AMENDED DISCIPLINARY COMPLAINT RESOLUTION AGREEMENT

pursuant to section 55(2)(a.1) of the *Health Professions Act*

BETWEEN:

COLLEEN CARTIER, #76,134
(the **"Registrant"**)

and

College and Association of Registered Nurses of Alberta
also known as **College of Registered Nurses of Alberta**
(the **"College**")

An Amended Disciplinary Complaint Resolution Agreement ("**ADCRA**") was executed between the Registrant and the College, dated with effect **January 27, 2023**. The below constitutes a summary of such ADCRA:

Through a ADCRA with the College, COLLEEN CARTIER, #76,134 (the "**Registrant**"), acknowledged and admitted that their behaviour constituted unprofessional conduct. Particulars of the Registrant's unprofessional conduct arises from one (1) complaint to the College and includes the following:

- In 2021 and while working a shift as a RN in an emergency room ("**ER**") setting, the Registrant failed to provide adequate patient care to Patient 1, who presented at the ER with symptoms of hypotension, sepsis and dehydration, when the Registrant:
    - failed to conduct an initial assessment of Patient 1 as the primary RN assigned to the patient after the patient was admitted to the ER at 0936h;
    - failed to adequately assess and respond to Patient 1's symptom of sepsis;
    - failed to complete physician orders that were ordered at approximately 0933h and on a STAT basis, including to complete an ECG and request laboratory results;
    - failed to complete physician orders that were ordered at approximately 0951h, including to administer fluids and intravenous ("**IV**") antibiotics;
    - failed to adequately use, and monitor, the Connect Care documentation system that was used by the health care team to ensure they provided required patient care;
    - failed to adequately monitor Patient 1, including when they did not conduct ongoing assessments or take the patient's vital signs after

they were advised by their colleague that the patient had low blood pressure at 0937h; and

- failed to respond to, and address, Patient 1's monitor that was alarming throughout their shift due to their low blood pressure.

- On the same shift, the Registrant failed to provide adequate patient care to Patient 2, who presented at the ER for severe nausea and vomiting and was triaged as a CTAS 2, when the Registrant:

    - failed to assess and/or document their assessment of Patient 2's vital signs in their initial assessment at 0903h;

    - failed to complete physician orders that were ordered between approximately 0921h and 0929h, and on a STAT basis, including laboratory results, to administer fluids and to administer IV medication before the end of their shift at 1100h;

    - failed to adequately prioritize the care of Patient 2, specifically seeking assistance initiating an intravenous line prior to going on break; and

    - failed to adequately use, and monitor, the Connect Care documentation system that was used by the health care team to ensure they provided required patient care, including failing to acknowledge physician orders.

- Furthermore, on the same shift, the Registrant failed to provide adequate patient care to Patient 3, who was admitted to the inpatient unit ("**IPU**") during the Registrant's shift, when the Registrant:

    - between 0927h and 1000h, failed to document their medication administration, specifically 0.5mg SC of hydromorphone, and causing an additional dose to be administered to Patient 3 as it was not adequately documented in the medication administration record; and

    - failed to provide report to their nurse colleague on the IPU, including that the Registrant did not know Patient 3's name, admitting diagnosis, past medical history and the Registrant did not advise their nurse colleague that they had administered hydromorphone to the patient.

The Registrant agreed to complete coursework on critical thinking, documentation, medication administration and the duty to provide care as well as complete a behavior improvement plan on nursing care in an ER setting. The Registrant further agreed to confirm their practice setting(s) with the Complaints Director, including one self-employment setting, and must receive confirmation from one of their practice setting(s) that they have reviewed the Behavior Improvement Plan. The Registrant is further is

restricted from changing their approved practice setting(s) unless a new practice setting is approved by the Complaints Director for a period of two years. Conditions shall appear on the College register and on the Registrant’s practice permit.