INVESTIGATION COMMITTEE
of the
COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

-and-

Jennifer Brown
RN #0050304
[redacted] SASKATCHEWAN

DECISION

of the

DISCIPLINE COMMITTEE

of the

COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

Legal Counsel for the Investigation Committee:	Lynsey Gaudin
Legal Counsel for Jennifer Brown	Marcus Davies
Legal Counsel for the Discipline Committee:	Brittnee Holliday
Chairperson for the Discipline Committee:	Kris Dutchak, RN

Date of Hearing:	**March 27, 2025**
Location:	*Via Videoconference* College of Registered Nurses of Saskatchewan 1-3710 Eastgate Drive Regina, Saskatchewan S4Z 1A5
Date of Decision:	**June 25, 2025**

I. INTRODUCTION

1. The Discipline Committee of the College of Registered Nurses of Saskatchewan ("CRNS") convened on March 27, 2025, via videoconference, to hear and determine a complaint of professional misconduct and/or professional incompetence against Registered Nurse #0050304, Jennifer Brown. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act, 1988* (the "Act").

2. The charges against Jennifer Brown are outlined in a Notice of Hearing dated February 4, 2025. There is one charge of professional incompetence, and that charge is as follows:

Charges & Particulars

1. **You have committed an act of professional incompetence as per section 25 of *The Registered Nurses Act,* 1988, in that, on December 15, 2023, while working a night shift [redacted] Saskatchewan, you displayed a lack of knowledge, skill, or judgement when you failed to provide appropriate care and assessment for a post-stroke patient who had a small-bore enteral feeding tube in place.**

   Particulars:

   A. **You failed to follow policy when you restrained a patient without the family's consent or a physician's order on the patient's chart, or obtaining such within 12 hours of applying the restraint, and when you did not complete the documentation requirements regarding the care and monitoring of a patient who has been restrained;**
   B. **You failed to confirm that you held the required certification to remove the stylet from the patient's feeding tube, you failed to confirm the inserted length of the feeding tube prior to securing the tube to the patient's nose, and you removed the stylet without first flushing the tube;**
   C. **When the patient's health deteriorated, you failed to recognize symptoms, provide appropriate follow-up care, reach out for assistance to manage the situation, and notify the Charge Nurse or the physician, in a timely manner; and/or,**
   D. **You failed to appropriately document a physician's order and adequately and accurately document about the patient, the placement of the feeding tube, the removal of the stylet, and your assessment.**

II. RELEVANT LEGISLATION

3. The Notice of Hearing alleges that Jennifer Brown is guilty of professional incompetence, contrary to section 25 of the Act, and that provision provides:

> **25 For the purpose 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 to this Act.**

4. The provisions of the CRNS Bylaws, 2023, the Code of Ethics for Registered Nurses (2017), the SRNA Registered Nurse Practice Standards (2019), and the SRNA Registered Nurse Entry-Level Competencies (2019), alleged to have been contravened in the Notice of Hearing are set out in Appendix A of this Decision.

III. HEARING

5. When the Discipline Hearing began on March 27, 2025, neither counsel for the Investigation Committee nor counsel for Jennifer Brown raised any objection regarding the composition of the Discipline Committee.

6. Prior to the Hearing, counsel for the Investigation Committee tendered a binder described as "Document Package for Filing with Discipline Committee". The binder consisted of an Agreed Statement of Facts, Joint Submission of Penalty, a Costs Breakdown, Supporting Case Law. The following were marked as Exhibits:

Exhibit J1: Agreed Statement of Facts
Exhibit J2: Joint Submission as to Penalty and Costs
Exhibit J3: Costs Breakdown

7. Paragraph 53 of the Agreed Statement of Facts, Exhibit J1, states:

> **Ms. Brown admits to the conduct (the charge and particulars) as stated in the Notice of Hearing, Appendix A, dated February 4, 2025. Ms. Brown further admits that her conduct constitutes professional incompetence as defined in section 25 of The Registered Nurses Act, 1988, and contravenes the provisions of the Code of Ethics for Registered Nurses, SRNA Registered Nurse Practice Standards, Registered Nurse Entry-Level Competencies, as outlined in Appendix A of the Notice of Hearing.**

8. Ms. Brown's legal counsel also confirmed her guilty plea to the Charges set out in the Notice of Hearing.

IV. FACTS

9. Jennifer Brown, of , Saskatchewan, is a registered nurse ["RN"] and practicing member of the CRNS.

10. Ms. Brown graduated from the University of Regina Nursing Program and has been registered with CRNS since July 28, 2023.

11. Ms. Brown was employed at from September 20, 2023, to the termination of her employment on January 24, 2024.

12. On December 15, 2023, Ms. Brown was working a night shift on the from 1930 to 0747.

13. The patient was a 77-year-old male who had been admitted to the on November 22, 2023. The patient had a history of stroke, left sided-weakness, difficulty speaking and swallowing.

14. The patient was receiving medications and nutrition through a Duotube.

15. The Agreed Statement of Facts contains a number of paragraphs with evidence to support the charges. It is important to set out several of those facts.

16. In relation to Particular A:

a) Ms. Brown began her night shift at 1930. Ms. Brown entered the patient's room at or around 2200 and applied a soft restraint to the patient's right wrist.

b) Before applying the soft restraint, Ms. Brown did not:

(i) Check the patient's chart for a signed consent form or a physician's order; or

(ii) Obtain a physician's order or a signed consent form from the patient's family.

Ms. Brown acknowledges that doing so was her responsibility.

c) After Ms. Brown applied the soft restraint, Ms. Brown did not document that a restraint had been applied. Further, after initial application of the restraint, Ms. Brown did not check the patient after 15 minutes nor did she continue to observe and assess the patient every 30 minutes as required. Additionally, Ms. Brown failed to (a) document that any checks were performed; or (b) ensure that checks were performed by someone else and were properly documented.

17. In relation to Particular B:

a) The patient pulled out his Duotube at the end of the December 15, 2023 day shift. The Duotube was re-inserted by RN day staff to 40 cm, then advanced an additional 15 cm to roughly 55 cm length per physician's order and secured to the patient's face with tape. At this time, the Duotube was correctly placed. As it was the end of the day shift, Ms. Brown was then asked by day RN staff to remove the stylet from the Duotube during the night shift, as the physician had given the order that the feeding tube was ready to be used.

b) At the relevant time, the [redacted] required RNs to successfully complete a certification process to perform this procedure. Ms. Brown was informed of the certification process and the checklist by the Clinical Nurse Educator during her orientations. Ms. Brown had not completed this process and was not certified to remove the stylet from the patient's Duotube.

c) Ms. Brown completed the removal of the patient's Duotube at or around 2100. She secured the Duotube with a butterfly-type bandage to the patient's nose and then removed the stylet. After removing the stylet, Ms. Brown flushed the Duotube, assessed the patient for signs of distress and administered the tube feed and medication.

d) Ms. Brown did not review the Enterel Feeding Tube policy, check the patient's chart to determine insertion length or flush the Duotube prior to removing the stylet.

e) Ms. Brown did not chart the removal of the stylet, and did not chart any assessment for correct placement of the Duotube after the removal.

f) Following the removal of the stylet, Ms. Brown did not assess the feeding tube for correct placement at any time.

g) On December 17, 2023, the physician documented that during the night shift of December 15, 2023, while receiving their tube feed, the patient's tube was displaced, and they likely aspirated, became symptomatic early morning on December 16, 2023, and passed away that day.

18. In relation to Particular C:

a) At or around 2100, the LPN assessed that the patient had a wet cough. The LPN recorded this in the Patient Chart.

b) The LPN then assessed the patient later that night at 0120. The LPN noted that the patient was sounding "wet" at that time. Upon assessment, the patient's oxygen saturation level had decreased to 85% on room air, so the LPN applied oxygen at 6L/min via nasal prongs. The LPN recorded this in the Patient Chart.

c) If she were called to testify, the LPN would state that at or around this time, she told Ms. Brown that oxygen had been applied to the patient and that there was something wrong with the patient, but Ms. Brown did not seem concerned.

d) The LPN also assessed the patient at 0320 and turned the oxygen down to 4L/min given the patient's oxygen saturation was 94% at that time. The LPN recorded this in the Patient Chart.

e) Ms. Brown then assessed the patient at or around 0600. The patient's condition had deteriorated. The patient's respiratory rate was 44, heart rate 141, oxygen saturation 88% on 7L/min oxygen and the patient has an increased work of breathing. Ms. Brown called the physician, who ordered an x-ray. That x-ray showed the Duotube was displaced and positioned in the patient's throat. Ms. Brown recorded this in the Patient Chart.

f) Ms. Brown's actions were contrary to the Enteral Feeding Tube Policy. Section 3.2.2. requires an RN to assess the patient for potential signs of feeding tube migration/dislodgement every 4 hours and with any change in respiratory status. Section 3.2.4. establishes that signs and symptoms of possible improper tube placement into the lungs may include respiratory distress, dyspnea or cyanosis, crackles on auscultation, decrease oxygen saturation, and to further assess for coiling of the tube if the patient presents with gagging, coughing, or vomiting. Ms. Brown took no action to assess for feeding tube dislodgement, to obtain assistance to manage the situation or to notify the Charge Nurse or physician from 2100 on December 15, 2023 to 0600 on December 16, 2023 despite the patient's changing respiratory status. Ms. Brown acknowledges she should have contacted the Charge Nurse or physician when the patient first needed oxygen.

19. In relation to Particular D:

a) On December 15, 2023, an RN co-worker verbally passed on a physician's order on to Ms. Brown. Ms. Brown documented the physician's order on the patient's chart as "tube ok to use" and co-signed the physician's order. Ms. Brown acknowledges that charting a verbal physician's order passed on to her by another RN was improper and she should have called the physician herself to receive the order.

b) Ms. Brown's failure to document the placement and position of the Duotube, the removal of the stylet and the assessments performed are contrary to s. 3.4 of the Enteral Feeding Tube Policy which requires ongoing documentation.

20. The Discipline Committee finds that the Agreed Statement of Facts and supporting evidence substantiates the Charges and the Discipline Committee accepts Ms. Brown's guilty plea to the charges.

21. Ms. Brown has been found to have contravened section 25 of the Act, as well as the following, which are specifically laid out in Appendix A:

a) CRNS Bylaws (2023), Bylaw XIV Section 1: Code of Ethics of the Association
b) CRNS Bylaws (2023), Bylaw XV Section 1: Standards and Competencies
c) Section D Code of Ethics for Registered Nurses (2017): Honouring Dignity
d) Section G Code of Ethics for Registered Nurses (2017): Being Accountable
e) SRNA Registered Nurse Practice Standards (2019):
    (i) Standard 1: Professional Responsibility and Accountability
    (ii) Standard 2: Knowledge-Based Practice
    (iii)Standard 3: Ethical Practice
f) SRNA Registered Nurse Entry-Level Competencies, 2019:
    (i) Competency 1: Clinician
    (ii) Competency 2: Professional
    (iii) Competency 3: Communicator
    (iv) Competency 4: Collaborator
    (v) Competency 5: Coordinator
    (vi) Competency 7: Advocate

V. PROPOSED SANCTION

22. Having found that the Charges are sustained, and the guilty plea is accepted, the next task for the Discipline Committee is the imposition of an appropriate sanction pursuant to section 31 of the Act.

23. The Discipline Committee was presented with a Joint Submission as to Penalty and Costs, Exhibit J2 ("Joint Submission") which broadly consisted of the following:

a) Continued practice, provided Ms. Brown completes three educational courses, writes a research/reflective essay to the Registrar or designate, and meet with the Registrar, designate, or a CRNS practice advisor; and,

b) Payment of costs of the investigation and hearing in the amount of $7,500.00 within two years of the effective date of the Discipline Committee's Order.

24. Exhibit J3 outlines the total approximate costs to the CRNS in this professional disciplinary proceeding as $39,199.85. Although this is described as the total actual and anticipated costs, the Joint Submission provides that Ms. Brown would pay $7,500.00 or approximately 19.1% of the total actual and anticipated costs of the investigation and hearing.

25. Several factors are considered when determining an appropriate sanction for a professional. While the list is not intended to be exhaustive, a frequently cited list of factors established by case law can be found in the decision of *Jaswal v Medical Board (Newfoundland)*, 1996 CanLII 11630 (NL SC), 138 Nfld & PEIR 181 ["*Jaswal*"], at paragraph 35:

1. the nature and gravity of the proven allegations
2. the age and experience of the offending physician
3. the previous character of the physician and in particular the presence or absence of any prior complaints or convictions
4. the age and mental condition of the offended patient
5. the number of times the offence was proven to have occurred
6. the role of the physician in acknowledging what had occurred
7. whether the offending physician had already suffered other serious financial or other penalties as a result of the allegations having been made
8. the impact of the incident on the offended patient
9. the presence or absence of any mitigating circumstances
10. the need to promote specific and general deterrence and, thereby, to protect the public and ensure the safe and proper practice of medicine
11. the need to maintain the public's confidence in the integrity of the medical profession
12. the degree to which the offensive conduct that was found to have occurred was clearly regarded, by consensus, as being the type of conduct that would fall outside the range of permitted conduct
13. the range of sentence in other similar cases

26. In *Camgoz v College of Physicians and Surgeons (Sask.)*, 1993 CanLII 8952, 114 Sask R 161, the Court of Queen's Bench, as it then was, also outlined the *Jaswal* factors as factors to consider when determining penalty. The Court specifically noted that the list is not exhaustive and does not mean that each specified factor will be relevant in every instance. As such, the factors need to be considered in relation to the specific facts of each case.

27. Counsel for the Investigation Committee reviewed the range of sentence in similar cases, particularly the 2023 Decision of the Discipline Committee of the CRNS in *Ortman*[1] and *College of Nurses of Ontario and Popo*[2] ("*Popo*"). *Ortman* and *Popo* both involved a lack of skill and judgment of experienced nurses in monitoring a patient and initiating proper intervention, including elements of deceit in *Popo*. In *Ortman*, the Discipline Committee ordered a one month suspension, educational requirements, continued work under supervision, and a portion of costs. In *Popo*, a longer suspension of three months was ordered, along with a reprimand and educational requirements.

28. The Investigation Committee suggested that for both specific and general deterrence and to protect the public's confidence, there is no question that a penalty needed to be imposed; however, it was argued that significant mitigating factors would support an educational and remedial approach to sanction. Counsel for the Investigation Committee noted that Ms. Brown was a new nurse, having only worked for four months with no disciplinary record, Ms. Brown lost her employment and being a new nurse, it took time to find a new position, and Ms. Brown was very cooperative throughout the discipline process, including her guilty plea, agreement to facts and penalty, and having taken ownership for her conduct.

29. The Discipline Committee members considered several *Jaswal* factors during its deliberation, including those raised by counsel for the Investigation Committee. Ms. Brown showed a lack of skill and judgment and there is no question that the nature and gravity of her conduct was very serious. She omitted steps in procedures and was not certified in the specific skills required, making numerous critical errors and failing to comply with appropriate policies and procedures. Ms. Brown was a new nurse, having only worked a couple of months, the evidence demonstrated that Ms. Brown had numerous instances of professional incompetence throughout her shift. She has acknowledged these failings.

30. It is necessary to maintain the public's confidence in the integrity of the nursing profession. The Discipline Committee members are of the opinion that there is a great need to

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[1] Investigation Committee of the College of Registered Nurses of Saskatchewan and Christine Ortman, July 7, 2023

[2] 2020 CanLII 50571 (ON CNO)

stress deterrence in this case. The evidence presented indicates that Ms. Brown's actions did not align with the established policies and procedures, contributing to a fatal patient outcome. It is essential that all members of the profession understand the gravity of not maintaining high standards in practice.

31. The Discipline Committee recognizes that Ms. Brown has experienced other serious consequences of her misconduct, including the loss of employment and a period of unemployment. The Discipline Committee further recognizes that Ms. Brown was cooperative throughout the discipline process and expressed remorse, committing to learning from the mistakes made.

32. Applying the appropriate sentencing principles, including principles regarding joint submissions on penalty, the Discipline Committee has concluded that the Joint Submission is fit, reasonable, consistent with the public interest mandate of the CRNS, and within the range of appropriate dispositions.

33. While this decision is focused on Ms. Brown's conduct, the Discipline Committee members would like to draw attention to the importance of effective mentorship in nursing practice, especially in acute care settings such as this case. Mentorship and direct supervision from senior nurses and management is important for new nurses. Ongoing performance appraisals should be provided, and new nurses themselves should seek out the same if not provided.

VI. ORDER

34. In light of the above conclusions, the Discipline Committee makes the following Order pursuant to section 31 of the Act:

1. Pursuant to section 31(1)(c) of *The Registered Nurses Act, 1988* (the "Act"), Ms. Brown shall complete the Saskatchewan Polytechnic Health Record Documentation (NURS-1685) and Health Assessment (RN) (NURS-1710) courses, and the John Collins Critical Thinking in Nursing (CTNRN01) course

within six months of the effective date of this Order, the full cost to be borne by her. Ms. Brown must also provide proof of completion to the Registrar or designate. A failure to successfully complete these three courses within six months shall result in a suspension of Ms. Brown's license until such time that the courses are completed.

2. Pursuant to section 31(1)(e) of the Act, within three months of the effective date of this Order. Ms. Brown shall submit a research/reflective essay to the Registrar or designate exploring the CNPS InfoLaw: Patient Restraints and the RNAO Clinical Best Practice Guideline Promoting Safety: Alternative Approaches to the Use of Restraints, and what has been learned from this specific situation. The essay shall be between eight to ten pages with a minimum of two references cited appropriately.

3. Pursuant to section 31(1)(e) of the Act, within one month of the submission of Ms. Brown's research/reflective essay, she will have a discussion with the Registrar, designate, or practice advisor regarding the issues explored in her essay.

4. Pursuant to section 31(1)(e) of the Act, all documents and information requested in this Order must be sent to the CRNS directly from source, marked "Personal and Confidential," to the attention of the Registrar, c/o Assistant to the Registrar, CRNS, 1-3710 Eastgate Drive, Regina, Saskatchewan, S4Z 1A5.

5. Pursuant to section 31(1)(e) of the Act, Ms. Brown shall ensure that the Registrar is provided with updated and current telephone, address and email information and on an ongoing basis for so long as she is subject to any continuing conditions or restrictions of this Order.

6. Pursuant to section 31(2)(a)(ii) of the Act, Ms. Brown shall pay costs of the investigation and hearing process fixed in the amount of $7,500.00.

7. The costs shall be paid within two years of the effective date of this Order. Pursuant to section 31(2)(b) of the Act, failure to pay the costs within the time set

by the Discipline Committee shall result in the immediate suspension of Ms. Brown's license until payment is made in full.

35. Pursuant to section 31(3) of the Act, a copy of this decision shall be sent to Ms. Brown and [redacted]

June 25, 2025

Kris Dutchak, RN, Chairperson
On behalf of Members of the Discipline Committee
Anne KoKesch, RN
Joanne Petersen, RN
Frank Suchorab, RN
Leah Currie, Public Representative

Pursuant to section 31(1)(e) of the Act, a copy of this decision will also be forwarded to:

(a) The editor of the CRNS news bulletin and the administrator for the CRNS website;

(b) All Canadian Registrars of registered nurses;

(c) College of Licensed Practical Nurses of Saskatchewan;

(d) College of Psychiatric Nurses Association of Saskatchewan;

(e) The College of Physicians and Surgeons of Saskatchewan; and,

Any other jurisdictions or other stakeholders as may be seen as appropriate by the Registrar.

Right of Appeal

Pursuant to section 34(1) of *The Registered Nurses Act, 1988,* a nurse who has been found guilty by the discipline committee or who has been expelled pursuant to section 33 may appeal the decision or any order of the discipline committee within 30 days of the decision or order to:

(a) the council by serving the executive director with a copy of the notice of appeal; or

(b) a judge of the court by serving the executive director with a copy of the notice of appeal and filing it with a local registrar of the court.

Appendix A

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

The Registered Nurses Act, 1988

25 For the purpose 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:

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

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

is professional incompetence within the meaning to this Act.

The CRNS Bylaws (2023)

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

Code of Ethics for Registered Nurses (2017)

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:

3. 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.

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.
6. Advocating, intervening and participating with others, as needed, to ensure client safety.

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.

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:

29. Communicating respectfully and effectively in collaboration with client, family, colleagues and others, and resolving conflict should it occur.

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-centred 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.

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

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

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.

2.3 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.

4. Collaborator

Registered nurses are collaborators who play an integral role in the health care team partnership.

4.4 Applies knowledge about the scopes of practice of each regulated nursing designation to strengthen intraprofessional collaboration that enhances contributions to client health and well-being.

5. Coordinator

Registered nurses coordinate point-of-care health service delivery with clients, the health care team, and other sectors to ensure continuous, safe care.

5.1 Consults with clients and health care team members to make ongoing adjustments required by changes in the availability of services or client health status.

5.2 Monitors client care to help ensure needed services happen at the right time and in the correct sequence.

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.