DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Tanya Dion, RN	Chairperson
Sherry Szucsko-Bedard, RN	Member
Margaret Tuomi	Public Member
Chuck Williams	Public Member
Ingrid Wiltshire-Stoby, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
LISA DIANE HALLEY	)	CAROL STREET for
Reg. No. 9807140	)	Lisa Diane Halley
	)	
	)	PATRICIA HARPER
	)	Independent Legal Counsel
	)	
	)	Heard: March 12, 2018

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on March 12, 2018 at the College of Nurses of Ontario ("the College") at Toronto.

The Allegations

The allegations against Lisa Diane Halley (the "Member") as stated in the Notice of Hearing dated December 19, 2017 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 you were employed as a Registered Nurse at Hotel Dieu Grace Hospital and/or Windsor Regional Hospital in Windsor, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession with respect to accessing personal health information without consent or other proper authorization of the client [the Client], on February 11, 2015, February 12, 2015,

February 20, 2015, February 24, 2015, February 25, 2015, March 3, 2015, and/or March 4, 2015; 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 you were employed as a Registered Nurse at Hotel Dieu Grace Hospital and/or Windsor Regional Hospital in Windsor, 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 of the profession as disgraceful, dishonourable or unprofessional with respect to accessing personal health information without consent or proper authorization, of the client [the Client], on February 11, 2015, February 12, 2015, February 20, 2015, February 24, 2015, February 25, 2015, March 3, 2015, and/or March 4, 2015.

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

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

THE MEMBER

1. Lisa Diane Halley (the "Member") obtained a diploma in nursing from St. Clair College in 1997.

2. The Member has been registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") since January 7, 1998. Prior to that, the Member was registered with the College as a Registered Practical Nurse ("RPN") from June 27, 1986 until she resigned her RPN certificate of registration on February 1, 2013.

3. The Member was employed at Windsor Regional Hospital (the "Hospital") from October 2013 to May 28, 2015, when she resigned. Prior to starting at the Hospital in October 2013, the Member worked at Hotel Dieu Grace Hospital ("HDGH"), from August 2005 to October 2013. On October 1, 2013, there was a realignment of services and a merger between the Hospital and HDGH, which resulted in the Member becoming an employee of the Hospital. Her role remained the same both before and after the realignment; her physical location remained the same as well.

THE HOSPITAL

4. The Hospital is located in Windsor, Ontario.

5. The incidents below occurred while the Member was employed as an Advanced Practice Nurse in the District Stroke Program in the Tayfour Rehabilitation Unit of the Hospital. This is an

inpatient and outpatient Unit providing rehabilitation to both stroke and brain injured patients. If the Member were to testify, she would say that she considered her role was to provide risk factor management, recovery support and education, and to link clients with community services following a hemorrhagic or ischemic event. She was able to access records in her role at both HDGH and the Hospital, and did so on a regular basis to identify patient load coming to her from Acute Care, among other reasons. The Member worked independently and autonomously in this role.

THE CLIENT

6. [ ] (the "Client") was 62 years old at the time of the incidents.

7. The Client was a physician at the Hospital.

8. The Member and the Client's receptionist were friends before the incident. If the Member were to testify, she would say she also had a casual workplace friendship with the Client for about three years prior to her injury. If the Client were to testify, she would say she did not consider the Member a close friend.

9. On February 11, 2015, the Client slipped on ice in a parking lot and fell, hitting her head. She suffered an intracranial bleed, and surgery was performed to drain the hematoma.

10. She was admitted to the Hospital from February 11 to 27, 2015 and from March 3 to 5, 2015, in relation to the fall.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

HDGH's Audit

11. The Client was deemed a high profile client because she was a physician at the Hospital. As a result, HDGH ran an audit for the time period from January 1 to March 26, 2015, with respect to staff access of the Client's health record.

12. The audit revealed that the Member had accessed the Client's patient file on February 11, 2015 at 14:54:36 hours. If the Member were to give evidence, she would say that she was contacted by the Client's receptionist, who was in tears because she had been advised that the Client had been brought to the Hospital in an ambulance as a result of a fall and had been admitted. The Member admits to accessing the Client's record at this time in order to determine where in the Hospital the Client was located, so that she and the Client's receptionist could go and provide support to the Client's family, which they immediately did.

13. The Client did not have a stroke and the Hospital did not consider the Client to be in the Member's circle of care. If the Member were to give evidence, she would say that she considered it part of her role to provide education and support to the Client's family, particularly to the Client's son, who was distraught.
14. Because the Member was no longer a HDGH employee, HDGH advised the Hospital of its findings, and the Hospital ran its own two audits.

The Hospital's Audits

15. The Hospital's first audit was run for the time period from February 10, 2015 to March 31, 2015. The Hospital's second audit was run for the time period from March 1 to March 31, 2015.

16. The Hospital's audit results revealed that the Member accessed the Client's record on multiple occasions during the Client's first admission, as follows:

    - on February 11, 2015 commencing at 14:51:45 hours, including access to the Client's hematology (blood) results, ambulance call report, and drug/toxicology/alcohol report, with her final access on that day at 14:55:27 hours;

    - on February 12, 2015 at 13:54:24 hours, including opening the Client's CT scan results;

    - on February 20, 2015 at 13:49:11 hours, including reviewing consultation reports from [Doctor A] and [Doctor B];

    - On February 24, 2015 at 15:50:48 hours, including reviewing a consultation report by [Doctor B] and haemoglobin results; and

    - On February 25, 2015 at 09:50:30 hours, including accessing the Client's CT scan results, and then again later that same day at 14:54:08 hours, including accessing progress notes by [Doctor B].

17. The Hospital's audit also revealed that when the Client was re-admitted in March 2015, the Member accessed her records again, as follows:

    - On March 3, 2015 at 09:47:05 hours, including reviewing the Client's CT scan results and a consultation report by [Doctor C].; and

    - On March 4, 2015 at 09:20:05 hours, including reviewing a consultation report by [Doctor C]and the Client's EEG results.

18. In total, the Member accessed 13 of the Client's records over seven separate days.

19. The Client informed the Hospital that she had not given the Member permission to access her records and that she found the Member's privacy breach concerning.

COLLEGE STANDARDS

20. The College issued a Practice Standard titled *Confidentiality and Privacy – Personal Health Information* ("Practice Standard"). It was first published in 2004 and updated in 2009. It largely addresses the *Personal Health Information Protection Act* ("PHIPA").

21. The Practice Standard begins with a general statement about the purpose of practice standards:

> Nursing standards are expectations that contribute to public protection. They inform nurses of their accountabilities and the public of what to expect of nurses. Standards apply to all nurses regardless of their role, job description or area of practice.

22. The Practice Standard provides key indicators nurses can use to ensure they are meeting the standard, including:

> The nurse meets the standard by:
>
> - seeking information about issues of privacy and confidentiality of personal health information;
>
> - maintaining confidentiality of clients' personal health information with members of the healthcare team, who are also required to maintain confidentiality, including information that is documented or stored electronically;
>
> - maintaining confidentiality after the professional relationship has ended, an obligation that continues indefinitely when the nurse is no longer caring for a client or after a client's death;
>
> - ensuring clients or substitute decision-makers are aware of the general composition of the health care team that has access to confidential information;
>
> - collecting only information that is needed to provide care;
>
> - not discussing client information with colleagues or the client in public places such as elevators, cafeterias and hallways;
>
> - **accessing information for her/his clients only and not accessing information for which there is no professional purpose**; [emphasis added]
>
> …
>
> - safeguarding the security of computerized, printed or electronically displayed or stored information against theft, loss, unauthorized access or use, disclosure, copying, modification or disposal;
>
> - not sharing computer passwords; ….

23. The Member acknowledges that she was bound by the College's Practice Standard and that a nurse who breaches those standards and the statutory obligations set out in PHIPA is subject to discipline by the College.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

24. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing in that her unauthorized accesses to the Client's personal health information, as described in paragraphs 11 to 23 above, constituted breaches of the College's standard on *Confidentiality and Privacy – Personal Health Information*.

25. 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 11 to 23 above.

Decision

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 12 – 19 in the Agreed Statement of Facts. The Member breached the standards of practice of the profession when she repeatedly accessed personal health information of a client from who she neither had consent nor authorization.

Allegation #2 in the Notice of Hearing is supported by paragraphs 12 - 19 in the Agreed Statement of Facts.

With respect to Allegation # 2, the Panel finds that the Member's conduct in accessing personal health information without consent or proper authorization of the client repeatedly, on 7 different dates, was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations as set out in the Practice Standard titled *Confidentiality and Privacy- Personal Health Information*.

The Panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through accessing information she had no reason to access in the performance of her professional duties as this client was not under her care.

Penalty

Counsel for the College and the Member advised the Panel that a Joint Submission on Order had been agreed upon. The Joint Submission 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 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 Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

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

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

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

        vi. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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

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

viii. If the Member does not comply with any 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 12 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; and

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

Penalty Submissions

Submissions were made by College Counsel and the Member's Counsel.

College Counsel advised the Panel that the Joint Submission on Order is appropriate and addresses all three of the overriding concerns of a penalty in that it addresses protection of the public, which is the most important, while providing for specific deterrence to the Member and general deterrence to the profession. College Counsel went on to submit that the penalty was carefully arrived at by experienced counsel and the Panel should accept it unless it is contrary to public protection or would bring the administration of justice into disrepute.

The mitigating factors in this case were that the Member had no previous findings, she co-operated with the College, takes full responsibility for her actions, demonstrated remorse and agreed to the penalty.

The aggravating factors in this case were the seriousness of the breach of trust concerning the clients private health information. Even though it was only one client, the Member accessed the information 13 times over 7 days, which was not a mistake but deliberate. These actions could cause potential harm and caused the client concern. The Member's actions brings discredit to the profession.

The proposed penalty provides for specific deterrence through all aspects of the penalty. The reprimand, two month suspension, the two meetings with the expert and the 12 month employer monitoring are all significant enough to deter the Member from future professional misconduct.

The proposed penalty provides for general deterrence as it sends a strong message to the profession that privacy breaches are taken very seriously by the College, even though this was only one client it is still considered to be a very serious breach of Practice Standard on Confidentiality. The two month suspension, meetings with the expert and 12 month employer monitoring sends a strong message to the profession this conduct will not be tolerated.

The proposed penalty provides for remediation and rehabilitation through the meetings with the expert, which gives the Member the opportunity to improve her practice by education in the area of the professional standards and specifically in the standard on Confidentiality and Privacy – Personal Health Information. The meeting with the expert also allows the Member to reflect on her errors in judgement and learn from the experience.

Overall, the public is protected because all aspects of the penalty address the most important issue of public protection and send a very strong message to the public that these actions are not acceptable and will not be tolerated by the profession.
Counsel for the College submitted two cases to the Panel to demonstrate that the proposed penalty fell within the range of similar cases from this Discipline Committee.

CNO v. Brutzki (Discipline Committee, 2016)

In this case the member accessed 24 personal health records of clients, there was an agreed statement of facts and a joint submission on order. The penalty ordered was a reprimand, two month suspension, two meetings with a nursing expert and 12 month employer notification. This case was similar in the fact there were accesses to client personal information.

CNO v. Raeburn-Lewis (Discipline Committee, 2016)
In this case the member accessed a single personal health record of a client. This proceeded as an agreed statement of facts and a joint submission on order. The penalty was a reprimand, one month suspension, two meetings with a nursing expert and an 18 month employer notification. This case was similar in the fact it was a single client but it was only one access and the member received only a one month suspension.

The Member's Counsel agreed with College Counsel reinforcing the importance of accepting the Joint Submission on Order and adding the Member had agreed and the Panel should accept it as presented and so order.

Independent Legal Counsel advised the Panel to consider the three important issues of Protection of the Public, Deterrence and Remediation of the Member, while considering the aggregating and mitigating factors. She advised the Panel they were obliged to accept the Joint Submission on Order unless it was not in the public interest. The Joint Submission on Order was negotiated between experienced counsel and should only be rejected if so disproportionate to the offence in question that it would cause the administration of justice to be in disrepute or be contrary to the public interest.

Penalty Decision

The Panel accepts the Joint Submission as to 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 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 Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. 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 College publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

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

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

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

vi. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member's clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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

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

viii. If the Member does not comply with any 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 12 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; and

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

Reasons for Penalty Decision

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. All aspects of the penalty protect the public, namely the reprimand, two month suspension, two meetings with the expert and 12 month employer reporting. The penalty sends a strong message to the profession and provides the Member with the tools to become a better nurse, while showing her these actions are not acceptable. The penalty is in line with what has been ordered in previous matters.

I, Tanya Dion, 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.

_____ _____

Chairperson Date