



**THE COLLEGE OF COMPLEMENTARY HEALTH PROFESSIONALS
OF BRITISH COLUMBIA (the “College”)**

In the matter of a Regulatory Complaint under the
Health Occupations and Professions Act, SBC [2022] c 43 (“HPOA”), regarding:

Dr Graziella Francescato, ND
INQ-2025-00044ND

**CONSENT ORDER
(pursuant to section 158 of the HPOA)**

BY THE REGISTRAR:

WHEREAS:

- A. On February 11, 2025, pursuant to section 33 (1) of the *Health Professions Act*, RSBC 1996, c 183 (the “HPA”), the College initiated an investigation following a complaint submitted by a patient (the “Complainant”) alleging that Graziella Francescato, ND, (the “Respondent”), failed to provide safe, quality patient care by administering treatments that the Complainant did not consent to. The complaint further alleged that the Respondent was dismissive of their concerns and did not respond to written requests for information (the “Complaint”).
- B. On April 15, 2025, the Respondent was provided with notice of the investigation regarding the Complaint and was provided with an opportunity to respond to the investigation before the College's Investigation Committee deliberated on the disposition of the Complaint.
- C. On August 20, 2026, a panel of the College's Investigation Committee assessed the Complaint pursuant to section 134 (2) (b) of the HPOA.
- D. Pursuant to section 136 of the HPOA, the Panel determined it had reasonable grounds to believe the Respondent committed an act of misconduct by:



- i. Failing to take all reasonable steps to ensure that the Complainant understood the information provided before and during treatment, in violation of the Informed Consent practice standard (in place at the time)
 - ii. Failing to record a discussion of the potential benefits and risks or side effects of treatment, including but not limited to the risk unintended or non-uniform results, in the treatment record, in violation of the Informed Consent practice standard (in place at the time)
 - iii. Failing to include the following in the treatment record, in violation of the Record-Keeping Standard (in place at the time):
 - a) Emergency contact information and details of the Complainant's family doctor
 - b) Personal health history, personal health number, ongoing medical concerns, family health history, allergies or drug reactions,
 - c) The Respondent's assessments and observations
 - d) Any tests or reports
 - e) The reasons for the proposed treatment
 - f) The specifics of any treatment plan, recommendation, follow-up plan, and contraindications
 - g) The Complainant's consent to treatment
 - h) The Complainant's reaction to treatment
 - iv. Failing to ensure that the Complainant's concerns were being addressed in a professional manner, in violation of the Code of Conduct and Code of Ethics (in place at the time)
- E. Pursuant to section 136 (2) (a) of the HPOA, the Panel directed the Registrar to dispose of the Complaint by making an order with the Respondent's consent pursuant to section 158 of the HPOA.
- F. The Respondent consents to the making of this Consent Order pursuant to section 158 of the HPOA and acknowledges that she has read and understood the terms of this Consent Order and was given the opportunity to seek independent legal advice before consenting



to the terms of the order.

- G. The Respondent acknowledges that, in accordance with section 256 of the HPOA, the Registrar must publish the terms of the Disciplinary Order and the reasons for the Disciplinary Order.
- H. The Respondent acknowledges that a breach of the terms of this Consent Order constitutes misconduct pursuant to section 11 of the HPOA and any alleged breach may result in an investigation under the HPOA and lead to further regulatory consequences.

DISCIPLINARY ORDER

PURSUANT TO SECTION 158 (2) (b) AND 269 OF THE HPOA, THE REGISTRAR ORDERS THAT:

- 1. The Respondent acknowledges that they engaged in misconduct and consents to a reprimand for the following conduct:
 - a. Failing to take all reasonable steps to ensure that the Complainant understood the information provided before and during treatment, in violation of the Informed Consent practice standard (in place at the time)
 - b. Failing to record a discussion of the potential benefits and risks or side effects of treatment, including but not limited to the risk unintended or non-uniform results, in the treatment record, in violation of the Informed Consent practice standard (in place at the time)
 - c. Failing to include the following in the treatment record, in violation of the Record-Keeping Standard (in place at the time):
 - i. Emergency contact information and details of the Complainant's family doctor
 - ii. Personal health history, personal health number, ongoing medical concerns, family health history, allergies or drug reactions,
 - iii. The Respondent's assessments and observations



- iv. Any tests or reports
 - v. The reasons for the proposed treatment
 - vi. The specifics of any treatment plan, recommendation, follow-up plan, and contraindications
 - vii. The Complainant's consent to treatment
 - viii. The Complainant's reaction to treatment
 - d. Failing to ensure that the Complainant's concerns were being addressed in a professional manner, in violation of the Code of Conduct and Code of Ethics (in place at the time)
2. The Respondent undertakes not to repeat the following conduct, which constitutes a breach of the current College Bylaws, Professional Standards and Clinical Practice Standards:
- a. Failing to take all reasonable steps to ensure that the patient understands the information provided before and during treatment in violation of principle 1.1.3 of the Informed Consent Professional Standard
 - b. Failing to Document the attainment of consent in the patient health care records in violation of principle 1.9 of the Informed Consent Professional Standard
 - c. Failing to maintain clear and comprehensive health care records, in violation of Principle I of the Record Keeping Professional Standard
 - d. Failing to communicate in a manner with patients that is respectful and clear, in violation of Principle 4 of the Communication and Professionalism Standard
3. The Respondent is required to review the current College Bylaws and the Professional Standards for Record-Keeping, Informed Consent, and Communication and Professionalism and report completion to the College within one month of consenting to the order; (s. 269 (d) (ii)).
4. The Respondent is required to repeat, at their own cost, the College's self-led learning module 7: Record-Keeping and Informed Consent and confirm to the College that they have done so, within two months of consenting to the order.



5. The Respondent is required to cooperate with random audits of their clinic or any other practice locations (as the case may be), to assess records (as defined in Schedule 1 of the Freedom of Information and Protection of Privacy Act) by an inspector appointed by the Registrar for a period of 12 months commencing on the date of signing the consent order.

College of Complementary Health Professionals of British Columbia:

Marta Kumor Fane
Deputy Registrar

Dated at Vancouver this 7th day of October, 2026.