DISCIPLINE COMMITTEE
OF THE COLLEGE OF NURSES OF ONTARIO

PANEL:

Tanya Dion, RN	Chairperson
Catherine Egerton	Public Member
Terry Holland, RPN	Member
Ashleigh Molloy	Public Member
Susan Roger, RN	Member

BETWEEN:

COLLEGE OF NURSES OF ONTARIO	)	JEAN-CLAUDE KILLEY for
	)	College of Nurses of Ontario
- and -	)	
	)	
KARIN ZORN	)	ED HOLMES for
Reg. No. 7633993	)	Karin Zorn
	)	
	)	LUISA RITTACA
	)	Independent Legal Counsel
	)	
	)	Heard: May 2, 2017

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee ("the Panel") on May 2, 2017 at the College of Nurses of Ontario ("the College") at Toronto. The hearing did start on time, and the Panel then recessed to permit the Member to meet with legal counsel.

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), 2(b) and 5(e) of the Notice of Hearing dated February 2, 2017. The Panel granted this request. The remaining allegations against Karin Zorn (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

you contravened a standard of practice of the profession or failed to meet the standard of practice of the profession, and in particular:

a. between about October 2015 and June 2016, you advertised your practice using non-verifiable and/or misleading information on your website;

b. between about October 2015 and June 2016, you advertised your practice using client testimonials on your website;

c. between about October 2015 and June 2016, you advertised products on your website that you sell, and/or made reference on your website to products that you use and/or sell, and/or advertised on your website that you sell products;

d. at various times from 2012 to 2015, you failed to document orders for the administration of a substance by injection; and

e. [withdrawn].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 you failed to keep records as required, and in particular:

a. at various times from 2012 to 2015, you failed to document orders for the administration of a substance by injection; and

b. [withdrawn].

3. You have committed an act of professional misconduct as provided by subsection 5(2) of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and/or 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 you contravened a provision of the *Nursing Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts, and in particular, at various times from 2012 to 2015, you performed the controlled act administering a substance by injection without authorization, contrary to s 5(1) of the *Nursing Act, 1991*, S.O. 1991, c. 32, and s. 27(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

4. 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 you contravened a provision of the *Nursing Act, 1991*, the *Regulated Health Professions Act, 1991*, or the regulations under either of those Acts, and in particular, at various times from 2012 to 2015, you performed the controlled act of selling a drug without authorization, contrary to s. 27(1) of the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

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(37) of *Ontario Regulation 799/93*, in that you engaged in conduct or performed an act, relevant to the practice of nursing, that,

having regard to all the circumstances, would reasonably be regarded by members of the profession as disgraceful, dishonourable or unprofessional, and in particular:

a. between about October 2015 and June 2016, you advertised your practice using non-verifiable and/or misleading information on your website;

b. between about October 2015 and June 2016, you advertised your practice using client testimonials on your website;

c. between about October 2015 and June 2016, you advertised products on your website that you sell, and/or made reference on your website to products that you use and/or sell, and/or advertised on your website that you sell products;

d. at various times from 2012 to 2015, you failed to document orders for the administration of a substance by injection;

e. [withdrawn]; and

f. on or about September 18, 2014, you subleased a portion of your business premises to S.C. for the purpose of enabling S.C. to carry out the controlled act of administering substances by injection, without taking adequate steps to verify whether S.C. was authorized to administer substances by injection.

Member's Plea

The Member admitted the allegations set out in paragraphs 1(a), 1(b), 1(c), 1(d), 2(a), 3, 4, 5(a), 5(b), 5(c), 5(d) and 5(f) 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

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

THE MEMBER

1. Karin Zorn (the "Member") obtained a diploma in nursing from Algonquin College in 1976.

2. The Member registered with the College of Nurses of Ontario (the "College") as a Registered Nurse ("RN") on January 1, 1976. The Member was suspended for non-payment of fees between May 3, 2002 and January 20, 2004. Since then, the Member's certificate of registration in the general class has been active.

THE CLINIC

3. The Member operates YES – Your Enhancement Solution (the "Clinic"), where she provides Botox injections and other cosmetic procedures to clients.

4. The Clinic is located Toronto, Ontario.

INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

Subleasing to Illegal Practitioner

5. The College received complaints from two individuals about Sara Castelluzzo ("S.C."), alleging that S.C. was holding herself out as a nurse and providing Botox injections when she was not in fact registered as a nurse (S.C. is not a member of the College). The Member was implicated in the complaint because S.C.'s clinic, Solo Clinica, was in the same location as the Member's Clinic and the complainants believed that the two clinics were associated.

6. In fact, S.C. was not the Member's employee nor did she work for the Member or her Clinic in any other capacity. However, the Member did, through her corporation Karin Zorn Inc., enter into a sublease agreement ("Sublease"), dated September 18, 2014, with S.C. The Sublease specified that the premises at issue in the Member's Clinic "shall be used for carrying out injections only and for no other purpose including, but not limited to, teaching," and furthermore that S.C. was not to perform injections in any location other than the premises subleased to her by the Member.

7. The Member knew that S.C.'s intention was to use the space that the Member subleased to her for the exclusive purpose of operating a clinic in which she would perform the controlled act of administering cosmetic injections. The Member did not take any steps to investigate whether S.C. was legally authorized to perform injections at any point before or after agreeing to sublease the space to S.C.

8. If the Member were to testify, she would say that she first learned that S.C. was not a nurse in November 2014, after she had already entered into the sublease with her. She would say that at that point, she did tell S.C. to stop holding herself out as an RN. She would also say she alerted [Doctor A], S.C.'s delegating physician, at that time.

9. The Member admits that, before entering into a business arrangement with S.C. in which S.C. would be performing cosmetic injections on premises that the Member was subleasing to her for that purpose, she should have taken reasonable steps to inquire into whether S.C. had legal authority to perform injections. The Member admits that, had she searched for S.C. on the College's online register, Find A Nurse, she would have discovered that S.C. was not a Member of the College and not authorized to perform injections.

10. The Member accepts responsibility for leasing a portion of her Clinic to S.C., for the purpose of performing injections, without verifying her credentials first.

Advertising on Clinic Website

11. The College's Practice Guideline on *Independent Practice* contains a specific section on advertising. It states:

> The College maintains the public's trust in the nursing profession by regulating nurses' advertisements to ensure that the public is given relevant information and is not misled.
>
> When advertising your services to the public, you are accountable for:
>
> - including a description of your services, to help clients make informed decisions
> - **including only accurate, factual and verifiable information**
> - providing evidence-based references to support statements
> - including your name and protected title (RPN, RN or NP).

12. It goes on to say:

> Your advertisements must not include:
>
> - the College's logo
> - guarantees
> - **references to products that you use or sell**
> - **comparative or superlative statements**
> - sensational claims.
>
> When your nursing practice involves direct interaction with individual clients, **you must not include client testimonials in your advertising**. [*emphasis added*]

13. The Member's Clinic had a website, which contained information that is contrary to the College's Practice Guideline for independent practitioners.

14. For example, the Member noted on the Clinic's website that she is "one of the most respected aesthetic practitioners" and that "you will not find a better skin care clinic in Toronto." The Member admits that these statements are not verifiable.

15. The Member also posted misleading information on the website, including that she was awarded "Top Nurse for Ontario" when in fact she was honoured as "a Top Nurse for Toronto, Ontario." The Member acknowledges the error and has subsequently corrected the misleading geographical reference.

16. As well, the Clinic's website advertised products (20% Vitamin C + E Serum Treatment, Super Active Retinol Face Serum and EyEnvy™ Conditioner) and provided client testimonials, contrary to the Practice Guideline.

17. The Member has since changed the Clinic's website to comply with the Practice Guideline. She accepts responsibility for the fact that the Clinic's website did not comply with the Guideline until the deficiencies were pointed out to her by the College in the course of its investigation into this matter.

Performing Controlled Acts without Delegation

18. The *Nursing Act, 1991*, authorizes members to perform the controlled act of administering a substance by injection, but only where the administration is ordered by a practitioner with the authority to do so, such as a physician. This principle is articulated in the College document, *RHPA: Scope of Practice, Controlled Acts Model*.

19. The College's *Medication* Standard states:

> Nurses must have the necessary authority to perform medication practices.
>
> Registered Nurses and Registered Practical Nurses require an order for a medication practice when:
>
> - a **controlled act** is involved
> - administering a prescription medication, or
> - it is required by legislation that applies to a practice setting.

20. The Member's clients and former clients, Clients A, B, C, D, E and F, did not consult with a physician in any way (whether in person, by phone, or otherwise) prior to receiving injections at the Clinic between 2012 and 2015. The Member did not document in the client records to indicate that they met or consulted with a physician.

21. These clients, therefore, did not have a legitimate order for the administration of a substance by injection. None of the client records contained any documentation of an order by a physician for Botox. There was no documentation of any formal delegation arrangement between the Member and any physician.

22. Nevertheless, the Member performed the Botox injections on the clients identified above in paragraph 20 and she recorded in the client records the location where Botox was administered and the sale of units of Botox to the clients.

23. If the Member were to testify, she would say that [Doctor A] was the Clinic's delegating physician from 2012 to 2016, and that the process she and [Doctor A] had established was for [Doctor A] to perform an initial consultation with every client, either in person or via FaceTime video teleconferencing.

24. If the Member were to testify, she would say that it was furthermore her practice to obtain verbal orders from [Doctor A] over the phone. If [Doctor A] were to testify,

he would confirm that his regular practice was to give orders to the Member on the phone.

25. The Member admits, however, that to the extent that the authorizing order she received from [Doctor A] was provided verbally over the phone, it should have been documented in the clients' health records, which it was not in the cases of the clients referred to in paragraph 20. The Member admits that those clients did not, in fact, meet with [Doctor A] before receiving their injections.

26. The Member would also testify that she has since amended the Clinic's processes to ensure that a physician gives a valid order to authorize the administration of substances by injection in every case and that the order is documented in the client's record.

27. The Member admits that she performed the controlled acts of selling a drug (Botox) and administering a substance by injection, without having authorization to do so in the cases of the clients in paragraph 20.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

28. The Member admits that she committed the acts of professional misconduct as described in paragraphs 5 to 27 above, and as alleged in the Notice of Hearing in the following paragraphs:

    - 1(a), (b), (c), (d)
    - 2(a)
    - 3
    - 4

29. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 5 (a), (b), (c), (d), and (f) of the Notice of Hearing, and in particular, her conduct was dishonourable and unprofessional, as described in paragraphs 5 to 27 above.

30. With leave of the Discipline Committee, the College withdraws allegations 1(e) 2(b), and 5(e) of the Notice of Hearing.

Decision

The Panel finds that the Member committed acts of professional misconduct as alleged in paragraphs 1(a), 1(b), 1(c), 1(d), 2(a), 3, and 4 in the Notice of Hearing. As to the allegations 5(a), 5(b), 5(c), 5(d) and 5(f), the Panel finds that the Member engaged in conduct that would reasonably be considered by members to be dishonourable and unprofessional in that the Member failed to stay within her scope of practice by advertising with non-verifiable information, using testimonials on her website, failing to document orders to the administration of a substance by injection and subleasing a portion of her business to an individual without verifying their credentials.

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), 1(b) and #4 in the Notice of Hearing is supported by paragraphs 11 to 15 in the Agreed Statement of Facts. The Member had stated on the website "one of the most respected aesthetic practitioners", "you will not find a better skin care clinic in Toronto" and "Top Nurse for Ontario". As stated in paragraph 11 of the College's Practice Guideline on *Independent Practice*, when it comes to advertisements, they may only include accurate, factual and verifiable information.

Allegation #1(c) in the Notice of Hearing is supported by paragraph 16 in the Agreed Statement of Facts. The Member had advertised products for sale on her website. As stated in paragraph 12 with reference to the College's Practice Guidelines on *Independent Practice*, advertisements must not include reference to products that you use or sell, and cannot include any comparative or superlative statements.

Allegation 1(d), 2(a) and 3 in the Notice of Hearing is supported by paragraphs 20, 21, 22, 25, 26 and 27 in the Agreed Statement of Facts. The Member failed to document the delegation to her by administrating substance by injection and sale of those drugs. This was supported by former clients' records and the lack of documentation showing a consultation with a physician. The Member preformed injections of Botox, which she did record but had no prior approval from the delegated physician [Doctor A].

As to Allegation 5(a), 5(b), 5(c), 5(d) and 5(f) in the Notice of Hearing, the Panel finds that the Member's conduct was unprofessional and dishonorable as it demonstrates a serious and persistent disregard for her professional obligations. Not only did the Member not follow the College's Practice Guidelines on *Independent Practice*, she also showed a lack of regard for the College by not confirming the status of a sublease to an individual holding themselves out to be a "nurse" when in fact they were not. Her actions rise to the level of dishonourable, showing an element of moral failing and deceptiveness.

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 intial 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 he agreed with those submissions.

The parties agreed that the mitigating factors in this case were the Member had no prior history with the College. The Member was co-operative with the College and admitted to allegations and took steps to make the necessary changes to comply with the College's Guidelines.

The aggravating factors in this case were that the Member's actions where serious and she went beyond her scope of practice. The Member fell below the standard on more than one client file and posed a risk to public safety.

The proposed penalty provides for general deterrence through a three-month suspension along with terms, conditions and limitations.

The proposed penalty provides for specific deterrence through meetings with a nursing expert which will promote personal reflections, along with the reprimand.

The proposed penalty provides for remediation and rehabilitation through the reprimand, the nursing expert and the monitoring of the Member by the College's Monitoring Team.

Overall, the public is protected because the suspension along with the required meetings with the nursing expert and the required monitoring shows the Member's willingness to improve her practice. This also sends a clear message to the profession that this behaviour will not be tolerated.

<u>Cases presented by College Counsel</u>

CNO v Cecilioni (Discipline, 2008)
This was a similar case where the member had prescribed and administered Botox to two private clients without a physician's diagnosis. The member received a one month suspension and similar terms and conditions on her certificate. She also agreed to sign a letter of undertaking regarding her scope of practice. This case was not as severe as the member worked in the same office as the doctor and only two clients were involved.

CNO v Cecilioni (Discipline, 2013)
This involved the same member as the 2008 case but this was her second appearance before the Discipline Committee for similar allegations. This time, someone went to the member's practice undercover. The suspension was four months and terms, conditions and limitations where imposed. This case shows the seriousness of the second offence being brought to the College.

CNO v Smith (Discipline, 2014)
The member knowingly left a piece of catheter inside the client's urethra at the end of his shift and did not report to the oncoming shift staff. He also had changed the medication to Hadol without the consent of a physician. The member was suspended for six months with terms, conditions and limitations on his certificate. This was a breach of protocol and abuse of the scope of nursing with medication directives.

CNO v Brown (Lawrence) (Discipline, 2005)

The member admitted she received two intermuscular injections of Toradol and she gave an intramuscular injection to another nurse when there was no physician's order for the Toradol. There was a three month suspension and terms, conditions and limitations imposed. This also showed the Panel the seriousness of issuing a medication without a physician's order.

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

I, Tanya Dion 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