DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Ingrid Wiltshire-Stoby, NP	Chairperson
	Sylvia Douglas	Public Member
	Tomoko Fukushima, RN	Member
	Sarah Louwagie, RPN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JOSEPH BERGER for
	)	College of Nurses of Ontario
- and -	)	
	)	
ANGELA FAZZARI	)	DANIELLE BISNAR for
Registration No. 09378014	)	Angela Fazzari
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: November 25, 2022

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 November 25, 2022, 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 the public disclosure and banning the publication or broadcasting of the identities 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 Angela Fazzari.

The Panel considered the submissions of College Counsel and the Member's Counsel and decided that there be an order preventing the public disclosure and banning the publication or broadcasting of the identities 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 Angela Fazzari.

The Allegations

The allegations against Angela Fazzari (the "Member") as stated in the Notice of Hearing dated October 13, 2022 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 the *Ontario Regulation 799/93*, in that, while working as a Registered Nurse at Hamilton Health Sciences Centre – Hamilton General Hospital in Hamilton, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that you accessed personal health information for approximately 57 patients between in or around 2011 and 2018 without consent, authorization and/or professional purpose.

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, while employed as a Registered Nurse at Hamilton Health Sciences Centre – Hamilton General Hospital in Hamilton, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional in that you accessed personal health information for approximately 57 patients between in or around 2011 and 2018 without consent, authorization and/or professional purpose.

Member's Plea

The Member admitted the allegations set out in paragraphs 1 and 2 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. Angela Fazzari (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on May 8, 2009.

2. The Member is currently employed on a full-time basis at Wentworth Lodge, a long-term care home in Dundas, Ontario.

3. At the time of the incidents below, the Member was working at Hamilton Health Sciences – Hamilton General Hospital Campus in Hamilton, Ontario (the "Hospital").

4. The Member was employed at the Facility from September 8, 2011 until December 27, 2018. She worked on the Neurosurgery Unit (7 West). The Neurosurgery Unit provides pre- and post-operative care to patients before and after brain surgery.

PRIOR HISTORY

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

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Hospital Audit and Summary of Unauthorized Access of Health Records

6. On or around October 2, 2018, the Hospital's Patient Experience Office received an anonymous voicemail alleging improper access of patient records by the Member. Following receipt of the anonymous call, the Hospital conducted an audit of the Member's access to health records.

7. The audit revealed that the Member had engaged in a pattern of unauthorized access of health records beginning around the time the Member was hired in September 2011, continuing to November 2018, the time of the audit.

8. The audit identified that the Member accessed health records for 57 patients that were not on her unit, and for some patients who were not patients at the Hospital site where the Member worked.

9. The Member accessed information such as visit history, medical reports, admission and demographic information, diagnostic imaging reports, blood tests, orders, lab results, nursing documentation and emergency department information. A table setting out the patients, approximate dates of access, and number of accesses, for each of the 57 patients is attached as **Appendix A**.

10. When the Hospital presented her with the results of the audit, the Member acknowledged that she accessed health records of individuals outside of her circle of care for no clinical purpose.

11. If the Member were to testify, she would state that some of the individuals for whom she accessed health records were known to her and had requested that she do so on their behalf. The Member nonetheless acknowledges that she had a professional obligation to advise individuals requesting that she access their records

to obtain them through the official process. The Member regrets not asking them to use official channels to view their medical records and is committed to following the correct processes in the future.

12. The Hospital notified all patients that had been affected by the Member's improper access of health records, two of whom made complaints to CNO: Patients A and Patient BB as listed in Appendix A.

Patient A and Family Members

13. [The Member previously had personal relationships and/or friendships with Patient A and her husband.]. The Hospital's audit shows that the Member accessed Patient A's health records on 48 different occasions between 2012 and 2018. The Member also accessed health records for both of Patient A's children, and her husband.

14. Neither Patient A nor her children, nor her husband, were in the Member's circle of care. The Member had no professional purpose in accessing health records for Patient A, her husband, or their children.

15. Patient A was upset that the Member could become aware of her personal health issues, including a miscarriage, and about her son's health issues.

16. The Member acknowledges that she accessed the medical records of Patient A and her family without clinical purpose and is deeply sorry for having done so. She recognizes that this was a violation of Patient A's family's privacy and is committed to never making such a mistake again.

Patient BB and Family Members

17. At the relevant times, the Member was in a relationship with [an individual who knew Patient BB]. The Hospital's audit demonstrated that the Member accessed Patient BB's health records a total of 39 times between 2014 and 2018. The Member also accessed the health records for three of the children of Patient BB and Patient BB's ex-husband.

18. Neither Patient BB nor her children were in the Member's circle of care. The Member had no professional purpose in accessing health records for Patient BB or her children.

19. Patient BB was concerned and upset when she learned of the Member's conduct, as the information included highly sensitive personal information including information about miscarriages.

20. If the Member were to testify, she would state that she accessed the records of Patient BB and her children under pressure from her partner at the time [ ]. In hindsight, the Member acknowledges that she should not have done so. She deeply

regrets having accessed the records and recognizes that doing so was an unacceptable violation of Patient BB's family's privacy.

PROFESSIONAL OBLIGATION TO PROTECT PERSONAL HEALTH INFORMATION

21. The *Personal Health Information Protection Act, 2004* ("PHIPA") governs health care information in Ontario. Under PHIPA, the Hospital and its "agent" nurses are required to have the consent of an individual in order to collect, use or disclose their personal health information subject to specific exceptions, which are not applicable in this case. It is an offense under section 72(1)(a) of PHIPA to willfully collect, use or disclose personal health information in contravention of the Act or its regulations.

22. The Hospital's policy with respect to personal health information provides that personal health information is collected for enumerated purposes, including delivery of patient care, administration of the health care system, research, teaching, statistics, fundraising, and meeting regulatory requirements. Personal health information will not be used or disclosed for purposes other than those for which it was collected, except with the consent of the patient or as required by law. The policy also provides that if a patient requests access to their own records, they should submit written requests to the Hospital. The Hospital has a confidential flag that appears at every access to the electronic health records system:

> YOU ARE ABOUT TO ENTER A SYSTEM WHICH CONTAINS CONFIDENTIAL INFORMATION. It is inappropriate to access a patient's health record unless you are currently providing care to that individual or have specific authorization from such caregiver. Any unauthorized access is a breach of confidentiality and is subject to disciplinary action both within the hospital and through the professional regulating bodies.

23. Prior to commencing her employment at the Facility in September 2011, the Member agreed to a "Pledge of Confidentiality", acknowledging that she "must hold all clinical or health related, personal, social and/or psychological information concerning patients, visitors and staff, **in strictest confidence**; whether means of access to such information be verbal, documented, computerized or otherwise obtained" [emphasis in original].

24. The Member also completed education modules on the Hospital's privacy policies.

CNO STANDARDS

25. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring their practice and conduct meets legislative requirements and the standards of the profession. It also states that nurses are

responsible for their actions and the consequences of those actions and they are also accountable for conducting themselves in ways that promote respect for the profession.

26. CNO's *Professional Standards* further provide that ethical nursing care means promoting the values of patient well-being, respecting patient choice, assuring privacy and confidentiality, respecting the sanctity and quality of life, maintaining commitments, respecting truthfulness and ensuring fairness in the use of resources. It also includes acting with integrity, honesty and professionalism in all dealings with the patient and other health care team members.

27. The Member admits and acknowledges that accessing personal health information without professional purpose was a breach of CNO's *Professional Standards.*

28. CNO's *Confidentiality and Privacy – Personal Health Information* standard incorporates and confirms the obligations of nurses under PHIPA. In particular, the Standard states that a nurse meets the standard with respect to personal health information practices by "accessing information for her/his [patients] only and not accessing information for which there is no professional purpose".

29. The Member admits and acknowledges that accessing personal health information for patients without professional purpose was a breach of the *Confidentiality and Privacy: Personal Health Information* standard.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

30. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, in that, she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession as described in paragraphs 6 - 29 above.

31. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 6 – 29 above.

APPENDIX A

	Patient	**Date Range**	**Number of Accesses**
1.	Patient A	February 13, 2012 to May 5, 2018	48
2.	Patient B (Patient A Family member)	May 11, 2017	1

3.	Patient C (Patient A Family member)	March 23, 2014 to May 1, 2016	6
4.	Patient D (Patient A Family member)	August 30, 2014 to September 23, 2017	8
5.	Patient E (Patient A Family member)	August 9, 2017	1
6.	Patient F	March 16, 2012 to August 8, 2015	8
7.	Patient G	March 17, 2012	1
8.	Patient H	December 19, 2012 to March 29, 2018	3
9.	Patient I	August 27, 2016	1
10.	Patient J	November 11 to 15, 2017	3
11.	Patient K (Member's relative)	September 6, 2012 to April 18, 2016	7
12.	Patient L (Member's relative)	November 24, 2012	1
13.	Patient M (Member's relative)	February 17, 2013	1
14.	Patient N (Member's relative)	February 12, 2014 to July 12, 2015	14
15.	Patient O (Member's relative)	December 23, 2014	1
16.	Patient P (Member's relative)	February 18, 2015	1
17.	Patient Q (Member's relative)	February 2, 2017	1
18.	Patient R (Member's relative)	August 13, 2017	1
19.	Patient S	February 11, 2014 to September 28, 2016	11
20.	Patient T	January 30, 2016	1
21.	Patient U	May 20, 2018	1
22.	Patient V	May 8, 2013 to February 13, 2016	6
23.	Patient W	May 18, 2015 to June 1, 2015	4
24.	Patient X	June 1 to 14, 2015	2
25.	Patient Y	April 10, 2012 to February 26, 2016	3
26.	Patient Z	May 19, 2013 to May 23, 2013	3
27.	Patient AA	January 2 to 3, 2014	4
28.	Patient BB	June 8, 2014 to July 28, 2018	39
29.	Patient CC (Patient BB Family member)	January 6, 2015	1

30.	Patient DD (Patient BB Family member)	May 19, 2015	1
31.	Patient EE (Patient BB Family member)	July 15, 2014 to October 10, 2014	6
32.	Patient FF (Patient BB Family member)	October 12, 2014 to June 28, 2017	6
33.	Patient GG (Patient BB Family member)	August 4, 2014 to January 26, 2015	4
34.	Patient HH (Patient BB Family member)	August 4, 2014 to February 18, 2015	5
35.	Patient II (Patient BB Family member)	November 16, 2014	1
36.	Patient JJ (Patient BB Family member)	June 1, 2016 to July 18, 2017	4
37.	Patient KK (Patient BB Family member)	February 16, 2016	4
38.	Patient LL	August 4, 2014	1
39.	Patient MM	July 29 to July 30, 2014	3
40.	Patient NN	November 28, 2014	1
41.	Patient OO	February 17, 2016	1
42.	Patient PP	November 28, 2014	1
43.	Patient QQ	January 26, 2015	1
44.	Patient RR	December 26, 2015 to June 20, 2018	13
45.	Patient SS	December 26, 2015	1
46.	Patient TT	January 30, 2016	1
47.	Patient UU	February 4 to 13, 2016	6
48.	Patient VV	March 25, 2016	1
49.	Patient WW	June 1 to August 24, 2016	2
50.	Patient XX	June 1 to 2, 2016	6
51.	Patient YY	April 22 to 23, 2017	2
52.	Patient ZZ	October 3, 2017 to June 13, 2018	4
53.	Patient AAA	September 4, 2018	1
54.	Patient BBB	November 25, 2017	2
55.	Patient CCC	June 8, 2018	1
56.	Patient DDD	June 23, 2018	3
57.	Patient EEE	June 28, 2018	1

College Counsel asked the Panel to accept the Agreed Statement of Facts and the Member's admissions to all the allegations as set out in the Agreed Statement of Facts, and to find that the Member committed acts of professional misconduct. College Counsel submitted to the Panel that the Member's actions were relevant to the practice of nursing in that she was only able to commit the misconduct as part of her nursing practice. Her actions are likely to be considered by members as dishonourable and unprofessional as they showed a serious disregard for her nursing obligations and were a marked departure from standards. There was a pattern of unauthorized accesses over many years. The Member has repeatedly breached the public's trust and brought shame on herself and the profession.

Member's counsel submitted that the Member has admitted her professional misconduct, has no prior disciplinary history, has cooperated with the College and has expressed remorse.

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 and 2 of the Notice of Hearing. As to allegation #2, 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.

Allegation #1 in the Notice of Hearing is supported by paragraphs 6-30 in the Agreed Statement of Facts. An audit by the Hamilton Health Sciences – Hamilton General Hospital Campus (the "Hospital") revealed that the Member who worked at the Hospital as a Registered Nurse ("RN") had engaged in unauthorized access of health records beginning around the time the Member was hired in September 2011, continuing to November 2018, the time of the audit. The audit identified that the Member accessed health records for 57 patients that were not on her unit, and for some patients who were not patients at the Hospital site where the Member worked. When the Hospital presented her with the results of the audit, the Member acknowledged that she accessed health records of individuals outside of her circle of care for no clinical purpose.

The Member's conduct breached the College's *Professional Standards,* which provides that "Each nurse is accountable to the public and responsible for ensuring that her/his practice and conduct meets legislative requirements and the standards of the profession." It also states that "Nurses are responsible for their actions and the consequences of those actions. They're also accountable for conducting themselves in ways that promote respect for the profession."

The College's *Professional Standards* further provide that "Ethical nursing care means promoting the values of client well-being, respecting client choice, assuring privacy and confidentiality ... It also includes acting with integrity, honesty and professionalism in all dealings with the client and other health care team members."

The Member admitted and acknowledged that accessing personal health information without professional purpose was a breach of the College's *Professional Standards*.

The Member's conduct also breached the College's *Confidentiality and Privacy – Personal Health Information* Standard, which incorporates and confirms the obligations of nurses under the *Personal Health Information Protection Act, 2004* ("PHIPA"). In particular, the *Confidentiality and Privacy – Personal Health Information* Standard states that a nurse meets the standard with respect to personal health information practices by "accessing information for her/his clients only and not accessing information for which there is no professional purpose".

The Member admitted and acknowledged that accessing personal health information for patients without professional purpose was a breach of the *Confidentiality and Privacy: Personal Health Information* Standard.

Allegation #2 in the Notice of Hearing is supported by paragraphs 6-29 and 31 in the Agreed Statement of Facts. The Panel finds that the Member's conduct in accessing health records of individuals outside of her circle of care for no clinical purpose was clearly relevant to the practice of nursing as she was able to commit the misconduct through her employment as a nursing professional.

The Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations as set out in the *Professional Standards* and the *Confidentiality and Privacy – Personal Health Information* Standard.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through the repeated unauthorized access of health records, involving 57 patients over 7 years, and multiple accesses for some patients. The Member repeatedly breached the public's trust. The Member also 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 3 months. This suspension shall take effect from January 1, 2023 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 the Member's 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 CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, 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 and decision tools (where applicable):
            1. *Code of Conduct,*
            2. *Professional Standards*,
            3. *Confidentiality and Privacy – Personal Health Information*;
            4. *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

        iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

        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 their report to CNO, 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 the Member's 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 the Member's certificate of registration;

b) For a period of 18 months from the date the Member returns to the practice of nursing, the Member will notify the Member's employers of the decision. To comply, the Member is required to:
   i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

   ii. Ensure that CNO 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;

   iii. Provide the Member's 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;

iv. Only practice nursing for an employer who agrees to, and does, forward a report to CNO 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 notify CNO immediately upon receipt of any information that the Member has breached the standards of practice of the profession, and
3. that they agree to perform 3 random spot audits of the Member's accesses to electronic health records at the following intervals and provide a report to CNO regarding the Member's practice after each audit:

    a. the first audit shall take place within 4 months from the date the Member begins or resumes employment with the employer,
    b. the second audit shall take place within 8 months from the date the Member begins or resumes employment with the employer,
    c. the third audit shall take place within 12 months from the date the Member begins or resumes employment with the employer;

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

Penalty Submissions

Submissions were made by College Counsel.

The aggravating factors in this case were:

- The Member's extensive pattern of unauthorized access of patient health records over seven years, only ending when the Hospital audit revealed the misconduct;
- 57 patients outside the Member's circle of care were affected;
- Two individuals made complaints to the College;
- It is a privilege to have access to personal and vulnerable information; and
- It was a significant breach of trust.

The mitigating factors in this case were:

- The Member admitted to the allegations when confronted, accepted responsibility, and entered into an Agreed Statement of Facts and a Joint Submission on Order with the College; and
- The Member had no prior discipline history with the College.

The proposed penalty provides for general deterrence through the 3-month suspension of the Member's certificate of registration, which sends a message to the profession as a whole that unauthorized access to personal health information is a serious breach and will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3-month suspension of the Member's certificate of registration, which will send a strong signal that should deter the Member from future professional misconduct.

The proposed penalty provides for remediation and rehabilitation through the 2 meetings with a Regulatory Expert and review of the College's publications, which will assist the Member with her return to ethical practice.

Overall, the public is protected through the 18 months of employer notification and the 3 random spot audits of the Member's accesses to electronic health records, which will provide for a heightened level of employer oversight on the Member's return to practice.

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

CNO v. Quinn (Discipline Committee, 2018): This case is similar to the case before this Panel in that the member accessed electronic health records for a large number of patients who were not in her circle of care. An aggravating factor was that there was a personal relationship with several of the patients. The penalty included an oral reprimand, a three-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 18 months of employer notification.

CNO v. Evoy (Discipline Committee, 2019): In this case, the member accessed information for a number of patients, including family members. The misconduct included the impersonation of a family member in an effort to excuse the member's conduct in accessing records improperly. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert, 18 months of employer notification and 3 random spot audits of the member's accesses to patient's electronic health records.

CNO v. Church-Labrie (Discipline Committee, 2020): In this case, the member improperly accessed her own and several patients' personal health information without authorization or clinical purpose over a five-year period. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, 2 meetings with a Regulatory Expert and 12 months of employer notification.

Submissions were made by Member's Counsel.

Member's Counsel submitted as mitigating factors the Member's willingness to cooperate with the College through the negotiation of the Agreed Statement of Facts and the Joint Submission on Order which included an additional element of three random spot audits, which is not found in all penalties. The Member's Counsel also noted that the 3-month suspension will lead to a loss of income for the Member, which is significant.

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 3 months. This suspension shall take effect from January 1, 2023 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 the Member's 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 CNO in advance of the meetings;

        ii. At least 5 days before the first meeting, or within another timeframe approved by the Expert, 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 and decision tools (where applicable):

            1. *Code of Conduct,*

2. *Professional Standards*,
3. *Confidentiality and Privacy – Personal Health Information*;
4. *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

iv. At least 5 days before the first meeting, or within another timeframe approved by the Expert, the Member provides the Expert with a copy of the completed Reflective Questionnaires;

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 their report to CNO, 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 the Member's 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 the Member's certificate of registration;

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

i. Inform any employer of the decision prior to commencing or prior to resuming employment in any nursing position;

ii. Ensure that CNO 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;

iii. Provide the Member's 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;

iv. Only practice nursing for an employer who agrees to, and does, forward a report to CNO 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 notify CNO immediately upon receipt of any information that the Member has breached the standards of practice of the profession, and
3. that they agree to perform 3 random spot audits of the Member's accesses to electronic health records at the following intervals and provide a report to CNO regarding the Member's practice after each audit:

a. the first audit shall take place within 4 months from the date the Member begins or resumes employment with the employer,
b. the second audit shall take place within 8 months from the date the Member begins or resumes employment with the employer,
c. the third audit shall take place within 12 months from the date the Member begins or resumes employment with the employer;

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

Reasons for Penalty Decision

The Panel understands that the penalty ordered should protect the public and enhance public confidence in the ability of the College to regulate nurses. This is achieved through a penalty that addresses specific deterrence, general deterrence and, where appropriate, rehabilitation

and remediation. The Panel also considered the penalty in light of the principle that joint submissions should not be interfered with lightly.

The Panel 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.

The proposed penalty provides for general deterrence through the 3-month suspension of the Member's certificate of registration, which sends a message to the profession as a whole that unauthorized access to personal health information is a serious breach and will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3-month suspension of the Member's certificate of registration, which will send a strong signal that should deter the Member from future professional misconduct.

The proposed penalty provides for remediation and rehabilitation through the 2 meetings with a Regulatory Expert and review of the College's publications, which will assist the Member with her return to ethical practice.

Overall, the public is protected through the 18 months of employer notification and the 3 random spot audits of the Member's accesses to electronic health records, which will provide for a heightened level of employer oversight on the Member's return to practice.

The penalty is also in line with what has been ordered in previous cases in similar circumstances.

I, Ingrid Wiltshire-Stoby, NP, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.