DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:	Grace Fox, NP	Chairperson
	Dawn Cutler, RN	Member
	Catherine Egerton	Public Member
	Carly Gilchrist, RPN	Member
	Margaret Tuomi	Public Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	NICK COLEMAN for
	)	College of Nurses of Ontario
- and -	)	
	)	
NDIRIKA OZUEH	)	EMIR CROWNE for
Reg. No. JI737984	)	Ndirika Ozueh
	)	
	)	
	)	JUSTIN SAFAYENI
	)	Independent Legal Counsel
	)	
	)	
	)	Heard: August 28, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on August 28, 2017 at the College of Nurses of Ontario ("the College") at Toronto.

The Allegations

Counsel for the College advised the panel that the College was requesting leave to withdraw the allegations set out in paragraphs 1(e),1(g); 3; 4; 6(e) and 6(g) of the Notice of Hearing dated June 22, 2017. The panel granted this request. The remaining allegations against Ndirika Ozueh (the "Member") 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 engaged in the practice of nursing at The Beauty Lounge in Toronto, Ontario, you contravened a

standard of practice of the profession or failed to meet the standard of practice of the profession with respect to the following incidents:

(a) administering injections of Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional;

(b) selling Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional;

(c) failing to obtain, carryout, and/or document any pre-treatment assessment and/or authorization by a physician or other qualified health care professional for Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table A;

(d) failing to obtain and/or document client contact and/or medical history information in relation to Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table B;

(e) [*Withdrawn*]

(f) misusing the protected title of Registered Nurse on consent forms for Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table A; and/or

(g) [*Withdrawn*]

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(13) of *Ontario Regulation 799/93*, in that, while engaged in the practice of nursing at The Beauty Lounge in Toronto, Ontario, you failed to keep records as required with respect to the following incidents:

(a) failing to document any pre-treatment assessment and/or authorization by a physician or other qualified health care professional for Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table A; and/or

(b) failing to document client contact and/or medical history information in relation to Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table B.

3. [*Withdrawn*]

4. [*Withdrawn*]

5. 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(19) of *Ontario Regulation 799/93*, in that, while engaged in the practice of nursing at The Beauty Lounge in Toronto, Ontario, you contravened a provision of the Act, the *Regulated Health Professions Act, 1991* and/or the regulations under either of those Acts, and in particular, section 27 of the *Regulated Health Professions Act*, *1991*, S.O. 1991, c. 18, and/or section 5 of the *Nursing Act, 1991*, S.O. 1991, c.32, with respect to the following incidents:

(a) performing the controlled acts of administering injections of Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional; and/or

(b) performing the controlled acts of selling Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional.

6. 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 engaged in the practice of nursing at The Beauty Lounge in Toronto, Ontario, you engaged in conduct or performed an act, relevant to the practice of nursing, that, having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional with respect to the following incidents:

(a) administering injections of Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional;

(b) selling Botox and/or dermal fillers to numerous clients in 2015, including the clients listed in Table A, without authorization from a physician or other qualified health care professional;

(c) failing to obtain, carryout, and/or document any pre-treatment assessment and/or authorization by a physician or other qualified healthcare professional for Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table A;

(d) failing to obtain and/or document client contact and/or medical history information in relation to Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table B;

(e) [*Withdrawn*];

(f) misusing the protected title of Registered Nurse on consent forms for Botox and/or dermal filler injections administered to numerous clients in 2015, including the clients listed in Table A; and/or

(g) [*Withdrawn*]

Table A

Patient	**Date of Injection (on or about)**
[Client A]	January 7, 2015
[Client B]	January 8, 2015
[Client C]	January 8, 2015
[Client D]	January 15, 2015
[Client E]	January 30, 2015
[Client F]	March 24, 2015
[Client G]	March 24-25, 2015 and/or September 8, 2015
[Client H]	April 1, 2015
[Client I]	April 4, 2015 and/or April 7, 2015
[Client J]	May 20, 2015 and/or August 10, 2015
[Client K]	July 9, 2015
[Client L]	July 23, 2015
[Client M]	July 30, 2015
[Client N]	September 2, 2015
[Client O]	September 10, 2015
[Client P]	September 17, 2015 and/or September 25, 2015
[Client Q]	October 22, 2015
unknown	October 22, 2015
[Client R]	November 9, 2015 and/or November 10, 2015
[Client S]	November 10, 2015

Table B

Patient	**Date of Injection (on or about)**
[Client A]	January 7, 2015
[Client B]	January 8, 2015
[Client C]	January 8, 2015
[Client D]	January 15, 2015
[Client E]	January 30, 2015

[Client F]	March 24, 2015
[Client G]	March 24-25, 2015 and/or September 8, 2015
[Client H]	April 1, 2015
[Client I]	April 4, 2015 and/or April 7, 2015
unknown	October 22, 2015

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a),(b),(c),(d),(f); 2(a),(b); 5(a),(b); 6(a),(b),(c),(d) and (f) in the Notice of Hearing. With respect to the allegations at 6(a),(b),(c),(d) and (f), the Member admitted that her conduct would reasonably be regarded as dishonourable and unprofessional. The panel received a written plea inquiry which was signed by the Member. The panel also conducted an oral plea inquiry and was satisfied that the Member's admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

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

THE MEMBER

1. Ndirika Ozueh (the "Member") obtained a diploma in nursing from Humber College in 2009.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Practical Nurse ("RPN") on July 20, 2009.

THE CLINIC

3. The Member operates The Beauty Lounge (the "Clinic"), where she provides Botox injections, dermal fillers and other cosmetic procedures to clients.

4. The Clinic is located in Toronto, Ontario.

RELEVENT LEGISLATION

5. The controlled acts set out in the *Regulated Health Professions Act, 1991*, section 27(2), include prescribing a drug, selling a drug and administering a substance by injection.

6. The *Nursing Act, 1991*, section 4, paragraph 2 provides that a nurse may administer a substance by injection or inhalation. However, a nurse cannot initiate the procedure unless authorized by the regulations or authorized by a physician or other prescriber. In

particular, an RPN can only administer a substance by injection if authorized by a physician or other prescriber. The authorization may be by medical directive for patients who meet the criteria specified in the directive, or by medical order regarding a specific patient.

7. The *Nursing Act, 1991*, section 4.1 provides that a nurse in the extended class may prescribe or sell a drug in accordance with the regulations. However, an RPN cannot perform the controlled acts of prescribing or selling a drug unless the controlled act is delegated by a physician or other health care professional authorized to perform the controlled act.

8. *Ontario Regulation 274/94*, section 33 (under the *Nursing Act, 1991*) provides that a member can only accept delegation of a controlled act in accordance with the regulation. *Ontario Regulation 274/94*, sections 41-42, stipulate that certain details must be recorded by a nurse to whom a controlled act has been delegated, including the date of the delegation, the delegator's name and the conditions, if any, applicable to the delegation.

COLLEGE STANDARDS

9. The College's Practice Standard on *Medication, Revised 2008* (in effect to April 2015) provided, at page 6, that "nurses prepare and administer medication(s) to clients in a safe, effective and ethical manner." The College's Practice Standard on *Medication, Revised 2015* (in effect from May 2015) provided, at page 3, that "nurses must have the necessary authority to perform medication practices."

10. The College's Practice Standard on *Documentation, Revised 2008* provides, at page 6, that "nurses ensure that documentation presents an accurate, clear and comprehensive picture of the client's needs, the nurses interventions and the client's outcomes."

11. The College's Guideline on *Independent Practice* provides, at page 4, that, "… if your nursing practice involves client interaction with individual clients, you should not: offer discounts or coupons for your services, provide promotional offers, or charge fees in advance for a service you have not yet provided."

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

12. As noted above, the Member operates the Clinic where Botox and dermal fillers are injected.

13. Botox is a prescription medication, typically used cosmetically to smooth facial wrinkles between the eyebrows and around the eyes. Dermal (soft tissue) fillers are also administered by injection for cosmetic purposes to smooth out facial and other skin wrinkles or to enhance physical features.

14. In 2015, the Member had contracts with three physicians – [Doctor A], [Doctor B] and [Doctor C] – in which they provided delegation to the Member to perform controlled acts associated with Botox and dermal filler injections. According to the physicians, the arrangements provided for the physicians to conduct an initial consultation with each

client and, if appropriate, to give authorization over the phone, Skype or via FaceTime for the Member to administer the injections. The delegations were not by medical directive so a specific delegation was required for each patient.

15. The client records from the Clinic show that the Member administered Botox injections to the 20 clients listed in Table A to the Notice of Hearing dated June 22, 2017 ("Notice of Hearing").

16. The Member documented the quantity of Botox or dermal filler injected. However, she did not document any authorization from a physician or any record of any communication between the physician and the client. Furthermore, there was no documentation to indicate that the Member assessed the clients prior to administering Botox. For the clients listed in Table B to the Notice of Hearing, the Member also failed to record the client's medical history and/or contact information in the chart.

17. The clients interviewed by the College denied that they had ever spoken to a physician about the Botox and dermal filler injections, either in person, by telephone call, Skype or FaceTime. Specifically, they recalled interactions with the Member and other staff at the Clinic but no interactions by telephone call, Skype or FaceTime with a physician.

18. The Member also performed the controlled act of selling Botox to clients, without documenting the delegation of the controlled acts to the Member.

19. If the Member were to testify, she would say that it was her practice to obtain a verbal order authorizing the injection from a physician, either by telephone, Skype or via FaceTime. She would acknowledge, however, that a delegation of controlled acts, if obtained, should have been documented. The Member further acknowledges that undocumented delegations of controlled acts would be invalid under the *Nursing Act* regulation because she failed to record the details regarding the delegation, as required. The Member would also acknowledge that the physicians did not communicate directly with the clients listed in Table A, by telephone, Skype, FaceTime, or any other means, regarding the injections.

20. The Member used a standard form consent for the injections. The consent form signed by the clients listed in Table A to the Notice of Hearing used the protected title of Registered Nurse ("RN") to identify the health care professional who might administer the injections. The consent form did not indicate that the injections might be administered by an RPN. The Member administered the injections but, as noted above, she is an RPN not an RN.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

21. The Member admits that she committed the acts of professional misconduct as described in paragraphs 12-20 above, and as alleged in Notice of Hearing in the following paragraphs:

    - 1(a), (b), (c), (d) and (f)
    - 2(a) and (b)

- 5(a) and (b).

22. The Member also admits that she committed the acts of professional misconduct as alleged in paragraphs 6 (a), (b), (c), (d) and (f) of the Notice of Hearing, and in particular, that her conduct was dishonourable and unprofessional, as described in paragraphs 12-20 above.

23. With leave of the panel of the Discipline Committee, the College withdraws allegations 1(e), 1(g), 3, 4, 6(e) and 6(g) of the Notice of Hearing.

Decision

The panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a),(b),(c),(d) (f); 2(a),(b); 5(a) and (b) of the Notice of Hearing. As to allegations 6(a),(b),(c),(d) and (f), the panel finds that the Member engaged in conduct that would reasonably be regarded by members of the profession as 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) in the Notice of Hearing is supported by paragraphs 9,10,11,15 and 17 in the Agreed Statement of Facts. The Member did not have the necessary authority to perform this medical procedure and she did not ensure the documentation presented a clear, accurate and comprehensive picture of the client's needs.

Allegation #1(b) in the Notice of Hearing is supported by paragraphs 11 and 18 in the Agreed Statement of Facts. The Member performed the controlled act of selling Botox without the proper documentation.

Allegation #1(c) in the Notice of Hearing is supported by paragraphs 10,15,16,17 in the Agreed Statement of Facts. Physicians were not involved in the assessment or treatment of these patients.

Allegation #1(d) in the Notice of Hearing is supported by paragraphs 10,15,16,17,19 in the Agreed Statement of Facts. The Member failed to obtain and document client contact and medical history information.

Allegation #1(f) in the Notice of Hearing is supported by paragraph 20 in the Agreed Statement of Facts. The consent form signed by the clients used the protected title of Registered Nurse (RN). The Member is in actual fact a Registered Practical Nurse (RPN).

Allegation #2(a) in the Notice of Hearing is supported by paragraphs 9,10,15,16,19 in the Agreed Statement of Facts. The Member failed to document any communication between the physician and the client relating to the client's needs, the nurses interventions and the client's outcomes.

Allegation #2(b) in the Notice of Hearing is supported by paragraphs 16 and 19 in the Agreed Statement of Facts. The delegation of controlled acts was not documented.

Allegation #5(a) in the Notice of Hearing is supported by paragraphs 9 and 19 in the Agreed Statement of Facts. The Member administered injections of Botox without authorization from a qualified health care professional.

Allegation #5(b) in the Notice of Hearing is supported by paragraphs 11 and 18 in the Agreed Statement of Facts. The Member performed the controlled act of selling Botox to clients without proper documentation.

With respect to Allegations #6(a),(b),(c),(d),(f), the panel finds that the Member acted with a lack of regard for her clients' best interests and conducted her business with no or inadequate documentation. This amounted to unprofessional conducted, as it demonstrated a serious and persistent disregard for her professional obligations. Putting the public at risk in this manner repeatedly shows gross neglect of the safety and well-being of her clients and lack of respect for her profession.

The panel also finds that the Member's conduct was dishonourable. It demonstrated an element of dishonesty and deceit through repeatedly treating patients without the appropriate pre-treatment assessments and without proper authorization from any qualified health care professional. Further her misuse of the title of Registered Nurse on her consent forms was troubling and clearly dishonest.

Penalty

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

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

2. Directing the Executive Director to suspend the Member's certificate of registration for 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 practising class.

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

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

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

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

1. *Professional Standards*,
2. *Medication*,
3. *Documentation*,
4. *RHPA: Scope of Practice, Controlled Acts Model*.

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 clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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 Mentor (a mentor is one or more nurses who enter into an agreement with the Member to provide ongoing professional support to the Member, as described more fully below in paragraph 3(c)) and/or 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 Mentor(s) and 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 Mentor(s) and 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

c) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will obtain a Mentor, who is a member of the College of Nurses of Ontario and who is approved by the Director (the "Mentor"), at her expense. To comply,

   i. The Member will ensure that the Director is notified of the name, address, and telephone number of the Mentor, within 14 days of commencing the mentoring relationship;

   ii. The Member will provide the Mentor with the documents listed in paragraph 3(b)(ii) within 14 days of commencing the mentoring relationship or within 14 days after the release of such documents, whichever is earliest;

   iii. The Member will ensure that within 30 days of commencing the mentoring relationship, the Mentor forwards a report to the Director, in which he or she 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;

iv. The Mentor will conduct a chart audit of ten randomly selected clients within 30 days of the date the Member's suspension ends and provide recommendations to the Member to remedy deficiencies in her practice, and provide an initial report to the Director in respect of the Member's practice forthwith;

v. Thereafter, the Mentor will conduct a chart audit of ten randomly selected clients and will provide a report to the Director in respect of the Member's practice every three months for 12 months (for a total of five audits including the initial audit described in paragraph 3(c)(iv));

vi. The Mentor will raise any concerns he or she develops about the Member's practice with the Director; and

vii. The Member will abide by any and all recommendations of the Mentor in respect of her practice.

4. All documents delivered by the Member to the College, the Expert, the Mentor 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 Member's Counsel indicated that she agreed with those submissions.

The parties agreed that the mitigating factors in this case were: that the Member admitted to her wrongdoing and as such a contested hearing was not required

No aggravating factors were presented by Counsel.

The proposed penalty provides for general deterrence through the publication of the terms, conditions and limitations for the Member's certificate of registration.

The proposed penalty provides for specific deterrence through the suspension of the Member's certificate of registration for a period of three months along with a verbal reprimand.

Overall, the public is protected because the Member will be working closely with a Mentor for a period of twelve months after she returns to practice and this Mentor will communicate directly with the College about the Member's progress.

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

Cases Presented By College Counsel

CNO v Zorn (Discipline 2017)
In this case the Member fell below the Standards including advertising the practice on a website and on more than one client file failing to document orders for administration of a substance by injection. The Member was given a three month suspension and terms and conditions on the certificate of registration.

CNO v Cecilioni (Discipline 2013)
This Member had a prior history with the College of Nurses from 2008. The Member was found to have intended to perform the controlled act of injecting Botox without a physician's order or proper delegation. Also she was not meeting the conditions of a medical directive, failed to ensure the client was assessed by a physician, failed to retain records and lastly she failed to abide by an undertaking given to the College in 2008. The Member's certificate of registration was suspended for a period of four months.

Penalty Decision

The panel accepts the Joint Submission as to Order and accordingly orders:

1. The Member is required to appear before the Panel to be reprimanded within three months of the date that this Order becomes final.

2. The Executive Director is directed to suspend the Member's certificate of registration for 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 practising class.

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

    a) The Member will attend two meetings with a Nursing Expert (the "Expert"), at her own expense and within six months from the date of this Order. To comply, the Member is required to ensure that:

        i. The Expert has expertise in nursing regulation and has been approved by the Director of Professional Conduct (the "Director") in advance of the meetings;

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

            1. the Panel's Order,
            2. the Notice of Hearing,
            3. the Agreed Statement of Facts,
            4. this Joint Submission on Order, and

5. if available, a copy of the Panel's Decision and Reasons;

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

1. *Professional Standards*,
2. *Medication*,
3. *Documentation*,
4. *RHPA: Scope of Practice, Controlled Acts Model.*

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 clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publications, questionnaires and modules set out above, and
5. the development of a learning plan in collaboration with the Expert;

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 Mentor (a mentor is one or more nurses who enter into an agreement with the Member to provide ongoing professional support to the Member, as described more fully below in paragraph 3(c)) and/or 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 Mentor(s) and 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 Mentor(s) and 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

c) For a period of 12 months from the date the Member returns to the practice of nursing, the Member will obtain a Mentor, who is a member of the College of Nurses of Ontario and who is approved by the Director (the "Mentor"), at her expense. To comply,

i. The Member will ensure that the Director is notified of the name, address, and telephone number of the Mentor, within 14 days of commencing the mentoring relationship;

ii. The Member will provide the Mentor with the documents listed in paragraph 3(b)(ii) within 14 days of commencing the mentoring relationship or within 14 days after the release of such documents, whichever is earliest;

iii. The Member will ensure that within 30 days of commencing the mentoring relationship, the Mentor forwards a report to the Director, in which he or she 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;

iv. The Mentor will conduct a chart audit of ten randomly selected clients within 30 days of the date the Member's suspension ends and provide recommendations to the Member to remedy deficiencies in her practice, and provide an initial report to the Director in respect of the Member's practice forthwith;

v. Thereafter, the Mentor will conduct a chart audit of ten randomly selected clients and will provide a report to the Director in respect of the Member's practice every three months for 12 months (for a total of five audits including the initial audit described in paragraph 3(c)(iv));

vi. The Mentor will raise any concerns he or she develops about the Member's practice with the Director; and

vii. The Member will abide by any and all recommendations of the Mentor in respect of her practice.

4. All documents delivered by the Member to the College, the Expert, the Mentor 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 proposed 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.

I, Grace Fox, NP, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel.

_____ _____

Chairperson Date