

NOTICE TO ATTEND A HEARING

BY THE HEARING TRIBUNAL

OF THE

COLLEGE AND ASSOCIATION OF REGISTERED NURSES OF ALBERTA (“CARNA”)
pursuant to section 120(1) of the Health Professions Act

November 19, 2021

TO: MARCIA CAMPBELL

TAKE NOTICE that you, **MARCIA CAMPBELL, REGISTRATION #63,867** (the “Registrant”) are required to attend on the **26th, 27th, 28th, 29th, and 30th days of September, 2022**, commencing at **9:30 (nine-thirty)** o’clock, at which time the Hearing Tribunal of CARNA will conduct a virtual hearing (the “Hearing”) into the complaint of the Registrant’s practice while employed as a Registered Nurse (“RN”) at [an Alberta hospital].

FURTHER TAKE NOTICE that the Registrant’s 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:

<i>Canadian Nurses Association (CNA) Code of Ethics</i>	“ CNACE ”
<i>CARNA’s Documentation Standards for Regulated Members (2013)</i>	“ CDSRM ”
<i>CARNA’s Practice Standards for Regulated Members (2013)</i>	“ CPSRM ”

FURTHER TAKE NOTICE that the Registrant’s 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 Registrant’s 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 Registrant 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 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 reversible 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.

THIS NOTICE IS ISSUED BY:

A handwritten signature in blue ink, appearing to read "Sherry Botti".

on behalf of

Sherry Botti, Hearings Director

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