AMENDED NOTICE TO ATTEND A HEARING

BY THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as COLLEGE OF REGISTERED NURSES OF ALBERTA (the "COLLEGE")

pursuant to section 120(1) of the *Health Professions Act*

February 22, 2023

TO: MARCIA CAMPBELL AND HOLLY CONNERS

TAKE NOTICE that **you, MARCIA CAMPBELL, REGISTRATION #63,867 and you, HOLLY CONNERS, REGISTRATION #74,216**, (the "**Registrants**") are required to attend on the **22nd, 23rd, and 24th days of March 2023**, commencing at **9:30 (nine-thirty)** o'clock, at which time the Hearing Tribunal of the College will conduct a virtual hearing (the "**Hearing**") to consider, jointly, the complaints of the Registrants' practice while employed as a Registered Nurse ("**RN**") at [an Alberta hospital].

FURTHER TAKE NOTICE that the Registrants' practice fell below the standard expected of a RN and constitutes unprofessional conduct, contrary to section 1(1)(pp) of the *Health Professions Act,* including, but not limited to, the behavior described in the particulars below (the "**Hearing Particulars**").

FURTHER TAKE NOTICE that for the purpose of this Notice and the Hearing Particulars, the following terms apply:

Canadian Nurses Association (CNA) Code of Ethics	"**CNACE**"
CARNA's Documentation Standards for Regulated Members (2013)	"**CDSRM**"
CARNA's Practice Standards for Regulated Members (2013)	"**CPSRM**"

FURTHER TAKE NOTICE that the Registrants' failure to attend at the hearing may, in itself, be found by the Hearing Tribunal to be unprofessional conduct, pursuant to section 1(1)(pp)(vii)(D) of the *Health Professions Act*.

FURTHER TAKE NOTICE that the Registrants' failure to attend at the hearing may result in the Hearing Tribunal proceeding in the absence of the Registrant, pursuant to section 79(6) of the *Health Professions Act*.

FURTHER TAKE NOTICE that the Registrants may be compelled to testify at their hearing, pursuant to section 72(1) of the *Health Professions Act.*

FURTHER TAKE NOTICE that Hearings of the Hearing Tribunal are open to the public unless the Hearing Tribunal directs otherwise, pursuant to section 78(1) of the *Health Professions Act.*

FURTHER TAKE NOTICE of the following Hearing Particulars of Marcia Campbell to be determined at the Hearing:

a. Between [Date] and [Date], the Registrant failed to demonstrate adequate judgment when they contributed clinical bias by verbalizing their past experience with [Patient 1] and informing the attending physician and colleague RN that the patient was on [medication 1] and had attended the emergency room the previous month for [health information redacted], after [Patient 1] arrived at approximately 2120h to the emergency room and without having observed [Patient 1], contrary to the *Canadian Nurses Association Code of Ethics (2017)* ("**CNACE**") and the *Practice Standards for Regulated Members (2013)* ("**CPSRM**").

b. Between [Date] and [Date], the Registrant failed to demonstrate adequate professionalism in all their interactions with other members of the healthcare team, specifically when they spoke critically about [Patient 1] having out of town visitors and the COVID-19 pandemic, in the presence of their RN [colleague 1] ("**RN 1"**) and emergency medical services colleagues ("**EMS"**) and prior to an initial assessment and care being provided to [Patient 1] by [RN 1], contrary to the *CNACE* and the *CPSRM.*

c. Between [Date] and [Date], the Registrant failed to demonstrate adequate judgment when they contributed to the treatment of [Patient 1's] spouse and their [information redacted] by verbalizing their past experience with [Patient 1's] spouse ("**Spouse"**) to the attending physician and [RN 1], contrary to the *CNACE,* the *CPSRM* and applicable Alberta Health Services policies ("**AHS policies**").

d. Between [Date] and [Date], the Registrant, while in the role of charge nurse, failed to deescalate conflict arising between [Spouse] and [RN 1] and failed to promote family first strategies, contrary to the *CNACE,* the *CPSRM* and AHS policies.

e. Between [Date] and [Date], the Registrant failed to accurately document [Patient 1's] admission record at approximately 0033h without assessing or speaking to [Patient 1], contrary to the CNACE, the *CPSRM*, the *Documentation Standards for Regulated Members (2013)* ("**CDSRM"**) and AHS policies.

f. Between [Date] and [Date], the Registrant failed to accurately document when they documented that they assessed [Patient 1's] vital signs on the Adult Vital Signs Record at 0015h when they had not completed an assessment or provided direct care to the patient and copied [RN 1's] assessment of [Patient 1's] vital signs and initialed at the bottom of the page, contrary to the *CNACE*, the *CPSRM, CDSRM* and AHS policies.

g. Between [Date] and [Date], the Registrant failed to accurately document [Patient 1's] admission record when they wrote "C/L" instead of married while referencing [Patient 1's] marital status, contrary to the *CNACE,* the *CPSRM,* the *CDSRM* and AHS policies.

h. On [Date], the Registrant failed to adequately prioritize the urgent care of [Patient 1], failed to practice competently and failed to perform critical and necessary interventions while performing cardiopulmonary resuscitation ("**CPR"**), contrary to the *CNACE,* the *CPSRM* and AHS policies, when:

    i. The Registrant failed to prioritize [Patient 1's] CPR interventions between approximately 0059h and 0103h;

    ii. the Registrant failed to connect, or contributed to a delay in connecting, [Patient 1] to the Lifepack 15 monitor between approximately 0059h and 0106h to detect an initial cardiac rhythm;

    iii. the Registrant failed to maintain, or contributed to a delay in maintaining, an adequate airway for [Patient 1] between approximately 0059h and 0114h when an oral pharyngeal airway ("**OPA"**) was inserted;

    iv. the Registrant failed to start, or contributed to a delay in starting, an intravenous line for [Patient 1] between approximately 0059h and 0120h;

    v. the Registrant failed to advocate to administer, or contributed in a delay in administering, [Patient 1] a dose of [medication 2] between 0059h and 0106h when [Patient 1's] initial cardiac rhythm was detected and every three (3) to five (5) minutes thereafter until 0125h when [Patient 1] was administered their first dose of [medication 2];

    vi. the Registrant failed to demonstrate adequate judgment when they advocated for, or contributed to, treating reversable causes prior to the administration of [medication 2], specifically [information redacted];

    vii. the Registrant failed to verify and use suction equipment, or contributed to a delay in verifying and using suction equipment, between approximately 0059h and 0125h, when portable suction equipment was supplied by their EMS colleagues; and

    viii. the Registrant failed to connect, or contributed to a delay in connecting, an end tidal carbon dioxide ("**EtCO2"**) monitor capnometry cable to the Lifepack 15 monitor to verify [Patient 1's] EtCO2 levels between approximately 0059h and 0139h, when it was connected by their EMS colleagues.

i. On [Date], the Registrant failed to demonstrate adequate clinical judgment when they analyzed [Patient 1's] Lifepack 15 monitor between approximately 0106h and 0108h and failed to correctly visually identify and assess [Patient 1's] initial cardiac rhythm as ventricular fibrillation and thereafter deliver a defibrillation shock, contrary to the *CNACE*, the *CPSRM* and AHS policies.

j. On [Date], the Registrant failed to demonstrate adequate clinical judgment when they inordinately focused on, or contributed to inordinately focusing on, potential [health information redacted] or [information redacted] during [Patient 1's] resuscitation attempts, contrary to the *CNACE* and the *CPSRM.*

k. On [Date], the Registrant failed to document [Patient 1's] initial cardiac rhythm and continued cardiac rhythms checks between each two (2) minute cycle of CPR during resuscitation interventions between 0106h and [Time] on the whiteboard used for documentation, contrary to the *CNACE,* the *CPSRM,* the *CDSRM* and AHS policies.

l. On [Date], the Registrant, while in the role of Charge Nurse, failed to effectively delegate an assigned recorder for [Patient 1's] resuscitation interventions after their EMS colleagues arrived at 0125h, contrary to the *CNACE,* the *CPSRM* and AHS policies.

m. On [Date], the Registrant, while in the role of Charge Nurse, failed to effectively coordinate, supervise and direct the resuscitation interventions for [Patient 1] when they knew, or ought to have known, that they had no formal team leader, contrary to the *CNACE,* the *CPSRM* and AHS policies.

n. On [Date], the Registrant, after volunteering to transcribe and document [Patient 1's] cardiac event and resuscitation interventions in their health record, failed to adequately and accurately document [Patient 1's] care, contrary to the *CNACE,* the *CPSRM,* the *CDSRM* and AHS policies, when:

   i. the Registrant documented at 0057h that [Patient 1] was transferred and provided care by [RN 1] when the information did not relate to their own encounter or observations of [Patient 1];

   ii. the Registrant failed to note their documentation after [Patient 1's] death as late entries, specifically their entries at [information redacted]; and

   iii. the Registrant failed to document [Patient 1's] initial cardiac rhythm and continued cardiac rhythms between interventions in their late-entry documentation.

o. On [Date], the Registrant, after volunteering to transcribe and document [Patient 1's] cardiac event and resuscitation interventions in their health record, failed to adequately and accurately document [Patient 1's] care, contrary to the *CNACE*, the *CPSRM,* the *CDSRM* and AHS policies, when:

   i. the Registrant failed to verify and review the recorded information from the whiteboard with all involved health care providers;

   ii. the Registrant failed to note that their documentation was collaboratively completed and transcribed after [Patient 1's] death at [Time] with [RN 1]; and

   iii. the Registrant failed to describe the names of other health care providers involved in [Patient 1's] resuscitation interventions.

p. On [Date], the Registrant failed to demonstrate honesty and integrity in all their interactions when they advised their on-call site administrator at approximately 0355h that [Patient 1] had a "temper tantrum" in the x-ray room and refused to leave the hospital prior to [Patient 1's] resuscitation attempts and death, contrary to the CNACE and the CPSRM.

AND FURTHER TAKE NOTICE of the following Hearing Particulars of Holly Conners to be determined at the Hearing:

1. On [Date], the Registrant failed to demonstrate adequate professionalism in their interactions with other members of the healthcare team, specifically during report from their emergency medical services ("**EMS"**) [colleague 1], contrary to the CNACE and the CPSRM.

2. On [Date], the Registrant failed to demonstrate critical inquiry and failed to use appropriate information to enhance client care, specifically when they did not adequately consider the information and report provided by their EMS [colleague 1] at approximately 2120h about [Patient 1's] physiologic condition, including that they were diaphoretic, pale, in pain, having difficulty breathing, slow to respond and had an altered level of consciousness ("**LOC**"), contrary to the CNACE and the CPSRM.

3. On [Date], the Registrant failed to provide client centered, respectful and compassionate care during their initial assessment of [Patient 1] in their language and body language, contrary the CNACE and the CPSRM.

4. On [Date], the Registrant failed to demonstrate adequate judgment and failed to practice competently when they performed an inadequate head to toe initial emergency assessment of [Patient 1] at approximately 2130h that did not reflect the severity of [Patient 1's] physiologic condition presented by EMS [colleague 1], contrary to the CNACE, the CPSRM and applicable Alberta Health Services policies ("**AHS policies"**) when:

    a. the Registrant failed to complete an adequate respiratory assessment, including listening to lung sounds;

    b. the Registrant failed to complete an adequate cardiovascular assessment, including taking [Patient 1's] postural vital signs, assessing [Patient 1's] capillary refill and listening to heart sounds;

    c. the Registrant failed to complete an adequate central nervous system assessment, including assessing [Patient 1's] pain score, LOC and lack of engagement and cooperation;

    d. the Registrant failed to critically consider [Patient 1's] respiratory distress, LOC, pain and other relevant objective Canadian Triage and Acuity Scale ("**CTAS"**) modifiers;

    e. the Registrant failed to adhere to CTAS scoring guidelines; and

    f. [information redacted]

5. On [Date], the Registrant failed to adequately and accurately document their initial assessment of [Patient 1] at approximately 2130h, contrary to the CNACE, the CPSRM and AHS policies, when:

    a. the Registrant failed to adequately document their respiratory assessment of [Patient 1], including that it hurt to breathe;

    b. [information redacted]

    c. the Registrant failed to accurately document [Patient 1's] skin colour; and

    d. the Registrant failed to accurately document [Patient 1's] level of consciousness and orientation.

6. Between [Date] and [Date], the Registrant failed to adequately and accurately document their care of [Patient 1] between approximately 2142h and 0057h, contrary to the CNACE, the CPSRM and AHS policies, when:

    a. the Registrant failed to document [Patient 1's] physiological decompensation in the x-ray room, specifically that [Patient 1] became unsteady while standing up, indicated that [Patient 1] was short of breath, was diaphoretic and laid on the floor;

    b. the Registrant failed to adequately document their interactions with [Patient 1's] spouse ("**Spouse**");

    c. [information redacted]

    d. the Registrant failed to accurately and objectively document when they indicated that [Patient 1] was refusing to be discharged at 0010h;

    e. the Registrant failed to objectively document about [Patient 1's] condition and respiratory rate between approximately 0010h and 0057h when they described that [Patient 1] was hyperventilating;

    f. the Registrant failed to adequately and objectively document their assessment of [Patient 1's] after administering medication, specifically [medication 1] [dose] and [Medication 2] [dose]; and

    g. the Registrant failed to document their entry at 0057h as a late-entry.

7. Between [Date] and [Date], the Registrant failed to demonstrate adequate critical inquiry during [Patient 1's] care in recognizing signs and symptoms of physiologic decompensation between 2142h and 0057h, including but not limited to, [Patient 1's] increasing heart rate at 2319h (109/64) and 0015h (121/66), their pale skin colour, their diaphoretic state at 2319h, their increased respiratory rate and depth of respiration, their assertion that they could not breathe and it hurt to breathe, their lack of improvement after [medication 1] [dose] was administered at 2319h, their rapid respiratory rate at 0010h after [dose] of [medication 2] was administered and their rapid respiratory rate at 0057h during their transfer to [room], contrary to the CNACE, the CPSRM and AHS policies.

8. Between [Date] and [Date], the Registrant failed to adequately monitor and assess [Patient 1] considering the severity of [Patient 1's] physiologic condition and decompensation, contrary to the CNACE, the CPSRM and AHS policies.

9. Between [Date] and [Date], the Registrant failed to adequately and effectively explain nursing care to [Spouse], specifically that [Patient 1] had been assessed in the x-ray room by the physician, contrary to the CNACE, the CPSRM and AHS policies.

10. Between [Date] and [Date], the Registrant failed to adequately and effectively explain nursing care to [Spouse], specifically when they spoke to [Spouse] in a condescending and abrupt manner when they requested assistance for [Patient 1], contrary to the CNACE, the CPSRM and AHS policies.

11. Between [Date] and [Date], the Registrant failed to provide client-centered care and compassionate care through their speech and body language when they administered [dose] of [medication 1] to [Patient 1], contrary to the CNACE and the CPSRM.

12. Between [Date] and [Date], the Registrant failed to provide family focused care, contrary to the CNACE, the CPSRM and AHS policies, specifically when:

    a. the Registrant failed to respond to [Spouse's] request for assistance in a timely manner;

    b. the Registrant failed to communicate with [Spouse] with respect, dignity and compassion; and

    c. the Registrant failed to de-escalate and assist [Spouse] when they began recording and became upset.

13. On [Date], the Registrant failed to adequately prioritize the urgent care of [Patient 1], failed to practice competently and failed to perform critical and necessary interventions while performing cardiopulmonary resuscitation ("**CPR**"), contrary to the CNACE, the CPSRM and AHS policies, when:

    a. The Registrant failed to prioritize [Patient 1's] CPR attempts between approximately 0059h and 0103h;

b. the Registrant failed to connect, or contributed to a delay in connecting, [Patient 1] to the Lifepack 15 monitor between approximately 0059h and 0106h to detect an initial cardiac rhythm;

c. The Registrant applied Lifepack 15 monitor chest leads instead of defibrillation combo pads (“**Combo Pads”**) to [Patient 1] at approximately 0106h;

d. the Registrant failed to maintain, or contributed to a delay in maintaining, an adequate airway for [Patient 1] between approximately 0059h and 0114h when an oral pharyngeal airway (“**OPA”**) was inserted;

e. the Registrant failed to start, or contributed to a delay in starting, an intravenous line for [Patient 1] between approximately 0059h and 0120h;

f. the Registrant failed to advocate to administer, or contributed in a delay in administering, [Patient 1] a dose of [medication 3] between 0059h and 0106h when [Patient 1’s] initial cardiac rhythm was detected and every three (3) to five (5) minutes thereafter until 0125h when [Patient 1] was administered their first dose of [medication 3];

g. the Registrant failed to demonstrate adequate judgment when they advocated for, or contributed to, treating reversable causes prior to the administration of [medication 3], specifically [information redacted];

h. the Registrant failed to verify and use suction equipment, or contributed to a delay in verifying and using suction equipment, between approximately 0059h and 0125h, when portable suction equipment was supplied by their EMS colleagues; and

i. the Registrant failed to connect, or contributed to a delay in connecting, an end tidal carbon dioxide (“**EtCO2”**) monitor capnometry cable to the Lifepack 15 monitor to verify [Patient 1’s] EtCO2 levels between approximately 0059h and 0139h, when it was connected by their EMS colleagues.

14. On [Date], the Registrant failed to demonstrate adequate clinical judgment when they analyzed [Patient 1’s] Lifepack 15 monitor between approximately 0106h and 0108h and failed to correctly visually identify and assess [Patient 1’s] initial cardiac rhythm as ventricular fibrillation and thereafter deliver a defibrillation shock, contrary to the CNACE, the CPSRM and AHS policies.

15. On [Date], the Registrant failed to demonstrate adequate clinical judgment when they inordinately focused on, or contributed to inordinately focusing on, potential [medication 1] [information redacted] during [Patient 1’s] resuscitation attempts, contrary to the CNACE and the CPSRM.

16. On [Date], the Registrant failed to document [Patient 1's] initial cardiac rhythm and continued cardiac rhythms checks between each two (2) minute cycle of CPR during resuscitation interventions between 0106h and [Time] on the whiteboard used for documentation, contrary to the CNACE, the CPSRM, the CDSRM and AHS policies.

17. On [Date], the Registrant failed to adequately document their observations of [Patient 1] between 0057h and 0059h, specifically that [Patient 1] became unresponsive, contrary to the CNACE, the CPSRM, the CDSRM and AHS policies.

18. On [Date], the Registrant failed to accurately document their entry at 0057h about moving [Patient 1] to [room] as a late entry, contrary to the CNACE, the CPSRM, the CDSRM and AHS policies.

19. On [Date], the Registrant failed to document their involvement in [Patient 1's] cardiac event and resuscitation between approximately 0059h and [Time], contrary to the CNACE, the CPSRM, the CDSRM and AHS policies, when:

    a. the Registrant failed to document that they connected [Patient 1's] chest leads and verified the ECG lead position;

    b. the Registrant failed to document that they started [Patient 1's] intravenous line at 0120h; and

    c. the Registrant failed to document their other nursing interventions after a critical cardiac event and resuscitation interventions prior to [Patient 1's] death.

20. On [Date], the Registrant failed to adequately document and identify that the documentation and transcription by their RN [colleague 2] regarding [Patient 1's] resuscitation attempts between 0059h and [Time], that was completed after [Patient 1's] death, was accurate and complete when they initialed below [colleague 2]'s late entry at 0500h at the bottom of the page, contrary to the CNACE, the CPSRM, the CDSRM and AHS policies.

THIS NOTICE IS ISSUED BY:

Amy Payne, Hearings Director

COLLEGE OF REGISTERED NURSES OF ALBERTA
PURSUANT TO SECTION 77 OF THE HEALTH PROFESSIONS ACT