DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Catherine Egerton	Public Member
Mary MacNeil, RN	Member
Desiree-Ann Prillo, RPN	Member
Devinder Walia	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
ANNIE P. CAMPEAU	)	CHRISTOPHER BRYDEN for
Registration No. 9210782	)	Annie P. Campeau
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: January 30, 2020

AMENDED DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on January 30, 2020 at the College of Nurses of Ontario (the "College") at Toronto.

Publication Ban

College Counsel brought a motion pursuant to s. 45(3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, for an order banning the disclosure, including the publication and broadcasting of the name of the patient or any information that could disclose the patient's identity referred to in the Discipline Hearing of Annie P. Campeau due to the privacy interests of the patient.

The Panel considered the submissions of the College and decided that there be an order prohibiting disclosure including a ban of the publication and broadcasting of the name of the patient or any information that could disclose the patient's identity referred to in the Discipline Hearing of Annie P. Campeau.

The Allegations

College Counsel advised the Panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(b)(i), 1(b)(v), 3(b)(i) and 3(b)(v) of the Notice of Hearing dated November 27, 2019. The Panel granted this request. The remaining allegations against Annie P. Campeau (the "Member") 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 practising as a Registered Nurse at Bendale Acres Long-Term Care Home, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular:

    (a) on or about June 14, 2016, in the course of attending to [the Patient] who had suffered an injury while disembarking a Wheel-Trans vehicle, and while you were working as the RN-In-Charge, you:

        (i) failed to assess the client;

        (ii) failed to complete an incident report; and/or

        (iii) failed to assess the situation and coordinate actions, including ensuring that appropriate reports were completed;

    (b) on or about June 15, 2016, while you were working as the RN-In-Charge, you:

        (i) [withdrawn];

        (ii) failed to assess and/or identify significant changes to [the Patient's] health condition;

        (iii) failed to take appropriate action in relation to [the Patient's] declining health status, including but not limited to failing to consult with and/or report to the physician on call and/or the nurse manager;

        (iv) failed to review [the Patient's] health records from her stay in hospital and/or to contact the hospital to obtain information with respect to her care there;

        (v) [withdrawn]; and/or

        (vi) failed to provide clinical support and leadership to the RPN providing care to [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 practising as a Registered Nurse at Bendale Acres Long-Term Care Home, you failed to keep records as required, and in particular:

(a) on or about June 14, 2016, in the course of attending to [the Patient] who had suffered an injury while disembarking a Wheel-Trans vehicle, and while you were working as the RN-In-Charge, you failed to complete an incident report;

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that, while practising as a Registered Nurse at Bendale Acres Long-Term Care Home, 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, and in particular:

(a) on or about June 14, 2016, in the course of attending to [the Patient] who had suffered an injury while disembarking a Wheel-Trans vehicle, and while you were working as the RN-In-Charge, you:

(i) failed to assess the client;

(ii) failed to complete an incident report; and/or

(iii) failed to assess the situation and coordinate actions, including ensuring that appropriate reports were completed;

(b) on or about June 15, 2016, while you were working as the RN-In-Charge, you:

(i) [withdrawn];

(ii) failed to assess and/or identify significant changes to [the Patient's] health condition;

(iii) failed to take appropriate action in relation to [the Patient's] declining health status, including but not limited to failing to consult with and/or report to the physician on call and/or the nurse manager;

(iv) failed to review [the Patient's] health records from her stay in hospital and/or to contact the hospital to obtain information with respect to her care there;

(v) [withdrawn]; and/or

(vi) failed to provide clinical support and leadership to the RPN providing care to [the Patient].

Member's Plea

The Member admitted the allegations set out in paragraphs #1(a)(i), (ii), (iii); #1(b)(ii), (iii), (iv), (vi); #2(a) and #3(a)(i), (ii), (iii); #3(b)(ii),(iii),(iv), (vi) 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 reads, unedited, as follows:

THE MEMBER

1. Annie P Campeau (the "Member") obtained a diploma in nursing from Iligan Medical Centre College in 1979.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on January 22, 1992.

3. The Member was employed at Bendale Acres (the "Facility") from July 4, 1989 to November 18, 2016. The Member initially worked at the Facility as a Personal Support Worker ("PSW") before working as a RN.

PRIOR HISTORY

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

THE FACILITY

5. The Facility, located in Toronto, Ontario, is a Long-Term Care Home.

6. The Member worked as a full-time nurse on the evening shift. The Member was the Registered Nurse in Charge ("RNIC") on the dates of the incidents.

7. At the Facility, the RNIC was in the charge nursing role for the Facility and acted in place of the Administrator during the Administrator's off hours. The RNIC was also responsible for 50 percent of the patients and their medication administration on the 5th floor.

THE PATIENT

8. [ ] (the "Patient") was 65 years old at the time of the incidents.

9. The Patient was admitted to the Facility on [ ]. The Patient used an electric scooter. The Patient would often go out of the Facility and was able to organize a transit bus on her own.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incident #1

10. On June 14, 2016, the Patient organized a transit bus to pick her up and drop her back off at the Facility. Upon her return, the Patient suffered a fall while disembarking from the transit bus outside of the Facility. She caught her foot under her electric scooter, causing her to fall from the scooter, and causing some significant injury to her foot. The Patient exhibited obvious signs of being in significant pain.

11. The Acting Nurse Manager, [ ], was outside the Facility waiting for a ride at the end of her shift. [The Acting Nurse Manager] was the first staff member to attend to the Patient after her fall, although [the Acting Nurse Manager] was not on duty.

12. [The Acting Nurse Manager] recognized the Patient as being from the 5th Floor of the Facility and she asked the receptionist at the Facility to contact the Member, who was the RNIC working on the 5th floor, to attend the scene of the fall.

13. When the Member attended the scene of the fall, [the Acting Nurse Manager] and at least one other RN were on the scene. [The Acting Nurse Manager] provided the Member with information about the situation. At this point, Facility staff had already called an ambulance to have the Patient transferred to the hospital; however, the ambulance had not arrived yet.

14. [The Acting Nurse Manager] requested that the Member complete the necessary paperwork to transfer the Patient to the hospital. The Member advised [the Acting Nurse Manager] that she needed to return to her unit to give medications. [The Acting Nurse Manager] informed the Member that she was required to stay at the scene of the fall as the RNIC; however, the Member repeated that she could not stay as she had medication to administer.

15. The Facility's policy titled Resident Incident Report requires that a "Resident Incident Report" be completed "whenever a resident is involved in a harmful or potentially harmful incident." It also requires that staff "conduct a nursing assessment of resident's health status including vital signs, head injury routine (where indicated), initial and ongoing interventions and record in progress notes referencing incident by number in red."

16. Since the Member was the RNIC and the Patient was from the Member's unit, it was the Member's responsibility to ensure that the Patient was assessed before being sent to the hospital and that the Resident Incident Report was completed. Although the Facility's Acting Nurse Manager was on the scene, she was off-duty.

17. Despite this, the Member left the scene of the fall without completing an assessment of the Patient, and without completing a Resident Incident Report.

18. The Member did complete the paperwork to transfer the Patient to the hospital and documented the incident in the Patient's progress note.

19. The Member's role as RNIC, and the fact that the Patient was from the Member's unit, also put some responsibility on the Member for ensuring that the Patient was properly assessed and cared for following the incident. However, the Member removed herself from the situation and returned to her duties on the 5th floor, without taking any particular steps to ensure that someone else had the situation handled, or to delegate responsibility for the scene to someone else.

20. If the Member were to testify, she would state she had a significant workload. The Member acknowledges and admits that while she may have had a significant workload, this does not excuse her for failing to take responsibility for the scene or the Patient and failing to take responsibility for ensuring the appropriate incident reports were properly completed.

21. The Patient was ultimately transferred to the hospital, where she stayed overnight. The Patient returned to the Facility during the afternoon on June 15, 2016.

Incident #2

22. When the Patient returned from the hospital, she was observed to be "confused and sleepy" and "groggy and incoherent". She had suffered a fracture in the incident the day before and had a cast on her leg.

23. On June 15, 2016, the Member worked the evening shift at the Facility from 3:00pm to 11:00pm.

24. The Registered Practical Nurse assigned to provide primary care to the Patient during the Member's shift, Tamara Whyte, documented in the progress note that the Patient was in poor condition. For example, the progress note states that the Patient was unable to eat, drink or take medication due to incoherence and noted that the Patient was confused.

25. In addition, during the Member's shift, a PSW, [ ], who was assigned to care for the Patient observed the Patient to be "in a bad condition" and stated she had never seen the Patient look that way. [The PSW] communicated her observations to Ms. Whyte and asked Ms. Whyte to send the Patient to the hospital.

26. The Member attended to the Patient during her shift when she assisted staff members with turning the Patient and again when she attended to give the Patient her B12 injection. The Member observed the Patient's altered condition during these interactions.

27. From the time that she returned from the hospital, the Patient was not herself. She was normally articulate and alert, but was groggy and incoherent. She appeared to experience significant pain around her injured leg, particularly when she needed to be moved.

28. If the Member were to testify, she would testify that she assumed the Patient was tired and groggy from the events that day and the previous day.

29. In addition, if the Member were to testify, she would testify that Ms. Whyte did not advise the Member of any concerns Ms. Whyte had regarding the Patient.

30. However, the Member did have at least one opportunity to observe the Patient's altered condition. The Member admits and acknowledges that she should not have assumed why the Patient was tired and groggy, and that she failed to assess or identify any significant changes with respect to the Patient's health condition and she failed to take appropriate action in relation to the Patient's declining health status including, but not limited to, failing to consult with and/or report to the physician on call or the nurse manager.

31. During her shift, the Member failed to conduct follow-up assessments of the Patient. In addition, the Member failed to review the Patient's health records from her stay at the hospital and/or contact the hospital to obtain information with respect to the Patient's care there, and failed to provide clinical support and leadership to Ms. Whyte.

32. The Patient's condition deteriorated markedly over the course of the evening shift on June 15, 2016. The Patient was transferred to hospital the following morning, where she died at approximately 11:30am.

CNO STANDARDS

33. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of practice of the profession. A nurse demonstrates this standard by actions such as:

    a. providing, facilitating, advocating and promoting the best possible care for clients;

    b. assessing/describing the client situation using a theory, framework or evidence-based tool and identifying/recognizing abnormal or unexpected client responses and taking action appropriately;

    c. advocating on behalf of clients;

    d. seeking assistance appropriately and in a timely manner;

    e. taking action in situations in which client safety and well-being are compromised; and

    f. evaluating/describing the outcomes of specific interventions and modifying the plan/approach.

34. 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 in a timely manner and completing documentation during, or as soon as possible after, the care or event; and

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

ADMISSIONS OF PROFESSIONAL MISCONDUCT

35. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a)(i) to (iii) and 1(b)(ii), (iii), (iv) and (vi) 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 10 to 34 above.

36. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2(a) of the Notice of Hearing in that she failed to keep records as required, as described in paragraphs 10 to 32 above.

37. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3 (a)(i) to (iii) and 3(b) (ii), (iii), (iv) and (vi) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 10 to 32 above.

OTHER

38. With the leave of the Panel of the Discipline Committee, CNO withdraws the remaining allegations in the Notice of Hearing, which are as follows:

- 1(b)(i)
- 1(b)(v)
- 3(b)(i)
- 3(b)(v)

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)(i), (ii), (iii); #1(b)(ii), (iii), (iv), (vi); #2(a) and #3(a)(i),(ii),(iii); #3(b)(ii), (iii), (iv), (vi) of the Notice of Hearing. As to Allegations #3(a)(i), (ii), (iii), #3(b)(ii), (iii), (iv),(vi), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be unprofessional and dishonourable.

Reasons for Decision

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

Allegation #1(a)(i) in the Notice of Hearing is supported by paragraphs 13, 14, 15, 16, 17, 19, 20, 33 and 35 in the Agreed Statement of Facts. The Member failed to assess a client who had suffered an injury while disembarking a transit bus.

Allegation #1(a)(ii) in the Notice of Hearing is supported by paragraphs 14, 15, 16, 17, 20, 34 and 35 in the Agreed Statement of Facts. The Member failed to complete an incident report in regards to the client's fall.

Allegation #1(a)(iii) in the Notice of Hearing is supported by paragraphs 13, 14, 15, 16, 17, 19, 20, 33, 34 and 35 in the Agreed Statement of Facts. The Member failed to assess the situation of the client's accident and coordinate actions including ensuring that appropriate reports were completed.

Allegation #1(b)(ii) in the Notice of Hearing is supported by paragraphs 22, 23, 26, 27, 28, 29, 30, 31, 33 and 35 in the Agreed Statement of Facts. The Member failed to assess and/or identify significant changes in the client's health condition the next day after the accident.

Allegation #1(b)(iii) in the Notice of Hearing is supported by paragraphs 26, 27, 28, 30, 31, 33 and 35 in the Agreed Statement of Facts. The Member failed to take appropriate actions in relation to the client's declining health status on her return from the hospital after the accident. The Member failed to consult with or report to the physician on call or a charge nurse.

Allegation #1(b)(iv) in the Notice of Hearing is supported by paragraphs 30, 31, 33 and 35 in the Agreed Statement of Facts. The Member failed to review the client's health records from their stay in the hospital nor did the Member attempt to obtain information with respect to the client's care.

Allegation #1(b)(vi) in the Notice of Hearing is supported by paragraphs 30, 31, 33 and 35 in the Agreed Statement of Facts. The Member failed to provide support and leadership to the RPN providing care for the client with declining health.

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 15, 16, 17, 20 and 36 in the Agreed Statement of Facts. The Member, who was the RN in Charge at the time of the incident/accident of the client while disembarking a transit bus, failed to complete an incident report.

With respect to Allegations #3(a)(i), (ii), (iii) and #3(b)(ii), (iii,), (iv), (vi), the Panel finds that the Member's conduct would reasonably be regarded by members of the profession as dishonourable and unprofessional. This is supported by paragraphs 13–31 in the Agreed Statement of Facts. The Member by her own admission, in paragraph 37 in the Agreed Statement of Facts, acknowledges that her conduct was dishonourable and unprofessional. The Member's conduct was unprofessional as she failed to assess and document the condition of a client who had an accident when returning to the facility and disembarking from a transit bus. The Member also failed to document the incident. The Member's conduct was also dishonourable when she failed to take appropriate action when the client's condition was declining after returning from the hospital. The Member's lack of consultation with the RPN and failure to report to an on call physician, was conduct that the Member knew or ought to have known, falls below the standard expected of a professional.

Penalty

College Counsel and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission on Order requests that this Panel make an order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within 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 the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practising 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*,

        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 clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/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) For a period of 12 months from the date the Member returns to the practice of nursing, 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 mitigating factors in this case were:

- The Member had no disciplinary history with the College;
- The Member has fully accepted responsibility and acknowledged her misconduct; and
- The Member has cooperated with the College.

The aggravating factors in this case were the Member's conduct was very serious and the client did die. The Member's lack of assessment of the situation and documentation showed a serious disregard for her professional obligations.

The proposed penalty provides for general deterrence through a three month suspension. This sends a clear message to the profession that the failure to meet one's professional obligations can result in serious disciplinary sanctions. The suspension along with the terms, conditions and limitations on the Member's certificate of registration indicate to the membership, and the public, that this type of behaviour is taken very seriously by the College and by this Discipline Committee. The proposed penalty also sends a strong message that this is a profession that is capable of governing itself.

The proposed penalty also provides for specific deterrence through a three month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of how her actions are perceived by both the profession and the public. The terms, conditions and limitations placed on the Member will provide monitoring of the Member's practice and conduct.

The proposed penalty provides for remediation and rehabilitation through the two meetings with a Nursing Expert, the review of the College's publications and completion of the Reflective Questionnaires, online learning modules and participation forms in the areas specific to the Member.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. The 12 month employer notification will ensure that the Member is monitored for a significant period of time ***after*** she returns ***from*** the suspension.

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

CNO v Nkwelle (Discipline Committee 2018). This was a hearing about a member who failed to complete routine checks on patients and failed to complete documentation. The member admitted to his

actions by way of an Agreed Statement of Facts and Joint Submission on Order. The member's conduct was found to be unprofessional and dishonourable. The terms and notification period along with the suspension were the same.

CNO v Simone (Discipline Committee 2017). In this hearing, the member also had an Agreed Statement of Facts along with a Joint Submission on Order. This member failed to meet the standard of practice with various clients, including improper delegation of care. The member received a 5 month suspension along with two meetings with a nursing expert and an 18 month notification. This member also had a condition on their certificate that did not allow independent nursing practice once they returned to practice.

CNO v Branton (Discipline Committee 2012). In this hearing, the member did not appear and was not represented. The member was found to have left an elderly patient with dementia and other serious health issues in his room and closed the door. The client was agitated and hit his head so hard on the door that he broke a hip, had an intracranial hemorrhage and died shortly thereafter. The panel found this case not to be in line with the other cases as the member did not appear nor did the penalty align with this case.

The Member's counsel submitted that the penalty proposed by the Joint Submission on Order was appropriate in the circumstances.

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 the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practising 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*,

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 clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/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) For a period of 12 months from the date the Member returns to the practice of nursing, 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. Members of the profession will be reminded that there can be serious, tragic and irreversible consequences when Nursing Standards are not followed.

I, Dawn Cutler, 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.