DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Sherry Szucsko-Bedard, RN	Chairperson
	Andrea Arkell	Public Member
	Tim Crowder	Public Member
	Tyler Hands, RN	Member
	Mary MacNeil, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	ALYSHA SHORE for
	)	College of Nurses of Ontario
- and -	)	
	)	
TARA OGIER	)	ADRIENNE ANDERSON for
Registration No. 11443529	)	Tara Ogier
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: July 13, 2022

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 July 13, 2022, via videoconference.

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 public disclosure and banning publication or broadcasting of the name(s) of the patient(s), or any information that could disclose the identity(ies) of the patient(s) referred to orally or in any documents presented in the Discipline hearing of Tara Ogier.

The Panel considered the submissions of College Counsel and Member's Counsel and decided that there be an order preventing public disclosure and banning publication or broadcasting of the name(s) of the patient(s), or any information that could disclose the identity(ies) of the patient(s) referred to orally or in any documents presented in the Discipline hearing of Tara Ogier.

The Allegations

The allegations against Tara Ogier (the "Member") as stated in the Notice of Hearing dated April 19, 2022 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 Dryden Regional Health Centre in Dryden, Ontario, you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession when you accessed personal health information of patients without consent or other proper authorization on the dates listed in Appendix "A"; 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 Dryden Regional Health Centre in Dryden, 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 when you accessed personal health information of patients without consent or other proper authorization on the dates listed in Appendix "A".

Appendix "A"

Patient	**Date**
[Patient A]	September 13, 2018
[Patient B]	September 29, 2018
[Patient C]	September 29, 2018
[Patient D]	October 29, 2018
[Patient E]	October 29, 2018
[Patient F]	October 29, 2018
[Patient G]	October 29, 2018

Patient	Date
[Patient H]	October 29, 2018
[Patient I]	October 29, 2018
[Patient J]	December 2, 2018
[Patient K]	December 5, 2018
[Patient L]	December 5, 2018
[Patient M]	December 5, 2018
[Patient N]	December 5, 2018
[Patient O]	December 5, 2018
[Patient P]	December 5, 2018
[Patient Q]	December 5, 2018
[Patient R]	December 5, 2018

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

THE MEMBER

1. Tara Ogier (the "Member") registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on January 18, 2011. She registered as an RN in the Extended Class – Primary Health Care ("Nurse Practitioner") on February 16, 2011.

2. The Member is registered with the College of Registered Nurses of Alberta as a Nurse Practitioner with conditions.

3. The Member has no prior CNO disciplinary history.

THE FACILITY

4. The Member was employed as a full-time primary care NP with the Family Health Team at Dryden Regional Health Centre in Dryden, Ontario (the "Facility") from December 30, 2010 until her resignation on June 30, 2020.

5. The Member usually worked day shifts, from 8:30 AM until 4:30 PM, Monday to Friday, with one evening shift per week from 12:00 PM until 8:00 PM.

6. The Member attended a privacy and confidentiality training session offered by the Facility on January 11, 2017. The Member also completed the Facility's two-part workshop about the *Personal Health Information Protection Act, 2004* on October 20, 2016 and March 3, 2017, which included writing and passing a series of tests following the presentations.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

The Facility's Electronic Medical Record (EMR) Database

9. The Facility uses electronic medical records (EMRs) for all patients. The EMRs can be accessed remotely by staff through work-provided laptops and through a software application on personal mobile devices.

10. The Facility's database tracks the type of device used to access the EMRs, such as laptops, mobile devices or workstations at the Facility, and the nature of the access gained by staff for the specific EMR.

11. When staff access the database on a mobile device and search for a patient's name without opening the patient's chart, the activity will be logged as "Mobile Activity". When the patient's chart is viewed and opened, the activity will register as "Mobile Activity, Patient Viewed".

12. It was not the Facility's policy at the time of the incidents described below to remove staff members' EMR database access while on leaves of absence.

The Facility's Internal EMR Audit

13. The Member went on an extended medical leave from the Facility from August 2018 through June 2020. The Member continued to have remote access to the

EMR database. She was not assigned any patients or continuity-of-care responsibilities while on medical leave.

14. The Facility conducted an EMR database audit from December 1-17, 2018.

15. The audit results showed that the Member searched for and opened patient charts on her personal mobile device on December 2 and 5, 2018. The audit report categorized the Member's activity as "Mobile Activity, Patient Viewed".

16. In response to the results of the first audit, the Facility conducted a second expanded audit spanning August 2018 through December 2018.

17. In addition to the initial December 2018 results, the expanded audit revealed that the Member also accessed the EMR database in the following ways on the dates set out below:

- September 3, 2018 – Mobile Activity;
- September 17, 2018 – Mobile Activity;
- September 21, 2018 – Mobile Activity;
- September 29, 2018 – Mobile Activity, Patient Viewed; and
- October 29, 2018 – both Mobile Activity and Mobile Activity, Patient Viewed.

18. The Facility identified the patients impacted by the privacy breach and assessed the extent to which patients' personal health information were compromised.

19. The Facility noted that the Member cared for some of the impacted patients during their prior admissions to the Facility, but that the Member had no discernable nurse-patient relationship with others.

Inappropriately Accessed 18 Patient EMRs Without a Clinical Purpose

20. On September 13, 2018, the Member searched for and viewed Patient [A]'s chart on the EMR database and sent an encrypted note to a colleague through the Facility's messaging system regarding Patient [A]'s treatment.

21. If the Member were to testify, she would state that she intended to follow-up with one of her assigned patients before going on leave from the Facility but did not have time to do so. As a result, she entered the Facility while on leave and logged into a workstation with the specific purpose of sending a message to a nursing colleague respecting the patient's care. The Member understands, however, that this access was still inappropriate and that she accessed with patient's record without authorization.

22. On September 29, 2018, the Member entered the following patients' names into the EMR database and opened their charts without authorization, consent or a clinical purpose:

- Patient [B];
- Patient [C]; and,
- Patient [D].

23. On October 29, 2018, the Member entered the following patients' names into the EMR database and opened their charts without authorization, consent or a clinical purpose:

- Patient [E];
- Patient [F];
- Patient [G];
- Patient [H]; and,
- Patient [I].

24. On December 2, 2018, the Member entered Patient [J]'s name into the EMR database and opened their chart without authorization, consent or a clinical purpose.

25. On December 5, 2018, the Member entered the following patients' names into the EMR database and opened their charts without authorization, consent or a clinical purpose:

- Patient [K];
- Patient [L];
- Patient [M];
- Patient [N];
- Patient [O];
- Patient [P];
- Patient [Q]; and,
- Patient [R].

26. If the Member were to testify, she would state that she accessed the Facility's EMR database to check on the wellbeing of some of her patients for whom she had provided care during previous admissions to the Facility. However, the Member acknowledges that she did not have a nurse-patient relationship with all 18 patients whose EMRs she viewed, and one of the records she viewed was for a patient whom the Member knew personally.

27. If the Member were to testify, she would state that she does not recall accessing records of people she did not know or did not previously provide care. Nevertheless, the Member admits that she inappropriately accessed the Facility's EMR database when she opened and viewed 18 patient records on her personal mobile device without authorization while on extended medical leave.

28. If the Member were to testify, she would say that at the time of the incident she was experiencing some medical issues that affected her judgment. These issues have since been resolved.

29. In her response to the CNO investigation, the Member acknowledged that she breached privacy when she inappropriately accessed patient records and noted that she has taken proactive steps to educate herself since the incident occurred. The Member is committed to maintaining a reflective and accountable practice that meets the standards of the profession.

CNO STANDARDS

30. CNO's *Professional Standards* provides that each nurse is accountable to the public and responsible for ensuring their practice and conduct meets legislative requirements and the standards of the profession. It also states that nurses are responsible for their actions and the consequences of those actions and they are also accountable for conducting themselves in ways that promote respect for the profession.

31. CNO's *Professional Standards* further provides that ethical nursing care means promoting the values of patient well-being, respecting patient choice, assuring privacy and confidentiality, respecting the sanctity and quality of life, maintaining commitments, respecting truthfulness and ensuring fairness in the use of resources. It also includes acting with integrity, honesty and professionalism in all dealings with the patient and other health care team members.

32. In addition, CNO's *Professional Standards* provides that a nurse demonstrates leadership by providing, facilitating and promoting the best possible care/service to the public. A nurse demonstrates this standard by actions such as role-modelling professional values, beliefs and attributes.

33. The Member admits and acknowledges that accessing personal health information without professional purpose was a breach of CNO's *Professional Standards.*

34. CNO's *Confidentiality and Privacy: Personal Health Information* standard largely incorporates the *Personal Health Information Protection Act, 2004* ("PHIPA"). This standard requires that personal health information be kept confidential and secure. Nurses comply with this standard by accessing information for their

patients only and not accessing information for which there is no professional purpose.

35. The Member admits and acknowledges that accessing personal health information for patients without professional purpose was a breach of the *Confidentiality and Privacy: Personal Health Information* standard.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

36. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 1 of the Notice of Hearing and that she contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, as described in paragraphs 9 to 29 above.

37. The Member admits that she 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 dishonourable and unprofessional, as alleged in paragraph 2 in the Notice of Hearing and as described in paragraphs 9 to 29 above.

Submissions on liability were made by College Counsel.

College Counsel asked the Panel to make findings on all allegations and submitted three cases for consideration.

CNO v. Church-Labrie (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and involved allegations that the member accessed her own patient record as well as the health record of four patients that the member was acquainted with, but to whom she had no relationship. There was also an allegation of a verbal confrontation with a colleague about a personal matter. With respect to the privacy breach, the panel found the member breached the College's *Professional Standards* in regard to Confidentiality and Privacy similar to the Agreed Statement of Facts presented before this Panel. The panel also found the member's conduct to be unprofessional and dishonourable. The member showed a persistent disregard for her professional obligations. Her repeated access to patient records showed an element of dishonesty and deceit. College Counsel submitted that there are similar allegations in the case before this Panel and submitted the same findings should be made.

CNO v. Trudel (Discipline Committee, 2018): This case proceeded by way of an Agreed Statement of Facts. The member accessed 63 patient records without authorization and some of these records belonged to people that the member knew. Evidence was also presented that the member used information in the health record for her own purposes. The panel found the member's conduct to be unprofessional as it breached the College's *Confidentiality and Privacy – Personal Health Information* standard. The panel also found that the member's conduct was

dishonourable as it demonstrated an element of dishonesty and deceit through the repeated unauthorized access to private records over an extended period of time.

CNO v. Vaughan (Discipline Committee, 2017): This case also proceeded by way of an Agreed Statement of Facts. The member was alleged to have accessed 10 records including the health record of her friend's boyfriend. The panel found that the member breached the College's *Professional Standards* and the *Confidentiality and Privacy – Personal Health Information* standard. The panel found that the member's conduct was unprofessional and dishonourable for the same reasons as the other two cases.

The Member's Counsel made no submissions on liability.

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 unprofessional and dishonourable.

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 and 9-36 in the Agreed Statement of Facts. While on medical leave from Dryden Regional Health Centre (the "Facility") and as a result of a Facility electronic medical records ("EMR") database audit from December 1-17, 2018, the Member was found to have accessed and opened patient charts on her personal mobile device on December 2 and 5, 2018. A further audit revealed a total of eighteen patient charts were accessed between September 3, 2018 and December 5, 2018 without authorization or consent. Some of the patients had been in the care of the Member, but some had not. The Member had attended privacy and confidentially training offered by the Facility in January 2017 so she would have been reminded of her obligations related to the privacy of the patient record. The Panel also acknowledged that follow up on a chart at the start of an extended leave might be rationalized but the large number of charts accessed over multiple dates during the fall of 2018 and all without authorization was inappropriate and contravened and failed to meet the standards of practice of the profession. The College's *Professional Standards* require nurses to conduct themselves with integrity and honesty and also respect privacy and confidentiality. The *Confidentiality and Privacy: Personal Health Information*

standard requires nurses to access information for their patients only and not access information for which there is no professional purpose. While on leave, there was no professional purpose for the Member to access the patient charts, nor did she have authorization while on leave to be accessing patient records. The Panel accepted the Member's admissions that her conduct contravened and failed to comply with these standards.

Allegation #2 in the Notice of Hearing is supported by paragraphs 9-29 and 37 in the Agreed Statement of Facts, the Member's conduct was clearly relevant to the practice of nursing. While on medical leave, the Member had access to the Facility's EMR database through her employment as a Registered Nurse. Therefore, by accessing the patient charts without authorization and while on leave, the Member was acting in her professional capacity as a nurse. Accessing eighteen charts without consent or other proper authorization and while on leave was highly invasive and a violation of the *Professional Standards* and was therefore unprofessional. The Member showed a serious and persistent disregard for her professional obligations.

The Panel also finds that the Member's conduct was dishonourable. Accessing multiple patient charts over multiple dates, when the Member knew or ought to have known she had no authority to access them, demonstrated an element of moral failing. The Member also knew or ought to have known that her conduct was unacceptable and fell below the standards of a professional.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 3 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 CNO in advance of the meetings;

ii. At least 5 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,*
    2. *Confidentiality and Privacy – Personal Health Information,* and
    3. *Professional Standards*;

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 5 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 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;

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

1. that they received a copy of the required documents, and
2. that they agree to notify CNO 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.

The aggravating factors in this case were:

- The Member demonstrated a pattern of misconduct on multiple dates involving multiple patients and multiple records;
- The Member's conduct was intentional;
- The Member's conduct breached patient privacy, was dishonest and thereby breached patient trust; and
- The Member's conduct brought discredit to the profession and indicated a disregard for her professional obligations.

The mitigating factors in this case were:

- The Member is an experienced nurse with no prior discipline history with the College;
- The Member has cooperated with the College, participating honestly and completely in the process by entering into an Agreed Statement of Facts and a Joint Submission on Order with the College;
- The Member has shown remorse and taken accountability for her conduct; and
- The Member engaged in in-depth reflections and has taken proactive steps to not repeat her behaviour and to also continue with an accountable and professional nursing practice.

The proposed penalty provides for general deterrence through the 3-month suspension of the Member's certificate of registration, which will send a strong signal to members of the profession that there are serious consequences for engaging in similar misconduct.

The proposed penalty provides for specific deterrence through the oral reprimand and the 3-month suspension of the Member's certificate of registration, which will send a strong signal to the Member that this misconduct is not acceptable.

The proposed penalty provides for remediation and rehabilitation through the 2 meetings with the Regulatory Expert allowing the Member time to learn and reflect.

Overall, the public is protected through the 12 months of employer notification giving the Member the opportunity to remediate her behavior.

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

CNO v. Church-Labrie (Discipline Committee, 2020): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member accessed, without any clinical purpose, her health record and the health record of four other people she knew. The member also had a verbal confrontation with a colleague. The penalty included an oral reprimand, a 3-month suspension of the member's certificate of registration, 2 meetings with a Regulatory

Expert and 12 months of employer notification. The panel made the same finding as in the case before this Panel and as well, the Joint Submission on Order was also identical to the penalty proposed in the case before this Panel.

CNO v. Trudel (Discipline Committee, 2018): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. The member accessed sixty-three health records including those of a family member and acquaintances and used the information for her own purpose. Inappropriate access involved more patient records than presented in this case and many of the records were people the member knew personally. The penalty included an oral reprimand, a four-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification. In the case before this Panel the Member accessed only one health record of someone she knew. Unlike in the *Trudel* case, there is also no indication that the Member used the health information for her own benefit. Because of the seriousness, the *Trudel* case warranted a longer four-month suspension.

CNO v. Vaughan (Discipline Committee, 2017): This case proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. Ten patient records were accessed and only one record was someone the member knew personally. The penalty included an oral reprimand, a three-month suspension of the member's certificate of registration, two meetings with a Nursing Expert and 12 months of employer notification. The panel in the *Vaughan* case gave the same penalty as in the case before this Panel.

Submissions were made by the Member's Counsel.

The Member's Counsel submitted that the Member was an experienced and dedicated nurse who was committed to maintaining the standards of the profession. Her conduct was unfortunate and not reflective of her practice. It was a difficult time for her and she took a leave and then inappropriately accessed records. She understands that this was wrong and has reflected on her conduct. She is currently working in Alberta at a children's hospital and is an accountable member of both Colleges.

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 3 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 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 CNO in advance of the meetings;

        ii. At least 5 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,*
            2. *Confidentiality and Privacy – Personal Health Information,* and
            3. *Professional Standards*;

        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 5 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 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;

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

1. that they received a copy of the required documents, and
2. that they agree to notify CNO 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. Specifically, the oral reprimand and the 3-month suspension of the Member's certificate of registration provides for specific deterrence. The 3-month suspension of the Member's certificate of registration provides for general deterrence. The 2 meetings with a Regulatory Expert will allow for rehabilitation and remediation and the 12 months of employer notification will ensure the public is protected.

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

I, Sherry Szucsko-Bedard, 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.