INVESTIGATION COMMITTEE
of the
COLLEGE OF REGISTERED NURSES OF SASKATCHEWAN

-and-

Warren Koch
Saskatchewan RN 0041280
[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 Warren Koch	None
Warren Koch	Self-Represented
Legal Counsel for the Discipline Committee:	Brittnee Holliday
Chairperson for the Discipline Committee:	Chris Etcheverry, RN

Date of Hearing:	**June 2, 3, 4, and 23, 2026**
Location:	*Via Videoconference* College of Registered Nurses of Saskatchewan 1-3710 Eastgate Drive Regina, Saskatchewan S4Z 1A5
Date of Decision:	**October 19, 2026**

I. INTRODUCTION

1. The Discipline Committee of the College of Registered Nurses of Saskatchewan ("CRNS") convened on June 2, 3, 4, and 23, 2026, via videoconference, to hear and determine a complaint of professional misconduct and/or professional incompetence against Registered Nurse 0041280, Warren Koch. The Discipline Committee is established pursuant to section 30 of *The Registered Nurses Act, 1988* (the "Act").

2. The charges against Warren Koch are outlined in a Notice of Hearing dated August 5, 2025. There is one (1) Charge of professional misconduct and/or professional incompetence, broken down into several sub-Charges, as follows:

> **1. You, Warren Koch, are alleged to be guilty of professional incompetence and professional misconduct contrary to sections 25 and 26(1) of *The Registered Nurses Act, 1988*, regarding events that occurred while working for the Saskatchewan Health Authority as a Registered Nurse at [redacted], including but not limited to:**
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> **(a) between August 24 and October 20, 2023, you engaged in inappropriate communications and behaviour at work, which included:**
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> **(i) on August 24 and September 16, 2023, you engaged with physicians in an inappropriate and aggressive manner;**
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> **(ii) on September 16 and 17, 2023, you wrote your employee number on the emergency code board rather than your name; and**
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> **(iii) on September 18 and October 16, 2023, you used profanity at work when speaking with other hospital staff;**
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> **(b) on September 16, 2023, you failed to adequately assess and triage an emergency department pediatric patient;**
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> **(c) on September 16, 2023, you failed to completely and accurately document a pediatric patient's schedule of medication administration;**
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> **(d) on September 18, 2023, you communicated in an inappropriate manner with an obstetrics patient when seeking consent to administer oxytocin;**

(e) on October 19, 2023, you left work without approval and without providing proper patient handoff; and

(f) on October 20, 2023, you failed to report to a scheduled shift.

II. RELEVANT LEGISLATION

3. The Notice of Hearing alleges that Warren Koch is guilty of professional incompetence and professional misconduct contrary to sections 25 and 26 of the Act, which provide:

> **25 For the purposes of this Act, professional incompetence is a question of fact, but the display by a nurse in the professional care of a client of a lack of knowledge, skill or judgment or a disregard for the welfare of a client of a nature or to an extent that demonstrates that the nurse is unfit:**
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> **(a) to continue in the practice of registered nursing; or**
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> **(b) to provide one or more services ordinarily provided as part of the practice of registered nursing;**
>
> **is professional incompetence within the meaning of this Act.**
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> **26(1) For the purpose of this Act, professional misconduct is a question of fact but any matter, conduct or thing, whether or not disgraceful or dishonourable, that is contrary to the best interests of the public or nurses or tends to harm the standing of the profession of nursing is professional misconduct within the meaning of this Act.**
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> **(2) Without restricting the generality of subsection (1), the discipline committee may find a nurse guilty of professional misconduct if the nurse has:**
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> **(a) abused a client verbally or physically;**
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> **(b) misappropriated a client's personal property;**
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> **(c) inappropriately used the nurse's professional status for personal gain;**
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> **(d) influenced a client to change the client's last will and testament;**
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> **(e) wrongfully abandoned a client;**
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> **(f) misappropriated drugs;**
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> **(g) misappropriated property belonging to a nurse's employer;**
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> **(h) failed to exercise discretion with respect to the disclosure of confidential information about a client;**
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> **(i) falsified a record with respect to the observation, rehabilitation or treatment of a client;**
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> **(j) failed to inform an employer of the nurse's inability to accept specific responsibility in areas where special training is required or where the nurse does not feel competent to function without supervision;**

(k) failed to report the incompetence of colleagues whose actions endanger the safety of a client;
(l) failed to comply with the code of ethics of the college;
(m) failed without reasonable cause to respond to inquiries from the college regarding alleged professional misconduct or professional incompetence;
(n) an addiction to the excessive or habitual use of intoxicating liquor, opiates, narcotics or other habit forming substances;
(o) conspired to do any professional misconduct or counselled a person to do any professional misconduct;
(p) obtained registration by misrepresentation or fraud;
(q) contravened any provision of this Act or the bylaws.

4. The provisions of the CRNS Bylaws, 2023, the CNA Code of Ethics for Registered Nurses (2017) ("*Code of Ethics*"), the SRNA Registered Nurse Entry-Level Competencies (2019) ("*Entry Level Competencies*"), and the SRNA Registered Nurse Practice Standards (2019) ("*Nurse Practice Standards*") applicable to this Decision are set out in Appendix A of this Decision.

III. HEARING

5. Before the hearing on the merits, the Discipline Committee heard Preliminary Applications on November 4, 2025 and, on January 27, 2026, issued a Decision dismissing the Investigation Committee's Application to lead evidence by Affidavit and dismissing Mr. Koch's procedural fairness and "double jeopardy" arguments. At the outset of the June 2, 2026 Hearing, Mr. Koch again referred to the suspension of his registration. Those matters were determined in the Preliminary Decision, no notice of a constitutional question was given, and, as such, they are not revisited in this Decision.

6. When the Discipline Hearing began on June 2, 2026, neither counsel for the Investigation Committee nor Mr. Warren Koch raised any objection regarding the composition of the Discipline Committee.

7. Mr. Koch was not represented by counsel. At the outset of the Hearing, he confirmed that he understood he was entitled to be represented. Mr. Koch entered a plea of not guilty and contested the Charge in its entirety.

8. Over the course of three days, the Discipline Committee heard from a total of five witnesses. The Investigation Committee called four witnesses. Mr. Koch testified and did not call any other witnesses.

9. After the evidence was concluded, the Hearing stood down until June 23, 2026, when the Hearing reconvened to hear closing submissions. When the Hearing reconvened, the Investigation Committee filed a Brief. Mr. Koch was provided until July 9, 2026 to file written submissions or a Brief. Nothing was received from Mr. Koch.

IV. SUMMARY OF EVIDENCE

10. Throughout the course of the Hearing, the following were entered as Exhibits:

P1 – Notice of Hearing dated August 5, 2025
P2 – Affidavit of Service of the Notice of Hearing
P3 – Patient chart, redacted – Patient PM
P4 – Safety report dated September 17, 2023 – Patient PM
P5 – Patient chart, redacted – Patient KM
P6 – Safety report dated September 17, 2023 – Patient KM
P7 – Safety report dated September 22, 2023 – Patient AC
P8 – Patient chart – Patient AC
P9 – Complaint to the CRNS dated October 16, 2023
P10 – Letter #1 from SHA dated October 12, 2023 to W. Koch
P11 – SHA Workplace Expectations Policy and Code of Conduct
P12 – Letter # 2 from SHA dated October 12, 2023 to W. Koch
P13 – Complaint to the CRNS dated October 27, 2023
P14 – Letter from SHA dated October 26, 2023 to W. Koch
P15 – Leave request form dated 'Today'
D1 – SHA letter dated March 23, 2023
D2 – Residential contract of purchase and sale
D3 – Family law proceedings document (1 page)
D4 – Criminal record check, dated January 5, 2026

11. Counsel for the Investigation Committee called four witnesses: [redacted], [redacted], [redacted] and [redacted]. Their evidence, and that of Mr. Koch, is summarized below. The summaries are not exhaustive; the Discipline Committee has considered all evidence, including the Exhibits, in reaching its decision.

[redacted]

12. [redacted] was a General Duty RN at [redacted] (the "Facility") from December 1, 2014 to October 6, 2025, and had worked with Mr. Koch since 2014. The Facility houses an Emergency Department, a 16-bed Acute Care ward and a Long-Term Care home under one roof. [redacted] worked day shifts with Mr. Koch on September 16, 17, and 18, 2023. On each of those shifts Mr. Koch was the Charge Nurse and Float Nurse, a role that moves between Acute Care and the Emergency Department as needed.

13. [redacted] explained that the Code Board, located behind the Acute Care desk, is a reference point that staff consult when a code is called or a high-acuity patient arrives. It lists the physicians on duty, the Charge Nurse, and the roles assigned for a code, each identified by the staff member's name. Because time is critical in those situations, roles are pre-assigned at the start-of-shift huddle so that no time is lost from direct patient care. The Charge Nurse is responsible for completing the board.

14. [redacted] testified that on September 16, 2023, Mr. Koch identified every other staff member on the Code Board by name but identified himself only by his employee number. [redacted] found this odd and not in keeping with standard practice. Her concern was that staff do not know one another's employee numbers, which made it difficult to identify who the Charge Nurse was.

15. Also on September 16, 2023, a five-year-old boy, Patient PM, presented to the Emergency Department after a bee sting (the "Bee Sting Pediatric Patient"). [redacted] was working in the Emergency Department. Mr. Koch triaged the child. [redacted] identified Mr. Koch as the primary assessor on the Pediatric Triage Assessment Record (Exhibit P3) from his handwriting and initials.

16. The triage documentation recorded a history of bee allergy, involvement of two body systems (hives on the skin and wheezing in the lungs), a cough and swelling. Mr. Koch assigned a Canadian Triage and Acuity Scale ("CTAS") score of 3, with a 4 also circled. [redacted] explained that CTAS is a five-level scale, with 1 being the most urgent and 5 non-urgent, used

to prioritize patients for physician assessment and to set nursing reassessment intervals. A CTAS 3 does not indicate an emergency. After triage, Mr. Koch placed the child in the waiting room.

17. While [redacted] does not recall specifically how she came to review the chart, [redacted] recognized the child was having an anaphylactic reaction, moved him to a treatment room, placed him on a cardiac monitor, arranged frequent vital signs, obtained a physician, and epinephrine was administered. In her view, the child should have been triaged as CTAS 2 (emergent, requiring immediate nursing care and physician assessment within 15 minutes). [redacted] testified that she was shocked by the CTAS score, because anaphylaxis is something registered nurses are well versed in and receive yearly training on.

18. As a result, [redacted] filed a Safety Report on September 17, 2023 (Exhibit P4), classifying the event as a "near miss" (an event that could have caused harm but did not because of timely intervention) and as a procedural or process error, because the history and symptoms all pointed to anaphylaxis and the proper CTAS score was not assigned.

19. [redacted] also testified that on September 16, 2023, a pediatric patient, Patient KM, with respiratory concerns was admitted to short stay (the "Nebulizer Pediatric Patient"). The physician ordered "Ventolin nebs QID x 24 hours then reassess" (Exhibit P5). QID is a medical abbreviation for administration of a medication four times per day. Mr. Koch was assigned to this patient on the day shift and transcribed the order onto the Medication Administration Record ("MAR"). He recorded only one administration time (1800) rather than the four required and recorded no reassessment time. In addition, the transcription was not double-checked by a second nurse, which is the responsibility of the nurse assigned to the patient to ensure it is completed. [redacted] testified that the Ventolin, an important part of a child's respiratory treatment, was "missed pretty much completely", as the patient received it only twice over two days. She discovered the problem when taking apart the chart after the patient left the Facility.

20. [redacted] explained that the MAR is the primary reference nurses use to know what medication to give, when, and how. When an order is transcribed from the physician's orders onto the MAR, the transcribing nurse records the drug, dose, route, frequency and the times at which each dose is due. Recording the times prompts nurses to give each dose so that

medications are not missed. Where an order does not specify times, the nurse caring for the patient sets them.

21. [redacted] filed a Safety Report on September 17, 2023 (Exhibit P6), classifying the event as a Level 1 near miss and recording a medication error (doses were missed), a procedural error (there was no double-check) and a documentation error (the order was not properly documented).

22. [redacted] also testified regarding an incident on September 18, 2023. Mr. Koch was again the Charge Nurse and Float Nurse and, in the latter role, took on the care of a labouring patient, Patient AC (the "Labouring Patient"). The Emergency Department was quiet, so [redacted] went to see whether Mr. Koch needed help setting up. She observed that the patient was not coping well. Mr. Koch was preparing oxytocin and, in seeking consent, told the patient that many years ago women died during or after childbirth, and asked for her permission to give an intramuscular injection "so she doesn't bleed out". The patient became more frightened and said words to the effect of "I don't know what to do, I can't do this". [redacted] took the patient's hand, explained calmly that she would give an injection in the thigh when the baby's shoulder was delivered to help minimize bleeding, and reassured her that staff were there for her.

23. [redacted] asked to speak with Mr. Koch away from the patient. The conversation became heated, and Mr. Koch left the room agitated; [redacted] assumed the patient's care. She testified that what Mr. Koch said was completely inappropriate, that the therapeutic relationship is central to nursing, and that while obtaining informed consent is part of a nurse's role, "there is a way in which you can go about that and scare tactics are not them." [redacted] indicated that a later conversation with Mr. Koch that day went nowhere; his guard was up and he remained focused on informed consent rather than on his approach. [redacted] filed a Safety Report on September 22, 2023 (Exhibit P7).

24. In cross-examination, Mr. Koch focused largely on the number and colour of triage forms, privacy at the triage chair, staffing, the breadth of acute care responsibilities, the meaning of "short stay", and the definition of post-partum hemorrhage. To the extent his questions touched on the charges, [redacted] advised that she was not aware of any other time Mr. Koch had placed his employee number on the Code Board. [redacted] agreed that the Bee Sting

Pediatric Patient was seen by a physician about five minutes after registration but explained that this happened because she called the physician. rejected the suggestion that Mr. Koch had identified an emergency, noting that the child had been placed in the waiting room, which is not an appropriate place for a patient in an emergency. She agreed that "allergic reaction" was an appropriate chief complaint, explaining that the problem was the CTAS score. She agreed that a heart rate of 176 in a five-year-old is concerning while an oxygen saturation of 96% does not on its own indicate respiratory distress. On the MAR and as related to the Nebulizer Pediatric Patient, clarified that one of the four scheduled times (1800) had been recorded, agreed that nurses may adjust the timing of a QID order, and confirmed that the missed doses fell on night shifts when Mr. Koch was not working. Regarding the Labouring Patient, agreed that post-partum hemorrhage is a risk of childbirth, that oxytocin is used to prevent it, and that women have died in childbirth; however, maintained that the problem was not the rationale for obtaining informed consent, but the manner of communication in order to do so. evidence on the matters relevant to the charges was not shaken.

25. is a physician whose clinical practice for the past four years has focused on palliative care. . She has known Mr. Koch and worked with him clinically since 2011.

26. On September 16, 2023, a weekend, attended the Facility to see a long-term care resident receiving palliative sedation. testified that due to a communication issue about this patient's care the day before, she wanted to give her plan directly to the nurse who would assume care after 3:00 p.m. She went to the Acute Care desk, where several staff were present, and asked Mr. Koch, whom she had seen in Long-Term Care earlier, whether he was the "float nurse". acknowledged that this may have offended Mr. Koch. testified that Mr. Koch's response was "charged" and turned to system-level complaints about the SHA and how the Facility was set up. testified that she told him she was there to

support a patient and would gladly discuss those issues another time. [redacted] testified that Mr. Koch continued, growing louder and more aggressive. Another nurse stepped in to take the report, but [redacted] testified that Mr. Koch did not stop. [redacted] advised that she twice raised her hand and said this needed to stop and was not productive. [redacted] testified that she felt "attacked and really intimidated and embarrassed" and ultimately walked away in tears. The exchange lasted up to five minutes in an open area near Long-Term Care, Acute Care and the Emergency Department, where patients, families and staff could hear. [redacted] advised that she was used to Mr. Koch raising controversial topics, but this interaction was different in intensity from anything she had experienced with him before.

27. In cross-examination, Mr. Koch questioned [redacted] at length about who filed the complaint, whether the term "nurse" includes licensed practical nurses, long-term care staffing, and whether she had repeated her question several times. [redacted] confirmed that she did not file a complaint herself, having sought advice from Human Resources given her administrative role, and that another staff member reported the incident. When questioned by Mr. Koch about asking her question three times, [redacted] did not recall repeating her question three times. She explained that her only purpose in approaching Mr. Koch was to identify the most responsible nurse after 3:00 p.m. so that she could convey her plan and avoid a repeat of the previous day's safety issue, and that she did not intend to offend Mr. Koch. None of the questions asked of [redacted] by Mr. Koch detracted from her account of how Mr. Koch spoke to her.

28. is a family physician with , a division of the University of Saskatchewan. In August 2023, she was a family medicine resident at the Facility and was familiar with Mr. Koch, having worked some shifts with him.

29. On August 24, 2023, testified that she was not on shift in the Emergency Department and that she had come in only to reassess two short-stay patients from her shift the previous day. While she was at the physicians' workstation next to the nursing station, testified that Mr. Koch approached her about two other patients awaiting transfer to for CT scans, for whom he could not find a requisition or consult note. was not responsible for the patients but testified that she offered to help and searched their charts. found a note of a planned transfer of care to an accepting physician in , but not the documents Mr. Koch required. Mr. Koch then asked, in a raised and "yelling" tone, whether she was telling him there was no doctor in the facility responsible for these patients. advised that she told Mr. Koch there is always a doctor in the Facility, but that she could not find the paperwork. testified that she provided the best explanation she could, and it seemed he was not accepting of the explanation and repeated the question two or three times. testified that the exchange took place at the nursing station, separated from triage and the entrance only by a curtain, where patients, families and staff could overhear, and lasted under ten minutes. At first, thought Mr. Koch was having a bad day. After a nurse who witnessed the exchange checked on her and suggested she report it, she concluded it had been unprofessional and submitted an incident report to , Manager of .

30. In cross-examination, Mr. Koch's questions focused on the transfer paperwork, who the most responsible physician was, and the progression of residents' responsibilities. agreed that Mr. Koch was trying to determine who was most responsible for the patients, that she did not find a CT requisition, and that the most responsible physician would have been the day Emergency physician. When asked about whether patient safety had been endangered, confirmed that she did not believe that patient safety had been endangered and her

concern was the unprofessional manner of the verbal exchange. advised she had acknowledged in her report that missing documentation is frustrating. During this cross-examination, Mr. Koch acknowledged that there had been a conflict between them and apologized, stating that he had not intended to be verbally aggressive and had been trying to advocate for patients.

31. is a registered nurse who has worked for the SHA since 2002 and at the Facility for 24 years. , and she was Mr. Koch's manager at the relevant times.

32. confirmed she had filed complaints with the CRNS on October 16 and October 27, 2023 (Exhibits P9 and P13) because Mr. Koch was not meeting workplace expectations relating to accountability, respect and safety.

33. confirmed that she investigated the events of August 24 and September 16-18, 2023 with Human Resources and on October 12, 2023, the SHA issued Mr. Koch a six-shift unpaid suspension (Exhibit P10). Exhibit P10 references the August 24, 2023 altercations with , the September 16, 2023 altercation with , Mr. Koch writing his employee number on the Code Board on September 16 and 17, 2023, improper assessment and triage of the Bee Sting Pediatric Patient on September 16, 2023, the failure to document the time medication was to be administered regarding the Nebulizer Pediatric Patient on September 16, 2023, inappropriate conveyance of information while obtaining consent to administer medication to the Labouring Patient on September 18, 2023, as well as making an inappropriate comment while leaving the Facility on September 18, 2023. further testified to a verbal disciplinary warning Mr. Koch had received on October 12, 2023 that was outlined in a letter of the same date (Exhibit P12). testified that this letter and disciplinary warning arose because Mr. Koch had reported late to his scheduled shifts of September 15, 16, 17, and 18 and did not adjust his time to reflect the same. testified that Mr. Koch was not following the required process to call in and advise he would be late for shifts and that he had missed the

shift change report on each of those days. [redacted] confirmed that shift change report typically runs approximately a half hour to 45 minutes.

34. Regarding the statement that Mr. Koch had made an inappropriate comment while leaving the Facility on September 18, 2023, [redacted] testified that on Monday, September 18, 2023, after learning of concerns from the weekend, she met with the Director of [redacted] and consulted with the Director of Human Resources, and it was decided to send Mr. Koch home with pay while the concerns were reviewed. [redacted] testified that as Mr. Koch was leaving the Facility, he turned toward [redacted] and the Director of [redacted] and said "quit fucking looking at me". [redacted] testified that this statement occurred in the hallway between Acute Care and the Emergency Department, a public area where short-stay patients are located.

35. [redacted] also testified that on October 16, 2023, during a shift-change report attended by her and other RNs and LPNs, the group discussed a patient's high-dose medication that would need to be ordered from a local pharmacy, and Mr. Koch said, "well he is going to fucking need it".

36. [redacted] also testified that on October 19, 2023, Mr. Koch was scheduled for a 12-hour day shift (7:00 a.m. to approximately 7:15 p.m.) in the Emergency Department and attended report at the start of the shift, during which she smelled alcohol on him. Later that morning she learned from Protective Services that Mr. Koch intended to leave the Facility. When [redacted] asked Mr. Koch about this, [redacted] testified that he told her he had a financial appointment at 10:00 a.m. and a child's hockey game at 5:00 p.m. [redacted] advised that she reminded Mr. Koch that he had not requested leave, that the request did not appear urgent, and that the unit was already short one RN. At [redacted] direction, [redacted] testified that Mr. Koch completed a leave request (Exhibit P15), dated "today", requesting "general leave" until "grievances" and family matters "can be settled" and stating that he had "perceived abusers in the workplace". [redacted] noted that the leave request did not mention a financial appointment or a hockey game. [redacted] testified that she could not fill the vacancy and did not approve the request, noting "short notice, no staff coverage". [redacted] also testified that she had been consulting with the Director of Human Resources regarding her concern about the smell of alcohol on Mr. Koch and when she went to find Mr. Koch, he had already left, at approximately 10:30 a.m. [redacted]

testified that to her knowledge he had not told anyone he was leaving, and his seven Emergency Department patients were left without an RN assigned to their care. explained that proper handoff is a verbal report to the receiving nurse, with the charts present, to ensure continuity of care and patient safety.

37. further testified that on October 20, 2023, Mr. Koch was scheduled for a day shift beginning at 7:00 a.m. but he did not attend and did not call in. described the call-in process, under which a nurse who cannot attend must call as early as possible so that the absence can be recorded and the shift filled. Mr. Koch was recorded as a "no call, no show" and absent without approved leave. confirmed that attempts were made to contact Mr. Koch on October 20, 2023 as the SHA process requires.

38. On October 26, 2023, the SHA issued a twelve-shift unpaid suspension for the October 16, 19 and 20 events (Exhibit P14).

39. Mr. Koch's cross-examination of was lengthy. Much of it concerned her job title (Exhibit D1), his family circumstances, his employment status after October 2023, the Collective Agreement, the charge nurse policy, training requirements, and the completeness and discharge time of the Labouring Patient's chart. On the relevant issues, confirmed that she did not witness the August 24 or September 16 interactions with physicians, that she did not interview the Labouring Patient or her family, and that her investigation concerned the manner in which consent was sought rather than any physical harm. did not recall being told on October 2, 2023 that Mr. Koch's children were being held at an undisclosed location, although she recalled that Human Resources had explored other departments for him due to family issues he was experiencing. rejected Mr. Koch's suggestion that the comment he made while leaving the Facility on September 18, 2023 might have been made in another language, stating that she heard him use profanity. Under cross-examination regarding the night nurse's responsibility to administer the medication to the Nebulizer Pediatric Patient, maintained that the nebulizer doses were missed because the administration times were not transcribed. In answer to questions from the Discipline Committee, confirmed that Mr. Koch had appropriate CTAS training as of September 16, 2023.

Warren Koch

40. Mr. Koch testified on his own behalf after being advised of the implications of doing so, including that he would be subject to cross-examination by legal counsel for the Investigation Committee. Much of Mr. Koch's testimony concerned his education and background, his work with the Saskatchewan Union of Nurses and his former role as president of the Saskatchewan Registered Nurses Association (as it then was), events in 2020, his separation from his former partner, his attempts to secure housing near his children, the CRNS suspension of his registration in late 2023, and his perspective on prior dealings with the SHA. Mr. Koch tendered a residential contract of purchase and sale (Exhibit D2), a document from family proceedings commenced against him (Exhibit D3), and a criminal record check dated January 5, 2026 (Exhibit D4). The Discipline Committee accepts that Mr. Koch was experiencing significant personal and family difficulty in the fall of 2023, including the breakdown of his relationship on or about September 29, 2023 and his departure from the family home on October 4, 2023. However, this evidence did not bear on whether the conduct alleged occurred or whether it met the professional standard.

41. Mr. Koch testified to how the family difficulties he was experiencing had flowed into the workplace and that he was ultimately "banished" on November 1, 2023 and not permitted to return to work. Mr. Koch testified that he felt like he was being hunted in the workplace and getting hauled into investigation after investigation.

42. On the charges themselves, Mr. Koch's evidence was largely by way of explanation rather than denial. Regarding the August 24, 2023 altercation with [redacted], Mr. Koch said he was advocating for patients to ensure that the paperwork for their transfer and CT scans was in order, that he was ultimately successful, and that he did not intend to be negative toward [redacted], to whom he had apologized.

43. Regarding the September 16, 2023 altercation with [redacted], Mr. Koch said he felt she was repeating her question and speaking as though he were not there, and Mr. Koch felt an ongoing debate over who may use the title "nurse" was relevant to the question [redacted] had asked him.

44. He admitted writing his employee number on the Code Board instead of his name because he "felt like a number" following an employment investigation, and said he did not do so again after the employer raised it.

45. While it was not ultimately clear whether Mr. Koch admitted to the use of profanity in the workplace, Mr. Koch did not specifically deny the profane remarks, and apologized "to everyone present, depending on which language anyone is speaking".

46. With respect to the Bee Sting Pediatric Patient, Mr. Koch testified that he triaged the child, that he changed the CTAS score from 4 to 3, that he was concerned by the heart rate of 176, and felt he needed to get a physician immediately. Mr. Koch testified that CTAS 2 would have been the proper CTAS score for this patient. He explained that he had not completed a full set of vital signs, that the 96% oxygen saturation made him feel there was "a bit of time", that he had notified others, that bed assignment was the responsibility of the outpatient nurse, and that the child was seen by a physician within five minutes.

47. With respect to the Nebulizer Pediatric Patient, Mr. Koch acknowledged recording one administration time rather than the four required. Mr. Koch advised that he left the remaining times to the nurse who would assume care because the short-stay patient's condition might change and require more frequent Ventolin, and that the order was otherwise accurately transcribed. Mr. Koch noted that when administering any medication, the nurse administering should read through the whole order before doing it, although he is aware that some nurses look straight down the time column rather than reviewing the entire order, describing this as a short-cut. In cross-examination, Mr. Koch agreed that the next day he felt some responsibility, regretted not filling in the times, and recognized that his decision "could have been a contributing factor" to the patient not receiving the medication.

48. As to the Labouring Patient, Mr. Koch said he entered a delivery room that was not set up as expected, believed oxytocin would be needed soon, and wanted the patient to understand the rationale and risks. Mr. Koch testified that he did not believe providing rationale when obtaining informed consent should be considered professional incompetence or professional misconduct and explained that when he obtains informed consent, he does not think a nurse should try and sell the mediation. Mr. Koch testified that he wants a patient to understand the

rationale and the risks associated and to him, the reason oxytocin is given is so people do not suffer from post-partum hemorrhage or die from blood loss. Mr. Koch acknowledged that "the language I used was felt abrasive" and testified that he adjusted the patient assignment when his colleague felt she could better care for the patient.

49. Finally, regarding October 19 and 20, 2023, Mr. Koch testified that, after he had been disciplined, he had requested a transfer to another location and his request for a transfer was denied. He testified that he requested a general leave, felt "hunted" in the workplace, and left the Facility on October 19, 2023 because it was no longer good for him to be there; he also testified that he had an appointment with a lawyer that day. Mr. Koch testified that he told RN [redacted] that he was leaving in a "short and brief" conversation in which he conveyed what needed to be done at the moment and whether "someone will die if I walk out of the building". He acknowledged that [redacted] had no authority to approve his departure, that he did not take or hand over the patient charts, and acknowledged he "could have done a better patient handover" but maintained that he did not fall below the minimum standard because three RNs, counting [redacted], were in the building and [redacted] was a highly competent practicing nurse. In answer to questions from the Discipline Committee, Mr. Koch agreed that the manager does not ordinarily work at the point of care. Mr. Koch gave no evidence that his leave request had been approved on October 19, 2023 or that he called in for the October 20, 2023 shift. Mr. Koch testified that he no longer felt safe or secure in his employment and needed to focus on his health and the health of his children.

General Comments on Witness Testimony

50. The Discipline Committee found each of the Investigation Committee's witnesses to be credible and reliable. Their evidence was clear, consistent, and supported by the documentary record. In large part, it was also consistent with what Mr. Koch himself acknowledged in his testimony. Mr. Koch did not seriously dispute the core facts. He did not put to any of these witnesses a different version of the events underlying the charges, and his cross-examination did not undermine the substance of their evidence. Much of his cross-examination, and much of his own testimony, was instead directed to matters that were not relevant to the charges, for example:

the colour and number of pages of triage forms; staffing levels and the breadth of acute care responsibilities; the meaning of the word "nurse" under provincial legislation; the history of the charge nurse policy; the relationship between the union and the employer; his employment status after October 2023; and whether patient harm had resulted out of his action. The Chair repeatedly explained the purpose of cross-examination and invited Mr. Koch to direct his questions to the Charges.

51. The Discipline Committee wishes to be clear about the significance it attaches to this. The Discipline Committee does not find that Mr. Koch was untruthful. The difficulty is that his evidence and arguments largely did not engage with the issues the Discipline Committee must decide. Where Mr. Koch did address the Charges, he did not substantively challenge the evidence against him; rather, he offered explanations or justifications for his conduct or focused on issues completely extraneous to the Charges before him. With this said, the Discipline Committee did find that Mr. Koch's evidence regarding the patient handover he provided to [redacted] on October 19, 2026 and his testimony that the unit was appropriately staffed with 3 RNs was disingenuous and lacked transparency. Ultimately, it was determined that the third RN Mr. Koch had referenced was the manager who does not provide acute care in the Facility.

V. ANALYSIS OF CHARGES

52. The Investigation Committee bears the burden of proving each allegation on a balance of probabilities, on evidence that is clear, convincing and cogent: *F.H. v McDougall*, 2008 SCC 53, [2008] 3 SCR 41; *Shamsuzzaman v College of Physicians & Surgeons (Saskatchewan)*, 2011 SKCA 41.

53. Section 26(1) of the Act defines professional misconduct broadly as conduct that is contrary to the best interests of the public or nurses, or that tends to harm the standing of the profession; the conduct need not be disgraceful or dishonourable. Section 26(2) lists specific forms of misconduct without limiting s. 26(1). Under ss. 26(2)(l) and (q), a failure to comply with the *Code of Ethics*, or a contravention of the Bylaws (which adopt the *Entry-Level Competencies* and the *Practice Standards*), is itself professional misconduct.

54. Professional incompetence under s. 25 requires a display, 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 to continue in practice or to provide one or more services ordinarily provided as part of nursing practice. Because s. 25 is tied to the care of a client, the Discipline Committee has considered professional incompetence in respect of only the clinical matters, sub-Charges 1(b), 1(c) and 1(d).

55. The Discipline Committee has carefully considered all witness evidence, the Exhibits, including the whole of Mr. Koch's evidence and each of the explanations Mr. Koch provided regarding the charges and, for the reasons that follow, does not accept that Mr. Koch's explanations answer the charges. The Discipline Committee also specifically notes that professional misconduct does not require proof that a patient was harmed. The question is whether the nurse's conduct fell below the standards of the profession, as those standards are set by the Act, the Bylaws, the *Code of Ethics*, the *Entry-Level Competencies* and the *Practice Standards*.

Charge 1(a) – Inappropriate Workplace Communications and Behaviour

56. Charge 1(a) alleges three categories of inappropriate workplace communication and behaviour: that Mr. Koch engaged with physicians in an inappropriate and aggressive manner on August 24 and September 16, 2023; that he wrote his employee number on the Code Board instead of his name on September 16 and 17, 2023; and that he used profanity at work when speaking with other hospital staff on September 18 and October 16, 2023. The Discipline Committee must decide whether the evidence establishes this conduct and, if so, whether it amounts to professional misconduct.

57. The Discipline Committee finds that each particular of Charge (a) is proven on the evidence and amounts to professional misconduct.

August 24, 2023 and September 16, 2023 encounters with [redacted] and [redacted] (Charge 1(a)(i))

58. The Discipline Committee accepts [redacted] account regarding the events of August 24, 2023. Mr. Koch did not dispute that the exchange occurred; he acknowledged a "conflict" and apologized during the Hearing. His questions in cross-examination, which focused on whether a physician was responsible for the patients, mirror the question [redacted] testified Mr. Koch repeated to her in a raised voice.

59. Mr. Koch's explanation was that he was advocating for his patients. The Discipline Committee accepts that obtaining the paperwork needed for a transfer was a legitimate concern; however, the charge is not about why he approached [redacted]; it is about how he spoke to her. A legitimate purpose does not justify repeatedly raising one's voice at a colleague, in a public clinical area, after she has offered to help and explained that she could not find what was needed.

60. As for September 16, 2023, the Discipline Committee accepts [redacted] evidence that Mr. Koch responded to a simple question about patient handover with a loud and escalating discussion of system issues, that persisted after she asked him to stop, after a colleague intervened and after she raised her hand a second time, and that she left in tears. Mr. Koch did not offer a different account. His explanation, that he felt [redacted] was repeating herself or speaking as if he were not there and that her terminology was incorrect, does not excuse the manner in which he responded to a legitimate question raised by a physician making attempts to arrange for appropriate care for a patient. Even if Mr. Koch took offence, the professional response was to answer her question and raise his concern at another time, as [redacted] proposed.

61. The Discipline Committee finds that Mr. Koch's interactions with [redacted] and [redacted] constitute professional misconduct pursuant to sections 26(1), 26(2)(l), and 26(2)(q) of the Act.

62. The Discipline Committee finds under s. 26(1) of the Act that Mr. Koch's conduct is contrary to the best interests of nurses and the public and tends to harm the standing of the profession. In a small northern facility with limited resources, or any facility for that matter, safe care depends on nurses and physicians being able to communicate with one another collaboratively and without confrontation. Mr. Koch's conduct undermined team functioning and

both incidents took place in open areas where patients and families could hear, which is entirely inappropriate and does not rise to the conduct expected of an RN.

63. The Discipline Committee also finds that Mr. Koch's conduct in his interactions with [redacted] and [redacted] were contrary to several provisions of the *Code of Ethics*, which is professional misconduct under section 26(2)(l) of the Act. The *Code of Ethics* requires nurses to foster a safe, quality practice environment[1], to use constructive and collaborative approaches to resolving differences[2], and to treat colleagues and other health-care providers respectfully and resolve differences constructively[3]. Mr. Koch repeatedly raising his voice at a physician who was trying to help him and refusing to disengage from a confrontation that another physician had twice asked him to end, all in a public setting, is not consistent with these obligations.

64. Pursuant to section 26(2)(q) of the Act, the Discipline Committee also finds that Mr. Koch contravened the *Entry-Level Competencies* and the *Practice Standards*. As Bylaw XV, adopts the *Entry-Level Competencies* and the *Practice Standards*, a breach of the same constitutes professional misconduct. The *Entry-Level Competencies* call for respect in all interactions[4], the use of conflict transformation strategies[5], effective communication in complex situations[6], and demonstration of collaborative professional relationships[7]. The Discipline Committee has found that Mr. Koch did not meet these competencies in his interactions with [redacted] or [redacted]. Additionally, the *Practice Standards* require effective collaborative practice, including communication and conflict resolution[8], respectful and effective communication with colleagues and the resolution of conflict when it arises[9], and practice in accordance with employer policies[10], which would include the SHA Workplace Expectations Policy[11]. Mr. Koch's conduct toward both physicians fell short of each of these requirements.

[1] Section A, para 12
[2] Section A, para14
[3] Section D, para13
[4] Competency 2, para 2.2
[5] Competency 3, para 3.3
[6] Competency 3, para 3.7
[7] Competency 4, para 4.1
[8] Standard 1, para 5
[9] Standard 3, para 29
[10] Standard 5, para 49
[11] Exhibit P-11. See in particular paragraphs 3.1, 3.2, 3.3, 3.6, 4.1 and Appendix "C".

Code Board (Charge 1(a)(ii))

65. With respect to the Code Board on September 16 and 17, 2023, [redacted] spoke specifically to September 16, 2023 and testified that Mr. Koch had written his employee number as opposed to his name on the Code Board. Further, Mr. Koch admitted that he wrote his employee number rather than his name, explaining that he "felt like a number". The Discipline Committee accepts that Mr. Koch may have been frustrated, but frustration with an employer is not a reason to depart from a patient safety tool. Mr. Koch's contention that he did not repeat the conduct after it was raised with him may be relevant to penalty, however, it does not justify his actions and constitutes professional misconduct pursuant to sections 26(1), 26(2)(l), and 26(2)(q) of the Act.

66. The Discipline Committee finds that Mr. Koch's conduct is professional misconduct under s. 26(1). The Code Board exists so that, in an emergency, staff know immediately who is fulfilling each important role. Obscuring the identity of the Charge Nurse on that board compromised a patient safety tool and was contrary to the best interests of the public.

67. The conduct further engages section 26(2)(l) as it is a breach of the *Code of Ethics*. Nurses must foster a safe practice environment[12], represent themselves clearly with respect to name, title and role[13], and overall, provide safe, compassionate, competent, and ethical care[14]. Identifying himself on a code reference board only by a number his colleagues would not recognize is contrary to these obligations and undermined patient safety.

68. The Discipline Committee also finds that Mr. Koch's conduct breached section 26(2)(q) of the Act in contravening the *Practice Standards* and *Entry-Level Competencies* related to appropriate identification[15]. The evidence also established that the Charge Nurse is expected to identify staff on the Code Board by name and a failure to do so engages *Practice Standard* 5, para 49, which requires an RN to abide by employer policies.

Use of Profanity on September 18 and October 16, 2023 (Charge 1(a)(iii))

[12] Section A, para 12
[13] Section G, para 2
[14] Section A
[15] Standard 1, para 2 and Competency 2, para 2.2

69. Turning to the profanity on September 18 and October 16, 2023, the Discipline Committee accepts [redacted] evidence of both statements. [redacted] testified that when leaving the Facility of September 18, 2026 and while in a public hallway, Mr. Koch stated to [redacted] and a Director "Quit fucking looking at me" and while attending shift change report on October 16, 2023 with [redacted] and other members of the care team, Mr. Koch stated "Well, he's going to fucking need it" when discussing a patient's medication. Mr. Koch's suggestion in cross-examination that the September 18 remark may have been in another language is contrary to [redacted] clear testimony of the profanity she heard and is not accepted.

70. The Discipline Committee finds that Mr. Koch's use of profanity constitutes professional misconduct under sections 26(1), 26(2)(l), and 26(2)(q) of the Act.

71. Swearing at one's manager and a director in a public hallway, and using profanity during a formal shift report, is inconsistent with various requirements in the *Code of Ethics*, such as the requirement to treat colleagues respectfully[16] and to foster a safe, quality practice environment[17], and is therefore professional misconduct under s. 26(2)(l).

72. The same conduct is contrary to section 26(2)(q) of the Act. The Discipline Committee finds that Mr. Koch's use of profanity falls short of the requirements in the *Entry-Level Competencies* of ensuring professional presence and respect in all interactions[18] and of participating in creating and maintaining a respectful, psychologically safe workplace[19] , as well as, the requirements in the *Practice Standards* to communicate respectfully[20] and to model professional behaviour[21].

73. The conduct is also professional misconduct under s. 26(1). The public is entitled to expect nurses to conduct themselves professionally in a hospital, particularly in patient areas. The September 18 remark was made in a hallway where short-stay patients are located, and the

[16] Section D, para 13
[17] Section A, para 12
[18] Competency 2, para 2.2
[19] Competency 6, para 6.4
[20] Standard 3, para 29
[21] Standard 4, para 35

October 16 remark was made during a clinical handover. The Discipline Committee finds that Mr. Koch's behaviour fell below the professional behaviour expected of an RN, tending to harm the standing of the profession.

General Comments on Findings regarding Charge 1(a)

74. The Discipline Committee is mindful that a professional regulator should not discipline members merely for rudeness or "bad manners": *Li v College of Pharmacists (British Columbia)* (1994), 116 DLR (4th) 606 (BC CA); however, the Discipline Committee has found Mr. Koch's conduct goes well beyond "bad manners" and is a breach of fundamental obligations of RNs, spanning interactions with physicians, management, and other health care team members, and in some cases impacting patient safety.

75. The Discipline Committee finds Mr. Koch guilty of professional misconduct on Charge 1(a).

Charge 1(b) – Failure to Adequately Assess and Triage a Pediatric Patient

76. Charge 1(b) alleges that on September 16, 2023, Mr. Koch failed to adequately assess and triage an emergency department pediatric patient. The Discipline Committee must decide whether Mr. Koch was responsible for assessing and triaging the Bee Sting Pediatric Patient, whether his assessment and triage were inadequate, and, if so, whether this amounts to professional misconduct or professional incompetence.

77. Mr. Koch's responsibility for the triage is not in dispute. He is recorded as the primary assessor on the triage record,[22] [redacted] identified his handwriting, and Mr. Koch confirmed in his testimony that he triaged the child.

78. The Discipline Committee finds that the triage was inadequate. Mr. Koch documented a bee sting in a child with a known bee allergy, hives, hand swelling, wheezing, a cough and a heart rate of 176 beats per minute, a rate he agreed was alarming and warranted getting a

[22] Exhibit P3

physician immediately. Mr. Koch nonetheless assigned a CTAS score of 3, having first circled 4, and the child was returned to the waiting room. Mr. Koch suggested in cross-examination of [redacted] that he had placed the child in the waiting room as the Charge Nurse was not responsible for bed assignments; however, [redacted] disagreed stating the waiting room was not an appropriate place for an emergency. The Discipline Committee agrees with [redacted] statement, regardless of responsibility for bed assignments.

79. The child was showing signs of anaphylaxis, a potentially life-threatening emergency. [redacted] evidence, which Mr. Koch ultimately accepted, was that the child should have been triaged as CTAS 2 and placed where he could be monitored and treated immediately. It was [redacted], not Mr. Koch, who moved the child, arranged monitoring and obtained the physician.

80. The Discipline Committee finds that this conduct is both professional misconduct and professional incompetence.

81. The fact that no patient harm occurred is not relevant to the Discipline Committee's determination on this matter. Mr. Koch's principal explanation was that the child was seen by a physician within five minutes of registration, which he said was consistent with a CTAS 1 or 2 response. The Discipline Committee does not accept this explanation. The physician saw the child promptly because [redacted] intervened and called the physician. The timeliness of that response reflects her judgment, not his.

82. Similarly, the Discipline Committee does accept Mr. Koch's other explanations. Whether bed assignment was formally the responsibility of the outpatient nurse does not change the fact that he, as the triaging nurse, assigned the score that determined the child's priority. A reassuring oxygen saturation did not displace the other findings, including the heart rate he himself found alarming and a favourable outcome does not answer a charge about the adequacy of the nurse's assessment.

83. The Discipline Committee finds that Mr. Koch's conduct is professional misconduct on several bases. Under section 26(1) of the Act, leaving a five-year-old in anaphylaxis in a waiting room is contrary to the best interests of the public and tends to harm the standing of the

profession. Under section 26(2)(l) of the Act, it was contrary to the *Code of Ethics*: Mr. Koch did not provide safe and competent care[23], did not foster a safe practice environment[24], and did not meet his obligation to be accountable for his practice[25]. Assigning a non-urgent score to an emergent presentation and leaving the child in the waiting room created a real risk that his deterioration would go unnoticed. In addition, under section 26(2)(q) of the Act, Mr. Koch's conduct breached the *Entry-Level Competencies* requiring nurses to provide safe, competent care[26], to analyse and interpret assessment data[27], to develop plans of care using critical inquiry[28], and to anticipate potential health risks[29]. The *Practice Standards* similarly require nurses to anticipate potential health problems and respond appropriately[30] and to take action to create a safe environment for clients[31]. Mr. Koch gathered the data that pointed to anaphylaxis but did not act on it appropriately. He did not translate his own findings into an appropriate triage score or plan of care, and he did not anticipate the rapid deterioration that anaphylaxis can cause.

84. The Discipline Committee also finds that Mr. Koch's conduct constitutes professional incompetence pursuant to section 25(b). Recognizing and appropriately triaging anaphylaxis is a core competency for a nurse working in an emergency department, and Mr. Koch was trained in CTAS. His failure to act on clear findings that he himself recorded demonstrates a lack of knowledge, skill or judgment, in the professional care of a client, of a nature that shows he was unfit to provide a service ordinarily provided as part of registered nursing practice, namely emergency triage, within the meaning of section 25(b) of the Act.

85. The Discipline Committee finds Mr. Koch guilty of professional misconduct and professional incompetence on Charge (b).

Charge 1(c) – Failure to Completely and Accurately Document a Pediatric Patient's Medication Schedule

[23] Section A
[24] Section A, para 12
[25] Section G, para 4
[26] Competency 1, para 1.1
[27] Competency 1, para 1.4
[28] Competency 1, para 1.5
[29] Competency 1, para 1.7
[30] Standard 2, para 17
[31] Standard 3, para 34

86. Charge (c) alleges that on September 16, 2023, Mr. Koch failed to completely and accurately document a pediatric patient's schedule of medication administration. The Discipline Committee must decide whether Mr. Koch was responsible for documenting the medication schedule for the Nebulizer Pediatric Patient, whether he failed to document it completely and accurately, and, if so, whether this amounts to professional misconduct or professional incompetence.

87. There is no question that Mr. Koch was assigned to the Nebulizer Pediatric Patient and transcribed the physician's order. [redacted] and [redacted] both testified that a QID order requires four doses a day and that the transcribing nurse is to record the four administration times on the MAR. Mr. Koch recorded only one (1800). He did not record a reassessment time and did not have the transcription double-checked by another nurse, as is required.

88. Mr. Koch did not dispute these facts. His explanation was that he deliberately left the remaining times blank because the short-stay patient's condition might change and require more frequent Ventolin, and because he wished to leave the timing to the nurse assuming care. He also emphasized that the doses were missed on night shifts when he was not working, and that nurses administering medication should read the whole order rather than rely on the time column.

89. The Discipline Committee does not accept that these explanations answer the charge. Mr. Koch is not charged with missing doses; he is charged with failing to completely document the medication schedule. The purpose of recording administration times on the MAR is precisely to ensure that the nurses who follow, including night-shift nurses, are prompted to give each dose. Leaving the schedule incomplete in anticipation that the order might later change was not Mr. Koch's decision to make. The physician's order already provided for reassessment after 24 hours, and any change in frequency was a matter for the prescriber, which may or may not have occurred in consultation with the night nurse. In the meantime, the order as written was the order to be documented, with the times for doses also recorded. The Discipline Committee accepts that Mr. Koch acknowledged that he regretted not recording the times and that his decision could have contributed to the patient not receiving the medication.

90. The Discipline Committee finds that this conduct is both professional misconduct and professional incompetence.

91. The Discipline Committee finds that Mr. Koch's conduct is professional misconduct on several bases. Under section 26(1) of the Act, the Discipline Committee finds that Mr. Koch's substitution of his own view of what an order might become is contrary to the best interests of the public and tends to harm the standing of the profession. Nurses who transcribe physician orders must document them fully and accurately; patients, and the nurses who care for them on later shifts, depend on it. Similarly, under section 26(2)(l), Mr. Koch breached the *Code of Ethics* as incompletely transcribing a medication order, including the times for dosage, for a child with respiratory symptoms was not safe and competent care[32], Mr. Koch did not foster a safe practice environment[33], and Mr. Koch did not reflect accountability for his practice as part of a team[34].

92. Under section 26(2)(q) of the Act, the Discipline Committee also finds Mr. Koch's conduct contravened several *Entry-Level Competencies* and *Practice Standards*. The *Entry-Level Competencies* require nurses to provide safe, competent, ethical, and evidence-informed care[35], develop plans of care to support professional judgment and reasoned decision-making[36], anticipate actual and potential health risks and possible unintended outcomes[37], and apply principles of safe medication practice[38]. The *Practice Standards* require nurses to be accountable for their decisions[39], to anticipate and respond appropriately to potential health problems[40], to engage in critical inquiry to inform clinical decision-making[41], to take action to create a safe work environment that contributes to optimal client outcomes[42] and to practise in accordance with employer policies[43]. The Discipline Committee finds Mr. Koch fell short of each of these requirements. The foreseeable consequence of leaving three of four medication times blank,

[32] Section A
[33] Section A, para 12
[34] Section G, para 4
[35] Competency 1, para 1.1
[36] Competency 1, para 1.5
[37] Competency 1, para 1.7
[38] Competency 1, para 1.11
[39] Standard 1, para 1
[40] Standard 2, para 17
[41] Standard 3
[42] Standard 3, para 34 and Standard 4, para 37
[43] Standard 5, para 49

namely that doses would be missed, is what occurred. This did nothing to create a safe environment or demonstrate that Mr. Koch was meeting the expectations regarding clinical-decision making, safe medication practices, or anticipating unexpected outcomes. The further evidence established that the MAR required both the recording of administration times and a double-check of the transcription. Mr. Koch's continued focus and attempt to shift focus to the night nurse that had missed the doses, shows a lack of accountability.

93. The Discipline Committee has also concluded that Mr. Koch's failure to appropriately document the physician's order, including scheduled medication times, constitutes professional incompetence pursuant to section 26(b) of the Act. Accurate transcription of a medication order and scheduling its administration is a basic and routine nursing responsibility. Mr. Koch's decision to leave the schedule incomplete, and his explanation for doing so, reflect a lack of skill, knowledge, and judgment in the care of a patient related to safe medication management that meets section 25(b) of the Act.

94. The Discipline Committee finds Mr. Koch guilty of professional misconduct and professional incompetence on Charge (c).

Charge 1(d) – Inappropriate Communication with an Obstetrics Patient

95. Charge 1(d) alleges that on September 18, 2023, Mr. Koch communicated in an inappropriate manner with an obstetrics patient when seeking consent to administer oxytocin. The Discipline Committee must decide whether Mr. Koch communicated with the Labouring Patient to seek her consent, whether that communication was inappropriate, and, if so, whether this amounts to professional misconduct or professional incompetence.

96. The facts are not in dispute. Mr. Koch was seeking the Labouring Patient's consent to administer oxytocin. [redacted] account of what he said was not challenged in cross-examination or contradicted in his evidence. While the patient was in labour and already struggling to cope, Mr. Koch stated that "Many years ago, women died during or after childbirth" and asked the patient "for permission to give her an intramuscular injection so she doesn't bleed out".

97. Mr. Koch's explanation was that what he told the patient was accurate: post-partum hemorrhage is a real risk, oxytocin is given to prevent it, and women have died in childbirth. Much of his cross-examination of [redacted] and [redacted] was directed to establishing these points, and to whether the mother or baby suffered harm. He also referred to the state of the delivery room and his wish to be ready for the delivery.

98. The Discipline Committee accepts that the information was medically accurate and that consent was required. However, the charge does not allege that Mr. Koch conveyed inaccurate information; it alleges that he communicated in an inappropriate manner. Accurate information can be conveyed in a way that informs a patient without frightening them, as [redacted] own explanation to the patient demonstrates. Whether the patient or baby suffered physical harm is not an element of the charge.

99. The Discipline Committee finds that Mr. Koch's communication was inappropriate. It accepts [redacted] evidence that the patient became more frightened, and Mr. Koch himself acknowledged that his language may have been received as "abrasive". The Discipline Committee finds that this conduct displays both professional misconduct and professional incompetence.

100. The Discipline Committee finds that Mr. Koch's conduct is professional misconduct on several bases. Under section 26(1) of the Act, the Discipline Committee finds that obtaining informed consent is part of a nurse's role and there is a proper way to do it. The use of scare tactics and frightening the patient is not the appropriate way to obtain informed consent. A patient in labour is in a particularly vulnerable position. Communicating with her in a way that heightened her fear is contrary to the best interests of the public and tends to harm the standing of the profession.

101. Similarly, the Discipline Committee finds Mr. Koch guilty of professional misconduct regarding section 26(2)(l) due to breaches of the *Code of Ethics*. The *Code of Ethics* requires RNs to engage in compassionate care through their speech and body language and through efforts

to understand and care about others' health care needs[44] and to build trustworthy relationships with people in their care[45]. Under section 26(2)(q) of the Act, the Discipline Committee also finds Mr. Koch's conduct contravened several *Entry-Level Competencies* and *Practice Standards*. The *Entry-Level Competencies* require nurses to provide safe, competent, ethical, compassionate, and evidence-informed care[46], as well to use evidence-informed communication skills to build trusting, compassionate and therapeutic relationships with clients[47], to demonstrate respect in all interactions[48], and to engage in reflective practice[49]. Further, the *Practice Standards* require respectful and effective communication with clients and families[50].

102. Telling a frightened labouring patient that women used to die in childbirth, and that the injection was so she would not "bleed out", was the opposite of compassionate and trust-building communication. Building a trusting relationship with a patient is inherently important to understanding a patient's needs and concerns and developing appropriate communication when obtaining informed consent. Mr. Koch fell below the expected requirements in the *Code of Ethics*, *Entry-Level Competencies*, and *Practice Standards* in his statements to this patient and failed to demonstrate respect, reflective practice, or effective communication during the interaction and following the same.

103. The Discipline Committee has also concluded that Mr. Koch's approach with this patient constitutes professional incompetence pursuant to section 26(b) of the Act. Explaining a medication and obtaining consent in a therapeutic manner is routine in nursing, as well as developing appropriate language to obtain consent in a therapeutic and respectful manner. Mr. Koch's communication with this vulnerable patient in active labour, which caused her significant distress and led a colleague to take over her care, demonstrated a lack of judgment and a disregard for the patient's welfare of a nature that meets section 25(b).

[44] Section A, para 2
[45] Section A, para 3
[46] Competency 1, para 1.1
[47] Competency 3, para 3.3
[48] Competency 2, para 2.2
[49] Competency 6, para 6.6
[50] Standard 3, para 29

104. The Discipline Committee finds Mr. Koch guilty of professional misconduct and professional incompetence on Charge 1(d).

Charge 1(e) – Leaving Work Without Approval or Proper Handoff

105. Charge 1(e) alleges that on October 19, 2023, Mr. Koch left work without approval and without providing proper patient handoff. The Discipline Committee must decide whether Mr. Koch was scheduled for a shift that day, whether he left without approval, whether he failed to provide proper handoff and, if so, whether this amounts to professional misconduct.

106. The Discipline Committee finds the facts in support of this charge are established. Mr. Koch was scheduled for, and began, a day shift in the Emergency Department on October 19, 2023. He submitted a leave request but left the Facility at approximately 10:30 a.m., before receiving any response to it. Mr. Koch acknowledged that the colleague he told he was leaving had no authority to approve his departure. The Discipline Committee also finds that Mr. Koch did not provide proper handoff. The Discipline Committee accepts [redacted] evidence that his seven patients were left without an RN assigned to their care. On his own account, Mr. Koch's conversation with [redacted] focused on emergent issues. He did not ensure another nurse was assigned care for his patients, provide [redacted] with patient charts, or communicate each patient's status to facilitate a proper transfer of care. Mr. Koch acknowledged that he could have done a better handover.

107. Mr. Koch explained in his evidence that he left because he felt "hunted" and unsafe in the workplace, that his earlier transfer request had been denied, that he was dealing with a serious family crisis, and that he had an appointment with a lawyer. He also said three RNs were in the building. The Discipline Committee accepts that Mr. Koch was under real personal strain at the time and takes no issue with his wish to seek leave, but those circumstances did not entitle him to leave his patients without approval and without properly handing over their care. It is notable that Mr. Koch provided varying reasons for his leave request on October 19, 2023, making it very difficult for [redacted] to grant the leave request. In addition, Mr. Koch's less than

transparent count of three RNs included [redacted], his manager, who does not work at the point of care, and the unit was already short one RN that day.

108. The Discipline Committee finds that this conduct is professional misconduct on several bases. Under section 26(1) of the Act, the Discipline Committee finds that leaving the Emergency Department of a remote facility without approval, without assigning his patients to another nurse, and without a proper report placed patients at risk, and was contrary to the best interests of the public and of the nurses left to absorb the workload. Handoff exists to ensure continuity and safety of care. Section 26(2)(e) of the Act specifies that it is professional misconduct where a nurse has wrongfully abandoned a client. The Discipline Committee finds that Mr. Koch left 7 Emergency Department patients without properly transferring their care to another nurse which amounts to wrongfully abandoning a patient.

109. As with the other charges, there are many provisions of the *Code of Ethics*, *Entry-Level Competencies*, and *Practice Standards* that were breached when Mr. Koch left without approval or appropriate handoff which amount to professional misconduct under sections 26(2)(l) and 26(2)(q) of the Act. These breaches include such provisions as the requirements of nurses to provide safe care and foster a safe practice environment[51], to be accountable for their actions, practice, and decisions[52], to demonstrate a professional presence[53], to take action to create a safe environment for clients[54], to contribute to a safe practice environment[55], and to comply with employer policies[56], which here required approved leave and proper handoff. The Discipline Committee finds that Mr. Koch did not meet these requirements, compromising patient safety and showing a lack of accountability and responsibility.

110. The Discipline Committee finds Mr. Koch guilty of professional misconduct on Charge 1(e).

Charge 1(f) – Failure to Report to a Scheduled Shift

[51] *Code of Ethics*, Section A
[52] *Code of Ethics*, Section G, *Entry-Level Competencies*, Section 2, para 2.1, Practice Standards, Standard 1, para 1
[53] *Entry-Level Competencies*, Section 2, para 2.2
[54] *Practice Standards*, Standard 3, para 34
[55] *Practice Standards*, Standard 4, para 37
[56] *Practice Standards*, Standard 5, para 49

111. Charge 1(f) alleges that Mr. Koch failed to report to a scheduled shift on October 20, 2023. The Discipline Committee must decide whether Mr. Koch was scheduled for a shift that day, whether he failed to attend it and, if so, whether this amounts to professional misconduct.

112. The evidence establishes that Mr. Koch was scheduled for a day shift on October 20, 2023 and did not attend, did not call in as SHA policy required, and was recorded as a "no call, no show". Mr. Koch did not dispute any of this.

113. Mr. Koch's position was that he had requested a general leave the day before and Mr. Koch testified that he no longer felt safe or secure in his employment and needed to focus on his health and the health of his children. While the Discipline Committee has accepted the personal strain Mr. Koch was under, the Discipline Committee does not accept that these circumstances relieved him of the obligation either to attend or to give notice of his absence in the ordinary way and pursuant to SHA policy.

114. The Discipline Committee finds that this conduct is professional misconduct pursuant to section 26(1) of the Act. Patients [redacted] depend on adequate nursing coverage, and colleagues bear the burden when a nurse fails to attend without notice. An unannounced absence is contrary to the best interests of the public and of nurses, and tends to harm the standing of the profession.

115. As with the other charges, there are many provisions of the *Code of Ethics*, *Entry-Level Competencies*, and *Practice Standards* that were not met when Mr. Koch did not report or call in to report his absence on October 20, 2023, which the Discipline Committee finds amount to professional misconduct under sections 26(2)(l) and 26(2)(q) of the Act. These include breaching the requirements that nurses demonstrate accountability, particularly accountability for their actions and practice[57], demonstrate professional presence[58], and comply with employer policies[59]

[57] *Code of Ethics*, Section G, *Entry-Level Competencies*, Competency 1, para 1.1, and *Practice Standards*, Standard 1, para 1
[58] *Practice Standards*, Standard 4
[59] *Practice Standards*, Standard 5, para 49

116. The Discipline Committee finds Mr. Koch guilty of professional misconduct on Charge 1(f).

Cumulative Impact of Charges

117. In light of the Discipline Committee's findings, the Discipline Committee does not need to comment on the Investigation Committee's submissions that if a particular or charge did not on its own amount to professional misconduct or incompetence, the conduct when viewed as a whole does. Having found that each sub-charge independently establishes professional misconduct, the Discipline Committee need not rely on a cumulative analysis. It observes, however, that the conduct occurred over a period of about two months and reflects a consistent pattern: difficulty communicating respectfully with colleagues and patients, departures from basic clinical and documentation standards, and disregard for the workplace processes that protect patients. Viewed together, the Discipline Committee is of the opinion that the cumulative effect of the conduct reinforces the Discipline Committee's conclusions.

VI. CONCLUSION

118. For the reasons above, the Discipline Committee finds Mr. Koch guilty of the Charge set out in the Notice of Hearing dated August 5, 2025, as follows: professional misconduct on each of particulars (a) through (f); and professional incompetence on particulars (b), (c) and (d).

119. In light of the above conclusions, the Discipline Committee will reconvene to hear submissions of the parties on sanction. The Discipline Committee asks the Hearing Facilitator to make efforts to schedule the Penalty Hearing on a date that works for Mr. Koch, counsel for the Investigation Committee, all members of the Discipline Committee, and counsel for the Discipline Committee. If there are difficulties obtaining possible dates from any party, they shall be advised that a Penalty Hearing will be set on a date that works best for the remaining parties, with appropriate notice. The Discipline Committee requests that any written submissions on penalty be provided to the Hearing Facilitator no less than 10 days prior to the scheduled Penalty Hearing.

120. Pursuant to section 31(3) of the Act, a copy of this decision shall be sent to Warren Koch and the complainant, [redacted]. Counsel for the Investigation Committee will also be sent a copy of the decision.

October 19, 2026

Chris Etcheverry, RN, Chairperson
On behalf of Members of the Discipline Committee
Christine Barlow, RN (retired)
Joanne Blazieko, RN
Leonard Wegner, RN
Russ Marchuk, 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 Registered Psychiatric Nurses of Saskatchewan;
(e) The College of Physicians and Surgeons of Saskatchewan; and,
(f) 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 purposes of this *Act*, professional incompetence is a question of fact, but the display by a nurse in the professional care of a client of a lack of knowledge, skill or judgment or a disregard for the welfare of a client of a nature or to an extent that demonstrates that the nurse is unfit:

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

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

is professional incompetence within the meaning of this Act.

26(1) For the purpose of this Act, professional misconduct is a question of fact but any matter, conduct or thing, whether or not disgraceful or dishonourable, that is contrary to the best interests of the public or nurses or tends to harm the standing of the profession of nursing is professional misconduct within the meaning of this Act.

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

…

(e) wrongfully abandoned a client;

…

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

…

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

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)

A. Providing Safe, Compassionate, Competent and Ethical Care

Nurses provide safe, compassionate, competent and ethical care.

Ethical responsibilities:

1. Nurses have a responsibility to conduct themselves according to the ethical responsibilities outlined in this document and in practice standards in what they do and how they interact with persons receiving care and other members of the health-care team.
2. Nurses engage in compassionate care through their speech and body language and through their efforts to understand and care about others' health-care needs.

3. Nurses build trustworthy relationships with persons receiving care as the foundation of meaningful communication, recognizing that building these relationships involves a conscious effort. Such relationships are critical to understanding people's needs and concerns.
12. Nurses foster a safe, quality practice environment (CNA & Canadian Federation of Nurses Unions [CFNU], 2015).
14. When differences among members of the health-care team affect care, nurses seek constructive and collaborative approaches to resolving them and commit to conflict resolution and a person-centred approach to care.

D. Honouring Dignity

Nurses recognize and respect the intrinsic worth of each person.

Ethical responsibilities:

13. Nurses treat each other, colleagues, students and other health-care providers in a respectful manner, recognizing the power differentials among formal leaders, colleagues and students. They work with others to honour dignity and resolve differences in a constructive way.

G. Being Accountable

Nurses are accountable for their actions and answerable for their practice.

Ethical responsibilities:

1. Nurses, as members of a self-regulating profession, practise according to the values and responsibilities in the *Code* and in keeping with the professional standards, laws and regulations supporting ethical practice.
2. Nurses are honest and practise with integrity in all of their professional interactions. Nurses represent themselves clearly with respect to name, title and role.
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.

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.
1.4 Analyses and interprets data obtained in client assessment to inform ongoing decision-making about client health status.
1.5 Develops plans of care using critical inquiry to support professional judgment and reasoned decision-making.

Critical inquiry is a: … process of purposeful thinking and reflective reasoning where practitioners examine ideas, assumptions, principles, conclusions, beliefs and actions in the context of nursing practice. In addition, this process is associated with a spirit of inquiry, discrimination, logical reasoning and application of standards … (Brunt, 2005, p. 61)

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

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

2. Professional

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

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

2.2 Demonstrates a professional presence, and confidence, honesty, integrity and respect in all interactions.

Professional presence is the demonstration of respect, confidence, integrity, optimism, passion and empathy in accordance with professional standards, guidelines and codes of ethics. It includes a nurse's verbal and nonverbal communications and the ability to articulate a positive role and professional image, including the use of full name and title. The demonstration of professional presence leads to trusting relationships with clients, families, communities and other health care team members. (College of Nurses of Nova Scotia, 2019, p. 2)

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.

3.3 Uses evidence-informed communication skills to build trusting, compassionate and therapeutic relationships with clients.

3.4 Uses conflict transformation strategies to promote healthy relationships and optimal client outcomes.

3.7 Communicates effectively in complex and rapidly-changing situations.

4. Collaborator

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

4.1 Demonstrates collaborative professional relationships.

4.3 Determines their own professional and interprofessional role within the team by considering the roles, responsibilities and the scope of practice of others.

4.5 Contributes to health care team functioning by applying group communication theory principles and group process skills.

6. Leader

Registered nurses are leaders who influence and inspire others to achieve optimal health outcomes for all.

6.4 Participates in creating and maintaining a healthy, respectful and psychologically safe workplace.
6.5 Recognizes the impact of organizational culture and acts to enhance the quality of a professional and safe practice environment.
6.6 Demonstrates self-awareness through reflective practice and solicitation of feedback.

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:
1. Being accountable and accepting responsibility for their own actions and decisions.
2. Consistently identifying self by first and last name and professional designation to clients, co-workers and others.
5. Demonstrating effective collaborative practice, including communication, problem-solving strategies, decision-making and conflict resolution.

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:
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:
26. Practicing in accordance with the current *CNA Code of Ethics for Registered Nurses.*
29. Communicating respectfully and effectively in collaboration with client, family, colleagues and others, and resolving conflict should it occur.
34. Taking action to create a safe work environment that contributes to healthy teams and optimal client outcomes.

Standard 4: Service to Public
The registered nurse demonstrates leadership in quality and ethical nursing practice, delivery of health care services and establishing professional relationships.
The registered nurse upholds this standard by:
35. Demonstrating professional presence and modelling professional behaviour.
37. Contributing to a professional ethical and safe practice environment to support the provision of optimal health care outcomes.

Standard 5: Self-Regulation

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

The registered nurse upholds this standard by:

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