**DISCIPLINE COMMITTEE**
**OF THE COLLEGE OF NURSES OF ONTARIO**

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| **PANEL:** | Barbara Titley, RPN | Chairperson |
| | Nancy Sears, RN | Member |
| | Margaret Tuomi | Public Member |

**BETWEEN:**

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| COLLEGE OF NURSES OF ONTARIO | ) | LINDA ROTHSTEIN for |
| | ) | College of Nurses of Ontario |
| - and - | ) | |
| | ) | |
| GAIL ALLEYNE | ) | NO REPRESENTATION for |
| Registration No. JB00014 | ) | Gail Alleyne |
| | ) | |
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| | ) | |
| | ) | Heard: May 28, 2012 |

## DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on May 28, 2012, at the College of Nurses of Ontario ("the College") at Toronto.

The Member was present and not represented.

### The Allegations

The allegations against Gail Alleyne (the "Member") as stated in the Notice of Hearing dated March 12, 2012, 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 on September 20, 2007, while working as a registered practical nurse at [the Clinic], you contravened a standard of practice of the profession or failed to meet a standard of practice of the profession with respect to your assessment, care, and documentation of a client [ ].

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 on September 20, 2007, while working as a registered practical nurse at [the Clinic], you failed to keep records as required regarding a client [ ].

3. You have committed an act of professional misconduct as provided by subsection 51(1)(c) of the *Health Professions Procedural Code* of the *Nursing Act, 1991*, S.O. 1991, c. 32, as amended, and defined in subsection 1(37) of *Ontario Regulation 799/93*, in that on September 20, 2007, while working as a registered practical nurse at [the Clinic], you engaged in conduct or performed acts, relevant to the practice of nursing that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional, and in particular with respect to your assessment, care and documentation of a client [ ].

**Member's Plea**

Gail Alleyne admitted the allegations set out in paragraphs numbered 1, 2 and 3 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 provided as follows.

**THE MEMBER**

1. Gail Alleyne (the "Member") completed the practical nursing program [ ] in 2001 and registered with the College of Nurses of Ontario ("College") as a registered practical nurse ("RPN") on December 27, 2001.

2. The Member has no prior complaint or discipline history with the College.

**THE CLINIC**

3. The Member began working at [the Clinic] as a circulating nurse in June 2007.

4. As circulating nurse, the Member's role include[ed] obtaining supplies for the OR, assisting in handing instruments to the persons scrubbed for surgery, bringing [clients] into the RR, and, on occasion, caring for [clients] in the RR.

5. At the relevant time, the Member had no formal nursing education or training as a circulating nurse or in caring for [clients] in the RR. All of her orientation to the Clinic was provided by staff at the Clinic. The only training the Member received in post-surgical nursing care was provided by Drs. [A and B].

6. At the time, the Clinic was owned and operated by [Dr. A], a family physician who had focused her practice on cosmetic surgery, and in particular, breast augmentation and liposuction surgery.

7. The Clinic contained, among other rooms, an operating room ("OR"), a recovery room ("RR") immediately across a hall from the OR, and a prep room, which was in between the OR and RR.

8. The hall was monitored by a security camera which recorded some, but not all, of the activities in the hall on September 20, 2007.

**Overview of Post Anesthesia Nursing Care**

9. The immediate post-surgical period is considered a critical care period. Post anesthesia nursing requires extensive expertise. In addition to general nursing knowledge, post-anesthesia nurses must have specialized knowledge regarding [ ] all types and techniques of anesthetic administrative agents, post anesthetic complications, fluid management and resuscitation, thermoregulation, cardiac and hemodynamic monitoring and interpretation, respiratory management, and physiological assessment and care. In addition to advanced nursing education and/or training, most post-anesthesia nurses have certification in Critical Care nursing and a certificate in advanced cardiac life support (ACLS, or PALS for pediatric [clients]).

10. Clients immediately after surgery have complex and changing needs, require constant monitoring and assessment, may have unpredictable changes in health condition, and changes can be associated with immediate effects and create urgent or emergent situations.

11. For this reason, the standards of nursing practice require that a client be constantly observed in the period after surgery. The nursing priority is the evaluation and stabilization of the client. Vital signs and other observations are documented every 15 minutes, or more frequently if the client is unstable. Clients should never be left unattended. The standards of practice recommend that two registered nurses, both competent in perianesthesia nursing, must be present at all times as a client is recovering immediately following anesthesia.

12. There is a formal transfer where the post anesthesia or RR nurse accepts the client after surgery. The nurse who accepts care for the client after surgery is the client's primary nurse. The nurse must obtain a report from the anesthetist and OR nurse including information such as:

    - the client's name;

    - the client's significant medical history (i.e., allergies, comorbidites, etc.) and code status;

- report on the procedure performed, including type of surgery, length of surgery, type of anesthetic used, whether and how the client was "reversed", adverse events during the surgery, and how adverse events were managed;

- immediate post surgery assessment, including vital signs/O2 saturation, neurological status, skin and wound assessment, significant status changes, and medications administered/pending; and

- recommendations, including the interventions implemented and monitoring required, and pending treatments or medications.

13. The nurse then performs a preliminary assessment of the client, including assessing the client's airway, breathing and circulation, taking a set of vital signs, assessing level of consciousness, checking the surgical site(s), assessing pain and nausea etc. and documentation of all findings.

14. In general, after surgery, clients should have an oxygen saturation of at least 94%, and a blood pressure +/-20 % mmHg of the pre-operative value.

15. If, in the nurse's judgment, the client's condition is too unstable or requires care that is too complex to be managed safely in the circumstances, the nurse can refuse to accept the client, can request that the anesthetist stay with the client until the client can be cared for safely by the nurse, or can require that the client be moved to an environment where the client can receive the appropriate medical and nursing care.

16. Client complications can occur at any time during the initial recovery period and the client's status has to be assessed continually to identify potential complications, and ensure they are treated promptly and effectively.

17. A client is only considered stable and ready for the next phase of care when the client's vital signs have stabilized, the client can maintain his or her own airway, and the client is alert enough to communicate needs and discomforts.

**The Events of September 20, 2007**

18. On September 20, 2007, the health care providers at the Clinic were:

    (i) Dr. [A];

    (ii) Anesthesiologist, [Dr. B], who worked at the Clinic on a piecemeal basis when needed;

    (iii) [RN A], whose job was to provide nursing care in the RR to clients after they had surgery. [RN A] had been working at the Clinic for two days;

    (iv) the Member; and

(iv) OR assistant [ ].

19. Three clients received liposuction surgery at the Clinic on September 20, 2007.

20. [RN A] performed the first client's pre-operative assessment, assisted in the OR with the surgery, and cared for the first client in the RR after the client's surgery.

21. The second surgical [client] of the day was [the Client], a 32-year-old, healthy woman. [The Client]'s pre-operative vital signs were blood pressure ("BP") 114/72, heart rate ("HR") 72, and respiratory rate of 20 breaths per minute

22. [The Client] had liposuction under general anesthesia on her abdomen, lower back, flanks and inner thighs. The surgery started at approximately 1000 hours. Liposuction was performed on 34% of [the Client]'s body area. Fat aspirated was 2725 ml with total aspirate volume 6075 ml. The surgery was completed at approximately 1302 hours.

23. The last set of vital signs recorded in the OR at approximately 1305 hours was BP 110/60, HR 80.

24. [The Client] was moved to the RR on a stretcher at approximately 1310 hours.

25. The Member admits she was responsible for providing nursing care to [the Client] in the RR until such time as [RN A] discharged the first client and assumed [the Client]'s care.

26. As noted above, the security camera in the hallway did not record continuously, and therefore only captured some, and not all of the events in the hallway between the OR and the RR.

27. The security camera recorded the following:

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| 1308 hours: | The Member takes a stretcher from the RR to the OR; |
| 1310 hours: | [Dr. B] leaves the RR. The Member leaves the OR. Less than a minute later, the Member returns to the OR; |
| 1311 hours: | The Member goes back and forth between the OR and the RR; |
| 1313 hours: | [Dr. B] goes from the RR to the washroom; |
| 1314 hours: | [RN A] takes the first surgical client of the day in a wheelchair towards the Clinic exit; |
| 1315 hours: | The Member is in the hallway near some boxes taking inventory/checking orders for the upcoming surgical case; |
| 1320 hours: | [RN A] returns to the RR with an empty wheelchair; the Member goes from the RR to the OR carrying something; |

1322 hours: [RN A] is in the hall;

1324 hours: The Member leaves the RR with a plate and goes to the kitchen;

1325 hours: The Member is in the hall;

1328 hours The Member returns to the RR with a bottle;

1331 hours: The Member goes to the Prep Room to prepare for the 3rd surgical patient of the day. Thereafter, she goes back and forth from the OR to the RR and to the Prep Room to obtain equipment for the 3rd surgical [client]'s surgery and deal with an issue with the electrical panel; and

1338 hours: The 3rd surgical [client] of the day is brought to the OR.

28. During the period 1310 – 1314 hours, [RN A] was in the RR caring for the first surgical client of the day.

29. The Member admits that she was responsible for, and failed to, document any assessment of [the Client,] including vital signs and any care that she provided to [the Client] in the initial post-operative period.

30. Had the Member testified, she would have said that when she first saw [the Client] in the RR, [the Client]'s systolic blood pressure was in the "mid 80s". The Member agrees that when she assumed [the Client]'s care, she did not consider [the Client]'s blood pressure and oxygen saturation to be abnormally low, and that [the Client] was in critical condition, unstable and required immediate medical intervention.

31. Had the Member testified she would have said that [Dr. B] considered it to be acceptable for [clients] to have a systolic blood pressure in the 70's on arrival in the RR, and that she had questioned [Dr. B] about this in the past and was assured that it was an acceptable post-operation blood pressure. Had [Dr. B] testified, he would have said it was unacceptable for a [client] to have a systolic blood pressure in the 70's on arrival in the RR, and as soon as he was informed that the [clients]'s systolic blood pressure was in the 70's, he took immediate steps to treat the [client].

32. The Member admits that she was in and out of the RR during the period she was responsible for [the Client]'s care. Had the Member testified, she would have said that [the Client] was alert and talkative, and, to the Member, this indicated [the Client] did not need immediate intervention.

33. [RN A] returned to the RR at approximately 1320 hours, at which time she assumed care for [the Client]. The Member admits there was no "official" hand over of [the Client]. Had the Member testified, she would have said she had a brief discussion with [RN A] about [the Client]'s blood pressure. [RN A] was concerned because it was so low. At that time, based on the chart, [the Client]'s blood pressure was 66/30, and her oxygen saturation was 88%.

34. The Member then left the RR to prepare for the third surgical client.

35. At approximately 1351 hours, the Member went to the RR and found [RN A] was concerned about [the Client]'s low blood pressure. She assisted [RN A] in taking a bilateral blood pressure, and they confirmed [the Client]'s systolic blood pressure was mid 60s to mid 70s. The Member went to the OR and informed [Dr. B] of the low blood pressure. [Dr. B] ordered [the Client] be put in Trendelenberg (lower the head of the bed so the client's feet were higher then her head) and receive a fluid bolus.

36. At approximately 1445 hours, [the Client] became restless, agitated, lost consciousness and had a dramatic decreased in oxygen saturation.

37. The Member was in the RR at that time, and she immediately got [Dr. B], who was in the OR, to attend to [the Client] On his arrival in the RR, [Dr. B] intubated [the Client], ordered her to receive fluid boluses under pressure, and ordered her to be catheterized. The Member assisted, and documented on [the Client]'s Recovery Room Record that 3000 cc of RL [Ringers Lactate] were given and that [the Client] was catheterized for 100 cc urine. [The Client] was draining heavily from her surgical wounds, to the extent that her surgical dressings and binder were soaked with blood and tumescent fluid.

38. At approximately 1517 hours, the Member assisted in putting a binder on [the Client,] who was unconscious and continued to drain from her surgical wounds. [Dr. A] had ordered the binder to try staunch the flow of blood and tumescent fluid.

39. The Member was in and out of the RR on many other occasions.

40. At approximately 1552 hours, [Dr. A] called 911 and informed the operator that she needed an ambulance for a [client] who had crashed, was unconscious, intubated and not breathing, and was bleeding a lot.

41. EMS arrived at the Clinic at approximately 1557 hours. The Member brought EMS into the Clinic at 15:59 hours. They found [the Client] to be unconscious, chalky white, lying supine with legs elevated, intubated and being manually ventilated via ambu-bag by [RN A], and lying in a pool of pinkish fluid. When EMS attempted to take [the Client]'s vital signs, they found she had no palpable blood pressure or pulse. CPR was initiated.

42. [The Client] was transported by EMS to the emergency department of a nearby hospital, where attempts were made to resuscitate her. [The Client] was pronounced dead in the emergency department. The cause of death was hemorrhagic shock.

**ADMISSIONS**

43. The Member admits that, as an RPN, she did not have the knowledge, skill or judgment to care for a client immediately after surgery, and especially one who, like [the Client], had a low blood pressure and was unstable. Had the Member testified, she would have

said that she did not realize, at the relevant time, that she did not have the knowledge, skill or judgment to care for a client in the RR. The Member admits that she never took any steps to determine whether it was appropriate for her to provide nursing care in such a capacity, including contacting the CNO or reviewing the CNO Practice Guideline: Utilization of RNs and RPNs. The Member admits that she never should have accepted [the Client] as a client, and in doing so, she failed to maintain the standards of practice of the profession and that her conduct was unprofessional.

44. The Member admits that she failed to document any assessment of [the Client] including vital signs and any care that she provided to [the Client] in the initial post-operative period. The Member admits that by doing so, she failed to maintain the standards of practice of the profession, she failed to keep records as required, and that her conduct was unprofessional.

45. The Member admits that she was "in and out of the RR" during the period she was responsible for [the Client]. The Member admits that [the Client] never should have been left alone in the immediate post-surgical period, and that in leaving [the Client] alone and unattended, the Member failed to maintain the standards of practice of the profession and her conduct was unprofessional.

46. The Member admits that, although she was not [the Client]'s primary care nurse for the majority of the time [the Client] was in the RR, and an RN and one or more physicians were providing care to [the Client] at various times in the RR, she had enough information about the situation to recognize [the Client] needed emergency care and should have taken steps to ensure that the appropriate emergency care was received after [the Client]'s sudden deterioration at 1445 hours. The Member admits that her failure to do so was a failure to maintain the standards of practice of the profession.

47. The Member therefore admits to having committed the acts of professional misconduct as set out in allegations 1, 2, and 3 of the Notice of Hearing, as more specifically described above.

Council for the College clarified that while there is no specific standard of practice regarding perianesthesia nursing published by the College of Nurses, an expert report was used by the parties to determine the standard that would apply.

**Decision**

The panel considered the Agreed Statement of Facts and finds that the facts support findings of professional misconduct and, in particular, finds that the Member committed acts of professional misconduct as alleged in paragraphs 1 and 2 of the Notice of Hearing in that she failed to meet the standard of practice with respect to the assessment, care and documentation of a client, and she failed to keep records as required regarding this [client]. In addition, as set out in Allegation 3, her conduct, would reasonably be regarded by members of the profession as unprofessional.

**Reasons for Decision**

The parties submitted an Agreed Statement of Facts which the panel found was clear and the panel accepted it as sufficient evidence of misconduct. Unprofessional conduct includes a serious disregard for professional obligations. Failure to live up to the standard of practice demonstrates that the Member was unprofessional.

**Penalty**

Counsel for the College advised the panel that a Joint Submission on Order had been agreed upon. The Joint Submission as to Order provides as follows:

1. Requiring the Member to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date of the Order.

2. Directing the Executive Director to suspend the Member's certificate of registration for a period of three months.

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

    (a) So long as she is a registered practical nurse, the Member shall practi[s]e within her scope of practice and will not provide nursing care to clients in the immediate post-operative period or in other circumstances where client care needs are highly complex, outcomes are unpredictable, and there are risks for unpredictable, systemic or wide-ranging negative outcomes in response to care;

    (b) The Member shall successfully complete at her own expense a course or courses that have received prior approval of the Director of Professional Conduct ("Director") regarding scope of practice for a registered practical nurse, assessment, nursing interventions and documentation, and shall provide to the Director proof of enrolment and successful completion of the course(s);

    (c) Until the Member has successfully completed the course or courses required in paragraph 3b, above, she shall only provide direct nursing care to clients if the Director has agreed that the nursing care she will be providing is within the scope of practice of a registered practical nurse;

    (d) For an 18-month period after the suspension is lifted, the Member must:

        i. Notify the Director of the name, address, and telephone number of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position;

        ii. Provide her employer(s) with a copy of the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Order and, if available, the Panel's written Decision and Reasons, together with any attachments. If the Decision and Reasons are not available on the day that the Member returns to practice, the Member shall provide her employer with a copy of

the Decision and Reasons within fourteen (14) days of it becoming available;

iii. Only obtain employment where her employer(s) agrees to, and does, write to the Director, within fourteen (14) days of the commencement or resumption of the Member's employment and provide the Director with the following:

A. confirmation that the employer(s) has received a copy of the documents referred to in paragraph 3(c)(iii) above;

B. confirmation that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has breached the standards of practice of the profession; and

C. confirmation that the employer agrees to provide the Director with performance appraisals regarding the Member's nursing practice as set out in 3(d), below, completed by a member of the College after three (3) months, six (6) months, and one (1) year of employment.

(e) The Member's employer shall provide to the Director performance appraisals completed by a registered member of the College after three (3) months, six (6) months, and one (1) year of employment regarding the Member's nursing practice.

4. All deliveries and notifications to be given by or on behalf of the Member to the College, and the employer(s) pursuant to these terms are to be made by verifiable method of delivery, the proof of which the Member shall retain.

**Penalty Submissions**

Counsel for the College spoke to the principles that inform the development of joint submissions. These include truth-seeking and the attribution of responsibility in a way that is reasonable and fair. It provides an opportunity for the parties to review and agree on evidence in fact and in law. It allows the evaluation of the circumstances in a way that reflects the issues. Resolution agreements are fair and efficient and do not incur the cost and trauma of a full hearing.

Counsel for the College continued that orders in cases of professional misconduct related to failing to meet the standards of the profession include specific and general deterrence, and should emphasize rehabilitation and remediation. Specific deterrence is not punishment. It is primarily about protection of the public. It assesses the degree of risk posed by allowing an individual to hold herself out as a nurse and hence able to provide nursing care to the public. The order should consider the seriousness of the conduct, aggravating and mitigating factors related to the member's conduct, and prior decisions made by disciplinary panels in similar cases. In this case, Ms Alleyne has cooperated with the College, and has acknowledged professional misconduct, demonstrating insight and accepting responsibility. Ms Alleyne has

had no prior complaints or disciplinary matters before this College. However, failing to meet the standard of practice is serious and the penalty should address remediation, along with a short period of suspension that provides for both specific and general deterrence.

The circumstances that gave rise to the allegations involved a number of regulated health professionals. Each health professional was responsible for different aspects of [client] care and all failed to provide the care that was needed. The physicians involved in this circumstance have been the subject of disciplinary proceedings by their regulatory body. Ms Alleyne testified as a witness at those proceedings. The registered nurse involved in this circumstance has been the subject of disciplinary proceedings by the College of Nurses of Ontario. The College accepts that Ms Alleyne's role was less significant than that of the physicians or the registered nurse involved. Ms Alleyne was the primary nurse for a short period immediately after surgery and then assisted with care of the [Client] on several occasions. While she was responsible for her actions and failed to meet professional standards, a significant component of Ms Alleyne's conduct occurred because she was not aware of the appropriate standards of practice of an RPN and the care required in the immediate post-operative period. Ms Alleyne made no attempt to determine if it was appropriate for an RPN to practi[s]e in this setting and to determine if she had the knowledge, skills and ability to do so. Every nurse has an independent obligation to ensure that his/her practice is consistent with practice standards and obligations, to practi[s]e safely and to refrain from performing actions for which they are not competent. Nurses must take immediate action if [client] safety and wellbeing is compromised, even if the other health professionals present are not doing so.

The joint submission on order provides for a suspension as a general deterren[t] emphasizing to the membership as a whole the importance of practi[s]ing within [one's] skill sets and competences. The remainder of the joint submission addresses remediation, which is the correction of deficiencies through re-education and supervision.

Ms Alleyne submitted that this investigation and disciplinary proceeding has been a learning experience. She has taken steps to improve her practice and has looked into taking courses on assessment of care. She now realizes that she can supersede the actions and decisions of other health professionals and communicates this responsibility to other nurses.

**Penalty Decision**

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

1. The Member to appear before the Panel to be reprimanded at a date to be arranged but, in any event, within three (3) months of the date of the Order.

2. The Executive Director to suspend the Member's certificate of registration for a period of three months.

3. The Executive Director to impose the following terms, conditions and limitations ("Conditions") on the Member's certificate of registration:

(a) So long as she is a registered practical nurse, the Member shall practi[s]e within her scope of practice and will not provide nursing care to clients in the immediate post-operative period or in other circumstances where client care needs are highly complex, outcomes are unpredictable, and there are risks for unpredictable, systemic or wide-ranging negative outcomes in response to care;

(b) The Member shall successfully complete at her own expense a course or courses that have received prior approval of the Director of Professional Conduct ("Director") regarding scope of practice for a registered practical nurse, assessment, nursing interventions and documentation, and shall provide to the Director proof of enrolment and successful completion of the course(s);

(c) Until the Member has successfully completed the course or courses required in paragraph 3b, above, she shall only provide direct nursing care to clients if the Director has agreed that the nursing care she will be providing is within the scope of practice of a registered practical nurse;

(d) For an 18-month period after the suspension is lifted, the Member must:

i. Notify the Director of the name, address, and telephone number of all employer(s) within fourteen (14) days of commencing or resuming employment in any nursing position;

ii. Provide her employer(s) with a copy of the Notice of Hearing, Agreed Statement of Facts, Joint Submission on Order and, if available, the Panel's written Decision and Reasons, together with any attachments. If the Decision and Reasons are not available on the day that the Member returns to practice, the Member shall provide her employer with a copy of the Decision and Reasons within fourteen (14) days of it becoming available;

iii. Only obtain employment where her employer(s) agrees to, and does, write to the Director, within fourteen (14) days of the commencement or resumption of the Member's employment and provide the Director with the following:

A. confirmation that the employer(s) has received a copy of the documents referred to in paragraph 3(c)(iii) above;

B. confirmation that the employer agrees to notify the Director immediately upon receipt of any reasonable information that the Member has breached the standards of practice of the profession; and

C. confirmation that the employer agrees to provide the Director with performance appraisals regarding the Member's nursing practice as set out in 3(e), below, completed by a member of the College after three (3) months, six (6) months, and one (1) year of employment.

(e) The Member's employer shall provide to the Director performance appraisals completed by a registered member of the College after three (3) months, six (6) months, and one (1) year of employment regarding the Member's nursing practice.

4. All deliveries and notifications to be given by or on behalf of the Member to the College, and the employer(s) pursuant to these terms are to be made by verifiable method of delivery, the proof of which the Member shall 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.

I, Barbara Titley, 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:
Nancy Sears, RN
Margaret Tuomi, Public Member