DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Jay Armitage	Public Member
Karen Goldenberg	Public Member
Max Hamlyn, RPN	Member
Carolyn Kargiannakis, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
LISA KEATING	)	NO REPRESENTATION for
Registration No. 0439240	)	Lisa Keating
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: October 9, 2020

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 9, 2020, via videoconference.

The Allegations

The allegations against Lisa Keating (the "Member") as stated in the Notice of Hearing dated August 24, 2020, are as follows:

IT IS ALLEGED THAT:

1. You have committed an act of professional misconduct as provided by subsection 51(1)(b.0.1) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, in that you failed to cooperate with the Quality Assurance Committee or any assessor appointed by that committee, and in particular, you failed to participate after being selected by the Quality Assurance Committee for practice assessment in or around 2017.

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 you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, in that you failed to participate after being selected by the Quality Assurance Committee for practice assessment in or around 2017.

Member's Plea

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

Agreed Statement of Facts

College Counsel and the Member 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. Lisa Keating (the "Member") obtained certificate in nursing from Fleming College in December 2001 and a diploma in nursing from George Brown College in July 2004.

2. The Member first registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on March 1, 2002. She resigned her RPN certificate on February 1, 2013.

3. The Member registered with CNO as a Registered Nurse ("RN") on November 5, 2004. She retains this certificate and is entitled to practice nursing in Ontario without restrictions.

4. The Member was suspended twice for non-payment of fees for her RN certificate of registration but has since paid her fees and is no longer administratively suspended.

5. The Member is currently employed in a part-time charge nurse capacity at Extendicare – Peterborough (the "Facility"). She has worked with the Extendicare organization since November 1, 2017. She transferred from the Lakefield to the Peterborough location on August 27, 2019.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Failure to Participate in 2017 Quality Assurance Program

6. In a letter dated February 13, 2017, the Member was notified that she was randomly selected to participate in a 2017 Practice Assessment, as part of CNO's Quality Assurance ("QA") Program. The Member was given until March 23, 2017 to complete the Practice

Assessment, which included the submission of a Learning Plan and the completion of online multiple-choice tests. The letter stated that her participation was mandatory.

7. The Member neither responded to CNO's notification nor participated in the assessment by March 23, 2017.

8. In a letter dated April 20, 2017, the Quality Assurance Committee ("QAC") provided the Member another opportunity to complete the Practice Assessment. She was informed that the new deadline to complete the Practice Assessment was May 16, 2017.

9. The Member was also advised that if she did not complete the assigned activities by the new deadline, the QAC may report her to the Inquires, Complaints and Reports Committee (the "ICRC") for professional misconduct on account of having not participated in the QA Program.

10. The Member neither responded to CNO's outreach nor completed the Practice Assessment by May 16, 2017.

11. In a letter dated June 2, 2017, the QAC notified the Member that she had been referred to the ICRC. The Member was given 14 days to provide written submissions in response to the QAC's decision.

12. The Member did not provide a response by the June 2, 2017 deadline.

13. On November 15, 2018, CNO appointed an Investigator to inquire into and examine the Member's practice.

14. On February 14, 2019, the CNO Investigator sent notice to the Member that the ICRC had directed an investigation into the Member's practice.

15. On or about July 31, 2019, the CNO Investigator sent the Member a disclosure package with an invitation to respond to the ICRC by September 3, 2019. CNO sent the disclosure package to the Member's last known address. The package was returned to CNO.

16. CNO initiated a skip trace of the Member. Once an updated address was obtained, the CNO Investigator re-sent the disclosure to the Member's updated address on August 30, 2019.

17. On September 4, 2019, the Member was also personally served with the disclosure. The Member was invited to respond to the disclosure package by October 4, 2019.

18. The Member did not provide a response to the ICRC.

19. On or about March 4, 2020, the CNO Investigator sent notice to the Member that additional documents were obtained during the investigation that were relevant to the investigation into her nursing practice. The CNO Investigator invited the Member to respond by March 16, 2020.

20. The Member did not provide a response to the ICRC by the March 16, 2020 deadline. As a result, the ICRC referred the Member to the Discipline Committee on March 25, 2020.

21. In total, CNO sent five letters to the Member's address on file, two of which were sent to the Member following CNO's obtaining a skip trace to obtain the Member's updated contact information, including mailing address.

22. If the Member were to testify, she would say that she was homeless for a period, which impacted her ability to receive mail.

23. Despite her issues with receiving mail, the Member acknowledges that she is obligated to provide CNO with updated contact information. She also recognizes that it was her professional responsibility to complete the QA Program Practice Assessment as directed by CNO.

24. The Member further admits that she received CNO's disclosure package that was personally served on September 4, 2019, explaining her requirement to participate in the QA program. She was, therefore, aware of her obligation and is prepared to take responsibility, and be accountable, for her actions.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

25. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing, as described in paragraphs 6 to 24 above, in that she failed to cooperate with the QAC or any assessor appointed by that committee, and in particular, she failed to participate after being selected by the QAC for practice assessment in 2017.

26. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, and in particular that her conduct was dishonourable and unprofessional, as described in paragraphs 6 to 24 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 paragraphs 1 and 2 of the Notice of Hearing. As to allegation #2, the Panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession to be dishonourable and unprofessional.

Reasons for Decision

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

Allegation #1 in the Notice of Hearing is supported by paragraphs 6-24 and 25 in the Agreed Statement of Facts.

The Member was randomly selected in 2017 to participate in the Quality Assurance Program ("QA Program") and despite multiple opportunities the Member failed to complete the Practice Assessment. She acknowledges that she received the College's disclosure package that was personally served on her on September 4, 2019, explaining her requirement to participate in the QA Program. The Member was aware of her obligation to participate.

Allegation #2 in the Notice of Hearing is supported by paragraphs 6-24 and 26 in the Agreed Statement of Facts.

The Member acknowledges that she is obligated to provide the College with updated contact information. She also admits that it was her professional responsibility to participate in the QA Program. The Member admits that she committed acts of professional misconduct and in particular her conduct was dishonourable and unprofessional.

With respect to allegation #2, the Panel finds that the Member's conduct in choosing not to complete the Practice Assessment 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 as she knew or ought to have known that her conduct through her decision not to participate for two years in the QA Program; and her decision not to provide the College with updated contact information that she admits was her obligation, was unacceptable and fell below the standards of a professional.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for two 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 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 two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six months from the date of 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 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,
    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. *Code of Conduct,* and
    2. *Professional Standards*;

iv. 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 (as applicable);

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;

b) The Member shall participate in CNO's next available Quality Assurance program within 24 months from the date the Order becomes final.

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.

College Counsel submitted that the proposed penalty is tailored appropriately to deter this Member from similar behaviour in the future. All aspects of the Joint Submission on Order work towards deterrence going forward. The oral reprimand and a two-month suspension provide for general and specific deterrence as it conveys to the Member and the profession that this type of conduct will not be tolerated.

The proposed penalty provides general deterrence through the length of the suspension of the Member's certificate reinforcing the seriousness of this behaviour. College Counsel submitted that the College wants to retain good nurses. Recently there has been an increase in members not participating in the QA Program and this length of suspension, for two months, is being sought to send a message of deterrence to other members.

The proposed penalty also provides for specific deterrence through the oral reprimand which signifies disapproval of this Member's behaviour and the significant suspension of the Member's certificate, which will prevent misconduct by this Member in the future.

The proposed penalty provides for remediation and rehabilitation through the terms, conditions and limitations on the Member's certificate of registration that include two meetings with a Regulatory Expert to review the standards of practice and the Member's requirement to participate in the next available QA Program.

Overall, the public is protected as this decision illustrates the denunciation of the conduct. Public confidence is maintained through self-regulation and maintenance of standards.

The aggravating factor in this case was the seriousness of the offence. Participation in the QA Program is important to meet the standards of self-regulation as this speaks to the overall governability of its members by the College. Failure to complete the Practice Assessment brings discredit to the profession. This behaviour is not in line with what the public or the College expects of nurses.

The mitigating factors in this case were that the Member had no prior disciplinary history with the College, cooperated with the College, admitted remorse over her conduct and took accountability for

her actions by agreeing to the Agreed Statement of Facts and the Joint Submission on Order. The Member reported that her life over the last few years had not been the easiest outside of her work practice. Her requirement to participate in the QA Program fell by the wayside and she was apologetic for this inaction.

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

CNO v. Desante (Discipline Committee, 2016). This matter related to a similar offence but did not proceed with an Agreed Statement of Facts. Rather it was a contested hearing as the member did not attend the hearing. Amongst other things, the member was given a 3-month suspension, was to attend 2 meetings with a Nursing Expert and participate in the QA Program.

CNO v. Castor (Discipline Committee, 2017). This matter related to a similar offence and proceeded by Agreed Statement of Facts and a Joint Submission on Order. The member attended the hearing and, amongst other things, was given a 1-month suspension, was to attend 2 meetings with a Nursing Expert and participate in the QA Program.

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 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 two 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 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 two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six months from the date of 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 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,
            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. *Code of Conduct,* and
2. *Professional Standards*;

iv. 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 (as applicable);

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;

b) The Member shall participate in CNO's next available Quality Assurance program within 24 months from the date the Order becomes final.

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 proposed penalty meets all of the goals of penalty and members will be reminded that they cannot ignore the requirements of the College's statutory committees. The Member has co-operated with the College and, by agreeing with 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 Panel finds the non-compliance with the Quality Assurance Committee ("QAC") after numerous attempts by the QAC, the College investigator and the ICRC to contact the Member to be a serious concern.

The Panel believes that the length of this suspension will signal that this is serious and provide specific and general deterrence. Every nurse in Ontario is aware that they have a responsibility to participate in the QA Program and that a failure to cooperate with the QAC will result in disciplinary consequences.

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

I, Dawn Cutler, RN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.