IN THE MATTER OF:	***The Regulated Health Professions Act, C.C.S.M. c.R117***
AND IN THE MATTER OF:	**TAMMY WOLFE, A MEMBER OF THE COLLEGE OF REGISTERED NURSES OF MANITOBA, REGISTRATION #140381.**
AND IN THE MATTER OF:	**A HEARING BEFORE A PANEL OF THE INQUIRY COMMITTEE OF THE COLLEGE OF REGISTERED NURSES OF MANITOBA**

DECISION AND REASONS

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DECISION AND REASONS

Inquiry Committee Panel Members: Jennifer Colvine, Chair/Registered Nurse ("RN")

Anne-Marie Brown, RN

Jean Dalman, Public Representative

Joseph Lovelace, Public Representative

Tricia Tyerman, RN

Counsel to and representative of the Complaints Investigation Committee:

David Swayze K.C. and Keith Murkin
Meighen Haddad LLP

Denise Nakonechny
CRNM Manager of Professional Conduct

Registrant and counsel: Tammy Wolfe

Jeff Smorang
Myers LLP

Counsel to the Panel: Jeff Hirsch K.C.
Thompson Dorfman Sweatman LLP

I. Introduction and Preliminary Issues

1. On Wednesday, November 26, 2025, an Inquiry Committee Panel (the "Panel") of the College of Registered Nurses of Manitoba (the "College") held a hearing into charges against Tammy Wolfe, a registrant of the College (the "Registrant").

2. The initial return date for the hearing was January 10, 2025, and was adjourned based on the Registrant's signed Waiver. A subsequent return date, as agreed by all parties, was set for November 26, 2025.

3. At the commencement of the hearing, it was established that the Notice of Hearing dated November 7, 2024 (the "Notice"), had been properly served and the jurisdictional requirements set forth in subsections 102(3), 116(2), and 116(4) of The Regulated Health Professions Act, C.C.S.M., c.R117 (the "Act") had been met.

4. The parties raised no objections to the composition of the Panel.

5. The Registrant indicated their intention to enter a plea of guilty to the charges contained in the Notice except for count 4(j) (the "Charges") which was withdrawn by the Complaints Investigation Committee (the "CIC"). At the direction of the Chair, counsel to the Panel conducted a plea inquiry with respect to the Charges. The Panel was satisfied that the Registrant: was voluntarily pleading guilty; understood that by pleading guilty, they gave up the right to contest the factual accuracy of the allegations made against them; acknowledged the breaches alleged in the Charges; that they constituted professional misconduct; and that even though a joint recommendation may be made with respect to the appropriate sanction, the Panel – subject to the law applying to joint recommendations – is not bound to follow the joint recommendation, and that the Panel will determine the appropriate penalty after considering the evidence and the submissions of counsel.

6. The Registrant entered a plea of guilty to the Charges, namely that on or about April 18 and 19, 2022, in the course of providing registered nursing care to a 68 year-old critically ill patient (the "Patient"), they displayed a lack of knowledge or lack of skill or judgment in the practice of registered nursing and/or have contravened a practice direction, entry-level competency and/or the The Code of Ethics for Registered Nurses (2017 Edition) (the "Code"), and committed professional misconduct by:

   (a) failing to demonstrate critical thinking and apply the nursing process;

   (b) failing to check in on the patient and assess their condition;

(c) failing to administer prescribed medication;

(d) failing to communicate their concerns about the Patient and their change in condition; and

(e) failing to properly document the nursing care provided or not provided.

7. The Registrant admitted that their conduct constituted professional misconduct.

8. The parties agreed that references to the Patient would be anonymized.

9. The Panel heard submissions from counsel for the CIC, describing the background facts giving rise to the matter raised in the Notice.

10. The Panel also heard from the Registrant and their counsel who provided additional information on the Registrant's personal background and current circumstances.

11. The Registrant and the CIC jointly recommended the following disposition:

(a) The Registrant be suspended from practice for a period of three weeks commencing on the date of the Order of the Panel;

(b) The Registrant pay costs in the amount of $8,000.00;

(c) The Registrant attend and complete the following courses within four months of the date of the Order of the Panel:

i. McEwan University's Medication Management NURS 0161;

ii. McEwan University's Documentation in Nursing NURS 0162;

iii. John Collins Consulting *Critical Thinking in Nursing*; and

(d) The Panel's decision and disposition will be published on the College website pursuant to subsection 129(1) of the Act.

(the "Joint Recommendation")

12. The Panel advised the parties on November 26, 2025 that it would accept the Joint Recommendation and would subsequently provide written reasons for decision. These are those reasons.

II. Facts

13. Ms. Wolfe registered as an RN in 2003 and has been employed with various employers throughout her career. Since 2018, Ms. Wolfe has been employed as a Charge Nurse at the Grace Hospital Medicine Unit 3 North, an acute medicine unit (the "Unit).

14. Patients who are admitted to the Unit could be experiencing acute illness such as Post Myocardial Infarction (heart attack), Congestive Heart Failure, or Chronic Obstructive Pulmonary Disorder.

15. The typical nurse to patient ratio is one nurse to six or seven patients. On the night of the incident, the Unit was one nurse short, and the ratio was one nurse to eight patients.

16. The Patient was 68 years old with an extensive medical history of chronic illness. They were brought to Grace Hospital by ambulance on April 15, 2022, showing a three-to-four-day history of progressively worsening shortness of breath secondary to pneumonia and bright red blood per rectum with decreased hemoglobin requiring a blood transfusion while in the Grace Hospital Emergency Department (the "ED").

17. While at the ED on April 15, 2022, the Grace Hospital Intensive Care Physician determined that the Patient was not a candidate for Intensive Care.

18. An Internal Medicine consultation determined that, once medically stable, the Patient was to be admitted to an Internal Medicine teaching unit at the Grace Hospital under Dr. Frank Bovell.

19. The Patient was admitted to the Unit on April 18, 2022, at approximately 10 p.m.

20. The Registrant was responsible for the Patient's care during her 12-hour night shift beginning on the night of April 18, 2022, through to the morning of April 19, 2022.

21. Ms. Wolfe was expected to follow the National Early Warning Score Vital Signs Record recording process ("NEWS2") and use the NEWS2 recording form. The NEWS2 determines the needs and care of patients.

22. When NEWS2 is utilized, a stable patient should be assessed every four hours. As the Patient was unstable, they ought to have been assessed more frequently.

23. At 10:15 p.m., the Registrant documented a partial assessment in the NEWS2 form but did not complete the NEWS2 'scoring'.

24. The Registrant failed to document on the NEWS2 that the Patient was lethargic and confused and instead scored the Patient as alert. On admission to the Unit, the Registrant had noted in the Integrated Progress Notes (the “IPN”) that the Patient was ‘lethargic and confused’.

25. The Registrant documented the Patient’s score as a one (1) in the Consciousness section even though Confusion should be documented as a score of three (3). A score of three (3) in any section requires that the RN inform the medical team who will review and decide whether the care plan should change.

26. The Registrant did not inform the medical team as required.

27. Had the Registrant properly documented and added the score, the Patient’s score would have been a seven (7). With a total score over five (5), the medical team must be informed urgently to review and decide whether the care plans need to change.

28. If a Patient has a score of seven (7) or more, the RN must immediately inform the medical team, including the Attending Physician, consider consulting a higher level of care or ICU, and continuously monitor vital signs.

29. The Registrant failed to calculate the NEWS2 score and failed to notify the health care team that the Patient had a total score over five (5) and a single category score over three (3).

30. Based on the information documented by the Registrant, the Patient was not stable and required at least hourly monitoring.

31. At 10:15 p.m., the Registrant applied a Bluetooth oxygen saturation probe on the Patient’s finger which continuously read the Patient’s oxygen saturation levels, respiratory rate and heart rate. The Registrant placed the monitor which showed these levels on the nursing desk and set it to alarm should the oxygen level drop below 90%.

32. The Registrant applied a blood pressure cuff on the Patient's arm which automatically measured the Patient’s blood pressure every hour.

33. The Registrant did not document any vitals, oxygen saturation or heart rate for the Patient between 11:15 p.m. and 6:05 a.m.

34. The Registrant failed to document numerous medications on the Medical Administration Record (the “MAR”) which were to be administered by the Registrant to the Patient.

35. The Registrant was to have administered the following medications to the Patient: Vancomycin; Pip-Tazo; Atrovent; and Ventolin. These medications were then to be documented on the MAR. The Registrant claims to have administered them but failed to document their administration.

36. The Pyxis machine withdrawal records confirmed that Pip-Tazo and Vancomycin were withdrawn by the Registrant for the Patient.

37. At midnight, the Registrant recorded on the MAR that a Hydromorphone dose was held due to the Patient's reduced "LOC" (level of consciousness). There is no explanation or documentation to explain the change in consciousness from 10:15 p.m. to midnight.

38. The Registrant did not consult with the prescribing physician prior to holding the Hydromorphone.

39. The Patient had an indwelling urinary catheter inserted while admitted to the hospital.

40. The Registrant claimed that as part of her rounds she would ensure the Patient had adequate urine output.

41. The Registrant, at 10:15 p.m., documented in the IPN that the Patient was producing clear amber urine but did not document the volume of urine output. Following that entry, the Registrant failed to record any documentation regarding the Patient's urine output.

42. The Registrant first assessed the Patient at 10:15 p.m. but did not document vital signs, her assessments or note any changes in the Patient's condition until 3 a.m. when they documented on the IPN that the Patient's oxygen saturation had maintained above 90%, that their blood pressure remained stable and that they were "confused". There was no information documented as to the nature or level of the confusion.

43. The Registrant did not document vital signs, her assessments or note any changes in the Patient's condition between 3 a.m. and 6:05 a.m.

44. There is no documentation of the Registrant having performed any assessment of the Patient between 10:15 p.m. and 3 a.m. and again between 3 a.m. and 6:05 a.m.

45. The Registrant maintained that the Patient was too ill to be on the Unit and should have been in the Intensive Care Unit.

46. The Registrant did not document their concern about the Patient being admitted to the Unit.

47. At around 5:20 a.m., the remote oxygen monitor alarmed indicating the Patient's oxygen saturation levels dropped below 90%. The Patient coded at approximately 5:23 a.m. and was pronounced deceased at 5:50 a.m.

III. Submission of the CIC

48. Counsel for the CIC stressed the expectation on RNs to properly document their work which is critical for identifying changes in a patient's condition and the resultant need for reassessment and alteration, if required, of a patient's care plan.

49. Mr. Swayze noted that, in this instance, the Registrant had already formed the opinion that the Patient's needs were greater than what the Unit could provide which ought to have triggered even more attention to patient care and proper documentation.

50. Counsel referred to the applicable Code breaches making reference to:

(a) Value A, Providing Safe, Compassionate, Competent and Ethical Care

4. Nurses question, intervene, report and address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent and ethical care; and they support those who do the same.

(b) Value B, Promoting Health and Well-Being

4. Nurses collaborate with other health-care providers and others to maximize health benefits to persons receiving care and with health-care needs and concerns, recognizing and respecting the knowledge, skills and perspectives of all.

(c) Value D, Honouring Dignity

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.

(d) Value G, Being Accountable

4. 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)

51. Mr. Swayze also directed the Panel to the College's *Practice Direction: Practice Expectations for*

RNs, noting that registrants are accountable to apply them to their own nursing practice:

(a) Client-centered Practice

23. When engaging in the practice of registered nursing, you must apply, as a framework, the nursing process, which is the systematic approach to the practice that encompasses all steps taken by RNs in planning for the needs of your client, including assessment, diagnosis or determination, planning, implementation and evaluation.

(e) Collaborative care

27. Document on the client's record the nursing care you provided with enough information for another health-care professional to be sufficiently informed of the care provided.

(f) Client records - As an RN, you must appropriately document the nursing care you provided

31. In a record specific to each client.

32. In the client's record as the nursing care is provided or as soon as possible after the care is provided.

52. Counsel also referred to the College's *Entry Level Competencies for the Practice of Registered Nurses* (the asterisk denotes a critical competency):

(a) 1.2* Conducts a holistic nursing assessment to collect comprehensive information on client health status. Assessment may include but is not limited to: observation, interview, history taking, interpretation of laboratory data, mental health assessment, physical assessment, including inspection, palpation, auscultation, and percussion;

(b) 1.4* Analyzes and interprets data obtained in client assessment to inform ongoing decision-making about client health status and make a diagnosis when appropriate;

(c) 3.7* Communicates effectively in complex and rapidly changing situations;

(d) 3.8* Documents and reports clearly, concisely, accurately, and in a timely manner;

(e) 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;

(d) 5.2* Monitors client care to help ensure needed services happen at the right time and in the correct sequence;

(e) 7.6* Advocates for safe, competent, compassionate and ethical care for clients; and

(f) 9.2 Translates knowledge from relevant sources into professional practice.

53. With respect to penalty, counsel for the CIC noted the parties' Joint Recommendation and reviewed the jurisprudence adopting the *Anthony Cook v Her Majesty the Queen* public interest test – that is, an adjudicator may reject and depart from a joint recommendation on penalty only where the proposed disposition would bring the administration of justice into disrepute or would otherwise be contrary to the public interest.

54. Mr. Swayze submitted that the sentencing objectives the Panel ought to keep in mind were punishment, specific and general deterrence, rehabilitation, proportionality, and ensuring the public retained confidence in the ability of the College to properly regulate its registrants.

55. Counsel indicated the need for the Panel to express its disapproval of the Registrant's conduct, suggesting that the Registrant needs to be deterred from ever repeating this behaviour. As to general deterrence, he submitted that it was important for other RNs to recognize they must also meet expected practice standards.

56. Counsel noted that the proposed disposition was within the range of some similar jurisprudence including two decisions from the Discipline Committee of the College of Nurses of Ontario (*Mohammed* – October 8, 2008 and *Martyn* – August 25, 2022), two decisions from the College of Registered Nurses of Saskatchewan (*Mitchell* – January 10, 2025 and Brown – June 25, 2025), and a recent College Inquiry Committee Panel decision (*Marius* – February 14, 2024).

57. Mr. Swayze emphasized the punitive nature of the proposed suspension, indicating it would have the required specific and general deterrent value. With respect to rehabilitation, he submitted that the proposed courses should assist the Registrant in future RN practice.

58. He noted that the College's costs were considerable, including a required expert's report and that the entirety of those costs would be too much for the College's membership as a whole to cover.

59. Counsel urged the Panel to accept the Joint Recommendation.

IV. Submission of the Registrant

60. Counsel for the Registrant noted that the Registrant's admission of the allegations in the Charges and that they constituted professional misconduct demonstrated their insight and accountability. He noted that the Registrant expressed remorse at an early stage of the proceedings.

61. Mr. Smorang indicated that the Registrant's agreement to plead guilty and avoid a contested hearing shows that they have taken responsibility for their actions and are prepared to face the consequences head-on.

62. Counsel for the Registrant, in addressing the Joint Recommendation, submitted that it is in line with similar jurisprudence and appropriately satisfies the sentencing considerations the Panel ought to keep in mind including the general deterrence of the profession.

63. He noted that the Registrant's need to be specifically deterred from this conduct was lesser than in other cases based on the Registrant's discipline-free record of 23 years. He submitted that publication will also contribute to the specific deterrence of the Registrant.

64. Mr. Smorang referred to the fact that this was one shift with one patient and was an isolated incident on a shift where the Unit was understaffed and had an increased workload.

65. Counsel stated that the Registrant has taken additional training on the NEWS2 tool.

66. Finally, Mr. Smorang reminded the Panel that the Registrant expressed sincere remorse and regret for their misconduct. He also submitted that the Joint Recommendation be accepted.

V. Analysis and Decision

67. Subsection 124(1) of the Act authorizes the Panel to make any finding permitted under subsection 124(2) which includes that an investigated member has breached the Code, a practice direction, or is guilty of professional misconduct.

68. The Panel finds that the facts submitted establish that the Registrant is guilty of professional misconduct as alleged in the Notice. The Registrant acknowledged and admitted that their conduct amounted to professional misconduct. The panel accepted the guilty plea.

69. The authority of a Panel to make sentencing orders, and orders related to costs are found in sections 126 and 127 of the Act.

70. In reaching its decision, the Panel acknowledges the submissions of counsel to the CIC and the

Registrant and was mindful of the objectives of such orders which have been articulated by various authorities.

71. In *The Regulation of Professions in Canada*, Carswell 2021, James T. Casey describes the purpose of sentencing in professional discipline cases, citing *McKee v. College of Psychologists* (British Columbia), [1994] 9 W.W.R. 374 (at page 376):

> [W]here the legislature has entrusted the disciplinary process to a self-governing professional body, the legislative purpose is regulation of the profession in the public interest. The emphasis must clearly be upon the protection of the public interest...

72. Citing *McKee* and a number of other authorities, Casey goes on to list the factors in determining how the public is protected including:

> … specific deterrence of the member from engaging in further misconduct, general deterrence of other members of the profession, rehabilitation of the member, punishment of the offender, ..., the denunciation by society of the conduct, the need to maintain the public's confidence in the integrity of the profession's ability to properly supervise the conduct of its members and ensuring that the penalty imposed is not disparate with penalties in other cases.

73. When determining an appropriate penalty, in accordance with *Jaswal v. Medical Board* (Nfld.) 1996 CanLII 11630 (NLSC), the Panel considered the following factors:

(a) the nature and gravity of the proven allegations;

(b) the experience of the Registrant;

(c) the absence of any prior discipline history;

(d) the number of times the offence was proven to have occurred;

(e) the role of the Registrant in acknowledging what had occurred;

(f) the presence or absence of any mitigating circumstances;

(g) the need to promote specific and general deterrence and, thereby, to protect the public;

(h) the need to maintain the public's confidence in the integrity of the profession; and,

(i) 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 the range of sentence in other similar cases.

74. Several factors may serve to mitigate the severity of an appropriate penalty in a particular case. As noted by Casey in his text, these include:

(a) the attitude of the [Registrant] since the offence was committed, with a less severe punishment being justified where the individual genuinely recognizes that their conduct was wrong;

(b) the age and inexperience of the [Registrant] at the time the offences were committed;

(c) whether the misconduct was a "first offence" for the [Registrant]; and

(d) whether the [Registrant] pleaded guilty to the charges of professional misconduct, which may be taken as demonstrating the acceptance of responsibility for their actions.

75. In this case, the Panel noted the following aggravating factors:

(a) the Registrant was a very experienced RN and a charge nurse on that shift and therefore ought to have known that of the Patient's acuity was high (as they recognized at the outset), the Registrant ought to have made sure of their charting as it would have been an ongoing indication of the Patient's suitability to be on that Unit;

(b) the apparent absence of critical thinking in dealing with the Patient;

(c) the failure to consult with respect to the withholding of the medication;

(d) the overall dramatic neglect of documentation and charting - undocumented work cannot be proven and cannot be part of RN practice; and

(e) the failure to communicate with the rest of the team.

76. The Panel also took into consideration the following mitigating factors, noting that the Registrant:

(a) has no previous discipline/complaints history;

(b) pled guilty to all charges thereby saving the time and expense of a protracted disciplinary hearing; and

(c) has apologized for their misconduct.

77. The Panel had some sympathy for the fact this was conduct by an RN with an unblemished record on one shift on an understaffed unit but ultimately finds that the Registrant failed in their continuity of care for the Patient. This failure would not only have impaired the ability of the Registrant's team to work together to provide proper nursing care but also had lasting impacts on the Patient's family and for the reputation of the nursing profession.

78. In light of the Panel's overall assessment of the various aggravating and mitigating factors, it is

satisfied that the Joint Recommendation is in line with prior decisions acknowledging the seriousness of the misconduct and sending a message to the profession that the Code and practice directions apply to all registrants who must be accountable for their conduct.

79. The Panel is of the view that the penalty it is imposing properly addresses and protects the public interest, and achieves the purpose of:

(a) specifically deterring the Registrant from repeating this conduct;

(b) providing general deterrence to all registered nurses that this type of conduct will be investigated, reviewed, and punished; and

(c) reassuring the public that the College is working to maintain standards and ensure continued trust in registered nurses.

VI. Order

80. The Panel has therefore accepted the Joint Recommendation and makes the following Order**:**

(a) The Registrant be suspended from practice for a period of three weeks commencing on the date of the Order of the Panel;

(b) The Registrant pay costs in the amount of $8,000.00;

(c) The Registrant attend and complete the following courses within four months of the date of the Order of the Panel:

a. McEwan University's Medication Management NURS 0161;

b. McEwan University's Documentation in Nursing NURS 0162;

c. John Collins Consulting *Critical Thinking in Nursing*; and

(d) The Panel's decision and disposition will be published on the College website pursuant to subsection 129(1) of the Act.

DATED at Winnipeg, Manitoba, the 12th day of January, 2026.

JENNIFER COLVINE, Chair/RN, *has authorized the use of electronic signature*

ANNE-MARIE BROWN, RN, *has authorized the use of electronic signature*

JEAN DALMAN, Public Representative, *has authorized the use of electronic signature*

JOSEPH LOVELACE, Public *Representative, has authorized the use of electronic signature*

TRICIA TYERMAN, RN, *has authorized the use of electronic signature*