INVESTIGATION COMMITTEE
of the
College of Registered Nurses of Saskatchewan

-and-

Christine Ortman
[redacted]

DECISION

of the

DISCIPLINE COMMITTEE

of the

COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

Legal Counsel for the Investigation Committee:	Titli Datta
Legal Counsel for Christine Ortman:	Ronni Nordal, K.C.
Legal Counsel for the Discipline Committee:	Darcia G. Schirr, K.C.
Chairperson for the Discipline Committee:	Frank Suchorab, RN

Date of Hearing:	March 14, 2023
Location:	*Via Videoconference* College of Registered Nurses of Saskatchewan 1-3710 Eastgate Drive Regina, Saskatchewan S4Z 1A5
Date of Decision:	July 7, 2023

INTRODUCTION

1. The Discipline Committee of the College of Registered Nurses of Saskatchewan ("CRNS") convened to hear and determine a complaint of professional incompetence and professional misconduct against Registered Nurse #0037210, Christine Ortman on March 14, 2023. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act, 1988* (the Act).

2. The charges against Christine Ortman are outlined in a Notice of Hearing dated February 8, 2023. The Notice sets out the following charges:

> **1. You have committed an act of professional incompetence as per section 25 of *The Registered Nurses Act*, *1988*, in that, between May 28 and May 29, 2022, during your care of a pediatric patient who presented to the emergency department at the [redacted] after an accidental ingestion of infant liquid acetaminophen, you displayed a lack of knowledge, skill, or judgment of a nature or to an extent that demonstrates you are unfit to provide one or more services ordinarily provided as part of the practice of registered nursing. More particularly:**
>
> **(a) You failed to thoroughly and appropriately assess and monitor the pediatric patient:**
>
> **i. You failed to take vital signs on the patient during your 12-hour shift except for one temperature check at 2045 hrs;**
>
> **ii. You did not perform a complete assessment during your 12-hour shift and only completed visual assessments of the patient.**
>
> **(b) You failed to competently review and assess the Medication Administration Record (MAR), the physician's orders, and the nursing notes for the patient;**
>
> **(c) On two occasions, when the SMART pump alarmed, you cleared the pump settings and reprogrammed the pump to infuse the 150 mg/kg loading dose of N-acetylcysteine instead of the 15 mg/kg maintenance dose;**
>
> **(d) You failed to take the proper steps to be knowledgeable of the protocol for infusing N-acetylcysteine using the SMART pump by not reviewing the SK SMART Pump Program Parenteral Manual for N-acetylcysteine (monograph) at any time during your shift;**

(e) You failed to recognize that the SMART pump was infusing the wrong dose of N-acetylcysteine including when adverse effects of nausea and vomiting occurred beyond the loading dose time-frame and despite anti-emetics being administered; and

(f) You administered 150 mg/kg instead of 15 mg/kg of N-acetylcysteine to the pediatric patient from 1936 hrs through the remainder of your 12-hour shift.

2. You have committed an act of professional misconduct as per section 26(2)(l) and (q) of *The Registered Nurses Act*, *1988*, in that, between May 28 and May 29, 2022, during your care of a pediatric patient who presented to the emergency department at the after an accidental ingestion of infant liquid acetaminophen, you failed to comply with the code of ethics of the association, and contravened provisions of The Registered Nurses Act, 1988, and the SRNA Bylaws.

3. The Notice alleges that Ms. Ortman is guilty of professional incompetence and professional misconduct contrary to sections 25 and 26(2)(l) and (q) of the Act and those provisions provide:

Professional incompetence

25 For the purposes of this Act, professional incompetence is a question of fact, but the display by a nurse in the professional care of a client of a lack of knowledge, skill or judgment or a disregard for the welfare of a client of a nature or to an extent that demonstrates that the nurse is unfit:

(a) to continue in the practice of registered nursing; or

(b) to provide one or more services ordinarily provided as part of the practice of registered nursing;

is professional incompetence within the meaning of this Act.

Professional misconduct

(2) Without restricting the generality of subsection (1), the discipline committee may find a nurse guilty of professional misconduct if the nurse has:

(l) failed to comply with the code of ethics of the association;

(q) contravened any provision of this Act or the bylaws.

4. It is also alleged that a number of *Practice Standards, Entry Level Competencies* and *Code of Ethics* provisions have been breached. Those are set out in the Notice of Hearing and Appendix "A" to this decision.

HEARING

5. At the outset of the hearing, counsel for the Investigation Committee tendered a binder described as "Evidence Binder". The binder consisted of an Agreed Statement of Facts, Notice of Hearing, Joint Submission Regarding Proposed Penalty, Christine Ortman's verification of registration with the CRNS, and a series of documents relevant to the charges. The following were marked as Exhibits:

> Exhibit P1: Notice of Hearing dated February 8, 2023 with proof of service
>
> Exhibit P2: Agreed Statement of Facts, supporting documents, Joint Submission Regarding Proposed Penalty

6. At paragraphs 45 and 46 of the Agreed Statement of Facts state:

> **Admission of Charges as Contained in the Notice of Hearing**
>
> **45. Ms. Ortman admits that she erred in not realizing the SMART pump was set and continued to be set at the STEP l Loading Dose rate, recognizes she should have taken vital signs and charted more thoroughly, and takes responsibility for the errors she made.**
>
> **46. Ms. Ortman admits that her conduct between May 28 and 29, 2022, as outlined in the Notice of Hearing attached at Tab 1 and this Agreed Statement of Facts constitutes professional incompetence and professional misconduct as defined in sections 25, 26(2)(1) and (q) of *The Registered Nurses Act, 1988*, and the delineated provisions of the SRNA Bylaws, *Code of Ethics for Registered Nurses*, and *SRNA Registered Nurse Practice Standards, 2019* as outlined in the Notice of Hearing.**

7. Ms Ortman's counsel confirmed her guilty pleas to the charges set out in the Notice.

Facts

8. Christine Ortman first registered with the CRNS on September 23, 2005 and she has remained a practicing member since that date. Ms. Ortman began working at the [redacted] in 2009.

9. On May 28, 2022, Ms. Ortman was working the night shift from 1900 hours to 0700 hours on May 29. To use the words of Ms. Ortman's counsel, a "devastatingly tragic" series of events occurred involving a [redacted] pediatric patient. The following paragraphs (without the tabs) from the Agreed Statement of Facts describe what occurred:

> Background to Charges
>
> 12. On May 28, 2022, at 1434 hrs, the Patient, a [redacted] pediatric patient, was brought into the ER at the [redacted] after an accidental ingestion of infant liquid acetaminophen.
>
> 13. At 1716 hrs the Patient's blood work returned and showed an acetaminophen level of 821, and the day-shift [redacted] nurse, [redacted], reviewed the results with Poison and Drug Information Service ("PADIS") who provided recommendations to administer an IV medication, Nacetylcysteine (NAC) (note: Acetylcysteine may be referred to as acetylcysteine, NAC and/or Mucomyst). [redacted] provided this PADIS recommendation to the physician who reviewed the Patient's acetaminophen levels and compared it to the Acetaminophen Nomogram shown on page 16 of the Patient Chart, Part 2, and deemed it necessary to write the N-acetylcysteine order based on the recommendation from PADIS. A copy of the relevant blood work which forms part of the patient chart is attached as Tab 4.
>
> 14. This IV medication infusion is a 2-step process, with an initial loading dose (the "Loading Dose") that is infused over 1 hour and a maintenance dose (the "Maintenance Dose") that is infused over 20 hours. The N-acetylcysteine for the Patient was to be infused as per Physician Orders in consultation with PADIS which provided recommendations and the step-by-step protocol as outlined in the Saskatchewan Health Authority SMART pump monograph. A copy of the NAC Monograph is attached as Tab 5.
>
> 15. At 1745hrs, the physician ordered the Loading Dose and the Maintenance Dose of NAC based on the Patient's weight of [redacted]:
>
> - Loading dose 150 mg/kg

(1431 mg over 1 hour)

7.155 ml over l hour

Followed by

- Maintenance 15 mg/kg/hour for 20 hrs

  0. 7155 ml/hr for 20 hrs

A copy of the relevant Physician Orders is attached as Tab 6.

16. If the day-shift ER nurse, [redacted], RN ("[redacted]"), were to testify, her evidence would be that she printed off the monograph for NAC (the "NAC Monograph") and the information provided from PAD IS and placed it in the patient chart for reference, mixed the NAC solution and had another RN, [redacted], complete a double check to ensure the accuracy of the calculations and the mixture, and then initiated the Loading Dose on the SMART pump at 1836. [redacted] also had a graduate nurse double check the SMART pump using the NAC Monograph.

17. Based on the Physician Orders and the NAC Monograph, [redacted] programmed the SMART pump to run Acetylcysteine STEP 1: Loading Dose for one hour at 150mg/kg. The Loading Dose was to be completed at 1936 hrs, at which time Acetylcysteine STEP 2: Maintenance Dose (15mg/kg over 20 hours) was to be initiated as per the Physician Orders.

18 . [redacted] transcribed the Loading Dose and Maintenance Dose orders onto the Patient's Medication Administration Record (the "MAR").

- Loading Dose Acetylcysteine 150 mg/kg/hr x 1hr = 1431 mg

- Maintenance Dose Acetylcysteine 15 mg/kg/hr x 20hr

A copy of the MAR is attached as Tab 7.

19. [redacted] would testify that upon initiation of the Loading Dose, the MAR was signed by [redacted] and co-signed by [redacted]. According to the MAR, the Loading Dose was started at 1836 hrs. [redacted] highlighted the Loading Dose in yellow to signify that it had been hung and it was running. The signing and co-signing of the MAR by [redacted] and [redacted] respectively and the highlighting of the MAR were both appropriate and in accordance with facility practice to signify initiation. A copy of the MAR is attached as Tab 7.

Charges and the Underlying Facts :

20. Ms. Ortman started her 12-hour night shift at 1900 hrs in the ER and was responsible for the Patient.

21. If she were to testify, Ms. Ortman's evidence would be that, based on the verbal report from [redacted], Ms. Ortman's understanding was that the acetylcysteine medication had been mixed, was running, and was to continue to nm until 1500 hrs the next day when labs would be repeated.

22. If she were to testify, [redacted] evidence would be that at the 1900 hrs shift change, [redacted] provided a verbal report to Ms. Ortman which included the fact that she had just started the Loading Dose, and that the Maintenance Dose would start about 1930 hrs and would run until 1500 hrs the next day. [redacted] did not specifically say that there was a rate change, she just said it would have to be switched to the Maintenance Dose. [redacted] recalls the only question Ms. Ortman asked was "so this will be running until 3 p.m. tomorrow" and that [redacted] replied "yes".

23. [redacted] reported to Ms. Ortman at shift change that the Patient was extremely irritable, did not like to be approached by staff and was difficult to obtain vital signs on.

24. Prior to this shift, Ms. Ortman had no experience with administering acetylcysteine.

25. If Ms. Ortman were to testify, Ms. Ortman's evidence would be that her usual nursing practice is to do a full assessment of patients at the start of her shift, including vital signs however, in this situation, because the report sounded like the child had just been settled and she could see visually that the child was "fine", she decided not to do vital signs at that time. She checked the Patient's capillary refill in the foot with the IV, otherwise her assessments were visual.

26. Ms. Ortman did not document a complete assessment or the capillary refill on the Patient's chart and the patient chart showed that the most recent vital signs taken prior to Ms. Ortman's shift were taken at 1615 hrs. A copy of the relevant patient chart is attached as Tab 8.

27. The Pump Event/Alarm Log showed that at 1935 hrs, the SMART pump was set to run 1000 ml to be infused at the STEP 1 Loading Dose. If Ms. Ortman were to testify, her testimony would be that she entered the Patient's weight but does not recall whether she "actually programmed that volume [1000 ml VTBI] to be an [sic] infused, or if that was populated by the pump." At 1941 hrs and 1953 hrs, the SMART pump had occlusion alarms which required Ms. Ortman to tum the SMART pump off and on, clear the SMART pump settings, and completely reprogram the SMART pump. If Ms. Ortman were to testify, Ms. Ortman's evidence would be that at that time, she did not change the infusion to the STEP 2 Maintenance Dose. When Ms. Ortman programmed the SMART

pump, she programmed it for Acetylcysteine STEP 1, which required Ms. Ortman to enter the Patient's weight and select the Acetylcysteine STEP 1 dose. A copy of the Pump Event/ Alarm Log is attached as Tab 9.

28. Ms. Ortman did not competently review and/or competently assess the MAR, Physician Orders, or the NAC Monograph to confine the medication, when reprogramming the SMART pump. If Ms. Ortman were to testify, her evidence would be that she reviewed the Physician Orders but missed the change in dosage. She did not review the NAC Monograph at any point on her shift. If Ms . Ortman were to testify, Ms. Ortman's evidence would be that she had understood the Acetylcysteine was to continue running at the rate already programmed in the SMART Pump until 1500 hrs the next day.

29. If Ms. Ortman were to testify, her evidence would be that she reviewed the MAR noting the Loading Dose in the MAR was highlighted yellow which meant completion. The MAR showed that the Loading Dose was signed for by two RNs and was highlighted yellow. The Maintenance Dose on the MAR had no initials or time to indicated it had been started. If Ms. Ortman were to testify, her evidence would be that she did not question why the Maintenance Dose on the MAR had not been signed for.

30. Ms. Ortman missed the right dose, the right time, the right documentation, the right evaluation and the right assessment when she programmed incorrect information into the SMART pump.

31. The Patient had episodes of emesis at 2045 hrs, 2117 hrs, 2140 hrs, 2216 hrs and 2323 hrs. Ms. Ortman consulted the physician pertaining to the emesis at 2045 hrs and 2216 hrs and received orders for anti-emetics. Ms. Ortman's documentation in the MAR showed that she administered a Gravol suppository at 2100 hrs on May 28, 2022 and IV Ondansetron at 2215 hrs on May 28, 2022 and 0615 hrs on May 29, 2022. There are no documented vital signs of the Patient at these times. With the exception of a temperature at 2045 hrs, there are no vital signs or complete assessments of the Patient that have been documented. Relevant portions of the patient chart are attached as Tab 10.

32. The NAC Monograph indicated adverse effects included: nausea, vomiting; may be profuse with loading dose typically improves with maintenance infusion. A copy of the NAC Monograph is attached as Tab 5. If Ms. Ortman were to testify, Ms. Ortman's testimony would be that she had done her own research on the side effects of both acetaminophen overdose and acetylcysteine and confirmed that nausea and vomiting were side effects of both.

33. At 2323 hrs, Ms. Ortman documented that the Patient continued to have emesis. There is no further documentation from Ms. Ortman until 0621 hrs. At 0621 hrs, Ms. Ortman documented that the Patient slept for the remainder of the night with occasional retching. Ms. Ortman did not notify the physician about the retching. Relevant portions of the patient chart are attached as Tab 11.

> 34. If Ms. Ortman were to testify, her evidence would be that she did visual assessments of the Patient between 2323 hrs and 0621 hrs and completed hourly checks for the remainder of her shift, although she did not wake the Patient on each check as the Patient appeared to be settled including in the morning when the Patient was settled in the mother's arms. If Ms. Ortman were to testify it would be that the patient had no further emesis after 2323 hrs. Ms. Ortman's night shift ended at 0717 hrs on May 29, 2022. The care of the Patient transferred to another Registered Nurse.
>
> Evidence subsequent to Ms. Ortman's shift conclusion on May 29, 2022:
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> 35. The following day on May 29, 2022 at 1150 hrs, the Patient was found unresponsive, cyanotic and without a pulse. CPR was initiated and spontaneous circulation was regained.
>
> 36. A consultation with PADIS led to the discovery that the NAC infusion had been running at the Loading Dose rate (of 54.9 mL/hr) instead of the Maintenance Dose of 5.4 mL/hr since it was initiated at 1835 hrs on May 28, 2022. The infusion was immediately discontinued.
>
> 37. The Patient was subsequently transferred by Air Ambulance to Jim Pattison Children's Hospital in Saskatoon. A copy of the Outpatient Record is attached as Tab 12.
>
> 38. On May 30, 2022, after extensive testing, brain death was declared, and the Patient passed away a short time later. The patient chart showed N-acetylcysteine overdose documented as the diagnosis on the Patient's Neurological Determination of Death Record. A copy of the relevant patient chart is attached as Tab 13.

10. The Agreed Statement of Facts also indicate that the incident was investigated by the Saskatchewan Health Association. Through the investigation, Ms. Ortman was on paid leave. The investigation concluded with a letter of expectation dated September 8, 2022 issued to Ms. Ortman. The letter of expectation set out certain courses that Ms. Ortman must take. The Discipline Committee was advised that Ms. Ortman has completed the educational courses.

11. The Agreed Statement of Facts contains a number of paragraphs under the heading “Evidence for Further Context”. It is important to set out three of those paragraphs:

42. There was no policy in the [redacted] facility which outlined documentation and assessment requirements in the ER. Shift change report in the [redacted] facility was verbal only.

43. lf [redacted], SMART Pump Program, Clinical Standards and Professional Practice were to testify, it would be [redacted]' testimony that the SMART pump lacked fail safe limits for how long acetylcysteine could run at the Step I rate. [redacted] would also testify that administration of acetylcysteine through the SMART Pump is not intuitive for a Registered Nurse. [redacted] would also testify that Acetylcysteine Step l is the last line on the first screen when programming the SMART Pump and Acetylcysteine Step 2 is the top line on the next screen when programming the SMART Pump. Notwithstanding the foregoing, [redacted] would also state that RNs would be expected to verify that all the information entered into the SMART pump was accurate and correct in accordance with the Physician Orders.

44. The evidence of [redacted], is that there was no malfunction of the SMART pump in this situation. Since May 29, 2022 the Saskatchewan Health Authority has implemented a fail-safe limit for acetylcysteine on SMART Pumps and has designated acetylcysteine as a high alert medication.

12. The Discipline Committee finds that the Agreed Statement of Facts and supporting documentation substantiates the charges and the Discipline Committee accepts Ms. Ortman's guilty pleas to those charges.

Proposed Sanction

13. Having found that the charges are sustained and the guilty pleas accepted, the next task for the Discipline Committee is the imposition of an appropriate sanction under section 31 of the Act.

14. The Discipline Committee was presented with a Joint Submission Regarding Proposed Penalty ("Joint Submission") (Exhibit P2, Tab B) which broadly consisted of the following:

(a) A suspension for one month.

(b) Ms. Ortman shall complete three specified educational courses.

(c) Following completion of the suspension, Ms. Ortman would be subject to the condition that she practice under direct supervision of a registered nurse in relation to the administration of IV medications delivered by SMART pump and the administration of all medication to pediatric patients within the acute care facility of the [redacted].

(d) Payment of costs in the amount $23,000.00 on or before March 31, 2024.

15. While both Ms. Ortman and the Investigation Committee agreed to a one month suspension, there was no agreement regarding the start date of the suspension.

16. Before addressing the issue of the start date, it is appropriate for the Discipline Committee to address the proposed length of the suspension and its length. The Investigation Committee filed a brief and referenced an Ontario decision which is similar. In *College of Nurses of Ontario v Soriano and Doerksen*, 2005 ONCNO 79616, two nurses faced discipline following the death of a ten year old pediatric patient. To quote from the Investigation Committee Brief:

> **The patient had been admitted with increased pain in the right leg, and had eventually died while in hospital. Ms. Doerksen had settled the patient into a room for the night with the assistance of Ms. Soriano. In the course of the patient's are, while Ms. Doerksen attached her to a Corometric monitor, she failed to ensure that the Corometric monitor was properly set and functioning. Ms. Soriano filed to adequately assess the patient including completing vital signs, and pain and sedation scales. Both nurses admitted that they had failed to maintain the standards of the profession.**

17. In *Soriano and Doerksen*, there was an Agreed Statement of Facts and a Joint Submission which was accepted by the Discipline Committee. The nurses were suspended for one month.

18. In its Brief, the Investigation Committee fairly sets out the mitigation factors which include:

(a) Inexperience of Ms. Ortman with respect to pediatric care;

(b) Acknowledgment and remorse for the incident;

(c) No prior history of discipline with the CRNS;

(d) Agreeing to a joint submission for penalty;

(e) Entering into an agreement with the CRNS to undergo the outlined training, courses and supervision.

19. Ms. Ortman's counsel advised that Ms. Ortman fully cooperated with the employer's investigation and that of the College and that she took full responsibility and accountability for her actions which contributed to the tragic result.

20. Applying the appropriate sentencing principles including principles regarding joint submissions, the Discipline Committee finds that a one-month suspension which has been jointly proposed is reasonable, in the public interest and within the range of appropriate dispositions.

21. The Investigation Committee argued that the suspension should be effective as of the date of the Discipline Committee Order or at most, seven days from the date of the Discipline Committee Order. The Investigation Committee further submitted that if the start of the suspension was delayed, Ms. Ortman should be subject to immediate direct supervision of administration of IV medications delivered by SMART pump and administration of all medication to pediatric patients.

22. Ms. Ortman submitted that the start date of the one month suspension should be delayed until July or August 2023. The basis of that submission was a letter her counsel tendered dated March 8, 2023 from [redacted] (D1). The letter in its entirety is as follows:

> **To whom it may concern**
>
> **Surgical program at the [redacted] operates 10 months of the year. Typically, no surgical procedures are booked in the months of July and August.**
>
> **With one of the 2 OR nurses moving to a different position next week and Christine Ortman being the only OR nurse at this time, there is a strong**

> **possibility that we may have to cancel booked procedures in the month of March till June, should Christie be unable to work.**

23. The Discipline Committee was presented with a number of discipline decisions from other jurisdictions where a suspension was deferred or delayed. In some of the cases, the commencement of a suspension was deferred because of limited nursing resources through the COVID 19 pandemic. (For example, see *College of Nurses of Ontario v Sherry Hope*, 2021 CanLII 149501 and *College of Nurses of Ontario v Jacqueline Carter*, 2021 CanLII 39065).

24. A deferred suspension is not intended to accommodate or convenience the member. A discipline committee faced with a request to delay a suspension must always consider the public interest. In other words, would the public be harmed and impacted if the member were subject to an immediate suspension?

25. In *Law Society of Upper Canada v Paul Robson*, 2010 ONLSHP 58 (CanLII), the hearing panel was presented with a joint submission for a one month suspension. The Law Society argued that the suspension should start immediately. The lawyer requested a start date of two months in order for him to deal with client matters and the lawyer's own personal litigation. The suspension was delayed. The chairperson wrote:

> **A suspension will obviously be, and is intended to be, a hardship for the guilty lawyer; that is why it is a punishment. But hardships on clients and unduly severe situational hardships on the lawyer that are avoidable by a short, reasonable delay in serving the suspension, go beyond the legitimate punitive aspects of the suspension. A one-month suspension is not meant to, nor should it, destroy or irreparably damage a lawyer's practice. Certainly the timing of a suspension must have regard to the interests of innocent clients. Having regard to the limitations on the Lawyer's practice while these proceedings were outstanding, the list of client files to be dealt with in the immediate future and the serious financial interests at stake in the Lawyer's personal litigation – financial interests which may well impact his ability to pay the costs order to be imposed – a reasonable delay in serving the suspension as the Lawyer requested was granted.**

26. In this case, the Discipline Committee was satisfied that a deferral of Ms. Ortman's suspension was reasonable and in the public interest. The Discipline Committee requested

that if the start time of the suspension was delayed, Ms. Ortman should be subject to immediate direct supervision when she is administering IV medications via SMART pump and administration of all medication for pediatric patients. The employer did not impose any restrictions on Ms. Ortman after the incidents of May 28 and May 29, 2022. Ms. Ortman has been practicing without direct supervision since then. No rationale was provided for the suggestion that Ms. Ortman should be subject to a direct supervision requirement if her suspension was delayed for a short period.

27. On March 16, 2023, the Discipline Committee issued an Order endorsing the Joint Submission. As to the start date of the one month suspension, the Discipline Committee ordered that the suspension would be effective June 1, 2023. The purpose in issuing an Order promptly was to provide certainty for Ms. Ortman and equally importantly, to provide the [redacted] sufficient and advance notice to plan given Ms. Ortman's suspension.

ORDER OF THE DISCIPLINE COMMITTEE

28. The Discipline Committee made the following Order:

1. Pursuant to section 31(1)(b) of *The Registered Nurses Act*, 1988 (the "Act"), Christine Ortman shall be suspended for the period of one month effective June 1, 2023.

2. Pursuant to section 31(1)(e) of the Act, Ms. Ortman shall satisfactorily complete the following courses and bear the costs of the following courses:

   (a) ENPC course prescribed and offered by the Saskatchewan Health Authority (the "SHA") within the deadline and in accordance with the terms, if any, prescribed by the SHA.

   (b) John Collins Consulting – Critical Thinking in Nursing (CTNRN01).

   (c) Saskatchewan Polytechnic Course – Safe Medication Administration (PHAR-1608).

   (d) Saskatchewan Polytechnic Course – Heath Assessment (NRSG-104). CRNS will assist in arranging for this course to be offered to Ms. Ortman as a stand-alone course.

3. Within 30 days of her completion of each of the courses outlined above, Ms. Ortman shall provide to the Registrar a written certificate or confirmation from each course provider stating:

   (a) That Ms. Ortman has successfully completed the required course.

   (b) Regarding the John Collins Consulting course, the course provider should also confirm that a copy of the Agreed Statement of Facts, Joint Submission of Penalty documents and the Order of the Discipline Committee has been received and reviewed.

4. Following completion of the suspension and pursuant to section 31(1)(c) of the Act, Ms. Ortman may continue to practice subject to the condition that she shall be under the direct supervision of a Registered Nurse in relation to:

   (a) The administration of IV medications delivered via SMART pump; and

   (b) Administration of all medication for pediatric patients within the acute care facility at the [redacted]

5. The condition of direct supervision shall remain in place until Ms. Ortman provides proof of successful completion of the courses set out at paragraph 2 to the Registrar.

6. Pursuant to section 31(2)(a)(ii) of the Act, Ms. Ortman shall pay the costs of the inquiry and hearing which shall be fixed in the amount of $23,000.00. The costs shall be paid on or before March 31, 2024. Failing payment, Ms. Ortman shall be suspended from the College pursuant to section 31(2)(b) of the Act until payment of the costs is made in full.

7. Pursuant to section 31(3) of the Act, a copy of this decision shall be provided to Christine Ortman and the complainants.

July 7, 2023

Frank Suchorab, RN, Chairperson
On behalf of Members of the
Discipline Committee
Len Wegner, RN
Anne Kokesch, RN
Jodi Romanow, RN
Sophie Grahame, Public Representative

APPENDIX A

BYLAWS, CODE OF ETHICS, PRACTICE STANDARDS & COMPETENCIES CONTRAVENED:

The SRNA Bylaws (2021)

Bylaw XIV Section 1: Code of Ethics of the Association Bylaw XV Section 1: Standards and Competencies

Bylaw IV, Section 2(3)(a) and (b)

Code of Ethics for Registered Nurses (2017)

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

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 healthcare team.

6. Nurses practise "within their own level of competence and seek [appropriate] direction and guidance . . . when aspects of the care required are beyond their individual competence" (Licensed Practical Nurses Association of Prince Edward Island [LPNAPEI], Association of Registered Nurses of Prince Edward Island, & Prince Edward Island Health Sector Council, 2014, p. 3).

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

6. Nurses utilize practice standards, best practice guidelines, policies and research to minimize risk and maximize safety, well-being and/or dignity for persons receiving care.

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, practise according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice.

7. Nurses practise within the limits of their competence. When aspects of care are beyond their level of competence, they seek additional information or knowledge, report to their supervisor or a competent practitioner and/or request a different work assignment. In the meantime, nurses remain with the person receiving care until another nurse is available.

8. Nurses are accountable for their practice and work together as part of teams. When the acuity, complexity or variability of a person's health condition increases, nurses assist each other (LPNAPEI et al., 2014).

SRNA Registered Nurse Practice Standards (2019)

Standard 1: Professional Responsibility and Accountability

The registered nurse is responsible for practicing safely, competently and ethically, and is accountable to the client, public, employer and profession.

The registered nurse upholds this standard by:

3. Recognizing the registered nurse scope of practice and individual competence limitations within the practice setting and seeking guidance as necessary.

5. Demonstrating effective collaborative practice, including communication, problem-solving strategies, decision-making and conflict resolution.

8. Challenging and taking action on unclear or questionable orders, decisions or actions made by other health care team members.

9. Practicing in accordance with agency policy and legislation, and in a timely manner, recognizes and reports near misses and errors (own and others), adverse events and critical incidents, and taking action to stop and minimize harm.

Standard 2: Knowledge-Based Practice

The registered nurse practices using evidence-informed knowledge, skills and judgment from diverse sources of knowledge and ways of knowing.

The registered nurse upholds this standard by:

12. Applying a knowledge base from nursing in the practice of registered nursing.

17. Anticipating potential health problems or issues for clients, the possible consequences and responding appropriately.

18. Proactively seeking new information and knowledge, employing a critical inquiry process and utilizing best practice in the provision of registered nursing care.

Standard 3: Ethical Practice

The registered nurse applies the principles in the current CNA *Code of Ethics for Registered Nurses* when making practice decisions and using professional judgment. The registered nurse engages in critical inquiry to inform clinical decision-making, and establishes therapeutic caring and culturally-safe relationships with clients and the health care team.

The registered nurse upholds this standard by:

26. Practicing in accordance with the current CNA *Code of Ethics for Registered Nurses*.

Standard 5: Self-Regulation

The registered nurse demonstrates an accountability to regulate themselves in accordance with their legislated scope of practice.

The registered nurse upholds this standard by:

49. Practicing in accordance with *The Registered Nurses Act, 1988*, other current relevant legislation, bylaws, scope of practice, standards, entry-level competencies, guidelines and employer policies.

SRNA Registered Nurse Entry-Level Competencies (2019)

1. **Clinician**

Registered nurses are clinicians who provide safe, competent, ethical, compassionate and evidence-informed care across the lifespan in response to client needs. Registered nurses integrate knowledge, skills, judgment and professional values from nursing and other diverse sources into their practice.

1.1 Provides safe, ethical, competent, compassionate, client-centered and evidence informed nursing care across the lifespan in response to client needs.

1.2 Conducts a holistic nursing assessment to collect comprehensive information on client health status.

1.4 Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.

1.5 Develops plans of care using critical inquiry to support professional judgment and reasoned decision-making.

1.7 Anticipates actual and potential health risks and possible unintended outcomes.

1.8 Recognizes and responds immediately when client safety is affected.

1.9 Recognizes and responds immediately when client's condition is deteriorating.

1.11 Applies knowledge of pharmacology and principles of safe medication practice.

2. Professional

Registered nurses are professionals who are committed to the health and well-being of clients. Registered nurses uphold the profession's practice standards and ethics and are accountable to the public and the profession. Registered nurses demonstrate accountability, accepts responsibility and seeks assistance as necessary for decisions and actions within the legislated scope of practice.

2.1 Demonstrates accountability, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated scope of practice.

2.3 Exercises professional judgment when using agency policies and procedures, or when practicing in their absence.

3. Communicator

Registered nurses are communicators who use a variety of strategies and relevant technologies to create and maintain professional relationships, share information and foster therapeutic environments

3.7 Communicates effectively in complex and rapidly-changing situations.

3.8 Documents and reports clearly, concisely, accurately and in a timely manner.

7. Advocate

Registered nurses are advocates who support clients to voice their needs to achieve optimal health outcomes. Registered nurses also support clients who cannot advocate for themselves.

7.1 Recognizes and takes action in situations where client safety is actually or potentially compromised.

7.2 Resolves questions about unclear orders, decisions actions or treatment.

9. Scholar

Registered nurses are scholars who demonstrate a lifelong commitment to excellence in practice through critical inquiry, continuous learning, application of evidence to practice and support of research activities.

9.1 Uses best evidence to make informed decisions.