicators nurses must demonstrate, including:

- … ensuring practice is consistent with CNO’s standards of practice and guidelines as well as legislation; [and]
- taking action in situations in which [patient] safety and well-being are compromised…

21. The Member admits that he contravened the Professional Standards through his conduct as described at paragraphs 5-9 above.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

22. The Member admits that he committed the acts of professional misconduct as described in paragraphs 5 to 9 above, and as alleged in the Notice of Hearing, as follows:

- 1(a) and 2(a) in that he spoke to Patient 1 in an inappropriate tone of voice;
- 1(b) and 2(b) in that he threw the contents of a glass of liquid at Patient 1;
- 1(c) and 2(c) in that he spoke to Patient 2 in an inappropriate tone of voice;
- 1(d) and 2(d) in that he made rude and inappropriate comments directed at Patient 2;
- 1(e) and 2(e) in that he yelled at Patient 3;
- 1(f) and 2(f) in that he hit/struck Patient 3;
- 1(g) and 2(g) in that he pushed Patient 3’s wheelchair using inappropriate force;
- 1(h) and 2(h) in that he failed to take appropriate steps to ensure Patient 3 received appropriate care, including but not limited to ensuring her soiled pants were changed;
- 1(i) and in that he made rude and inappropriate comments directed at Patient 4;
- 1(j) and in that he forced or attempted to force Patient 4 to eat.

23. The Member admits that he committed the acts of professional misconduct as alleged in paragraphs 3 of the Notice of Hearing, and in particular, that his conduct was disgraceful, dishonourable and unprofessional, as described in paragraphs 5-9 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 and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraph #1 of the Notice of Hearing as follows:

- 1(a) in that the Member spoke to [Patient 1] in an inappropriate tone of voice;
- 1(b) in that the Member threw the contents of a glass of liquid at [Patient 1];
- 1(c) in that the Member spoke to [Patient 2] in an inappropriate tone of voice;
- 1(d) in that the Member made rude and inappropriate comments directed at [Patient 2];
- 1(e) in that the Member yelled at [Patient 3];
- 1(f) in that the Member hit/struck [Patient 3];
- 1(g) in that the Member pushed [Patient 3]’s wheelchair using inappropriate force;
- 1(h) in that the Member failed to take appropriate steps to ensure [Patient 3] received appropriate care, including but not limited to ensuring her soiled pants were changed;
- 1(i) in that the Member made rude and inappropriate comments directed at [Patient 4];
- 1(j) in that the Member forced or attempted to force [Patient 4] to eat.

With respect to Allegation #2, the Panel finds that the Member verbally, physically and emotionally abused a patient as follows:

- 2(a) in that the Member spoke to [Patient 1] in an inappropriate tone of voice;
- 2(b) in that the Member threw the contents of a glass of liquid at [Patient 1];
- 2(c) in that the Member spoke to [Patient 2] in an inappropriate tone of voice;
- 2(d) in that the Member made rude and inappropriate comments directed at [Patient 2];
- 2(e) in that the Member yelled at [Patient 3];
- 2(f) in that the Member hit/struck [Patient 3];
- 2(g) in that the Member pushed [Patient 3]’s wheelchair using inappropriate force;
- 2(h) in that the Member failed to take appropriate steps to ensure [Patient 3] received appropriate care, including but not limited to ensuring her soiled pants were changed.

As to Allegation #3, the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be disgraceful, dishonourable and unprofessional.

**Reasons for Decision**

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

Allegation #1(a) in the Notice of Hearing is supported by paragraphs #5 and #10 to #21 in the Agreed Statement of Facts. The Member was sitting with Patient 1, assisting him to take his evening medications. The Member was having difficulty administering the medications and spoke to Patient 1 in a tone that a dietary aide described as “harsh” and “mean”. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs #5 and #10 to #21 in the Agreed Statement of Facts. The Member was sitting with Patient 1. He stood up suddenly, took a glass filled
with liquid, and threw its contents at Patient 1. The Member walked away, leaving Patient 1 in wet clothing. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs #6 and #10 to #21 in the Agreed Statement of Facts. Patient 2 has Dementia and often takes longer to eat, the Member admits to and was overheard speaking to Patient 2 in a “stern” and “agitated” tone. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs #6 and #10 to #21 in the Agreed Statement of Facts. The Member was overheard stating to Patient 2 “suit yourself if you want to die”, “fine then don’t eat if you don’t want to. Doesn’t bother me none”. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs #7 and #10 to #21 in the Agreed Statement of Facts. The Member admits to yelling at Patient 3. Patient 3 was very ill. He was transferring Patient 3 with a PSW and spoke to the patient in a very loud stern voice, yelling at the patient to take off her oxygen. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs #7 and #10 to #21 in the Agreed Statement of Facts. When Patient 3 started to fall asleep before taking off her oxygen, the Member used the palm of his hand to strike or slap Patient 3’s right shoulder. The contact startled Patient 3, waking her up. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(g) in the Notice of Hearing is supported by paragraphs #8 and #10 to #21 in the Agreed Statement of Facts. Patient 3 required incontinence care. The Member brought Patient 3 to the nursing station and pushed her wheelchair with force down the hall. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(h) in the Notice of Hearing is supported by paragraphs #8 and #10 to #21 in the Agreed Statement of Facts. Patient 3 had been incontinent of urine. The Member refused to change Patient 3 and did not use the call bell to request assistance. The Member then told the patient to “yell at one of you guys” (referring to one of the other staff at the Facility). The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(i) in the Notice of Hearing is supported by paragraphs #9 and #10 to #21 in the Agreed Statement of Facts. The Member was feeding Patient 4 who was unwell and very sleepy. The Member became agitated and aggressive with Patient 4. The Member said words to the effect of “wake up [Patient 4]” and “do you want to eat or not” “what are you doing? Stop that.” Patient 4 started to cry during the interaction. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegation #1(j) in the Notice of Hearing is supported by paragraphs #9 and #10 to #21 in the Agreed Statement of Facts. The Member was feeding Patient 4 who was unwell and very sleepy. The Member
became agitated and aggressive with Patient 4. The Member then began “force feeding” Patient 4 by shoving the utensil into Patient 4’s mouth before she was ready to eat. The Member admitted to contravening both the TNCR Standard and the Professional Standards.

Allegations #2(a) to 2(h) in the Notice of Hearing are supported by paragraphs #5 to #9 in the Agreed Statement of Facts and the Member’s admission that he verbally, physically and emotionally abused his patients, [Patient 1], [Patient 2] and [Patient 3].

With respect to Allegation #3, the Panel finds that the Member’s conduct in verbally and physically abusing four patients was unprofessional as it demonstrated a serious and persistent disregard for his professional obligations. The Panel also finds that the Member’s conduct was dishonourable as the Member knew or ought to have known that his conduct was unacceptable and failed to meet the standards of a professional through repeatedly failing to provide safe appropriate care. Finally, the Panel finds that the Member’s conduct was disgraceful as it shames the Member and by extension the profession. The conduct of repeatedly abusing patients verbally and physically casts serious doubt on the Member’s moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

**Penalty**

College Counsel and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order 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 seven 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 practicing 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 a minimum of two meetings with a Regulatory Expert (the “Expert”) at his own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the “Director”) regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 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 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 CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

1. Code of Conduct,
2. Professional Standards, and
3. Therapeutic Nurse-Client Relationship Standard;

iv. Before the first meeting, the Member reviews and completes the CNO’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 patients, 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 24 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

c. The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

4. All documents delivered by the Member to CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Submissions were made by College Counsel.

The mitigating factors in this case included the following:

- The Member has no history with the College;
- The Member has shown early remorse in the proceedings;
- The Member has participated in a Joint Submission on Order and an Agreed Statement of Facts;
- The Member has voluntarily admitted to the allegations.
The aggravating factors in this case included:

- The Member demonstrated a repeated pattern of verbal, emotional and physical abuse directed towards individuals with cognitive and physical impairments;
- Numerous breaches of standards;
- Multiple interactions with the same patient;
- The Member demonstrated inappropriate tone towards a patient, threw/spilled a glass of liquid towards a patient, made rude/inappropriate comments towards a patient, yelled at a patient, hit/struck/used inappropriate force towards a patient;
- The incidents were not isolated.

The proposed penalty provides for general deterrence through the seven month suspension. It sends a clear message to the membership that this conduct will not be tolerated.

The proposed penalty also provides for specific deterrence through a suspension of seven months. During this time, the Member will be guided through a process whereby he will gain increased knowledge and will have time to reflect on the serious consequences of not following his professional obligations. The oral reprimand will assist the Member in gaining greater understanding of the impact of his conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert, reviewing the Code of Conduct as well as Professional Standards and The Nurse-Client Relationship Standard.

Overall, the public is protected because the Member’s seven month suspension will provide him with the opportunity to reflect and improve his practice. The 24 month employer notification as well as no independent practice for 24 months will ensure that once he returns to work, the Member’s employer will be aware of this decision and they will continue to provide supervision.

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

CNO v. Cheryl Yvonne Rowe (Discipline Committee, 2017). The member was present and represented by counsel. It was an uncontested hearing and evidence was demonstrated through an Agreed Statement of Facts and the penalty was based on a Joint Submission on Order. The member acknowledged a pattern of physical abuse of her elderly patients and failure to communicate in a professional manner with a patient’s daughter. The penalty was an oral reprimand, a 6 month suspension of the member’s certificate of registration, two meetings with a Nursing Expert and an employer notification of 18 months.

CNO v. Patrick Lento (Discipline Committee, 2017). The member was present and represented by counsel. It was an uncontested hearing and evidence was demonstrated through an Agreed Statement of Facts and the penalty was based on a Joint Submission on Order. In this case the member failed to meet the standard of practice by communicating in an inappropriate manner with numerous clients as well as displaying an inappropriate attitude toward a client. The penalty was an oral reprimand, a 5
month suspension of the member’s certificate of registration, two meetings with a Nursing Expert and an employer notification of 24 months.

The Member advised the Panel that he had no further submissions.

**Penalty Decision**

The Panel accepts the Joint Submission on Order and accordingly orders:

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

2. The Executive Director is directed to suspend the Member’s certificate of registration for seven 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 practicing 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 a minimum of two meetings with a Regulatory Expert (the “Expert”) at his own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the “Director”) regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 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 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 CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

       1. *Code of Conduct*,
2. *Professional Standards*, and
3. *Therapeutic Nurse-Client Relationship Standard*;

iv. Before the first meeting, the Member reviews and completes the CNO’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 patients, 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 24 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

c. The Member shall not practice independently in the community for a period of 24 months from the date the Member returns to the practice of nursing.

4. All documents delivered by the Member to CNO, 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 concludes that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility. The Panel finds that the penalty satisfies the principles of specific and general deterrence, rehabilitation and remediation, and public protection and is in line with what has been ordered in previous cases.

I, Catherine Egerton, 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.