DISCIPLINARY COMPLAINT RESOLUTION AGREEMENT

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

BETWEEN:

JUDITH MCLELLAN, #101,097
(the "**Registrant**")

and

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

A Disciplinary Complaint Resolution Agreement ("**DCRA**") was executed between the Registrant and the College, dated with effect **MARCH 14, 2022.** The below constitutes a summary of such DCRA:

Through a DCRA with the College, JUDITH MCLELLAN, #101,097 (the "**Registrant**"), acknowledged and admitted that their behaviour constituted unprofessional conduct. Particulars of the Registrant's unprofessional conduct arises from three (3) complaints to the College and includes the following:

- While working on a pediatric intensive care unit with 1:1 RN care assignments, the Registrant failed to adequately document their nursing care of a critically ill pediatric patient ("**Patient 1"**) who had received brain surgery including but not limited to, failing to document the patient's transfer of care, initial assessments of the patient, neuro-vital signs as required each hour for the totality of their shift, urine intake and output levels as required each hour for the totality of their shift, the decompensation and changes in the patient's condition, including that they had dislodged their ETT tube, required to be re-intubated and required an emergency bedside burr hole procedure to reduce intracranial pressure, discontinuation of medications, medication administration, assessments through the patient's decompensation and emergency procedure. The Registrant only documented "clamped" for the entirety of their shift.

- In addition, while providing care to Patient 1 on the same shift, the Registrant:

    - Failed to ensure proper medication administration, including but not limited to failing to adequately accurately and adequately document their medication administration, failing to verify adequate medication was administered, miscalculating medication amounts, failing to label medication during an emergency, failing to discontinue and disconnect

sedative infusions after ordered to do so and failing to administer a STAT blood transfusion order until reminded by their RN colleague.

- Failed to demonstrate adequate judgment and failed to prioritize the care of Patient 1 when they failed to failed to adequately assess and monitor the patient, failed to notified the physician about the patient's decompensation and they left the patient unattended on more than one occasion during their shift and without advising other members of the healthcare team to ensure the patient was being monitored by another RN resulting in a respiratory therapist colleague ("**RT"**) responding to the patient alarms and finding Patient 1 alone after vomiting and dislodging his ETT tube.

- Over a period of three months, the Registrant failed to uphold medication administration policies and failed to adequately document their medication administration on numerous occasions, including the adequate documentation of wastage of hydromorphone and ketamine.

- While working on a pediatric intensive care unit with 1:1 RN care assignments, the Registrant failed to adequately document their medication administration of a critically ill pediatric patient ("**Patient 2"**), specifically on two or more occasions, their medication preparation and mixing of a new hydromorphone infusion bag and their wastage of hydromorphone; and on two occasions, their wastage of ketamine.

- In addition, while providing care to Patient 2 on the same shift, the Registrant:

    - Failed to demonstrate adequate judgment and failed to prioritize the care of Patient 2 when they left them unattended on more than one occasion during their shift when they were assigned 1:1 care to the patient and without advising other members of the healthcare team to ensure the patient was being monitored by another RN resulting in a physician finding the patient unattended and severely decompensating. The Registrant also failed to address or monitor the patient's feed bags, infusion tubing or pump rates.

    - Failed to uphold medication administration policies when they calculated the incorrect amount of ketamine and rocuronium for Patient 2 after receiving urgent orders from the physician who discovered the unattended and decompensating.

    - Failed to demonstrate critical inquiry and failed to uphold medication administration policies when they withdrew 2mg of hydromorphone for a pediatric patient ("**Patient 3"**), without providing care to the patient,

being asked by the patient's primary RN and without having the withdrawal witnessed or co-signed the wastage.

- Failed to demonstrate adequate professionalism while on shift in their behavior and actions.

- On two occasions while working shifts, the Registrant failed to adequately monitor their fitness to practice as a RN.

The Registrant must pay a fine of $3,000.00 to the College and has agreed to complete coursework on documentation, medication administration, professionalism, and ethics. The Registrant must also complete a period of direct and indirect supervision in their practice setting. Conditions shall appear on the College register and on the Registrant's practice permit.