DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

	TAMMY HEDGE, RPN	Chairperson
	CATHY EGERTON	Public Member
	SHIRAZ IRANI, RN	Member
	ASHLEIGH MOLLOY	Public Member
	GEORGE RUDANYCZ, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
SURUJDEO NARAIN	)	ROBERT STEPHENSON for
Registration No. 0434209	)	Surujdeo Narain
	)	
	)	
	)	
	)	
	)	Heard: May 27, 2016

AMENDED DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on May 27, 2016 at the College of Nurses of Ontario ("the College") at Toronto.

The Allegations

At the outset of the hearing, College Counsel advised that the College was seeking leave to withdraw certain allegations. The panel granted that request. The remaining allegations against Surujdeo Narain (the "Member") as stated in the Notice of Hearing dated are as follows.

1. You have committed an act or acts of professional misconduct as provided by subsection 51(1)(c) of *Health Professions Procedural Code* of the *Nursing Act, 1991,* S. O. 1991, c. 32 and defined in paragraph 1(1) of *Ontario Regulation 799/93* as amended, in that you contravened or failed to meet standards of practice of the profession while working as a registered nurse employed by [the Agency] and in particular:

a. between about December 31, 2011 and January 2, 2012, with respect to [Client A.], you:

   i. [*Withdrawn*];

   ii. [*Withdrawn*];

   iii. Failed to maintain the confidentiality of the client health information by making a personal copy of the client health record;

   iv. [*Withdrawn*];

   v. Failed to promptly report the death of [Client A.] to [the Agency]; and/or

b. between about January 28, 2012 and January 29, 2012, with respect to [Client B.], you:

   i. [Withdrawn];

   ii. Failed to ask for and/or seek assistance to ensure timely and/or appropriate nursing care was provided.

2. [*Withdrawn*];

3. [*Withdrawn*];

4. You have committed an act or acts 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 and defined in paragraph 1(37) of *Ontario Regulation 799/93* as amended, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional while working as a registered nurse employed by [the Agency] and in particular:

   a. between about December 31, 2011 and January 2, 2012, with respect to [Client A.], you:

      i. [*Withdrawn*];

      ii. [*Withdrawn*];

      iii. Failed to maintain the confidentiality of the client health information by making a personal copy of the client health record;

      iv. [*Withdrawn]*;

v. Failed to promptly report the death of [Client A.] to [the Agency];

vi. [*Withdrawn*];

vii. [*Withdrawn*];

viii. [*Withdrawn*];

ix. Inaccurately charted that you visited and/or treated clients at 21:45, 21:50, 22:00, 22:50, 23:00 and/or 23:15 when you did not do so; and/or

b. Between about January 28 and January 29, 2012, with respect to [Client B.], you:

i. [*Withdrawn*];

ii. Failed to ask for and/or seek assistance to ensure timely and/or appropriate nursing care was provided; and/or failed to document your attempted visits and/or discussions with [Client B.].

5. [*Withdrawn*];

6. 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 practising as a Registered Nurse at [the Facility], you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

a. on or about October 4, 2014, you provided inadequate care to [Client C.], and/or inadequately documented the care you provided, including in the following respects:

i. [*Withdrawn*];

ii. [*Withdrawn*];

iii. [*Withdrawn*];

iv. [*Withdrawn*];

v. you failed to indicate that several entries you made on the Integrated Patient Record were late entries;

b. on or about November 19 and/or November 20, 2014, you provided inadequate care to [Client D.], and/or inadequately documented the care you provided, including in the following respects:

i. on or about November 20, 2014, you documented an order to reinsert the Client's NG tube, that you received on November 20, 2014, on the Ordering Practitioner Form dated November 4, 2014;

ii. [*Withdrawn*];

iii. on or about November 20, 2014, you failed to administer and/or failed to document that you administered Lasix 20mg as ordered and/or required;

iv. [*Withdrawn*];

c. on or about November 24 and/or 26, 2014, you provided inadequate care to [Client E.], and/or inadequately documented the care you provided, including in the following respects:

i. [*Withdrawn*];

ii. on or about November 24, 2014, you failed to assess the Client and/or failed to document an assessment of the client upon the Client's return from hospital;

iii. on or about November 26, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

d. on or about November 18 and/or 20, 2014, you provided inadequate care to [Client F.], and/or inadequately documented the care you provided, including in the following respects:

i. on or about November 18, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

ii. [*Withdrawn*];

iii. [*Withdrawn*];

iv. [*Withdrawn*];

e. on or about November 19, 2014, you provided inadequate care to [Client G.] and/or inadequately documented the care you provided, including in the following respects:

i. you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

ii. [*Withdrawn*];

f. on or about November 24 and/or 25, 2014, you provided inadequate care to [Client H.] and/or inadequately documented the care you provided, including in the following respects:

i. [*Withdrawn*];

ii. on or about November 25, 2014, you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

iii. [*Withdrawn*];

7. You have committed an act of professional misconduct, as provided by subsection 51 (1)(c) of the *Health Professions Procedural Code* of the *Nursing Act*, 1991, S. O. 1991, c. 32, as amended, and defined in paragraph 1(13) of Ontario Regulation 799/93, in that, while practising as a Registered Nurse at the Facility, you failed to keep records as required, and in particular:

a. on or about October 4, 2014, you provided inadequate care to [Client C.], and/or inadequately documented the care you provided, including in that you failed to indicate that several entries you made on the Integrated Patient Record were late entries;

b. on or about November 19 and/or November 20, 2014, you provided inadequate care to [Client D.], and/or inadequately documented the care you provided, including in the following respects:

i. on or about November 20, 2014, you documented an order to reinsert the Client's NG tube, that you received on November 20, 2014, on the Ordering Practitioner Form dated November 4, 2014;

ii. [*Withdrawn*];

iii. on or about November 20, 2014, you failed to administer and/or failed to document that you administered Lasix 20mg as ordered and/or required;

iv. [*Withdrawn*];

c. on or about November 24 and/or 26, 2014, you provided inadequate care to [Client E.], and/or inadequately documented the care you provided, including in the following respects:

i. [*Withdrawn*];

ii. on or about November 24, 2014, you failed to assess the Client and/or failed to document an assessment of the Client upon the Client's return from hospital;

iii. on or about November 26, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

d. on or about November 18 and/or 20, 2014, you provided inadequate care to [Client F.], and/or inadequately documented the care you provided, including in the following respects:

i. on or about November 18, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

ii. [*Withdrawn*];

iii. [*Withdrawn*];

e. on or about November 19, 2014, you provided inadequate care to [Client G.] and/or inadequately documented the care you provided, including in the following respects:

i. you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

ii. [*Withdrawn*];

f. on or about November 24 and/or 25, 2014, you provided inadequate care to [Client H.] and/or inadequately documented the care you provided, including in the following respects:

i. on or about November 25, 2014, you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

ii. [*Withdrawn*];

8. 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 practising as a Registered Nurse at [the Facility], you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the

circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, and in particular:

a. on or about October 4, 2014, you provided inadequate care to [Client C.], and/or inadequately documented the care you provided, including in the following respects:

   i. [*Withdrawn*];

   ii. [*Withdrawn*];

   iii. [*Withdrawn*];

   iv. [*Withdrawn*];

   v. you failed to indicate that several entries you made on the Integrated Patient Record were late entries;

b. on or about November 19 and/or November 20, 2014, you provided inadequate care to [Client D.], and/or inadequately documented the care you provided, including in the following respects:

   i. on or about November 20, 2014, you documented an order to reinsert the Client's NG tube, that you received on November 20, 2014, on the Ordering Practitioner Form dated November 4, 2014;

   ii. [*Withdrawn*];

   iii. on or about November 20, 2014, you failed to administer and/or failed to document that you administered Lasix 20mg as ordered and/or required;

   iv. [*Withdrawn*];

c. on or about November 24 and/or 26, 2014, you provided inadequate care to [Client E.], and/or inadequately documented the care you provided, including in the following respects:

   i. [*Withdrawn*];

   ii. on or about November 24, 2014, you failed to assess the Client and/or failed to document an assessment of the Client upon the Client's return from hospital;

   iii. on or about November 26, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

d. on or about November 18 and/or 20, 2014, you provided inadequate care to [Client F.], and/or inadequately documented the care you provided, including in the following respects:

   i. on or about November 18, 2014, you failed to assess the Client and/or failed to document any assessment of the Client and/or failed to document any care in the Integrated Patient Record at all that day;

   ii. [*Withdrawn*];

   iii. [*Withdrawn*];

   iv. [*Withdrawn*];

e. on or about November 19, 2014, you provided inadequate care to [Client G.] and/or inadequately documented the care you provided, including in the following respects:

   i. you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

   ii. [*Withdrawn*];

f. on or about November 24 and/or 25, 2014, you provided inadequate care to [Client H.] and/or inadequately documented the care you provided, including in the following respects:

   i. [*Withdrawn*];

   ii. on or about November 25, 2014, you failed to assess the Client and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all that day;

   iii. [*Withdrawn*];

9. [*Withdrawn*];

<u>Member's Plea</u>

The Member admits to the allegations as set out in the Notice of Hearing at paragraphs:

- 1(a) (iii), (v)
- 1(b) (ii)
- 4(a) (iii), (v), and (ix) in that the conduct was unprofessional;
- 4(b) (ii) in that the conduct was unprofessional;

- 6(a) (v)
- 6(b) (i), (iii)
- 6(c) (ii), (iii)
- 6(d) (i)
- 6(e) (i)
- 6(f) (ii)
- 7(a)
- 7(b) (i), (iii)
- 7(c) (ii), (iii)
- 7(d) (i)
- 7(e) (i)
- 7(f) (i)
- 8(a) (v) in that the conduct was unprofessional
- 8(b) (i), (iii) in that the conduct was unprofessional
- 8(c) (ii), (iii) in that the conduct was unprofessional
- 8(d) (i) in that the conduct was unprofessional
- 8(e) (i) in that the conduct was unprofessional
- 8(f) (ii) in that the conduct was unprofessional

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 Fact

The panel received an agreed statement of facts, which set out as follows.

THE MEMBER

1. Surujdeo Narain (the "Member") first obtained a certificate in nursing [ ] in 1997. He then obtained a diploma in nursing [ ] in 2003.

2. The Member initially registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") on January 27, 1998. His certificate of registration was suspended for non-payment of fees on March 11, 2010 and he formally resigned as an RPN on February 1, 2013.

3. The Member registered with the College as a Registered Nurse on September 22, 2004.

4. The Member was employed [the Agency], from February 2011 to February 2012, when his employment was terminated as a result of the incidents that occurred while he was employed at the Agency as described below.

5. The Member was also employed by [the Facility] between January 2009 and December 2014 [ ] when his employment was terminated as a result of the incidents that occurred at the [Facility] as described below.

THE AGENCY

6. The Agency provides home healthcare services, including nursing care, personal and home support, as well as therapy and rehab.

7. The Member was employed as a casual nurse at the Agency, but worked full time hours as well. The Member usually worked evenings.

THE HOSPITAL

8. The [Facility] is an acute care community hospital with several sites that provide care [ ].

9. Since 2009, the Member was employed as a part-time staff nurse on the Unit. [ ]

10. Registered staff, such as the Member, worked 12 hour shifts on the Unit, either between 0730 and 1930 or 1930 and 0730.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

The Agency

[Client A.] - December 31, 2011

11. [Client A.] was a 91 year old male who was suffering from pneumonia. He was discharged from [hospital] on December 26, 2011, with a referral for home care [ ].

12. The referral form for [homecare] services was faxed to the Agency on December 30, 2011 at 3:44pm. It provided that intravenous hydration for [Client A.] should start that day, December 30, 2011, with 1L Normal Saline ("NS") for at least five hours.

13. The [homecare] Service Offer provided that the first visit to the Client should take place by around 1300 on December 31, 2011, because the IV supplies would not be delivered to the Client's residence until around noon on December 31, 2011, which was New Year's Eve. If the Member were to testify, he would say that, unknown to him, the Agency made no arrangements to have extra staff available, and that he was the only nurse working.

14. The Member attended at [Client A.]'s residence at 1330 on December 31, 2011. He took [Client A.]'s vitals and initiated hydration to run at 200 mL/h. He noted that there was only one 250 mL bag of NS at the residence, so he obtained one 1000 mL bag from his car. Once the 250 mL bag was finished, he hung the 1000 mL bag

before leaving the residence at 1430. The Member was planning to return later that evening (after about 5 hours) to change the IV bag.

15. The Member did not leave [Client A.]'s family with any instructions when he left. He did however leave them with his cell phone number. Although this was contrary to the Agency's policy (as clients are to call the Agency directly with any issues), if the Member were to testify he would say that he was trying to be helpful and to make himself accessible to the Clients for follow-up.

16. At 1630, [Client A.]'s [spouse], [ ], called the Member to indicate that they were having trouble with the intravenous pump, which was alarming "AIR". The Member instructed [the spouse] to shut off the pump and clamp the line, but she was unable to, and she asked the Member to return to their residence. The Member advised that he was too busy to return at that time because he had a backlog of clients to care for.

17. At 1640, [Client A.]'s daughter called the Member and asked him to return to their residence. The Member indicated that he was busy and could not return until later because he had a backlog of clients to care for.

18. At about this time, the Member called the Agency and asked that another nurse be sent to [Client A.]'s residence, advising that [Client A.] needed to be seen again that day. The Agency informed the Member that no other nurse was available to see [Client A.] that day.

19. The Member arrived back at [Client A.]'s residence at around 2000. The Member assessed [Client A.] and attempted to flush the intravenous line. During the course of the Member's providing care to him, [Client A.] slumped over. The Member assessed [Client A.] for decreased consciousness and began CPR. He instructed [Client A.'s spouse] to call 911.

20. When EMS arrived, [Client A.] was hooked up to a heart monitor and an oxygen monitor. EMS intubated [Client A.] and administered a dose of epinephrine. [Client A.] was moved to the floor and CPR was continued there. After EMS arrived the Member stood aside and let EMS assume resuscitation efforts. After approximately 25 minutes, EMS contacted a physician for direction. The physician advised that CPR be ceased. [Client A.] was pronounced dead at 2045.

21. If the Member were to testify, he would say that after the Client was pronounced dead, he offered his condolences to the family and left to attend to his other clients. EMS left, except for one paramedic, who stayed to wait for the coroner. C.G. remained on the floor. The Member failed to immediately advise the Agency of C.G.'s death. He reported the death to the Agency the following afternoon.

22. When he left, the Member took [Client A.]'s health record with him. If the Member were to testify, he would say that he returned [Client A.]'s confidential client health

information to the Agency the next day on January 1, 2012. The Member retained a copy of [Client A.]'s health record.

23. The Agency's policy on documentation was that client records were to remain at the Client's home to ensure continuity of care. If a client was discharged or died, the nurse was required to return all records to the Agency within seven days. If the Member were to testify, he would state that he copied the chart because he became concerned when the family started to make allegations about his care.

24. The only documentation that a nurse was entitled to keep were the Client Service Records that were forwarded [ ] as proof that a nurse's visit to a client was authorized.

25. The coroner indicated that [Client A.] passed away from natural causes. The coroner had no concerns about the intravenous line to which [Client A.] had been hooked up nor did the coroner make any findings against the care provided by the Member. An autopsy was not performed.

<u>[Client B.] - January 28-29, 2012</u>

26. [Client B.] was a high risk client with multiple sclerosis and was entirely dependent on others for care. [Client B.] had a history of suicidal ideation.

27. The Member was scheduled to visit [Client B.] once on both January 28 and 29, 2012, (a Saturday and Sunday) for wound care and catheter management. The Member was not [Client B.]'s regular homecare nurse, but had agreed to take his regular nurse's shifts that weekend.

28. The Member tried but failed to visit [Client B.] on both days.

29. On January 28, 2012, the Member called [Client B.] at 1600 to indicate that he would be late that evening. At approximately 2200, the Member attended [Client B.]'s [home] and rang the buzzer. [Client B.] did not respond. The Member did not contact his employer or anyone else to advise that he was unable to reach [Client B.]

30. On January 29, 2012, the Member called [Client B.] at 1000. [Client B.] advised that he had fallen asleep and had not heard the buzzer the previous evening. They agreed that the Member would attend again at about 2200. When the Member attended, [Client B.] again did not respond to the buzzer. The Member failed to contact anyone to advise that he was, again, unable to reach [Client B.].

31. The Member did not document any conversations he had with [Client B.], or that he attempted to visit [Client B.] on January 28 and January 29, 2012.

32. The Agency only became aware of the missed visits because the nurse who attended to [Client B.] on January 30, 2012, advised the Agency of the missed visits. The nurse had noted that the dressings on [Client B.] had not been changed.

33. The Member acknowledged that he was aware of the "Not Seen/Not Found Visits" policy and knew he should have followed it. The policy stated that if the Member was unable to contact the Client, he should have "immediately contact[ed] the branch office to speak with any available coordinator and clearly indicate the Client is 'Not Seen/Not Found'."

34. The Member also failed to follow the "Adverse Event Management" policy. This policy stated that a missing client who has not been found within three hours is considered a "Serious Adverse Event" and must be reported to the Agency.

Inaccurate charting

35. The Member recorded, on an Agency document used for payroll, that he treated six clients on December 31, 2011, at the following times: 21:45, 21:50, 22:00, 22:50, 23:00 and 23:15.

36. The following is a summary of approximate distances and travel times between each visit, and of the care each client required:

Client	**Visit Time (documented by the Member)**	**Distance (from previous appointment)**	**Travel time (from previous appointment)**	**Care Required**
[Client I.]	2145			Wound care
[Client J.]	2150	3.2 km	6 minutes	Wound care
[Client K.]	2200	4.4 km	7 minutes	Medication administration
[Client L.]	2250	6.9 km	11 minutes	Medication administration
[Client M.]	2300	3.8 km	7 minutes	No information provided
[Client N.]	2315	4.4 km	8 minutes	Intermittent catheterization

37. Given that the Member had to travel to each of the Clients' residences and his assertion that traffic was slow as it was New Year's Eve, it was not possible for the Member to have visited and provided care to the six clients at the times he recorded on the Agency payroll document.

38. The Member was paid by the Agency on a per-visit basis. If he were to testify, he would say that he did make each of the visits documented, however it is possible that, a few days later when he completed his timesheet for this day, he estimated the times of the visits inaccurately. The Member also produced written statements from several of these clients confirming that he did visit them on December 31, 2011.

The [Facility]

[Client C.]

39. On October 4, 2014, the Member was working the 0730 to 1930 shift and was assigned to care for [Client C.] who had been admitted to the Unit on March 31, 2014 due to a recent stroke.

40. [Client C.]'s condition had deteriorated the night before the Member was assigned to care for her. As a result, during morning rounds on October 4, 2014, the Most Responsible Physician wrote new orders for blood work, IV hydration, antibiotics and a chest x-ray. The physician's notes also indicated that the Client was in respiratory distress.

41. When the Member assumed care of [Client C.] was wearing a 100% oxygen non-rebreather mask and had intermittent decreased levels of consciousness. The Member charted that morning that the Client was "alert on and off" and that he noted a "fine crackle" in the Client's breathing.

42. At around 1300, [Client C.]'s son noticed that [Client C.] had stopped breathing. [Client C.]'s son ran to the nursing station next to [Client C.]'s room to report this. The Member attended to [Client C.], assessed her, and then left the room and returned to the nursing station to call a code blue.

43. [Client C.] subsequently died, and was pronounced dead at 1350.

44. On the Integrated Patient Record ("IPR") for [Client C.], a Respiratory Therapist's entry is noted at 0840. The note is then followed by the Member's 0800 note, 0815 note, 0830 note, and a 0840 note in which the Member documented paging the Respiratory Therapist.

45. These entries were all made some time after the Respiratory Therapist's 0840 entry. However, the Member failed to document on the IPR that these four entries were "late entries".

The Member's Monitored Practice

46. In the aftermath of [Client C.]'s death, her family alleged that the Member had failed to respond appropriately to being notified that she had stopped breathing, including that the Member had failed to call the code blue with adequate promptness, and that

the Member had administered medication and Ensure to [Client C.] orally when he ought not to have done so (although there was no NPO order for this client).

47. In response to these alleged concerns, the Clinical Practice Leader, [ ], was assigned to monitor the Member following [Client C.].'s death. [The Clinical Practice Leader] monitored the Member's practice from November 18-20 and November 24-26, 2014. The following incidents were witnessed by [the Clinical Practice Leader] while she was monitoring the Member.

48. As [the Clinical Practice Leader] was able to intervene, no clients were harmed. If the Member were to testify, he would state that he felt under stress due to the close supervision he was subjected to and that this stress contributed to these incidents.

[Client D.]

49. The Member was assigned to [Client D.] on November 19 and 20, 2014, from 0730 to 1930.

50. [Client D.] was assessed with decreased oral intake and required a feeding tube (NG tube or PEG tube).

51. On November 20, 2014, the Member received a verbal order to reinsert [Client D.]'s NG tube.

52. To document the order, the Member opened the Client's chart (Ordering Practitioner Form) to an arbitrary location, which was a sheet with an empty space dated November 4, 2014, and documented the order. Although the Member correctly dated the order for November 20, 2014, there were already several orders documented between November 4 and November 20, 2014. The Member clearly documented the order out of chronology, contrary to [Facility] policy.

53. If this error had not been caught by [the Clinical Practice Leader], the order would have been missed by staff as staff would not have reviewed outdated orders.

54. [Client D.]'s Ordering Physician Form indicates that an order for Lasix 20mg IV was made on November 17, 2014, to start on November 18, 2014. [Client D.]'s MAR for November 20, 2014 has a blank space for the administration of Lasix 20mg IV at 0900, even though the Member initialled the administration of Prevacid 30mg OG at 0900, which appears on the same MAR immediately below the Lasix order.

55. If the Member were to testify, he would say that he did in fact administer the Lasix, but neglected to document that he had done so.

[Client E.]

56. The Member was assigned to [Client E.] on November 24, 25 and 26, 2014 from 0730 to 1930.

57. The Member failed to assess [Client E.] when he returned to the [Facility] from [another facility] on November 24, 2014. The Member only assessed the Client at 0900 and made a note stating that the Client "is going to [another facility] for radiation. He will go again on Nov 25, 2014." This was his only entry in the IPR.

58. The Member administered three different medications to the Client at 1800, which establishes that the Member was still on shift at this point in time, and that the Client had returned from [the other facility] by then.

59. On November 22 and 23, 2014, when a different nurse was caring for [Client E.], there is a note in the IPR in the afternoon, noting that the Client returned from [the other facility] at 1200. There is also documentation on the Assessment and Routine Care Flowsheet recording that the Client was assessed at 1200 on both days.

60. On November 26, 2014, the Member either failed to assess [Client E.] or document any care or assessment in relation to the Client in either the IPR or the Medical Surgical Vital Sign Record. It is clear that the Member was caring for the Client throughout the day because he initialled in the MAR the administration of medications to the Client at 0900, 1200, 1700 and 1800.

[Client F.]

61. The Member was assigned to [Client F.] on November 18, 19 and 20, 2014, from 0730 to 1930.

62. Although the Member was not originally scheduled to work on November 18, 2014, it is clear that he worked on this day as he appeared on the attendance report for that day and initialled repeatedly on [Client F.]'s MAR throughout the day.

63. Other than the MAR, the Member either failed to assess [Client F.] or document any care or assessment in relation to [Client F.] on November 18, 2014, on either the IPR or the Medical Surgical Vital Sign Record.

[Client G.]

64. The Member was assigned to [Client G.] on November 19 and 20, 2014, from 0730 to 1930.

65. The Member failed to assess the Client and/or complete the Assessment and Routine Care Flowsheet for [Client G.] at all on November 19, 2014.

[Client H.]

66. The Member was assigned to [Client H.] on November 24 and 25, 2014, from 0730 to 1930.

67. On November 25, 2014, the Member failed to assess the Client and/or failed to document any assessment on the Assessment and Routine Care Flowsheet of [Client H.].

ADMISSIONS OF PROFESSIONAL MISCONDUCT

College Standards

68. The Member acknowledges that the following College Standards of Practice were in place at the time of the incidents and reflect the standards expected of a nurse at that time:

- *Professional Standards, Revised 2002*;
- *Confidentiality and Privacy: Personal Health Information*; and
- *Documentation*.

69. The Member admits that he breached the above standards of practice of the profession by engaging in the conduct described in paragraphs 11 to 67 above.

The Agency

[Client A.]

70. The Member admits that he made a copy of [Client A.]'s records, which he kept for himself, thereby failing to maintain its confidentiality, and that he failed to report [Client A.]'s death to the Agency promptly.

[Client B.]

71. The Member admits that he failed to ask for and/or seek assistance to ensure timely and/or appropriate nursing care was provided to [Client B.].

Inaccurate charting

72. The Member admits that he created inaccurate records when he did not provide care to the six clients at the times he documented on the Agency document.

The [Facility]

[Client C.]

73. The Member admits that he inadequately document the care he provided to [Client C.] on October 4, 2014, when he failed to indicate that several entries he made on the IPR were late entries.

74. The Member admits that he failed to keep records as required when he failed to note that several entries he made on the IPR were late entries.

[Client D.]

75. The Member admits that he inadequately documented the care he provided to [Client D.] on November 20, 2014, when he documented an order from November 20, 2014, on the Ordering Practitioner Form dated November 4, 2014, and when he failed to document that he administered a medication as ordered.

76. The Member admits that he failed to keep records as required when he inadequately documented the care he provided to [Client D.] on November 20, 2014, as described in paragraph 75, above.

[Client E.]

77. The Member admits that he provided inadequate care to [Client E.] and/or inadequately documented the care he provided to [Client E.] on November 24 and 26, 2014, when he either failed to assess or to document an assessment of the Client upon his return from [another facility], and either failed to assess or to document any assessment of the Client and/or document any care of the Client in the IPR for the entire day of November 26, 2014.

78. The Member admits that he failed to keep records as required when he provided inadequate care to [Client E.] and/or inadequately documented the care he provided to [Client E.] on November 24 and 26, 2014, as described in paragraph 77, above.

[Client F.]

79. The Member admits that he provided inadequate care to [Client F.] and/or inadequately documented the care he provided to [Client F.] on November 18, 2014 when he either failed assess and provide care to the Client, or failed to document any assessment of the Client and/or failed to document any care of the Client in the IPR for the entire day of November 18, 2014.

80. The Member admits that he failed to keep records as required when he provided inadequate care to [Client F.] and/or inadequately documented the care he provided to [Client F.] on November 18, 2014, as described in paragraph 79, above.

[Client G.]

81. The Member admits that he provided inadequate care to [Client G.] and/or inadequately documented the care he provided to [Client G.] on November 19, 2014, when he failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all during that day.

82. The Member admits that he failed to keep records as required when he provided inadequate care to [Client G.] and/or inadequately documented the care he provided to [Client G.] on November 19, 2014, as described in paragraph 81, above.

[Client H.]

83. The Member admits that he provided inadequate care to [Client H.] and/or inadequately documented the care he provided to [Client H.] on November 25, 2014, when he failed to assess and/or failed to document any assessment of the Client in the Assessment and Routine Care Flowsheet at all on November 25.

84. The Member admits that he failed to keep records as required when he provided inadequate care to [Client H.] and/or inadequately documented the care he provided to [Client H.] on November 25, 2014, as described in paragraph 83, above.

General

85. The Member and the College consent to this Panel of the Discipline Committee adjudicating all of the allegations of professional misconduct set out in the Notice of Hearing dated May 12, 2016.

86. The Member admits that he committed the acts of professional misconduct as described in paragraphs 11 to 67 above, and as alleged in the Notice of Hearing at paragraphs:

- 1(a) (iii), (v)
- 1(b) (ii)
- 4(a) (iii), (v), and (ix) in that the conduct was unprofessional;
- 4(b) (ii) in that the conduct was unprofessional;
- 6(a) (v)
- 6(b) (i), (iii)
- 6(c) (ii), (iii)
- 6(d) (i)
- 6(e) (i)
- 6(f) (ii)
- 7(a)
- 7(b) (i), (iii)
- 7(c) (ii), (iii)
- 7(d) (i)
- 7(e) (i)
- 7(f) (i)
- 8(a) (v) in that the conduct was unprofessional
- 8(b) (i), (iii) in that the conduct was unprofessional
- 8(c) (ii), (iii) in that the conduct was unprofessional
- 8(d) (i) in that the conduct was unprofessional

- 8(e) (i) in that the conduct was unprofessional
- 8(f) (ii) in that the conduct was unprofessional

OTHER

87. With leave of the Panel of the Discipline Committee, the College withdraws the remaining allegations in the Notice of Hearing, which are the following:

- 1(a)(i), (ii), (iv)
- 1(b)(i)
- 2
- 3
- 4(a)(i), (ii), (iv), (vi), (vii), (viii)
- 4(b)(i)
- 5
- 6(a)(i), (ii), (iii), (iv)
- 6(b)(ii), (iv)
- 6(c)(i)
- 6(d)(ii), (iii), (iv)
- 6(e)(ii)
- 6(f)(i), (iii)
- 7(b)(ii), (iv)
- 7(c)(i)
- 7(d)(ii), (iii)
- 7(e)(ii)
- 7(f)(ii)
- 8(a)(i), (ii), (iii), (iv)
- 8(b)(ii), (iv)
- 8(c)(i)
- 8(d)(ii), (iii), (iv)
- 8(e)(ii)
- 8(f)(i), (iii)
- 9

Decision

The Panel considered the Agreed Statement of Facts and finds that this evidence supports findings of professional misconduct 1(a)(iii),(v), 1(b)(ii) ,6(a)(v), 6(b) (i),(iii), 6(c)(ii),(iii), 6(d)(i), 6(e)(i) 6(f)(ii), 7(a), 7(b)((i),(iii), 7(c)(ii),(iii), 7(d)(i), 7(e)(i) and 7(f)(i) The findings also supported that the conduct was unprofessional 4 (a) (iii),(v),(ix) and 8(a)(v), 8(b)(i),(iii), 8(c)(ii),(iii), 8(d)(i), 8(e)(i) and 8(f)(ii) as set out in the Notice of Hearing.

Reasons for Decision

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

Allegation # 1(a)(iii) in the Notice of Hearing is supported by paragraphs 22, 23 and 24 in the Agreed Statement of Facts

Allegation # 1(a)(v) in the Notice of Hearing is supported by paragraph 21 in the Agreed Statement of Facts

Allegation # 1(b)(iii) in the Notice of Hearing is supported by paragraphs 29, 30, 33 and 34 in the Agreed Statement of Facts

Allegation # 6(a)(v)in the Notice of Hearing is supported by paragraphs 44 and 45 in the Agreed Statement of Facts

Allegation # 6(b)(i) in the Notice of Hearing is supported by paragraphs 51, 52, 53 and 54 in the Agreed Statement of Facts

Allegation # 6(b)(iii) in the Notice of Hearing is supported by paragraphs 54 and 55 in the Agreed Statement of Facts

Allegation # 6(c)(ii) in the Notice of Hearing is supported by paragraphs 57, 58, 59 and 60 in the Agreed Statement of Facts

Allegation # 6(c)(iii) in the Notice of Hearing is supported by paragraphs 56 and 60 in the Agreed Statement of Facts

Allegation # 6(d)(i) in the Notice of Hearing is supported by paragraphs 61, 62 and 63 in the Agreed Statement of Facts

Allegation # 6(e)(i) in the Notice of Hearing is supported by paragraphs 64 and 65 in the Agreed Statement of Facts

Allegation # 6(f)(ii) in the Notice of Hearing is supported by paragraphs 66 and 67 in the Agreed Statement of Facts

Allegation # 7(a) in the Notice of Hearing is supported by paragraphs 44, 45, 68, 69, 73 and 74 in the Agreed Statement of Facts

Allegation # 7(b)(i) in the Notice of Hearing is supported by paragraphs 52, 53, 75 and 76 in the Agreed Statement of Facts

Allegation # 7(b)(iii) in the Notice of Hearing is supported by paragraphs 55, 75 and 76 in the Agreed Statement of Facts

Allegation # 7(c)(ii) in the Notice of Hearing is supported by paragraphs 57, 77 and 78 in the Agreed Statement of Facts

Allegation # 7(c)(iii) in the Notice of Hearing is supported by paragraphs 60, 77 and 78 in the Agreed Statement of Facts

Allegation # 7(d)(i) in the Notice of Hearing is supported by paragraphs 63, 69 and 80 in the Agreed Statement of Facts

Allegation # 7(e)(i) in the Notice of Hearing is supported by paragraphs 65, 81 and 82 in the Agreed Statement of Facts

Allegation # 7(f)(i) in the Notice of Hearing is supported by paragraphs 67, 83 and 84 in the Agreed Statement of Facts

The Panel considered the Agreed Statement of Facts and finds that this evidence supports findings that the conduct was unprofessional as alleged in the Notice of Hearing

Allegation # 4(a)(iii) in the Notice of Hearing is supported by paragraphs 22, 23 and 24 in the Agreed Statement of Facts

Allegation # 4(a)(v) in the Notice of Hearing is supported by paragraphs 21 and 23 in the Agreed Statement of Facts

Allegation # 4(a)(ix) in the Notice of Hearing is supported by paragraphs 35, 36, 37 and 38 in the Agreed Statement of Facts

Allegation # 4(b)(ii) in the Notice of Hearing is supported by paragraphs 29, 30, 31, 33 and 34 in the Agreed Statement of Facts

Allegation # 8(a)(v) in the Notice of Hearing is supported by paragraphs 44, 45, 68, 69,73 and 74 in the Agreed Statement of Facts

Allegation # 8(b)(i) in the Notice of Hearing is supported by paragraphs 52, 68, 69, 75 and 76 in the Agreed Statement of Facts

Allegation # 8(b)(iii) in the Notice of Hearing is supported by paragraphs 54, 55, 68 and 69 in the Agreed Statement of Facts

Allegation # 8(c)(ii) in the Notice of Hearing is supported by paragraphs 57, 68 and 69 in the Agreed Statement of Facts

Allegation # 8(c)(iii) in the Notice of Hearing is supported by paragraphs 60, 68 and 69 in the Agreed Statement of Facts

Allegation #8 (d)(i) in the Notice of Hearing is supported by paragraphs 63, 68 and 69 in the Agreed Statement of Facts

Allegation # 8(e)(i) in the Notice of Hearing is supported by paragraphs 65, 68 and 69 in the Agreed Statement of Facts

Allegation # 8(f)(iii) in the Notice of Hearing is supported by paragraphs 67, 68 and 69 in the Agreed Statement of Facts

For allegations 4 and 8, the panel finds that the conduct admitted by the Member would reasonably be regarded as unprofessional.

Penalty

The parties jointly requested 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 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 Nursing Expert (the "Expert"), at his own expense and within six months of the date of this Order. If the Expert determines that a greater number of sessions are required, the Expert will advise the Member and write to 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 18 months of the date of the Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:
            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires and online learning modules (where applicable):

            1. *Professional Standards*,
            2. *Documentation*,
            3. *Medication,*

4. *Therapeutic Nurse-Client Relationship*, and
5. *Confidentiality and Privacy - Personal Health Information*;

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

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into his behaviour;

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

b) The Member shall successfully complete, at his own expense, with a minimum passing grade of 65%, nursing courses (with clinical or laboratory components) that have received prior approval from the Director regarding: Practice Standards, Health Assessment, Communication and Medication Administration. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%.

c) Until the Member completes the requirements set out in paragraphs 2(a) and 2(b) and for 12 months thereafter, the Member will notify each current and new employer 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. Only practise nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

      1. that they received a copy of the required documents,
      2. that they agree to provide or to arrange to provide the mentorship required in paragraphs 2(d) and 2(e),
      3. 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. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

         a. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,
         b. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,
         c. the third audit shall take place within nine months from the date the Member begins or resumes employment with the employer, and
         d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer.

   iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of the Member's charts and timesheets (where applicable) to ensure they meet both College and employer standards,
2. discussing (by telephone or in person), with at least three of the Member's clients, the care provided by the Member to ensure that the Member is utilizing appropriate communication techniques consistent with the *Therapeutic Nurse-Client Relationship* Standard and employer standards, and
3. discussing with the Member's Mentor (as defined below) whether any deficiencies have been noted in the Member's nursing practice.

d) From the date of this Order and until the Member completes the requirements set out in paragraphs 2(a) and 2(b), the Member must meet weekly with a Registered Nurse who is employed at the same facility as the Member ("Mentor") to discuss his efforts to ensure that his care, communications with clients and documentation are meeting the standards of practice of the profession. The Mentor shall be aware of the Member's discipline history and agree to notify the employer immediately if he/she has information that the Member has breached the standards of practice of the profession.

e) After the Member completes the requirements set out in paragraphs 2(a) and 2(b), the Mentor will determine whether further meetings are required with himself or herself and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

f) If the Member is not engaged in the practice of nursing as of the date of this Order, paragraphs 2(c), 2(d) and 2(e) will apply when the Member returns to the practice of nursing after the date of this Order.

3. 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

The parties submitted that the proposed penalty had provisions for general deterrence, specific deterrence and rehabilitation and remediation. They submitted that the proposed penalty protected the public and was within the appropriate range.

The College presented the panel with four cases to review, which included:

CNO v. Allison Russell (Discipline Committee, 2014);
CNO v. Dalit Mann (Discipline Committee, 2012);
CNO v. Anab Mohamed (Discipline Committee, 2012); and

CNO v. Rosa Lazarte (Discipline Committee, 2012).

The panel did review them and found each case had some similarity to the present case.

Penalty Decision

The panel accepts the Joint Submission as to Order and makes an order as follows:

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 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 Nursing Expert (the "Expert"), at his own expense and within six months of the date of this Order. If the Expert determines that a greater number of sessions are required, the Expert will advise the Member and write to 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 18 months of the date of the Order. To comply, the Member is required to ensure that:

      i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

      ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

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

      iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires and online learning modules (where applicable):

         1. *Professional Standards*,
         2. *Documentation*,
         3. *Medication,*
         4. *Therapeutic Nurse-Client Relationship*, and
         5. *Confidentiality and Privacy - Personal Health Information*;

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

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into his behaviour;

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

b) The Member shall successfully complete, at his own expense, with a minimum passing grade of 65%, nursing courses (with clinical or laboratory components) that have received prior approval from the Director regarding: Practice Standards, Health Assessment, Communication and Medication Administration. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%.

c) Until the Member completes the requirements set out in paragraphs 2(a) and 2(b) and for 12 months thereafter, the Member will notify each current and new employer 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. Only practise nursing for an employer who agrees to, and does, forward a report to the Director within 14 days of the commencement or resumption of the Member's employment in any nursing position, confirming:

1. that they received a copy of the required documents,
2. that they agree to provide or to arrange to provide the mentorship required in paragraphs 2(d) and 2(e),
3. 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. that they agree to perform random spot audits of the Member's practice at the following intervals and provide a report to the Director regarding the Member's practice after each audit:

    a. the first audit shall take place within three months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within six months from the date the Member begins or resumes employment with the employer,
    c. the third audit shall take place within nine months from the date the Member begins or resumes employment with the employer, and
    d. the fourth audit shall take place within 12 months from the date the Member begins or resumes employment with the employer.

iv. The audits shall, on each occasion, involve the following:

1. reviewing a random selection of the Member's charts and timesheets (where applicable) to ensure they meet both College and employer standards,
2. discussing (by telephone or in person), with at least three of the Member's clients, the care provided by the Member to ensure that the Member is utilizing appropriate communication techniques consistent with the *Therapeutic Nurse-Client Relationship* Standard and employer standards, and
3. discussing with the Member's Mentor (as defined below) whether any deficiencies have been noted in the Member's nursing practice.

d) From the date of this Order and until the Member completes the requirements set out in paragraphs 2(a) and 2(b), the Member must meet weekly with a Registered Nurse who is employed at the same facility as the Member ("Mentor") to discuss his efforts to ensure that his care, communications with clients and documentation are meeting the standards of practice of the profession. The Mentor shall be aware of the Member's discipline history and agree to notify the employer immediately if he/she has information that the Member has breached the standards of practice of the profession.

e) After the Member completes the requirements set out in paragraphs 2(a) and 2(b), the Mentor will determine whether further meetings are required with himself or herself and will arrange those meetings with the Member as necessary. When the Mentor determines that no further meetings are required, the Mentor will advise the Director in writing that the meetings have ended and explain why they are no longer required.

f) If the Member is not engaged in the practice of nursing as of the date of this Order, paragraphs 2(c), 2(d) and 2(e) will apply when the Member returns to the practice of nursing after the date of this Order.

3. 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 concluded the parties' Joint Submission on Order is in the public interest and provided both specific and general deterrence, as well as the opportunity for remediation of the Member's practice. It is reasonable and is in the public interest. It is in line with what has been ordered in similar cases that were presented to the panel.

The Member has co-operated with the College and in agreeing to the facts and proposed penalty, has accepted responsibility for his actions. The penalty allows for specific deterrence in that it provides for an oral reprimand and remediation. It also provides for general deterrence in that it sends a clear message to the membership. It provides sufficient protection for the public and provides for remediation and monitoring by way of random audits in regards to the Member's charts and timesheets.

I, TAMMY HEDGE, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

_______________________	_______________________
Chairperson	Date

Panel Members:

Cathy Egerton, Public Member
Shiraz Irani, RN
Ashleigh Molloy, Public Member
George Rudanycz, RN