DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Dawn Cutler, RN	Chairperson
Margarita Cleghorne, RPN	Member
Karen Goldenberg	Public Member
Linda Marie Pacheco, RN	Member
Lalitha Poonasamy	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
MARIA ADELIA RUBINAS	)	NO REPRESENTATION for
Registration No. J1727254	)	Maria Adelia Rubinas
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: October 20, 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 20, 2020, via videoconference.

The Allegations

The allegations against Maria Adelia Rubinas (the "Member") as stated in the Notice of Hearing dated August 13, 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 about January-June, 2019; and

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 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 about January-June, 2019.

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. Maria Adelia Rubinas (the "Member") initially registered with the College of Nurses of Ontario ("CNO") as a Registered Practical Nurse ("RPN") on February 25, 2009.

2. The Member is employed with Mavencare Home Care.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Quality Assurance

3. On or about January 18, 2019, CNO informed the Member by letter that she had been randomly selected to participate in practice assessment as part of CNO's Quality Assurance ("QA") program. The Member was required to complete and submit her 2019 Learning Plan and multiple-choice tests (the "Practice Assessment Activities") by March 6, 2019.

4. The Member did not respond to the letter and failed to complete the Practice Assessment Activities by March 6, 2019.

5. On or about March 25, 2019, CNO sent a second letter to the Member, instructing her to complete the Practice Assessment Activities by April 14, 2019. The Member was also advised that if she did not complete the assigned activities by the deadline, the QA Committee may report her to the Inquiries, Complaints and Reports Committee ("ICRC") for professional misconduct.

6. The Member did not respond to the letter and failed to complete the Practice Assessment Activities by April 14, 2019.

7. On or about April 23, 2019, CNO wrote to the Member by letter and offered her a third opportunity to complete the Practice Assessment Activities, by May 9, 2019. The Member

was advised again that if she did not complete the activities by the deadline, the QA Committee may report her to the ICRC.

8. The Member did not respond to the letter and failed to complete the Practice Assessment by May 9, 2019.

9. On May 16, 2019, CNO called and left a voicemail message for the Member.

10. On May 22, 2019, the Member called CNO and advised that she had not received CNO's correspondence because she was not presently living at the address on CNO's records. CNO reminded the Member of her obligation to keep CNO informed of her current address. The Member asked for another opportunity to participate in the QA Program.

11. On May 22, 2019, the Member also emailed CNO and stated that she had not received the QA program letters because she had been displaced by a fire in her apartment building in August 2018, and that her return to the building had been continuously delayed. The Member asked CNO to re-send her the QA Program letters and to allow her to proceed with the program.

12. On May 24, 2019, the QA Committee informed the Member by letter that she was being provided with another opportunity to participate in the QA Program. The Member was directed to complete the Practice Assessment Activities by June 10, 2019.

13. On May 27, 2019, CNO emailed the Member to remind her to update her address and to notify her that the May 24, 2019 letter had been sent to the Member's address on file, which she had not updated following her May 22, 2019 conversation with CNO. CNO informed the Member that if she wanted to receive the May 24, 2019 letter by email, she would have to provide her written consent. The Member subsequently updated her address with CNO, but she did not respond to CNO, nor did she complete the Practice Assessment Activities by June 10, 2019, or to date.

14. On June 18, 2019, the QA Committee decided to refer the Member to the ICRC. The QA Committee informed the Member of this decision by letter dated June 19, 2019. The letter asked the Member to make written submissions within 14 days in response to the QA Committee's decision to refer her to the ICRC. The Member did not respond or provide written submissions.

15. On July 16, 2019, the Member's name was provided to the ICRC.

16. If the Member were to testify, she would state that she had personal issues which led to her failure to complete the Practice Assessment Activities, including that she was displaced by a fire at her apartment building where her mail was delivered. However, the Member acknowledges that she has an obligation to keep her address updated with CNO and that she failed to respond to CNO's correspondence or to complete the Practice Assessment Activities even after she spoke with CNO in May of 2019.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

17. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing in that she failed to cooperate with the QA Committee or any assessor appointed by that Committee, and in particular, she failed to participate after being selected by the QA Committee for practice assessment in or about January-June 2019, as described in paragraphs 3 to 16 above.

18. 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 unprofessional, as described in paragraphs 3 to 16 above.

College Counsel's Submissions

College Counsel submitted that the Panel should accept the Agreed Statement of Facts and the Member's admissions and make findings of professional misconduct for allegations #1 and #2 and that with respect to allegation #2, the College was only seeking a finding that the Member's conduct was unprofessional.

Member's Submissions

The Member addressed the Panel and spoke of her remorse and how she would like to continue to be a nurse. The Member asked the Panel to take into consideration her displacement due to the fire in her building and any financial implications due to the penalty that might be imposed. The Member wants to make amends for her failures and to move forward.

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 nursing profession to be 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 3 to 17 in the Agreed Statement of Facts. The evidence is clear that the Member disregarded the requirements of the Quality Assurance Committee.

Allegation #2 in the Notice of Hearing is supported by paragraphs 3 to 16 and 18 in the Agreed Statement of Facts. The Panel finds that the Member's conduct in failing to participate in the Quality Assurance Program was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations.

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 3 months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for 2 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 a 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 2 meetings with a Regulatory Expert (the "Expert") at her own expense and within 6 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*, and
            2. *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;

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

4. All documents delivered by the Member to the CNO and the Expert will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

Submissions were made by College Counsel.

In the past suspensions for this conduct have usually been for one month, however, given the number of these type of cases still being referred to the Discipline Committee, the College is now seeking longer suspensions of two months to promote general deterrence.

The aggravating factors in this case were that the Member was contacted 4 times by the Quality Assurance Committee without responding which creates doubt about her governability and insight into how serious she takes her professional obligations.

The mitigating factors in this case were that the Member accepts responsibility for not updating her address with the College, cooperated with the College, agreed to the Agreed Statement of Facts and the Joint Submission on Order and showed remorse.

The proposed penalty provides for general deterrence through the suspension of the Member's certificate and sends a signal to nurses that failure to comply with the Quality Assurance Committee is serious and is not to be tolerated.

The proposed penalty provides for specific deterrence through the suspension and the reprimand which sends a clear signal of disapproval of the misconduct.

The proposed penalty provides for remediation and rehabilitation through the terms conditions and limitations on the Member's certificate, as well as meetings with the Regulatory Expert to review the professional standards and the code of conduct. The penalty is aimed at improving practice, public protection and maintaining confidence in standards and the regulatory process. The Member's

requirement to participate in the next round of Quality Assurance will reinforce the importance of continued education.

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

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

In *CNO v. Castor* (Discipline Committee, 2017) the circumstances were similar in that there was a failure to comply with the Quality Assurance Program requirements. The member was present, and the hearing proceeded on an Agreed Statement of Facts and Joint Submission on Order. The terms, conditions and limitations as well as the suspension were slightly different with the suspension being one month.

In *CNO v. Keating* (Discipline Committee, 2020) there was a failure to participate in the Quality Assurance program. The penalty imposed was the same as proposed in this case.

The Member advised the Panel that she agreed with the penalty.

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 2 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 a 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 6 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*, and
2. *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;

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

4. All documents delivered by the Member to CNO and the Expert 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 increase from a one month to a two month suspension is due to the fact there has been an unacceptable increase of nurses not participating in the Quality Assurance program. This increase will serve to deter other nurses from not participating in Quality Assurance in the future.

The penalty is 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.