IN THE MATTER OF A DISCIPLINE HEARING BY A DISCIPLINE COMMITTEE, ESTABLISHED PURSUANT TO *THE LICENSED PRACTICAL NURSES ACT, 2000* AND BYLAWS TO INQUIRE INTO THE CONDUCT OF LICENSED PRACTICAL NURSE BARB OEN

REASONS FOR DECISION BY:

SASKATCHEWAN ASSOCIATION OF LICENSED PRACTICAL NURSES

DISCIPLINE COMMITTEE

INTRODUCTION:

On September 5, 2018, the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses ("SALPN") held a hearing concerning allegations of professional misconduct and professional incompetence against Licensed Practical Nurse, Barb Oen. This matter was previously set to be heard on June 14, 2018 but was adjourned at Ms. Oen's request so that she may be afforded an opportunity to seek and retain legal counsel. That request was granted by the Discipline Committee on June 8, 2018. The hearing was then rescheduled.

At the hearing, Ms. Darcia Schirr, Q.C., appeared as legal counsel for the Counselling and Investigation Committee ("Investigation Committee"). The Member, Ms. Oen, was present and represented herself at the hearing. Ms. Oen acknowledged that she had previously requested and was provided an opportunity to retain legal counsel but had ultimately chosen not to do so.

Legal counsel for the Investigation Committee filed an Affidavit of Service of a process server who affirmed that Ms. Oen was personally served on May 24, 2018 with a copy of the Notice of Discipline Hearing. Appendix A to the Notice of Discipline Hearing dated May 22, 2018, set out the particulars of the allegations against Ms. Oen as follows:

1. On May 4, 2015, you executed an Alternative Dispute Resolution Agreement (the Agreement) with the SALPN Counselling and Investigation Committee that was intended to address a complaint received about your practice from the Five Hills Health Region. The Agreement included the following provision:

7.0. Notification of change of personal information

7.1 The Member agrees to notify the Committee within seven days of any change in her address, telephone number, e-mail or employment.

You breached this provision as you left employment with Five Hills Health Region to begin working at West Park Crossing Retirement Community (West Park) in Moose Jaw without notifying the Committee.

2. Further to charge #1, the Agreement also provided the following:

8.0 Copy to employers

8.1 The Member agrees to provide her current nursing employer(s), and any future nursing employer(s) by whom she is employed during the term of this

Agreement, with a copy of this Agreement and the name and contact information for the SALPN Investigator, and shall provide the Committee with written confirmation from each such employer that she has done so.

You breached this provision by failing to provide a copy of the Agreement to your nursing employer, West Park.

3. By an Addendum to the Agreement dated April 6, 2016, you agreed to arrange for your nursing employer to provide performance appraisals at two specified intervals being the completion of 200 and 500 worked hours of nursing practice. You did not request your nursing employer to provide the performance appraisals as the Committee had to initiate the request to the employer.

4. While working at F.W. Wigmore Hospital in Moose Jaw, you:

   (a) failed to follow proper procedures regarding wastage of narcotics, to wit morphine and Dilaudid.

   (b) failed to follow proper procedures regarding storage and security of narcotics.

   (c) failed to properly document the administration of narcotics and controlled drugs.

   (d) failed to conduct appropriate pain assessments for patients who had PRN pain medication orders. Alternatively, if pain assessments were conducted, the assessment and rationale for the administration of the PRN medication was not documented.

   (e) failed to fully complete all admission documentation regarding patients and where the admission documentation was incomplete, you failed to advise your colleagues of that fact.

5. On January 10, 2018 while working at West Park, you:

   (a) failed to properly document the administration of narcotics and controlled drugs.

   (b) failed to follow proper procedures regarding wastage of narcotics, to wit morphine.

   (c) failed to follow proper procedures regarding storage and security of narcotics with the result that one ampule of 7.5 mg morphine sulphate was missing and could not be accounted for.

At the hearing Ms. Oen pleaded guilty to all allegations contained in the Notice of Discipline.

EVIDENCE:

At the outset of the hearing, the following Agreed Statement of Facts and Documents was filed with the Discipline Committee [the information referenced in the "Appendix" is not included]:

1. Barb Oen of the City of Moose Jaw in the Province of Saskatchewan is a licensed practical nurse and a member of the Saskatchewan Association of Licensed Practical Nurses (SALPN). At the times material to these proceedings, Ms. Oen was employed as a licensed practical nurse at the Dr. F.H. Wigmore Regional Hospital (Wigmore Hospital) and at West Park Crossing, both in Moose Jaw, Saskatchewan.

2. Ms. Oen first registered with SALPN on June 18, 1997 and she has been a practicing member since that date.

Background to the Complaint

3. In June 2014, Five Hills Health Region submitted a complaint to SALPN with a number of concerns regarding Ms. Oen's practice. The complaints were investigated and concluded on the basis of an Alternative Dispute Resolution Agreement (ADR). The ADR and a subsequent extension of it contained a number of provisions including performance appraisals.

4. In July 2017, SALPN received a performance appraisal from the Wigmore Hospital raising a number of concerns about Ms. Oen's practice.

5. While working at the Wigmore Hospital, Ms. Oen was also working as a licensed practical nurse at West Park Crossing in Moose Jaw. In April 2018, SALPN received a complaint from West Park Crossing regarding Ms. Oen.

6. The concerns set out in the performance appraisal submitted by Wigmore Hospital and the complaint letter submitted by West Park Crossing were investigated by the Counselling and Investigation Committee (the Investigation Committee). The Investigation Committee directed that an investigation be conducted by Lori Hutchison-Hunter.

7. Upon completion of the investigation, the Investigation Committee recommended, pursuant to section 26(2)(a) of the Act, that the Discipline Committee hear and determine the complaint. The charges are set out in Appendix A to a Notice of Discipline Hearing dated May 22, 2018.

8. Barb Oen admits the allegations described in charges 1 through 5 inclusive and admits that the conduct described in those charges constitutes professional incompetence and professional misconduct and a breach of the Act, Regulatory Bylaws, Code of Ethics and Standards of Practice particularized in Appendix A to the Notice of Discipline Hearing.

2014 Complaint, ADR and Charges 1-3

9. On July 18, 2014, SALPN received a letter dated June 13, 2014 from Ms. Oen's employer, Five Hills Health Region. Attached as **Appendix A** is letter dated June 13, 2014 from Susan Macknak with various attachments.

10. Ms. Macknak's concerns were investigated by the Investigation Committee. Upon completion of the investigation, the Investigation Committee offered and Ms. Oen agreed to an ADR. Attached at **Appendix B** is ADR dated April 10, 2015.

11. As certain provisions of the ADR had not been met, the Investigation Committee offered and Ms. Oen agreed to the terms of an addendum to the ADR. Attached at **Appendix C** is the addendum dated April 6, 2016.

12. The addendum obligated Ms. Oen to arrange for her nursing employer to provide performance appraisals at 200 and 500 of actual worked hours of nursing practice. At both intervals, Ms. Oen did not request performance appraisals as SALPN, on both occasions, had to initiate the requests for the performance appraisals directly from Wigmore Hospital.

13. On August 23, 2016, Ms. Oen began employment at West Park Crossing in Moose Jaw as a casual licensed practical nurse. She continued to work at the Wigmore Hospital at the same time. Contrary to paragraph 7.1 of the ADR, Ms. Oen did not notify the Investigation Committee within 7 days or at all of her change in employment. Further and contrary to paragraph 8.1 of the ADR, Ms. Oen did not advise West Park Crossing that she was the subject of an ADR or fulfill any of the terms of paragraph 8.1 of the ADR. West Park Crossing only learned of the ADR after it had submitted its own complaint to SALPN and after the investigator made inquiries.

Wigmore Hospital – Charge 4

14. Through her employment at Wigmore Hospital, Ms. Oen was the subject of disciplinary, non-disciplinary and coaching meetings regarding narcotic administration and documentation and other concerns. In June 2015, Wigmore Hospital developed a "work plan" for Ms. Oen regarding a number of issues and primarily medication issues.

15. Attached at **Appendix D** is the work plan. This "work plan" is what is referred to in paragraph 3.4 of the ADR which reads as follows:

> **3.4 On or before August 30, 2015, the member shall provide a written report to the Committee outlining her progress in meeting each aspect of the work plan developed by the employer on June 10, 2014.**

16. Ms. Oen did provide a response regarding the work plan and her handwritten response is attached at **Appendix E**.

17. Despite the work plan, coaching meetings and disciplinary meetings, problems continued. In the course of the meetings with her employer, Ms. Oen was reminded of the Health Region's policies and procedures regarding narcotic administration, documentation and hourly rounding. In all of those meetings, Ms. Oen advised that she was aware of the policies and understood them. Attached at **Appendix F** are those policies.

18. Attached at **Appendix G** is the performance appraisal form dated April 4, 2017 submitted by Wigmore Hospital which covered 200 actual worked hours as required under the ADR.

19. In July 2017, the Investigation Committee requested and received another performance appraisal from Wigmore Hospital to address the 500 hour mark. Attached at **Appendix H** is a performance appraisal from dated 7/7/2017. In all categories, the employer assessed Ms. Oen's competencies as "unsatisfactory". The performance appraisal raised significant concerns for the Investigation Committee and in particular, significant concerns regarding Ms. Oen's handling of narcotics.

20. The July 7, 2017 performance appraisal was treated as a complaint by the Investigation Committee which, upon investigation, resulted in charge 4(a) through (e) inclusive.

21. In the performance appraisal form dated July 7, 2017 and under the heading "Competencies", Ms. Kuntz wrote:

> **This past week, it was reported that Barb has again violated narcotic policy. Barb has not documented the explanations for the patient needing a narcotic (no pain assessment, documentation of request, etc). She has not had a witness for wasting the narcotics for 5 hours. Our organization currently has 8 mg of unwitnessed wastage of a narcotic as the second nurse refused to sign for wastage she did not properly witness. Barb confirmed she had again been storing the medication in an unlocked drawer. Barb signed that she administered a narcotic at 1340 to another nurse's patient but the patient denies receiving this dose (Barb states the patient refused it). Barb then administered the dose to the patient at 1640 while the primary nurse was drawing up the medication to administer to the patient. This was not communicated to the primary nurse and was luckily only a near-miss as the patient was competent and stopped the second dose.**

22. This passage refers to 8 mg of unwitnessed wastage of a narcotic. This refers to an incident on July 5, 2017 at 1346 hrs. Attached at **Appendix I** is the following:

(a) Handwritten note prepared by Allison Hall, a registered nurse at Wigmore Hospital.

(b) Narcotic sheet.

(c) Ms. Oen's nursing note entries for July 5, 2017.

23. As a result of the July 2017 performance appraisal, Wigmore Hospital issued a written warning letter to Ms. Oen. Attached at **Appendix J** is letter dated August 8, 2017 from Heather Kuntz. Ms. Kuntz refers to the main area of concern as "medication administration, narcotic waste and charting".

24. On August 18, 2017, Ms. Oen submitted notice of her intention to retire and resign from Wigmore Hospital effective October 1, 2017. Attached at **Appendix K** is Ms. Oen's handwritten note dated August 18, 2017. After Ms. Oen submitted her resignation letter, she worked only a few shifts as she took vacation days, a leave of absence for 3 days and called in sick for a number of shifts until her employment ended on October 1, 2017.

West Park Crossing – Charge 5

25. West Park Crossing is a personal care home in Moose Jaw that offers independent living, assisted living and nursing supports for residents including individuals suffering from Alzheimer's disease and dementia. The facility opened in March 2016. The facility consists of 79 suites with 22 suites being set aside for residents in the "memory care" wing. The balance of the suites are for residents who may be completely independent or require care equivalent to level 3 or 4. If residents are terminally ill and depending on their condition, the residents may remain at West Park Crossing.

26. Barb Oen was hired by Bright Water Senior Living which is a related entity to West Park Crossing. Ms. Oen was hired as a charge nurse, starting her employment in August 2016 on a casual basis. West Park has one nurse on staff 24 hours per day. With 3 shifts available, the nurse is assisted by care aides and the nurse is expected to handle the needs of all of the residents in the facility.

27. In the course of Ms. Oen's employment, she was placed on a performance improvement plan which West Park treated as a written warning on her personnel file. Attached at **Appendix L** is a copy of the performance improvement plan with an evaluation date of March 20, 2017 and the available medication error reports are also at Appendix M.

28. After an incident on January 10, 2018 Ms. Oen's employment was suspended.

29. On April 3, 2018, Ms. Oen participated in a meeting with West Park management, West Park's legal counsel and her union representative. The purpose of the meeting was to discuss the incident that occurred on January 10, 2018. After the meeting concluded, Ms. Oen submitted a written letter of resignation to West Park. Attached at **Appendix M** is her written resignation notice.

30. On April 13, 2018, West Park submitted an online complaint to SALPN regarding the incident that occurred on January 10, 2018. A copy of the online complaint is attached at **Appendix N**.

31. The incident that occurred on January 10, 2018 is described in the following documents attached at **Appendix O**:

(a) At the material time, Tara Coakwell was the nursing director. She was interviewed by Ms. Hutchison-Hunter on May 8, 2018 and excerpts from that interview are attached.

(b) Excerpts from Ms. Oen's interview conducted May 8, 2018.

(c) Individual Narcotic Records for the patient.

(d) Electronic medication records for the patient. The handwritten notes are those of Tara Coakwell and Ms. Hutchison-Hunter. The records show two columns with two time entries. The first column is the time Ms. Oen made the chart entry and the second column shows the time Ms. Oen administered the drug.

Complaint History

32. The complaint from Five Hills Health Region dated June 13, 2014 was Ms. Oen's first complaint to SALPN.

Ms. Schirr and Ms. Oen executed the Agreed Statement of Facts to demonstrate their agreement with its contents. Ms. Schirr submitted that the Discipline Committee should accept the facts as set out, and also submitted that Ms. Oen's conduct on January 10, 2018 and her violation of the conditions of her April 10, 2015 ADR constitutes professional misconduct and professional incompetence under the Act.

Counsel for the Investigation Committee submitted the following recommendation as to penalty:

1. Pursuant to section 30(1)(e) of *The Licensed Practical Nurse Act, 2000* (the "Act"), Barb Oen shall be reprimanded.

2. Pursuant to section 30(1)(b) of the Act, Barb Oen's license to practice shall be suspended for a period of 3 to 4 months.

3. Pursuant to section 30(1)(d) of the Act, Barb Oen's license to practice shall be subject to the following conditions:

   (a) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Roles, Responsibilities and Ethics* (NURS-1677) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

   (b) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Health Record Documentation* (NURS-1685) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

   (c) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Safe Medication Administration* (PHAR-1608) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

4. Pursuant to section 30(2)(a)(ii) of the Act, Barb Oen shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $12,000. The costs shall be paid as follows:

   (a) On or before December 31, 2018, the sum of $3,000.

   (b) On or before May 1, 2019, the sum of $6,000.

   (c) On or before October 1, 2019, the sum of $3,000.

If an installment is not made on the due date or within 5 days of the due date, Ms. Oen's license shall be suspended until payment is made pursuant to section 30(2)(b) of the Act.

5. Pursuant to section 30(1)(f) of the Act, Barb Oen shall be required to provide a copy of the decision of the Discipline Committee to any nursing employer for a two year period from the date of this Order and provide written confirmation of the same to the Registrar.

6. Pursuant to section 30(5) of the Act, a copy of the Order and the written reasons of the Discipline Committee shall be provided to the Wigmore Hospital Attention: Heather Kuntz and West Park Crossing Attention: Melody Norberg.

Counsel for the Investigation Committee submitted that the facts outline a long standing concern with Ms. Oen's practice as a licensed practical nurse and as such the proposed order addresses the following principles of sentencing: public protection and public confidence in the profession; general and specific deterrence; and rehabilitation of Ms. Oen.

Counsel for the Investigation Committee submitted that the reprimand serves as both a general and specific deterrent, as well as sends a clear message of consequences to Ms. Oen so that she might learn from her misconduct.

Counsel for the Investigation Committee submitted that the suspension, while lengthy, was appropriate given Ms. Oen's conduct. Further, that the terms, conditions and limitations imposed on Ms. Oen's license, including the coursework at Saskatchewan Polytechnic, will serve to remediate and rehabilitate Ms. Oen insofar as this coursework would target the concerns regarding Ms. Oen's conduct. Furthermore, the requirement to advise her current and any future employer of this decision would serve to assure the public once she returns to nursing.

As such, it was important to send a message both to Ms. Oen, as well as to the profession as a whole, that the conduct that occurred in this case is unacceptable. In that way, the suspension would act as both a specific and general deterrent.

Ms. Schirr provided additional submissions as to the costs incurred in the investigation of this matter, specifically that Ms. Oen prior to the adjournment of the original hearing date was encouraged to seek legal counsel but waited until just before the hearing to do so. Legal counsel was well into preparing for the case and witnesses had been subpoenaed. Ms. Schirr did not then hear again from Ms. Oen until August 27, 2018 at which time she advised she would be prepared to enter into an agreed statement as to facts and would be pleading guilty. At that point, Ms. Schirr submitted that the preparations for what was thought to be a contested hearing were again under way and witnesses had been subpoenaed.

Ms. Schirr submitted that the proposed penalty would adequately serve as a specific deterrent for Ms. Oen as well as a general deterrent for the rest of the profession. It would also confirm for the public that they are able to have confidence in the ability of SALPN to enforce the standards expected of licensed practical nurses.

Ms. Oen acknowledged that Counsel for the Investigation Committee's recommendations seemed fair, but requested an end payment date for the investigation and hearing costs rather than staggered payment dates due to her current personal circumstances and financial limitations. Ms.

Schirr advised that the staggered payments were intended to achieve a balance between bringing rigor to the process and micromanaging one's finances.

DECISION:

The primary issue before the Discipline Committee is whether the conduct of Ms. Oen as summarized in the Agreed Statement of Facts, is professional incompetence and professional misconduct within the meaning of sections 23 and 24 of the Act, and if so, are the proposed penalties appropriate under section 30 of the Act. Sections 23, 24, and 3 of the Act read as follows:

> *23 Professional incompetence is a question of fact, but the display by a member of a lack of knowledge, skill or judgment or a disregard for the welfare of a member of the public served by the profession of a nature or to an extent that demonstrates that the member is unfit to:*
>
> > *(a) continue in the practice of the profession; or*
> >
> > *(b) provide one or more services ordinarily provided as a part of the practice of the profession;*
>
> *is professional incompetence within the meaning of this Act.*
>
> *24 Professional misconduct is a question of fact, but any matter, conduct or thing, whether or not disgraceful or dishonourable, is professional misconduct within the meaning of this Act if:*
>
> > *(a) it is harmful to the best interests of the public or the members;*
> >
> > *(b) it tends to harm the standing of the profession;*
> >
> > *(c) it is a breach of this Act or the bylaws; or*
> >
> > *(d) it is a failure to comply with an order of the counselling and investigation committee, the discipline committee or the council.*
>
> *30(1) Where the discipline committee finds a member guilty of professional misconduct or professional incompetence, it may make one or more of the following orders:*
>
> > *(a) an order that the member be expelled from the association and that the member's name be struck from the register;*
> >
> > *(b) an order that the member's licence be suspended for a specified period;*
> >
> > *(c) an order that the member's licence be suspended pending the satisfaction and completion of any conditions specified in the order;*
> >
> > *(d) an order that the member may continue to practise, but only under conditions specified in the order, which may include, but are not restricted to, an order that the member:*
> >
> > > *(i) not do specified types of work;*

(ii) successfully complete specified classes or courses of instruction;

(iii) obtain medical or other treatment or counselling or both;

(e) an order reprimanding the member;

(f) any other order that the discipline committee considers just.

(2) In addition to any order made pursuant to subsection (1), the discipline committee may order:

(a) that the member pay to the association, within a fixed period:

(i) a fine in a specified amount not exceeding $5,000; and

(ii) the costs of the investigation and hearing into the member's conduct and related costs, including the expenses of the counselling and investigation committee and the discipline committee and costs of legal services and witnesses; and

(b) where a member fails to make payment in accordance with an order pursuant to clause (a), that the member's licence be suspended.

(3) The executive director shall send a copy of an order made pursuant to this section to the member whose conduct is the subject of the order and to the person, if any, who made the complaint.

(4) Where a member is expelled from the association or a member's licence is suspended, the registrar shall strike the name of the member from the register or indicate the suspension on the register, as the case may be.

(5) The discipline committee may inform a member's employer of the order made against that member where that member has been found guilty of professional misconduct or professional incompetence.

In reaching its decision, the Discipline Committee considered the evidence presented in the Agreed Statement of Facts, as well as the submissions of Ms. Schirr and Ms. Oen. The Discipline Committee accepts the facts as set out in the Agreed Statement of Facts. The Discipline Committee considered Ms. Oen's admission as to guilt and found that the evidence supports the findings of professional misconduct and professional incompetence as alleged in the Notice of Hearing.

The proper handling, administration, and documentation of narcotics is fundamental to maintaining the public's confidence in the profession. Upon review of the facts surrounding Ms. Oen's charting and administration of medications, and particularly narcotics, the Discipline Committee has concluded that she has fallen short of the standard expected for the profession but also the policies and procedures of Five Hills Health Region. Ms. Oen's record keeping is not reliable. Ms. Oen's failure to properly document the administration of narcotics was not in the best interests of the public nor the profession and reflects poorly on other licensed practical nurses.

Further, the Discipline Committee found that her failure to abide by the conditions of the ADR and, as such, her breach of an agreement reached with a regulatory body is significant and serious, in particular as the purpose of that ADR was to address a complaint over Ms. Oen's practice as a nurse.

The Discipline Committee understands that the penalty ordered should protect the public and enhance public confidence in the ability of SALPN to regulate licensed practical nurses. This is achieved through a penalty that addresses specific and general deterrence. In this regard, the Discipline Committee finds that the submission as to penalty made by Ms. Schirr satisfies these principles, but believes two modifications are appropriate in the circumstances.

Firstly, due to serious nature of the conduct and Ms. Oen's past history of failing to adhere to disciplinary conditions, the Discipline Committee finds that additional protection is required to ensure that Ms. Oen completes the remedial training she unquestionably needs. In this regard, if Ms. Oen's fails to complete the three Saskatchewan Polytechnic courses by July 1, 2019, as outlined in the submission as to penalty, her license to practice will be suspended until such time as the courses are successfully completed.

Secondly, while the Discipline Committee agrees with the amount of investigation and hearing costs proposed by Ms. Schirr, it has determined that a modification to the staggered payments is appropriate in light of Ms. Oen's current personal circumstances and financial limitations. In this regard, Ms. Oen shall be required to pay the sum of $1,500.00 on or before December 31, 2018, the sum of $6,000.00 on or before May 1, 2019, and the sum of $4,500.00 on or before October 1, 2019, for a total of $12,000.00.

ORDERS:

Upon consideration of the evidence and submissions of Counsel for the Investigation Committee and the Member, the Discipline Committee issued the following Order on September 5, 2018 for the professional misconduct and professional incompetence committed by Ms. Oen:

1. Pursuant to section 30(1)(e) of the Act, Barb Oen shall be reprimanded.

2. Pursuant to section 30(1)(b) of the Act, Barb Oen’s license to practice shall be suspended for a period of 4 months.

3. Pursuant to section 30(1)(c)(d) of the Act, Barb Oen’s license to practice shall be subject to the following conditions:

    (a) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Roles, Responsibilities and Ethics* (NURS-1677) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

    (b) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Health Record Documentation* (NURS-1685) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

    (c) On or before July 1, 2019, she shall successfully complete the Saskatchewan Polytechnic course *Safe Medication Administration* (PHAR-1608) and provide verification of completion to the Registrar. Ms. Oen shall bear all costs of the course.

If one of the courses outlined at paragraph 3(a)(b) and (c) are not completed by July 1, 2019, Ms. Oen's licence shall be suspended until the course is successfully completed.

4. Pursuant to section 30(2)(a)(ii) of the Act, Barb Oen shall pay the costs of the investigation and hearing which costs shall be fixed in the amount of $12,000.00. The costs shall be paid as follows:

   (a) On or before December 31, 2018, the sum of $1,500.00.

   (b) On or before May 1, 2019, the sum of $6,000.00.

   (c) On or before October 1, 2019, the sum of $4,500.00.

   If an installment is not made on the due date or within 5 days of the due date, Ms. Oen's licence shall be suspended until payment is made pursuant to section 30(2)(b) of the Act.

5. Pursuant to section 30(1)(f) of the Act, Barb Oen shall be required to provide a copy of this Order and written reasons of the Discipline Committee to any nursing employer for a two year period from the date of this Order and provide written confirmation of the same to the Registrar.

6. Pursuant to section 30(5) of the Act, a copy of the Order and the written reasons of the Discipline Committee shall be provided to the Wigmore Hospital Attention: Heather Kuntz and West Park Crossing Attention: Melody Norberg.

7. A copy of this Order and written reasons shall be published on the Saskatchewan Association of Licensed Practical Nurses website.

DATED at Regina, Saskatchewan, this 1st day of November, 2018.

D. Robinson, Chairperson of the Discipline Committee of the Saskatchewan Association of Licensed Practical Nurses on behalf of the Discipline Committee consisting of A. Patron, J. Carlson, B. Lalonde and K. Bradford.