DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Catherine Egerton	Chairperson
Deborah Graystone, NP	Member
Honey Palalon, RN	Member
George Rudanycz, RN	Member
Richard Woodfield	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	EMILY LAWRENCE for
	)	College of Nurses of Ontario
- and -	)	
	)	
MONIQUE FORRESTER	)	NO REPRESENTATION for
Registration No. JC82721	)	Monique Forrester
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 19, 2019

AMENDED DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on July 19, 2019 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 Monique Forrester or any information that could disclose the identity of the patient, including a ban on the publication or broadcasting of these matters.

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 Monique Forrester or any information that could disclose the identity of the patient, including a ban on the publication or broadcasting of these matters.

The Allegations

The allegations against Monique Forrester (the "Member") as stated in the Notice of Hearing dated May 14, 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 Practical Nurse at Bayshore Home Health Care in Belleville, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession as follows:

    a. in or about November 2016 to February 2017, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Patient], while [the Patient] was your client and/or after his discharge on December 19, 2016, including but not limited to:

        i. engaging in a personal relationship;

        ii. texting and speaking to [the Patient] on matters unrelated to your assigned nursing care;

        iii. driving [the Patient] to medical appointments; and/or

        iv. making disclosure to [the Patient] about your personal life and circumstances;

    b. you failed to take appropriate steps after [the Patient] disclosed plans of self-harm on or about January 9, 2017; and/or

    c. you accessed personal health information regarding [the Patient], without a clinical purpose, and without consent or other authorization, on or about January 10, 2017; 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 Practical Nurse at Bayshore Home Health Care in Belleville, 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, as follows:

    a. in or about November 2016 to February 2017, you failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Patient], while [the Patient] was your client and/or after his discharge on December 19, 2016, including but not limited to:

        i. engaging in a personal relationship;

ii. texting and speaking to [the Patient] on matters unrelated to your assigned nursing care;

iii. driving [the Patient] to medical appointments; and/or

iv. making disclosure to [the Patient] about your personal life and circumstances;

b. you failed to take appropriate steps after [the Patient] disclosed plans of self-harm on or about January 9, 2017; and/or

c. you accessed personal health information regarding [the Patient], without a clinical purpose, and without consent or other authorization, on or about January 10, 2017.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i), (ii), (iii), (iv); 1(b); 1(c); 2(a)(i), (ii), (iii), (iv); 2(b); 2(c) 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. Monique Forrester (the "Member") obtained a diploma in nursing from St. Lawrence College in August 2003.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on September 16, 2003.

3. The Member was employed at Bayshore Home Health (the "Agency") as an RPN beginning in 2015. Following the incidents described below, the Agency implemented a Performance Improvement Plan, requiring the Member to participate in educational activities, review Agency policies and to ensure no further reports of inappropriate behaviour. The Member completed the requirements and is still employed at the Agency to date.

THE AGENCY

4. The Agency is located in Belleville, Ontario.

5. The Member provided nursing to the Agency's patients in their homes.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Incidents with [the Patient] in 2016

6. [The Patient] required twice daily in-home nursing care for multifocal pneumonia. His care included IV therapy. The Patient [ ] had mental health conditions.

7. The Agency provided daily in-home nursing care to the Patient from November 9, 2016 to December 6, 2016. His chart also indicates that Agency staff provided care on December 7, 12 and 19, 2016. The Member was regularly assigned to provide care to the Patient.

8. While the Member was assigned to care for the Patient, she admits that she brought coffee to him. If the Member were to testify, she would state that she intended to return his kindness after he prepared a coffee for her during an appointment.

9. The Member also admits that she gave him her personal cell phone number. The Member and the Patient spoke very regularly and texted each other hundreds of times in November and December 2016, including after his discharge from the Agency on December 19, 2016. Their discussions were conversational, friendly and not for a clinical purpose related to the Member's nursing care. They communicated on the Member's days off, weekends, and while the member was on shift.

10. The Member admits that she disclosed details of her family life and circumstances, including discussing her two children. If the Member were to testify, she would state that she did not initiate the discussion, but truthfully answered questions about whether she was married and had children.

11. The Member also drove the Patient to a doctor's appointment on one occasion. Driving patients was not part of her assigned duties at the Agency, and was in fact, contrary to the Agency's policies.

12. On December 19, 2016, the Member provided a discharge report, stating that home care services did not need to be extended after this date. After December 19, 2016, the Patient was no longer a patient of the Agency or the Member.

13. The Member made an additional notation in the Patient's chart on December 25, 2016, after the Patient had been discharged. She stated that she saw the Patient on Saturday, December 24, "after receiving report that the Patient attempted to remove his own PICC line". She also noted a "quick visit" on December 24 to assess his condition. She indicated that the Patient was now discharged and that she would report the PICC line issue to his physician.

14. The Member admits that she attended at the Patient's home on December 24, 2016. The Patient did not request a nursing appointment through the Agency; he had called the Member directly.

15. If the Member or the Patient were to testify, they would both state that they had a friendship and personal connection, but did not have a romantic or sexual relationship.

January 2017 Incidents with [the Patient]

16. On January 10, 2017, the Member accessed the Patient's electronic record. If the Member were to testify, she would state that she did so because the Patient had disclosed to her during a telephone call on January 9, 2017 that he might engage in self-harm, and then he abruptly fell asleep. She would testify that she accessed his record to obtain the contact details for his landlord, and that she called the landlord to perform a wellness check.

17. The Member did not chart this discussion, or advise her manager or anyone else that the Patient had disclosed that he may engage in self-harm.

18. The Member acknowledges that she should have used formal channels within the Agency if she had a concern about the wellbeing of the Patient (a former patient of the Agency by this point), and that accessing his record was improper. She further acknowledges that she accessed the personal health records of the Patient without an appropriate clinical purpose.

COLLEGE STANDARDS

Professional Standards

19. CNO's *Professional Standards* ("Professional Standards") provides that "[e]ach nurse establishes and maintains respectful, collaborative, therapeutic and professional relationships." One way of doing so is "demonstrating respect and empathy for, and interest in clients."

20. In terms of accountability, the standard sets out indicators nurses must demonstrate, including:

    - …explaining his/her role to clients;
    - seeking assistance appropriately and in a timely manner;
    - … ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation; [and]
    - taking action in situations in which client safety and well-being are compromised…

Therapeutic Nurse-Client Relationship

21. CNO's *Therapeutic Nurse-Client Relationship* ("TNCR") standard places the responsibility for establishing and maintaining the therapeutic nurse-client relationship on the nurse.

22. The TNCR standard states:

> [c]rossing a boundary means that the care provider is misusing the power in the relationship to meet his/her personal needs, rather than the needs of the client, or behaving in an unprofessional manner with the client.

23. The TNCR standard further clarifies that a nurse may cross a boundary in a number of different ways, including:

    - self-disclosure that does not meet a specified therapeutic client need;
    - failing to ensure that the nurse-client relationship promotes the well-being of the client and not the needs of the nurse;
    - … engaging in other behaviour that suggests a special relationship between the nurse and the client; and
    - entering into a personal or romantic relationship with a client.

24. To demonstrate compliance with the TNCR standard, nurses should ensure that any approach or activity that could be perceived as a boundary crossing is included in the care plan developed by the health care team and should consult with colleagues and/or the manager in any situation in which it is unclear whether a behaviour may cross a boundary of the therapeutic relationship, especially circumstances that include self-disclosure.

Access to Personal Health Information

25. CNO's *Confidentiality and Privacy – Personal Health Information* Practice Standard ("Confidentiality and Privacy Practice Standard") incorporates and confirms the obligations of nurses under *Personal Health Information Protection Act, 2004*.

26. The Confidentiality and Privacy Practice Standard states that a nurse meets the standard with respect to personal health information practices by "accessing information for her/his clients only and not accessing information for which there is no professional purpose".

27. In addition, nurses meet the Confidentiality and Privacy Practice Standard by:

    - seeking information about issues of privacy and confidentiality of personal health information;
    - maintaining confidentiality of clients' personal health information… including information that is documented or stored electronically; [and]
    - maintaining confidentiality after the professional relationship has ended.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

28. The Member acknowledges, and the parties agree, that she failed to maintain the appropriate boundaries of the nurse-patient relationship with the Patient, as required by the Professional Standards and the TNCR standard, when she became friends with the Patient, texted and spoke to him on matters unrelated to his nursing care, drove him to medical appointments, and made disclosures to him about her personal life.

29. The Member acknowledges and agrees that her conduct was a breach of the standards of practice in relation to the incidents in 2016. She admits that she committed the acts of professional misconduct as described in paragraphs 6 to 15 above, in that she contravened a

standard of practice of the profession or failed to meet the standard of practice of the profession, as alleged in paragraphs 1(a)(i)-(iv) and 1(b) of the Notice of Hearing.

30. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2 (a)(i)-(iv) of the Notice of Hearing, and in particular that her conduct was dishonourable and unprofessional, as described in paragraphs 6 to 15 above.

31. The Member acknowledges and agrees that her conduct was a breach of the standards of practice in relation to the incidents of January 2017. She admits that she committed the acts of professional misconduct as described in paragraphs 16 to 18 above, in that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as alleged in paragraphs 1(b) and 1(c) of the Notice of Hearing, Specifically, the Member accessed the Patient's personal health information without clinical purpose and without consent or authorization, and failed to take appropriate steps after the [Patient] disclosed plans of self-harm.

32. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 2(b) and 2(c) of the Notice of Hearing, and in particular that her conduct was dishonourable and unprofessional, as described in paragraphs 16 to 18 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(a (i), (ii), (iii), (iv); 1(b); 1(c) 2(a)(i), (ii), (iii), (iv); 2(b) and 2(c) in the Notice of Hearing. As to Allegation 2(a)(i) (ii), (iii), (iv); 2(b) and 2(c), the Panel finds that the Member engaged in conduct that would reasonably be considered by members 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)(i) to (iv) in the Notice of Hearing are supported by paragraphs 6 to 15, 28 and 29 in the Agreed Statement of Facts. The Panel finds that the Member contravened a standard of practice of the profession and failed to meet the standards of practice of the profession when she: engaged in a personal relationship; texted and spoke to [the Patient] on matters unrelated to her assigned nursing care; drove [the Patient] to medical appointments; and made disclosure to [the Patient] about her personal life and circumstances.

Allegation 1(b) in the Notice of Hearing is supported by paragraphs 16 to 18, 28 and 31. The Panel finds that the Member failed to meet the standards of practice of the profession when she failed to take appropriate steps after [the Patient] disclosed plans of self-harm on or about January 29, 2017.

Allegation 1(c) in the Notice of Hearing is supported by paragraphs 16 to 18 and paragraphs 28 and 31. The Panel finds that the Member has contravened the standards of practice of the profession and failed to meet the standards of practice when she accessed personal health information regarding [the Patient] without a clinical purpose and without consent or other authorization on or about January 20, 2017.

Allegations 2(a)(i),(ii),(iii),(iv), 2(b) and 2(c) in the Notice of Hearing are supported by paragraphs 6 to 18, 30 and 32 in the Agreed Statement of Facts. The Member failed to maintain the boundaries of the therapeutic nurse-client relationship with [the Patient] while [the Patient] was her client and after his discharge on December 19, 2016. The Member has also admitted to failing to take appropriate steps after [the Patient] disclosed plans of self-harm on or about January 9, 2017. The Member also admitted to accessing personal health information regarding [the Patient] without a clinical purpose and without consent or other authorization on or about January 10, 2017. The Panel finds this conduct of the Member would reasonably be regarded as dishonourable and unprofessional as it demonstrates a serious and persistent disregard for her professional obligations.

Penalty

College Counsel and the Member advised the Panel that a Joint Submission on Order ("JSO") had been agreed upon. The JSO 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 four 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 two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six 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 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. *Professional Standards*,
2. *Therapeutic Nurse-Client Relationship*; and
3. *Code of Conduct*.

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

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) For a period of 18 months from the date the Member's suspension ends, 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 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 who asked the Panel to accept the proposed JSO, (Exhibit 4), as it met the goals of penalty and included specific and general deterrence as well as remediation and rehabilitation components. College Counsel submitted that the JSO is consistent with other cases, but noted that there are no perfect parallels.

College Counsel reminded the Panel that the JSO should be accepted unless to do so would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

The mitigating factors in this case were:

- The Member has cooperated with the College;
- The Member has no prior discipline record with the College; and
- The Member admitted to the allegations of professional misconduct.

The aggravating factors in this case were:

- The patient was vulnerable in that he had mental health issues [ ];
- The Member failed to maintain the therapeutic nurse-client relationship by continuing a relationship with the patient after he was discharged from her care; and
- The Member failed to report and use appropriate channels to notify a health professional regarding the patient's communication of potential self-harm.

The proposed penalty provides for general deterrence through the four month suspension of the Member's certificate of registration. This suspension sends a clear message to the membership about the importance of maintaining the boundaries of the nurse-client relationship. Employer notification for a period of 18 months also demonstrates that this type of behaviour will not be tolerated.

The proposed penalty provides for specific deterrence through the four month suspension and the 18 month employer notification of this decision and reasons. Having terms, limitations and conditions on the Member's certificate of registration will ensure the Member understands the seriousness of her behaviour and actions.

The proposed penalty provides for remediation and rehabilitation through two meetings with a nursing expert. Review of the *Professional Standards*, the *Therapeutic Nurse-Client Relationship* and the *Code of Conduct* will ensure the Member learns how her behaviour contravened the standards of practice.

Overall, the public is protected because the Member's certificate of registration is suspended for four months and an 18 month employer notification of this decision will ensure public awareness of the Member's behaviour and mitigate risk of repeated behaviour.

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 O'Connell* (Discipline Committee 2019). This case is similar in that this member failed to maintain the boundaries of the therapeutic nurse-client relationship. The member also failed to document clinical findings in an appropriate manner. The differences in this case, from the case at hand, are that this member was in a psychotherapeutic relationship with the patient. This member was represented by legal counsel.

The Member indicated that she agreed with the submissions of College Counsel.

The Member provided submissions related to her reasons for continuing to interact with the patient after his discharge from her care. She considered it a "supportive" role at the time. She acknowledged that she had crossed the boundaries of a therapeutic nurse-client relationship. The Panel Chair clarified with the Member that she understood the meaning of signing the JSO and that it is binding. The Member confirmed that she understood.

Penalty Decision

The Panel accepts the JSO 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 four 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 two meetings with a Regulatory Expert (the "Expert"), at her own expense and within six 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 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. *Professional Standards*,
            2. *Therapeutic Nurse-Client Relationship*; and
            3. *Code of Conduct*.

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

        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) For a period of 18 months from the date the Member's suspension ends, 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 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.

I, Catherine Egerton, Public Member, sign this decision and reasons for the decision as Chairperson of this Discipline Panel and on behalf of the members of the Discipline Panel.