**DISCIPLINE COMMITTEE**
**OF THE COLLEGE OF NURSES OF ONTARIO**

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| **PANEL:** | Karen Laforet, RN | Chairperson |
| | Tyler Hands, RN | Member |
| | Carly Hourigan | Public Member |
| | Ingrid Wiltshire-Stoby, NP | Member |
| | Sandra Larmour | Public Member |

**BETWEEN:**

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| COLLEGE OF NURSES OF ONTARIO | ) | EMILY LAWRENCE for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| MARISSA BROQUEZA | ) | NO REPRESENTATION for |
| Registration No. AE123536 | ) | Marissa Broqueza |
| | ) | |
| | ) | PATRICIA HARPER |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | Heard: October 24, 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 October 24, 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 public disclosure and banning the publication or broadcasting of the name of the patient, or any information that could disclose the identity of the patient, referred to orally or in any documents presented at the Discipline hearing of Marissa Broqueza.

The Panel considered the submissions of the College and decided that there be an order preventing public disclosure and banning the publication or broadcasting of the name of the patient, or any information that could disclose the identity of the patient, referred to orally or in any documents presented at the Discipline hearing of Marissa Broqueza.

## The Allegations

The allegations against Marissa Broqueza (the "Member") as stated in the Notice of Hearing dated August 24, 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 *Ontario Regulation 799/93*, in that, while registered as Registered Practical Nurse and while employed at Sunrise of Oakville in Oakville, Ontario (the "Facility"), you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, in that:

    a. on or about July 15, 2018, you failed to send your patient, [Patient A], to the hospital when he required a reinsertion of his catheter;

    b. on or about October 21, 2018, you failed to report to the Facility that a colleague smelled of alcohol while on shift; and/or

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(25) of *Ontario Regulation 799/93*, in that, while registered as Registered Practical Nurse and while employed at the Facility, you failed to report an incident of unsafe practice or unethical conduct of a health care provider to the employer or other authority responsible for the health care provider, in that:

    a. on or about October 21, 2018, you failed to report to the Facility that a colleague smelled of alcohol while on shift;

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 registered as Registered Practical Nurse and while employed at the Facility, you engaged in conduct that would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that:

    a. on or about July 15, 2018, you failed to send your patient, [Patient A], to the hospital when he required a reinsertion of his catheter;

    b. on or about October 21, 2018, you failed to report to the Facility that a colleague smelled of alcohol while on shift.

## Member's Plea

The Member admitted the allegations set out in paragraphs #1(a), (b), #2(a), #3(a) and (b) 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 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. Marissa Broqueza (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on October 6, 2015.

2. The Member was employed as a part-time Care Manager at Sunrise of Oakville (the "Facility") located in Oakville, Ontario when she was terminated on October 30, 2018 as a result of one of the incidents described below.

3. The Facility is a long-term care facility that provides assisted living, as well as memory, palliative and respite services.

4. The Member previously worked as a full-time RPN in the Facility's Memory Care Unit from December 2017 to July 2018, at which time she transitioned back to the Care Manager and Personal Support Worker ("PSW") role that she held from April 2012 to December 2017.

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

**THE PATIENT**

6. [Patient A] (the "Patient") was 90 years old at the time of the incident.

7. The Patient was diagnosed with Alzheimer's, schizoaffective disorder - bipolar type and major depressive disorder, among other comorbidities.

8. The Patient was admitted to the Facility's Memory Care Unit on July 6, 2018.

**RELEVANT FACILITY POLICIES**

9. The Responding to Medical Emergencies Policy sets out the Facility's requirements for responding to emergencies and when it is appropriate to call 911 and transport patients to hospital.

10. The Continence and Bowel Management Policy ("CBM Policy") sets out the Facility's expectations with respect to continence care, along with identifying mandatory practices and reinforcing the scope of staff duties.

11. Both policies were in force at the time of the incidents below.

**INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

**Inappropriate Handling of Patient [A]'s Medical Emergency**

12. On July 14, 2018, the Patient's catheter was pulled out during an accidental fall.

13. The Patient was taken to hospital via ambulance for catheter reinsertion.

14. The Patient returned to the Facility at 11:05 on July 15, 2018.

15. Upon his return, the Patient's son, his Power of Attorney for Personal Care, requested that his father not be sent to hospital again unless there was a head injury.

16. At around 23:15 on July 16, 2018, the Patient suffered a second fall.

17. The Member found the Patient by the front door of his room with his catheter pulled out.

18. The Member assessed the Patient for signs of head injury. Finding none, she conducted a physical examination of his body and noticed penile bleeding due to the catheter's sudden, accidental removal.

19. At approximately 23:40, the Member left voicemails for the Patient's son (his Power of Attorney for Personal Care) and the Patient's daughter, and documented these attempts.

20. The Responding to Medical Emergencies Policy requires Facility staff to immediately call 911 if patients present with uncontrollable bleeding and to send patient to hospital if the Facility cannot provide the medical intervention that is required.

21. The Facility's CBM Policy instructs that only appropriate nursing staff can insert catheters. Catheterization should also always be judged in the patient's best

interest and in concert with considering whether the catheterization needs exceed staff members' scope of clinical expertise.

22. Given the Patient's circumstances, the Patient required catheter reinsertion to be completed by a nurse sent to the Facility through Home and Community Care Support Services (CCSS), formerly known as the Local Health Integration Network.

23. As Care Manager, it was the Member's responsibility to ensure timely intervention for the Patient, who was experiencing medical distress as evidenced by penile bleeding and agitation. If the Member were to testify, she would state that she was aware of the CBM Policy and that catheter reinsertion fell outside her scope of practice in her role at the Facility.

24. The Member texted her supervisor, the Facility's Resident Care Director, as well as a second supervisor, asking both to advise on next steps.

25. They told the Member to transfer the Patient to the hospital immediately in accordance with Facility policies.

26. The Patient was transferred to hospital shortly thereafter, and did not suffer health complications because of the delayed catheter reinsertion.

27. If the Member were to testify, she would state that she was well-intentioned in contacting Facility management given the verbal instructions from the Patient's Power of Attorney for Personal Care to not send the Patient to hospital unless there was a head injury. However, she acknowledges that she was expected to follow the Facility's CBM Policy and Reporting to Medical Emergencies Policy to ensure no urinary retention, physical harm or infection occurred.

**Failure to Report Colleague Who Smelled of Alcohol**

28. On October 21, 2018, several co-workers reported to the Member that they could smell alcohol on a colleague's ("Colleague A") breath while on shift. The Member was the staff in charge on the day in question.

29. Like the Member, Colleague A was also employed at the Facility as a Care Manager/PSW.

30. The Member approached Colleague A and asked why she smelled of alcohol.

31. Colleague A responded that she had been "eating grapes".

32. The Member did not report Colleague A to Facility management.

33. If the Member were to testify, she would state that, although she also smelled alcohol on Colleague A's breath, she did not report the incident to Facility management because she did not want to get Colleague A in trouble. Upon further reflection, the Member feels ashamed that she did not put patient safety first when she suspected Colleague A was unsafe to practise while on shift.

34. The Facility terminated the Member as a result of this incident.

**CNO STANDARDS OF PRACTICE**

35. CNO's published standards of practice inform nurses of their accountabilities and apply to all nurses regardless of their role, job description or area of practice.

***Professional Standards***

36. CNO's *Professional Standards* provides an overall framework for the practice of nursing. Many of its principles are interwoven with other published standards, guidelines and competencies developed by CNO. It includes seven broad standard statements pertaining to accountability, continuing competence, ethics, knowledge, knowledge application, leadership and relationships.

37. The *Professional Standards* requires that each nurse possess, through basic education and continuing learning, knowledge relevant to their professional practice.

38. CNO's *Professional Standards* also provides that each nurse continually improves their application of professional knowledge. A nurse demonstrates this standard by actions such as:

    a. maintaining competence and refraining from performing activities that they are not competent in;

    b. taking appropriate action to maintain patient safety;

    c. recognizing limits of practice and consulting appropriately; and

    d. identifying and addressing practice-related issue.

***Ethics Standard***

39. Nurses have an obligation to maintain the commitments they assumed as regulated health professionals. Maintaining commitments means being honest and meeting implicit and explicit obligations toward themselves, their patients and their colleagues.

40. The *Ethics Standard* states that nurses have an obligation to intervene in situations in which the safety and well-being of patients is compromised, and report any behaviours that are unsafe and unprofessional. Nurses' primary responsibility is to their patients, not their colleagues, in situations where patient safety is compromised.

41. Collegiality is critical for members to learn, grow and professionally develop in practice settings. However, these friendships can never come at the expense of poor patient care or allow situations to occur where the result could be patient harm or inadequate care. The *Ethics Standards* requires that nurses take action when colleagues put patients at risk in any way.

42. CNO's *Ethics Standard* also provides, in relation to maintaining commitments, that nurses have a commitment to the nursing profession and being a member of the profession brings with it the respect and trust of the public.

43. To continue deserving this respect, nurses have a duty to uphold the standards of the profession, conduct themselves in a manner that reflects well on the profession, and participate in and promote the growth of the profession.

**ADMISSIONS OF PROFESSIONAL MISCONDUCT**

44. The Member admits that she contravened CNO's *Professional Standards* and *Ethics Standard* by:

    a. failing to refer the Patient to hospital for catheter reinsertion following a discovery of penile bleeding after the Patient fell; and

    b. failing to report Colleague A to Facility management when several of the Member's co-workers reported, with reasonable cause, that Colleague A was under the influence of a substance while on shift and the Member herself smelled alcohol on Colleague A's breath.

45. The Member admits that, regardless of her intent with respecting the wishes of the Patient's Power of Attorney for Personal Care, she should have followed Facility policies by ensuring that the Patient received urgent intervention to reinsert his catheter.

46. The Member also admits that failing to report her suspicion of Colleague A's unsafe or unethical practice impacts patients as well as public confidence in the ability of the profession to self-regulate. The Member acknowledges and appreciates that nurses are accountable for providing uncompromised healthcare to all patients, but especially vulnerable patients who rely on nurses' good judgment to advocate on

their behalf. She admits that she failed to escalate concerns of unsafe and unethical practise when her professional obligation demanded that she do so.

47. The Member admits that she committed the acts of professional misconduct as described in paragraphs 1(a) in the Notice of Hearing and as described in paragraphs 12 to 27 above.

48. The Member admits that she committed the acts of professional misconduct as described in paragraphs 1(b) and 2(a) in the Notice of Hearing and as described in paragraphs 28 to 34 above.

49. With respect to the acts of professional misconduct as described in paragraphs 3(a) and 3(b) of the Notice of Hearing, and as described in paragraphs 12 to 34 above, the Member admits that her conduct was dishonourable and unprofessional, as alleged.

**Additional Submissions**

The Panel reviewed the Agreed Statement of Facts and asked College Counsel to provide further submissions specific to the evidence supporting the Member's decision to not act in a timely manner.

College Counsel directed the Panel to paragraphs 12–19 in the Agreed Statement of Facts which sets out Patient [A]'s first accidental fall on July 15, 2018 wherein he was taken to the hospital for catheter reinsertion. Following Patient [A]'s return from the hospital, his son who was his Power of Attorney for Personal Care requested that Patient [A] not be sent to the hospital again unless there was a head injury. Patient [A] suffered a second fall at around 23:15 on July 16, 2018 which again caused his catheter to be pulled out. The Member left voicemails for Patient [A]'s Power of Attorney for Personal Care and Patient [A]'s daughter at approximately 23:40. What is unknown is when Patient [A] was sent to the emergency. The Member admitted that her actions were not timely. The Member's admission in paragraph 27 of the Agreed Statement of Facts confirms that she delayed in sending Patient [A] to the emergency based on the Power of Attorney for Personal Care's request rather than follow the Continence and Bowel Management Policy and the Responding to Medical Emergencies Policy (the "Facility's Policies") that required her to act immediately.

The Member submitted that the Personal Support Worker reported the fall to her and that when she assessed Patient [A] once he was put back to bed, she noticed the penile bleeding. The Member submitted that this was not unusual and that he was urinating without a catheter. The Member contacted the Home and Community Care Support Services, formerly known as the Local Health Integration Network to send a nurse, however, due to the time they could not send one.

In reply, College Counsel reiterated that the evidence before the Panel is the Agreed Statement of Facts. The Member is not sworn as a witness therefore the basis of decision-making needs to be with the evidence provided by the Agreed Statement of Facts and not the additional information provided by the Member.

Independent Legal Counsel ("ILC") reminded the Panel that the question is whether the College has provided sufficient evidence in the Agreed Statement of Facts to support the allegations presented.

**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), #2(a), #3(a) and (b) in the Notice of Hearing. As to allegations #3(a) and (b), the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be unprofessional. The Panel did not find the Member's conduct to be dishonourable.

**Reasons for Decision**

Allegation #1(a) in the Notice of Hearing is supported by paragraphs 9–27, 35-45 and 47 in the Agreed Statement of Facts. The Member admitted that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession. While working as a part-time Care Manager at Sunrise of Oakville (the "Facility") the Member failed to follow the Facility's Policies requiring staff to immediately call 911 if patients presented with uncontrolled bleeding and to send the patient to hospital if the Facility could not provide the medical intervention required. The Member has admitted that she was aware of the Facility's Policies as well as what was within her scope of practice at the Facility.

Patient [A] required re-catheterization due to a fall that caused the sudden, accidental removal of his catheter. This procedure was beyond the scope of the Member's practice.

The Member acknowledged she was expected to follow the Facility's Policies to immediately send Patient [A] to the hospital in the presence of active bleeding. Based on the Facility's Policies the Member was mandated to act immediately in the situation rather than seek clarification. The Member chose to not follow these policies based on the verbal request of Patient [A]'s Power of Attorney for Personal Care. The Member contacted the Facility's Resident Care Director and a second supervisor for advice which further delayed Patient [A] being transferred to the hospital. The Member was instructed to transfer Patient [A] immediately to the hospital as dictated by the Facility's Policies.

The Panel finds that the Power of Attorney for Personal Care's verbal request was insufficient to act upon in an emergency situation.

The *Professional Standards* require nurses to take appropriate action to maintain patient safety. The Member breached the Standard when she failed to act immediately with Patient [A] despite a clear policy for immediate intervention and knowing catheter reinsertion fell outside her scope of practice in her role at the Facility.

Allegations #1(b) and #2(a) in the Notice of Hearing are supported by paragraphs 28–44, 46 and 48 in the Notice of Hearing. The Member admitted that she failed to report an incident of unsafe practice or unethical conduct of a health care provider to the employer or other authority responsible for the health care provider. The Member, in her capacity as Care Manager, was approached by a number of staff stating that they could smell alcohol on a colleague's ("Colleague A") breath. The Member admitted that she also smelled alcohol on Colleague A's breath and approached Colleague A and asked why she smelled of alcohol to which Colleague A responded that she had been eating grapes. The Member did not report Colleague A to the Facility's management. In paragraph 33 of the Agreed Statement of Facts, the Member acknowledged that she did not want to get Colleague A in trouble and also admitted that she did not put patient safety first when she suspected Colleague A was unsafe to practise while on shift.

The Member failed to adhere to the College's *Ethics* Standards and *Professional Standards* when she failed to intervene in a situation where the safety and wellbeing of patients may have been compromised. She breached the Ethics Standards when she put the welfare of her colleague above patient safety.

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(25) of *Ontario Regulation 799/93* provides that failure to report an incident of unsafe practice is professional misconduct. Based on the facts set out above, the Panel finds that the Member committed professional misconduct as alleged in para 2(a) of the Notice of Hearing.

Allegation #3(a) in the Notice of Hearing is supported by paragraphs 9–27, 35-43 and 49 in the Agreed Statement of Facts. The Panel finds that the Member's conduct, in failing to follow the Facility's Policies, resulting in delayed intervention for Patient [A] who was in distress, was clearly relevant to the practice of nursing. The Member's decision, in an emergency situation, to try to respect the verbal request from Patient [A]'s Power of Attorney for Personal Care rather than follow the Facility's Policies was unprofessional. It demonstrated a serious disregard for her professional obligations as set out in the *Professional Standards*.
The Panel did not find that the Member's conduct was dishonourable. Following Patient [A]'s fall, the Member, as set out in the Agreed Statement of Facts, assessed Patient [A], and determined that there was no head injury. She was well-intentioned in contacting the Facility's management due to the verbal instructions from Patient [A]'s Power of Attorney for Personal Care to not sent the Patient to hospital unless there was a head injury. In the Panel's view,

there is insufficient evidence to show that the Member acted with deceit or dishonesty, nor was there an element of moral failing.

The Member assessed [Patient A] for signs of head injury and finding none chose to seek further direction from [Patient A]'s Power of Attorney for Personal Care (POA-PC) prior to transfer to the emergency department for penile bleeding. The decision to seek direction prior to transfer was not deceitful or dishonest or an element of moral failing. The Panel determined the Member did not have sufficient knowledge and judgement to act in the situation with perceived conflicting directives provided verbally by the POA-PC as stated in paragraph #27 in the ASF and the institution's policy stated in paragraph #20 in the ASF.

Allegation #3(b) in the Notice of Hearing is supported by paragraphs 28–32, 35–43 and 49 in the Agreed Statement of Facts. The Panel finds that the Member's conduct in making the decision to not report a suspected case of alcohol use during working hours was clearly relevant to the practice of nursing and was unprofessional. It demonstrated a serious disregard for her professional obligations as set out in the *Professional Standards* and the *Ethics* Standard.

The Panel did not find sufficient evidence to support a finding of dishonourable conduct. The Panel recognizes that dishonourable conduct is that which demonstrates dishonesty, deceit or some element of moral failing. The Panel determined that the Member attempted to address the issue as stated in paragraphs 30 – 31 in the Agreed Statement of Facts. She asked why Colleague A's breath smelled like alcohol and Colleague A responded that she was "eating grapes". The Panel did not find that the Member intended to deceive regarding the Member's conduct. In reviewing the totality of the evidence, the Panel concluded the Member's failure to report her colleague was due to limited experience in a nursing leadership role.

**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 2 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 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,* and
      2. *Professional Standards*;

   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 6 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. 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;

ii. 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;

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 CNO, in which it will confirm:

1. that they received a copy of the required documents, and
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.

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 care were:

- The Member failed to abide by the legislative requirement to report a colleague suspected of being intoxicated thereby risking patient safety; and
- The Member failed to follow the Facility's Policies resulting in a delay in treatment.

The mitigating factors in this care were:

- The Member has shown remorse and taken full responsibility for her conduct by admitting to the allegations and entering into an Agreed Statement of Facts and a Joint Submission on Order with the College; and
- The Member has no prior discipline history with the College.

The proposed penalty provides for general deterrence through the 2-month suspension of the Member's certificate of registration, sending a clear message to other members of the profession that such misconduct will not be tolerated.

The proposed penalty provides for specific deterrence through the oral reprimand and the 2-month suspension of the Member's certificate of registration, sending a clear message to the Member that such misconduct, including the failure to report suspected substance abuse, will not be tolerated.

The proposed penalty provides for remediation and rehabilitation through the 2 meetings with a Regulatory Expert, serving to deepen the Member's understanding of her obligations to the profession and the public.

Overall, the public is protected through the 6 months of employer notification as there will be employer oversight on the Member's return to practice.

The penalty to which the parties have agreed, demonstrates that this conduct is serious and results in a serious sanction. Taken together, the penalty demonstrates to the public that nursing is a profession that is capable of governing itself.

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. De Walle* (Discipline Committee, 2017): In this contested case, the member was found to have committed professional misconduct in failing to report a colleague who was physically abusive to a patient. The penalty included an oral reprimand, a two-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification.

*CNO v. Fisher* (Discipline Committee, 2017): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member was found to have

committed professional misconduct in failing to report a colleague she had observed physically abusing a patient. The penalty included an oral reprimand, a one-month suspension of the member's certificate of registration and two meetings with a Nursing Expert.

*CNO v. Campeau* (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member failed to assess the patient, failed to document, failed to intervene when the patient's health was deteriorating and failed to notify the patient's change in status. 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.

College Counsel submitted that while there are no cases specific to nurses failing to report substance abuse, the failure to report cases provide context for the length of suspension and other elements of penalty. These cases confirm that the Joint Submission on Order in the case before this Panel is reasonable, meets penalty requirements and demonstrates to the profession and the public the obligation to report.

The Member made no submissions on penalty.

**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 2 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 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,* and
2. *Professional Standards*;

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 6 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. 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;

ii. 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;

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 CNO, in which it will confirm:

1. that they received a copy of the required documents, and
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.

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 penalty provides for general deterrence through the 2-month suspension of the Member's certificate of registration, which sends a clear message to other members of the profession that failure to report will not be tolerated.

Specific deterrence is achieved through the oral reprimand and the 2-month suspension of the Member's certificate of registration, which sends a clear message to the Member that such misconduct, including the failure to report, incidents of unsafe practice of a colleague will not be tolerated.

Remediation and rehabilitation are provided through the 2 meetings with a Regulatory Expert, which will increase the Member's understanding of her obligations to the profession and to the public.

The 6 months of employer notification will ensure the public is protected as the employer will monitor the Member on her return to practice.

The penalty to which the parties have agreed, demonstrates that this conduct is serious and results in a serious sanction. Taken together, the penalty demonstrates to the public that nursing is a profession that is capable of governing itself.

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

I, Karen Laforet, 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.