DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:
Carly Gilchrist, RPN Chairperson
Sylvia Douglas Public Member
Deborah Graystone, NP Member
Terah White, RPN Member
Richard Woodfield Public Member

BETWEEN:
COLLEGE OF NURSES OF ONTARIO)
- and - )
) JEAN-CLAUDE KILLEY for
) College of Nurses of Ontario
) TAMARA WHYTE )
Registration No. JD03006 ) REBECCA YOUNG for
) Tamara Whyte
) ) CHRISTOPHER WIRTH
) Independent Legal Counsel
) ) Heard: February 25, 2020

DECISION AND REASONS

This matter came on for hearing before a Panel of the Discipline Committee (the “Panel”) on February 25, 2020 at the College of Nurses of Ontario (the “College”) at Toronto.

Publication Ban

College Counsel brought a motion pursuant to s. 45(3) of the Health Professions Procedural Code of the Nursing Act, 1991, for an order preventing the public disclosure, including a ban on the publication or broadcasting of the identity of the patient in the Discipline hearing of Tamara Whyte or any information that could disclose the patient’s identity, including any reference to the patient’s name contained in the allegations in the Notice of Hearing and in any exhibits filed with the Panel.

The Panel considered the submissions of the Parties and decided that there be an order preventing the public disclosure, including a ban on the publication or broadcasting of the identity of the patient in the Discipline hearing of Tamara Whyte or any information that could disclose the patient’s identity, including any reference to the patient’s name contained in the allegations in the Notice of Hearing and in any exhibits filed with the Panel.
The Allegations

College Counsel advised the Panel that the College was seeking leave to withdraw the allegations set out in paragraphs 1(c), 2(a) and 3(c) of the Notice of Hearing. The Panel permitted these allegations to be withdrawn.

The remaining allegations against Tamara Whyte (the “Member”) as stated in the Notice of Hearing dated January 17, 2020 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 practising as a Registered Practical Nurse at Bendale Acres Long-Term Care Home, you contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, and in particular, on or about June 15, 2016, while assigned to provide care to [the Patient], you:

(a) failed to assess the client’s blood pressure, vital signs, blood glucose levels, and/or level of consciousness, in circumstances where such assessments were indicated, and/or you failed to document such assessments;

(b) failed to assess and/or respond to changes in the client’s health condition throughout the shift;

(c) [Withdrawn];

(d) failed to review [the Patient’s] health records from her stay in hospital and/or to contact the hospital to obtain information with respect to her care there;

(e) failed to transfer [the Patient] to the hospital;

(f) failed to report accurately the change in the client’s condition to the client’s daughter and/or to co-workers; and/or

(g) failed to document vital signs assessed at around 1615 hrs until around 2300 hrs;

2. (a) [Withdrawn];

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 practising as a Registered Nurse at Bendale Acres Long-Term Care Home, 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, and in particular:
Member’s Plea

The Member admitted the allegations set out in paragraphs 1(a), (b), (d), (e), (f) and (g) and allegations 3(a), (b), (d), (e), (f) and (g) 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 admissions were 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. Tamara Whyte (the “Member”) obtained a certificate in nursing from George Brown College in 2002.

2. The Member registered with the College of Nurses of Ontario (“CNO”) as a Registered Practical Nurse (“RPN”) on June 24, 2004.

3. The Member was hired by the City of Toronto on August 11, 2004 and worked at other facilities before working at Bendale Acres (the “Facility”). The Member was employed at the Facility for less than a year when her employment was terminated on August 31, 2016 as a result of the incident described below.
PRIOR HISTORY

4. The Member has no prior disciplinary findings with CNO.

THE FACILITY

5. The Facility, located in Toronto, Ontario, is a Long-Term Care Home.

6. The Member worked on the 5th floor of the Facility as a full-time staff nurse during the evening shift.

THE PATIENT

7. [ ] (the “Patient”) was 65 years old at the time of the incidents.

8. The Patient was admitted to the Facility on [ ]. The Patient used an electric scooter. The Patient would often go out of the Facility and was able to organize a transit bus on her own.

INCIDENT RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

9. On June 14, 2016, the Patient organized a transit bus to pick her up and drop her back off at the Facility. Upon her return, the Patient suffered a fall while disembarking from the transit bus outside of the Facility. Following the fall, the Patient was transferred to the hospital, where she stayed overnight. The Patient returned to the Facility during the afternoon on June 15, 2016.

10. The Patient was received into care by [ ], a Registered Nurse (“RN”). The Patient’s progress notes by [the RN] record that over the span of about two hours after the Patient returned from the hospital, she was “confused and sleepy”, and “groggy and incoherent.”

11. The Member worked the evening shift at the Facility that day from 1500hrs to 2300hrs. The Member was assigned to provide primary care to the Patient. The Member knew the Patient well and was familiar with the Patient’s health issues, such as the fact that the Patient was diabetic.

12. At the start of the Member’s shift, the Member received a report from the day shift RN, [the RN]. [The RN] advised the Member that she should monitor the Patient for confusion, for low blood pressure, and that she should follow-up on medications that were ordered, administering them as soon as they arrived.

13. The Member failed to document and/or complete any monitoring of the Patient for confusion. The Member only assessed the Patient’s vital signs and blood pressure around 1615hrs and she did not document these vital signs and blood pressure until approximately 2300hrs.
14. At approximately 2200hrs, a Personal Support Worker (“PSW”), [ ] asked the Member, the RN-In-Charge Annie Campeau, and [ ] (another PSW) to assist with a four-person turn. Ms. Campeau administered a B12 shot to the Patient at this time, and did not document any concerns about the Patient’s condition during that interaction.

15. The Member made one progress note regarding the Patient at the end of her shift at 2300hrs. The Member’s progress note documented the Patient’s poor condition. The progress note states that the Patient was unable to eat, drink or take medication due to incoherence and noted that the Patient was confused. As documented on the Member’s progress note, the Patient’s condition required assessment and follow-up that the Member failed to perform in this case.

16. The Member failed to assess and/or respond to changes in the Patient’s condition throughout the shift and she failed to assess the Patient’s blood glucose levels, and/or level of consciousness.

17. The Member did not review the Patient’s health records from her stay in the hospital or otherwise contact the hospital to assist in assessing the changes in the Patient’s condition, nor did the Member send the Patient to the hospital.

18. The standards of practice required that the Member act on her observations of the Patient’s serious and deteriorating condition. The courses of action available to the Member to escalate the concerns about the Patient’s condition which the Member did not complete, included, without limitation:
   - verifying the medications administered to the Patient while in the hospital including by reviewing the Patient’s records from her stay in the hospital and/or contacting the hospital, if necessary;
   - assessing the Patient herself for confusion; and
   - sending the Patient to the hospital.

19. During the course of the day, the Member spoke to the Patient’s daughter. A note was left for the Member to contact the Patient’s daughter to get consent to order a medication. The Member contacted the daughter for this purpose and also would say that she told her that the Patient was sleepy and hadn’t eaten. The Member told the Patient’s daughter that she would contact her if there was a change in the Patient’s condition. The Member did not call the daughter back before the end of her shift.

20. At the end of her shift at 2300hrs, the Member provided a report to the oncoming RPN and described the Patient as being in poor condition, incoherent, unable to eat or drink, and left a note in the communication book stating that the family was to be updated of the Patient’s condition.

21. The Patient’s daughter understood from her call with the Member that the Member would call her back after checking on the Patient to let her know of any concerns about
the Patient’s condition. Because the Member did not call her back, the Patient’s daughter assumed the Patient’s condition was fine. If the Member were to testify, she would say that she told the Patient’s daughter she would be updated on the Patient’s condition, which is why the Member left a note in the communication book for the oncoming nurse to update the Patient’s daughter. The Member regrets this miscommunication and accepts responsibility for the failure to provide the daughter with an accurate update on the Patient’s condition.

22. By 0700, the Patient was no longer responding to verbal, touch or pain stimuli. The Patient was sent to hospital by oncoming day shift staff shortly thereafter. The Patient’s family was notified.

23. The Patient died in hospital approximately 1130hrs.

24. If the Member were to testify, she would say that she takes responsibility, and is remorseful for, her actions and omissions in this matter, and that this has been an immense learning experience for her.

25. The Member would testify that she has reflected upon this matter and has undertaken a proactive review of the relevant CNO publications, in an effort to enhance and improve her practice.

CNO STANDARDS

26. CNO’s Professional Standards provides that each nurse is accountable to the public and responsible for ensuring her or his practice and conduct meets the legislative requirements and the standard of practice of the profession. A nurse demonstrates this standard by actions such as:

a. providing, facilitating, advocating and promoting the best possible care for clients;

b. assessing/describing the client situation using a theory, framework or evidence-based tool and identifying/recognizing abnormal or unexpected client responses and taking action appropriately;

c. advocating on behalf of clients;

d. seeking assistance appropriately and in a timely manner;

e. taking action in situations in which client safety and well-being are compromised; and

f. evaluating/describing the outcomes of specific interventions and modifying the plan/approach.
27. CNO’s *Documentation* standard provides that nurses are accountable for ensuring their documentation of client care is accurate, timely and complete.” The standard further clarifies that a nurse meets the standard by:

- a. Ensuring documentation is a complete record of nursing care provided and reflects all aspects of the nursing process, including assessment, planning, intervention (independent and collaborative) and evaluation;
- b. Documenting significant communication with family members/significant others, substitute decision-makers and other care providers;
- c. Documenting in a timely manner and completing documentation during, or as soon as possible after, the care or event;
- d. Indicating when an entry is late as defined by organizational policies; and
- e. Ensuring that relevant client care information is captured in a permanent record.

**ADMISSIONS OF PROFESSIONAL MISCONDUCT**

28. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1(a) with respect to failing to assess blood glucose levels and/or level of consciousness, 1(b), 1(d), 1(e), 1(f) insofar as it relates to reporting to the Patient’s daughter, and 1(g) of the Notice of Hearing in that she contravened a standard of practice of the profession or failed to meet the standards of practice of the profession, as described in paragraphs 9 to 27 above.

29. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 3(a) with respect to failing to assess blood glucose levels and/or level of consciousness, 3(b), 3(d), 3(e), 3(f) insofar as it relates to reporting to the Patient’s daughter, and 3(g) of the Notice of Hearing, and in particular her conduct was dishonourable and unprofessional, as described in paragraphs 9 to 27 above.

**OTHER**

30. With leave of the Panel of the Discipline Committee, CNO withdraws the remaining allegations in the Notice of Hearing, which are as follows:

- 1(c);
- 2(a); and
- 3(c).

**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) with respect to failing to
assess blood glucose levels and level of consciousness, (b), (d), (e), (f) insofar as it relates to reporting to the patient’s daughter and (g) of the Notice of Hearing. As to Allegations #3(a) with respect to failing to assess blood glucose levels and level of consciousness, (b), (d), (e), (f) insofar as it relates to reporting to the patient’s daughter and (g) the Panel finds that the Member engaged in conduct that would reasonably be considered 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(a) in the Notice of Hearing is supported by paragraphs 9 to 18 and 26 to 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to assess the client’s blood glucose levels, and level of consciousness, in circumstances where such assessments were indicated.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 9 to 20 and 26 to 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to assess and respond to changes in the client’s health condition throughout the shift.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs 9 to 11, 17, 18, 24, 25, 26 and 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to review the client’s health records from her stay in hospital and contact the hospital to obtain information with respect to her care there.

Allegation #1(e) in the Notice of Hearing is supported by paragraphs 11, 12, 13, 15, 16, 17, 18, 20, 24, 26 and 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to transfer the client to the hospital.

Allegation #1(f) in the Notice of Hearing is supported by paragraphs 10 to 24, 26 and 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to report accurately the change in the client’s condition to the client’s daughter.

Allegation #1(g) in the Notice of Hearing is supported by paragraphs 11, 12, 13, 15, 16, 24, 26 and 27 in the Agreed Statement of Facts. The Panel makes a finding of professional misconduct in that the Member failed to document vital signs assessed at around 1615 hrs. until around 2300 hrs.

With respect to Allegations #3(a), (b), (d), (e), (f) and (g) in the Notice of Hearing, the Panel finds that the Member’s conduct was unprofessional as she failed to live up to the standards expected of the profession by demonstrating a serious and persistent disregard for her professional obligations. The Panel also finds the Member’s conduct was dishonourable in that she demonstrated an element of moral failing and ought to have known that her actions fell well below the standards of the profession.

The Member failed to assess the client’s blood glucose levels and level of consciousness in circumstances where such assessments were indicated. The Member failed to assess and respond to changes in the
client’s health condition throughout the shift. The Member failed to review the client’s health records from her stay in hospital and contact the hospital to obtain information with respect to her care there. The Member failed to transfer the client to the hospital. The Member failed to report accurately the change in the client’s condition to the client’s daughter. The Member also failed to document vital signs assessed at around 1615 hrs. until around 2300 hrs. This conduct is supported by paragraphs 9 to 29 of the Agreed Statement of Facts.

**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 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 a minimum of 2 meetings with a Regulatory Expert (the “Expert”) at her own expense and within 6 months from the date that this Order becomes final. If the Expert determines that a greater number of sessions 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 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*,
2. *Documentation*
3. *Code of Conduct*,

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

viii. Within 12 months from the date that this Order becomes final, or a longer time period as approved by the Director, the Member shall successfully complete at her own expense, with a minimum passing grade of 65%, a nursing course with clinical or laboratory or other practical components that have received prior approval from the Director regarding: health assessment. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%.
b) For a period of 24 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.

4. All documents delivered by the Member to the 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 and the Member’s Counsel.

College Counsel submitted that this penalty is responsive to the objectives of general deterrence aimed at the profession at large and specific deterrence aimed at the Member. The penalty also provides for rehabilitation and remediation of the Member and the oral reprimand is a denunciation which signals to the profession that such conduct is unacceptable. Protection of the public is maintained through the suspension of the Member’s certificate, the rehabilitation and remediation requirements placed on the Member, and the restrictions placed on the Member’s practice, as well as the 24 month employer notification. All terms of this penalty help to maintain public confidence in the College.

The mitigating factors in this case were:
- The Member admitted misconduct and expressed remorse and accepts responsibility for her conduct; this demonstrated insight into the issues.
The aggravating factors in this case were:

- There was a significant consequence to the patient, however College Counsel emphasised that there was no causal link between the Member’s conduct and the outcome for the patient and that there needs to be consideration of the situation as a whole.

The proposed penalty provides for general deterrence through the 24 month employer notification, and 3 month suspension of the Member’s certificate.

The proposed penalty provides for specific deterrence through the 3 month suspension of the Member’s certificate, an oral reprimand and 24 month employer notification.

The proposed penalty provides for remediation and rehabilitation through 2 meetings with a Regulatory Expert, completion of the Reflective Questionnaires and completion of a nursing course with clinical or laboratory or other practical components.

Overall, the public is protected through the Member’s 3 month licence suspension, 24 month employer notification of the discipline decision and through rehabilitation and remediation of the Member.

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. Campeau_ (Discipline Committee, 2020). College Counsel submitted this recent case involving the same patient but this member was involved in the situation prior to the hospital visit. It was also noted that this decision has not yet been published. Similarities include the failure of the member to assess the patient, identify significant changes to the patient’s condition, review health records of the patient from her hospital visit and failure to transfer the patient to hospital. Penalty similarities are the 3 month certificate suspension of the member, 2 meetings with a Regulatory Expert and an oral reprimand. The member in this case received an employer notification of 12 months.

_CNO v. Williams_ (Discipline Committee, 2014). Similarities in this case include the member’s failure to document the patient’s change in condition and to provide appropriate measures to intervene in patient care when required. Penalty differences include 3 meetings with a Nursing Expert, a 2 month certificate suspension. Penalty similarities include a 24 month employer notification and an oral reprimand.

_CNO v. Alleyne_ (Discipline Committee, 2012). This case is similar in that it involved an RPN who failed to assess the patient’s vitals and document the patient assessment. The similarity of facts to the present case is that the member failed to recognize the clinical instability of the patient. Penalty similarities include a 3 month certificate suspension, oral reprimand and completion of a nursing course. Penalty difference is an 18 month employer notification compared to this Member’s 24 month employer notification.

_CNO v. Sicar_ (Discipline Committee, 2011). Similarities involved the member’s failure to recognise changes in the patient’s clinical condition, failure to document a complete initial assessment and failure to intervene and initiate the required immediate medical intervention. The differences in this case were that the member was an RN and was working in an outpatient clinic setting. Penalty similarities
include an oral reprimand and completion of a nursing course. Penalty differences in this case are a 5 month certificate suspension compared to a 3 month suspension of this Member and a 12 month employer notification compared to a 24 month suspension.

Member’s Counsel submitted the following for the Panel’s consideration:
- The Member is a single mother of 2 children;
- The Member has no previous history with the College;
- The Member has undertaken a proactive review by agreeing to meet with a Regulatory Expert and by agreeing to take the nursing course as required;
- The Member has demonstrated remorse;
- There is no causal link between the conduct of the Member and the patient outcome.

**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 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 a minimum of 2 meetings with a Regulatory Expert (the “Expert”) at her own expense and within 6 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 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*,
2. *Documentation*
3. *Code of Conduct*,

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

viii. Within 12 months from the date that this Order becomes final, or a longer time period as approved by the Director, the Member shall successfully complete at her own expense, with a minimum passing grade of 65%, a nursing course with clinical or laboratory or other practical components that have received prior approval from the Director regarding: health assessment. The Member must provide the Director with proof of enrolment and successful completion of the courses with a minimum passing grade of 65%. 
b) For a period of 24 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.

4. All documents delivered by the Member to the 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.

The Panel accepts that specific deterrence is satisfied through the oral reprimand, the 3 month certificate suspension and 24 month employer notification.
The Panel accepts that general deterrence is satisfied through the 3 month certificate suspension and 24 month employer notification. This sends a strong message to the profession at large that this conduct will not be tolerated by the College.

The Panel accepts that rehabilitation and remediation of the Member is satisfied through the 2 meetings with a Regulatory expert, completion of a nursing course and review of standards and completion of Reflective Questionnaires.

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

I, Carly Gilchrist, 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.