DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on May 28 & 29, 2015, at the College of Nurses of Ontario (“the College”) at Toronto.

As Christina Stefanescu (the “Member”) was not present, the hearing recessed for 15 minutes to allow time for the Member to appear. Upon reconvening, the panel noted that the Member was not in attendance and was not represented.

Counsel for the College provided the panel with evidence that the Member had been sent the Notice of Hearing on December 15, 2014 and that various other attempts had been made to contact the Member [ ]. The panel was satisfied that every available attempt had been made to contact the Member to provide adequate notice of the time, date, place and nature of the hearing. The panel therefore proceeded with the hearing in the Member’s absence.
The Allegations

The allegations against the Member as stated in the Notice of Hearing dated December 15, 2014, are as follows.

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of Ontario Regulation 799/93, in that on April 3, 2011, while working as a registered nurse at [the Facility], you contravened a standard of practice of the profession or failed to meet a standard of practice of the profession in that:
   a) you documented that you had completed Hourly Round checks of [the Client] between 19:00 and 23:00 that you had not personally performed;
   b) your documentation on the Hourly Round form of [the Client] for 22:00 and 23:00 is illegible; and/or
   c) you failed to provide appropriate measures to [the Client] when you discovered [the Client] with vital signs absent.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the Health Professions Procedural Code of the Nursing Act, 1991, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of Ontario Regulation 799/93, in that on April 3, 2011, while working as a registered nurse at [the Facility], you engaged in conduct or performed acts, relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that:
   a) you documented that you had completed Hourly Round checks of [the Client] between 19:00 and 23:00 that you had not personally performed; and/or
   b) your documentation on the Hourly Round form of [the Client] for 22:00 and 23:00 is illegible; and/or
   c) you failed to provide appropriate measures to [the Client] when you discovered [the Client] with vital signs absent.

Member’s Plea

Given that the Member was not present nor represented, she was deemed to have denied the allegations in the Notice of Hearing. The Hearing proceeded on the basis that the College bore the onus of proving the allegations in the Notice of Hearing against the Member.

Overview

The Member was a registered nurse from July 2001 until February 2012 when she was suspended for non-payment of fees. In August of 2012 she resigned her membership. At the time
of the allegations on April 3, 2011, the Member was working in [a section] of a Mental Health Unit of [the Facility]. The Member was the charge nurse for her shift.

It is alleged that the Member contravened a standard of practice of the profession or failed to meet a standard of practice of the profession and that the Member engaged in conduct that would reasonably be regarded by members of the profession as disgraceful, dishonourable and/or unprofessional. The issues are as follows:

a. Did the Member document that she had completed hourly round checks of [the Client] that she had not personally done?
b. Was the Member’s documentation illegible?
c. Did the Member fail to provide appropriate measures to [the Client] when [the Client] was discovered with vital signs absent?

The panel heard from six lay witnesses and one expert witness.

The panel found that the Member committed acts of professional misconduct in that she contravened a standard of the profession while working as an RN at [the Facility] as described in the Notice of Hearing dated December 15, 2014, at paragraphs 1(a), 1(b) and 1(c). The panel further found the Member’s actions in 2(a) to be unprofessional and dishonourable; in 2(b) to be unprofessional and in 2(c) to be disgraceful, dishonourable and unprofessional.

**The Evidence**

The panel heard from seven witnesses and was provided with 26 exhibits.

Witness # 1, [ ], Program Director of [the Facility], gave the panel a general description of the layout of [the Unit] where the Member worked. It had 50 available beds in total, 11 of which were allocated to seniors [ ]. There were three pods in the Unit.

[The Program Director] described the [client] population and provided examples of [client] diagnoses, as related to their mental health. He further described the process for training staff prior to the opening and transfer of [clients] from [another] site. Staff were required to complete online training [ ] and also to attend specialized mental health education orientation [ ]. Part of the training was centered on the various hospital emergency codes and the procedures to be followed. Staff were also trained in policy and procedures of the hospital. The panel was provided with the [Facility’s] emergency procedures manual [ ], the hospital documentation policy [ ] and the Unit policy used in the acute units [ ].

[The Program Director] said there was an expectation for documentation to be accurate and completed in a timely manner before the completion of staff’s shifts. Sometimes [clients] were under orders to be observed every 15 minutes. When a [client] was in a 15-minute observation, documentation was to occur at the time of the observation. He stated it was definitely not the practice for one nurse to see a [client] and another nurse to document.
In the acute unit, each Pod had a charge nurse assigned for the shift. The charge nurse was an RN who also had [clients] assigned to them. Whenever possible, the staff was assigned to the same area so [clients] would have the same nurse and a sense of consistency.

[The Program Director] said the incident giving rise to this hearing occurred on April 3, 2011 in Pod 2, around 11:50 p.m. [The Client] was found to have died. He provided proof that the Member was working and was the charge nurse for Pod 2 (as she was the RN on shift) [ ].

[The Client] had been mentally ill for many years. He had panic attacks and could not control his actions or anxiety. The plan of care for [the Client] was not to seclude him when these attacks happened but to sit with him, provide calming techniques and do subsequent 15-minute assessments for client safety [ ]. Some staff (including [RPN A], the RPN on duty at the time) felt this did not work and had scheduled a meeting with management to deal with [the Client’s] care plan.

[The Program Director] also identified a document entitled the Review of the Unexpected Death in Specialized Mental Health at [the Facility] [ ]. This determined that nurses who had been on duty in the Pod when [the Client] died should be subject to discipline for their lack of actions. The Member was issued a letter of dismissal based on the findings [ ]. The panel was presented with the Coroner’s Investigation Statement [ ], which found [the Client] had died from natural causes.

Witness # 2, [RPN A], was working with the Member when the incident occurred. He was also terminated and subject to a hearing at the College [ ]. He took responsibility for his actions with an Agreed Statement of Facts and a Joint Submission on Order. [RPN A] testified that on April 3, 2011, he did the hourly checks of the [clients], reported to the Member and she filled out all the forms and initialled them. He stated that on the night of the incident, [the Client] was being very disruptive in that he sprayed pop all over his room and dismantled the call system in his room. [RPN A] was keeping [the Client] in his room away from the other [clients]. He did not put him on constant observation due to a lack of staff and he felt he could not manage [the Client] by himself. When he found [the Client] with no pulse, he immediately went and found the Member and was told by her not to touch the body. He said the Member did not know the procedure for calling the code blue at the facility. As a result, nothing was initiated until two nurses from upstairs came down and told him to call a code. He thought that [RPN B] from Pod 1 came and called the code blue as he stated he was busy helping. The code blue had to be called a second time as the first one was announced at the facility’s other site. After nurses came with the crash cart, CPR was initiated.

Witness # 3, [RPN B], had been working in Pod 1 at the time of the incident. She was transferred to [the Facility] in November of 2010 and went through two weeks’ orientation and then shadowed an adult mental health nurse. Code procedures were on the computer modules and they had to be completed as part of the training. On the night of the incident, a student she was working with came to find her to help on Pod 2, just after 2300 hours.

When she arrived at [the Client’s] room, she checked his pulse and asked if there was a do not resuscitate order. The Member and [RPN A] were having a discussion. The Member did not
want to initiate CPR as she felt she would get fired for tampering with evidence. [RPN A] was saying they should start CPR. [RPN B] told them to start CPR and call code blue. [RPN B] paged the administration on call and then returned to Pod 1. There was no call received from administration as switchboard forgot to notify administration. After the second call was placed to administration, [RPN B] received a call back. She was going back and forth between Pod 1 and 2. She observed that the Member was concerned about another [client] who was a friend to [the Client], but [RPN B] believed the [client] was sleeping. She could not remember the exact times, who called code blue or who started CPR.

Witness #4, [RPN C], worked full-time on Pod 3. She has never worked on Pod 1 or 2. She learned about the April 3, 2011, incident when the Member called and asked her what is the difference between a [client] having a heart attack or found dead. The Member was unclear about the code blue procedure and wanted clarification with other staff members. This occurred sometime after 2300 hours. [RPN C] went to Pod 2 and the Member asked her to go upstairs and ask the other nurses [ ] what the actual procedure was for calling a code blue. [RPN C] went upstairs and the nurses on [there] had the same understanding as [RPN C] so she came back and told the Member. [RPN C] heard the code blue called and [ ], an RN, went down to assist. [RPN C] had no other involvement.

Witness #5, [an RN], worked on Pod 3. On April 3, 2011, she was working on Pod 3 when a call came in from the Member about hospital policy concerning finding [the Client’s] vital signs absent. [The RN] went down to Pod 2. She observed the Member using the phone at the Pod 2 nursing station. She was directed to [the Client’s] room and did not see anyone else in the room. She was informed that CPR had been initiated but CPR had not been started and there was no emergency equipment in the room. [The RN] went to get equipment. Meanwhile, two nurses arrived with the crash cart and initiated CPR. These nurses took the lead and the witness assisted until the fire fighters arrived and took over. She heard code blue while performing CPR. The witness stated that neither the Member nor [RPN A] were present during this time.

Witness #6, [RPN D], an RPN with 25 years’ experience, was working on [another] unit at that time. [RPN D] said she was not familiar with Pod 2 and did not know the other staff there. On April 3, 2011, [RPN C] came in and said a [client] was unresponsive in Pod 2 and she wanted to know what to do. [RPN D] told her to call code blue. When [RPN C] returned to [the other unit, around 11:15 p.m. to 11:20 p.m., [RPN D] got the crash cart and went downstairs. She was directed to [the Client’s] room and started CPR. She checked for the [client’s] pulse but found no pulse. [Nurse E] compressed and she, [RPN D], bagged. [RPN D] told others in the room to chart everything that was going on. When firemen arrived they took over. She testified she did not know who filled out the Freeport Resuscitation Record, only that she and [Nurse E] signed it [ ].

While reviewing the materials given to the panel, it came to [the] attention of two of the panel members [that] they knew two names listed in the materials. One panel member knew [the Program Director’s] supervisor in a professional capacity because of a board they sit on but had no prior knowledge of this case. The other panel member currently works with a doctor mentioned in one of the exhibits but has no prior knowledge of this case arising from her professional relationship with the doctor or for any other reason. These facts were disclosed to College Counsel, who had no concerns with the panel members continuing to participate in the
hearing. Independent legal counsel’s advice was there was no reasonable apprehension of bias in either case as both were professional relationships, neither of the people mentioned were witnesses in this case and the panel members had no information about the case other than what they had learned during the course of the hearing.

[The Program Director’s] evidence for the most part was to introduce background information, such as the training, policies, procedures, work schedule of the Member, hourly round count form completed by the Member, the layout of the hospital and the specialized unit. He also gave evidence about the investigation of the Member and the termination of the Member’s employment. The panel accepted [the Program Director’s] evidence as to these facts.

As for the witnesses who testified about the actual incident, the panel found the witnesses had for the most part poor memory over the specific details of the incident, especially about the timing of events and where the Member and [RPN A] were. When all the evidence was considered together, the witnesses’ testimonies were credible as a whole. [RPN D] had the clearest memory of her involvement and observations of the incident. She knew the policies and procedures and followed them accordingly.

The final witness was [ ] tendered by the College as an expert witness. The panel was given [the expert’s] curriculum vitae [ ] and a written Acknowledgment of Expert Duty signed by [the expert] [ ]. The panel accepted [the expert] as an expert witness qualified in the specific areas of standards of care, documentation and intervention requirements in psychiatric inpatient units.

[The expert] was sent a retainer letter with questions [ ] and a hypothetical facts scenario for the basis of her expert opinion [ ]. In her opinion, [the expert] referred to the College’s Professional Standards, Revised 2002 [ ], the College’s Standard on Documentation, Revised 2008 [ ] and the College’s Ethics standard [ ].

[The expert] stated that the documentation is the [client’s] record of care and safety. It is to communicate what has happened with the client and provides others with much needed information for vulnerable [client]. Mental health [clients] are especially vulnerable as they are often unable to express their wishes or demands. Communication and documentation, with and for these clients, is extremely important. All documentation should be made in a timely, legible manner and signed with a clear signature. The documentation is the history of the [client’s] wellness and care and should always be done by the same person who does the intervention. In noting that it is a requirement of the College, [the expert] referred to the Documentation standard, page 7, which requires, “documenting in a timely manner and completing documentation during or as soon as possible after the care or event” and to page 6, paragraph i, which requires, “ensuring that hand-written documentation is legible and completed in permanent ink”.

[The expert’s] opinion was that it is a breach of standards to sign a document that you conducted rounds, when in fact you had not done so. Clearly such a document would be a falsified document and represents an act of dishonesty, as well as unprofessional and disgraceful conduct. Illegible documentation is not an acceptable practice. It is a clinical record and should be easily read by others. Legible documentation is a core function of nursing practices. [The expert’s]
opinion was that illegible documentation is disgraceful, dishonourable and unprofessional conduct.

[The expert’s] opinion on the code blue situation was in keeping with the standard requiring accountability. Nurses are required to take action, to not delay CPR to look up information, to call for help, assess the situation and start CPR. Any significant delay in response puts the [client] in danger. With education and orientation provided by the hospital and the College standards, nurses should be able to act quickly. If they can’t, they should call for help. [The expert] stated that it appeared as if the Member was more concerned about her job than the [client’s] well-being. The College’s standards state that nurses are to perform CPR until a qualified individual pronounces the [client] dead. The Member’s failure to respond to the absence of a [client’s] vital signs is disgraceful, dishonourable and unprofessional conduct.

The panel accepted [the expert] as a credible expert witness. She used references to the College’s published professional standards to back up her opinions.

Final Submissions

College Counsel summarized the evidence for the panel and submitted the Member’s actions go beyond a mere error in [judgment] and demonstrate a serious disrespect for her obligations. She was the RN in charge on Pod 2 and her first priority should be the safety of the [client]. The Member lacks accountability, does not follow procedures or standards, signs that she did rounds but sends someone else to do them, and then she fills in forms in a completely illegible way so no one else can read them in the future.

College Counsel submitted that all the Member’s actions detailed in the Notice of Hearing were disgraceful, dishonourable and unprofessional. Her failure to act in a timely manner was way below public expectations and professional standards. Her conduct casts doubt on her inherent abilities to discharge her responsibilities. It appears the Member did not know how to respond and what to do in the situation. The Member could have taken more training to become competent in code procedures and documentation standards.

Decision

The panel deliberated, bearing in mind the burden and standard of proof. Having considered all of the evidence given by the witnesses and the documentation provided in the exhibits, the panel made the following findings.

- For allegation 1a, the Member documented that she had completed hourly round checks, when in fact she had not done so. This was a breach of the standards of practice.
- For allegation 1b, the Member’s documentation on [the Client’s] hourly round form was illegible. This was a breach of the standards of practice.
- For allegation 1c, the Member failed to provide appropriate measures to [the Client] when she discovered [the Client] with vital signs absent. This was a breach of the standards of practice.
For allegation 2a, the Member’s false documentation would reasonably be regarded by members as unprofessional and dishonorable.

For allegation 2b, the Member’s illegible documentation would reasonably be regarded by members as unprofessional.

For allegation 2c, the Member’s failure to provide appropriate measures to [the Client] would reasonably be regarded by members as disgraceful, dishonorable and unprofessional.

**Reasons for Decision**

**1(a) and 2(a)**

The panel accepted the testimony of [RPN A] concerning the Member’s practice of documenting hourly round checks on [the Client] between 1900 and 2300 that she had not personally performed. [The expert witness] referred to the *Documentation* practice standard [ ] which states that a nurse meets the standard by ensuring documentation is completed by the individual who performed the action or observed the event. The panel found this action was dishonest, because the Member signed but did not perform the actions, and unprofessional because her behaviour showed a serious disregard for her professional obligation.

**1(b) and 2(b)**

The panel reviewed the documentation [ ] and could not identify the Member’s initials. [RPN A] testified that the Member had completed the form. [The expert witness] referred to the *Documentation* practice standard [ ], which states that the nurse meets the standard by ensuring that hand-written documentation is legible and completed in permanent ink. The panel found this to be unprofessional as she failed to meet her professional standards.

**1(c) and 2(c)**

The panel reviewed the testimony of the witnesses regarding the Member’s failure to provide appropriate measures to [the Client] when she discovered [the Client] with vital signs absent. The Member showed a lack of knowledge and judgment in responding to the clinical situation. [The expert witness] referred the panel to the *Professional Standards*, [ ] which state that a nurse meets the standard by being accountable for the [client’s] health and wellbeing; providing, facilitating, advocating and promoting the best possible care for clients.

[The expert] also referred to the *Ethics* practice standard, [ ] which states that a nurse meets the standard by promoting client wellbeing, which means facilitating the client’s health and welfare, and preventing or removing harm; respect for life means that human life is precious and needs to be respected, protected and treated with consideration.

The panel found her conduct was unprofessional in that it showed serious disregard for the Member’s responsibility and obligations. It was dishonourable as it showed a moral failing that fell well below the professional standards. It was disgraceful in that a serious doubt was cast on
the Member’s moral fitness and inherent ability to discharge the higher obligations the public expects professionals to meet.

**Penalty Submissions**

College Counsel requested the panel make an order that included a reprimand; a two-month suspension of the Member’s certificate of registration, such suspension to take effect from the date the Member obtains an active certificate of registration; and various terms, conditions and limitations to be placed on the Member’s certificate of registration should the Member obtain a certificate of registration.

The College submitted that this proposed order provides specific and general deterrence, and includes an element of rehabilitation of the Member, while ensuring public protection. College counsel stated the only mitigating factor was that there was no past discipline record for the Member. The aggravating factors, as presented by College counsel, are the Member chose not to participate, causing a lengthy hearing and the need to call [seven] witnesses. The Member showed a disregard for her professional obligations and this can have serious consequences.

Counsel also provided the panel with several similar cases, with a range of penalties ordered, to show that the penalty proposed by the College was in line with what was ordered in similar cases.

College Counsel stated even though the Member had resigned, the College is seeking a penalty which includes an oral reprimand, a two-month suspension of the Member’s certificate and the imposition of various terms, conditions and limitations on the Member’s certificate. She submitted that even though the Member does not currently have a certificate of registration (since she has resigned), the panel has jurisdiction to make the order requested by the College.

Independent Legal Counsel then gave advice and reminded the panel that her advice was not binding on the panel. Subsection 14(1) of the Code gives the College continuing jurisdiction over a member whose certificate has been revoked, resigned or expired with respect to professional misconduct that occurred while the member had a certificate of registration. This means that members continue to be subject to the College for misconduct at the time when they were members and disciplinary panels can conduct a hearing and make findings of professional misconduct. However, if a panel makes findings, the question is whether a panel can issue a suspension and order terms, limits and conditions on a certificate of registration when the Member has resigned and thus no longer has a certificate of registration.

ILC referred to subsection 51(2) of the Code and said that her interpretation of this is that the Member’s certificate of registration has to be an active one to impose a penalty that affects the certificate of registration. If there is no certificate at the time of the order, there is nothing to suspend, or to put terms, conditions and limitations on. The panel can comment in its reasons on what they would have imposed if the Member had a certificate of registration at the time of the hearing. However, the Code does not authorize the panel to impose suspensions, or terms, limits and conditions, on a certificate that does not exist. ILC referred to this as a prospective penalty.
Should the Member seek readmission to the College, under section 15 of the Code the Executive Director would be required to refer the Member to the Registration Committee, and the Registration Committee could refuse registration or could impose terms, conditions or limitations. That will be an issue for the Registration Committee to determine should the Member ever choose to reapply following her resignation.

ILC advised that an oral reprimand could be ordered, as this penalty was not depending on an existing certificate of registration.

ILC referred to the recent decision of CNO v. Dumchin, a decision of the Discipline Committee dated March 5, 2015, noting the panel is not bound by any other panel’s decisions but should strive for consistency and apply their own [judgment].

College Counsel disagreed with ILC’s advice. She submitted that the legislative intent is for the College to have continuing jurisdiction over resigned members. ILC’s advice does not account for the different roles of the Discipline and Registration Committees. It is inconsistent with decades of case law at the College and other professional colleges. She further submitted that subsection 51(2) of the Code does give the panel jurisdiction to make an order on penalty, particularly when read alongside subsection 14(1) of the Code which states a member continues to be subject to the jurisdiction of the College for professional misconduct referable to the time when the person was a member and had an active certificate. College Counsel stated that ILC has taken an unduly technical approach regarding the College’s continuing jurisdiction. College counsel said the Registration Committee performs a gate-keeper function whereas the mandate of the Discipline Committee is to protect the public and provide sanctions when needed. College Counsel submitted that ILC’s advice would encourage members to resign in an effort to side-step disciplinary sanctions. She then presented the panel with several past cases of members who had resigned and were still subject to penalty orders impacting the certificate of registration, indicating the practice of this College over the years.

ILC cautioned the panel when relying on past cases to assist with the decision on penalty where the issue of the jurisdiction of the panel over resigned members was not argued by the parties and not adjudicated by the panels. CNO v. Dumchin was the only recent case where this issue was specifically argued and discussed in detail. In that case, the panel decided that it did not have jurisdiction to order a revocation of a certificate of registration of a resigned member, as the member did not have a certificate of registration to revoke. The panel ordered a reprimand and indicated that it would have revoked the Member’s certificate if the Member had one at the time of the panel’s findings.

College Counsel agreed that not every decision carries equal weight and the panel needs to look to its jurisdiction in the context of the statutory and regulatory framework. If the panel’s decision is not acceptable to the parties, then it will be up to the courts to decide.

**Penalty Decision**

The panel finds that the Member’s professional misconduct would have resulted in a penalty that included two months’ suspension, plus the terms, conditions and limitations suggested by the
College in the College Submission on Order [ ], had the Member held an active certificate of registration at the time of the hearing.

The Member is ordered to appear before the panel to be reprimanded within three months of this order.

**Reasons for Penalty Decision**

The panel considered the penalty submissions of College Counsel, the advice of ILC and its own [judgment] to arrive at the decision. The panel’s interpretation of the *Code* is that when a member has resigned their certificate of registration, the panel has the ability to hold a hearing, make findings of professional misconduct and impose penalty orders other than those that refer to a certificate of registration. Since Cristina Stefanescu resigned her certificate of registration and was not a member at the time of the hearing, she does not fall under the jurisdiction of the College to impose a penalty order dependent on the existence of a certificate of registration.

I, Margaret Tuomi, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:

_____________________________  ______________________________
Chairperson                                              Date

**Panel Members:**

Donna Rothwell, RN  
Andrea Vidovic, RN  
Mary MacMillan-Gilkinson, Public Member