DISCIPLINE COMMITTEE  
OF THE COLLEGE OF NURSES OF ONTARIO  

PANEL:  
Tammy Hedge, RPN Chairperson  
Samantha Diceman, RPN Member  
Marianne Fletcher, RN Member  
Linda Bracken Public Member  
Catherine Egerton Public Member  

BETWEEN:  
COLLEGE OF NURSES OF ONTARIO )) EMILY LAWRENCE for  
) ) College of Nurses of Ontario  
- and -  
) )  
BARBARA CECILIONI ) ) NO REPRESENTATION for  
Registration No. 6836613 ) ) Barbara Cecilioni  
) )  
) ) Heard: May 1, 2013  

DECISION AND REASONS  
This matter came on for hearing before a panel of the Discipline Committee on May 1, 2013, 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(b), 1(d); 2(a), 2(c); 4(b) and 4(d) of the Notice of Hearing dated March 20, 2013. The panel granted this request. The remaining allegations against Barbara Cecilioni (the “Member”) as set out in the Notice of Hearing 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 failed to maintain the standards of practice of the profession with respect to a client [ ] by:
a. intending to perform on [the Client] a controlled act authorized to nursing, namely administration of a substance by injection, without a physician’s order, without proper delegation from a physician, and/or without meeting the conditions of an applicable medical directive, on or about October 20, 2010;

b. [Withdrawn]; and/or

c. failing to ensure that [the Client] was assessed by the supervising physician, before agreeing to provide treatment to [the Client], on or about October 20, 2010;

d. [Withdrawn];

e. failing to retain records of your interactions with [the Client] on or about September 25, 2010;

f. failing to retain records of your interactions with [the Client] on or about October 20, 2010; and/or

g. failing to abide by and/or intending to fail to abide by an undertaking given by you to the College on or about February 8, 2008, on or about October 20, 2010.

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 by:

a. [Withdrawn];

b. failing to retain records of your interactions with [the Client] on or about September 25, 2010;

c. [Withdrawn];

d. failing to retain records of your interactions with [the Client] on or about October 20, 2010.

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(24) of Ontario Regulation 799/93, in that you failed to abide by a written undertaking given by you to the College on or about February 8, 2008 by:

a. performing or intending to perform on [the Client] a controlled act within the controlled acts authorized to nursing, namely administration of a substance by injection, without a physician’s order and without proper delegation from a physician, on or about October 20, 2010.

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(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 of the circumstances would reasonably be regarded by members of
the profession as disgraceful, dishonourable or unprofessional, with respect to a client known as “[the Client]”, by:

a. intending to perform on [the Client] a controlled act authorized to nursing, namely administration of a substance by injection, without a physician’s order, without proper delegation from a physician, and/or without meeting the conditions of an applicable medical directive, on or about October 20, 2010;

b. [Withdrawn];

c. failing to ensure that [the Client] was assessed by the supervising physician, before agreeing to provide treatment to [the Client], on or about October 20, 2010;

d. [Withdrawn];

e. failing to retain records of your interactions with [the Client] on or about September 25, 2010;

f. failing to retain records of your interactions with [the Client] on or about October 20, 2010; and/or

g. failing to abide by and/or intending to fail to abide by an undertaking given by you to the College on or about February 8, 2008, on or about October 20, 2010.

Member’s Plea

The Member admitted the allegations set out in paragraphs numbered 1(a), 1(c), 1(e), 1(f), 1(g); 2(b), 2(d); 3 and 4(a), 4(c), 4(e), 4(f) and 4(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 admission was voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts which has been reproduced below, without the appendix that is referenced therein.

**THE MEMBER**

1. Barbara Cecilioni (“the Member”) received her nursing diploma [abroad] in 1967.

2. The Member has been registered with the College of Nurses of Ontario (“the College”) as a registered nurse (“RN”) since 1968.

3. The Member has over ten years’ experience working in medical aesthetics physician practices and was most recently employed by a medical aesthetics company (the
“Clinic”). She worked at multiple spa locations and in her home as a "nurse clinician," injecting Botox and other dermal fillers for cosmetic purposes.

4. On August 13, 2012, the Member resigned her certificate of registration and retired from nursing practice. The member is 68 years of age.

PRIOR HISTORY

5. In 2008, the Member was found guilty of acts of professional misconduct, including performing controlled acts in contravention of the Nursing Act and Regulated Health Professions Act; providing treatment without consent by diagnosing and treating clients in a situation in which consent is required by law, without such a consent; failing to advise clients to obtain services from another health care professional when the clients’ conditions were outside her scope of practice; falsifying records related to her nursing practice with respect to two clients; and signing or issuing, in a professional capacity, a false or misleading statement in documents with respect to two clients.

6. The findings of professional misconduct involved the injection of Botox for therapeutic purposes.

7. The Discipline Committee ordered a one-month suspension of the Member's certificate of registration and imposed other terms, conditions and limitations (Appendix “A”).

8. In addition, on February 8, 2008, the Member provided an Undertaking to the College, whereby she agreed to only practise nursing within the controlled acts authorized to nursing and to only perform a procedure within these controlled acts if permitted by the regulations or if the procedure was ordered by a member of specific professions.

THE CLINIC

9. [Dr. A] was the Medical Director of the Clinic. As a physician, [Dr. A] was authorized to perform controlled acts, including the injection of Botox. [Dr. A] was also authorized to delegate certain controlled acts, including Botox injections, to members of the College via a physician’s order or written medical directive.

10. [Dr. A] provided a written medical directive for registered Clinic staff in respect of the Botox injection (the “Medical Directive”). The Medical Directive set out the supervision, contra indications, injection dosage and procedure, record-keeping and documentation requirements, and Clinic staff training requirements for Botox injection. The Medical Directive applied to Clinic locations and to the Member’s home clinic.

11. For new clients, the Medical Directive could be implemented only after [Dr. A] had completed a face-to-face or video consultation with the client, and where [Dr. A] had established a physician-client relationship with the client. [Dr. A] regularly completed his consultation with clients via video conferencing.
12. The Clinic’s written policies required its nurses, including the Member, to undertake an assessment and treatment procedure for new clients, as follows:

   a. the client completes a client health questionnaire, which the nurse then reviews with the client;

   b. the nurse discusses client goals and develops a treatment plan;

   c. if [the] client is inclined to proceed, the nurse provides the client with two forms for execution:
      
      i. a product (Botox) consent form, and

      ii. a consent form to conduct video consultation (as opposed to face-to-face consultation) and to permit delegation of the Botox injection from [Dr. A] to the nurse;

   d. the nurse initiates a video consultation with [Dr. A] via video conferencing;

   e. the physician assesses the client and, if appropriate, communicates a diagnosis and treatment plan to the client;

   f. the nurse photographs the client and administers the product in accordance with the Medical Directive;

   g. the nurse charts the treatment in the client’s Clinic chart;

   h. the nurse provides the client with the post-treatment instructions; and

   i. the nurse completes all forms and payment records, and ensures they are placed in the client Clinic chart, including the video consultation form that the physician has filled out remotely.

13. For returning clients, the Clinic staff were required to obtain the client’s chart from the Clinic’s head office, review the client’s chart with the client and perform an assessment, and obtain informed consent. If there were changes to the client’s health history or if the Clinic staff felt uncomfortable with injecting Botox for any other reason, the Clinic staff were to arrange a consultation with [Dr. A]. If not, the Clinic staff were permitted to inject Botox in accordance with the Medical Directive and document the injection without a follow-up consultation with [Dr. A].

14. Clients who received Botox for cosmetic purposes were not required to have a prescription when injected, from the Clinic’s stock, pursuant to the Medical Directive.
INCIDENTS RELEVANT TO ALLEGATIONS OF PROFESSIONAL MISCONDUCT

[The Client]

15. [The Client] was a television producer who went “undercover” as a potential client for a television segment on Botox. [The Client] met with the Member on September 25, 2010, and again on October 20, 2010.

(i) September 25, 2010

16. On September 25, 2010, [the Client] met with the Member for a consultation at a Clinic location. The Member and [the Client] discussed the nature of Botox treatments, cost and risks. [The Client] did not fill out any health assessment or medical forms, or a consent form. The Member did not ask [the Client] any medical questions.

17. [The Client] did not see [Dr. A] or any other physician at this visit. The Member advised her that the physician would see her using “Skype” (video conferencing), but that he was currently away in Mexico.

18. Despite the unavailability of a physician to assess [the Client] and (if appropriate) delegate the Botox injection to the Member, the Member would have been prepared to inject [the Client] with Botox, without [Dr. A] having performed a consultation with [the Client] and, without [Dr. A]’s delegation to perform the Botox injection, provided that the client’s health questionnaire would not have revealed a circumstance which in the Member’s view would have rendered the treatment inappropriate or unsafe. The Member did not inject [the Client], because [the Client] advised that she was looking only for a consultation. [the Client] took the Member’s business card.

19. The Member did not retain any records from this visit.

(ii) October 20, 2010

20. At a later date, [the Client] arranged a second appointment with the Member directly. The Member and [the Client] arranged to have [the Client] attend at the Member’s home on October 20, 2010.

21. On October 20, 2010, [the Client] attended at the Member’s home. The Member escorted her to an open space on the second floor of her home, which was set up with an examining table. [The Client] advised the Member that she had not yet had any Botox injections, and had only attended for a consultation.

22. The Member began an initial assessment of [the Client] by touching her face and making notes.
23. The Member did not orally review the potential risks/side effects of the Botox with [the Client] at this stage in the assessment.

24. The Member did not ask [the Client] to fill out any consent forms or medical forms nor did she ask [the Client] any medical questions at this stage of the assessment.

25. If the Member were to testify, she would state that after her initial assessment of [the Client] and if [the Client] was a good candidate for Botox, she would have reviewed the potential risks/side effects with [the Client] and would have had [the Client] complete a client health questionnaire and consent forms.

26. The Member knew that [Dr. A] was not available to conduct a consultation with [the Client] on October 20, 2010. She indicated to [the Client] words to the effect of “normally, we would go on Skype, but he’s gone for the day. But next time I see you we’ll probably Skype him.”

27. Despite [Dr. A]’s unavailability to assess [the Client] and (if appropriate) delegate the Botox injection to the Member, the Member would have been prepared to inject [the Client] with Botox, without [Dr. A] having performed a consultation with [the Client] and without [Dr. A]’s delegation to perform the Botox injection, provided that the client’s health questionnaire would not have revealed a circumstance which in the Members view would have operated as a bar to the procedure.

28. During the initial assessment, [the Client] spontaneously disclosed to the Member that she was pregnant. The Member immediately advised [the Client] that the Member could not proceed further with the assessment of [the Client] and the Member did not inject her with Botox.

29. If [the Client] were to testify, she would state that she was 100% sure that the Member intended to complete the Botox injection without completing a therapeutic assessment.

30. The Member did not retain any records from this visit.

ADMISSIONS OF PROFESSIONAL MISCONDUCT

31. The Member admits that she committed the acts of professional misconduct as alleged in paragraphs 1 (a), (c), (e), (f) and (g), 2(b) and (d), 3(a), to 4 (a), (c), (e), (f) and (g) of the Notice of Hearing, as described in paragraphs 1 to 30 above, and in particular that her conduct was disgraceful, dishonourable and unprofessional.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed an act of professional misconduct as alleged in paragraphs 1(a), 1(c), 1(e), 1(f), 1(g); 2(b), 2(d); 3 and 4(a), 4(c), 4(e), 4(f) and 4(g) of the Notice of Hearing in that the Member intended to perform controlled acts not authorized to nursing without a physician’s order, namely an injection. The
Member failed to ensure that the client was assessed by the supervising physician before agreeing to provide treatment to [the Client]. This was a breach of the standards of practice of the profession. The Member failed to retain records on two occasions, and failed to abide an undertaking given by her to the College in a previous encounter with the Discipline panel. As to allegation 4, the Member’s conduct would reasonably be considered by members to be disgraceful, dishonourable and unprofessional.

**Reasons for Decision**

The evidence contained in the Agreed Statement of Facts was clear. The Member admitted to the panel that she should have known she could not perform a controlled act by injection and that she shouldn’t have taken a standing order but felt that she had extensive experience to perform the injections. This was sufficient evidence to make the findings of professional misconduct. The fact that the Member had appeared in the recent past on similar issues (injection of Botox), combined with the Member’s admission that she would have injected [the Client] without authority to do so and her admission that she breached her undertaking to the College, made the misconduct disgraceful, dishonourable and unprofessional.

**Penalty**

Counsel for the College advised the panel that a Joint Submission as to Order had been agreed upon. The Joint Submission as to Order requested 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 four months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption.

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 sessions with a Nursing Expert (the “Expert”), at her own expense and within five months of the date [ ] that the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

      i. The Expert has expertise in self-regulation, 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 and online learning modules:

1. *Professional Standards*, and
2. *Documentation*;

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

v. The subject of the sessions with the Expert will include:

1. the acts or omissions for which the Member was found to have committed professional misconduct,
2. the potential consequences of the misconduct to the Member’s clients, colleagues, profession and self,
3. strategies for preventing the misconduct from recurring,
4. the publication, questionnaire and module 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 of the requirements above, the Expert may cancel the sessions scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b. For a period of 12 months from the date the Member’s suspension ends, the Member will notify her employers of this decision. To comply, the Member is required to:
i. Provide the Director [with] 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 Penalty, 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;

c. The Member shall not practise independently in the community for a period of 12 months from the date her suspension ends.

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be [delivered] by verifiable method of delivery, the proof of which the Member will retain.

Penalty Submissions

College counsel submitted that there were five elements to this joint submission on Order which would meet the expectations of the public, the College and the membership: a reprimand, a four-month suspension which will take effect once the Member seeks to and successfully obtains an active registration, educational components, self-reporting and no independent practice for twelve months.

College counsel submitted that the Joint Submission on Order is appropriate. It meets the public and professional interests of promoting both specific and general deterrence. Both the suspension and the reprimand provide a clear message to the public and membership that every member of this College must practi[s]e within their scope and be diligent that they only perform controlled acts with authority. The proposed order also accounts for mitigating and aggravating factors, as follows.

Mitigating Factors
The Member had a lengthy career with no issues from 1968 until 2008. She cooperated with the College in the investigation process and avoided a lengthy and costly hearing by entering into an Agreed Statement of Facts.

**Aggravating Factors**

Appendix “A” to the Agreed Statement of Facts includes the previous findings from 2008. This is not the first time that this Member has appeared before the Discipline panel, with the first appearance being for similar issues. The Member diagnosed and treated two clients for hyperhidrosis by injecting Botox without authority or delegation. The Member falsified records in the form of receipts indicating that the doctor had delegated the procedure.

The Member complied with the terms and conditions that were placed on her certificate as a result of the 2008 findings. From 2009 until August 13, 2012, when she resigned, the Member was entitled to practice with no restrictions on her certificate of registration. The Member’s behaviour is concerning to the College as she is appearing now before the Discipline Committee for similar misconduct. This displays a persistent disregard for her professional obligations and suggests the Member did not take away from the 2008 proceeding what the College would have expected.

Finally, it is an aggravating factor that the nature of the conduct is very serious. In this case, [the Client] was not injected but the Member admitted she intended to do so without a medical directive, which elevates the level of risk to clients.

**Other Cases**

College counsel presented the panel with two previous decisions, *CNO v Roode* (CNO Discipline Committee, 2004) (“E.R.”) and *CNO v Dayboll* (CNO Discipline Committee, 2004) (“D.D.”). Both cases involved members performing a controlled act without proper delegation. In both cases the members were warned by the College that they were acting outside of their scope of practice. E.R. continued to practice outside of her scope and was given a heavier penalty than D.D., who ceased and desisted from her practice. College counsel submitted that the proposed penalty for this Member falls squarely within the range of appropriate outcomes, given this previous case law.

The Member had no submissions.

**Penalty Decision**

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

1. The Member shall 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 four months. This suspension shall take effect from the date the Member obtains an active certificate of registration and shall continue to run without interruption.
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 sessions with a Nursing Expert (the “Expert”), at her own expense and within five months of the date [] that the Member obtains an active certificate of registration. To comply, the Member is required to ensure that:

      i. The Expert has expertise in self-regulation, 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 and online learning modules:

         1. Professional Standards, and
         2. Documentation;

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

      v. The subject of the sessions with the Expert will include:

         1. the acts or omissions for which the Member was found to have committed professional misconduct,
         2. the potential consequences of the misconduct to the Member’s clients, colleagues, profession and self,
         3. strategies for preventing the misconduct from recurring,
         4. the publication, questionnaire and module 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 of the requirements above, the Expert may cancel the sessions scheduled, even if that results in the Member breaching a term, condition or limitation on her certificate of registration;

b. For a period of 12 months from the date the Member’s suspension ends, the Member will notify her employers of this decision. To comply, the Member is required to:

i. Provide the Director 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 Penalty, 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;

c. The Member shall not practise independently in the community for a period of 12 months from the date her suspension ends.

4. All documents delivered by the Member to the College, the Expert or the employer(s) will be [delivered] by verifiable method of delivery, the proof of which the Member will retain.

**Reasons for Penalty Decision**

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has cooperated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for her actions.
The penalty meets the goals of general and specific deterrence and the protection of the public. The Member has resigned her certificate of registration, and will need to meet entry requirements before obtaining a certificate of registration, in which case this penalty will then take effect.

The penalty sends a clear message to the membership that engaging in controlled acts without delegation will not be tolerated. The public safety and confidence in the profession can be strengthened by this message.

I, Tammy Hedge, 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 as listed below:

Chairperson

Date

Panel Members:
Marianne Fletcher, RN
Samantha Diceman, RPN
Linda Bracken, Public Member
Catherine Egerton, Public Member