DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Grace Fox, NP	Chairperson
Dawn Cutler, RN	Member
Margarita Cleghorne, RPN	Member
Renate Davidson	Public Member
Chuck Williams	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
KRISTA DUKE	)	NO REPRESENTATION for
Reg. No. JD84188	)	Krista Duke
	)	
	)	
	)	CHRIS WIRTH
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: FEBRUARY 8-9, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on February 8, 2018 at the College of Nurses of Ontario ("the College") in Toronto. At the commencement of the hearing, Krista Duke (the "Member") was not present nor represented by counsel.

As the Member was not present, the Panel recessed for 15 minutes to allow time for the Member to appear. Upon reconvening the Panel noted that the Member was not in attendance nor represented by counsel.

Counsel for the College provided the Panel with the affidavit of Nicole Gorospe which established that the Member had been sent the Notice of Hearing on November 7, 2017. The Panel was satisfied that the Member had received adequate notice and therefore proceeded with the hearing in the Member's absence.

Publication Ban

At the request of the College, the Panel made an order banning the publication and broadcasting of the identities of the patients and any information that could disclose the patients' identities, including any reference to the patients' names contained in the allegations in the Notice of Hearing and in any exhibit filed in the course of the hearing, pursuant to s.45(3) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*.

The Allegations

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 Practical Nurse at Timmins & District Hospital, in Timmins, Ontario (the "Hospital"), 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 in electronic medical records for approximately 355 clients, without consent or other authorization, between November 1, 2014 and October 31, 2015.

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 Practical Nurse at the Hospital, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional in that you accessed personal health information in electronic medical records for approximately 355 clients, without consent or other authorization, between November 1, 2014 and October 31, 2015.

Member's Plea

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

Overview

The Member was employed as a Registered Practical Nurse at Timmins and District Hospital and worked mainly in the Complex Continuing Care or Rehab areas. It is alleged that between November 1, 2014 and October 31, 2015, the Member accessed personal health information in electronic medical records for approximately 355 clients, without consent or other authorization and in so doing, committed Professional Misconduct by engaging in conduct, or performing an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as dishonorable and unprofessional and by contravening the Standards of Practice as set out by the College of Nurses of Ontario. The College of Nurses Practice Standard

incorporated the obligations of nurses under the *Personal Health Information Protection Act* ("PHIPA").

The Panel considered evidence from three witnesses who carefully described how one incident had been discovered during a routine chart audit, and after further investigation a total of 355 infractions were identified.

A nurse meets Practice Standards by only accessing information for clients in her circle of care. This applies to all nurses regardless of role or area of practice.

Exhibits included the Privacy Policy for the Hospital, the Code of Conduct from the Hospital, signed by the Member and the Privacy and Confidentiality module included in the annual Learning Management Systems schedule.

The Hospital Privacy Policy provides staff with guidance to be in compliance with the legislation and the Privacy and Confidentiality module defines the Code of Conduct. The Code of Conduct protects confidential information and defines disclosure in accordance with PHIPA. This includes physical or mental health and the plan of care.

The Member signed the Code of Conduct Policy in 2008 and was required to complete Privacy training on an annual basis. The Member is allowed to access information for the clients in her circle of care and not ever for any other purpose.

After the initial incident was discovered the Manager from that unit was contacted to discern if there would be any reason for the Member to have access to this chart. It was determined that The Member had no reason to legally access this chart, so Management and the Human Resources staff met with the Member to discuss the breach in Standards. The Member denied the allegations and blamed other staff. When no good reason was forthcoming, the Member's employment was terminated and a full chart audit was conducted over a one year time period. Any and all charts of patients that the Member may have had reason to open were allowed, in effect, giving the Member the benefit of the doubt.

The Hospital uses the Meditech system which allowed the Member to access any patient in any area of the Hospital, but would flash a warning to not continue if not in the circle of care of the client.

The Breach was reported to the Privacy Commission after the Member admitted to opening charts to "fill in time on her shifts." The Member asserted that she never made copies of the information found, nor disclosed to anyone what was in them.

The Panel found the Member committed professional misconduct by failing to meet the standards of practice and by engaging in conduct that would be regarded by members of the profession to be dishonourable and unprofessional.

<u>The Evidence</u>

Witness #1 was the investigator from the College who was assigned to this case as soon as the College was notified of the Member's termination from employment. He has been an investigator for the College since May 2013 and as such has access to every aspect of the Member's College file and records. He led the Panel through the steps he took to contact the Member at each stage of his investigation. He sent a letter to the Member to inform her of the investigation, then an email about the number of files found to be accessed and the fact that her licence was under suspension by the College. He enlisted the services of a private investigation firm to obtain her proper address as it was different from what was on file at the College, and used a professional process serving company to serve the Member the disclosure documents.

Only once did Witness #1 receive any communication from the Member. After the Member was served with the disclosure documents, the Member sent an email to him. All further communication sent to the Member from Witness #1 was not acknowledged. Witness #1 sent the Member an email when the deadline was approaching to contact him and with the outcome of the investigation. The case against the Member went to the College's Inquiries, Complaints and Reports Committee who in turn referred it to the Discipline Committee. The witness was calm and concise in his responses to questions and was deemed to be credible and honest.

Witness #2 has been the Health Information Management Specialist for the Timmins Hospital from 1989 until the present time. She oversees staff privacy audits and has thirty eight staff who report to her. She has been fully trained in PHIPA. Her department routinely audits five charts and five staff each month to ensure all accesses are appropriate.

Witness #2 explained the Code of Conduct for the Facility; that staff must sign this upon hire and adhere to it as in all policies and that all of this was in place at the time the Member was hired. Witness #2 then explained about the Code of Ethics for the Facility and how it relates to privacy and confidentiality. She then described the circle of care and how the Member as a Registered Practical Nurse would be included in this concept.

Witness #2 described the Learning Management System ("the LMS") and the privacy course used annually as a refresher on privacy and confidentiality. Staff are required to pass a quiz at the end of the course. The Member successfully passed this course. Witness #2 then took the Panel through the definition of Personal Health Information and the Act that has made it law. Lastly she explained consent in the healthcare setting and that the patient must consent to having health information revealed. Implied consent is usually within the circle of care concept and express consent must be verbal or written.

Witness #2 then led the Panel through the Meditech system of electronic documentation; that all staff have access to all patients in this system at the Facility and all have unique user names and passwords so each record visit can be tracked. With each access, a pop-up flashes on the screen and asks "do you wish to proceed?" Any staff member not part of the circle of care for this patient must not continue and can be easily identified by the system. All of this was in place when the Member breached the Standards of Practice and opened electronic documentation without consent. On a routine audit it was discovered that the Member opened a chart that she was not entitled to see. The Member was questioned about this and as her answers were unsatisfactory, a full year audit from November 1, 2014 through October 31, 2015 was conducted. It was determined that a total of 355 charts were illegally accessed by the Member.

Witness #2 answered the questions directly, knew her facts and supplied good chronology throughout testimony. She appeared to be honest and forthright.

Witness #3 is a registered nurse; graduate of Northern College in Timmins and employed by the Timmins Hospital for approximately thirty years. Since 2014, she has been the Manager on the Integrated Medical Unit, which includes the Complex Continuing Care Unit and the Rehab Unit, where the Member was working at the time of her dismissal. Witness #3 described her unit and explained the areas where the Member worked and that it did not include the mental health unit, or pediatric and acute patients.

Witness #3 followed up on the information given to the Panel by Witness #2 regarding the electronic Privacy Policy and the annual privacy module found on the LMS. The Panel was shown copies of the patient audit log in two formats; one with patient names and one without and were shown how to interpret the forms to see which patients charts were opened and where the computer was that was used to look in the files. Some on the list were celebrities in the area and some were known to the Member. Multiple parts of the charts were accessed. The Panel was shown a copy of the nursing schedule depicting where the Member was working at the times in question and it was shown that she could not have been in the circle of care for any of these patients.

Witness #3 gave complete detailed answers, her testimony was given in a calm concise manner and was consistent with that of the other two witnesses.

Final Submissions

The College submitted that the evidence presented by these three witnesses established the allegations in the Notice of Hearing. The Member committed professional misconduct and contravened the Standards of Practice by accessing 355 charts without consent or other authorization.

Decision

The Panel recognized that the burden of proof was on the College to prove, on a balance of probabilities, using sufficiently clear, cogent and convincing evidence, the allegations against the Member as set out in the Notice of Hearing. The Panel deliberated and having considered the evidence and the onus and standard of proof, finds that the Member has contravened a Standard of the Profession in that she accessed public health information in the health records of 355 patients between November 1, 2014 and October 31, 2015 without consent or other authorization. Further, the Member engaged in conduct that would reasonably be regarded by members of the profession as dishonorable and unprofessional.

Reasons for Decision

The Panel considered the exhibits supplied and the evidence provided by the three witnesses and finds that this evidence supports the findings of professional misconduct in the Notice of Hearing including allegations 1 and 2.

According to the law stipulated under the PHIPA, hospital staff including nurses are required to have the consent of the patient before accessing any information. PHIPA permits sharing of information to

other relevant staff. The College's practice standard incorporated the obligations under PHIPA. The Member signed a Code of Conduct at the Facility and is bound by that Code as well as the Privacy Policy that was in place at the time the Member was employed by them. The Member also breached the CNO Practice Standard – Confidentiality and Privacy – Personal Health Information by accessing the noted medical records for patients not in her circle of care.

The Member failed to live up to and in fact fell well below the standards of her profession as set out by the College and showed a serious disregard for her patients and the personal health information within their records.

For these reasons the Member's behaviour was also found by the Panel to be both dishonourable and unprofessional.

Penalty

College Counsel requested that the Panel make an Order as follows:

1. Requiring the Member to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for five months. This suspension shall take effect from the date the Member obtains an active certificate of registration 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 a minimum of two meetings with a Nursing Expert (the "Expert") at her own expense and within six months from the date the Member returns to the practice of nursing. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member returns to the practice of nursing. 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 seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. if available, a copy of the Panel's Decision and Reasons;

iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation (where applicable):

1. *Professional Standards*,
2. *Confidentiality and Privacy – Personal Health Information*,

iv. Before the first meeting, the Member reviews *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;

vi. 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;

vii. 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;

viii. If the Member does not comply with any 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 18 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, and
    3. 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; and

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

Penalty Submissions

Counsel for the College led the Panel through similar cases for comparison pertaining to penalty, as follows;

College v. Oliveira
Heard November 2, 2015
The member was present for the hearing.
The Member accessed 1300 files without consent or other authorization. The Member did not disclose any information related to the files accessed.
The hearing proceeded under an Agreed Statement of Facts.
The Penalty:
The Member was required to appear before the Panel for a reprimand,
The Member's certificate of registration was suspended for five months
The Member was to attend two meetings with a nursing expert and
The Member would for a period of eighteen months notify employers of this hearing and penalty.

College v. Calvano
Heard May 5 2015
The Member was present for the hearing.
The Member accessed 338 files without consent or other authorization.
The hearing proceeded under an Agreed Statement of Facts
The Penalty:
The Member was reprimanded by the Panel
The Member's certificate of Registration was suspended for three months
The Member would attend two hearings with the nursing expert
The Member for eighteen months would notify employers of this hearing and penalty.

College v. McLellan
Heard April 8 2016.

The Member was present for the hearing
The Member accessed 5800 files without consent or other authorization
The hearing proceeded under an Agreed Statement of Fact
The Penalty:
The Member appeared before the Panel for reprimand
The Member's certificate of registration was suspended for four months
The Member would meet with the nursing expert twice and
The member for a period of eighteen months would notify employers of this hearing and penalty

A mitigating factor was the lack of a prior history with the College.

Penalty Decision

The Panel made an Order as follows:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for five months. This suspension shall take effect from the date the Member obtains an active certificate of registration 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 a minimum of two meetings with a Nursing Expert (the "Expert") at her own expense and within six months from the date the Member returns to the practice of nursing. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 months from the date the Member returns to the practice of nursing. 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 seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing, and
            3. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation (where applicable):

1. *Professional Standards*,
2. *Confidentiality and Privacy – Personal Health Information*,

iv. Before the first meeting, the Member reviews *Circle of Care: Sharing Personal Health Information for Health-Care Purposes*, as released by the Information and Privacy Commissioner of Ontario;

v. At least seven days before the first meeting, the Member provides the Expert with a copy of the completed Reflective Questionnaires, and online participation forms;

vi. 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;

vii. 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;

viii. If the Member does not comply with any 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 18 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, and
3. 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; and

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

Reasons for Penalty Decision

When issuing a penalty, the Panel must consider the public, the profession and the Member. The Mandate of the College is to protect the public and maintain the confidence of the public in the effectiveness of self-regulation of the nursing profession.

The penalty will act as a general deterrent in that a five month suspension of the Member's registration conveys to the profession the seriousness that a breach of public trust through illegal access represents. It is a significant suspension whereby the College will send a clear message to the membership at large. The penalty will act as a specific deterrence to the Member. The Member must appear before the Panel to be reprimanded, the Member's certificate of registration will be suspended for a period of five months and the Member will attend a minimum of two meetings with a nursing expert. Lastly for a period of eighteen months from the date the Member returns to the practice of nursing, the Member will notify her employers of the decision of this Panel. Each aspect of the order responds to the need for specific deterrence, in that repetition of the infraction would have dire consequences.

The penalty will also encourage remediation and rehabilitation. The College does not want to keep nurses out of the profession, so hopefully this penalty will assist the Member to remediate her conduct and re-enter the profession.

Lastly, the penalty will ensure the protection of the public as the Member will be suspended and through the terms and conditions placed upon the Member, the College will be a in a position to monitor and act if there is a repeat offence.

I, Grace Fox, 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.

Chairperson Date