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

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| **PANEL:** | Grace Fox, NP | Chairperson |
| | Catherine Egerton | Public Member |
| | Carly Gilchrist, RPN | Member |
| | Tania Perlin | Public Member |
| | Heather Riddell, RN | Member |

**BETWEEN:**

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| COLLEGE OF NURSES OF ONTARIO | ) | EMILY LAWRENCE for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| MULVINA ADINA DYER | ) | BEN MILLARD for |
| Registration No.: 9327107 | ) | Mulvina Adina Dyer |
| | ) | |
| | ) | CHRISTOPHER WIRTH |
| | ) | Independent Legal Counsel |
| | ) | |
| | ) | Heard: January 21, 2020 |

## DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on January 21, 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 preventing the public disclosure of the name of the patient referred to orally or in any documents presented in the Discipline hearing of Mulvina Adina Dyer or any information that could disclose the identity of the patient, including a ban on the publication or broadcasting of this information.

The Panel considered the submissions of the parties and decided that there be an order preventing the public disclosure of the name of the patient referred to orally or in any documents presented in the Discipline hearing of Mulvina Adina Dyer or any information that could disclose the identity of the patient, including a ban on the publication or broadcasting of this information.

## The Allegations

The allegations against Mulvina Adina Dyer (the "Member") as stated in the Notice of Hearing dated October 7, 2019 are as follows:

**IT IS ALLEGED THAT:**

1. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(1) of *Ontario Regulation 799/93*, in that while employed as a Registered Nurse at Scarborough and Rouge Hospital – Birchmount (the "Hospital") in Scarborough, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, in that, on or about April 5, 2018:

    a. at approximately 0758 hours, you restarted an infusion of oxytocin for your [patient], [the Patient], that had been previously discontinued and/or without a valid physician's order and/or without advising the physician of your intent to do so;

    b. at approximately 0758 hours, you restarted an infusion of oxytocin for your [patient], [the Patient], that had been previously discontinued, at the infusion rate of 2mu/min instead of at the previous infusion rate of 1mu/min;

    c. at approximately 0834 hours, you increased the infusion rate of oxytocin for your [patient], [the Patient], from 2mu/min to 4mu/min without a valid physician's order and/or without advising the physician of your intent to do so;

    d. at approximately 0834 hours, you increased the infusion rate of oxytocin for your [patient], [the Patient], from 2mu/min to 4mu/min when the fetal heart rate of [the Patient]'s fetus was atypical or abnormal;

    e. at approximately 0758 hours, you failed to adequately document your rationale for restarting an infusion of oxytocin for your [patient], [the Patient] and/or at approximately 0834 hours, failed to adequately document your rationale for increasing the infusion of oxytocin for your [patient], [the Patient];

    f. you failed to identify the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] and/or failed to document your response to the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] and/or you failed to take appropriate steps to address the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] in a timely manner; 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(37) of *Ontario Regulation 799/93*, in that while employed as a Registered Nurse at the Hospital in Scarborough, Ontario, you engaged in conduct or performed an act,

relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that, on or about April 5, 2018:

a. at approximately 0758 hours, you restarted an infusion of oxytocin for your [patient], [the Patient], that had been previously discontinued and/or without a valid physician's order and/or without advising the physician of your intent to do so;

b. at approximately 0758 hours, you restarted an infusion of oxytocin for your [patient], [the Patient], that had been previously discontinued, at the infusion rate of 2mu/min instead of at the previous infusion rate of 1mu/min;

c. at approximately 0834 hours, you increased the infusion rate of oxytocin for your [patient], [the Patient], from 2mu/min to 4mu/min without a valid physician's order and/or without advising the physician of your intent to do so;

d. at approximately 0834 hours, you increased the infusion rate of oxytocin for your [patient], [the Patient], from 2mu/min to 4mu/min when the fetal heart rate of [the Patient]'s fetus was atypical or abnormal;

e. at approximately 0758 hours, you failed to adequately document your rationale for restarting an infusion of oxytocin for your [patient], [the Patient] and/or at approximately 0834 hours, failed to adequately document your rationale for increasing the infusion of oxytocin for your [patient], [the Patient]; and/or

f. you failed to identify the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] and/or failed to document your response to the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] and/or you failed to take appropriate steps to address the atypical or abnormal fetal heart rate of the fetus of your [patient], [the Patient] in a timely manner.

**Member's Plea**

The Member admitted to all the allegations set out in paragraphs 1 and 2 in the Notice of Hearing. The Panel received a written plea inquiry which was signed by the Member. The Panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

**Agreed Statement of Facts**

College Counsel and the Member's Counsel advised the Panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts, which reads, unedited, as follows:

**THE MEMBER**

1. Mulvina Adina Dyer (the "Member") obtained a diploma in nursing from Seneca College in 1993.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on June 9, 1993.

3. The Member was employed at the Scarborough and Rouge Hospital – Birchmount site (the "Facility") from 2003 until April 25, 2018, when she was terminated following an investigation into the incident described below.

**PRIOR HISTORY**

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

**THE FACILITY**

5. The Facility is located in Scarborough, Ontario.

6. The Member was a full-time RN in the Family Maternity Centre ("FMC") at the Facility.

**THE PATIENT**

7. [The Patient] (the "Patient") was 31 years old and 38 weeks pregnant at the time of the incident.

8. The Patient previously had a child, delivered via caesarean section. She wanted to have a vaginal birth for her second child.

9. The Patient was admitted to the Facility and the FMC in early labour on the evening of April 4, 2018.

**INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT**

**Trial of Labour After Caesarean**

10. Upon admission to the FMC, the Patient began a trial of labour after caesarean ("TOLAC"). She was under the care of a nurse on the night shift.

11. Patients who attempt a TOLAC are high risk, because there is a risk of uterine rupture in births after a caesarean section birth. The Patient was placed on external electronic fetal monitoring ("EFM") due to this high-risk factor, in accordance with the FMC's policy for vaginal births.

12. EFM monitors the fetal heart rate ("FHR") and can be performed using an external monitor or through an internal monitor, a fetal scalp electrode ("FSE"). During the active second stage of labour, which involves pushing, EFM evaluation is required every five minutes. The most reliable sign of uterine rupture is abnormal FHR tracings.

13. The Patient received an epidural at 0200.

14. Oxytocin is a medication that is used to induce and/or augment labour. Under the FMC's policy regarding oxytocin for augmentation of labour, nurses are directed to start the oxytocin infusion at 1-2 mu/min as ordered by a patient's physician, and increase the infusion rate every 30 minutes by 1-2 mu/min until adequate labour is established, to a maximum dose of 20 mu/min.

15. Under the same policy, whenever the rate is decreased or discontinued, the nurse must notify the physician.

16. At 0508, oxytocin was started for the Patient at the lowest dose of 1 mu/min, by the nurse on the night shift, pursuant to a physician's order.

17. At 0650, the night nurse discontinued the oxytocin infusion due to tachysystole, a hyper-stimulation of the uterus leading to multiple contractions in a short time frame, and abnormal FHR. The nurse advised the physician on duty, who communicated this information to the oncoming physician when she started her shift at 0700 on April 5, 2018. At this point, the Patient was pushing.

18. The Member assumed accountability for the Patient at 0730 on April 5, 2018.

**Restarting Oxytocin**

19. At 0758, the Member restarted oxytocin at 2 mu/min. The FMC's policy requires a physician's order to restart oxytocin. The FMC's policy also requires that oxytocin be restarted at the initial induction/augmentation dose, which was 1 mu/min for the Patient.

20. The Member did not obtain an order from the physician on duty to restart the oxytocin, nor did she advise the physician of her intent to restart the oxytocin. The Member also did not document the rationale for restarting the oxytocin or restarting it at 2 mu/min.

21. If the Member were to testify, she would state that she assessed the Patient as stable, and that the conditions that led to the cessation of the oxytocin were no longer present, and that she understood 2 mu/min to be the standard starting dose.

22. The Member acknowledges and admits that she was required to obtain a valid physician's order to restart the oxytocin and that she was required to notify the physician of her intention to restart the oxytocin, and that she did not do so.

23. The Member acknowledges and admits that she was required to restart the oxytocin at 1 mu/min, being the initial induction dose, and that she did not restart with this dose. Although the Member understood that 2 mu/min was the standard starting dose, she acknowledges that this is the standard starting dose for inducing labour as opposed to augmenting labour, and that she was required to return to the dose initially ordered by the physician for augmenting the Patient's labour.

24. The Member further acknowledges and admits that she was required to document her rationale for restarting the oxytocin, and for selecting 2 mu/min as the starting dose, and that she did not do so.

**Increasing Oxytocin**

25. At 0833, the Member paged the physician on duty to review the EFM strips because the Patient's fetus was experiencing FHR decelerations with each contraction. Coincidence alarms had also sounded, which indicated that the maternal and FHR were the same and that the EFM may not be working.

26. The FMC policy on oxytocin directs that the dose should be increased every 30 minutes until adequate labour is established. The policy also requires a reduction or discontinuance of oxytocin where atypical or abnormal FHR tracing is present. It also requires documentation setting out the reason for increasing the oxytocin.

27. At 0834, the Member increased the oxytocin to 4 mu/min, even though the FHR was decelerating and despite the Patient having moderately intense contractions every two minutes, with a desire to push.

28. The Member did not obtain a valid physician's order to increase the oxytocin, nor did she advise the physician of her intent to increase the oxytocin. The Member also did not document her rationale for increasing the oxytocin.

29. The Member acknowledges and admits she was required to obtain a valid physician's order to increase the oxytocin and that she was required to notify the physician of her intention to increase the oxytocin, and that she did not do so.

30. The Member further acknowledges and admits that it was not clinically appropriate to increase the oxytocin from 2 mu/min to 4 mu/min where the Patient was in adequate labour and where the Patient's fetus was experiencing FHR decelerations with each contraction.

31. The Member further acknowledges and admits that she was required to document her rationale for increasing the oxytocin, and that she did not do so, because there was no clinical rationale for increasing the oxytocin.

**Communications with the Physician**

32. The physician assessed the Patient at 0844. The Member and the physician discussed the FHR decelerations, but the Member did not specifically advise the physician that she had restarted the oxytocin at 0834. The physician ordered oxytocin to be continued at 4 mu/min and told the Patient not to push.

33. If the physician were to testify, she would state her view that the Member did not clearly communicate her concerns to the physician and did not advise the physician of how long

the Patient had been pushing, whether the uterus was recovering, the length of the contractions or the maternal status. The Member denies that she was not clear in her communications.

**Coincidence Alarms**

34. From 0848 to 0904, the EFM alarmed with the coincidence detection and low FHR, at least twice. The Member acknowledged/silenced these alarms, but did not document a rationale for doing so. The Member did not immediately page the physician when the alarms started.

35. Another nurse, [Nurse A], and the Member's shift partner observed the coincidence alarms from the central monitoring station and, on their own accord, went to assist.

36. According to [Nurse A], the Patient reported that she was experiencing pain in her vagina. The nurses placed an oxygen monitor on the Patient. [Nurse A] suggested that the Member contact the physician to place an FSE and the Member agreed.

37. The Member paged the physician and prepared the FSE equipment. After preparing the FSE equipment, the Member asked [Nurse A] if she could leave once the physician arrived to attend to a personal emergency.

38. The physician arrived between 0857 and 0905. The Member acknowledged a low FHR alarm at 0906 and left the room to seek permission to leave the FMC.

39. If the Member were to testify, she would state that she attempted to reposition the Patient in response to the alarms. The Member admits and acknowledges that she failed to identify and respond promptly to an atypical/abnormal FHR from 0848 to 0905. The Member recognizes that moving the Patient was an inappropriate response to the alarms.

**Emergency Caesarean Section**

40. After the Member left the room, the physician placed the FSE, which indicated a FHR of 67bpm, at 0910, which indicated fetal distress.

41. The physician called the code for an emergency caesarean section, and the Member returned to the Patient's room. The baby was born shortly after and died later that day.

42. During the delivery, the physician discovered that the Patient's uterus had ruptured, a known complication with TOLACs.

**STANDARDS OF PRACTICE**

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

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

a. Providing, facilitating, advocating and promoting the best possible care for [patients];

b. Seeking assistance appropriately and in a timely manner;

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

d. Taking action in situations in which [patient] safety and well-being are compromised;

e. Managing multiple nursing interventions simultaneously; and

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

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

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

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

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

d. Ensuring that relevant [patient] care information is captured in a permanent record.

45. CNO's *Decisions about Procedures and Authority* standard provides that nurses are required to "ensure that they have the appropriate authority before performing procedures." The standard further clarifies that a nurse meets the standard by:

a. Knowing when specific direction for [patient] care is required in the form of orders, directives, protocols or recommendations; and

b. obtaining direct [patient] orders or implementing directives appropriately.

46. The Member acknowledges and admits that she breached the standards of practice in her care of the Patient. In particular, she failed to follow the FMC's policy which accords with the clinical standards of practice for the use of oxytocin in the augmentation of labour, in addition to failing to meet the CNO's published standards.

## ADMISSIONS OF PROFESSIONAL MISCONDUCT

47. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1(a) to (f) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of the profession, as described in paragraphs 10 to 46 above.

48. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2 (a) to (f) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 10 to 46 above.

## Decision

The College bears the onus of proving the allegations in accordance with the standard of proof, that being the balance of probabilities based upon clear, cogent and convincing evidence.

Having considered the evidence and the onus and standard of proof, the Panel finds that the Member committed acts of professional misconduct as alleged in paragraph #1 in the Notice of Hearing. As to Allegation #2, the Panel finds that the Member engaged in conduct that would reasonably be considered by members of the profession to be dishonourable and unprofessional.

## Reasons for Decision

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

Allegations #1(a) and (b) in the Notice of Hearing are supported by paragraphs 19-24 and 43-47 in the Agreed Statement of Facts. The Member admitted to restarting Oxytocin at 0758hrs at a rate of 2 mu/min. The Member did not obtain an order from the physician on duty to restart the Oxytocin. The FMC's policy requires a physician order to restart Oxytocin. The Member acknowledged that she did not follow FMC's policy to restart an initial/augmentation dose of Oxytocin which would be 1 mu/min. If the Member were to testify she would state that she understood 2mu/min to be the standard starting dose.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs 27- 32 and 43-47 in the Agreed Statement of Facts. At approximately 0834hrs, the Member increased the Oxytocin to 4mu/min. The Member did not obtain a valid physician order to increase the Oxytocin and acknowledges that she was required to obtain a valid physician order to increase the Oxytocin and that she was required to notify the physician of her intention and rationale to increase the Oxytocin.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs 27-32 and 43-47 in the Agreed Statement of Facts. The Member acknowledges and admits that it was not clinically appropriate to increase the Oxytocin from 2 mu/min to 4 mu/min where the Patient was in adequate labour and where the Patient's fetus was experiencing FHR decelerations with each contraction.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 24, 31 and 43-47 in the Agreed Statement of Facts. The Member acknowledges and admits that she was required to document her

rationale for restarting the Oxytocin and for selecting 2mu/min as the starting dose and that she did not do so. The Member further acknowledges that she did not document her reasoning because there was no clinical rationale for increasing the Patient's Oxytocin. At approximately 0834, the Member increased the oxytocin to 4 mu/min, even though the FHR was decelerating. The Member did not obtain a valid physician's order to increase the oxytocin, nor did she advise the physician of her intent to increase the oxytocin. The Member also did not document her rationale for increasing the oxytocin.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs 25, 32-39 and 43-47 in the Agreed Statement of Facts. The Member did page the Physician on Duty to review the EFM strips which indicated that the Patient's fetus was experiencing FHR decelerations, however the Member did not clearly communicate her concerns of the Patient and Fetus' clinical status. If the Member were to testify she would admit and acknowledge that she failed to identify and respond promptly to an atypical/abnormal FHR. The Member failed to document her rationale for silencing the EFM alarms.

Allegation #2 in the Notice of Hearing is supported by paragraphs 10-46 and 48 in the Agreed Statement of Facts. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(a) to 2(f) in the Notice of Hearing and in particular her conduct was dishonourable and unprofessional.

With respect to Allegation #2, the Panel finds that the Member's conduct in failing to notify and obtain a physician order for administering Oxytocin and failing to document her rationale behind her clinical judgement and reasoning was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations. The Panel also finds that the Member's conduct was dishonourable. The Panel accepts the Member's conduct fell below the professional standards. It demonstrated an element of dishonesty and deceit through repeated actions: failing to follow Hospital Policy, failing to recognize abnormal/atypical fetal cardiac rhythm and failing to document her clinical reasoning. The Member ought to have known her conduct was unacceptable.

**Penalty**

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

1. Requiring the Member to appear before the Panel to be reprimanded within 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 7 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that this Order

becomes final. 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 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. *Decisions about Procedures and Authority,*
    4. *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 [patients], colleagues, profession and self,
    3. strategies for preventing the misconduct from recurring,
    4. the publications, questionnaires and modules set out above, and
    5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

1. the dates the Member attended the sessions,
2. that the Expert received the required documents from the Member,
3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

viii. Within 12 months from the date that this Order becomes final, or a longer time period as approved by the Director, the Member shall successfully complete at her own expense, with a minimum passing grade of 65%, a nursing course with clinical or laboratory or other practical components that have received prior approval from the Director regarding: obstetrics. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%.

b) For a period of 24 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 asking that the Panel accept the Joint Submission on Order unless it put the administration of justice in disrepute or it was not in the best interest of the public.

The Mitigating factors in this case were:

- The Member has accepted responsibility for her actions and has cooperated with the College;
- The Member has attended today's hearing and come to a mutual agreement on the facts of this hearing, avoiding the need for a contested hearing, and for the patient or others to testify;
- The Member has no past disciplinary hearings.

The Aggravating factors in this case were:

- The Member's conduct was serious;
- The seriousness of the conduct warrants a significant regulatory response;
- There were deficits in her clinical judgement which resulted in serious professional misconduct by failing to obtain a physician order;
- The patient was in a very vulnerable position, experiencing labour and delivery which requires the utmost of care and attention.

The proposed penalty provides for general deterrence through the seven month suspension of the Member's certificate and employer notification of the Decision for a period of 24 months. This sends a clear message to the membership that these actions fall well below the standards of nursing practice and will not be tolerated.

The proposed penalty provides for specific deterrence through the seven month suspension, an oral reprimand, attendance and participation in two Regulatory Expert meetings, completion of the Reflective Questionnaire, completion of learning modules and employer notification of this decision for a period of 24 months.

The proposed penalty provides for remediation and rehabilitation through attendance and participation in Regulatory Expert meetings, completion of a Reflection Questionnaire and, completion of learning modules. Rehabilitation is also provided through the requirement for the successful completion of an obstetrical nursing course with clinical or laboratory components with a minimum pass rate of 65% prior to any future practice in obstetrics.

Overall, the public is protected by the 7 month suspension of the Member's certificate and the requirement of employer notification of this decision for a period of 24 months. The requirement for the remedial education in Obstetrics also protects the public.

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

*CNO vs. Haas* (Discipline Committee, 2019). This case has similar components. The member worked in Labor and Delivery. The member failed to take any significant steps for at least 30 minutes to restore FHS Monitor Signals for both heart rates and contractions. The member failed to notify the medical team of a coincidence signal. The member failed to assess and document care. The baby was delivered with forceps and was born with vital signs absent. It was a hearing based on an Agreed Statement of Facts and the penalty decision was based upon a Joint Submission on Order. The member's penalty was an oral reprimand within three months, a 6 month suspension, two meetings with a Nursing Expert, Employer notification of 18 months and a completion of an obstetrics course with a clinical or laboratory component with a minimum passing grade of 65%.

The Member's Counsel agreed with the submissions of College Counsel as to the aggravating and mitigating factors in this case. He also pointed out further mitigating factors:

- The Member has had an "unblemished" career and is dedicated to her patients;
- The Member has been registered with the College since 1993, with a career in labor, delivery and postpartum with thousands of patients and babies;
- The Member has experienced a 27 year career without a complaint or investigation. No similar circumstance has occurred;
- No employment discipline history;
- No prior professional misconduct;
- The Member's Counsel argued that this error was an anomaly and should not reflect upon the Member as a nurse;
- There was no suggestion of intentional dishonest conduct;
- The Member has admitted to her mistakes, taken responsibility and shown accountability for her actions;
- The Member has accepted a guilty plea and agreed to a Joint Submission on Order.

**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 7 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 a minimum of 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 months from the date that this Order becomes final. 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 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. *Decisions about Procedures and Authority,*
    4. *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 [patients], colleagues, profession and self,
    3. strategies for preventing the misconduct from recurring,
    4. the publications, questionnaires and modules set out above, and
    5. the development of a learning plan in collaboration with the Expert;

vi. Within 30 days after the Member has completed the last session, the Member will confirm that the Expert forwards his/her report to the Director, in which the Expert will confirm:

    1. the dates the Member attended the sessions,
    2. that the Expert received the required documents from the Member,

3. that the Expert reviewed the required documents and subjects with the Member, and
4. the Expert's assessment of the Member's insight into her behaviour;

vii. If the Member does not comply with any one or more of the requirements above, the Expert may cancel any session scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

viii. Within 12 months from the date that this Order becomes final, or a longer time period as approved by the Director, the Member shall successfully complete at her own expense, with a minimum passing grade of 65%, a nursing course with clinical or laboratory or other practical components that have received prior approval from the Director regarding: obstetrics. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%.

b) For a period of 24 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. The penalty is in line with what has been ordered in previous cases.

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.