CONFIDENTIAL

Mar. 15, 2021

BC College of Nurses and Midwives
Attn: Complaints
900—200 Granville St.
Vancouver, BC V6C 1S4

Dear BCCNM:

I am writing to alert the BC College of Nurses and Midwives about serious practice concerns and recent investigation findings about Janine Maye (Registration # 0000000), a nurse in High Acuity Unit at ABC hospital. She has been working full time in the unit since September 2020. Prior to that, she worked on a medical unit at ABC hospital for approximately five years.

She has been off on sick leave since February 19, 2021.

On November 3, 2020, Janine failed to document assessments on her three assigned patients over a 7.5 hour period. While the nursing notes/flow sheets for each patient show some recorded vital signs, there were no documented systematic assessments and vital signs were not completed as often as required by unit policy. In her handover report, she also failed to provide critical information needed by the nurse taking over the care of her patients. When Nurse Yan came on shift she found:

- Patient A was extremely hypotensive. Nurse Yan needed to call the physician but was not able to provide any information regarding the patient's status or vital signs for the previous 5.5 hours.
- Patient B's dressing was saturated with serosanguinous drainage. The patient's temperature was 38.5 Celsius. Nurse Yan could not tell whether the patient had been assessed or the dressing changed in the past 7.5 hours.
- Patient C was complaining of a pain level of 10/10. Janine signed for administering narcotics in the MAR however, there was no documentation of any assessment of the patient or the effectiveness of the narcotics.

Copies of the patient charts are available.

The High Acuity Unit has a policy that requires nurses to document hourly assessments of unstable patients and every 4 hours on stable patients. A copy of the policy is available.

Janine received orientation to the policy during the week of October 12, 2020.

Nurse Yan completed a PSLS report and sent an email to the manager/incident report on November 4, 2020. Copies of the email and PSLS are available. Nurse Yan was a witness.

Nurse Yan talked to Janine about her concerns on November 4, 2020. Janine's response was “I’m sorry, it was really busy and nobody gave me any help! Thankfully it’s no big deal because everything got sorted out on nights and they were fine.” Nurse Yan sent an email to the manager regarding her conversation with Janine. The email is available upon request.

On November 10, 2020, an employer investigation meeting was held with Janine, her union representative, Karen, and human resources. Janine said she hadn’t had time to document on November 3, 2020 because it was busy and no one offered to help her. She said she couldn’t recall the specifics of the documentation policy or how often she was required to document, and that even though she did not document, she had provided a verbal report and her patients were all fine. She reiterated that it was busy but she had no support from others. A copy of the meeting notes is available.

In follow up to the meeting, Janine received a letter of expectation from her employer. The expectation was that she develop a learning plan related to documentation, and for her to review her assignment and documentation with the clinical nurse educator (CNE), Elizabeth Smith, at the end of each shift for two weeks, then on a weekly basis for another two. The letter was reviewed with Janine. Janine stated that she understood expectations related to documentation and agreed to develop a learning plan. After asking a few questions, she confirmed she understood what the plan was to include. A follow up meeting was planned for December 15, 2020. A copy of the letter of expectation is available.

On December 14, 2020, Nurse Redmond reported to the manager by email that Janine did not document at all on a critically ill patient who was subsequently transferred to ICU. In her handover report to the ICU nurse, she also failed to provide the information necessary to enable the nurse to safely take over care of the patient. There was no documentation in the chart about when the patient's condition began to deteriorate, or what circumstances (if any) precipitated the patient's sudden deterioration. Given that the patient required intubation and ventilation immediately upon arrival to the ICU, not having the necessary information put this patient at an even greater risk and may have delayed treatment. A copy of the chart is available. Witnesses include Nurse Redmond, Dr. Page and Nurse Jorge, who received the patient in ICU.

On January 7, 2021, Karen met with Janine, her union representative and human resources regarding the concern identified on December 14, 2020. Janine said she had been too busy to document on the patient and instead had given a verbal report to ICU nurse. She felt that the verbal report should be enough, since she tried to cover the important points and she was required urgently back in the unit. When asked about

the status of her learning plan, Janine said she had been too busy to complete one, and that she was waiting for the CNE to follow up with her. A copy of the meeting notes is available.

In follow up to the meeting, Janine received a letter of discipline advising her that she was removed from clinical care until she had developed and completed the learning plan. She was advised that following its completion, she was required to work under the supervision of the CNE for a minimum of twelve shifts, until her documentation was considered satisfactory. The letter was reviewed with Janine and she stated she understood what was expected of her.

On February 11, 2021, Janine submitted a learning plan consisting of three sentences unrelated to documentation, but instead commenting on unit issues in such as a lack of team work and support from others. At a follow up meeting with Karen, Janine stated that she didn't feel supported by Karen and the CNE.

On February 19, 2021, Janine provided documentation from her physician stating that she required medical leave.

All witnesses noted above are aware that they may be contacted by BCCNM and required to provide a statement.

Thank you for your attention to these concerns. Please contact me if you require any further information.

Sincerely,

Karen Red

Manager, High Acuity Unit
ABC Hospital
karen.red@abchospital.ca

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