DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Tanya Dion, RN	Chairperson
	Jay Armitage	Public Member
	Sharon Moore, RN	Member
	Fidelia Osime	Public Member
	Susan Roger, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
STACEY HOGUE	)	DANIEL FONG and VANESSA YANAGAWA for
Registration No. 0389221	)	Stacey Hogue
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: September 20, 2021

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") of the College of Nurses of Ontario (the "College") on September 20, 2021, via videoconference.

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 public disclosure and banning publication or broadcasting of the names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of Stacey Hogue.

The Panel considered the submissions of Counsel for the Parties and decided that there be an order preventing public disclosure and banning publication or broadcasting of the names of the patients, or any information that could disclose the identities of the patients referred to orally or in any documents presented in the Discipline hearing of Stacey Hogue.

The Allegations

The allegations against Stacey Hogue (the "Member") as stated in the Notice of Hearing dated July 13, 2021 as amended 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 employed as a Registered Nurse ("RN") at Niagara Health System – St. Catharines Site in St. Catharines, Ontario ("Hospital"), you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession regarding your care for the [Patient], on or about September 22, 2016, and in particular, you:

    (a) failed to monitor the fetal heart rate and/or recognize incidents of abnormal fetal heart rate;

    (b) failed to monitor the patient's labour and/or recognize inadequate progress of the labour;

    (c) failed to make sufficient efforts to seek medical assistance for the patient; and/or

    (d) failed to document:

        (i) your concerns about the fetal heart rate and review of those concerns with a fellow nurse;

        (ii) the patient's requests for you to seek medical assistance; and/or

        (iii) your efforts to seek medical assistance on behalf of the patient.

2. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991,* S.O. 1991, c. 32, as amended, and defined in subsection 1(13) of *Ontario Regulation 799/93*, in that, while employed as an RN at the Hospital, you failed to keep records as required regarding your care for the [Patient], on or about September 22, 2016, and in particular, you:

    (a) failed to document your concerns about the fetal heart rate and review of those concerns with a fellow nurse;

    (b) failed to document the patient's requests for you to seek medical assistance; and/or

    (c) failed to document your efforts to seek medical assistance on behalf of the patient.

3. You have committed an act of professional misconduct as provided by subsection 51(1)© 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 employed as an RN at the Hospital, 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 regarding your care for the [Patient], on or about September 22, 2016, and in particular, you:

    (a) failed to monitor the fetal heart rate and/or recognize incidents of abnormal fetal heart rate;

    (b) failed to monitor the patient's labour and/or recognize inadequate progress of the labour;

    (c) failed to make sufficient efforts to seek medical assistance for the patient; and/or

    (d) failed to document:

        (i) your concerns about the fetal heart rate and review of those concerns with a fellow nurse;

        (ii) the patient's requests for you to seek medical assistance; and/or

        (iii) your efforts to seek medical assistance on behalf of the patient.

Member's Plea

The Member admitted the allegations set out in paragraphs #1(a), (b), (c), (d)(i), (ii), (iii), #2(a), (b), (c), #3(a), (b), (c), (d)(i),(ii) and (iii) 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's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which, as amended, reads unedited, as follows:

THE MEMBER

1. Stacey Hogue (the "Member") obtained a Bachelor of Science in Nursing (with Honours) from York University in 2003.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on May 23, 2003.

3. The Member has been employed by the Niagara Health System at the St. Catharines site (the "Facility") since 2003. The Member initially worked as a RN on the surgical floor, a position she held until 2009, at which time the Member obtained an RN position in the Women and Babies Unit (the "Unit").

4. The Member completed coursework for a Perinatal Nursing Certificate and obtained a Perioperative Nursing for Cesarean Section Certificate from Mohawk College in 2011 and 2012, respectively.

5. Since March 2018, the Member has been working at the Facility's Outpatient Oncology Clinic.

PRIOR HISTORY

6. The Member has no prior disciplinary findings with CNO.

THE FACILITY

7. The Member was working as a full-time RN in the Unit in September 2016.

8. The Unit provides care to labouring mothers and babies.

9. Generally, the Unit has 10 RNs on the 12-hour day shift and eight RNs on nights.

10. Shifts start at either 0700 or 1900 hours.

11. Of the RN staff, one is assigned Charge Nurse duties, one is assigned to triage, and three RNs are assigned to the operating room ("OR"). The remaining RNs provide care to labouring mothers. An obstetrician and pediatrician are always on call for the Unit.

12. The ordinary practice on the Unit is for the Charge Nurse to act as intermediary between primary care nurses and the obstetrician on-call. If a primary care nurse needs the on-call obstetrician, she notifies the Charge Nurse, who can contact the obstetrician by phone; or, if the obstetrician is in OR, either attend the OR to speak to the obstetrician personally or call the second on-call obstetrician.

13. While a patient is in labour, the RN performs fetal heart monitor (FHM) readings every 15 minutes and records findings in the patient's electronic chart.

14. All care provided by the RN is recorded in the electronic nursing notes. The system indicates the nurse's name beside the record entered. For entries where the computer system automatically imports data, such as the fetal movement percentage (FMP), indication of FHM alarms, and several maternal heart rate readings, there is no nurse's name recorded.

15. The ordinary practice on the Unit is for the assigned nurse to stay with the patient throughout the course of her shift, during labour and delivery and afterward.

16. Generally, the nurse and the obstetrician will discuss the plan and together they will determine how often the physician will reassess the patient. In addition, the nurse will report major changes in status as they arise, including when the patient is ready to deliver.

THE PATIENT

17. [ ] (the "Patient") presented at the Unit in labour at approximately 2130 hours on September 21, 2016.

18. At the time, the Patient was 30 years old, 40 weeks and 2 days gestation, and was Group Beta Strep (GS) positive.

19. Prior to admission to the Unit, the Patient had an uncomplicated pregnancy; all antenatal testing was normal.

20. The Patient delivered [the baby] via C-section at approximately 2030 hours on September 22, 2016. [The Patient's baby] was in grave condition at birth and died six days later.

FETAL HEART MONITORING IN LABOUR

21. During labour, nursing staff attach two belts to the patient's abdomen: the ultrasound transducer, which measures the fetal heart rate (FHR), and the toco transducer, which measures uterine contractions.

22. FHR tracings are classified as normal, atypical, and abnormal. Medical staff make this classification based on interpretations of the FHR monitor readings.

23. Medical staff determine the baseline FHR, FHR variability, accelerations, and decelerations when interpreting FHR readings.

24. The FHR must be looked at in conjunction with the rate of labour, fetal heart rate patterns, and the mother's status to evaluate its significance.

25. The average FHR is between 110 and 160 beats per minute ("BPM").

26. Bradycardia is a FHR of less than 110 BPM for greater than 10 minutes, and can be caused by things like fetal and maternal position, fetal heart block, and fetal distress. A FHR of 100 to 119 BPM, in and of itself, is not usually a sign of compromise.

27. Tachycardia is a FHR of greater than 160 BPM for at least two minutes between contractions, and can be caused by a variety of factors affecting the mother or the fetus. It can be an initial response to fetal stress or early hypoxia.

28. Baseline FHR is the heart rate during a 10-minute segment rounded to the nearest 5 BPM increment, excluding periods of marked FHR variability, periodic or episodic changes, and segments of baseline that differ by more than 25 BPM. The minimum baseline duration must be at least 2 minutes.

29. FHR variability is a measure of baseline fluctuations. It is the difference between the lowest and highest rate in a period that is free from accelerations, decelerations and contractions. Fluctuations are graded on how much change there is from the baseline – both higher (peak) and lower (trough – the lowest point of the trough is the nadir). The distance from the peak to the trough is the amplitude range.

30. FHR variability may be:

    a. Absent: no amplitude range;

    b. Minimal: less than 5 BPM;

    c. Moderate: 6 – 26 BPM;

    d. Marked: more than 25 BPM;

    e. Sinusoidal

31. Acceleration is an abrupt increase in FHR above baseline with onset to peak of the acceleration of more than 30 seconds and less than 2 minutes in duration.

32. Variable deceleration is an abrupt decrease in FHR (from onset to the lowest point in less than 30 seconds) that is 15 bpm or more below the baseline for 15 seconds or greater and less than 2 minutes from onset to return to baseline.

33. Early decelerations are gradual decreases in FHR (from onset to the lowest point in 30 seconds or more) which returns to baseline. The onset, lowest point, and recovery are coincident with the beginning, peak, and ending of the contraction. They are secondary to fetal head compression and are considered to be a benign pattern, with no intervention required.

34. Late deceleration is a gradual decrease and return to baseline FHR in association with a uterine contraction. The onset, lowest point, and recovery of the deceleration occur after the beginning, peak, and end of the contraction. From the onset to the lowest point of the deceleration is usually greater than 30 seconds. Late decelerations can be associated with uteroplacental insufficiency: late decelerations that occur with tachycardia and very little variability may imply a degree of hypoxia.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

35. The Patient was admitted to the Unit at 2145 hours on September 21, 2016.

36. At the time of the Patient's admission, she was in early active labour, 3 cm dilated, and fully effaced, with contractions occurring every 2 – 5 minutes.

37. The Patient was transferred to room 13 at 2307 hours on September 21, 2016.

38. An IV was started at 2327 hours and external fetal heart monitoring ("FHM") was initiated.

39. At approximately 0200 hours on September 22, 2016, the night nurse assigned to the Patient noted that the Patient felt nauseated. She further noted that the fetus was at station -2 and that the Patient was dilated to 4 cm.

40. At 0302 hours on September 22, 2016, [Doctor A] assessed the Patient. The night nurse assigned to the Patient charted that the Patient was only 3 cm dilated.

41. The night nurse also charted several episodes of nausea and vomiting by the Patient: at 0348, 0440, and 0605.

42. The night nurse performed an internal exam of the Patient at 0612. She charted that the Patient was 7 cm dilated and the fetus was at station -1.

43. The night nurse monitored the FHM tracings between the time of their initiation until the end of her shift at 0700 hours. In general, she recorded moderate variability, absent or early decelerations, and spontaneous or absent accelerations.

Monitoring of the Patient's Labour Progression and the Fetal Heart Rate

44. The Member assumed care of the Patient at 0700 hours on September 22, 2016, when she started her day shift.

45. At approximately 0815, the Patient's cervix remained unchanged; she requested an epidural following her discussion with [Doctor A].

46. At 0825 hours, [Doctor B] came to the Patient's room to review her status with [Doctor A], as [Doctor B] was taking over the Patient's care as the on-call obstetrician. [Doctor C], a medical resident, was also in attendance.

47. The Patient's epidural was inserted at 0844 hours.

48. The Patient was catheterized by a student nurse at 0920 hours. The catheter drained a small amount of clear yellow fluid. The Member charted that it drained clear yellow urine at that time.

49. At 1000 and 1015 hours, the Member charted early decelerations of the fetal heart rate.

50. At 1030, the Patient was started on oxytocin. At that approximate time, the FHM strip showed variability in the FHR. The Member interpreted and charted this as: “early; variable uncomplicated” decelerations. In retrospect, the Member recognizes these may have been both early and late decelerations which should have been documented accordingly.

51. The Member also charted “early; variable uncomplicated” decelerations at 1045, 1100 and 1115 hours.

52. [Doctor B] and [Doctor C] attended to examine the Patient together at 1125 hours.

53. The Member charted at 1127 hours that a report on the Patient was given to [Doctor B] and [Doctor C] and the FHM strip was examined. [Doctor C] chart indicated that he would review the Patient again in two hours.

54. By 1200 hours, the FHM showed there were no accelerations. Instead, the fetal heart rate monitoring indicated complicated decelerations and a decreasing baseline.

55. The Member charted four incidents of bradycardia at 1159, 1238, 1305 and 1311 hours.

56. The Member charted that the Patient vomited at 1342, 1414, 1445, 1457, and 1642.

57. Another nurse also charted vomiting episodes at 1535 and 1600.

58. The Patient, through a family member, advised the Member of the Patient’s concerns with respect to the vomiting and requested assistance from a physician. The Member did not document this request.

59. If the Member were to testify, she would state it is common for labouring mothers to experience nausea and vomiting during labour. However, the Member did not document any actions taken for the Patient until she charted administering Gravol to the Patient at 1630. No further episodes of vomiting were documented.

60. In and around 1615 hours, the fetal heart rate was becoming more abnormal with persistent and prolonged decelerations.

61. Between 0920 hours and 1615 hours, the Patient had two vaginal examinations but no documented urinary output.

62. At 1615 hours, the member examined the Patient and noted that her cervix was 9 cm dilated. The Member also charted at 1620 that she found the catheter was in the Patient’s vagina and not her urethra.

63. The Member noted a period of about 40 seconds at 1742 hours, when the fetal heart rate was bradycardic.

Failure to Escalate and Document Communication with Medical Team

64. If the Member were to testify, she would state that at some point between approximately 1300 – 1330 hours, she went to the nurses' station and asked [the Charge Nurse], [ ], whether [Doctor B] was available to review the FHM tracings, and [the Charge Nurse] advised the Member that he was not available as he was in the OR.

65. If the Member were to testify, she would also state that she reviewed the FHM tracings with her colleague, [Registered Nurse A], between 1300 and 1330 hours. They concluded that the FHM tracings looked fine and did not require contacting a physician for further assessment.

66. The Member admits and acknowledges that she did not document either discussion with her colleagues and should have done so in accordance with CNO standards on documentation.

67. The resident, [Doctor C], attended to assess the Patient again at 1355. The Member charted that he reviewed the FHM strip and conducted a vaginal exam. [Doctor C] recorded that the Patient's cervix was 8 – 9 cm dilated and fully effaced. He also charted that the Patient was to be reviewed again by 1500.

68. Physicians did not attend to the Patient again for the duration of the Member's shift.

69. If the Member were to testify, she would state that she took the following steps to communicate the need for a physician to attend and assess the Patient:

    a. between 1500 and 1600 hours, she went to the nurses' station to ask the Charge Nurse about the location of [Doctor B], as he needed to assess the Patient. The Member would further state that the Charge Nurse informed the Member that [Doctor B] was unavailable because he was in the OR;

    b. at approximately 1700 hours, the Member spoke to the Charge Nurse again regarding the need for a physician to assess the Patient and was told that both [Doctor B]and [Doctor C] were in the OR; and

    c. at approximately 1800 hours, the Member advised the Charge Nurse that the physician should attend and assess the Patient.

70. The Member admits and acknowledges that she did not document the fact or content of any communication with the Charge Nurse between 1500 and 1600 hours, nor did she document the occurrence of any communication with the Charge Nurse at 1700 hours. The Member admits and acknowledges that she should have done so in accordance with CNO standards on documentation.

71. The Member admits and acknowledges that the documentation of her communication with the Charge Nurse at 1800 hours did not include any indication that she had concerns about the progression of the Patient's labour or that the Patient needed to be seen on an urgent basis.

72. The Charge Nurse ultimately did contact [Doctor B] in the OR at approximately 1800 hours and requested that he attend the Patient.

73. [Doctor B] did not attend to assess the Patient, despite the request.

74. The Member did not make any further efforts to have a physician attend the Patient.

75. The Member's shift ended at 1900 hours.

76. The night nurse who took over care of the Patient charted variable uncomplicated decelerations of the fetal heart rate at 1915 and 1930 hours.

77. At 1945 hours, the night nurse charted variable complicated decelerations and a significant bradycardia event at 1947 hours.

78. Further variable complicated decelerations were charted at 1955 and 2000 hours.

79. The night nurse identified the crisis and summoned the physician at 2014 hours.

80. The baby was delivered by C-section at 2035 hours in poor condition. She was transferred to another hospital where she died six days later.

81. The Coroner's Investigation Statement identifies the cause of death as hypoxic ischemic encephalopathy due to perinatal asphyxia associated with chronic placental villitis of unknown etiology. In lay terms, the baby suffered harm as a result of oxygen deprivation during the labour and delivery process due to unknown causes.

82. On August 8, 2017, CNO received a letter of report from the Office of the Chief Coroner of Ontario regarding concerns relating to the Member's quality of care provided to the Patient.

83. On April 17, 2018, CNO received a letter of complaint from the Patient.

84. CNO conducted parallel investigations of the complaint and report.

85. The College of Physicians and Surgeons of Ontario (the "CPSO") also reviewed the care provided by [Doctor B] to the Patient and found that he had failed to assess the Patient after 1130 hours.

86. Specifically, the Inquiry Complaints and Reports Committee of the CPSO found that the lack of progress in labour and abnormal FHR readings already present at 1127 hours

should have prompted [Doctor B] to prioritize the Patient and he should have returned from the OR to assess the Patient. Instead, he relied on the assessment of [Doctor C]. The Inquiry Complaints and Reports Committee of the CPSO required [Doctor B] to appear before a panel to be cautioned with respect to failing to recognize slow progress of labour and failing to assess a patient in a timely manner, and on failing to recognize FHR changes.

87. The Facility also conducted an internal review of the case, in which the Member participated, as part of a quality-of-care review. September 22, 2016 was noted to be an unusually busy day on the Unit. For the majority of the afternoon, [Doctor B] was in the OR performing three unscheduled, emergency C-sections and consequently, was not available to do his standard rounds.

88. The Facility adopted two main recommendations: to improve obstetrical team communication and to review the current Unit standards related to patient assessment/reassessment and Fetal Health Surveillance. Further, the Facility no longer permits visiting residents to perform independent and unsupervised assessments of patients.

Expert Opinion

89. CNO retained a nursing expert in labour and delivery, to provide an assessment of the Member's conduct with respect to the care she provided to the Patient during the day shift on September 22, 2016. In the expert's opinion, the Member contravened or failed to maintain the standards of practice of the profession with respect to:

    a) monitoring of the FHR and recognition of abnormal FHR, particularly regarding persistent and prolonged decelerations and bradycardia;

    b) monitoring of the Patient's labour and recognition of inadequate progress particularly since oxytocin had been administered;

    c) appropriate notification of the medical team/obtaining medical assistance/advocacy for the Patient; and

    d) documenting all care provided to the Patient, including any attempts to seek assistance for the Patient from other nursing or medical staff.

STANDARDS OF PRACTICE

90. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets legislative requirements and the standards of practice of the profession. As well, each nurse is expected to

continually improve the application of professional knowledge. A nurse demonstrates this standard by actions such as:

a) Providing, facilitating, advocating and promoting the best possible care for clients;

b) Seeking assistance appropriately and in a timely manner;

c) Ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;

d) Identifying/recognizing abnormal client responses and taking the appropriate action;

e) Taking action in situations in which client safety and well-being are compromised;

f) Evaluating/describing the outcomes of specific interventions and modifying the plan/approach;

g) Using communication and interpersonal skills; and

h) Sharing knowledge with others to promote the best possible outcome for the client.

91. CNO's *Documentation* standard provides that nurses are accountable for ensuring their documentation of client care is "accurate, timely and complete." The standard further clarifies that a nurse meets the standard by:

a) Ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;

b) Documenting significant communication with family members/significant others, substitute decision-makers and other care providers;

c) Documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event; and

d) Ensuring that relevant client care information is captured in a permanent record.

92. The Member acknowledges and admits that she breached the standards of practice in her care of the Patient. In particular, the Member admits that she failed to:

a) Monitor the FHR effectively to recognize the abnormal FHR, particularly regarding persistent and prolonged decelerations and bradycardia;

b) Monitor the Patient's labour effectively to recognize inadequate progress particularly since oxytocin had been administered;

c) Take appropriate steps to notify the medical team/obtain medical assistance/advocate for the Patient; and

d) document all care provided to the Patient, including any attempts to seek assistance for the Patient from other nursing or medical staff.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

93. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1(a) to (d) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of the profession, as described in paragraphs 44 to 92.

94. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2(a) to (c) of the Notice of Hearing in that she failed to keep records as required, as described in paragraphs 50 to 92 above.

95. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3 (a) to (d) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 44 to 92 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 paragraphs #1(a), (b), (c), (d)(i), (ii), (iii), #2(a), (b), (c), #3(a), (b), (c), (d)(i), (ii) and (iii) of the Notice of Hearing. As to allegations #3(a), (b), (c), (d)(i), (ii) and (iii), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be 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.

Allegations #1(a), (b), (c), (d)(i), (ii) and (iii) in the Notice of Hearing are supported by paragraphs 44 to 92 in the Agreed Statement of Facts. The Member admitted to failing to meet the standards of the profession, namely the College's *Professional Standards* and the *Documentation* Standard. The Member admitted and acknowledged that she breached the standards of practice in the care of this patient. The Member did not conduct herself in a manner consistent with providing the best quality care for her patient in that she failed to recognize deviations from normal fetal heart monitoring and subsequently failed to seek the appropriate assistance from her colleagues, her charge nurse or the

most responsible obstetrician for this patient. Processes considered to be normal practice are outlined in paragraphs 12 to 16 of the Agreed Statement of Facts and describe role clarity (for the charge nurse and RN), actions to take if the obstetrician is busy in the OR, documentation requirements while a patient is in labour and frequency of fetal heart monitor ("FHM") documentation in the patient's electronic record. The Panel recognizes that if the Member were to testify, she would state that she reviewed the patient's FHM with a colleague and requested assistance from her charge nurse however neither of these instances were documented in the patient's electronic record. The Member admits that she failed to recognize the abnormal fetal heart rate ("FHR"), failed to monitor the patient's labour effectively, failed to advocate for the patient including seeking assistance for the patient and failed to document care provided to the patient.

Allegations #2(a), (b) and (c) in the Notice of Hearing are supported by paragraphs 50 to 92 in the Agreed Statement of Facts. The Member acknowledges and admits that she is required to document all care provided to the patient, including any attempts to seek assistance for the patient from other nursing or medical staff. The Member failed to document the patient's request for assistance from a physician, failed to document urinary output for a period of approximately seven hours, failed to document consultation with colleagues, failed to document requests for the obstetrician to attend and assess the patient, nor any communication with the Charge Nurse between 1500 and 1600 hours nor at 1700 hours. The Member admits that her documentation at 1800 hours of a communication with the Charge Nurse did not indicate any concerns about the patient's labour.

With respect to Allegations #3(a), (b), (c), (d)(i), (ii) and (iii), the Panel finds that the Member's conduct in failing to recognize the abnormal FHR, monitor the patient's progress of labour and seek appropriate medical assistance was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

The Panel also finds that the Member's conduct was dishonourable in that the Member knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

College Counsel and the Member's Counsel 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 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 5 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 a 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

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

        ii. At least 7 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. *Professional Standards*,
            2. *Documentation*
            3. *Code of Conduct,* and
            4. *Decisions about Procedures and Authority.*

        iv. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and 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 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;

vi. 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 her 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 her certificate of registration;

b) Within 12 months from the date that this Order becomes final or the date the Member returns to a nursing practice in obstetrics, whichever date is later, or within such longer time period as approved by the Director, the Member shall successfully complete at her own expense a nursing course (with clinical or laboratory or other practical components) that have received prior approval from the Director regarding: obstetrics. The Member must pass the course. If the course is graded, the Member must receive a minimum passing grade of 65%. The Member must provide the Director with proof of enrolment, successful completion of the course and the specific grade[s] received (if applicable).

c) For a period of 12 months from the date the Member's suspension ends, the Member will notify her 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 her 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.

4. All documents delivered by the Member to the 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 aggravating factors in this case were:

- The seriousness of the Member's conduct and the patient outcome although the College did not attribute it to the Member;
- The seriousness of the Member's conduct warrants a significant regulatory response;
- The Member's responsibility to identify a crisis unfolding and ensure that suitable response was met, was overlooked;
- There were deficits in the Member's clinical judgement which resulted in serious professional misconduct and a tragic patient outcome.

The mitigating factors in this case were:

- The Member has accepted responsibility for her actions and has cooperated with the College by agreeing to the Agreed Statement of Facts and the Joint Submission on Order;
- The Member has no prior disciplinary history with the College.
- The proposed penalty provides for general deterrence through the 5-month suspension of the Member's certificate of registration. The penalty sends a clear message to the membership that these actions fall well below the acceptable standards of nursing practice and is a reminder of the consequences of such substandard practice.

The proposed penalty provides for specific deterrence through the 5 month suspension, an oral reprimand and employer notification of this decision for a period of 12 months.

The proposed penalty provides for remediation and rehabilitation through attendance and participation in two meetings with a Regulatory Expert, completion of Reflective Questionnaires and completion of learning modules. Rehabilitation is also provided through the requirement of the Member to pay for and successfully complete an obstetrical nursing course with clinical and laboratory components with a minimum pass rate of 65% prior to returning to practice in obstetrics.

Overall, the public is protected by the 5 month suspension of the Member's certificate of registration and the requirement of employer notification of this decision for a period of 12 months. The requirement for remedial education in Obstetrics strengthens the Member's future practice and therefore further protects the public.

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

CNO v. Dyer (Discipline Committee, 2020): This case is also an obstetrical case in which the member did not seek medical assistance for her patient or document abnormal findings, nor did she adequately document reasons and rationale for changes to medication infusion without the appropriate orders or authorization to do so. This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member's penalty in this case included an oral reprimand, a 7 month suspension of the member's certificate of registration, a minimum of two meetings with a Regulatory Expert including completion of associated learning modules, Reflective Questionnaires, completion of an obstetrics course with a clinical or laboratory component with a minimum passing grade of 65% and employer notification of 24 months.

CNO v. Haas (Discipline Committee, 2019): This case is similar in that the member worked in obstetrics, demonstrated multiple failures in practice including failing to take action when abnormal findings were identified by fetal monitoring, failure to notify medical staff and failure to document care provided or care required. This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member's penalty included an oral reprimand, a 6 month suspension, two meetings with a Regulatory Expert, employer notification of 18 months and completion of a nursing course in obstetrics with a minimum passing grade of 65%.
CNO v. Gyasi (Discipline Committee, 2014): In this case, the member was found to have failed to appropriately assess, monitor and provide appropriate nursing care to a patient, failed to seek assistance and failed to inform her employer that she was unable to accept responsibility for pregnant clients where she was not competent to deliver that care without supervision. This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member's penalty included an oral reprimand, a 5 month suspension of the member's certificate of registration, two meetings with a Nursing Expert, employer notification for a period of 12 months and the member could not practice independently in the community for a period of 12 months.

The Member's Counsel submitted that the Member acknowledged her deficiencies, was accountable for her actions and expressed her condolences to the family on their loss.

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 3 months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 5 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 a 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 2 meetings with a Regulatory Expert (the "Expert"), at her own expense and within 6 months from the date that this Order becomes final. To comply, the Member is required to ensure that:

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

        ii. At least 7 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. *Professional Standards*,
            2. *Documentation*
            3. *Code of Conduct,* and
            4. *Decisions about Procedures and Authority.*

        iv. At least 7 days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and 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 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;

vi. 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 her 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 her certificate of registration;

b) Within 12 months from the date that this Order becomes final or the date the Member returns to a nursing practice in obstetrics, whichever date is later, or within such longer time period as approved by the Director, the Member shall successfully complete at her own expense a nursing course (with clinical or laboratory or other practical components) that have received prior approval from the Director regarding: obstetrics. The Member must pass the course. If the course is graded, the Member must receive a minimum passing grade of 65%. The Member must provide the Director with proof of enrolment, successful completion of the course and the specific grade[s] received (if applicable).

c) For a period of 12 months from the date the Member's suspension ends, the Member will notify her 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 her 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.

4. All documents delivered by the Member to the 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 concluded 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 proportionate to the misconduct. The reprimand reinforces to the Member the seriousness of this misconduct and the suspension sends a clear message to the Member and the membership that professional misconduct of this nature will result in significant sanctions. The terms, conditions and limitations balance the interest of remediation with the need to ensure that public interest and protection are maintained.

The penalty is within a reasonable range of similar decisions made in the past.

I, Tanya Dion, RN, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.