DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	David Edwards, RPN	Chairperson
	Dawn Cutler, RN	Member
	Jacqueline Dillon, RPN	Member
	Devinder Walia	Public Member
	Richard Woodfield	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	DENISE COONEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
CLYSEN ELIZABETH POPO	)	VANESSA YANAGAWA for
Registration No. 9413576	)	Clysen Elizabeth Popo
	)	
	)	
	)	CHRISTOPHER WIRTH
	)	Independent Legal Counsel
	)	
	)	Heard: February 4, 2020

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee (the "Panel") on February 4, 2020, at the offices of Victory Verbatim Reporting Services Inc., 222 Bay Street, 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 or any other patient information in the Discipline hearing of Clysen Elizabeth Popo or any information that could disclose the patients identity, including a ban on the publication or broadcasting of this information.

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 or any other patient information in the Discipline hearing of Clysen Elizabeth Popo or any information that could disclose the patients identity, including a ban on the publication or broadcasting of this information.

The Allegations

The allegations against Clysen Elizabeth Popo (the "Member") as stated in the Notice of Hearing dated December 20, 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 working as a Registered Nurse at Joseph Brant Hospital (the "Hospital"), Burlington, Ontario, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession in that on or about December 28, 2017:

    a. you failed to ensure that [the Patient], received appropriate medical treatment, including but not limited to the following:

        i. you failed to appropriately monitor [the Patient] between approximately 2400-0700;

        ii. you failed to assess [the Patient] after being advised of your nursing colleague, [Nurse A]'s, intervention with respect to [the Patient];

        iii. you failed to initiate appropriate interventions after being advised of your nursing colleague, [Nurse A]'s, intervention with respect to [the Patient];

        iv. you failed to appropriately transfer accountability of [the Patient] to your nursing colleagues around 0400;

        v. you failed to initiate appropriate interventions after finding [the Patient] without vital signs around 0700; and/or

    b. you documented that you performed checks on [the Patient] at 0300, 0400, 0500, and 0600 when you had not.

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(15) of *Ontario Regulation 799/93*, in that, while employed as a Registered Nurse at the Hospital, you signed or issued, in your professional capacity, a document that you knew, or ought to have known contained a false or misleading statement, and in particular, on or about December 28, 2017, you documented that you performed hourly checks on [the Patient] at 0300, 0400, 0500, and 0600 when you had not.

3. 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 Nurse at the Hospital, 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 on or about December 28, 2017:

a. you failed to ensure that [the Patient] received appropriate medical treatment, including but not limited to the following:

   i. you failed to appropriately monitor [the Patient] between approximately 2400-0700;

   ii. you failed to assess [the Patient] after being advised of your nursing colleague, [Nurse A]'s intervention with respect to [the Patient];

   iii. you failed to initiate appropriate interventions after being advised of your nursing colleague, [Nurse A]'s, intervention with respect to [the Patient];

   iv. you failed to appropriately transfer accountability of [the Patient] to your nursing colleagues around 0400;

   v. you failed to initiate appropriate interventions after finding the Patient without vital signs around 0700;

b. you documented that you performed checks on [the Patient] at 0300, 0400, 0500, and 0600 when you had not.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a)(i), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(a)(v), 1(b); 2; 3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv), 3(a)(v) and 3(b) 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. Clysen Elizabeth Popo (the "Member") obtained a diploma in nursing from Sheridan College in 1993.

2. The Member registered with the College of Nurses of Ontario ("CNO") as a Registered Nurse ("RN") on January 19, 1994.

3. The Member was employed at Joseph Brant Hospital (the "Hospital") from January 21, 2002 until January 22, 2018.

THE PATIENT AND THE HOSPITAL

4. The Hospital is a facility located in Burlington, Ontario. It is a large, full-service acute care facility.

5. [ ] (the "Patient") was 87 years old at the time of the incident.

6. The Patient was admitted to the Hospital on December 21, 2017, for a prescheduled surgery. After his surgery, he was immediately admitted to the Hospital's ICU, and on December 27, 2017, he was transferred to the Hospital's Surgical Unit.

7. The Member was the team leader on the Surgical Unit on the December 27 to December 28, 2017 1930 to 0730 night shift. Three other nurses were assigned to the Surgical Unit that night: [Nurse A], RN, [Nurse B], RPN, and an agency nurse. The Member was assigned to provide care to the Patient.

8. On the night shift, the nurses on the Surgical Unit are given a specific patient assignment but the nurses take a team approach to caring for the patients on the unit.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

2300 to 0200: Care Provided to the Patient

9. The Member assessed the Patient around 2100 hours. She administered medication at 2300 and 2330 hours. The Member documented that she performed hourly checks on the Patient at 1200, 0100, and 0200 hours.

0300: Care Provided by [Nurse A], and Update to Member

10. At approximately 0300 hours, [Nurse A] noticed that the Patient was screaming, sweating, and breathing heavily. [Nurse A] connected nasal prongs to the Patient and increased his oxygen flow rate. The Patient became more stable and his oxygen saturation returned to normal levels.

11. The Patient asked [Nurse A] to provide breathing medication, which she administered. [Nurse A] noticed that the Patient's nasogastric tube was out of place, so she taped it in place. [Nurse A]'s interaction with the Patient lasted approximately 25 minutes.

12. [Nurse A] then provided a report to the Member about her intervention. [Nurse A] informed the Member that the Patient experienced oxygen saturation issues, that she had re-attached his nasal prongs, and repositioned his nasogastric tube.

13. The Hospital policy entitled *Medical Directive: Oxygen,* directs nurses to call the Critical Care Response Team for all patients demonstrating clinical signs of respiratory

distress. When a patient's oxygenation is less than 90%, a nurse is directed to call the Registered Respiratory Therapist to assess the patient.

14. If the Member were to testify, she would state that she relied on [Nurse A]'s report that the Patient responded to her interventions and was stable. However, the Member admits that she did not attend to and personally assess the Patient after receiving the report from [Nurse A] and did not call the Critical Care Response Team in relation to the Patient, and she ought to have done so.

15. The Member documented that she had performed an hourly check on the Patient at 0300 hours, though she admits she did not personally check on the Patient.

16. The Member went on break from approximately 0420 to 0530 hours. She did not check on the Patient before she went on break at 0400, or provide an appropriate report to her colleagues about the Patient before going on break.

17. The Member documented that she performed hourly checks on the Patient at 0400, 0500 and 0600 hours. The Member admits that she did not perform these checks.

18. Between 0620 and 0700 hours, the Member entered the Patient's room multiple times to provide care to other patients in the room. If the Member were to testify, she would state that, while providing care to the other patients, she visualized the Patient and believed he was sleeping.

19. If the Member were to testify, she would state that when she documented that the hourly checks were performed, she assumed that her nursing colleagues had performed checks, and so her documentation was to indicate that checks had been performed, but not necessarily by her. However, she acknowledges that documenting checks that she had not performed fails to meet the standard of practice with respect to documentation.

Patient without Vital Signs at 0710

20. At approximately 0710 hours, the Member went to check on the Patient and found him without vital signs. The Patient had indicated that he wanted every intervention done to attempt to save his life. The Hospital's *Code Blue Policy and Procedure* applies where staff recognize an unresponsive patient, cardiopulmonary arrest or life-threatening medical emergency, and sets out the expectation that a nurse initiate a Code Blue.

21. The Member admits that she did not initiate CPR or call a Code Blue, contrary to the Patient's wishes, and the Hospital's policy.

22. If the Member were to testify, she would state that she did not initiate cardiopulmonary resuscitation because she believed there was no reasonable prospect of resuscitation. After finding the Patient without vital signs, the Member reports that she called the on-call physician and the Patient's assigned surgeon to report the Patient's death. She acknowledges, however, that she ought to have initiated CPR and called Code Blue.

CNO STANDARDS

23. CNO has published nursing standards to set out the expectations for the practice of nursing. CNO's standards inform nurses of their accountabilities and apply to all nurses regardless of their role, job description, or area of practice.

Professional Standards

24. CNO's *Professional Standards* provide that each nurse is accountable to the public and responsible for ensuring that their practice and conduct meets legislative requirements and the standards of the profession. A nurse demonstrates this standard by:

- providing, facilitating, advocating and promoting the best possible care for [patients];
- seeking assistance appropriately and in a timely manner;
- ensuring practice is consistent with CNO's standards of practice and guidelines as well as legislation;
- taking action in situations in which [patient] safety and well-being are compromised;
- taking responsibility for errors when they occur and taking appropriate action to maintain [patient] safety.

25. In addition, the *Professional Standards* require nurses to demonstrate her/his leadership by providing, facilitating and promoting the best possible care/service to the public. A nurse demonstrates the standard by "collaborating with [patients] and the health care team to provide professional practice that respects the rights of [patients]." An RN demonstrates the standard by "coordinating for complex [patients] and demonstrating leadership when collaborating with care providers".

26. As well, each nurse is expected to continually improve the application of professional knowledge. A nurse demonstrates this standard by "using best-practice guidelines to address [patient] concerns and needs."

27. The Member admits that she contravened the *Professional Standards* through her conduct as described at paragraphs 11, 14-17, and 20 above.

***Documentation* Standard**

28. CNO's *Documentation* Standard states that:

> Nursing documentation is an important component of nursing practice and the interprofessional documentation that occurs within the [patient] health record. Documentation – whether paper, electronic, audio or visual – is used to monitor a [patient's] progress and communicate with other care providers. It also reflects the nursing care that is provided to a [patient].

29. The standard goes on to say that a nurse meets the standard by "ensuring their documentation of [patient] care is accurate, timely and complete."

30. The Member admits that she contravened the *Documentation* Standard through her conduct as described at paragraphs 15 and 17 above.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

31. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1 (a) and 1(b) of the Notice of Hearing, as described in paragraphs 12-22 above, in that the Member failed to ensure that [the Patient] received appropriate medical treatment, and that she documented that she performed checks on [the Patient] at 0300, 0400, 0500 and 0600 hours when she had not.

32. The Member admits that she committed the acts of professional misconduct as alleged in paragraph 2 of the Notice of Hearing, as described in paragraphs 15 and 17 above, and in particular, that she signed or issued, in her professional capacity, a document that she knew, or ought to have known contained a false or misleading statement when on or about December 28, 2017, she documented that she performed hourly checks on [the Patient] at 0300, 0400, 0500 and 0600 hours when she had not.

33. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a) and (b) of the Notice of Hearing, as described in paragraphs 12-22 above, and in particular, that her conduct was dishonourable and unprofessional.

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), 1(a)(ii), 1(a)(iii), 1(a)(iv), 1(a)(v), 1(b) and 2 of the Notice of Hearing. As to allegations #3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv), 3(a)(v) and 3(b), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonorable 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(a)(i) in the Notice of Hearing is supported by paragraphs 7, 8, 9, 12, 14, 15, 16, 17, 18, 19, 23, 24, 25, 26 and 27 in the Agreed Statement of Facts. The Member was specifically assigned to this patient; the staff worked in teams on this ward, and the Member was the Charge Nurse for this shift. The Member failed to ensure that the Patient received appropriate medical treatment.

Allegation #1(a)(ii) in the Notice of Hearing is supported by paragraphs 10, 11, 12, 13, 14, 15, 16, 23, 24, 25, 26 and 27 in the Agreed Statement of Facts. The Member was advised by her co-worker that the Patient's condition had deteriorated and yet failed to make her own assessment.

Allegation #1(a)(iii) in the Notice of Hearing is supported by paragraphs 13, 14, 23, 24, 25, 26 and 27 in the Agreed Statement of Facts. Hospital policies were in place to provide the Member with guidance in caring for this patient, but the Member failed to initiate the appropriate interventions. The Member admits that she did not attend to and personally assess the Patient after receiving the report from her co-worker.

Allegation #1(a)(iv) in the Notice of Hearing is supported by paragraphs 16, 23, 24, 25, 26 and 27 in the Agreed Statement of Facts. The Member was on break from 0420 until 0530, but did not check on the Patient, nor provide an appropriate report to another nurse before leaving on break.

Allegation #1(a)(v) in the Notice of Hearing is supported by paragraphs 20, 21, 22, 23, 24, 25, 26 and 27 in the Agreed Statement of Facts. The Member found the Patient without vital signs at approximately 0710 but despite the Patient indicating that he wanted every intervention to be done, the Member did not initiate cardiopulmonary resuscitation or call a Code Blue because she believed there was no reasonable prospect of resuscitation.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 15, 16, 17, 19, 23, 24, 25, 26, 27, 28, 29 and 30 in the Agreed Statement of Facts. When a nurse signs her name to a document it means that she was responsible for the actual work done. If the Member were to testify, she would state that when she documented that the hourly checks were performed, she assumed that her nursing colleagues had performed the checks. This constitutes an act of professional misconduct.

Allegation #2 in the Notice of Hearing is supported by paragraphs 15, 17, 19, 23, 24, 27, 28, 29 and 30 in the Agreed Statement of Facts. The Member signed or issued, in a professional capacity, a document that she knew, or ought to have known contained a false or misleading statement, and in particular, on or about December 28, 2017, she documented that she performed hourly checks on the Patient at 0300, 0400, 0500 and 0600 when she clearly had not.

With respect to Allegations #3(a)(i), 3(a)(ii), 3(a)(iii), 3(a)(iv), 3(a)(v) and 3(b), the Panel finds that the Member's conduct was unprofessional as it demonstrated a serious and persistent disregard for her professional obligations, by not assessing the Patient when her co-worker informed her of a change in his condition and documenting that the hourly checks were performed when she did not perform them.

The Panel also finds that the Member's conduct was dishonourable as she knew or ought to have known that her conduct was unacceptable and fell well below the standards of a professional. The Member did not perform an assessment on the Patient when his condition changed, she went on break without checking on him or giving an appropriate report to a co-worker and documented hourly checks on the Patient that she did not perform.

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 three months of the date that this Order becomes final.

2. Directing the Executive Director to suspend the Member's certificate of registration for three months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practicing class.

3. Directing the Executive Director to impose the following terms, conditions and limitations on the Member's certificate of registration:

    a) The Member will attend a minimum of two meetings with a Regulatory Expert (the "Expert") at her own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 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 in advance of the meetings;

        ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and
            5. if available, a copy of the Panel's Decision and Reasons;

        iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

            1. *Code of Conduct,*
            2. *Professional Standards*, and
            3. *Documentation;*

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

        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 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 CNO, the Expert or the employer(s) will be delivered by verifiable method, the proof of which the Member will retain.

Penalty Submissions

College Counsel submitted that the mitigating factors in this case were that the Member had a long and unblemished career and this was the first complaint either at the College, or through her workplace, and the errors were an anomaly and not reflective of who she was as a nurse. She took responsibility for her mistakes, expressed remorse and accepted accountability by way of an Agreed Statement of Facts and a Joint Submission on Order.

The aggravating factors in this case were that the Member showed serious disregard for her obligations to care for this Patient in failing to assess him after being notified that his condition had changed, failing to check him the rest of the night and documenting checks without actually seeing the patient.

The proposed penalty provides for general deterrence through a three month suspension. This sends a clear message to the profession that failure to meet one's professional obligations can result in serious disciplinary sanctions.

The proposed penalty provides for specific deterrence through a three month suspension. As well, the oral reprimand will assist the Member in gaining a greater understanding of how her actions are perceived by both the profession and the public.

The proposed penalty provides for remediation and rehabilitation through two meetings with a nursing expert, the review of the College's publications and the completion of the Reflective Questionnaires and on-line participation forms. These requirements will help to deepen the Member's understanding of her misconduct and will help to ensure that this conduct is not repeated.

The terms, conditions and limitations on the Member's certificate indicate to the membership and the public that this type of behaviour is taken very seriously by the College and sends a strong message that this is a profession that is capable of governing itself and will provide monitoring of the Member's practice and conduct.

Overall, the public is protected because this process will assist the Member in gaining additional insight and knowledge into her practice. This will inform her practice in the future. The eighteen month employer notification will ensure that the Member's practice is monitored for a significant time when she returns to nursing after her suspension.

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

CNO v Nkwelle (Discipline February 13, 2018)

The hearing proceeded with an Agreed Statement of Facts and Joint Submission on Order. Similarities include that the member failed to ensure 15 minute checks were carried out on his patient, he documented completion of the close observation checks not actually done and withdrew himself from service when he rested while on duty. The patient was found to have committed suicide on the member's shift. The member received a reprimand, a three month suspension and terms and conditions on his certificate of registration, including twelve months of employer notification.

CNO v Hoare (Discipline October 23, 2018)

This hearing also proceeded with an Agreement and a Joint Submission on Order. The member in this case inappropriately assessed a patient who had arrived in his emergency room with cardiac complaints. He also inappropriately disposed of one or more ECG's by crumpling them up and throwing them in the waste basket, instead of properly disposing of the confidential material. This patient also succumbed to his cardiac issues while in the care of the member. The member received a reprimand, a three month suspension and similar terms and conditions on his certificate of registration.

CNO v Blum (Discipline February 5, 2019)

This hearing proceeded by way of an Agreed Statement of Facts and a Joint Submission on Order. In this case, the member admitted that she did not take adequate steps to assess, intervene, seek assistance and/or de-escalate the patient's behaviour, which included banging his head and body and using the call bell. The member received a reprimand, a three month suspension and similar terms and conditions on her certificate of registration.

The Member's Counsel submitted that there were mitigating circumstances in that the Member had a sixteen year career at the hospital with hundreds of patients. This was a first complaint and the Member has no workplace discipline history. The errors were an anomaly. The Member admitted her mistakes, has taken responsibility and accepts 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 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 three months. This suspension shall take effect from the date that this Order becomes final and shall continue to run without interruption as long as the Member remains in the practicing class.

3. The Executive Director is directed to impose the following terms, conditions and limitations on the Member's certificate of registration:

a) The Member will attend a minimum of two meetings with a Regulatory Expert (the "Expert") at her own expense and within six months from the date that this Order becomes final. If the Expert determines that a greater number of session are required, the Expert will advise the Director of Professional Conduct (the "Director") regarding the total number of sessions that are required and the length of time required to complete the additional sessions, but in any event, all sessions shall be completed within 12 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 in advance of the meetings;

   ii. At least seven days before the first meeting, the Member provides the Expert with a copy of:

      1. the Panel's Order,
      2. the Notice of Hearing,
      3. the Agreed Statement of Facts,
      4. this Joint Submission on Order, and
      5. if available, a copy of the Panel's Decision and Reasons;

   iii. Before the first meeting, the Member reviews the following CNO publications and completes the associated Reflective Questionnaires, online learning modules, decision tools and online participation forms (where applicable):

      1. *Code of Conduct,*
      2. *Professional Standards*, and
      3. *Documentation;*

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

   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 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 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. Nurses are responsible for their actions and the consequences of their actions. Nurses are accountable for conducting themselves in ways that promote respect for the profession. Members of the profession will be reminded that there can be serious, tragic and irreversible consequences when hospital policies and College standards are not followed.

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

I, David Edwards, RPN, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.