COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA also known as COLLEGE OF REGISTERED NURSES OF ALBERTA (the “**College**”)

DECISION OF THE HEARING TRIBUNAL

RE: CONDUCT OF **HOLLY CONNERS,** R.N. REGISTRATION #**74,216**

AS A RESULT OF A HEARING HELD BEFORE

THE HEARING TRIBUNAL

OF THE COLLEGE

ON

March 22, 2023

INTRODUCTION

A hearing was held on **March 22, 2023,** via Microsoft Teams videoconferencing by the Hearing Tribunal of the College of Registered Nurses of Alberta (the "**College**") to hear a complaint against **Holly Conners** R.N. Registration #**74,216.**

Those present at the hearing were:

a. Hearing Tribunal Members:

Claire Mills, RN Chairperson
Roxine Wright, RN
Doug Dawson, Public Representative
Kevin Kelly, Public Representative

b. Independent Legal Counsel to the Hearing Tribunal:

Maya Gordon

c. CRNA Representative:

Jason Kully, Conduct Counsel

d. Registrant Under Investigation:

Holly Conners (sometimes hereinafter referred to as "the **Registrant**")

e. Registrant's Labour Relations Officer/Legal Counsel:

Kristan McLeod, Counsel
Tricia Gibbs, UNA

f. Additional Participants

Ms. Marcia Campbell, RN
Karen Smith, Counsel for Ms. Marcia Campbell
Nancy Tran, Co-Counsel for Ms. Campbell
Diana Halabi, Hearings Coordinator
Court Reporter

PRELIMINARY MATTERS

In advance of the hearing, two preliminary applications were made by counsel for the Registrant, Ms. McLeod, and counsel for Ms. Campbell, Ms. Smith – the joinder application (a), and the closure of the hearing application (b). The remaining preliminary matters (c), (d), and (e) were discussed during the hearing itself.

a. Joinder

The first application made to the Hearing Tribunal, in advance of the hearing, was an application to have the two separate hearings scheduled for Ms. Conners and Ms. Campbell joined together. All parties were in agreement with putting forth this application.

The joinder was requested because the Allegations for both registrants were stemming from the same incident, and therefore the Hearing Tribunal would be able to consider the conduct of both Ms. Conners and Ms. Campbell in one hearing, rather than having the same facts repeated in two separate hearings. The parties submitted that joinder was the most efficient and expeditious way to proceed.

The Hearing Tribunal has the discretion to hear the two matters jointly as the master of its own proceedings. In this instance, although the actions and roles of Ms. Conners and Ms. Campbell differed, the incidents in question involved the same parties, the same patient, [Patient 1], the same location during the same time period, and arose out of the same transaction or occurrence or series of transactions or occurrences. Although the hearings would be joined, the decision was that there would be two separate decisions for each of Ms. Conners and Ms. Campbell.

After deliberation, the Hearing Tribunal granted the joinder request prior to the commencement of the hearing, confirming to all parties that the hearing would take place starting on March 22, 2023 and would cover the Allegations against both Ms. Campbell and Ms. Conners. As agreed upon, this decision will only be related to the unprofessional conduct and sanctions for Ms. Conners.

b. Closure of the Hearing

Thereafter, the Hearing Tribunal received a letter from Ms. McLeod dated March 14, 2023, who wrote on behalf of both Ms. Conners and Ms. Campbell, seeking to have the hearing held in private, including excluding the Complainant except when he was testifying, pursuant to section 78(1)(a)(ii) – (v) of the *Health Professions Act*, RSA 2000, c. H-7 ("the **HPA**"). Conduct Counsel, Mr. Kully, took no position on the closure of the hearing.

In the letter, Ms. McLeod gave the following information in support of the closure of the hearing, with a number of screenshots to provide evidence of the below concerns:

1. The [Complainant], had been making comments, posts and videos on social media which expressed animus, threats, and punitive actions against Ms. Conners, Ms. Campbell and

others, and the two registrants fear for their safety if details regarding these hearings are public or their images are publicized. Details of these concerns include:

a. [Complainant] has made threatening comments about coming after people in the health care system who he believes are responsible for his spouse's death, and told health care workers he would destroy their lives and careers;

b. [Complainant] has called both Ms. Conners and Ms. Campbell "murderers" repeatedly;

c. [Complainant] has posted photos with guns on social media and accompanied them with statements about punishing people. Ms. Conners and Ms. Campbell are not mentioned, but view these postings as thinly veiled threats against them;

d. In a video from June 18, 2022, [Complainant] stated " … they pissed off the wrong human being … Justice will rain down on them as it should … I will not be quiet … you ain't going to shut me up, not unless you kill my ass … My wife was killed and governments are in control, hurting innocent people, and they're covering it up";

e. [Complainant] has stated many times that his spouse was killed by the [an Alberta town] hospital staff, including a statement in December 2022 on social media which includes: "They killed my wife 2 years ago and they need to pay for this crime and all other crimes that our healthcare systems have done"

f. In a video posted on social media on January 1, 2023, [Complainant] stated: "2022 is history. 2023 is still a mystery. For those that don't know what's coming, I know what's coming. I'm the one delivering it… It's 2023… This year, people are going to go down for the crime of killing my wife… I'm smiling because I know there is no damn way with the amount of evidence out there that these people are getting away with another year of walking around without going to prison for the murder of my wife…. I'm done being Mr. Nice Guy... I haven't been Mr. Forceful yet… I will be forcing a lot of things this year… I'm coming for all you guilty sons of bitches… I ain't giving up so just know that I'm here. Justice is coming. I'm still here… Peace everybody this year is our year let's take them sonsabitches down."

2. In addition, [Complainant] has been asked in past instances to observe requests and directions with respect to the recording of others and disseminating private information about others. Details of these concerns include:

    a. [Complainant] was asked to stop recording at the hospital before his spouse's death, and his refusal to do so was responsible for his removal from the hospital;

b. [Complainant] said in a social media video that he received a "gag order" related to a Law Society of Alberta complaint that he made but he continues to speak about it;

c. [Complainant] has repeatedly asked his supporters to register and observe the hearing of this matter. In a video, he states that until he is called as a witness, he cannot observe the hearing, but that he may have a "way around" that; and

d. In a written social media posting from early March 2023, a copy of which was provided to the Tribunal, [Complainant] stated the following: "The more people the better, as I was informed the nurses may be trying to get these proceedings closed to the public. I have made it clear that should not happen, specially since CRNA prides themselves on transparency. I do not expect everyone to be able to watch the whole trial, but set your phone up on wifi and a charger and let them run and catch what you can…"

The Hearing Tribunal has the discretion, under section 78 of the HPA, to hold the entire hearing or part of a hearing in private on the application of any person. Section 78 reads as follows:

Access to hearing

78(1) A hearing is open to the public unless

(a) the hearing tribunal holds the hearing or part of the hearing in private on its own motion or on an application of any person that the hearing or part of the hearing should be in private

(i) because of probable prejudice to a civil action or a prosecution of an offence,

(ii) to protect the safety of the person or of the public,

(iii) because not disclosing a person's confidential personal, health, property or financial information outweighs the desirability of having the hearing open to the public,

(iv) because the presence of the public or complainant could compromise the ability of a witness to testify, or

(v) because of other reasons satisfactory to the hearing tribunal,

or

(b) another Act requires that the hearing or part of the hearing be held in private.

(2) If a hearing or part of a hearing is held in private, the hearing tribunal must state the reason why and must include the reason in the record.

(3) Even if a hearing is held in private,

(a) the investigated person and the investigated person's counsel may attend,

(b) the complainant may attend unless the hearing tribunal directs otherwise, and

(c) the complaints director and hearing tribunal's, complaints director's and college's counsel may attend.

> **(4)** Even if a hearing is open to the public, a witness, except for the investigated person, may be excluded from the hearing until the witness has given evidence and has been released or dismissed from the hearing.

The Hearing Tribunal considered the application to close the hearing.

It considered [Complainant's] valid comment, in one of his postings, that this matter needed to be heard transparently and openly for the benefit of the public and weighed it against the evidence provided by counsel for Ms. Conners and Ms. Campbell about their subjective concerns for their own safety and security.

The Hearing Tribunal took notice of the fact that the [an Alberta town] population is small, and Ms. Conners and Ms. Campbell are living in that community with [Complainant]. Ms. Conners and Ms. Campbell made it clear that they were both concerned about their personal safety and the Hearing Tribunal takes such concerns seriously.

The Hearing Tribunal agreed with counsel that there is a clear potential, given [Complainant's] statements, that there may be inappropriate and unauthorized recordings of the hearing if it is not closed, and that those recordings may be disseminated in the community, and could be linked to statements about both registrants which do not convey the actual content of the proceedings.

Ultimately, the Hearing Tribunal decided to close the hearing, including to the Complainant, pursuant to section 78 of the HPA. The closure decision extends to all Exhibits of this hearing, which the Hearing Tribunal orders be sealed, and the transcript of the hearing, which the Hearing Tribunal also orders be sealed.

It made this decision to protect the safety of the registrants, given [Complainant's] threatening behavior and posts, and because the presence of the Complainant at the hearing, or his supporters recording the hearing (as he suggested) could compromise the ability of a witness or witnesses to testify.

This decision was communicated in advance of the hearing to all parties, the Complainant and anyone who had registered to view the hearing. Ms. Tricia Gibbs, Ms. Conners' UNA Representative, was entitled to stay during the closed hearing as she was acting as second counsel to Ms. McLeod for the duration of the matter. No other observers or members of the public were admitted.

c. Jurisdiction and Composition

At the commencement of the hearing, Conduct Counsel and the Labour Relations Officer/Legal Counsel for the Registrant confirmed that there were no objections to the composition of the Hearing Tribunal or to the Hearing Tribunal's jurisdiction to proceed with the hearing.

d. Additional Exhibit

At the commencement of the hearing, counsel for Ms. Conners and Ms. Campbell advised as a preliminary matter that although the parties were planning to enter an Agreed Statement of Facts and Liabilities, they were not in agreement about the inclusion of one particular exhibit.

The exhibit in question was a letter issued by the College of Physicians and Surgeons of Alberta ("**CPSA**") in relation to a complaint made about the conduct of [Doctor] to the CPSA, by [Complainant]. That CPSA decision was released in February 2023, and counsel for both Ms. Conners and Ms. Campbell felt that it was important context for the Hearing Tribunal to have a copy of the CPSA letter, as it was relevant and material to the Allegations relating to both registrants.

The Hearing Tribunal did not review the CPSA letter itself, as it was not provided, so no information from that letter forms part of the Hearing Tribunal's reasoning or decisions set out below.

In response, Conduct Counsel took the position that the CPSA letter was not relevant to the decision of whether Ms. Campbell or Ms. Conners engaged in unprofessional conduct. The question being considered by the CPSA was whether a separate professional, [Doctor], engaged in unprofessional conduct in relation to a separate profession.

Mr. Kully also noted that a decision from another administrative decision maker, dealing with a separate member in a separate profession, is not binding on the Hearing Tribunal. The CPSA letter did not contain agreed-upon facts, and were not being provided as firsthand evidence but rather as a summary of the CPSA's internal findings.

After hearing the submissions of the parties and considering the broad allowance for the entry of evidence in a hearing under section 79 of the HPA, the Hearing Tribunal concluded that the CPSA letter would not be admitted into evidence.

The CPSA letter is related to a separate professional, in a separate regulatory organization, and the findings made by that organization have no bearing on the findings that need to be made by this Hearing Tribunal. In addition, the information contained in that letter was not agreed upon by the parties, was not given under oath from a witness, and was not strictly related to the questions at hand before the Hearing Tribunal. As such, the CPSA letter was not admitted into evidence.

e. Agreement

Conduct Counsel confirmed at the beginning of his submissions that the matter was proceeding by Agreement.

ALLEGATIONS AND ADMISSION

Although the original Notice to Attend contained a number of allegations, the Hearing Tribunal was informed at the commencement of the hearing that although there were many initial allegations, many of them were withdrawn. The amended list of allegations was provided to the Hearing Tribunal in a document entitled "Hearing Particulars", marked as Exhibit #1.

The Allegations in the Notice to Attend against Ms. Conners ("**Allegations**") are as follows:

a. On December 25, 2020, Ms. Conners failed to adequately assess [Patient 1] immediately after [Patient 1] was observed unexpectedly on the ground in the X-ray room at approximately 2300 hours, contrary to the Canadian Nurses Association Code of Ethics (2017) ("Code of Ethics"), the Practice Standards for Regulated Members (2013) ("Practice Standards"), and applicable Alberta Health Services policies ("AHS policies").

b. On December 25, 2020, Ms. Conners failed to adequately document their observations and care of [Patient 1] between approximately 2142h and 0057h, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards for Regulated Members (2013) ("Documentation Standards") and AHS policies.

c. On December 26, 2020, Ms. Conners failed to document [Patient 1's] initial cardiac rhythm, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

d. On December 26, 2020, Ms. Conners failed to adequately document their interventions, observations and involvement in [Patient 1's] resuscitation efforts between 0057h and 0257h, including late-entry documentation after [Patient 1's] death, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

During the hearing, counsel for all parties waived the formal reading of the Allegations into the record.

The Registrant has admitted to the following:

1. Ms. Conners admits that while employed as a RN at [an Alberta hospital], Ms. Conners' practice fell below the standard expected of a RN when:

    a. On December 25, 2020, Ms. Conners failed to adequately assess [Patient 1] immediately after [Patient 1] was observed unexpectedly on the ground in the X-ray room at approximately 2300 hours, contrary to the Canadian Nurses Association Code of Ethics (2017) ("Code of Ethics"), the Practice Standards for

Regulated Members (2013) ("Practice Standards"), and applicable Alberta Health Services policies ("AHS policies").

b. On December 25, 2020, Ms. Conners failed to adequately document their observations and care of [Patient 1] between approximately 2142h and 0057h, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards for Regulated Members (2013) ("Documentation Standards") and AHS policies.

c. On December 26, 2020, Ms. Conners failed to document [Patient 1's] initial cardiac rhythm, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

d. On December 26, 2020, Ms. Conners failed to adequately document their interventions, observations and involvement in [Patient 1's] resuscitation efforts between 0057h and 0257h, including late-entry documentation after [Patient 1's] death, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

(collectively referred to as "**Ms. Conners' Conduct**").

2. Ms. Conners admits that Ms. Conners' Conduct constitutes unprofessional conduct as defined in the HPA.

3. Ms. Conners further admits that Ms. Conners' Conduct was contrary to the College's Practice Standards, Code of Ethics, and Documentation Standards.

4. Furthermore, Ms. Conners admits that Ms. Conners' Conduct was contrary to their employer's standards and policies included as appendices to the Agreed Statement of Facts and Liabilities.

EXHIBITS

The following documents were entered as Exhibits:

Exhibit #1 – Hearing Particulars

Exhibit #2 – Agreed Statement of Facts and Liabilities ("**ASFL**"), including Appendices

Exhibit #3 – Joint Recommendation, Conners

Exhibit #4 – Joint Recommendation, Campbell

SUBMISSIONS ON THE ALLEGATIONS

Submissions by Conduct Counsel:

Conduct Counsel made brief submissions on the four Allegations in relation to Ms. Conners. Conduct Counsel reviewed the Agreed Statement of Facts and Liabilities (Exhibit #2) and the Appendices to the Agreed Statement of Facts and Liabilities (appended to Exhibit #2).

Conduct Counsel submitted that the conduct of Ms. Conners constitutes unprofessional conduct and that the conduct was contrary to the applicable standards and Code of Ethics. Specifically, Conduct Counsel noted that these were failures in regard to assessment and documentation, which are fundamental responsibilities of a regulated member like Ms. Conners.

Conduct Counsel submitted that the following provisions from the Practice Standards were applicable: Standards: 1.1, 1.2, 2.5, 5, 5.3. Conduct Counsel submitted that the following provisions from the Documentation Standards were applicable: 1.2(f), 1.4(f), and 1.13. Finally, Conduct Counsel noted that the following provisions from the Code of Ethics applied: A1, D6, and G1. Conduct Counsel submitted that the conduct constitutes unprofessional conduct under sections 1(1)(pp)(i) and (ii) of the HPA.

Submissions by Legal Counsel for the Registrant, Ms. Conners:

Counsel for Ms. Conners made brief submissions in relation to the Agreed Statement of Facts and Liabilities. She was supported in these submissions by counsel for Ms. Campbell, who noted that their submissions were, in part, to be considered for both registrants.

Ms. McLeod and Ms. Smith both emphasized the context surrounding the events in question, noting that the events occurred in a short-staffed hospital on Christmas night 2020 in a rural community during the height of COVID restrictions. Both counsel noted that the Hearing Tribunal needed to assure itself that the facts, as agreed, reached a level of unprofessional conduct as defined in the HPA.

Questions from the Hearing Tribunal:

After a break to review the materials and to deliberate, the Hearing Tribunal asked the parties whether the use of “their” in the Allegations against both registrants was intended to be a plural “their” or a gender-neutral pronoun.

Counsel for all parties confirmed that in Ms. Conners’ case, all uses of “their” in the Allegations was intended to refer to Ms. Conners, and not to anybody else.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON THE ALLEGATIONS

The Hearing Tribunal has reviewed the exhibits and considered the submissions made by the parties. The reasons of the Hearing Tribunal for each allegation will be addressed below.

Allegation (a)

Allegation

Allegation (a) alleges the following:

a. On December 25, 2020, Ms. Conners failed to adequately assess [Patient 1] immediately after [Patient 1] was observed unexpectedly on the ground in the X-ray room at approximately 2300 hours, contrary to the Canadian Nurses Association Code of Ethics (2017) ("Code of Ethics"), the Practice Standards for Regulated Members (2013) ("Practice Standards"), and applicable Alberta Health Services policies ("AHS policies").

Facts

The Hearing Tribunal accepts the facts set out in the Agreed Statement of Facts as proven. Agreed facts which are relevant to this Allegation are set out below:

- Ms. Conners was working as a RN in the Emergency Room ("**ER**") at [an Alberta hospital] on a night shift between 1900h on December 25, 2020, and 0715h on December 26, 2020.

- Shortly after Ms. Conners' assessment and ECG of [Patient 1], [Complainant] arrived at the hospital and completed a COVID-19 screening form with Ms. Campbell. Ms. Campbell assisted him in donning personal protective equipment ("**PPE**"), explained COVID-19 protocols and completed a COVID-19 questionnaire. [Complainant] went to [Patient 1's] room.

- While in [Patient 1's] room, Ms. Conners explained to [Complainant] that they were completing tests, then left the room to provide [Doctor] with a report of the assessment and assist Ms. Campbell with acute care patients.

- [Lab Technician] arrived, asked [Patient 1] if she was able to walk to the x-ray room, put her housecoat around her shoulders, and walked [Patient 1] to the x-ray room. [Lab Technician] called out for help when [Patient 1] became unsteady at the door of the x-ray room.

- Ms. Conners was in the x-ray computer area when she heard [Lab Technician] say something to [Patient 1] as they entered the x-ray room. When Ms. Conners entered the room, she saw [Patient 1] leaning on a counter.

- Shortly after that, Ms. Conners saw [Patient 1] lying down on the floor in the front of the X-ray machine. [Patient 1] said that she could not stand up. [Lab Technician] encouraged

[Patient 1] to stand. [Patient 1] said she could not stand, and then [Doctor] and the Protective Services Guard arrived. Ms. Conners, [Lab Technician], and [Doctor] were beside [Patient 1] while she was laying on the floor.

- [Patient 1] stood up with assistance from [Doctor] and [Lab Technician] and completed her x-ray while standing and other tests while sitting on a stool. [Doctor] assessed [Patient 1]. During [Doctor's] assessment, [Patient 1] said she was taking [medication], had run out, and was in withdrawal.

- Ms. Conners was present for part of the time [Patient 1] was in the x-ray room, saw [Patient 1] lying down on the floor, was beside [Patient 1] while she was on the floor, and was alerted to the interactions between [Patient 1] and others in the x-ray room. Ms. Conners did not document these interactions nor her observations of [Patient 1's] condition in the x-ray room. [Patient 1] was in the x-ray room at approximately 2300h.

Within the documentation, the Hearing Tribunal reviewed the Multidisciplinary Notes and the Emergency Department Nursing Assessment and Treatment Record for [Patient 1] and it did not see an assessment completed by Ms. Conners at the relevant time.

Unprofessional Conduct

The Hearing Tribunal finds that the proven Conduct constitutes unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA, which states:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice.

Given the facts found and the admissions made in the Agreed Statement of Facts and Liabilities, the Hearing Tribunal has found that Allegation (a) constituted unprofessional conduct both because it displayed a lack of judgment in the provision of professional services and due to the fact that it breached various provisions of the Standards of Practice and the Code of Ethics.

The conduct displayed a lack of judgment in the provision of professional services due to the fact that assessments are critical to nursing care. If Ms. Conners was the nurse assigned to ensure the care of [Patient 1], it was her responsibility to do an assessment of her when she found her on the floor, and to document the assessment.

The Hearing Tribunal acknowledges that a physician was present, [Doctor], and that he completed an assessment of [Patient 1], but pursuant to the AHS Policies, assessments should also have

been completed by Ms. Conners in any event due to the dramatic change in circumstance when she saw [Patient 1] lying on the floor.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards for Regulated Members (Approved January 2013; Effective April 2013) ("**Practice Standard(s)**"): 1.2, 5, 5.3 as follows:

Standard 1: Responsibility and Accountability
The nurse is personally responsible and accountable for their nursing practice and conduct.

1.2 The nurse follows current legislation, standards and policies relevant to their practice setting.

Standard 5: Self-Regulation
The nurse fulfills the professional obligations related to self-regulation.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

Regarding Standard 1.2, Ms. Conners acknowledged, via the Agreed Statement of Facts and liabilities, that the following policies, among others, applied to her work setting as an RN at the time of the complaint:

1. Protocol – Altered Level of Consciousness – Adult (AHS Document # HCS-268-01); and
2. Protocol – Assessment and Reassessment of Patients (AHS Document # HCS-181-01).

Within the Altered Level of Consciousness Protocol, it specifically requires an RN to complete a nursing assessment when a patient has experienced a new onset altered level of consciousness.

Within the Assessment and Reassessment of Patients Protocol, an RN is required to complete a reassessment when, for example, a patient has a change in vital signs or there is another change in the patient's condition.

Accordingly, given those policies in place which were applicable to Ms. Conners, and the requirement under Practice Standard 1.2, the Hearing Tribunal found that Ms. Conners failed to comply with those policies in relation to Allegation (a).

In addition, in relation to Practice Standards 5 and 5.1, those standards again require the RN to fulfil the professional obligations of self-regulation, as well as all applicable standards, guidelines and position statements. As noted above, by failing to comply with the two AHS Protocols, Ms. Conners fell below the required Standards of Practice 5 and 5.1.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Code of Ethics for Registered Nurses (2017 Edition) ("**Code of Ethics**"): A1, D6, and G1, as follows:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the health care team.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

6. Nurses, in their professional capacity, relate to all persons receiving care with respect.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

The Code of Ethics requires nurses to ensure that they are following the Practice Standards and to ensure that they provide safe, compassionate, competent, and ethical care. The Practice Standards, as set out above, require compliance with the policies and in failing to make the proper assessments for [Patient 1], Ms. Conners did not comply with the Code of Ethics. Assessments that occur promptly and in accordance with established policies ensure the dignity of patients, and provide those receiving care with respect.

For the reasons set out above, for Allegation (a), the breaches of the Practice Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA.

Allegation (b)

Allegation

Allegation (b) alleges the following:

b. On December 25, 2020, Ms. Conners failed to adequately document their observations and care of [Patient 1] between approximately 2142h and 0057h,

contrary to the Code of Ethics, the Practice Standards, the Documentation Standards for Regulated Members (2013) ("Documentation Standards") and AHS policies.

Facts

The Hearing Tribunal accepts the facts set out in the Agreed Statement of Facts as proven. Agreed facts which are relevant to this Allegation are set out below:

- Ms. Conners was working as an RN in the ER at [an Alberta hospital] on a night shift between 1900h on December 25, 2020, and 0715h on December 26, 2020.

- Ms. Conners completed an ECG at 2142h.

- Shortly after Ms. Conners' assessment and ECG of [Patient 1], [Complainant] arrived at the hospital and completed a COVID-19 screening form with Ms. Campbell. Ms. Campbell assisted him in donning personal protective equipment, explained COVID-19 protocols and completed a COVID-19 questionnaire. [Complainant] went to [Patient 1's] room.

- While in [Patient 1's] room, Ms. Conners explained to [Complainant] that they were completing tests, then left the room to provide [Doctor] with a report of the assessment and assist Ms. Campbell with acute care patients.

- [Lab Technician] arrived, asked [Patient 1] if she was able to walk to the x-ray room, put her housecoat around her shoulders, and walked [Patient 1] to the x-ray room. [Lab Technician] called out for help when [Patient 1] became unsteady at the door of the x-ray room.

- Ms. Conners was in the x-ray computer area when she heard [Lab Technician] say something to [Patient 1] as they entered the x-ray room. When Ms. Conners entered the room, she saw [Patient 1] leaning on a counter.

- Shortly after that, Ms. Conners saw [Patient 1] lying down on the floor in front of the X-ray machine. [Patient 1] said that she could not stand up. [Lab Technician] encouraged [Patient 1] to stand. [Patient 1] said she could not stand, and then [Doctor] and the Protective Services Guard arrived. Ms. Conners, [Lab Technician], and [Doctor] were beside [Patient 1] while she was laying on the floor.

- [Patient 1] stood up with assistance from [Doctor] and [Lab Technician] and completed her x-ray while standing and other tests while sitting on a stool. [Doctor] assessed [Patient 1]. During [Doctor's] assessment, [Patient 1] said she was taking [medication], had run out, and was in withdrawal.

- Ms. Conners was present for part of the time [Patient 1] was in the x-ray room, saw [Patient 1] lying down on the floor, was beside [Patient 1] while she was on the floor, and was alerted to the interactions between [Patient 1] and others in the x-ray room. Ms. Conners did not document these interactions nor her observations of [Patient 1's] condition in the x-ray room. [Patient 1] was in the x-ray room at approximately 2300h.

- At approximately 2300h, [Protective Services Guard] brought [Patient 1] back to her room in a wheelchair and left the wheelchair beside the bed.

- At 2319h, Ms. Conners documented that [Patient 1] admitted to the physician that she took too much [medication], more than prescribed, feels she is having withdrawal, and is diaphoretic again. Ms. Conners documented that they administered [medication] to [Patient 1] at 2319h. Ms. Conners conducted an assessment and completed a set of vitals at 2319h.

- After [Complainant] was escorted from [an Alberta hospital], [Doctor] went into [Patient 1's] room with Ms. Conners and assessed [Patient 1] and ordered 1 mg of Ativan SL at approximately 0010h due to hyperventilation and anxiety. Ms. Conners administered 1 mg of Ativan SL.

- Ms. Conners completed vitals at approximately 0015h.

- Ms. Conners documented a post-administration assessment at 0033h.

- [Doctor] diagnosed [Patient 1] with [medication] withdrawal and anxiety. [Patient 1's] labs, ECG, x-ray, and physical assessments were unremarkable. [Doctor] then ordered that [Patient 1] be admitted at 0033h on December 26, 2020.

- Ms. Campbell began the admission paperwork at 0033h, without having physically assessed [Patient 1] and prior to providing care, she copied Ms. Conners' assessment information, including vital signs taken at 0015h and initialed "MC" below the vital signs. Ms. Campbell documented that [Patient 1's] heart rate was 126.

- At 0057h, Ms. Conners transferred [Patient 1] down and across the hall to Room 104 in a wheelchair for her admission. Room 104 is a designated inpatient COVID-19 room.

In addition to reviewing the Agreed Statement of Facts and Liabilities, the Hearing Tribunal also reviewed the Multidisciplinary Notes and the Emergency Department Nursing Assessment and Treatment Record for [Patient 1].

Unprofessional Conduct

The Hearing Tribunal finds that the proven Conduct constitutes unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA, which states:

Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:

(i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services.

(ii) contravention of this Act, a code of ethics or standards of practice.

Given the facts found and the admissions made in the Agreed Statement of Facts and Liabilities, the Hearing Tribunal has found that Allegation (b) constituted unprofessional conduct both because it displayed a lack of judgment in the provision of professional services and due to the fact that it breached various provisions of the Standards of Practice, the Documentation Standards for Regulated Members (January 2013) ("**Documentation Standards**") and the Code of Ethics.

Ms. Conners' conduct displayed a lack of judgment in the provision of professional services due to the fact that an experienced nurse such as Ms. Conners should have known that contemporaneous and accurate documentation is critical.

Acknowledging that Ms. Conners was in a high-stress situation with COVID protocols in place, in a short-staffed rural hospital, Ms. Conners should still have ensured that her documentation for [Patient 1] needed to be complete. It is important for documentation to occur contemporaneously as a safety measure, so that other members of the health care team can know at a glance what the status of a patient's state, assessments or medications are. As noted in the Documentation Standards, quality documentation and reporting are necessary to enhance efficient, individualized client care.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards: 1.1, 2.5, 5.3 as follows:

Standard 1: Responsibility and Accountability
The nurse is personally responsible and accountable for their nursing practice and conduct.

1.1 The nurse is accountable at all times for their own actions.

Standard 2: Knowledge-based Practice
The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

Standard 5: Self-Regulation

The nurse fulfills the professional obligations related to self-regulation.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

Regarding Standard 1.1, Ms. Conners must be accountable at all times for her actions, even when faced with extreme circumstances such as what occurred in [an Alberta hospital] on December 25 and 26, 2020. Ms. Conners has demonstrated that accountability by acknowledging in this hearing that her documentation practices on that particular shift fell below the Practice Standards.

Regarding Standard 2.5, that Standard expressly sets out that a nurse must document timely, accurate reports within their nursing practice. Ms. Conners' entries in respect of [Patient 1] from 2142h to 0057h were not timely or sufficiently accurate reports to constitute adequate documentation pursuant to this standard.

Regarding Standard 5.3, in her Agreed Statement of Facts and Liabilities, Ms. Conners acknowledged that the David Thomson Heath Region Standard "Documentation Standards for Nursing" (CC-I-10) applied to her work setting as an RN at the time of the complaint.

Within that Standard, documentation requirements include documenting nursing assessments at a minimum once per shift, and in cases where "the client is very ill and/or has unpredictable and complex health care needs, recording of nursing care provided should be more comprehensive, in depth and frequent" (1.1.1). The Standard also sets out a series of other requirements for nursing documentation. By failing to comply with this Standard in her documentation during this period, and for failing to comply with the Documentation Standards (as set out below), Ms. Conners did not comply with Standard 5.3.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Documentation Standards: 1.2(a), 1.2(f), 1.4(d) and 1.4(e), as follows.

Standard 1:
Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

1.2(a) The Nurse must … Document the following aspects of care: relevant objective information related to client care.

1.2(f) The Nurse must … Document the following aspects of care: any adverse event or adverse outcome.

1.4(d) The Nurse must … Record … chronologically, the client encounter with the health system

1.4(e) The Nurse must … Record … contemporaneously

In respect of the Documentation Standards, Ms. Conners' entries in respect of [Patient 1] during the relevant time for this Allegation are insufficient for full compliance with the Standard. They lack sufficient detail to allow someone reviewing the charts to ascertain what occurred, when, and in what manner. As she acknowledged, Ms. Conners' documentation standards fell below what is expected of an RN.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Code of Ethics: A1, D6, and G1, as follows:

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the health care team.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

6. Nurses, in their professional capacity, relate to all persons receiving care with respect.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practice according to the values and responsibilities in the Code and in keeping with the professional standards, laws and regulations supporting ethical practice.

The Code of Ethics requires nurses to ensure that they are following the Practice Standards and to ensure that they provide safe, compassionate, competent and ethical care. The Practice Standards, as set out above, require compliance with the policies and in failing to document in compliance with the Standards, Ms. Conners did not comply with the Code of Ethics. Registrants must document timely, accurate reports of assessment data.

For the reasons set out above, for Allegation (b), the breaches of the Practice Standards, the Documentation Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA.

Allegation (c)

Allegation

Allegation (c) alleges the following:

c. On December 26, 2020, Ms. Conners failed to document [Patient 1's] initial cardiac rhythm, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

Facts

The Hearing Tribunal accepts the facts set out in the Agreed Statement of Facts as proven. Agreed facts which are relevant to this Allegation are set out below:

- Ms. Conners was working as an RN in the ER at [an Alberta hospital] on a night shift between 1900h on December 25, 2020, and 0715h on December 26, 2020.

- The resuscitation attempts of [Patient 1] were a collaborative and team effort. Ms. Conners, Ms. Campbell and [Doctor] discussed [Patient 1's] care, cardiac rhythm, Hs & Ts (potential reversible causes for a cardiac arrest) and next steps throughout the resuscitation. [Doctor] was a visiting physician with [an Alberta hospital]. Due to COVID-19 restrictions, anyone entering or exiting the room would be required to don and doff PPE and no paper was permitted. A whiteboard was used to record information during resuscitation attempts and later transcribed to [Patient 1's] chart due to COVID-19 protocols.

- The resuscitation attempts occurred in room 104, which was a smaller patient room. [Patient 1] became unresponsive at 0059h and her death was declared by [Doctor] at 0257h.

- [RN Co-worker], who was working on the long-term care centre ("**LTC**") and was called at approximately 0200h and [Lab Technician] was called to return to the hospital at approximately 0130h to run additional tests. After [Patient 1's] death, documentation was completed and transcribed by Ms. Campbell with the assistance of Ms. Conners, [RN Co-worker] and the paramedics.

- The initial cardiac rhythm was not documented by Ms. Conners or Ms. Campbell.

- [Doctor] observed and verified [Patient 1's] initial cardiac rhythm as asystole and pulseless electrical activity ("PEA").

In addition to reviewing the Agreed Statement of Facts and Liabilities, the Hearing Tribunal also reviewed the Multidisciplinary Notes and the Emergency Department Nursing Assessment and Treatment Record for [Patient 1].

Unprofessional Conduct

The Hearing Tribunal finds that the proven Conduct constitutes unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA, which states:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice.

Given the undisputed facts and the admissions made in the Agreed Statement of Facts and Liabilities, the Hearing Tribunal has found that Allegation (c) constituted unprofessional conduct both because it displayed a lack of judgment in the provision of professional services and due to the fact that it breached various provisions of the Standards of Practice, the Documentation Standards and the Code of Ethics.

The conduct displayed a lack of judgment in the provision of professional services due to the fact that an experienced nurse such as Ms. Conners should have known that recording the initial cardiac rhythm during the resuscitation attempts was critical.

For the reasons expressed above regarding Allegation (b), documentation is a critical element to competent nursing practice. By failing to record the initial cardiac rhythm, Ms. Conners failed to comply with the Practice Standards, the Documentation Standards and the Code of Ethics provisions as set out under Allegation (b).

For the reasons set out above, for Allegation (c), the breaches of the Practice Standards, the Documentation Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(ii) of the HPA.

Allegation (d)

Allegation

Allegation (d) alleges the following:

> d. On December 26, 2020, Ms. Conners failed to adequately document their interventions, observations and involvement in [Patient 1's] resuscitation efforts between 0057h and 0257h, including late-entry documentation after [Patient 1's] death, contrary to the Code of Ethics, the Practice Standards, the Documentation Standards and AHS policies.

Facts

The Hearing Tribunal accepts the facts set out in the Agreed Statement of Facts as proven. Agreed facts which are relevant to this Allegation are set out below:

- Ms. Conners was working as a RN in the ER at [an Alberta hospital] on a night shift between 1900h on December 25, 2020, and 0715h on December 26, 2020.

- At 0057h, Ms. Conners transferred [Patient 1] down and across the hall to Room 104 in a wheelchair for her admission. Room 104 is a designated inpatient COVID-19 room.

- At 0059h, while Ms. Conners was placing the wheelchair outside the room, she heard a grunt. Ms. Conners called for help. Ms. Campbell arrived within seconds and donned PPE. [Doctor] arrived very quickly as well. Ms. Conners instructed the Protective Services Guard to call for Emergency Medical Services ("**EMS**") to return to [an Alberta hospital] at approximately 0100h.

- Ms. Conners did not complete documentation between 0057h and 0059h in [Patient 1's] chart.

- The resuscitation attempts of [Patient 1] were a collaborative and team effort. Ms. Conners, Ms. Campbell and [Doctor] discussed [Patient 1's] care, cardiac rhythm, Hs & Ts (potential reversible causes for a cardiac arrest) and next steps throughout the resuscitation. [Doctor] was a visiting physician with [an Alberta hospital]. Due to COVID-19 restrictions, anyone entering or exiting the room would be required to don and doff PPE and no paper was permitted. A whiteboard was used to record information during resuscitation attempts and later transcribed to [Patient 1's] chart due to COVID-19 protocols.

- The resuscitation attempts occurred in room 104, which was a smaller patient room. [Patient 1] became unresponsive at 0059h, and her death was declared by [Doctor] at 0257h.

- [RN Co-worker], who was working on the LTC was called at approximately 0200h and [Lab Technician] was called to return to the hospital at approximately 0130h to run additional tests. After [Patient 1's] death, documentation was completed and transcribed by Ms. Campbell with the assistance of Ms. Conners, [RN Co-worker] and the paramedics.

- The initial cardiac rhythm was not documented by Ms. Conners or Ms. Campbell.

- [Doctor] observed and verified [Patient 1's] initial cardiac rhythm as asystole and pulseless electrical activity ("**PEA**").

- An RN is responsible for reviewing all documentation with the recorder and ensuring that the CPR record is completed accurately.

- Between 0106h and 0257h, Ms. Conners and Ms. Campbell did not document [Patient 1's] cardiac rhythm throughout their resuscitation attempts in [Patient 1's] chart. Cardiac rhythms are required to be checked and documented between each two (2) minute cycle of CPR during resuscitation attempts. [Doctor] confirmed that Advanced Cardiac Life Support ("**ACLS**") algorithm and rhythm and pulse were checked every two minutes, and the team had good communication throughout.

- Ms. Campbell completed the documentation. She did not mark her entries between 0059h and 0257h as late entries, did not note that the documentation was completed collaboratively and did not include the names of the other healthcare providers involved.

- Ms. Conners did not add any documentation about their own care and resuscitation interventions nor initial that each entry completed by Ms. Campbell was accurate and complete. Instead, Ms. Conners initialed below one late entry at 0500h.

In addition to reviewing the Agreed Statement of Facts and Liabilities, the Hearing Tribunal also reviewed the Multidisciplinary Notes and the Emergency Department Nursing Assessment and Treatment Record for [Patient 1].

Unprofessional Conduct

The Hearing Tribunal finds that the proven Conduct constitutes unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA, which states:

> Unprofessional conduct means one or more of the following, whether or not it is disgraceful or dishonourable:
>
> (i) displaying a lack of knowledge of or lack of skill or judgment in the provision of professional services;
>
> (ii) contravention of this Act, a code of ethics or standards of practice.

Given the facts found and the admissions made in the Agreed Statement of Facts and Liabilities, the Hearing Tribunal has found that Allegation (d) constituted unprofessional conduct both because it displayed a lack of judgment in the provision of professional services and due to the fact that it breached various provisions of the Standards of Practice, the Documentation Standards and the Code of Ethics.

Ms. Conners displayed a lack of judgment by failing to document assessment data for, and her interactions with, [Patient 1] at 0057h and 0059h. In addition, although it is clear that with the short-staffing and COVID protocols, documentation during [Patient 1's] resuscitation was challenging, it was a lack of judgment for Ms. Conners to simply initial under the late entries made

by Ms. Campbell at 0500h, rather than documenting her own late entries while assisting in [Patient 1's] care.

The Hearing Tribunal finds that the Registrant breached the following provisions of the Practice Standards: 1.1, 2.5, 5.3 as follows:

Standard 1: Responsibility and Accountability
The nurse is personally responsible and accountable for their nursing practice and conduct.

1.1 The nurse is accountable at all times for their own actions.

Standard 2: Knowledge-based Practice
The nurse continually acquires and applies knowledge and skills to provide competent, evidence-informed nursing care and service.

2.5 The nurse documents timely, accurate reports of data collection, interpretation, planning, implementation and evaluation of nursing practice.

Standard 5: Self-Regulation
The nurse fulfills the professional obligations related to self-regulation.

5.3 The nurse follows policies relevant to the profession as described in CARNA standards, guidelines and position statements.

Regarding Standard 1.1, Ms. Conners must be accountable at all times for her actions, even when faced with extreme circumstances such as what occurred in [an Alberta hospital] on December 25 and 26, 2020. Ms. Conners has demonstrated that accountability by acknowledging in this hearing that her documentation practices on that particular shift fell below the Practice Standards.

Regarding Standard 2.5, that Standard expressly sets out that a nurse must document timely, accurate reports within their nursing practice. Ms. Conners' entries in respect of [Patient 1] during the period of 0057h and 0257h clearly do not meet the standard. Ms. Conners admits to failing to enter entries at 0057h and 0059h, and admits to initialing Ms. Campbell's late entry for the entire period of resuscitation. This is not timely or accurate and falls below the requirements of Standard 2.5.

Regarding Standard 5.3, for the reasons set out above in more detail under Allegation (b), Ms. Conners' actions for the period of 0057h to 0059h fell below the policies relevant to the profession, including the Documentation Standards (expressed below) and the requirements of the David Thomson Heath Region Standard "Documentation Standards for Nursing" (CC-I-10).

The Hearing Tribunal finds that the Registrant breached the following provisions of the Documentation Standards: 1.2(a), 1.2(f), 1.4(d), 1.4(e), 1.4(f) and 1.14, as follows.

Standard 1:
Nurses document the nursing care they provide accurately and in a timely, factual, complete and confidential manner.

1.2(a) The Nurse must … Document the following aspects of care: relevant objective information related to client care.

1.2(f) The Nurse must … Document the following aspects of care: any adverse event or adverse outcome.

1.4(d) The Nurse must … Record … chronologically, the client encounter with the health system

1.4(e) The Nurse must … Record … contemporaneously

1.4(f) The Nurse must … Record … late entries at the next available opportunity, clearly identified as such, and include any additional requirements as defined by practice setting policy.

1.14 When clarifying (or altering) information after the fact in the client care record, identify the person making the alteration, the date and time; the original entry must also be included in the client care record.

In respect of the Documentation Standard, Ms. Conners' entries in respect of [Patient 1] during the relevant time for this Allegation are insufficient for full compliance with the Standard. Ms. Conners acknowledges that during two interactions with [Patient 1] at 0057h and 0059h, she did not document those interactions in [Patient 1's] chart.

In addition, the Documentation Standard requires that Ms. Conners herself add in entries relating to her observations, concerns, assessment findings, and interventions provided. Although Ms. Campbell was the designated recorder during the resuscitation period with [Patient 1], Ms. Conners failed to make appropriate late entries at the next available opportunity, clearly identified as such, and simply initialed Ms. Campbell's entries.

In addition to the breaches of the Practice Standards and the Documentation Standards, set out above, the Hearing Tribunal finds that Ms. Conners breached the Code of Ethics provisions set out above in respect of Allegation (b).

For the reasons set out above, for Allegation (d), the breaches of the Practice Standards, the Documentation Standards and the Code of Ethics are serious and constitute unprofessional conduct pursuant to section 1(1)(pp)(i) and (ii) of the HPA.

SUBMISSIONS ON SANCTION

The Hearing Tribunal heard submissions on the appropriate sanction.

Submissions by Conduct Counsel:

Conduct Counsel noted there was a joint proposal on sanction and reviewed the Joint Recommendations for each Registrant. The Joint Recommendations in respect of Ms. Conners were entered as Exhibit #3**.**

Conduct Counsel noted that the sanctions are intended to be remedial in nature, and are accordingly focused on education and related closely to the conduct that was found by the Hearing Tribunal to be unprofessional conduct, as set out above. The sanctions were designed to promote self-reflection and to determine where they can improve as nurses, going forward.

In addition, the sanctions include a reprimand, which is intended to be a denunciation of the conduct, and the sanctions have ensured that the primary purposes of protecting the public – which Conduct Counsel noted is the intention of sanctions in the professional regulatory context – is met as they ensure that the public is not at risk of harm from these members again, given that they will go through the learning process and have that information in the future.

Conduct Counsel reviewed the factors in the decision of *Jaswal* v. *Newfoundland Medical Board* (1996 CanLII 11630) and how those factors applied to the present case.

1. *The nature and gravity of the proven allegations:* In this case the Complaints Director noted that there was not intentional misconduct. The unprofessional conduct found by the Hearing Tribunal arose from omissions and failures to document as expected in the applicable standards. This is not conduct that is at the egregious end of the spectrum. Nonetheless, there is still the failure to meet the standards expected of experienced nurses in the areas of assessment and documentation.

2. *The age and experience of the member:* In this case, Ms. Conners was not an inexperienced or new nurse – she was registered in 2002 and as such, she had the age and knowledge to be able to carry out these fundamental skills.

3. *The previous character of the member:* Ms. Conners did not have any prior disciplinary history.

4. *The number of times the offence was proven to have occurred:* In this case, it is acknowledged that this was an incident arising from one night with a single patient, [Patient 1]. All allegations relate to that one night with one patient.

5. *The role of the registered nurse in acknowledging what occurred:* In Ms. Conners' case, she entered an admission, agreed to certain facts, and attended the hearing. This is a

mitigating circumstance that is considered by the Hearing Tribunal in assessing the appropriate penalty.

6. *Whether the member has already suffered other serious financial or other penalties:* Conduct Counsel left this for Ms. McLeod to address.

7. *The impact on the offended patient:* In this case, the unprofessional conduct that was found related to Ms. Conners' failure to assess, and her documentation during that particular shift. There was no evidence before the Hearing Tribunal to indicate that, if these errors had not occurred, [Patient 1] would not have passed away.

8. *The presence or absence of any mitigating factors:* Conduct Counsel left this for Ms. McLeod to address.

9. *The need to promote specific and general deterrence:* Specific deterrence related to the need to impose a sanction that deters Ms. Conners from engaging in future unprofessional conduct. General deterrence speaks to the need to have a sanction that demonstrates to other members of the profession that similar behavior will be treated in this way, and that will prevent other members from engaging in this type of conduct because they will be aware of the sanctions. The Complaints Director submitted that these sanctions met both requirements for specific and general deterrence. The sanctions promote remedial education and will put Ms. Conners in a position going through this process, having this reprimand, from engaging in this type of behavior in the future. And the same message will go out to other members of the profession.

10. *The need to maintain public confidence:* Conduct Counsel noted that this aspect was met by the discussion noted above in respect of deterrence.

Submissions by the Legal Counsel for the Registrant, Ms. Conners:

Ms. McLeod, on behalf of Ms. Conners, spoke to the sanction. She wished to make clear, as stated by Conduct Counsel, that the death of [Patient 1] was not related to the misconduct admissions here, and therefore should not weigh in the Hearing Tribunal's assessment of the joint submission on sanction.

In addition, Ms. McLeod noted that Ms. Conners has experienced a high degree of stress, fear and anxiety related to the proceedings. She has had periods of time where she has been unable to work as a result of the incident, and has had concerns about her personal safety as a result as well.

Questions from the Hearing Tribunal:

The Hearing Tribunal had no questions.

DECISION AND REASONS OF THE HEARING TRIBUNAL ON SANCTION

The Hearing Tribunal adjourned to consider the submissions on sanction. The Hearing Tribunal has carefully considered the joint submissions on sanction and the submissions of the parties. The Hearing Tribunal has considered the factors noted in *Jaswal v. Newfoundland Medical Board*. For the reasons set out below, the Hearing Tribunal accepts the joint recommendation on sanction.

The Hearing Tribunal, in considering the sanctions, reflected on the circumstances that occurred in the [an Alberta hospital] facility on the night of December 25 and 26, 2020. Ms. Conners, as one of the two nurses on shift that evening and night, was faced with a terrible task – she was required to provide emergency care to [Patient 1] in an extremely critical state, while attempting to comply with COVID protocols and working in a short-staffed, rural ER. Prior to this particular shift, when Ms. Conners was under tremendous stress, Ms. Conners had no prior disciplinary history with the College during her approximately 18 years of nursing experience.

There is no doubt: the death of [Patient 1] was tragic. The Hearing Tribunal appreciates that for all involved, including the family of [Patient 1], this was a traumatic event that has had significant impacts on their lives to this day.

However, there were no facts presented to the Hearing Tribunal that suggested that the unprofessional conduct displayed during that night by Ms. Conners contributed to [Patient 1's] passing. These allegations relate to two things: a failure on the part of Ms. Conners to assess [Patient 1] when she was found on the floor at approximately 2300h, and her failure to document the events of that night in accordance with the applicable standards.

The Hearing Tribunal considered Ms. Conners' willingness to agree to the Agreed Statement of Facts and Liabilities, and to come to the hearing to discuss her conduct. The Hearing Tribunal commends Ms. Conners on her accountability and her willingness to resolve this matter with the College.

The Hearing Tribunal considered the specific orders being sought and finds that the reprimand is appropriate. The two courses being suggested are educational and directly related to the unprofessional conduct that was found. The requirement for a Behavior Improvement Plan will cause Ms. Conners to engage in some self-reflection and self-work to ensure that the conduct found here does not occur again. The requirement for the Order to be provided to Ms. Conners' supervisor and for the College to be aware of where Ms. Conners is practicing again ensures the safety of the public and accountability on the part of Ms. Conners.

In considering the sanction, the Hearing Tribunal was also conscious of the guidance of the Supreme Court of Canada in the R. v. Anthony-Cook decision and the deference that is owed to a joint recommendation on sanction. Having regard to all of the circumstances, the Hearing Tribunal did not find that the high threshold in R. v. Anthony-Cook to reject a joint submission was met (that the joint sanction was so unhinged from the circumstances of the case that it would lead

an informed person to conclude that the proper functioning of the justice system had broken down).

Accordingly, the Hearing Tribunal accepted the joint submission on sanction in respect of Ms. Conners and makes the following order pursuant to its powers under the HPA.

ORDER OF THE HEARING TRIBUNAL

The Hearing Tribunal orders that:

Sanction:

1. The Registrant shall receive a reprimand for unprofessional conduct.

2. By **December 1, 2023,** the Registrant shall provide proof satisfactory to the Complaints Director that they have successfully completed and passed the following courses of study and learning activities:

    a. Documentation in Nursing (NURS0162 — MacEwan University); and
    b. Nursing Process — Self Study (NURS0167 — MacEwan University).

3. By **December 1, 2023,** the Registrant shall provide to the Complaints Director a self-improvement plan for documentation and assessments **("Behavior Improvement Plan")** and the Behavior Improvement Plan must be satisfactory to the Complaints Director and must:

    a. Be typed and comply with professional formatting guidelines (American Psychological Association style);

    b. Be at least 1500 words in length;

    c. Include a list of **ten (10)** points of reflection, specifically:

        i. Describe how the Registrant will improve their practice, including strategies, plans and supports or resources that may assist their improvement; and

        ii. Cite at least **five (5)** applicable standards and responsibilities from the following:

            1. the *Documentation Standards for Regulated Members (2013);*

            2. the *Practice Standards for Regulated Members (2013);* and/or

3. the *Canadian Nurses Association Code of Ethics (2017).*

4. Within **fifteen (15) days** of the Order, the Registrant shall provide a letter ("**Practice Setting Letter**") to the Complaints Director from the Registrant's RN or NP Supervisor (the "**Supervisor**") at their current place of employment as listed in paragraph 11 below ("**Practice Setting**"), confirming:

   a. The Supervisor's name and contact information;

   b. The Practice Setting;

   c. The Registrant's role of employment; and

   d. That the Supervisor has reviewed the Order.

<u>Compliance:</u>

5. For clarity and certainty, the Registrant is, in addition to what is set out in this Order, is required to complete any and all requirements as have been, or may be, imposed from the College's Registration Department. This Order does not supersede, or if complied with serve to satisfy, any such requirements from the College's Registration Department.

6. Compliance with this Order shall be determined by the Complaints Director of the College. All decisions with respect to the Registrant's compliance with this Order will be in the sole discretion of the Complaints Director.

7. The Registrant will provide proof of completion of the above-noted Condition(s) by the dates set out therein, to the Complaints Director, via e-mail at procond@nurses.ab.ca or confidential fax to 780.453.0546. If the Complaints Director deems it appropriate, and for the sole purpose of permitting the Registrant to proceed toward compliance with this Order, the Complaints Director may in her sole discretion make other minor adjustments to the Order that are in keeping with this Hearing Tribunal Order, without varying the substance of the Order.

8. Upon written request by the Registrant, any timelines outlined in this Order may be extended at the unfettered discretion of the Complaints Director, acting reasonably.

9. Should the Registrant fail or be unable to comply with any of the requirements of this Order, or if any dispute arises regarding the implementation of this Order, the Complaints Director may exercise the authority under section 82(3) of the HPA, or the information may be treated as reasonable grounds under section 56 of the HPA and subject to a new complaint under Part 4 of the HPA.

10. The responsibility lies with the Registrant to comply with this Order. It is the responsibility of the Registrant to initiate communication with the College for any anticipated non-compliance and any request for an extension.

Conditions:

11. The Registrant confirms the following list sets out all the Registrant's employers and includes all employers even if the Registrant is under an undertaking to not work, is on sick leave or disability leave, or if the Registrant have not been called to do shifts, but could be called. Employment includes being engaged to provide professional services as a Registered Nurse on a full-time, part-time, casual basis as a paid or unpaid employee, consultant, contractor or volunteer. The Registrant confirms the following employment:

Employer Name	**Employer Address & Phone Number**
[an Alberta hospital]	[information redacted]

12. The Registrant understands and acknowledges that it is the Registrant's professional responsibility to immediately inform the College of any changes to the Registrant's employers, and employment sites, including self-employment, for purposes of keeping the Registrar current and for purposes of notices under section 119 of the HPA.

13. The Registrar of the College will be requested to put the following conditions against the Registrant's practice permit (current and/or future) and shall remain until the conditions are satisfied:

    a. Course work required — Arising from Disciplinary Matter;

    b. Behavior Improvement Plan required — Arising from Disciplinary Matter, and

    c. Confirmation of Practice Setting(s) required — Arising from Disciplinary Matter.

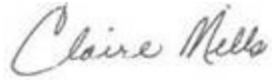
14. Effective on March 22, 2023, the date of the Hearing, or the date of this Order if different from the date of the Hearing, notifications of the above condition shall be sent out to the Registrant's current employers (if any), the regulatory college for Registered Nurses in all Canadian provinces and territories, and other professional colleges with which the Registrant is also registered (if any).

15. Once the Registrant has complied with a condition listed above, it shall be removed. Once all the conditions have been removed, the Registrar will be requested to notify the regulatory colleges in the other Canadian jurisdictions.

16. This Order takes effect on the date of the Hearing, and remains in effect pending the outcome of any appeal, unless a stay is granted pursuant to section 86 of the HPA.

This Decision is made in accordance with Sections 80, 82 and 83 of the HPA.

Respectfully submitted,



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Claire Mills, RN, Chairperson
On Behalf of the Hearing Tribunal

Date of Order: May 26, 2023