DISCIPLINARY COMPLAINT RESOLUTION AGREEMENT

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

BETWEEN:

CHRISTOPHER MCALLISTER, #101,036
(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 November 15, 2023**.** The below constitutes a summary of such DCRA:

Through a DCRA with the College, CHRISTOPHER MCALLISTER, #101,036 (the "**Registrant**"), acknowledged and admitted that their behaviour constituted unprofessional conduct. Particulars of the Registrant's unprofessional conduct arises from two (2) complaints to the College and includes the following:

On or about January 7, 2023, the Registrant demonstrated a lack of knowledge, skill and/or judgment in their care of Patient # 1 (KP), contrary to the *Canadian Nurses Association Code of Ethics (2017)* ("***Code of Ethics***"), *Entry Level Competencies for the Practice of Registered Nurses (2019)* ("***Entry Level Competencies***"), *Documentation Standards (2013) ("**Documentation Standards**")*, *Medication Management Standards (2022) ("**Medication Standards**"), Practice Standards for Regulated Members (2013)* ("***Practice Standards"***) and/or one (1) or more employer policies, when they engaged in one or more of the following:

- Failing to adequately review the patient's medical records prior to administering Hydromorphone to the patient;
- Administering the Hydromorphone to the patient before it was due, which was contrary to the physician's written orders;
- Failing to assess and monitor the patient or do so adequately post medication administration and throughout the shift;
- Failing to stay by the patient's side when the patient became unstable, unresponsive, lost consciousness, became pulseless and/or otherwise deteriorated;

- Failing to document or to adequately document:
    - the patient assessments and vital signs;
    - the patient's changing or deteriorating condition, and status;
    - the timing and sequence of emergency events that took place; and,
    - the emergency interventions performed, and their effectiveness or ineffectiveness;
- Failing to prioritize patient needs;
- Failing to take action, to act reasonably, and intervene in a timely manner;
- Failing to demonstrate adequate leadership, delegate appropriately or to seek assistance from other providers during an emergency situation;
- Failing to recognize the gravity of the situation, and the serious deterioration or a negative change in patient's condition;
- Failing to commence timely life-saving measures by not:
    - activating, pulling the call bell or otherwise requesting help and assistance from other healthcare providers;
    - communicating or reporting the patient's change in status and the gravity of the situation;
    - locating, bringing or asking others to locate and bring emergency medications and equipment to the patient's room;
    - failing to administer Narcan;
    - adequately securing and supporting the patient's airway;
    - calling a Code 66;
    - calling a Code Blue; and,

    - initiating, commencing or assisting with CPR.

- Failing to assess and report on own fitness to practice at the relevant time.

On or about January 17, 2023, the Registrant demonstrated a lack of knowledge, skill and/or judgment in their care of Patient # 2 (LA), contrary to the *Code of Ethics,* the *Entry Level Competencies*, the *Documentation Standards*, the *Medication Standards*, the *Practice Standards*, and/or one (1) or more employer policies, when they engaged in one or more of the following:

- Failing to complete post-operative spinal and neurological assessments;

- Failing to communicate the change in patient's condition or status or to elevate concerns appropriately up the proper chain of command;

- Failing to document or to document accurately the nursing care and interventions performed, and assessments;

- Failing to prioritize and time-manage patient needs;

- Failing to adequately evaluate, recognize and respond to the gravity of the patient's change in condition or deterioration in status;

- Failing to adequately anticipate and/or respond to patient's concerns and potential health risks; and,

- Failing to assess and report own fitness to practice at the relevant time.

The Registrant agreed to complete course work, write a self-reflective essay, complete 100 hours of direct supervision, 200 hours of indirect supervision, 800 hours of employer reference (practice report), provide a letter from treating physician, and complete CPR re-certification and courses. Conditions shall appear on the College register and on the Registrant's practice permit.