College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# Council Meeting

## June 28, 2017

21 St. Clair Ave East, Ste 303

Board Room

# COUNCIL AGENDA

**Wednesday, June 28, 2017, 09:30 am to 5:00 pm**
**College of Midwives of Ontario (21 St Clair Ave, Suite 303)**

| Item | Discussion Topic | Presenter | Time | Action | Materials | Pg |
|---|---|---|---|---|---|---|
| **1.** | **Call to Order:**<br>Welcome & Safety Review | **Tiffany Haidon** | **9:30** | **INFORMATION** | | |
| | | | | | | |
| **2.** | **Conflict of Interest** | **Tiffany Haidon** | **9:35** | | | |
| | | | | | | |
| **3.** | **Enquiries** | **Tiffany Haidon** | **9:36** | **INFORMATION** | | |
| | | | | | | |
| **4.** | **Review and Approval of Proposed Agenda** | **Tiffany Haidon** | **9:37** | **MOTION** | Agenda | |
| | | | | | | |
| **5.** | **Consent Agenda**<br>- Draft Minutes of March 22, 2017 Council Meeting<br>- Draft minutes of May 2, 2017 Council Meeting<br>- Inquiries, Complaints and Reports Committee Report<br>- Discipline Committee Report<br>- Fitness to Practise Committee Report<br>- Client Relations Committee Report | **Tiffany Haidon** | **9:40** | **MOTION** | 1. Draft Minutes of March 22, 2017<br>2. Draft Minutes of May 2, 2017<br>3. ICRC Report<br>4. Discipline Committee Report<br>5. Fitness to Practise Committee Report<br>6. Client Relations Committee Report | |
| | | | | | | |
| **6.** | **Professional Standards for Midwives** | **Professionalism Working Group** | **9:45** | **DISCUSSION** | 1. RIA Statement<br>2. Professional Standards – DRAFT<br>3. Proposed schedule | |
| | | | | | | |
| ***BREAK 11:15-11:30*** | | | | | | |
| | | | | | | |
| **7.** | **Registrar's Report to Council** | | **11:30** | **MOTION** | 1. Registrar's Report<br>2. Ministry Press Release | |
| | | | | | | |
| **8.** | **President's Report** | **Tiffany Haidon** | **12:00** | **MOTION** | | |
| | | | | | | |
| ***LUNCH 12:20-1:20*** | | | | | | |
| | | | | | | |

| Item | Discussion Topic | Presenter | Time | Action | Materials | Pg |
|---|---|---|---|---|---|---|
| **9.** | **In-camera: approval of in-camera minutes of May 2, 2017 & March 22, 2017** | **Tiffany Haidon** | **1:20** | **MOTION** | ** Will be provided separately* | |
| | | | | | | |
| **10.** | **Audited Financial Statements** | **Blair MacKenzie** | **1:30** | **MOTION** | 1. Audited Financial Statements<br>2. Assessment of External Auditor Tool | |
| | | | | | | |
| **11.** | **Executive Committee Report**<br>- Process for non-council committee member appointments<br>- Process for recording and saving in-camera minutes<br>- Q4 Statement of Operations | **Tiffany Haidon** | **2:30** | **MOTION** | 1. Executive Committee Report<br>2. Briefing Note on Non-Council Member Appointments<br>3. Non-Council Member Appointments Policy<br>4. Briefing note on In-Camera Minutes<br>5. In-Camera Minutes Template<br>6. Briefing Note on Q4 Statement of operations<br>7. Q4 Statement of Operations | |
| | | | | | | |
| **12.** | **New Policy Development Process** | **Tiffany Haidon/ Marina Solakhyan** | **3:00** | **MOTION** | 1. Briefing Note<br>2. Policy Development Process<br>3. RIA Statement template | |
| | | | | | | |
| **13.** | **College's Role in Infection Prevention and Control** | **Tiffany Haidon/ Kelly Dobbin** | **3:20** | **INFORMATION** | 1. Briefing Note<br>2. Memo from MOHLTC<br>3. Roles & Responsibilities<br>4. IPAC Compliant Protocol<br>5. IPAC Lapse Disclosure<br>6. IPAC Lapse Algorithm<br>7. PHO Checklist for Reprocessing<br>8. POH IPAC Core Elements | |
| | | | | | | |

| Item | Discussion Topic | Presenter | Time | Action | Materials | Pg |
|---|---|---|---|---|---|---|
| **14.** | **Quality Assurance Committee Report** | **Jan Teevan/ Johanna Geraci** | **3:45** | **MOTION** | 1. QAC Report<br>2. SAQ 2017<br>3. SAQ Guideline<br>4. Report on QAP Findings & Recommendations<br>5. QAP Skeleton Framework | |
| | | | | | | |
| ***BREAK 4:00-4:05*** | | | | | | |
| | | | | | | |
| **15.** | **Registration Committee Report**<br>- Continuing Competencies Policy | **Isabelle Milot/ Naakai Garnette** | **4:05** | **MOTION** | 1. Registration Committee Report<br>2. Briefing Note<br>3. Continuing Competencies Policy<br>4. Criteria for approving courses | |
| | | | | | | |
| **16.** | **Annual Report 2016-2017** | **Tiffany Haidon** | **4:20** | **MOTION** | Annual Report - Draft | |
| | | | | | | |
| **17.** | **Election of President** | **Kelly Dobbin** | **4:30** | **MOTION** | | |
| | | | | | | |
| **18.** | **Adjournment** | **Tiffany Haidon** | **5:00** | **MOTION** | | |
| | | | | | | |

**Next Meetings**
Oct 11-12, 2017; Dec 12-13, 2017
November 1, 2017 – Education Day (Toronto)

# Minutes of Council Meeting
## Held on March 22, 2017 9:30 am to 5:00 pm
## Boardroom (21 St. Clair Avenue East)

| | |
|---|---|
| **Chair** | Barbara Borland, RM |
| **Present** | Barbara Borland, RM, Caroline Brett, Carron Canning, RM, Rochelle Dickenson, Claudette Leduc, RM, Jennifer Lemon, Lilly Martin, RM, Wendy Murko, RM, Gemma Salamat, Jan Teevan, RM, Isabelle Milot, RM |
| **Regrets** | Philip Playfair, Tiffany Haidon, RM |
| **Ex-Officio** | Kelly Dobbin |
| **Staff** | Carolyn Doornekamp, Nadja Gale, Naakai Garnette, Johanna Geraci, Amy Fournier, Krista Madani, Marina Solakhyan |
| **Observers** | Lisa Nussey, RM, Rebecca Crone, Christi Johnston, RM |
| **Recorder** | Amy Fournier |



1. **Call to Order, Safety and Welcome**
   Barbara Borland, President, called the meeting to order at 9:36 am and welcomed all present.

2. **Declaration of Conflict of Interests**
   No conflict of interest was declared.

3. **Enquiries**
   One will be discussed later in meeting.

4. **Proposed Agenda**
   **MOTION:** THAT THE PROPOSED AGENDA OF MARCH 22, 2017, BE APPROVED AS AMENDED TO ADD PRE-AUDIT CONSULTATION.
   Moved: Rochelle Dickenson
   Seconded: Wendy Murko
   CARRIED

5. **Consent Agenda**
   **MOTION**: THAT THE CONSENT AGENDA CONSISTING OF:
   - Inquiries, Complaints and Reports Committee Report
   - Registration Committee Report
   - Discipline Committee Report
   - Fitness to Practise Committee Report
   - Quality Assurance Committee Report
   - Client Relations Committee Report

   BE APPROVED AS PRESENTED
   Moved: Jan Teevan
   Seconded: Caroline Brett
   Carried

6. **Draft Council Meeting Minutes of December 7, 2016**
   **MOTION:** THAT THE REVISED DRAFT MINUTES OF DECEMBER 7, 2016, BE APPROVED AS AMENDED

Moved: Lilly Martin
Seconded: Gemma Salamat
Abstain: Wendy Murko
CARRIED

**7. Presentation on Standards Review**

Johanna Geraci, Manager of Quality Assurance, presented on the College's Standards Review. The first version of the Professional Standards document will be presented to Council at its June meeting.

**8. Professional Misconduct Regulation**

Naakai Garnette, Director of Professional Conduct and Registration, provided Council with background information on the revisions to the Professional Misconduct Regulation and the results from the public consultation. The regulation was approved on December 7, 2016 for a 60-day public consultation. The proposed regulation has completed a 70-day consultation period (extended to account for December/January holidays) with the membership and stakeholders.

Naakai Garnette, Director of Professional Conduct and Registration, addressed the provisions and provided further rationale to keep wording in those provisions. She also informed the Council of changes to the provisions that resulted from the public consultation. After a thorough consideration, the following changes to three provisions were made by Council:

- Provision 34: 'Charging a client or a client's representative for midwifery services on a fee for service arrangement.'
- Provision 45: 'Engaging in conduct that would reasonably be regarded by members as conduct unbecoming a member of the profession.' Remove 'by members'.
- Provision 47: 'Engaging in conduct or performing an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional. O. Reg. 388/09, s. 1.' Naakai Garnette clarified that this provision refers to the membership, therefore, 'by members' must remain.

**MOTION:** THAT THE PROPOSED AMENDMENTS TO THE PROFESSIONAL MISCONDUCT REGULATION (388/09) UNDER THE *MIDWIFERY ACT, 1991*, BE APPROVED FOR FORMAL SUBMISSION TO THE MINISTRY OF HEALTH AND LONG-TERM CARE FOR ITS REVIEW AND APPROVAL.
Moved: Lilly Martin
Seconded: Caroline Brett
*(In favour: Barbara Borland, RM, Caroline Brett, Carron Canning, RM, Rochelle Dickenson, Claudette Leduc, RM, Jennifer Lemon, Lilly Martin, RM, Wendy Murko, RM, Gemma Salamat, Jan Teevan, RM, Isabelle Milot, RM*
*Opposed: None*
*Abstained: None)*
CARRIED

**9. General Regulation**

Kelly Dobbin, Registrar, introduced the proposed Quality Assurance Regulation and provided a summary of the feedback received through the public consultation. The regulation was approved on December 7, 2016 for a 60-day public consultation. The proposed regulation has completed a 70-day consultation period (extended to account for December/January holidays) with the membership and

stakeholders. No further changes were made to the proposed regulation in response to the feedback received.

**MOTION:** THAT THE PROPOSED AMENDMENTS TO THE GENERAL REGULATION (335/12) UNDER THE *MIDWIFERY ACT, 1991*, BE APPROVED FOR FORMAL SUBMISSION TO THE MINISTRY OF HEALTH FOR ITS REVIEW AND APPROVAL, AS FOLLOWS:

i. Rescind Part I of the General Regulation and create a new Quality Assurance Regulation with the proposed amendments.
ii. Rescind Part II of the General Regulation.
iii. Rescind Part III of the General Regulation *after* amendments to the *Midwifery Act* are made, including removal of 4.1 (1) A member is not authorized to perform a procedure under paragraph 10 of section 4 unless the member performs the act in accordance with the regulations. 2009, c. 26, s. 16 (1) and the amendments related to the performance of authorized acts are added.

Moved: Lilly Martin
Seconded: Wendy Murko
*(In favour: Barbara Borland, RM, Caroline Brett, Carron Canning, RM, Rochelle Dickenson, Claudette Leduc, RM, Jennifer Lemon, Lilly Martin, RM, Wendy Murko, RM, Gemma Salamat, Jan Teevan, RM, Isabelle Milot, RM*
*Opposed: None*
*Abstained: None)*
CARRIED

**10. In-camera Session**

**MOTION**: THAT THE PUBLIC BE EXCLUDED FROM THE MEETING PURSUANT TO CLAUSE 7.2(B) OF THE HEALTH PROFESSIONS PROCEDURAL CODE OF THE REGULATED HEALTH PROFESSIONS ACT, 1991, IN THAT FINANCIAL OR PERSONAL OR OTHER MATTERS MAY BE DISCLOSED OF SUCH A NATURE THAT THE HARM CREATED BY THE DISCLOSURE WOULD OUTWEIGH THE DESIRABILITY OF ADHERING TO THE PRINCIPLE THAT THE MEETINGS BE OPEN TO THE PUBLIC.
Moved: Claudette Leduc
Seconded: Wendy Murko
CARRIED

**MOTION:** THAT THE MEETING RESUME TO OPEN SESSION AT 3:25 PM.
Moved: Rochelle Dickenson
Seconded: Jan Teevan
CARRIED

**11. President's Report**

Barbara Borland, President, presented the President's Report to Council. She informed the Council of stakeholder meetings attended in between meetings. She informed Council that the three new non-Council members participated in an orientation session on March 1, 2017. The Council was informed that public member, Gemma Salamat, has been reappointed for an additional one-year term.

**MOTION**: THAT THE PRESIDENT'S REPORT BE ACCEPTED AS PRESENTED; AND THAT ISABELLE MILOT, RM, BE APPOINTED AS THE CHAIR OF THE REGISTRATION COMMITTEE.

Moved: Rochelle Dickenson
Seconded: Claudette Leduc
CARRIED

**12. Executive Committee Report**

Carolyn Doornekamp, Director of Operations, introduced the 2017-2018 proposed budget.

**MOTION:** THAT THE 2017-2018 BUDGET BE ACCEPTED AS PRESENTED FOR PRESENTATION TO THE MINISTRY OF HEALTH AND LONG-TERM CARE.
Moved: Gemma Salamat
Seconded: Jan Teevan
CARRIED

Carolyn Doornekamp, Director of Operations, introduced the Q3 Statements. Council discussed and agreed that the Executive Committee, as the Council's Finance and Audit Committee, will approve quarterly statements, and the statements will come to Council for information only. Council was also informed of Executive's decision to move forward with an annual auditor assessment, as opposed to a comprehensive assessment.

Barbara Borland, President, informed the Council of Executive Committee's support to rescind the College's Outcomes Policy and provided rationale for this decision. When designing the 2017-2020 strategic plan, Council moved away from its traditional way of focusing on goals only and chose to broadly define the strategic priorities as well as list the strategic initiatives and key performance indicators. Therefore, the policy is no longer necessary.

Finally, Barbara Borland, President, brought forward Executive's recommendation to appoint Rochelle Dickenson to the Discipline/Fitness to Practise Committees and Jennifer Lemon the Registration Committee and Discipline/Fitness to Practice Committees.

**MOTION:** THAT THE EXECUTIVE COMMITTEE REPORT, INCLUDING

i. rescinding the Outcomes Policy;
ii. appointing Rochelle Dickenson and Jennifer Lemon to Discipline/Fitness to Practise Committee;
iii. appointing Jennifer Lemon to Registration Committee; and
iv. approving the decision for Executive Committee to move forward with an annual auditor assessment.

BE APPROVED AS PRESENTED; AND THAT THE EXECUTIVE COMMITTEE'S REPORT, INCLUDING THE Q3 STATEMENT OF OPERATIONS BE ACCEPTED AS PRESENTED.

Moved: Wendy Murko
Seconded: Jan Teevan
CARRIED

**13. Pre-Audit consultation with Blair MacKenzie**

Blair MacKenzie, Managing Partner of Hillborn LLP, joined the meeting and provided Council with the opportunity to ask questions prior to audit season scheduled for May 2017. He identified the purpose of the audit and briefly outlined the audit procedures.

**14. Registrar's Report**

Kelly Dobbin, Registrar, presented some highlights of her report to Council. An operational plan was provided in the Council package outlining the College's planned activities and outcomes according to Council's new strategic plan priorities. A progress report on strategic priorities will be provided as a

separate report during the December Council meeting.

**MOTION**: THAT THE REGISTRAR'S REPORT TO COUNCIL, INCLUDING THE 2017 OPERATIONAL PLAN BE ACCEPTED AS PRESENTED
Moved: Gemma Salamat
Seconded: Claudette Leduc
CARRIED

**15. Strategic Framework 2017-2020**

Barbara Borland, President, introduced the College's Vision and Mission and thanked Council members for their participation in the previous day's training and Strategic Framework review.

**MOTION**: THAT THE 2017-2020 STRATEGIC FRAMEWORK BE APPROVED AS PRESENTED.
Moved by: Jan Teevan
Seconded: Caroline Brett
CARRIED

**16.Proposed Schedule for 2018**

**MOTION:** THAT THE FOLLOWING SCHEDULE FOR 2018 BE APPROVED AS AMENDED.

| Meeting | Date |
|---|---|
| Executive Committee | February 7, 2018 |
| Council | March 20 & 21, 2018 |
| Executive Committee | May 2, 2018 |
| Council | June 12 & 13, 2018 |
| Executive Committee | September 12, 2018 |
| Council | October 10 & 11, 2018 |
| Executive Committee | November 14, 2018 |
| Council | December 11 & 12, 2018 |

Moved: Jan Teevan
Seconded: Caroline Brett
CARRIED

**17. Adjournment**

MOTION: THAT THE MEETING BE ADJOURNED AT 5:10 PM.
Moved: Caroline Brett
Seconded: Wendy Murko
CARRIED

_____
Barbara Borland, President

# Minutes of Council Meeting
## Held on May 2, 2017 12:00 pm to 1:00 pm
## via teleconference

| | |
|---|---|
| **Chair** | Tiffany Haidon, RM |
| **Present** | Carron Canning, RM, Rochelle Dickenson, Tiffany Haidon, RM, Claudette Leduc, RM, Jennifer Lemon, Lilly Martin, RM, Isabelle Milot, RM, Wendy Murko, RM, Philip Playfair, Gemma Salamat, Jan Teevan, RM |
| **Regrets** | Caroline Brett, Barbara Borland, RM |
| **Ex-Officio** | Kelly Dobbin |
| **Staff** | Naakai Garnette, Marina Solakhyan |
| **Observers** | |
| **Recorder** | Marina Solakhyan |



**1. Call to Order, Safety and Welcome**

Tiffany Haidon, Chair, called the meeting to order at 12:05 am and welcomed all present.

**2. Declaration of Conflict of Interests**

Barbara Borland, President, declared a conflict of interest in advance of the meeting, and recused herself from the meeting.

**3. Enquiries**

None

**4. Proposed Agenda**

**MOTION:** THAT THE PROPOSED AGENDA OF MAY 2, 2017, BE APPROVED AS PRESENTED
Moved: Philip Playfair
Seconded: Jan Teevan
CARRIED

**5. In-camera Session**

**MOTION**: THAT THE PUBLIC BE EXCLUDED FROM THE MEETING PURSUANT TO CLAUSE 7.2(B) OF THE HEALTH PROFESSIONS PROCEDURAL CODE OF THE REGULATED HEALTH PROFESSIONS ACT, 1991, IN THAT FINANCIAL OR PERSONAL OR OTHER MATTERS MAY BE DISCLOSED OF SUCH A NATURE THAT THE HARM CREATED BY THE DISCLOSURE WOULD OUTWEIGH THE DESIRABILITY OF ADHERING TO THE PRINCIPLE THAT THE MEETINGS BE OPEN TO THE PUBLIC.
Moved: Rochelle Dickenson
Seconded: Gemma Salamat
CARRIED

**MOTION:** THAT THE MEETING RESUME TO OPEN SESSION AT 1:09 PM.
Moved: Rochelle Dickenson
Seconded: Wendy Murko
CARRIED

**6. Adjournment**

MOTION: THAT THE MEETING BE ADJOURNED AT 1:09 PM.

Moved: Isabelle Milot
Seconded: Claudette Leduc
CARRIED

_____
Tiffany Haidon, Chair

## INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE
## REPORT TO COUNCIL – JUNE 2017

**Committee Members**

| | |
|---|---|
| Chair | Wendy Murko, RM |
| Professional | Tiffany Haidon, RM, Wendy Murko, RM, Carron Canning, RM |
| Public | Rochelle Dickenson, Jennifer Lemon |
| Non-Council: | Heather Brechin, RM, Edan Thomas, RM, Lisa Nussey, RM |

**Committee Meetings**

- There have been no Committee meetings since the last report. Committee meetings have been deferred until September 2017 to allow for several necessary panel deliberations. Future meetings and/or trainings will be scheduled in September to review progress on the Professional Conduct work plan.

**Panel Meetings/Hearings**

- There have been the following panel meetings since the date of the last report provided to Council:
  - COIN 262C: for deliberation (teleconference, March 3, 2017)
  - COIN 243C: for deliberation (teleconference, March 8, 2017)
  - COIN 269/270RI: for the appointment of an investigator (via email, March 14, 2017)
  - COIN 271RI: for the appointment of an investigator (via email, March 14, 2017)
  - COIN 257RI: for deliberation (teleconference, April 5, 2017)
  - COIN 254RI: for deliberation (teleconference, April 27, 2017)
  - COIN 260/261C: for deliberation (teleconference, May 5 & June 1, 2017)
  - COIN 252R: for deliberation (teleconference, May 19 & 25, 2017)
  - COIN 272RI: for the appointment of an investigator (via email, May 18, 2017)
  - COIN 268I: for deliberation (teleconference, May 24, 2017)
  - COIN 274RI: for the appointment of an investigator (via email, May 26, 2017)
  - COIN 245/246/247C: for deliberation (teleconference, May 29, 2017)
  - COIN 255R: for deliberation (teleconference, June 7, 2017)
  - COIN 263/264C: for deliberation (teleconference, June 7, 2017)

**Items**

- **Panel Deliberations & Decisions:** The ICRC's focus since the last report has been to conduct as many deliberations and finalize as many decisions as possible within the time limits imposed by the RHPA for the disposition of complaint matters. The ICRC endeavours to conduct investigations as thoroughly as possible, and acknowledges that this means that a matter may extend beyond the legislatively prescribed time limits. Nevertheless, the ICRC is making best efforts to dispose of matters in a timely and efficient manner.

**Attachments:**
Professional Conduct – Current Files Listing (current to June 9, 2017)

As Chair, I'd like to thank the members of ICRC for their time engagement and commitment especially given the increased demands this spring to complete panels and decisions.

Respectfully submitted,

Wendy Murko, RM, Chair

**Professional Conduct – Current Files Listing**
**Updated as of June 9, 2017**
**Last Reported at March 2017 Council Meeting**

**Files in Progress as of June 9, 2017**

| | |
|---|---|
| **TOTAL ACTIVE CASES** | **26** |
| **Mandatory Reports**<br><br>COIN 252, 255 | **2** |
| **Complaints**<br><br>COIN 243, 254/246/247, 249, 260/261, 262, 263/264, 265, 267, 273, 275/276/277 | **16** |
| **Fitness to Practice/Incapacity**<br><br>COIN 268I | **1** |
| **Registrar's Investigations/ Registrar's Inquiries**<br><br>COIN 254, 266, 269/270, 271, 272, 274 | **7** |
| **Closed since last Report (March 2017)**<br><br>COIN 217A, 236C, 238/239C, 241C,244C, 251C, 257RI, 258C, 259C | **10** |
| **Active complaints beyond 150 days**<br><br>243, 245/246/247, 249, 260/261, 262, 263/264, 265, 267 | **12** |
| **Decision Drafting & Review**<br><br>243C, 245/246/247C, 249C, 252R, 254RI, 260/261C, 263/264C | **11** |

| | |
|---|---|
| **TOTAL MONITORED CASES** | **11** |
| **Discipline** | **0** |
| **Complaints & Reports**<br><br>COIN 214R, 217A, 236C, 238/239C, 244C, 250C, 251C, 257RI, 258C, 259C | **11** |
| **Fitness to Practice/Incapacity** | **0** |
| **HPARB / Judicial Review**<br>COIN 236C, 238/239C | **3** |
| **Closed since last Report (March 2017)**<br><br>COIN 116C, 126C, 134R, 208RI, 209R | **5** |

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# DISCIPLINE COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

## Committee Members

| | |
|---|---|
| Chair | Lilly Martin, RM |
| Professional | Lilly Martin, RM, Claudette Leduc, RM, Jan Teevan, RM |
| Public | Gemma Salamat, Philip Playfair, Jennifer Lemon, Rochelle Dickenson |

## Committee Meetings

- Future meeting and/or training will be scheduled in October. Updates to procedures from Bill 87 will be reviewed in October, along with the Professional Misconduct Regulation Guide.

## Panel Meetings/Hearings

N/A

## Trainings

See above.

## Items

N/A

## Formal Motions to Council

N/A

## Attachments:

Respectfully Submitted,

Lilly Martin, RM, Chair

# FITNESS TO PRACTISE COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

## Committee Members

| | |
|---|---|
| Chair | Lilly Martin, RM |
| Professional | Lilly Martin, RM, Claudette Leduc, RM, Jan Teevan, RM |
| Public | Gemma Salamat, Philip Playfair, Jennifer Lemon, Rochelle Dickenson |

## Committee Meetings

- Future meeting and/or training will be scheduled in October. Updates to procedures from Bill 87 will be reviewed in October, along with the Professional Misconduct Regulation Guide.

## Panel Meetings/Hearings

N/A

## Trainings

See above.

## Items

N/A

## Formal Motions to Council

N/A

## Attachments:

Respectfully Submitted,

Lilly Martin, RM, Chair

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# CLIENT RELATIONS COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

## Committee Members

| | |
|---|---|
| Chair | Carron Canning, RM |
| Professional | Carron Canning, RM, Tiffany Haidon, RM, Claudette Leduc, RM, Wendy Murko, RM |
| Public | Rochelle Dickenson |
| Non-Council | Christi Johnston, RM |

## Committee Meetings

- Committee meeting to be scheduled for Fall 2017 in relation to work arising from the Sexual Abuse Task Force Report and the passing of Bill 87 (Protecting Patients Act)

## Panel Meetings/Hearings

N/A

## Trainings

N/A

## Items

N/A

## Formal Motions to Council:

N/A

Respectfully Submitted,

Carron Canning, RM, Chair

# Regulatory Impact Assessment Statement

**Title of the Initiative:** Professional Standards for Midwives

## Context and Problem Definition

1. **Clearly identify and define the problem you are trying to solve. Demonstrate why it is a problem:**

   The College's overarching objective is the protection of the public, which involves the pursuit to protect, promote and maintain the health, well-being and safety of the public, and to promote and maintain public confidence in the midwifery profession in Ontario.

   Public protection can be a loaded term. It may imply a sense of immediate and widespread risk, which is not generally the case in midwifery services in Ontario. The overwhelming majority of the midwives working across Ontario aspire to, and succeed in, delivering safe, effective midwifery care that puts clients first. They are committed and hard-working professionals in whom the public rightly places its trust. While the quality of midwifery services relies, by and large, on the integrity and professionalism of the practitioner, in terms of both competence and conduct, it is the job of the regulator to set and maintain proper professional standards and conduct for midwives. The College must also take steps to ensure, as far as possible, that standards of competence and conduct across the midwifery profession are conducive to public confidence in midwifery services.

   Like all other regulatory Colleges, the CMO has a Professional Misconduct Regulation, which lists the recognized types of professional misconduct. It is based on a general framework used by the Ministry of Health and Long Term Care, and is consistent with professional misconduct provisions for other health professions regulated by the *Regulated Health Professions Act* (RHPA). However, the regulation acting alone does not provide the fair, proportionate and agile responses that are the hallmarks of the modern regulatory model, and which are necessary to deal with the increasingly wide range of issues brought to our attention. Nor does it provide a higher level direction to the members on their professional obligations without constraining practitioner flexibility and clinical and professional judgement.

   In addition, a systematic review of client complaints in healthcare system shows that rather than being grounded in issues of clinical competence, many complaints have their genesis in failures of communication and unprofessional attitudes. Notwithstanding evidence, the majority of the College standards are clinical in nature, i.e. list clinical steps. At the same time, the College does not provide any guidance on "soft competencies", such as professional behaviour, professional and interprofessional communication, risk management, and decision-making. Finally, the members of the public have no way of knowing or understanding a midwife's professional obligations. Our current standards of practice provide little guidance on what clients can expect when seeing a midwife and what may constitute unacceptable conduct or behaviour.

   The development of the document that will determine principles of professionalism for midwives will address the above problems and identified gaps. It will create a shared understanding of what professionalism means and why it matters. Our proposition is that it matters because shortcomings in competence and professional conduct have the potential

to undermine public confidence in midwifery services. This in turn matters because it has the potential to undermine the public's trust that the College regulates in the public interest.

**2. Is the problem about risk of harm?**

It is our view that the lack of clarity and guidance about what it means to be a professional poses a risk to our regulatory outcomes.

As the Working Group knows, in June 2016, Council approved a number of outcomes that the College is expected to achieve. All outcomes are compatible with the College's objectives as set out in the RHPA, and various other pieces of applicable legislation. The Council also agreed at the June 2016 meeting that any regulatory requirement that is *not* conducive to meeting these outcomes will be considered redundant. The outcomes approved by Council are as follows:

- Clients and the public can be confident that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care (*competence*)
- Clients and the public can be confident that midwives practise the profession with honesty and integrity, and regard their responsibility to the client as paramount (*ethical conduct*).
- Clients and the public can be confident that midwives maintain boundaries between professional and non-professional relationships (*appropriate boundaries*).
- Clients are safeguarded from sexual abuse from midwives (*prevention of sexual abuse*)
- Clients can expect midwives to facilitate their choice and autonomy in decision-making (*autonomy in decision-making*).
- Clients and the public can be confident that midwives demonstrate accountability by complying with legislative and regulatory requirements (*accountability*).
- Clients and the public can expect midwives to practise free of a condition that prevents them from providing safe care (*fitness to practise*)
- Clients and the public trust that the College of Midwives of Ontario regulates in the public interest (*public trust*).

**3. If yes, explain the risks:**

The articulation of the professional standards will help mitigate *the risks arising from the conduct and behaviour of College registrants (26 in total).* A few examples are provided below:

- Lack of professional attitude and behaviour (includes failure to demonstrate caring attitude; information sharing and inter-/intraprofessional collaboration; conflict management, interpersonal, communication and problem solving skills)
- Failure to act with integrity or ethics
- Breach of privacy
- Discontinuing professional relationship
- Boundaries violation
- Failure to maintain a standard of practice

## Options

1. **Are the risks you have identified currently managed?**

We believe that the risks the College has identified are not appropriately managed. Historically, the CMO's focus has been on ad-hoc solutions; spending time and resources focusing on the details of what were perceived to be at-risk issues instead of looking at the issues themselves. This has tended towards an emphasis on compliance using rigid, prescriptive rules. In keeping with current evidence, the CMO needs to adopt an approach that encourages individual practitioner flexibility and clinical and professional judgement and autonomy to enhance practice. The following outlines some important observations that can be made regarding the College's current standards as they relate to risk identification:

- **Clinical standards are not the mandate of the College**

The CMO has 21 standards that are primarily clinical in nature. One of the biggest problems with developing standards that include clinical steps or skills is that the CMO cannot provide the appropriate resources, both human and financial, to develop and continually monitor and update these standards. Organizations developing clinical practice guidelines (CPG), such as the SOGC and the AOM, take years to gather the research evidence, review the literature and seek expert opinion before they produce CPGs. This is not possible for the CMO and, as a result, when the CMO does develop clinical standards (e.g. **External Cephalic Version, Epidural Monitoring and Managing, Twin and Breech Birth**) they repeat the evidence gathered by other organizations and published elsewhere. The content of these CMO standards, therefore, has not benefitted from the filter of an expert panel. For example – the standard on **External Cephalic Version** cites two potential complications that a midwife must be aware of when performing an External Cephalic Version (cord entanglement and severe maternal discomfort) but does not mention other potential problems such as placental abruption. This does not give a complete picture of the issue addressed in the standard. Another problem with developing clinical standards is that there is no method for deciding which clinical components of care require standards and which do not. Without such a method, the CMO might require standards on things from routine antenatal care, to spontaneous vaginal birth to managing postpartum haemorrhage. This problem with developing clinical standards results in further problems articulated below.

- **Standards that are prone to conflicting or out-of-date information**

Conflicting or out-of-date information occurs when a standard that repeats information derived from another primary source is transcribed either incorrectly or out of context or when it is not updated when the primary source changes. For example, the CMO standard **Laboratory Testing** reiterates the regulations (Appendix B of R.R.O. 1990, Reg. 682: under the *Laboratory and Specimen Collection Centre Licensing Act, R.S.O. 1990, c. L.1*.) and was not updated when Appendix B changed. This led to confusion among members about what tests they were authorized to order. The CMO's standard on **Ambulance Transport** will also be outdated in December 2017 when the 2007 version of the Emergency Health Services Branch Ministry of Health and Long-Term Care is rescinding their **Midwives at the Scene** standard on which the CMO's **Ambulance Transport** standard is based. All CMO standards that repeat regulations fall into this category including **Diagnostic Imaging** and **Prescribing and Administering Drugs.** When CMO standards repeat information published in CPGs or educational activities developed by other organizations, this also puts midwives at potential risk of working below standards when information from the original source changes.

- **Standards that are not effective**

When standards have been developed in response to particular complaints, they can attempt to target an identified problem without necessarily introducing meaningful information for midwives. Examples of this are the standards on **Interprofessional Care** and **Practice Communication**. The latter standard essentially says that all members of midwifery practice groups must communicate with one another suggesting things like *"regular practice meetings, checklists, peer case reviews [and]… protocols and procedure*s". While these are all potentially valuable suggestions for practice communication, they are not addressing the underlying issues leading to breakdowns in practice communication and are best included as suggestions or recommendations rather than standards of practice.

- **Standards where there is no minimum standard**

The CMO should establish and enforce minimum standards on topics where a minimum standard of behavior exists. A standard should set out the minimum expectations, in terms of competence and conduct, that ALL members are required to meet and provide concrete guidance that can and must be achieved by ALL of its registrants. Examples of CMO standards that do not provide the guidance required to set a minimum standard for midwives to follow include **Essential Supplies and Equipment and Clinical Education and Student Supervision**. The former provides a list of equipment to carry and the latter essentially outlines what midwifery students are permitted to do in clinical placement.

- **Standards that are beyond the College's authority**

Standards hold midwives to a minimum standard of required behavior. It is within the CMO's jurisdiction to hold midwives accountable to the standard but it has little authority over the practice group. It is, therefore, a potential problem when the CMO develops standards meant for practices because the CMO cannot ultimately hold the practice group accountable. While the CMO can require midwives to uphold standards as part of a practice group, it cannot enforce anything at the practice level. One example of this is the standard on **Practice Protocols.**

**2. Are there any alternatives to regulation that will mitigate identified risks?**

Staff believes that there are no alternatives to regulation that will mitigate the identified risks. The College is the only organization with a *legislative* mandate to develop professional and ethical standards for the midwifery profession in Ontario. Pursuant to the RHPA, the College's primary obligation to the public is to ensure that members of the profession are *qualified, skilled and competent* in the areas in which they practice. Qualified, skilled and competent is a much broader concept than just clinical excellence—it also means safe, client-centred, accountable and ethical care. As demonstrated above, the College must change its approach to standard development to alleviate confusion and misunderstandings, and to provide clarity about professional obligations.

## Initial Assessment of Impacts

1. **What are the benefits and costs of the options you are considering?**

   The proposed changes will result in no costs for midwives or the College. Standards and policy development has always been one of the College's important regulatory functions. The College has full time permanent staff members with policy being a significant part of their portfolios.

   As for the benefits, staff anticipates that this new approach will provide the right amount of regulation based on the core principles of midwifery in Ontario and the goal of ensuring that high-level outcomes are achieved by individual midwives. By reducing its focus on the smaller details, the CMO will support the autonomy of midwives and their knowledge, skills and judgement as they focus more on substantive compliance and less on "box-ticking" compliance.

2. **Will the burden imposed by regulation be greater than the benefits of regulation?**

   The proposed changes will result in no burden imposed on the profession.

## Evidence Base, Planning of Further Work and Implementation

1. **What regulatory option are you recommending to introduce?**

   Staff envisions a single document that sets out the professionalism standards that all midwives practising in Ontario must uphold. The following is the College's definition of a standard:

   *Standards set minimum expectations that must be met by the profession. A standard should already exist and be generally accepted by the profession or be made by regulation. The College should not simply publish a new standard that does not reflect the generally accepted views of the profession. A standard is enforceable only if there is expert evidence that standard is widely accepted, which partly explains extensive consultation. Standards are approved by the Council of the College.*

   In creating this document, the College intends to move away from reliance on detailed, prescriptive rules and to rely more on high-level, broadly stated rules or principles to set the standards by which all Ontario midwives must practice. *The term 'principles' can be used simply to refer to general rules, or also to suggest that these rules are implicitly higher in the implicit or explicit hierarchy of norms than more detailed rules**: they express the fundamental obligations that all should observe.** (Black, 2015)*

   The professionalism standards will describe midwives' responsibilities to the clients and to the profession. All midwives will be required to act in line with these standards, whether they are providing direct care to clients, working with their peers and other health care practitioners or applying their knowledge and skills in other roles, such as an assessor or a preceptor.

   Based on the process so far, the professional standards will comprise the following principles:

   - Professional Knowledge and Practice
   - Person-Centred Care
   - Leadership and Collaboration
   - Integrity

- Commitment to Self-Regulation

Those who fail to maintain professional standards may be held accountable under the College's Professional Misconduct Regulation. Pursuant to the Professional Misconduct Regulation *failing to maintain a standard of practice of the profession* may constitute an act of professional misconduct. There are other provisions in the regulation related to specific acts of unprofessional behaviour that may constitute professional misconduct, e.g. *abusing a client, verbally, physically, psychologically or emotionally,* or *taking unfair advantage of a client as a result of the member's position in the midwife-client relationship*.

**2. What information and data are already available?**

A thorough review of all College standards was done in 2015-2016. The following recommendations were presented to Council at its October 2016 meeting.

Recommendation #1: All College standards *must* meet the following criteria:

- Set out the minimum expectations, in terms of competence and conduct, that members are required to meet
- Allow midwives to work within the regulations providing guidance only when there are either risks to the public or gaps in information
- Address topics that are not dealt with elsewhere through statutes, regulations or by-laws, or commonly accepted clinical practice guidelines

Recommendation #2: Develop a principles-based document that will articulate the professional standards that all midwives must uphold, and, once the document is approved by Council (December 2017), rescind the following standards of practice (22 in total):

1. Continuity of Care
2. Home and Out-of-Hospital Births
3. Informed Choice
4. Midwifery Model of Care
5. Interprofessional Collaboration
6. Clinical Education and Student Supervision
7. Postpartum/Newborn Visits
8. Practice Communication
9. Practice Protocols
10. Routine Childhood Vaccinations
11. Surgical Assistant in Obstetrics
12. Complementary and Alternative Medicine
13. Epidural Monitoring and Management
14. Induction and Augmentation of Labour
15. External Cephalic Version
16. Neonatal Resuscitation
17. Twin and Breech Birth
18. Epidural Monitoring and Management
19. Vaginal Birth After Caesarean Section and Choice of Birth Place (will be replaced with Position Statement)
20. Ambulance Transport
21. Essential Equipment, Supplies and Medication
22. Nitrous Oxide-Oxygen Blends

Recommendation #3: Revise those standards that were not rescinded and develop new

standards or guiding documents. (2018-2019)

Please refer to the attached table that includes detailed information on standards that are recommended for rescinding, revising or developing. A detailed plan for 2018-2019 will be made in early 2018.

3. **What further information needs to be gathered? How will this be done, and by when?**

Staff is currently analyzing the complaints that have been filed with the College since 2012. This analysis may determine if any changes or additions should be made to the professional standards.

4. **How do you plan to engage with those who will be affected by this policy proposal?**

Since October, staff has conducted extensive internal and external consultations, including with all College departments as well as members and stakeholders. Feedback was carefully considered and incorporated into the document, as appropriate. Staff met with representatives of the AOM and the MEP in December 2016 and February 2017, respectively, to give a presentation on proposed changes and to develop a collaboration plan for 2017 and beyond to ensure readiness and smooth transition when the principles document comes into effect in early 2018. Staff also met with the AOM again in March 2017 to discuss the first version of the professional standards document. Staff will be meeting with AOM in July 2017. The following consultation plan is proposed for consideration:

**July-August: First round of consultations**

- Prepare a consultation paper and provide the first draft of the document
- Ask both targeted questions and open-ended questions
- Post feedback on our website in accordance with the posting guidelines
- Carefully consider feedback, make changes if needed
- Bring the document to the Working Group in September
- Present to Council in October. Recommend approval for consultation

**October-November: Second round of consultations**

- Prepare a consultation paper and provide the final draft of the document
- Post feedback on our website in accordance with the posting guidelines
- Carefully consider feedback, make changes if needed
- Bring the document to Council in December for final approval

5. **Are there any areas of uncertainty that could impact the final decision?**

In drafting the principles staff must strike the right balance between broadly defined principles and specific details to ensure that the meaning of the principles is sufficiently clear, i.e. there is a shared understanding among the College and the membership as to their meaning and application in particular instances. Staff is fully aware that a principles-based approach will work only if there is ongoing dialogue between the College and its members, and increased communication and regulatory guidance provided by the College.

The standards review and staff recommendations were discussed at Council in October 2016 and March 2017. Council agreed, in principle, to the changes proposed by staff. A decision was made to launch the principles document in the Fall of 2017 and to simultaneously rescind a number of

standards that will no longer be necessary. The feasibility of the above plan will depend on the Council's willingness to approve the document as presented by the working group to Council in December 2017.

6. **Is any particular communication or information activity foreseen? If so, what, and by when?**

   The following communication and information activity if foreseen:

   1. Prepare the consultation paper to accompany the first version of the professional standards when the consultation opens in July.
   2. Include an article related to the professional standards in the newsletter to be published in August, 2017.
   3. Launch the professional standards document and the College's future direction at the Member Education Day scheduled for November 2017. Dr. Zubin Austin was asked, and agreed, to be the keynote speaker at the event.
   4. The Professional Standards will be presented to the membership by the members of the Working Group
   5. Hold member forums in January-March 2017 to present the approved document and provide further guidance or clarification to the membership. Locations TBD.

7. **How are you planning to implement and evaluate the proposed policy option?**

   Please see above (question 6). An evaluation plan will be developed at a later date to presented to Council in October.

## Attachments

1. Professional Standards for Midwives
2. Proposed Schedule for Standards Development & Revision

**Submitted by:** Professional Standards Working Group

# PROFESSIONAL STANDARDS FOR MIDWIVES

## Overview

The Professional Standards for Midwives (Professional Standards) describes what is expected of all midwives registered with the College of Midwives of Ontario (College). It sets out the College's mandatory requirements regarding your practice and conduct to help you achieve the best outcomes for your clients and the public.

All midwives involved in client care hold the role of a trusted professional. There are duties arising from this role and obligations owed to others, including your clients and the public, your peers and other health care providers as well as your regulator. No standard can foresee or address every issue or ethical dilemma which may arise throughout your professional career. You must always strive to uphold the intention of the Professional Standards. You must work in accordance with the legislation and regulations that apply to midwives as well as the clinical and community standards.

## The Principles

Five (5) mandatory principles form the Professional Standards. They define the fundamental ethical and professional standards that we expect all practices and individual midwives to meet when providing midwifery services. You must use your judgement in interpreting and applying the principles and the standards to the various situations you will face as a midwife. The standards, however, are not negotiable or discretionary. Compliance with the principles is subject to any overriding legal obligations.

You must ensure that your practice meets the standards expected of you by:

1. Demonstrating professional knowledge and practice
2. Providing person-centred care
3. Demonstrating leadership and collaboration
4. Acting with integrity
5. Being committed to self-regulation

## Structure of the Professional Standards

The Professional Standards is divided into five (5) sections. Each section includes the overriding principle, a definition of the principle and a set of standards. The standards describe what midwives are expected to achieve in order to comply with the relevant principle in the context of the relevant section. For those midwives who have practice management responsibilities, we have set out additional standards at the end of each section.

**Interpretation**

Words highlighted in grey are defined in the Glossary. *Note: The Glossary has not been developed yet.*

In the Professional Standards, we use the terms "must" and "should" in the following ways:

- "must" is used for an overriding principle
- "should" is used when we are providing an explanation of how you will meet the overriding principle

## 1. Professional Knowledge and Practice

This principle focuses on developing and maintaining the knowledge and clinical skills necessary to provide high quality care to clients. All midwives practicing in Ontario have a duty to possess knowledge, skills and behaviours relevant to their professional practice. They must exercise clinical and professional judgment to provide safe and effective care. Midwives must be committed to an ongoing process of learning, self-assessment, evaluation and identifying ways to best meet client needs.

*To demonstrate professional knowledge and practice, you must meet the following standards:*

1. Maintain core competencies set out in the *Canadian Competencies for Midwives* developed by the Canadian Midwifery Regulators' Council. In all situations you must:
    a. Be aware of deficiencies in your competence
    b. Take steps to address any deficiencies and carry out further training where necessary
2. Work within the boundaries of the *Midwifery Act* related to scope of practice, the controlled acts authorized to midwives, and the limits of your competence
3. Develop and maintain the skills required to work to the full scope of practice
4. Know, understand and adhere to the standards of the profession and other relevant standards that affect your practice
5.

6. When acting in a dual registrant capacity:
    a. take steps to ensure the client understands your dual registrant role
    b. inform clients if any part of a proposed service or treatment is outside the scope of midwifery practice
    c. inform clients if any part of a proposed service or treatment would not-be administered in the capacity of a midwife
    d. maintain separate midwifery records
7. Make records contemporaneously and chronologically
8. Maintain accurate, objective and legible records of the care that was provided and include:
    a. what was provided and to whom and relevant clinical findings
    b. when it was provided and by whom
    c. why it was provided and relevant clinical findings
    d. information given to clients and acknowledgement that it has been understood
    e. decisions made about care and the client's acceptance of associated risks when a choice conflicts with professional advice
    f. record of any drugs prescribed or other care or treatments performed or ordered
    g. the name and signature of the person writing entries and the date
9. Store health records securely, and in accordance with record protection requirements
10. Provide access to current clients' health records on the request of:
    a. the client
    b. a health care provider (or other authorized individual) who has the client's consent
    c. another health care provider in an emergency when the client is not capable of giving consent
11. Tell clients where their health records are stored if they have been transferred to a different location
12. Adhere to routine infection control and prevention practices in accordance with the provincial and municipal standards within the context of midwifery
13. Effectively manage and use the healthcare resources available to you
14. Continually monitor and improve the quality of your practice using client and peer feedback and practice reflection

*Midwives with practice management responsibilities must also:*

15. Facilitate compliance with relevant legislation, regulations, policies, standards and guidelines governing the practice of midwifery and the operation of midwifery clinics
16. Develop and maintain quality improvement systems to support the professional performance of midwives and to enhance the quality of client care

## 2. Person-Centred Care

Person-centred care is focused on the individual and their life context. Person-centred care recognizes the central role the client has in their own health care, and responds to their unique needs, values and preferences. Working with individuals in partnership, person-centred care offers individuals high-quality care provided with compassion, respect and trust.

*To demonstrate Person-Centred care, you must meet the following standards:*

1. Provide care that ensures:
    a. measures are in place for all your primary births to be attended by a second individual competent to perform this role.
    b. adequate assessment of a clients' conditions, taking account of their history as well as their views and values
    c. effective treatments consistent with the standards of the profession, and based on the current and accepted evidence
    d. treatments and medications are ordered and prescribed only when you have adequate knowledge of clients' health and are satisfied that treatment and medication are appropriate
    e. supplies and equipment necessary for care in home settings are maintained.
2. Provide equitable access to care for all midwifery clients and those seeking to become midwifery clients
3. Listen to clients and provide information in ways they can understand

4. Support clients to take an interest in, and responsibility for, managing their own health and the health of their newborns
5. Recognize clients as the primary decision-makers. Provide informed choice in all aspects of care by:
    a. respecting the degree to which they want to be involved in decisions about their care
    b. making every effort to understand and appreciate what is motivating their choices
    c. providing them with the necessary information to feel confident in their decisions about their care
    d. supporting their right to accept or refuse treatment
6. Ensure clients receive continuous care throughout pregnancy, birth and postpartum characterized by 24-hour access to midwifery care or, where midwifery care is not available, to appropriate alternative care known to the client.
7. Provide clients with a choice between home and hospital births
8. Provide care during labour, birth and the early postpartum in the setting chosen by clients
9. Ensure that your personal views do not adversely affect client care

*Midwives with practice management responsibilities must also:*

10. Ensure supplies and equipment necessary for care in home settings are available to midwives
11. Have a system in place to ensure equitable access to care for all midwifery clients and those seeking to become midwifery clients
12. Manage practice effectively for the benefit of your clients



**3. Leadership and Collaboration**

This principle requires that you work both independently and together with other regulated and unregulated health care providers in relationships of reciprocal trust. Leadership and Collaboration demand that midwives work with clearly defined roles and responsibilities in all

health care settings and when in health care teams. Communication, cooperation and coordination are integral to the principle of Leadership and Collaboration.

*To demonstrate Leadership and Collaboration, you must meet the following standards:*

1. Be accountable and responsible for clients in your care and for the outcome of your individual practise
2. Maximize continuity throughout the course of a client's care by developing and maintaining an ongoing relationship with the client
3. Establish and work within systems that are clear to clients when care is shared between midwives by:
    a. Assuming primary responsibility for all clients in your care, including when client care is routinely provided by more than one midwife
    b. Taking reasonable steps to ensure continuity of care providers
    c. Ensuring consistency regarding information and advice, and the philosophy of care
    d. Providing complete and accurate client information at the time care is handed over to another midwife
    e. Ensuring that clients know who is the most responsible provider (MRP) during all elements of client care
4. Coordinate client care with other providers when an alternate type of care is requested
5. Consult with or transfer care to another care provider when the required care exceeds your knowledge, skills, and/or scope, unless you believe that not providing care could result in harm
6. Provide complete and accurate client information during consultations at the time care is transferred to another health care provider
7. Coordinate care and ensure that clients and health care providers know who is the most responsible provider (MRP) throughout client care, including delegations, consultations and transfers
8. Continue in a supportive role when client care is temporarily transferred to another care provider
9. Advocate on your client's behalf
10. Be accountable for your decisions to delegate to and accept delegations by:

a. Delegating acts only to individuals whom you know to be competent to carry out the delegated act, and who are able to accept the delegation
b. Delegating only those acts you are authorized and competent to perform
c. Accepting only delegated acts that you are competent to perform

**4. Integrity**

Integrity is a fundamental quality of any person who seeks to practise as a member of the midwifery profession. Every midwife has a duty to practice the profession with honesty and decency. If a client has any doubt about their midwife's integrity, the midwife's usefulness to the client and reputation within the profession will be compromised, regardless of how clinically competent the midwife may be.

*To demonstrated Integrity, you must meet the following standards:*

1. Ensure that your conduct justifies your clients' trust in you and the public's trust in the midwifery profession
2. Be honest and candid about your experience, qualifications and current role
3. Disclose to clients any harm sustained to them while under your care. Disclosure must include explaining to clients promptly and accurately:
    a. the facts of the incident
    b. anticipated short-term and long-term effects
    c. recommended actions to address the consequences
4. Avoid acting in a conflict of interest, unless the following circumstances apply:
    a. you are satisfied that it is in the best interests of the clients for you to act
    b. you have explained the relevant issues and risks to the clients and you have a reasonable belief that they understand those issues and risks
    c. you have clients' consent in writing to you acting
5. Take every reasonable precaution to protect the privacy and confidentiality of your clients, unless release of information is required or permitted by law
6. Ensure that any publicity materials about your practice or any other practice is true, accurate and verifiable
7. Avoid the use of professional qualifications in the promotion of commercial products

8. Recommend the use of products or services only based on clinical judgement and not commercial gain
9. Make referrals that are not biased by any pre-set arrangements with other health care providers
10. Recognize the power imbalance inherent in the midwife-client relationship; establish and maintain clear and appropriate professional boundaries always
11. Abstain from using your professional position to establish and pursue ~~a~~ sexual or emotional relationships with client or their family members
12. Practise free of any condition that prevents you from providing safe and ethical care
13. Recognize the limits imposed by fatigue, stress or illness and adjust your practice to the extent that is necessary

*Midwives with practice management responsibilities must also:*

14. Manage practice in a way that encourages equality of opportunity and respect for diversity

**5. COMMITMENT TO SELF-REGULATION**

Self-regulation is an privilege that recognizes the maturity of the profession and honours the knowledge and skills possessed by its members. Midwifery was accorded this privilege based on the premise that midwives will uphold the standards and reputation of the profession, protect and promote the best interests of clients and the public, and collectively act in a manner that reflects well on the profession. Self-regulation requires that each midwife participate in the self-regulatory process.

*To demonstrate Commitment to Self-Regulation/Self-Governance, you must meet the following standards:*

1. Co-operate fully with all College procedures. This duty applies to:
    a. investigations against you or relating to others
    b. peer and practice assessments and audits
    c. referrals to a committee panel
    d. any other proceedings before the College

2. Comply with any written notice from the College
3. Communicate with the College in a cooperative manner. This includes:
    a. advising the College, in writing, of any changes to the information designated as public in the manner outlined in the College bylaws
    b. responding promptly to College correspondence
4. Not prevent anyone from filing a complaint or raising a concern against you
5. Appropriately supervise midwives whom you have a duty to supervise, and provide honest and objective assessments of their competence, performance and conduct
6. Ensure that students under your supervision ~~is~~ are adequately supported in developing the necessary competencies. Provide honest and objective assessments of their competence, performance and conduct
7. Know, understand and comply with mandatory reporting obligations
8. Provide appropriate information to your clients about how the midwifery profession is regulated in Ontario, including how the College's complaints process works

*Midwives with practice management responsibilities must also:*

9. Have a system in place to deal with clients' concerns promptly, fairly, openly and effectively

**This table presents the proposed changes to the College Standards. This is a second version of it.**
**All the current standards can be accessed on the College of Midwives website on the "Standards of Practice" page.**

| Standard | Rationale | Comments |
|---|---|---|
| **Year 1 – January 1, 2018 FOR APPROVAL AND MAY FOR IMPLEMENTATION** | | |
| **TO RESCIND WITH THE IMPLEMENTATION OF THE PROFESSIONAL STANDARDS** | | |
| Continuity of Care<br>States that midwifery care must be available to women for the full course of care and no more than 4 midwives can provide care | Clinical standard without detail to be a standard that midwives can follow | **PRINCIPLES 2 & 3**<br>**PERSON-CENTRED CARE &**<br>**LEADERSHIP AND COLLABORATION** |
| Home and out-of-hospital births<br>Clarifies the CMO's expectation that midwives offer and attend home and other out-of-hospital births | Standard does not provide any information not already housed elsewhere It is managed by other organizations<br>• CAM has position statement on Home Birth<br>• AOM has Clinical Practice Guideline on offering choice of birthplace | **PRINCIPLES 1 & 3**<br>**PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Informed choice<br>Describes the requirements for midwives regarding informed choice discussions with clients | Much of the contents of this are captured under "Consent to Treatment" in the *Health Care Consent Act* https://www.ontario.ca/laws/statute/96h02#BK12 | **PRINCIPLE 2**<br>**PERSON-CENTRED CARE** |
| Interprofessional Collaboration | Current standard provides no real guidance about how to do this | **PRINCIPLE 3**<br>**LEADERSHIP AND COLLABORATION** |

| | | |
|---|---|---|
| Sets the minimum standard for midwives working in interprofessional relationships. | Written elsewhere (Joint position statements between CAM, CNO, CAPWHN and between CMO and CPSO | |
| <u>Midwifery Model of Care</u><br>Describes the Ontario midwifery model of care including scope, philosophy, continuity of care, choice of birthplace, informed choice and two midwives at every birth | Difficult to establish a minimum standard on something as broad as a *model of care*<br>Unusual for a College to attempt to regulate a model of care rather than the components within a model that midwives can be held accountable to.<br>Model, scope and philosophy are not a "standard" | **ALL PRINCIPLES EXCEPT FOR 2 MIDWIVES AT A BIRTH.**<br>**Question for the Working Group: How to address requirement of 2 midwives at a birth?** |
| <u>Clinical Education and Student Supervision</u><br>Describes the requirements for midwives providing clinical education and supervision to student midwives and outlines the level of midwifery student involvement in the provision of midwifery care. | Not a standard of expected behaviour- more like a guideline telling midwives at what point in the program students can do certain things. | **PRINCIPLE 5**<br>**COMMITMENT TO SELF-REGULATION**<br><br>**(If this relationship needs to be defined – a guideline can be developed – not a standard)** |
| <u>Postpartum/Newborn Visits</u><br>Details when to perform postpartum visits and what to do during the visits | Not a minimum standard. Prescriptive. Limits ability to exercise clinical judgement and to adapt to changes in best practice | **PRINCIPLES 1 & 2**<br>**PROFESSIONAL KNOWLEDGE AND PRACTICE & PERSON-CENTRED CARE** |
| <u>Practice Communication</u><br>Clarifies the CMOs expectations regarding the use of tools and mechanisms to achieve effective communication among members of a practice | Difficult to set minimum standard on communication. It is difficult to enforce because it is based on a practice group rather than an individual midwife's responsibility to communicate.<br>The AOM has not found it helpful from a risk management perspective. | **PRINCIPLE 3**<br>**LEADERSHIP AND COLLABORATION** |

| | | |
|---|---|---|
| Practice Protocols<br>Describes the CMO expectations regarding the development of practice protocols and lists mandatory practice protocols | More of a guideline. Prescriptive and difficult to enforce because it is based on practice group and not individual midwife. Public interest may better be served if protocols are developed in accordance with community standards and adapted to community differences and changing practice rather than CMO directives. | **Question for the Working Group: Do we want a line in the professional standards?** |
| Routine Childhood Vaccinations<br>Sets out the expectations for midwives who discuss routine childhood vaccinations with their clients. | Prescriptive and more like a guideline. Covered in informed choice. | **PRINCIPLE 2**<br>**PERSON-CENTRED CARE** |
| Surgical Assistant in Obstetrics<br>Describes the requirements for midwives acting as surgical assistants in obstetrics. | It is a delegated act and not a standard of midwifery care.<br>Delegation is included in current standard on Delegation, Orders and Directives. | **PRINCIPLES 1 & 3**<br>**PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Complementary and Alternative Medicine (CAM)<br>Clarifies for midwives that they must be authorized to perform CAM therapies if they are controlled acts and that they must let clients know what their knowledge base is regarding CAM | No minimum standard of behaviour.<br>Falls under informed choice, authorized acts | **Question for the Working Group: Is it adequately covered in professional standards?** |
| Epidural Monitoring and Management<br>Clarifies the requirements for midwives monitoring and managing epidurals in labour. | Very prescriptive – it is a clinical guideline rather than a minimum standard.<br>The relevant, non-clinical information is part of Informed Choice, midwifery scope, delegation, orders and directives and hospital policies | **PRINCIPLES 1 & 3**<br>**PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |

| | | |
|---|---|---|
| Induction and Augmentation of Labour<br>Describes the requirements for midwives managing inductions and augmentations of labour for their clients. | Very prescriptive – it is a clinical guideline rather than a minimum standard.<br>Covered in Informed Choice, midwifery scope, delegation orders and directives, Hospital policies/protocols<br>SOGC CPG on Induction of Labour<br>http://sogc.org/guidelines/induction-labour-replaces-107-aug-2001/ | **PRINCIPLES 1 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| External Cephalic Version (ECV)<br>Describes the requirements for midwives who perform external cephalic versions. | Very prescriptive – it is a clinical guideline rather than a minimum standard. Does not provide new or College specific information | **PRINCIPLES 1, 2 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE, PERSON-CENTRED CARE & LEADERSHIP AND COLLABORATION** |
| Neonatal Resuscitation<br>Describes the requirements for performing neonatal resuscitation | Covered in the Midwifery Act O Reg. 335/12 Part III Intubation of the Newborn<br>Included in CMO Policy on Continuing Competencies | **PRINCIPLES 1 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Twin and Breech Birth<br>Describes the requirements for midwives managing twin and breech births of midwifery clients | Covered by scope of practice and informed choice, CTCS. Does not provide new or College specific information | **PRINCIPLES 1 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Epidural Monitoring and Management<br>Clarifies the requirements for midwives monitoring and managing epidurals in labour. | Very prescriptive – it is a clinical guideline rather than a minimum standard.<br>The relevant, non-clinical information is part of Informed Choice, midwifery scope, delegation, orders and directives and hospital policies | **PRINCIPLES 1 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Vaginal Birth After Caesarean Section and Choice of Birth Place | Covered in informed choice | **REPLACE WITH POSITION STATEMENT** |

| | | |
|---|---|---|
| Held as standard but called a “position statement"<br>The purpose of this Position Statement is to articulate the College’s position regarding choice of birthplace for women planning vaginal births after previous caesarean section | Leaves no room for clinical judgement<br>Covered in AOM CPG – Vaginal Birth after Caesarean Section and SOGC Guideline # 155 (2005)<br>Covered under Professional Misconduct Regulation O. Reg. 388/09:<br>*Failing without reasonable cause to provide services to a client during labour and child birth in the setting chosen by the client.* | |
| Ambulance Transport<br>Describes the requirements for midwives regarding ambulance transport for midwifery clients from an out-of-hospital setting to a public hospital | Details are more like guidelines – telling midwives what they must already be qualified to do.<br>Refers to an MOHLTC standard which is being removed December 2017.<br>Emergency transport is part of Emergency Skills Workshop (ESW) curriculum<br>Standard does not set minimum standard | **PRINCIPLES 1 & 3**<br>**PROFESSIONAL KNOWLEDGE AND PRACTICE & LEADERSHIP AND COLLABORATION** |
| Essential Equipment, Supplies and Medication<br>Provides a list of the minimum required equipment, supplies and medications necessary for the provision of safe and appropriate care in an out-of-hospital birth setting. | No minimum standard of behaviour but rather a list of equipment- more of a guideline.<br>Provides considerable degree of detail about some requirements and not others (scalpels for UVC but not UV catheter or stopcock. Blood draw equipment is vague yet says number (4) of haemostats). | **PRINCIPLE 2**<br>**PERSON-CENTRED CARE**<br><br>**Combine with nitrous oxide and move to guiding document or offer it to the AOM** |
| Nitrous Oxide-Oxygen Blends<br>Assists members in the safe use of nitrous oxide and oxygen blends (commonly known as Entonox) at planned out-of-hospital births and talks about storage and indications for use | Not a minimum standard – more of a guideline.<br>Infection control portion covered by Public Health<br>https://www.publichealthontario.ca/en/Bro | **Combine with Essential Equipment, Supplies and Medication and move to guiding document or offer it to the AOM (See above)** |

| | | |
|---|---|---|
| | wseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx | |
| **YEAR 2–3: 2019-2020** | | |
| **Rescind standards and refer to information and link to regulations** | | |
| Laboratory Testing<br>Tells midwives to work in accordance with Midwifery Act and the Laboratory and Specimen Collection Centre Licensing Act. | Repeats Appendix B of R.R.O. 1990 Reg. 682 | **PRINCIPLES 1, 2 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE, PERSON-CENTRED CARE & LEADERSHIP AND COLLABORATION**<br><br>**PROVIDE** Link to regulation *Laboratory and Specimen Collection Centre Licensing Act, R.S.O. 1990, c. L.1* |
| Newborn Eye Prophylaxis<br>States how midwives should reconcile the conflict between the CMO *Informed Choice* Standard and the *Health Protection and Promotion Act* (HPPA) with respect to the mandatory administration of newborn eye prophylaxis. | Repeats regulations Health Protection and Promotion Act R.R.O. 1990, Regulation 557<br>Called a "position statement" | Link to *Health Protection and Promotion Act R.R.O. 1990, Regulation 557*<br><br>***The professional standards on informed choice do not specify that midwives must adhere to acts. to add this kind of qualifier to professional standards and delete this or keep as position statement?*** |
| Diagnostic Imaging<br>States that midwives may order transvaginal and transabdominal ultrasound for their clients. | Repeats regulations O. Reg. 107/96, s. 4.<br>*A member of the College of Midwives of Ontario is exempt from subsection 27 (1) of the Act for the purpose of ordering the application of soundwaves for pregnancy diagnostic ultrasound or pelvic diagnostic ultrasound.* | **PRINCIPLES 1, 2 & 3 PROFESSIONAL KNOWLEDGE AND PRACTICE, PERSON-CENTRED CARE & LEADERSHIP AND COLLABORATION**<br>**PROVIDE** Link to O.Reg. 107/96.4. O. Reg. 107/96: Controlled Acts under the *Regulated Health Professions Act* |
| **Keep standard with revisions** | | |

| | | |
|---|---|---|
| Blood borne pathogens<br>States that midwives have an ethical and legal obligation to know their serologic status and report on it. Tells midwives they must be vaccinated and must keep client serological status confidential. | Exists in the regulations for providers working in hospitals (https://www.ontario.ca/laws/regulation/900965) but does not cover clinics or homes. The protocol developed by the Ontario Hospital Association and the Ontario Medical Association recommends that health care workers in hospital seek guidance from the professional regulatory body about their ethical obligations. So CMO should consider guiding document/policy. Focus of current standard is not clear so needs revision. | Keep as standard/policy about mandatory testing and reporting and include reference to these overarching documents |
| Prescribing and Administering Drugs<br>Describes CMO expectations regarding the prescribing and administering of drugs. | Members require guidance but parts of standard are very prescriptive – like a guideline, part of standard repeats regulations – Designated Drugs<br>Part of standard is a guideline "Guideline to Prescribing and Administering Drugs" which is beyond CMO mandate and prone to being out-of-date | Provide information and link to O. Reg. 884/93: Designated Drugs under the Midwifery Act, 1991, S.O. 1991, c. 31<br>Revise and retain as standard/policy.<br>**RESCIND THE GUIDELINE SECTION IMMEDIATELY AS OUT OF DATE, LINKS BROKEN.** |
| Record Keeping Standard for Midwives<br>Describes the record keeping and disposal of records requirements for midwives | Need to provide guidance/expectations about record keeping. Failing to keep records as required by the regulations is noted in the **Professional Misconduct Regulations** https://www.ontario.ca/laws/regulation/090388 but with no guidance about what that means. | **Possibly delete the details about record keeping but may still need standard on maintaining records** |
| Caring for Related Persons | This topic requires some guidance. It | **DELETE OR MOVE TO GUIDELINE** |

| | | |
|---|---|---|
| Clarifies CMO expectations of midwives who provide midwifery care to related persons. | comes up in Investigations and Hearings (I&H) –professional boundary cases where midwives have been confused about whether or how to provide care for related persons. CPSO has a Policy because of research showing that a "physician's ability to maintain the necessary amount of emotional and clinical objectivity may be compromised.[7] Physicians may then have difficulty meeting the standard of care". | . |
| <u>When a client chooses care outside midwifery standards of practice</u> | Midwives often ask for guidance around this commonly asked question (both at the CMO and AOM). It is important when considering public protection. This information is not described for midwives anywhere else at the College.<br>. | **There are only a few points that are not covered in the professional standards (i.e. the actual steps of sending a letter). Current standard my slightly contradict new professional standards.**<br>To update standard/develop guideline to carefully describe steps to be taken when clients request care that is not within the scope of practice or care that falls below CMO or community standards? |
| **Rescind standard and incorporate in new document** | | |
| <u>Delegations, Orders and Directives</u><br>Defines the terms "delegation, order, directive" and describes how midwives must work in accordance with Midwifery Act when accepting or directing these | No minimum standard on these acts.<br>Delegation defined by RHPA<br>CMO standard basically defines terms and expands on components of regulations<br>https://www.ontario.ca/laws/statute/91r18#BK25 | See "delegation" below under Proposed New Documents. |

| | | |
|---|---|---|
| Second Birth Attendants<br>To establish the requirements for second birth attendants at midwifery births.<br>Details the skills required of second attendant | Does not apply to all midwives and there is no minimum standard of behaviour.<br>College does not regulate the second birth attendant so cannot have a standard that a midwife could fall below.<br>Midwives working with a second birth attendant is about delegation. | See "delegation" below.<br>Guidance to be provided as part of Alternate Practice Arrangement (APA) program. |
| **Proposed New Documents** | | |
| Guidance related to scope of practice, authorized acts, delegation, directives and orders. | Lack of clarity about scope compared with standards, lack of clarity about authorized acts and delegation. | Guide |
| Midwifery care in a home setting | | Consider guiding document – antenatal, intrapartum and postpartum care in the home is unique to midwives who could perhaps benefit from some guidance on things-expectations that may different because of midwifery care provided outside of an institution (e.g. essential equipment, emergency transportation) |
| Ending the client/midwife relationship | Not written elsewhere<br>College and AOM get many calls about it suggesting midwives need some clarity about it. | Guideline |
| **Future** | | |
| Consultation and Transfer of Care Standard (CTCS)<br>Defines consultation and transfer of care and then lists all the reasons why a midwife would need to do so at each stage of care | The nature of content is more like a guideline – very prescriptive. Not a minimum standard of behaviour when it uses terms like "persistent and severe" – these are subject to interpretation. Does not allow for adapting to differences in practice environments or clinical | Provide guidance to midwives and interpretation of the regulations without the details of the CTCS. Can consider replacing with a kind of flow chart with questions similar to those developed by the Nursing and Midwifery Board of Australia |

| | | |
|---|---|---|
| | judgement. Creates need for additional arrangements (i.e. Alternate Practice Arrangements).<br><br>The Midwifery Act defines scope and authorized acts Practice is further defined by regulations around laboratory testing https://www.ontario.ca/laws/regulation/900682 and controlled acts in the RHPA midwives controlled acts https://www.ontario.ca/laws/regulation/960107 and designated drug regulation https://www.ontario.ca/laws/regulation/930884<br><br>Professional Misconduct regulation<br>*Providing or attempting to provide services or treatment that the member knows or ought to have known was beyond the member's knowledge, skills or judgement.* | https://www.google.ca/search?client=safari&rls=en&q=nursing+practice+decisions+summary+guide&ie=UTF-8&oe=UTF-8&gfe_rd=cr&ei=g1WSV5bfK6KC8Qfz9paoBw |

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

## Registrar-CEO Quarterly Report

**From: Kelly Dobbin, Registrar-CEO**
**To: Council**
**Date: June 28, 2017**

---

### 1. General Highlights

On May 30, 2017, Bill 87 was enacted and many of its provisions are now in force. Several additional provisions will take effect upon proclamation. The College is developing processes, under legal counsel's guidance, to implement the required changes. The College is mindful of the importance to be consistent with other Colleges in its approach and is therefore working closely with the Federation of Health Regulatory Colleges of Ontario (FHRCO). Committee members whose work/decisions are affected by these changes will be briefed thoroughly at upcoming committee meetings.

Highlights of changes *now in force*:

- The College can now disclose information to the Minister so that the Minister can evaluate whether the College is carrying out its duties.
- The Minister can make regulations specifying how Colleges are to investigate sexual abuse cases.
- Criteria for mandatory revocations has been expanded to include touching of a sexual nature of the client's genitals, anus, breasts or buttocks.
- Discipline panels are prevented from ordering gender-based restrictions in any cases (not just sexual abuse cases).
- Where a Discipline panel makes a finding that requires mandatory revocation and defers the penalty portion of the hearing, it must immediately suspend the member's certificate of registration until the mandatory revocation is ordered.
- Expansion of public register information to include (*not a complete list*) the date a former member died, oral cautions, SCERPs, acknowledgement and undertakings as long as they remain in effect.
- Colleges are required to post dates, agendas and materials for upcoming Council meetings on their websites.

Highlights of changes that will come into force *upon proclamation*:

- the Minister will have the power to make regulations controlling the composition of statutory committees.
- Funding will be made available to persons who have made complaints or is the subject of a report that alleges sexual abuse, from the time the report or complaint is made.
- Mandatory self-reporting obligations of members related to other regulatory bodies with which they are registered and any findings of professional misconduct or incompetence (but not incapacity) made by those bodies.

With the presentation of the College's financial statements to Council (Agenda item 10), the College completes its 2016-2017 financial audit process. Preparation for the audit occurred throughout April, and all requested materials were provided to the auditor in advance of their on-

site arrival. The audit team from Hilborn conducted their on-site audit during May 2017, and worked closely with the Director of Operations.

As part of the financial audit this year, the Director of Operations trained three members of the Executive Committee on the audit process, providing those members a fulsome understanding of all audit activities, including the materials provided in advance and throughout the audit. This training allowed Committee members to better understand the financial workings of the College, including accrual creation for open professional conduct matters. In addition, the Executive team members met with Hilborn's audit team in-person to ask questions of the lead auditor to inform their usage and completion of the *External Auditor Assessment Tool*.

The 2016-2017 Annual Report is presented to Council in draft (Agenda item 16). Upon the approval of the College's Financial Statements, the Annual Report will be provided to all members and stakeholders, including the Honorable Dr. Eric Hoskins, Minister of Health and Long-Term Care.

Information pertaining to the role of regulatory health colleges during Public Health investigations into IPAC breaches is provided to Council in the form of a separate briefing note attached to this report (Agenda item 13).

## 2. Strategic Priorities

### i. Modernization of Legislation & Regulations

As you are aware, Council approved proposed changes to the General Regulation (Quality Assurance) and the Professional Misconduct Regulation at its March 22, 2017 meeting. The College's formal submission to the Ministry will be made upon the approval of the minutes from that meeting.

Efforts are currently underway to propose changes to the Drug Regulation, the Laboratories Regulation under the *Laboratory and Specimen Collection Centre Licensing Act* and to the *Midwifery Act*. These proposed changes are expected to be brought forward to Council for consideration later in 2017. Proposed changes to the Registration Regulation are ongoing and remain at the Registration Committee level.

### ii. Implementation of Risk-Based Regulation

As demonstrated in the Council agenda, staff in all departments have supported Committees and working groups in bringing forward several important items for discussion or decision. Details and next steps of the Professional Standards for Midwives will be shared with Council in person under agenda items 6. Staff anticipate that the Professional Standards will provide the right amount of regulation based on the core principles of midwifery in Ontario and the goal of ensuring high-level outcomes are achieved by individual midwives. By reducing its focus on the smaller details, the College will support the autonomy of midwives and their knowledge, skills and

judgement. Most of all, it will allow the College to focus on matters that will result in better outcomes for clients in midwifery care.

Staff have also developed a new approach to policy making to ensure that policy decisions are based on a proper evaluation of risk, a solid evidence and a thorough analysis of options and impacts. This process will ensure that regulatory tools are not adopted as the default solution but rather introduced to mitigate risk when other non-regulatory options are unable to deliver the desired results. Details will be shared with Council in person under agenda item 12.

A new data strategy is in development and will be shared with Council when complete. With the implementation of risk-based regulation data is becoming integral to the College as a regulator. It will inform, direct and shape our activities and help us understand where to focus our attention. The strategy will explain how we want to collect and use data in the future, and, recognizing the true scope of the task ahead, our plan for implementation. In the meantime, our policy analyst has initiated a comprehensive review and analysis of past professional conduct matters. Relevant findings will be shared with Council, Committees, members and other stakeholders, as appropriate.

The Quality Assurance department completed a comprehensive review of the College's current Quality Assurance Program (QAP). Details will be shared with Council in person under agenda item 14. A written report, included in the Council package, combines the findings from the focus groups held in the fall of 2016 with the published research, and discusses discrete categories of the current and proposed new QAP with recommendations about how the goals of the program might be best achieved.

The Professional Conduct department is conducting a comprehensive file review to identify areas for process improvement and to establish benchmarks for complaints and Registrar's Investigations processes. Once complete, a report detailing the results and plans for improvement will be shared with ICRC and Council.

### iii. Public Participation & Engagement

The Federation of Health Regulatory Colleges of Ontario (FHRCO) launched a new website designed for the public as a one-stop gateway for patients/clients trying to find information about healthcare professionals. The purpose of the website is to:

- Educate the public about the role of regulatory colleges, the value of regulation, and the importance of a self-regulated system.
- Help drive traffic and engagement to the college websites, where individuals can get more detailed information about a regulated health professional.
- Educate Ontarians about their rights as healthcare consumers.
- Help people find regulated health professionals.

The College posted information and links to the new website in our News section of our website and on Facebook and Twitter. If Council has not already visited the website, please visit www.ontariohealthregulators.ca.

## 3. Stakeholder Engagement

The College is participating in a symposium presentation and a concurrent session at the International Confederation of Midwives Triennial Congress June 18-22, 2017 in Toronto. The Symposium topic is “Midwifery Regulation in Canada: achievements, challenges, and emerging issues”. Our co-presenters include the Canadian Midwifery Regulators’ Council and the College of Midwives of British Columbia. The CMO’s portion will provide detail of the historical and current context for midwifery regulation in Ontario and the College’s recent efforts to achieve and define best practices in professional regulation. The concurrent session, "Quality Assurance Programs: The rationale, the research and the regulations" is based on the recent QAP review, analysis and recommendations. A verbal report on the presentations and congress will be provided at Council.

College staff presented to McMaster and Laurentian Universities Midwifery Education Program students in April. These annual presentations inform midwifery students of the role of the College and the process of applying for registration with the College.

The College continues to meet regularly with stakeholders, including other health Colleges, midwifery sector representatives and the Ministry of Health. On June 22, 2017, the College is hosting an in-person Canadian Midwifery Regulators’ Council Board of Director’s meeting.

## 4. Executive Expectations

### i. Interaction with Registrants and Members of the Public

The College continues to communicate regularly with members and stakeholders through email notifications, quarterly newsletters, annual reports, Twitter and Facebook. In addition, we regularly assist members and stakeholders via email and telephone.

Efforts are underway in preparation for Member Education Day on November 1, 2017. We have plans to conduct regional Member Forums in the early months of 2018 to support the implementation of the new Professional Standards for Midwives.

### ii. Programs and Projects

Online Council elections are underway and will close at 11:59pm on June 30th. There are eight candidates running for three positions.

The database development project continues to evolve and requires leadership by the Director of Operations and additional time and effort by all departments. The database is now equipped to produce required data submissions, including weekly eHealth submissions and annual CIHI and HPDB submissions. The Professional Conduct department has begun to test its secure area for use.

The College continues to act in its role as regulator of the two Ontario Birth Centre facilities and is conducting a review and revision of the Clinical Practice Parameters and Facility Standards. This project requires consultation with the facilities and the Independent Health Facilities Program of the Ministry of Health and Long-Term Care.

On July 1, 2017, successful completion of the College's Jurisprudence Course becomes a registration requirement for all applicants. The course entails a review of the Jurisprudence Handbook, followed by the successful completion of an e-module which includes exam questions.

On May 4th, the College implemented two sittings of the Canadian Midwifery Registration Examination (CMRE) in Toronto and Sudbury. A total of 74 candidates wrote the exam in Ontario. Results Reports have been mailed.

Status updates of other projects can be provided at Council upon request.

### iii. Human Resources

In accordance with our new organizational structure presented to Council in March 2017, all previous vacancies have been filled and we are pleased to introduce Council to two new members of our staff:

- Vivian Simon, Registration Coordinator (contract to March 31, 2018)
- Victoria Marshall, Communication and Events Coordinator

In accordance with Council's governance policy RE7 (Registrar-CEO Expectations: Compensation Administration), the College has contracted Mungall Consulting to assess the salaries and positions within the organization to ensure they are based on fair market value in relation to the assigned tasks and level of responsibility. This work was last accomplished in 2014 and it is considered best practice to re-evaluate approximately every three years.

Ontario

NEWS

Ministry of Health and Long-Term Care

# Ontario Strengthens Laws to Prevent Sexual Abuse of Patients

*Protecting Patients Act Ensures Health and Safety of Patients and Families*

May 30, 2017 1:00 P.M.

Ontario has reinforced its zero tolerance policy on the sexual abuse of patients by any regulated health professional, and implemented new programs and policies to keep people healthy.

The province passed the Protecting Patients Act today, which includes legislative amendments to:

- Expand the list of acts of sexual abuse that will result in the mandatory revocation of a regulated health professional's certificate of registration
- Remove the ability of a health regulatory college to impose restrictions that would allow a regulated health professional to continue practising on patients of a specific gender
- Ensure more timely access to therapy and counselling for patients who make a complaint of sexual abuse by a regulated health professional to a health regulatory college
- Require that more information regarding the current and past conduct of regulated health professionals is available to the public in an easy-to-access and transparent way
- Incorporate feedback from stakeholders, including establishing a higher threshold for when third-party records may be ordered to be produced in discipline hearings involving sexual abuse.

Additional amendments passed today to help people in Ontario stay healthy and safe include:

- Improving the way immunizations are reported, which will help prevent children from being suspended from school for required school immunizations
- Helping parents make informed decisions about immunizing their children if they are considering a non-medical exemption
- Improving and modernizing Elderly Persons Centres to help seniors stay healthy, active and engaged
- Making it easier and more convenient for people to receive coverage under the Ontario Drug Benefit (ODB) Program for prescriptions that are written by nurse practitioners, and in the future, other authorized prescribers for products such as diabetes testing strips and nutritional products
- Continuing to ensure that community laboratory services are safe and effective by updating inspection provisions and streamlining licensing requirements.

Ontario is increasing access to care, reducing wait times and improving the patient experience through its Patients First Action Plan for Health Care and OHIP+: Children and Youth Pharmacare - protecting health care today and into the future.

## QUOTES

" Today marks an important milestone for our government. The passage of this legislation reinforces our commitment to putting patients first and protecting Ontario's health care system for generations to come. The Protecting Patients Act will help ensure that people in Ontario remain healthy and safe."
- Dr. Eric Hoskins
Minister of Health and Long-Term Care

" We commend the government on the passage of the Protecting Patients Act. This legislation is an important step in protecting patients and supporting survivors of sexual abuse. We look forward to working with the government to implement recommendations from To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act."
- Farrah Khan and Sly Castaldi, co-chairs of Ontario's Roundtable on Violence Against Women and Sheila Macdonald, member of Ontario's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act

## QUICK FACTS

- With the passage of the Protecting Patients Act, the government is able to make legislative amendments to several statutes that will ensure that patients in Ontario are healthy and safe.
- Ontario's health care budget will total $53.8 billion in 2017–18 — a 3.8 per cent increase from the previous year.
- As part of the 2017 Budget, Ontario is providing $8 million over the next three years to allow for an additional 40 new Elderly Persons Centres by 2018–19, to meet the growing needs of seniors and help support some of Ontario's most vulnerable populations.

## LEARN MORE

- Patients First: Action Plan for Health Care
- Patients First: Action Plan for Health Care Year Two Results
- Elderly Persons Centres
- To Zero: Independent Report of the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act

---

**Available Online**
**Disponible en Français**

# COLLEGE OF MIDWIVES OF ONTARIO

FINANCIAL STATEMENTS

MARCH 31, 2017

HILBORN LLP

HILBORN LLP

## Independent Auditor's Report

To the Council of the
**College of Midwives of Ontario**

We have audited the accompanying financial statements of the College of Midwives of Ontario, which comprise the statement of financial position as at March 31, 2017, and the statements of operations, changes in net assets and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

*Management's Responsibility for the Financial Statements*
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian accounting standards for not-for-profit organizations, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

*Auditor's Responsibility*
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the organization's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the organization's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

*Opinion*
In our opinion, the financial statements present fairly, in all material respects, the financial position of the College of Midwives of Ontario as at March 31, 2017, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Toronto, Ontario
To be determined

Chartered Professional Accountants
Licensed Public Accountants

# COLLEGE OF MIDWIVES OF ONTARIO

## Statement of Financial Position

| March 31 | 2017<br>$ | 2016<br>$ |
|---|---|---|
| **ASSETS** | | |
| Current assets | | |
| Cash and cash equivalents (note 4) | **1,792,539** | 1,139,898 |
| Accounts receivable (note 5) | **2,574** | 184,057 |
| Prepaid expenses | **33,542** | 60,754 |
| | **1,828,655** | 1,384,709 |
| Capital assets (note 6) | **199,284** | 241,521 |
| | **2,027,939** | 1,626,230 |
| **LIABILITIES** | | |
| Current liabilities | | |
| Accounts payable and accrued liabilities (note 8) | **172,266** | 212,041 |
| Deferred registration fees | **770,493** | 693,020 |
| Deferred project funding (note 9) | **11,800** | 11,800 |
| | **954,559** | 916,861 |
| Deferred lease incentives (note 12) | **64,632** | 76,563 |
| | **1,019,191** | 993,424 |
| **NET ASSETS** | | |
| Invested in capital and intangible assets | **165,855** | 201,921 |
| Internally restricted for therapy and counselling (note 14) | **10,000** | 10,000 |
| Unrestricted | **832,893** | 420,885 |
| | **1,008,748** | 632,806 |
| | **2,027,939** | 1,626,230 |

The accompanying notes are an integral part of these financial statements

Approved on behalf of the Council:

President

Vice-President

# COLLEGE OF MIDWIVES OF ONTARIO

## Statement of Operations

| Year ended March 31 | 2017<br>$ | 2016<br>$ |
|---|---|---|
| Revenues | | |
| Government grant - operations (notes 2 and 10) | **840,293** | 840,500 |
| Government grant - project funding (notes 2 and 9) | **95,155** | 206,815 |
| Government grant - capital asset funding (note 11) | **-** | 5,578 |
| Registration fees | **1,525,774** | 1,381,995 |
| Administration and other fees | **47,742** | 52,820 |
| | **2,508,964** | 2,487,708 |
| Expenses | | |
| Salaries and benefits | **1,244,996** | 1,084,841 |
| Professional fees | **99,946** | 93,917 |
| Council and committees | **151,896** | 167,265 |
| Office and general | **134,747** | 176,496 |
| Rent and utilities (note 12) | **156,687** | 122,541 |
| Quality assurance program | **3,355** | 44,944 |
| Investigations and hearings | **59,894** | 119,446 |
| Membership dues and fees | **29,948** | 26,706 |
| Information and communications technology | **112,320** | 117,517 |
| Birth Centres (note 9) | **95,155** | 174,650 |
| eHealth Ontario (note 9) | **-** | 32,165 |
| Amortization | **44,078** | 24,826 |
| | **2,133,022** | 2,185,314 |
| Excess of revenues over expenses before the following | **375,942** | 302,394 |
| Loss on disposal of capital assets (note 6) | **-** | (5,442) |
| Loss on disposal of intangible assets (note 7) | **-** | (6,250) |
| Intubation course revenue (note 13) | **-** | 138,114 |
| Intubation course expenses (note 13) | **-** | (89,045) |
| | **-** | 37,377 |
| Excess of revenues over expenses for the year | **375,942** | 339,771 |

The accompanying notes are an integral part of these financial statements

# COLLEGE OF MIDWIVES OF ONTARIO

## Statement of Changes in Net Assets

Year ended March 31

| | Invested in capital and intangible assets $ | Internally restricted for therapy and counselling *(note 14)* $ | Unrestricted $ | 2017 Total $ |
|---|---|---|---|---|
| Balance, beginning of year | 201,921 | 10,000 | 420,885 | **632,806** |
| Excess of revenues over expenses (expenses over revenues) for the year | (37,907) | - | 413,849 | **375,942** |
| Purchase of capital assets | 1,841 | - | (1,841) | **-** |
| Balance, end of year | 165,855 | 10,000 | 832,893 | **1,008,748** |

| | Invested in capital and intangible assets $ | Internally restricted for therapy and counselling *(note 14)* $ | Unrestricted $ | 2016 Total $ |
|---|---|---|---|---|
| Balance, beginning of year | 48,166 | 10,000 | 234,869 | 293,035 |
| Excess of revenues over expenses (expenses over revenues) for the year | (27,340) | - | 367,111 | 339,771 |
| Purchase of capital assets, net of tenant inducements | 181,095 | - | (181,095) | - |
| Balance, end of year | 201,921 | 10,000 | 420,885 | 632,806 |

The accompanying notes are an integral part of these financial statements

# COLLEGE OF MIDWIVES OF ONTARIO

## Statement of Cash Flows

| Year ended March 31 | 2017<br>$ | 2016<br>$ |
|---|---|---|
| Cash flows from operating activities | | |
| Excess of revenues over expenses for the year | **375,942** | 339,771 |
| Adjustments to determine net cash provided by (used in) operating activities | | |
| Government grant - operations | **(840,293)** | (840,500) |
| Government grant - project funding | **(95,155)** | (206,815) |
| Government grant - capital asset funding | **-** | (5,578) |
| Amortization | **44,078** | 24,826 |
| Loss on disposal of capital assets | **-** | 5,442 |
| Loss on disposal of intangible assets | **-** | 6,250 |
| Lease incentives - free rent benefits | **-** | 40,323 |
| Amortization of deferred lease incentives | **(11,931)** | (6,960) |
| | **(527,359)** | (643,241) |
| Change in non-cash working capital items | | |
| Decrease (increase) in accounts receivable | **6,833** | (9,087) |
| Decrease (increase) in prepaid expenses | **27,212** | (29,878) |
| Decrease in accounts payable and accrued liabilities | **(39,775)** | (53,081) |
| Increase in deferred registration fees | **77,473** | 74,328 |
| Decrease in deferred course fees | **-** | (74,763) |
| | **(455,616)** | (735,722) |
| Cash flows from investing activities | | |
| Purchase of capital assets | **(1,841)** | (224,295) |
| Receipt of lease incentives - tenant inducements | **-** | 43,200 |
| | **(1,841)** | (181,095) |
| Cash flows from financing activities | | |
| Receipt of government grant - operations | **840,293** | 840,500 |
| Receipt of government grant - project funding | **269,805** | 32,165 |
| Repayment of amounts due to the Ontario Ministry of Health and Long-Term Care | **-** | (275,116) |
| | **1,110,098** | 597,549 |
| Net change in cash and cash equivalents | **652,641** | (319,268) |
| Cash and cash equivalents, beginning of year | **1,139,898** | 1,459,166 |
| Cash and cash equivalents, end of year | **1,792,539** | 1,139,898 |

The accompanying notes are an integral part of these financial statements

March 31, 2017

**Nature and description of the organization**

The College of Midwives of Ontario ("College") was incorporated as a non-share capital corporation under the Regulated Health Professions Act, 1991 ("RHPA"). As the regulator and governing body of the midwifery profession in Ontario, the College's major function is to administer the Midwifery Act, 1991 in the public interest.

The College is a not-for-profit organization, as described in Section 149(1)(l) of the Income Tax Act, and therefore is not subject to income taxes.

1. **Significant accounting policies**

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations and include the following significant accounting policies:

(a) **Revenue recognition**

**Contributions**

The College follows the deferral method of accounting for contributions.

Restricted contributions, including funding received from the Ontario Ministry of Health and Long-Term Care and eHealth Ontario, are deferred and recognized as revenue in the year in which the related expenses are incurred.

**Registration fees**

Registration fees are recognized as revenue proportionately over the fiscal year to which they relate. The registration year of the College is October 1 to September 30. Registration fees received in advance of the registration year to which they relate are recorded as deferred registration fees.

**Administration and other fees**

Administration and other fees are recognized as revenue when the service is rendered.

(b) **Cash and cash equivalents**

Cash and cash equivalents consist of cash and guaranteed investment certificates which are readily convertible into cash, are not subject to significant risk of changes in value and have a maturity date of twelve months or less from the date of acquisition.

March 31, 2017

1. **Significant accounting policies (continued)**

(c) **Capital assets**

The costs of capital assets are capitalized upon meeting the criteria for recognition as a capital asset, otherwise, costs are expensed as incurred. The cost of a capital asset comprises its purchase price and any directly attributable cost of preparing the asset for its intended use.

Capital assets are measured at cost less accumulated amortization and accumulated impairment losses.

Amortization is provided for, upon commencement of the utilization of the assets, using methods and rates designed to amortize the cost of the capital assets over their estimated useful lives. The methods and annual amortization rates are as follows:

| | |
|---|---|
| Office equipment | 20% declining balance |
| Computer equipment | 20% - 30% declining balance |

Amortization of leasehold improvements is recorded on a straight-line basis over the remaining term of the respective lease.

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. If any potential impairment is identified, the amount of the impairment is quantified by comparing the carrying value of the capital asset to its fair value. Any impairment of the capital asset is charged to income in the year in which the impairment occurs.

An impairment loss is not reversed if the fair value of the capital asset subsequently increases.

March 31, 2017

1. **Significant accounting policies (continued)**

(d) **Intangible assets**

The costs of intangible assets are capitalized upon meeting the criteria for recognition as an intangible asset, with the exception of expenditures on internally generated intangible assets during the development phase, which are expensed as incurred. The cost of a separately acquired intangible asset comprises its purchase price and any directly attributable cost of preparing the asset for its intended use.

Intangible assets are measured at cost less accumulated amortization and accumulated impairment losses.

Amortization is provided for, upon commencement of the utilization of the assets, on a declining balance basis at rates designed to amortize the cost of the intangible assets over their estimated useful lives. The annual amortization rate is as follows:

| | |
|---|---|
| Computer application software | 30% declining balance |

An intangible asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. If any potential impairment is identified, then the amount of the impairment is quantified by comparing the carrying value of the intangible asset to its fair value. Any impairment of the intangible asset is charged to income in the year in which the impairment occurs.

An impairment loss is not reversed if the fair value of the intangible asset subsequently increases.

(e) **Net assets invested in capital and intangible assets**

Net assets invested in capital and intangible assets comprises the net book value of capital and intangible assets less the unamortized balance of deferred tenant inducements used to purchase capital assets.

(f) **Deferred lease incentives**

Lease incentives received include free rent benefits and tenant inducements received in cash.

Lease incentives received in connection with original leases are amortized to income on a straight-line basis over the terms of the original leases. Lease incentives received in connection with re-negotiated leases are amortized to income on a straight-line basis over the period from the expiration date of the original lease to the expiration date of the re-negotiated lease.

March 31, 2017

1. **Significant accounting policies (continued)**

(g) **Financial instruments**

**Measurement of financial assets and liabilities**

The College initially measures its financial assets and financial liabilities at fair value adjusted by the amount of transaction costs directly attributable to the instrument.

The College subsequently measures all its financial assets and financial liabilities at amortized cost.

Amortized cost is the amount at which a financial asset or financial liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization of any difference between that initial amount and the maturity amount, and minus any reduction for impairment.

Financial assets measured at amortized cost include cash and cash equivalents and accounts receivable.

Financial liabilities measured at amortized cost include accounts payable and accrued liabilities.

**Impairment**

At the end of each reporting period, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. Objective evidence of impairment includes observable data that comes to the attention of the College, including but not limited to the following events: significant financial difficulty of the issuer; a breach of contract, such as a default or delinquency in interest or principal payments; and bankruptcy or other financial reorganization proceedings.

When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the year in the expected timing or amount of future cash flows from the financial asset.

When the College identifies a significant adverse change in the expected timing or amount of future cash flows from a financial asset, it reduces the carrying amount of the financial asset to the greater of the following:

- the present value of the cash flows expected to be generated by holding the financial asset discounted using a current market rate of interest appropriate to the financial asset; and

- the amount that could be realized by selling the financial asset at the statement of financial position date.

March 31, 2017

1. **Significant accounting policies (continued)**

(g) **Financial instruments (continued)**

**Impairment (continued)**

Any impairment of the financial asset is charged to income in the year in which the impairment occurs.

When the extent of impairment of a previously written-down financial asset decreases and the decrease can be related to an event occurring after the impairment was recognized, the previously recognized impairment loss is reversed to the extent of the improvement, but not in excess of the impairment loss. The amount of the reversal is recognized in income in the year the reversal occurs.

(h) **Management estimates**

The preparation of financial statements in conformity with Canadian accounting standards for not-for-profit organizations requires management to make judgments, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the current year. Actual results may differ from these estimates, the impact of which would be recorded in future years.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

2. **Economic dependence**

The College is dependent upon the provision of government grants from the Ontario Ministry of Health and Long-Term Care. Without these government grants, the College would be unable to meet the terms of its mandate.

3. **Financial instrument risk management**

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the College's risk exposure and concentrations.

The financial instruments of the College and the nature of the risks to which those instruments may be subject are as follows:

| | Risks | | | | |
|---|---|---|---|---|---|
| | | | Market risk | | |
| Financial instrument | Credit | Liquidity | Currency | Interest rate | Other price |
| Cash and cash equivalents | X | | | X | |
| Accounts receivable | X | | | | |
| Accounts payable and accrued liabilities | | X | | | |

3. **Financial instrument risk management (continued)**

**Credit risk**

The College is exposed to credit risk resulting from the possibility that parties may default on their financial obligations, or if there is a concentration of transactions carried out with the same party, or if there is a concentration of financial obligations which have similar economic characteristics that could be similarly affected by changes in economic conditions, such that the College could incur a financial loss. The College does not hold directly any collateral as security for financial obligations of counterparties.

The maximum exposure of the College to credit risk is as follows:

| | 2017<br>$ | 2016<br>$ |
|---|---|---|
| Cash and cash equivalents | 1,792,539 | 1,139,898 |
| Accounts receivable | 2,574 | 184,057 |
| | 1,795,113 | 1,323,955 |

The College reduces its exposure to the credit risk of cash and cash equivalents by maintaining balances with a Canadian financial institution.

**Liquidity risk**

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due.

The College meets its liquidity requirements by preparing and monitoring detailed forecasts of cash flows from operations and anticipated investing and financing activities and holding assets that can be readily converted into cash.

**Market risk**

Market risk is the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk is comprised of currency risk, interest rate risk and other price risk.

**Currency risk**

Currency risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in foreign exchange rates.

The College is not exposed to currency risk.

3. **Financial instrument risk management (continued)**

**Interest rate risk**

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instrument will fluctuate due to changes in market interest rates.

The College is exposed to interest rate risk on its cash and cash equivalents.

The College does not use derivative financial instruments to manage its exposure to interest rate risk.

**Other price risk**

Other price risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate because of changes in market prices (other than those arising from currency risk or interest rate risk), whether those changes are caused by factors specific to the individual instrument or its issuer or factors affecting all similar instruments traded in the market.

The College is not exposed to other price risk.

**Changes in risk**

There have been no significant changes in the risk profile of the financial instruments of the College from that of the prior year.

4. **Cash and cash equivalents**

| | 2017<br>$ | 2016<br>$ |
|---|---|---|
| Cash | 1,491,889 | 838,898 |
| Guaranteed investment certificate - 0.65%, 11/30/2017 | 300,650 | - |
| Guaranteed investment certificate - 1.00%, 11/30/2016 | - | 301,000 |
| | 1,792,539 | 1,139,898 |

5. **Accounts receivable**

| | 2017<br>$ | 2016<br>$ |
|---|---|---|
| Project funding receivable from the Ontario Ministry of Health and Long-Term Care (note 9) | - | 174,650 |
| Other receivables | 2,574 | 9,407 |
| | 2,574 | 184,057 |

## 6. Capital assets

| | Cost $ | Accumulated Amortization $ | 2017 Net $ |
|---|---|---|---|
| Office equipment | 60,814 | 44,205 | 16,609 |
| Computer equipment | 55,302 | 30,812 | 24,490 |
| Leasehold improvements | 201,327 | 43,142 | 158,185 |
| | 317,443 | 118,159 | 199,284 |

| | Cost $ | Accumulated Amortization $ | 2016 Net $ |
|---|---|---|---|
| Office equipment | 60,814 | 40,053 | 20,761 |
| Computer equipment | 53,461 | 19,647 | 33,814 |
| Leasehold improvements | 201,327 | 14,381 | 186,946 |
| | 315,602 | 74,081 | 241,521 |

Computer equipment with a cost of $17,871 and accumulated amortization of $12,429 was disposed of during the prior year. A loss on disposal of $5,442 is recorded in the comparative statement of operations.

## 7. Loss on disposal of intangible assets

Computer application software with a cost of $33,306 and accumulated amortization of $27,056 was disposed of during the prior year. A loss on disposal of $6,250 is recorded in the comparative statement of operations.

## 8. Accounts payable and accrued liabilities

| | 2017 $ | 2016 $ |
|---|---|---|
| Trade payables and accrued liabilities | 74,419 | 75,536 |
| Accrued liabilities - investigations and hearings | 97,847 | 136,505 |
| | 172,266 | 212,041 |

March 31, 2017

9. **Deferred project funding**

The College previously received special project funding from the Ontario Ministry of Health and Long-Term Care to promote changes to narcotics regulation in order to ensure its members are able to perform their duties adequately.

Health Canada's Office of Controlled Drugs and Substances has authorized the provincial government to confer midwives with the authority to prescribe narcotics. The work related to the proposed narcotics regulation is planned for fiscal 2018.

The College receives special project funding from the Ontario Ministry of Health and Long-Term Care to develop and implement a quality assurance program for Birth Centres.

In the prior year, the College received special funding from eHealth Ontario to implement data acquisition support to the provider registry.

| | Narcotics Regulation $ | Birth Centres $ | eHealth Ontario $ | 2017 Total $ |
|---|---|---|---|---|
| Deferred project funding, beginning of year | 11,800 | - | - | 11,800 |
| Project funding received during the year | - | 95,155 | - | 95,155 |
| Project funding recognized as revenue in the year | - | (95,155) | - | (95,155) |
| Deferred project funding, end of year | 11,800 | - | - | 11,800 |

| | Narcotics Regulation $ | Birth Centres $ | eHealth Ontario $ | 2016 Total $ |
|---|---|---|---|---|
| Deferred project funding, beginning of year | 11,800 | - | - | 11,800 |
| Project funding received during the year | - | - | 32,165 | 32,165 |
| Project funding receivable (note 5) | - | 174,650 | - | 174,650 |
| Project funding recognized as revenue in the year | - | (174,650) | (32,165) | (206,815) |
| Deferred project funding, end of year | 11,800 | - | - | 11,800 |

## 10. Due to the Ontario Ministry of Health and Long- Term Care

| | 2017 $ | 2016 $ |
|---|---|---|
| Due to the Ontario Ministry of Health and Long-Term Care, beginning of year | - | 275,116 |
| Grant monies received during the year from the Ontario Ministry of Health and Long-Term Care to fund the operations of the College | 840,293 | 840,500 |
| Grant monies required to fund the operations of the College | (840,293) | (840,500) |
| Grant monies repaid during the year | - | (275,116) |
| Due to the Ontario Ministry of Health and Long-Term Care, end of year | - | - |

## 11. Government grant - capital asset funding

During the prior year, the project for which funded capital assets were designated for was discontinued. The capital assets were transferred to the College for use its normal operations. The remaining deferred funding was fully recognized as revenue in the prior year.

## 12. Deferred lease incentives

Pursuant to the lease agreement for the College's office premises, effective April 22, 2015, lease incentives totaling $83,523, comprised of tenant inducements of $43,200 and free rent benefits of $40,323 were received.

During the year, amortization of lease incentives in the amount of $11,931 (2016 - $6,960) was credited to rent and utilities expense.

| | Cost $ | Accumulated Amortization $ | 2017 Net $ |
|---|---|---|---|
| Tenant inducements | 43,200 | 9,771 | 33,429 |
| Free rent benefits | 40,323 | 9,120 | 31,203 |
| | 83,523 | 18,891 | 64,632 |

| | Cost $ | Accumulated Amortization $ | 2016 Net $ |
|---|---|---|---|
| Tenant inducements | 43,200 | 3,600 | 39,600 |
| Free rent benefits | 40,323 | 3,360 | 36,963 |
| | 83,523 | 6,960 | 76,563 |

13. **Intubation course**

On January 30, 2015, the regulation authorizing midwives to perform neonatal intubation was approved by the Ontario Ministry of Health and Long-Term Care. As a result of the new regulation, the College mandated that all its existing members attend an intubation training course.

Upon the completion of training existing members in the prior year, the College discontinued the training course. Intubation training is an education requirement for membership into the College and has been incorporated into the curriculum of training schools.

Course fees received from members and associated training costs are recorded separately in the comparative statement of operations.

14. **Net assets internally restricted for therapy and counselling**

The internal restriction represents monies restricted for the purposes of funding therapy and counselling for midwifery clients as directed under the RHPA.

15. **Commitment**

The College is committed to lease its office premises until August 2022. The future annual lease payments, including an estimate of premises common area expenses, are as follows:

| | $ |
|---|---|
| 2018 | 169,371 |
| 2019 | 172,822 |
| 2020 | 186,233 |
| 2021 | 187,151 |
| 2022 | 187,151 |
| Subsequent years | 77,978 |
| | 980,706 |


LISTENERS. THINKERS. DOERS.

401 Bay Street · Suite 3100 · P.O. Box 49 · Toronto · ON · CA · M5H 2Y4 · P416-364-1359 · F416-364-9503 · hilborn.ca.com

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# Annual & Comprehensive Assessment of the External Auditor by the Executive Committee[1]

Document Approved by Executive Committee: _____

[1] The tools and templates provided by the Chartered Professional Accountants of Canada (CPA) to businesses looking to conduct both annual and comprehensive audits were used as the base to create this tool.

# Table of Contents

# Introduction

The Executive Committee of the College of Midwives conducts both an Annual Assessment of the external auditor prior to reappointment, and a Comprehensive Audit Assessment in place of an Annual Assessment every five years (at minimum).[2] Assessments are conducted to align with best practices as laid out under the Enhanced Audit Quality Initiative put forward by the Chartered Professional Accountants of Canada (CPA). This process allows the Committee to produce quality improvement recommendations for the external auditor annually, recommend the auditor for tender or reappointment periodically, as well as note any concerns.

It should be noted that the Annual Assessment's purpose is to help the Committee identify areas for improvement for the audit firm, and not to decide if the auditor should be put forward for reappointment or tender. In the event that the Committee finds real concerns, they could choose to recommend tender early, but normally this would be a decision made at the time of the Comprehensive Assessment.

Following the Comprehensive Assessment the Executive Committee will either reassure Council of the quality and objectivity of the incumbent auditor and put that firm forward for re-appointment, or offer Council the recommendation that they should procure a new external auditor.

# Timelines

The annual audit takes place in May each year. The financial statements are presented for approval to the Council at their June meeting. After presentation of the statements the Executive Committee is in a position to reflect on the audit process and decide on its quality and objectivity. The Executive Committee should begin either the annual or Comprehensive Assessment process at their January/February Executive meeting with the goal of sharing with Council their recommendation at Council's October/November meeting. In the event that it is not recommended that the auditor be reappointed, this allows enough time for a procurement process to be undertaken to secure a new auditor in advance of the annual audit in May.

[2] It should be noted that the Comprehensive Assessment could be conducted earlier than every five years if the Executive Committee determines it is necessary to do a more fulsome assessment. Reasons might include a major change in corporate structure or a poor auditor assessment in the previous year.

## Annual Schedule

| TIME | DELIVERABLE |
|---|---|
| **Jan/Feb Executive Meeting** | At this meeting the Executive Committee will review the previous year's assessment and decide if any changes / altered focus is required in the current year's assessment. The Committee will determine if they will require any additional meetings with the auditor outside of the June Executive Meeting, and will determine if the Committee Chair should be present for any part of the audit. Staff will be directed to set meetings and create schedules as required. |
| **September Executive Meeting** | The formal assessment begins. The Executive will determine if meetings with either the auditor or staff are required and will request those meetings. If not, then they will distribute surveys and set deadlines for the feedback. |
| **October/November Executive Meeting** | The Committee will review all materials and create a report for Council. They will also determine their recommendation to Council on the upcoming years assessment (will it be the standard Annual Assessment or the Comprehensive Assessment). If recommendations are being made to the auditor or staff they will need to be delivered to the appropriate party after the meeting. |
| **October/November Council Meeting** | Executive presents their summary report and (in the event of a comprehensive audit) their recommendation. They will also inform Council of the recommended assessment structure for the following year (annual or Comprehensive Assessment). Council approves the recommended assessment choice for the following year, and either reappoints the auditor or decides to go to tender to find a new auditor. |

**ADDITIONAL NOTES REGARDING THE SCHEDULE:**

- The Executive Committee may require additional meetings to complete the work, these can be in addition to the schedule above.
- The Committee Chair plays a key role in assisting the Committee follow an appropriate process for the Annual Assessment. The Chair may opt to visit the College during the audit process or ask questions in advance of the initial Committee meeting so that they could guide the Committee on any changes in process or scope needed for the assessment.
- To ensure that all views are considered the Committee may wish to finalize their assessment during group discussions (as opposed to collecting comments separately) during a formal Committee meeting.

# Assessment Goals

As stated by the CPA tools for external auditor assessment, the assessment tools should assess three key factors[3]:

1. **Independence, objectivity and professional skepticism** – Do the auditors approach their work with objectivity to ensure they appropriately question and challenge management's assertions in preparing the financial statements?
2. **Quality of the audit team** – Does the audit firm put forward team members with the appropriate industry and technical skills to carry out an effective audit?
3. **Quality of communications and interactions with the external auditor** – Are the communications with the external auditor (written and oral) clear? Is the auditor open and frank, particularly in areas of significant judgments and estimates or when initial views differ from management?

# Assessment Elements

The Annual Assessment will consist of the following elements:

1) Survey(s) distributed to the Director of Operations and/or Registrar
2) Executive Committee Analysis
3) Observation of the Auditor's performance during Executive and Committee meetings. There is the option to observe part of the audit itself, and Executive would decide if this was necessary at the January/February Committee meeting.
4) Discussions with the auditor (as required)
5) Any other elements/processes that the Executive Committee deems necessary
6) Recommendation report prepared for Council (staff support will be provided for this)
7) Report to Council

The Comprehensive Assessment will consist of the following elements:

1) Survey(s) distributed to the Director of Operations and/or Registrar
2) Executive Committee Analysis
3) Observation of the Auditor's performance during Executive and Committee meetings. There is the option to observe part of the audit itself, and Executive would decide if this was necessary at the January/February Committee meeting.
4) Discussions with the Auditor (as required) and Auditor Feedback Survey
5) Any other elements/processes that the Executive Committee deems necessary
6) Recommendation report prepared for Council (staff support will be provided for this)
7) Council reappoints the auditor or goes to tender

[3] These details were taken directly (with one or two small language changes) from the "Annual Assessment of the External Auditor Tool (Jan 2014) available on the website of the Chartered Professional Accounts of Canada (CPA).

# Annual Assessment Process

## 1. Determine the scope, timing and process

Before proceeding with the Annual Assessment, the Executive Committee should review the process to ensure that no alterations are required for the current year's audit. If changes are required to the Annual Assessment they should be made before the assessment is undertaken. Changes can be suggested at the January/February Committee meeting after the document review, and staff can be engaged to make the required changes and send the revised document to the Committee members.

Guiding questions:

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| Have there been significant changes in the organization that require changes to the assessment process this year?[4] | |
| Do the results of the prior-year's assessment indicate areas that should be given particular focus this year? | |
| What additional information from the College is needed to help the Executive Committee conduct the assessment? | |
| What information, if any, from the auditor is needed to help the Executive Committee conduct the assessment (e.g., future changes to the audit team)? | |
| What changes need to be made to other sections of this tool to reflect the approach to this year's Annual Assessment? | |

These determinations are key drivers for conducting an assessment process.

[4] Note that it may be appropriate to conduct a Comprehensive Assessment rather than an Annual Assessment of the external auditor, for example, if significant issues have already been identified, or if another triggering event has occurred, such as a change in the College's corporate structure that could affect financial oversight (e.g. the Director of Operations leaves and a new system is put in place, or the Registrar leaves etc.).

## 2. Obtain Input from College Personnel

This section of the tool includes a number of questions the Executive Committee may want to ask College personnel, such as the Registrar and the Director of Operations. The Executive Committee needs to determine whether they wish to obtain input in writing or through discussions.

**QUESTIONS FOR COLLEGE PERSONNEL (Normally the Registrar and/or Director of Operations)**

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| **RE: INDEPENDENCE, OBJECTIVITY & PROFESSIONAL SKEPTICISM** | |
| How does the external auditor demonstrate integrity, objectivity and professional skepticism, (e.g. by maintaining a respectful but questioning approach throughout the audit)? | |
| How does the external auditor demonstrate independence (e.g. by proactively discussing independence matters and reporting exceptions to its compliance with independence requirements)? | |
| How were significant differences in views, if any, between management and the external auditor resolved? | |
| How did the external auditor adjust the audit plan to respond to changing risks and circumstances? | |
| How forthright is the external auditor in dealing with difficult situations (e.g. by proactively identifying, communicating and resolving technical issues)? | |
| To what extent do you have concerns about the relationship between the external auditor and College personnel that might affect the external auditor's independence, objectivity or professional skepticism? | |
| The auditor and the audit team should have performed risk assessment at the outset of the audit including assessment of fraud risk. Conclude if this process was followed. | |
| **RE: QUALITY OF AUDITOR AND HIS/HER STAFF** | |

| | |
|---|---|
| How would you assess the technical competence and ability of the external auditor to translate knowledge into practice (e.g. by using technical knowledge and independent judgment to provide realistic analysis of issues and by providing appropriate levels of competence across the team)? | |
| How would you assess the external auditor's understanding of our business and industry (e.g. by demonstrating an understanding of our specific business risks, processes, systems and operations)? | |
| How sufficient are resources assigned by the external auditor to complete work in a timely manner (e.g. by providing access to specialized expertise during the audit and assigning additional resources to the audit as necessary to complete work in a timely manner)? | |
| **RE: COMMUNICATION AND INTERACTION WITH THE EXTERNAL AUDITOR** | |
| How candid and complete was the dialogue between the auditor and management? How well did the auditor explain accounting and auditing issues? | |
| How effectively does the auditor provide timely and informative communications about accounting and other relevant developments? | |
| How does the external auditor communicate about matters affecting the College or its reputation? | |
| Provide your overall views on how your relationship with the external auditor contributed to your ability to produce reliable financial reporting throughout the assessment period. | |
| **RE: QUALITY OF SERVICE CONSIDERATIONS** | |
| To what extent is the external auditor effective in completing the audit on a timely basis? | |
| To what extent does the external auditor keep management informed about the progress of the audit and difficulties encountered? | |

| | |
|---|---|
| To what extent has the Auditor and his/her team maintained a respectful and professional attitude during the audit? | |
| To what extent is the external auditor proactive in identifying information requirements and timely in requesting information from management? | |
| **OTHER INPUT REQUESTED FROM STAFF** | |
| | |

## 3. Executive Committee Analysis

This section should be completed by the Executive Committee, either individually, or as a group. The meeting with the auditor at the May/June Committee meeting will help inform this section of the document.

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| **RE: INDEPENDENCE, OBJECTIVITY & PROFESSIONAL SKEPTICISM** | |
| Does the external auditor either confirm their independence or inform the Executive Committee about matters that might reasonably be thought to compromise their independence? | |
| Did the staff and auditor follow the Policy for Awarding Non-Audit Work to the External Auditor. | |
| How did the external auditor adjust the audit plan to respond to changing risks and circumstances? | |
| What steps does the auditor take to ensure that their staff exhibits the values, ethics and attitudes necessary to support a quality audit? | |
| If Executive is aware of any significant differences in views between management and the external auditor resolved? | |
| What evidence is there that the audit team challenges decisions made by management in preparing the financial statements? | |

| | |
|---|---|
| How would you assess the quality of the significant professional judgments made by the auditor? | |
| **RE: COMMUNICATION AND INTERACTION WITH THE EXTERNAL AUDITOR** | |
| How candid and complete was the dialogue between the auditor, the Executive Committee and/or the Executive Committee chair? How well did the auditor explain accounting and auditing issues? | |
| How would you assess the external auditor's discussion about the quality of the College's financial reporting, including the reasonableness of accounting estimates and judgments, appropriateness of the accounting policies and adequacy of the disclosures? | |
| What is your assessment of how the external auditor discussed sensitive issues (e.g. were concerns about management's reporting processes, internal control over financial reporting or the quality of the College's financial management team discussed in a timely, candid and professional manner)? | |
| How promptly did the auditor alert the Executive Committee if they did not receive sufficient cooperation from staff? | |
| How well did the external auditor inform the Executive Committee of current developments in accounting and auditing standards relevant to the College's financial statements and their potential impact on the audit? | |
| How does the audit firm provide continuity of team members and perform an orderly transition when key members of the team change? | |
| **RE: QUALITY OF SERVICE CONSIDERATIONS** | |
| During the audit, how well did the external auditor meet the agreed-upon performance criteria (e.g. by meeting agreed-upon performance delivery, being available and accessible to management and the Executive Committee?) | |
| How did the auditor and audit team ensure that | |

| | |
|---|---|
| the necessary knowledge and skills (College-specific, industry, accounting, auditing) were dedicated to the audit? | |
| How would you assess the professionalism of the auditor? | |
| How proactive is the external auditor in identifying opportunities and risks, (e.g by anticipating and providing insights and approaches for potential business issues and improving internal controls)? | |
| How would you assess the value for money delivered by the external audit (e.g. do the audit fees fairly reflect the cost of the services provided given the size, complexity and risks of the College and a cost-effective quality audit)? | |
| **OTHER INPUT REQUESTED FROM THE EXECUTIVE** | |
| | |
| | |
| | |

## 4. Conclude the Annual Assessment and Communicate Results

Conclude on the results of the Annual Assessment and prepare a summary report for Council. The summary report should include a recommendation on whether the next year's assessment should be an Annual or Comprehensive Assessment.

**Points to consider:**

- Has sufficient information been obtained to allow the Executive to reach a conclusion and consider the assessment complete? If the preliminary results of the assessment are not satisfactory, the Committee may need to perform further due diligence to determine whether it's preliminary conclusions are justified and to consult with those affected by its recommendations.

1. What recommendations for action should be made to the Council? These would include:
    - Recommendation for the following year's audit assessment type (annual or comprehensive)

- Recommendation to reappoint the auditor or go to tender (in year's where a Comprehensive Assessment took place)
- Any recommended changes to assessment procedures (as needed)

2. Does the Committee need to formally discuss the results of the assessment with the Council or will a written report suffice?

**Record items to be raised with the auditor for follow-up or future changes:**

| ITEM | PERSON RESPONSIBLE FOR FOLLOW-UP |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Potential future changes to the Annual Assessment, Comprehensive Assessment, or Executive Committee Process:**

| POTENTIAL CHANGE | PERSON RESPONSIBLE FOR FOLLOW-UP |
|---|---|
| | |
| | |
| | |
| | |
| | |

The Executive team needs to be sure they share necessary feedback with the necessary parties. As a rule the Chair of the Committee will lead on this dissemination of information.

The Committee may opt to meet with staff and the audit firm jointly to discuss actions that the audit firm and management need to take jointly to address Committee concerns and any inconsistencies between input obtained from the audit firm and the staff.

# Comprehensive Assessment Process

The Comprehensive Assessment assumes that the Committee has conducted robust Annual Assessments of the external auditor in the previous years. The Comprehensive Assessment includes all processes included in the Annual Assessment as well as the additional assessment elements discussed in these pages. This assessment would cover not just the previous year's audit but would also review all audits that underwent annual assessments since the last comprehensive assessment.

It should be noted that the Executive Committee is responsible for determining the scope, timing and process for the Comprehensive Assessment and not staff or the auditor. Although the staff and the auditor contribute, the process belongs to the Executive Committee. A Comprehensive Assessment should be conducted at least every five years.

As part of the Comprehensive Assessment process the Executive Committee should look for the external auditor to identify any threats to independence and describe safeguards they have put in place. Some factors to consider would be:

(a) Number of years the audit firm has served as external auditor
(b) Length of service of key audit team members (e.g. Blair, Peter from Hilborn)
(c) Whether familiarity threats have been identified and if so what safeguards have been put in place
(d) The transparency of audit firm and staff interactions and whether the Executive Committee is aware of any interactions that might impair independence.
(e) Whether the fees are sufficient to provide for an audit of appropriate quality taking into account changes in the College's business.

## 1. Additional Information to Determine Scope, Timing, and Process

In addition to the considerations noted in the Annual Assessment process, the Executive may wish to also consider the following:

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| When was the last Comprehensive Assessment conducted and what period should this assessment cover?[5] | |

## 2. Obtain Additional Information from Staff

**In advance of the discussion the Executive Committee will need to request to have the following information made available to them by staff:**

[5] The Comprehensive Assessment should, as a rule, cover all assessments since the previous Comprehensive Assessment.

- ☐ Relevant Executive Committee meeting minutes and results of Annual Assessments.
- ☐ The College policies for awarding non-audit work and any reports by management on how it has complied with those policies.
- ☐ Whistleblowing policy and associated reports that may have relevance to the relationship with the audit firm.
- ☐ Information about any significant financial reporting matters that have been questioned by regulators or the press that may have relevance for the relationship with the auditor.
- ☐ A summary of relevant information from the Canadian Public Accountability Board's (CPAB) most recent annual public report and periodic newsletters.[6]

## 3. Obtain Input from the Auditor

This section of the tool sets out the information that the Executive Committee may wish to obtain from the auditor.

**In advance of the discussion, the Executive Committee must have the following information made available to them by the auditor:**

- ☐ Analysis of total services provided by the audit firm, covering audit and non-audit services and related fees, since the last Comprehensive Assessment; explanations for differences between actual and estimated fees and between actual audit fees and cost recoveries. Consider obtaining an analysis of other auditors' fees for similar services to comparable entities, where available.
- ☐ Summary of auditor's reports (e.g., consolidated financial statements, subsidiary financial statements, reports to regulators, special reports).
- ☐ Summary of reports issued to the Executive Committee, including significant matters addressed.
- ☐ A communication from the firm regarding any conflict of interest issues, or independence issues.[7]
- ☐ Summary of reports to management.
- ☐ Summary of key elements of the firm's quality control processes and how they were applied to the College's audit.
- ☐ Transparency reports[8] of the audit firm (if reports are produced).

[6] CPAB releases periodic reports that offer guidance and recommendations to audit firms to ensure auditors remain accountable, and independent. Audit firms should be abreast of these reports and recommendations and be ensuring they are implementing any new recommended safeguards or quality assurance advice.

[7] Canadian auditing standards require the auditor to communicate with the Committee all relationships between the College and the firm that, in the auditor's professional judgment, may reasonably be thought to bear on independence. This includes total fees charged during the period covered by the financial statements for audit and non-audit services and the related safeguards that have been applied to eliminate identified threats to independence or reduce them to an acceptable level.

[8] As a result of legal and regulatory requirements, audit firms in certain jurisdictions now issue transparency reports on their governance. Audit firms in other jurisdictions issue such reports voluntarily to demonstrate their commitment to audit quality. Such reports can provide useful information about an audit firm's culture of integrity, professional excellence, accountability and continuous improvement.

☐ Annual reports of the audit firm (to confirm the best practices and liquidity of the firm).

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| How long has the audit firm been the external auditor? What steps have been taken to address possible institutional familiarity threats? | |
| What are the firm's plans for the training and development of the audit team? | |
| What are the firm's expectations as to future partner rotation or other changes to senior audit team personnel? | |
| How are the size, and resources of the audit firm changing? | |
| What efforts are being made to enhance audit quality within the audit firm generally and the external audit of the College specifically? | |
| How has the audit firm's relevant expertise in the industries and markets in which the College operates been evolving? What are the audit firm's future plans to serve the College with an audit team with appropriate expertise? | |
| How has the audit firm considered systemic audit quality issues identified by CPAB in its public reports? | |
| What reputational challenges, if any, are facing the audit firm and how are these being addressed? | |
| How have significant differences in views, if any, between CMO management and the firm been addressed? | |
| **OTHER INPUT REQUESTED FROM THE AUDIT FIRM** | |
| | |
| | |

# 4. Additional Executive Committee Analysis

This section is supplemental to the analysis completed in the Annual Assessment process. The Committee should complete that analysis and, during a Comprehensive Assessment, this additional analysis would be conducted. Again, this section should be completed by the Executive Committee, either individually, or as a group. The meeting with the auditor at the May/June Committee meeting will help inform this section of the document.

## A. Safeguards Against Institutional Independence and Familiarity Threats

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| What institutional familiarity threats has the audit firm identified? What steps have been taken to address them? | |
| To what extent has the College employed former audit firm staff in key financial positions? | |
| What personnel changes, if any, in the audit firm or the College could create a perception that the external auditor is no longer independent? | |
| What corporate hospitality has been provided to the audit firm/management by management/the audit firm that could bring the external auditor's independence into question? | |
| What reputational damage or regulatory action, if any, has the audit firm suffered that could bring into question its professionalism, independence or financial stability? | |
| To what extent does the policy for non-audit work by the external auditor adequately ensure that the auditor does not: it audits its own work, involve it in management decisions, act in advocacy role or create conflicts of interest? Has the policy been complied with? | |

## B. Auditor Responsiveness to CPAB reports

In this area the Executive may wish to include any specific concerns raised from their review of the summary of CPAB reports provided by staff. They can, using this area, ask about the auditor's response to specific recommendations made by CPAB. The Committee can discuss any relevant

materials with the auditor to understand how the auditor has mitigated risks pointed to in the report, and has followed recommendations. Blank boxes have been left for this purpose.

| POINTS TO CONSIDER | OBSERVATION |
|---|---|
| How has the audit firm responded to audit quality issues raised by the CPAB's public reports? | |
| If CPAB has inspected the audit file related to the College during the assessment period and made significant inspection findings, what was the cause of those findings and how has the audit firm responded? | |
| **OTHER INPUT REQUESTED FROM THE EXECUTIVE** | |
| | |
| | |

## 5. Revisit and Approve or Revise Related Policies

The following policies should be reviewed by Executive as part of the Comprehensive Assessment Process. They should be revised or approved.

1) Whistleblower Policy
2) Policy on Awarding Non-Audit Work to the External Auditor

## 6. Additional Information to Conclude the Comprehensive Assessment and Communicate Results

In addition to submitting a report to Council the Executive Committee must also decide if they will recommend the current auditor for reappointment or if they will recommend the College go to tender to procure a new audit firm.

# APPENDIX 1 - Templates

## TEMPLATE: ANNUAL ASSESSMENT REPORT TO COUNCIL

| | |
|---|---|
| Reporting Year: | |
| Summary Observations: | |
| Recommendations made to the Auditor: | |
| Recommended Audit Structure for the Following Year (FOR APPROVAL BY COUNCIL): | ☐ Comprehensive Assessment<br>☐ Annual Assessment |
| Any recommended changes to the Assessment Process for future: | |

# TEMPLATE: COMPREHENSIVE ASSESSMENT REPORT TO COUNCIL

| | |
|---|---|
| Reporting Year: | |
| Summary Observations: | |
| Recommendation to Council – renew auditor or go to tender (FOR APPROVAL BY COUNCIL): | |
| Recommended Audit Structure for the Following Year (FOR APPROVAL BY COUNCIL): | ☐ Comprehensive Assessment<br>☐ Annual Assessment |
| Any recommended changes to the Assessment Process for future: | |
| Recommendations made to the Auditor:<br><br>(In the event that the auditor is to be renewed) | |

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# EXECUTIVE COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

## Committee Members

| | |
|---|---|
| Chair | Tiffany Haidon, RM |
| Professional | Tiffany Haidon, RM, Claudette Leduc, RM |
| Public | Rochelle Dickenson, Jennifer Lemon |
| Non-Council | n/a |

## Committee Meetings
May 31, 2017

## Panel Meetings/Hearings
n/a

## Trainings
Three members of the Executive Committee (Tiffany Haidon, Jennifer Lemon, and Claudette Leduc) participated in an afternoon of training related to the financial audit and its associated preparation and processes. These Executive members also spent time with the audit representative during that time and asked questions to inform their usage of the *Assessment of the External Auditor* tool.

## Items

- **Approved on Behalf of Council – Q4 Statement of Operations**
  Carolyn Doornekamp, Director of Operations, will present the College's Q4 Statement of Operations – please see attached. This was approved at the Executive Meeting on May 31, 2017.

- **Audited Financial Statements**
  Blair MacKenzie, will present the College's Audited Financial Statements. Please see Agenda Item 10.

  During the audit presentation the Executive members will be asking questions associated with the Assessment of the External Auditor (included in this package). The Executive Committee continues to move through the tool in order to report their findings to Council in the fall.

- **President's Job Description**
  Executive discussed the recent changes in Council leadership and felt that this was a good opportunity to review and revise the President's job description. The committee recommended strengthening the role of the Vice Presidents including regular check-ins with President and Registrar prior to Council meetings. The Executive also suggested providing the elected president with a CMO laptop and access to a secure folder in Dropbox to draft and save in-camera meeting materials and minutes. They also suggested including standing items for the President's Orientation including:
    - Public relations & media
    - Participation in Chair Training
    - Finance Training
    - Tech Training
    - Meet with regulatory expert (e.g., Deanna Williams)

- **President's Written Report to Council**
  A template will be created for the President's Report using the accountabilities noted in the President's Job Description. The October 2017 President's Report will make use of this new template.

- **Process for Non-Council Member Appointments**
  This item is brought to Council for approval. Please see attached.

- **Process for in-camera minutes**
  This item is brought to Council for information. Please see attached.

**Formal Motions to Council**
Approve the Process for Non-Council Member Appointments.

**Attachments:**
1. Briefing Note re: Process for Non-Council Member Appointments
2. Process for Non-Council Member Appointments
3. Briefing Note re: Process for In-Camera
4. In-camera minutes - template
5. Briefing Note re: Q4 Statement of Operations
6. Q4 Statement of Operations
7. Assessment of the External Auditor Tool

Respectfully Submitted,

Tiffany Haidon, Chair

# Briefing Note for Council

**Subject:** Process for Non-Council Committee Member Appointments

## Background

Pursuant to the CMO's General By-Law, the Council may at its discretion, appoint members who are not members of the Council to any Committee or a working group. In making an appointment, the Council should take into consideration the location of practice, experience, expertise, availability and other qualifications and characteristics of the Member, to complement the attributes of the other Committee members.

The eligibility criteria for non-Council appointments are set out in the by-laws. The by-laws also note that the Council may remove a non-Council member of a committee at its discretion.

Expectations and duties of non-Council members are set out in Article 9 of the General by-law, Duties of Council and Committee members as well as the College's governance policies. The term of office for non-Council committee members is one year. Non-Council members can apply and be considered for an additional term based on the committee needs. Currently, the College has 7 non-Council members.

At the Executive Committee's February 22, 2017, meeting, staff was directed to draft a non-Council Committee Member Appointment policy to have a documented process to recruit and appoint non-Council members.

## Key Considerations

To strengthen the process for non-Council appointments, staff has drafted a governance policy document pertaining to the appointment of non-Council members. In addition to the information regarding non-Council appointments noted in the General By-laws (eligibility, term of office and removal), the drafted policy includes selection criteria, maximum term and application and re-appointment process. This information is not currently included in the General By-laws, but the Executive Committee may wish to consider including some of these details in the by-laws when they are revised in 2017/2018 – in particular, the eligibility criteria and maximum terms of non-Council member appointments.

## Recommendations

The following recommendations are submitted for Executive's consideration:

- Approve the Non-Council Member Appointments policy
- Consider whether to include information from the Non-Council Member Appointments policy in the General By-law, when they are revised in 2017/2018.

## Implementation Date

- 2017/2018 Council term

## Attachments

Non-Council Committee Member Appointments Policy

## Legislative and Other References

1. RHPA, Schedule 2, Health Professional Procedural Code, s. 4 Council and s. 5 Terms
2. General By-Law, Article 6 Committees (ss. 6.11; 6.12; 6.13; 6.14); Article 9, Duties of Council and Committee Members
3. Council and Committee Member's Role and Code of Conduct Policy (GP5)

**Submitted by:** Executive Committee

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

**Policy Type:** **Governance Process**
**Policy Title:** **Non-Council Committee Member Appointments**
**Reference:** **GP14**
**Date approved:**
**Date revised:**

---

In accordance with the College's By-laws (s. 6.11), the Council may appoint midwives who are not members of the Council to any Committee or Working Group at their discretion.

**Eligibility**
Eligibility for appointment is detailed in the College By-laws (s. 6.13).

**Selection Criteria**
In addition to the eligibility requirements outlined in the by-laws, Council may take the following into consideration when appointing non-Council members to committees:

- Practice demographics (e.g., geographic location in the province and size of practice)
- Practice profiles (urban, rural, remote)
- Years of practice in Ontario
- Professional competencies
- Years on Council as an elected professional member

**Term of Office and Removal**
Term of Office and Removal are detailed in the College By-laws (ss. 6.10; 6.14).

**Maximum Term**
A non-council member may serve a maximum of six consecutive terms, as an appointed non-council member.

**Application Process for Recruiting Non-Council Members**
When non-council member vacancies are available, the College will notify the membership via the member communique, member alert email and/or website posting. Interested applicants must submit a letter of interest along with their curriculum vitae to the College.

A list of applicants and any accompanying documents will be reviewed by the Executive Committee. The Executive Committee will select members for appointment based on the selection criteria and identified areas of expertise. This list will then be submitted to Council for approval.

**Process for Re-Appointing Non-Council Members**
Non-Council Members may be reappointed in accordance with the committee member appointment guidelines.

# Briefing Note for Council

**Subject:** Process for In-camera Minutes

## Background

Pursuant to the Health Professions Procedural Code (Schedule 2 of the *Regulated Health Professions Act*) the meetings of the Council shall be open to the public and reasonable notice shall be given to the members of the College, to the Minister, and to the public. *Reasonable notice* is further defined in Part 3 of the General Regulation made under the *Midwifery Act* and means *no less than 14 days before the date of the meeting*. In rare circumstances, the Council is allowed to exclude the public from any meeting or part of a meeting if the following conditions apply:

(a) matters involving public security may be disclosed;
(b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;
(c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;
(d) personnel matters or property acquisitions will be discussed;
(e) instructions will be given to or opinions received from the solicitors for the College; or
(f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2).

## Key Considerations

Although Council is currently following the appropriate processes, as noted in the Health Professions Procedural Code, to exclude the public from part of its meeting, Executive Committee approved the following process to better document in-camera minutes:

1. When the Council is ready to move in to the in-camera session, the following motion should be passed, properly moved and seconded: “That the public be excluded from the meeting pursuant to clause 7.2(*insert lettered clause here*) of the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, in that <<*insert wording from Schedule 2 as appropriate*>>.”
2. The following motion, properly moved and seconded, should be passed when the in-camera session ends: “That the meeting resume to open session.”
3. Minutes of an in-camera meeting should include, at a minimum, the following:
    a) The place, date and start time of the in-camera meeting;
    b) Council members present;
    c) Who served as chair and recorder;
    d) The text of all resolutions;
    e) The results of votes on all resolutions;
    f) Any formal objections of Council members; and
    g) The time of adjournment

4. To maintain confidentiality, the President will ensure that the minutes of in-camera sessions are filed in a digital folder specifically designated for minutes of in-camera Council meetings on the College's secure network.
5. In-camera minutes will be reviewed by the Council at the next Council meeting. The Council will review and approve the minutes while in camera.

## Recommendations

N/A

## Implementation Date

Immediately

### Attachments

In-camera minutes template

## Legislative and Other References

*Regulated Health Professions Act*, Schedule 2, Health Professional Procedural Code, s. 7.2

**Submitted by:** Executive Committee

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

| | | | |
|---|---|---|---|
| **Date of meeting** | | | |
| **Present** | | | |
| **Regrets** | | | |
| **Ex-officio** | | | |
| **Staff** | | | |
| **Recorder** | | | |
| **Motion to move in-camera** | | **Motion to move out of in-camera** | |
| **Reason for moving in-camera:** | From the *Regulated Health Professions Act, Sched. 2, Health Professions Procedural Code:*<br><br>**Exclusion of the public**<br><br>(2) Despite subsection (1), the Council may exclude the public from any meeting or part of a meeting if it is satisfied that,<br><br>☐ (a) matters involving public security may be disclosed;<br>☐ (b) financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public;<br>☐ (c) a person involved in a criminal proceeding or civil suit or proceeding may be prejudiced;<br>☐ (d) personnel matters or property acquisitions will be discussed;<br>☐ (e) instructions will be given to or opinions received from the solicitors for the College; or<br>☐ (f) the Council will deliberate whether to exclude the public from a meeting or whether to make an order under subsection (3). 1991, c. 18, Sched. 2, s. 7 (2); 2007, c. 10, Sched. M, s. 20 (2). | | |

| **Agenda Item** | **Discussion Notes & Resolutions** | **Result of votes** (note formal objections) | **Decision** |
|---|---|---|---|
| | | | |

| **Agenda Item** | **Discussion Notes & Resolutions** | **Result of votes** (note formal objections) | **Decision** |
|---|---|---|---|
| | | | |

| **Agenda Item** | **Discussion Notes & Resolutions** | **Result of votes** (note formal objections) | **Decision** |
|---|---|---|---|
| | | | |

| **Agenda Item** | **Discussion Notes & Resolutions** | **Result of votes** (note formal objections) | **Decision** |
|---|---|---|---|
| | | | |

# Briefing Note for Council

**Subject:** 4th Quarter Statement –Accompanying Details and Explanation

## Background

This 4th Quarter Statement was prepared after the completion of the Financial Statements and therefore includes final information after adjustments. This statement shows the College's spending by category and additional information is also supplied about special project funding usage, and the usage of our Investigations and Hearings accrual.

Note: At the end of each fiscal the College accrues estimated costs for each unfinished Professional Conduct matter. We accrue sufficient resources in order to take each case to completion. These accruals allow the College to have confidence that it has set adequate resources aside to manage its liabilities.

## Key Considerations

Most areas fall under the budgeted amount for the year. For areas that are more than the budgeted amount we can offer some additional information to consider:

1) **Professional Fees –** There are two factors that contributed to the overage in this area:
    - The auditor added a new accrual here of $15,000 to the books at year end. The argument being that since the next year's audit is for the next year's books we should accrue money for that cost in advance. Because of this new accrual the line shows over this year, next year it will show under. The actual cost of the audit for 2015-16 that was paid during the year was approximately 18K.
    - We used the Expert line under Professional Fees for the Jurisprudence Course development costs. This was approved with Executive in advance of the spending.
2) **Capital Assets-** At the end of 2015-16 we had to created an estimate of what we thought the new capital asset number would be after leasehold improvements. We estimated $40,000, and after auditor input the number for 2016-17 was finalized as slightly higher. This number fluctuates year to year, and as assets mature this amount decreases.

Other notes to consider when reading the Q4 Statement:

3) The College's revenue for the year lined up closely with our estimate. We estimated 1,592,802 in revenue, and we received $1,573,516. This is a difference of less than 20,000.
4) Overall the College underspent against its budget. This underspending resulted in the creation of net assets for the College.
5) An additional chart has been provided to show spending against the grant received for the Birth Centre project. You will note that we spent all of those funds.
6) You can see in a separate chart information about the spending against the accrual for Professional Conduct for this year. You will see that we underspent significantly in this

area.

## Recommendations

No action needed

## Attachments

Q4 Final Statement F16-17 (Council)

**Submitted by:** Executive Committee

## CMO STATEMENT OF OPERATIONS: FISCAL April 1, 2016- March 31, 2017 (F17)

***Q4 Final Statement***

| BUDGET CATEGORY | F17 BUDGET AMOUNT | Q4 Spending April 1, 2016-March 31, 2017 | Q4 Spending April 1, 2015-March 31, 2016 | Percentage Variance Against Budget | *Variance Notes F17 to Budget* |
|---|---|---|---|---|---|
| **STAFF- Salaries and Benefits** | | | | | |
| **Sub-Total** | **$1,330,853** | **$1,244,996** | **$1,084,843** | **93.55%** | |
| **OPERATIONAL COSTS** | | | | | |
| ***Professional Fees*** | | | | | |
| **Sub-Total** | **$91,530** | **$99,946** | **$93,918** | **109.19%** | *A new accrual for Finance costs (for this upcoming year's audit) is included here, and therefore next year that portion of this line will be lower. Also, costs for the Jurisprudence module development are included here.* |
| ***Council, Committees and Panels Per Diem Expenses*** | | | | | |
| **Sub-Total** | **$162,720** | **$151,896** | **$167,265** | **93.35%** | |
| ***Office and General*** | | | | | |
| **Sub-Total** | **$416,224** | **$340,009** | **$390,862** | **81.69%** | |
| ***Membership Fees*** | | | | | |
| **Sub-Total** | **$29,493** | **$24,174** | **$25,571** | **81.96%** | |
| ***Conferences and Meetings*** | | | | | |
| **Sub-Total** | **$20,340** | **$19,279** | **$20,041** | **94.79%** | |
| ***Program & Project Expenses*** | | | | | |
| **Sub-Total** | **$341,935** | **$113,489** | **$171,176** | **33.19%** | |
| **CAPITAL COSTS** | | | | | |
| **Sub-Total** | **$40,000** | **$44,077** | **$28,426** | **110.19%** | *Amortization related to the office expansion in 2015-16 is shown here.* |
| **TOTALS** | **$ 2,433,095** | **$ 2,037,867** | **$1,982,102** | **83.76%** | |
| **REVENUE FROM FEES** | **$ 1,592,802** | **$ 1,573,516** | **$1,434,816** | **98.79%** | |
| **GRANT FROM RPU/MOHLTC** | **$ 840,293** | **$ 840,293** | | | |
| **EXCESS OF REVENUE OVER EXPENSES FOR THE YEAR** | | **$ 375,942** | | | |

| **BIRTH CENTRE DETAILS F17** | |
|---|---|
| Birth Centre Grant | $ 91,338 |
| Birth Centre Expenses | $ 91,338 |
| Net Birth Centre | $ - |

| **ACCRUAL DETAILS** | |
|---|---|
| Accrued Liabilities for 12 months | $ 136,505 |
| Accrued Liabilities Usage for 12 months | $ 48,327 |

# Briefing Note for Council

**Subject:** New Policy Development Process

## Background

Setting and promoting regulations, standards and policies is one of the College's core regulatory functions. As part of its efforts to operate at the highest of regulatory standards, the College did a comprehensive review of its policy development processes. As part of this initiative, the College reached out to other regulatory Colleges, and reviewed best practices in the current regulatory environment to be able to adapt its own policy development processes, as appropriate.

## Key Considerations

The College developed a new policy development process to ensure that policy decisions are based on a proper evaluation of risk, a solid evidence and a thorough analysis of options and impacts. The new process will ensure that regulatory tools are not adopted as the default solution but rather introduced to mitigate risk when other non-regulatory options are unable to deliver the desired results. Please refer to the attached *Policy Development Process.*

## Recommendations

That the new policy development process be adopted as presented.

## Implementation Date

Immediately (Note: the risk impact assessment tool was used for the development of the Professional Standards document)

## Attachments

1. Policy Development Process
2. Regulatory Impact Assessment (RIA) Statement template

## Legislative and Other References

N/A

**Submitted by:** Marina Solakhyan

# Policy Development Process

## 1. Introduction

Setting and promoting regulation, standards and policies is one of the College's core regulatory functions. We developed and are committed to adhering to a rigorous approach to policy making to ensure that policy decisions are based on a proper evaluation of risk, a solid evidence and a thorough analysis of options and impacts. This process will ensure that regulatory tools are not adopted as the default solution but rather introduced to mitigate risk when other non-regulatory options are unable to deliver the desired results.

*[Risk-based] regulation means always asking what risk we are trying to regulate, being proportionate and targeted in regulating that risk or finding ways other than regulation to promote good practice and high quality healthcare (Professional Standards Authority, UK).*

Throughout this document, reference is made to "regulation" and "regulations". This should be understood to mean regulation as defined below as well as other regulatory tools used by the College, such as standards and policies.

## 2. Definitions

### 2.1. Regulatory Tools

The College has a number of different forms of authority to regulate and guide the profession, including acts or statutes, regulations, by-laws, standards of practice and policies.

**Act or Statute:** An Act or a statute is a written law passed by a legislature at the provincial or federal level. Statutes set forth general propositions of law that courts apply to specific situations. A statute may forbid a certain act, direct a certain act, make a declaration, or set forth governmental mechanisms to aid society. A bill is enacted or becomes an Act or a statute when it is passed by the Legislative Assembly after its third reading and receives Royal Assent. The terms "statute" and "Act" are used interchangeably[1].

The *Regulated Health Professions Act, 1991* (RHPA) and the *Midwifery Act, 1991,* determine how the profession is regulated in Ontario.

The RHPA applies to 26 health colleges that regulate 27 professions. The RHPA framework is intended to better protect and serve the public interest; provide mechanisms to improve quality of care and establish an accountable system of self-governance. The *Self Governing Health Professions*, which is Schedule 1 to the RHPA, lists all health regulatory colleges in Ontario. *The Health Professions Procedural Code* (Code),

*The Midwifery Act, 1991,* is the legislation that contains a scope of practice statement, controlled acts authorized to midwives as well as provisions on title protection.

[1] e-Laws definitions; Government of Ontario: https://www.ontario.ca/laws/e-laws-definitions

which is Schedule 2 to the RHPA, sets out the practical rules for the Colleges regarding registering members, handling complaints, conducting investigations, carrying out discipline complaints and fitness to practise hearings, quality assurance program, and other College functions.

**Regulation**
Regulation is a law that is made by a body whose authority to make the law is set out in a statute (e.g. RHPA). Usually the authority is given to the Lieutenant Governor in Council. Sometimes the authority is given to a Minister of the Government or to another person or body, such as a regulatory college. Regulations are considered "delegated legislation" because the authority to make them is delegated by the Legislative Assembly in a statute. A regulation deals with topics related to the statute under which it is made; the purpose of a regulation is to provide details to give effect to the policy established by the statute. The process for amending a regulation is usually shorter than the process for amending a statute.

The RHPA, through the Code, and the *Midwifery Act*, *1991*, gives the College the authority to develop regulations that establish various kinds of obligations for members (e.g. registration requirements, components of the quality assurance program, etc.). Any regulation that is developed by the College must be circulated to all members for their feedback. A proposed regulation must also be approved by the Ministry of Health and Long-Term Care, a provincial government cabinet committee, and finally it must be signed into law by the Lieutenant-Governor of the province. All approved regulations are filed with the Registrar of Regulations and are assigned a number based on the order in which they are filed in a given year. Regulations in Ontario are cited using the abbreviation O. Reg., followed by the regulation number. For example: The Registration Regulation, made under the *Midwifery Act*, *1991,* is cited as O. Reg. 168/11. This means it was the 168th regulation filed in 2011.

The following regulations are made under the *Midwifery Act, 1991:*

- Registration Regulation
- Professional Misconduct Regulation
- General Regulation
    - Quality Assurance
    - Notice of Meeting and Hearings
    - Intubation of a Newborn
- Designated Drugs Regulation

**By-Laws**
The College's by-laws are the rules that govern how the College operates. The Code (s. 94) authorizes Council to make by-laws relating to administrative and internal affairs of the College. The College currently has General By-laws and Fees and Remuneration By-law. By-laws are approved by the Council of the College and do not require the submission to the Ministry.

**Standard**
Standards set minimum expectations that must be met by any midwife in any setting or role. Standards guide the professional knowledge, skills and judgment needed to practise midwifery safely. A standard is enforceable only if there is expert evidence that standard is widely

accepted, which partly explains extensive consultation. Every College proposal designed to introduce or revise a standard *must* be accompanied by a Regulatory Impact Assessment (RIA) statement. Standards of practice are approved by the Council of the College.

**Record-keeping Standard**: This standard outlines general requirements and considerations about the collection, use, storage, and disclosure of client's personal health information.

**Policy**
College policies (program and operational) are necessary tools to describe, in greater detail, issues set out in legislation, regulation or by-laws. Policies alone are not legally binding. If a matter deals with procedures and actions related to an activity covered in the legislation or regulation but otherwise does not introduce any new information, a Guide or Information Sheet will be developed (see below under non-regulatory tools). Every College proposal designed to introduce or revise a program policy *must* be accompanied by a Regulatory Impact Assessment (RIA) statement. All College program policies (including governance policies) are approved by the Council of the College, except for the operational policies that are approved by the Registrar.

**Program: Policy on Active Practice Requirements (APR):** Active practice requirements are outlined in the College's Registration Regulation. The APR policy was developed to further outline active practice reporting requirements.

**Operational: Record Retention and Disposition Policy:** Legal retention requirements are defined in relevant federal and provincial statutes and regulations. The policy was developed to outline procedures and schedules developed by the College to ensure appropriate measures are in place to comply with legislative requirements.

### 2.2. Non-Regulatory Tools

Non-regulatory tools are information and education instruments developed with a simple objective of providing information or raising awareness of a particular issue. These instruments are often introduced to reinforce regulatory measures and should, therefore, be well integrated with existing regulatory arrangements. Unlike regulatory tools, information and education instruments do not impose any requirements or restrictions; rather, information is available for practitioners to use if they find it relevant and useful.

**Guidelines**
Guidelines are mere suggestions for best practices. They do not set a minimum standard and are, therefore, not mandatory. For example, suggestions on how to avoid complaints through good communication practices would be a typical guideline. In other words, guidelines, are a "word to the wise".

**Guideline to Appropriate Professional Behaviour with Clients:** The RHPA has provisions specific to sexual abuse. In addition, the College developed a Sexual Abuse Provision Policy that sets out the College's expectations of a midwife's behaviour within the midwife-client relationship. The guideline to Appropriate Professional Behaviour with Clients contains suggestions for enhanced practice that will assist midwives in fulfilling legislative requirements.

**Advisory Statement**
Advisory statements normally relate to legal obligations imposed by other authorities upon the practitioner. Many regulators issue advisory statements as a notice or warning to the profession alerting their members of new legislation and explaining its most significant implications. Some regulators also make suggestions as to strategies for complying with the legislation (without giving legal advice).

**Advisory Statement on Changes to Personal Health Information & Protection Act:** The College issued an Advisory Statement on changes to Personal Health Information Protection Act, 2004 (PHIPA), including informing the membership of important consequences and directing them to resources that might help them know what is expected.

**Guide or Information Sheet**
A type of document that outlines procedures and actions related to an activity covered in the legislation or regulation, and assists members with their understanding of College requirements or legal obligations imposed by other authorities. A Guide or Information Sheet do not introduce any new information.

**Guide on Compliance with Personal Health Information & Protection Act (PHIPA):** The purpose of this guide is to help midwives understand their privacy obligations under PHIPA that governs the collection, use and disclosure of personal health information by health information custodians (including midwives) practicing within Ontario.

**Position Statement (or Joint Position Statement)**
Position statement clarifies where the College stands on a topic or current debate and provides a description of how the regulator will approach or what they will do in certain circumstances. Position statements can be issued jointly with other organizations.

**CMO and CPSO Statement on Interprofessional Collaboration**: This joint position statement outlines the Colleges' commitment to working collaboratively at the regulatory level to support their members in meeting the primary maternity care needs of Ontario's women and families.

**Fact Sheets**
A fact sheet is a concise presentation of key points or statistics relating to a specific topic. They are normally used to summarize a longer document available on the College's website.

**Frequently Asked Questions (FAQs)**
FAQs is an online document that poses a series of commonly asked questions and answers relating to a particular topic (e.g. College's Quality Assurance Program requirements). Real or imaginary questions can be used to develop an FAQ.

**Other tools**
Other information and educational instruments may include newsletters, backgrounders, discussion papers, and webinars.

## 3. Regulatory Impact Assessment

Regulatory impact assessment is an assessment of the expected impact of each regulatory or

policy initiative that must be done before any regulatory measure is introduced or revised. The results of this analysis are, in effect, a justification of the need for regulation. Regulatory impact assessment is designed to help decision-makers (e.g. staff, Committees):

1. understand the impact of decisions;
2. structure ideas,
3. test assumptions; and
4. think beyond a regulation-based solution as the default.

**Every policy proposal designed to introduce a regulatory tool must be accompanied by a regulatory impact assessment (RIA) statement.** This tool is designed to encourage rigour and better policy outcomes from the beginning and addresses the following questions:

1. **What is the problem you are trying to solve? Is it about risk of harm?**
    - Focus on the College's regulatory outcomes. Any regulatory proposal you are considering must be conducive to meeting these outcomes.
    - Review the College's Risk Register (Appendix B). Regulation should NOT be used if there no risk of harm.
    - If the problem is about risk of harm, explain the risks; explain how great the risks are and explain how they are currently managed.

2. **Are the risks you have identified currently managed?**
    - If the risks are currently managed regulation should NOT be used.

3. **Are there any alternatives to regulation that mitigate identified risks? Can the issue be resolved locally?**
   This is intended to reveal whether you have thought through all of the viable options, including the option of not regulating. You need to analyze the problem from every angle to ensure that you are not overlooking a feasible, low-impact alternative.
    - Regulation should NOT be used, if an alternative to regulation is available.

4. **Will the burden imposed by regulation be greater than the benefits of regulation?**
    - Policy interventions come at a cost. It is important to assess the benefits of your proposed regulatory intervention against the burden you impose. Regulation should NOT be used if the burden is greater than the benefit. Look for alternatives, such as posting information on the website or creating non-regulatory tools to help guide the membership; collaborating with stakeholders; or reconsider the need to intervene at all.
    - If the burden is not greater than the benefit, INTRODUCE NEW REGULATORY MEASURES. This includes making an amendment to an existing regulatory tool.

5. **What regulatory measures are you recommending to introduce?**
   Refer to the College's definitions. Indicate what you are leaning towards recommending. Explain your decision-making process. Describe what consultations, including inter-departmental, were or will be carried out. Describe how you engaged or plan to engage with those who will be affected by your policy proposal. Explain the purpose of consultation and outline a plan for consultation, including who should and should not be consulted. Any areas of uncertainty must be discussed openly and assessed for their impact on the final decision. Make sure the decision-making process was robust enough

and can withstand external scrutiny. The members of the public and other stakeholders must understand why the College made this decision and on what information and arguments the decision was based.

6. **How are you planning to implement and evaluate your proposed policy option?**
   It is essential to have a clear implementation plan (including implementation date) for delivering your proposed policy option. There should be a clear understanding of expected outcomes and benefits as well as challenges, if relevant. This is even more important when a proposed policy intersects with other regulations, policies or projects. Your plan should also clearly reflect the importance of evaluation: how do you plan to assess that the policy remains relevant and needed and whether the policy has been a success.

# Regulatory Impact Assessment Statement

Every proposal designed to introduce or revise a regulatory measure must be accompanied by a Regulatory Impact Assessment (RIA) statement. This tool is designed to encourage rigour and better regulatory outcomes.

## Title of the Initiative:

## Context and Problem Definition

1. Clearly identify and define the problem you are trying to solve. Demonstrate why it is a problem.

   Focus on the College's regulatory outcomes. Any regulatory proposal you are considering must be conducive to meeting these outcomes.

2. Is the problem about risk of harm?

   Review the College's Risk Register. Regulation should NOT be used if there no risk of harm.

3. If yes, explain the risks.

   Explain how great the risks are. Consider the *likelihood* of risk as well as the *consequences* of the risk.

## Options

1. Are the risks you have identified currently managed?

   If yes, explain how the risks are currently managed. If the risks are currently managed, regulation should NOT be used.

2. Are there any alternatives to regulation that will mitigate identified risks?

Not every problem can be solved by the College. This question is intended to reveal whether you have thought through all of the viable options, including the option of not regulating. You need to analyze the problem from every angle to ensure that you are not overlooking a feasible, low-impact alternative. Regulation should NOT be used, if an alternative to regulation is available.

## Initial Assessment of Impacts

1. What are the benefits and costs of the options you are considering?

Please explain how your proposed regulatory measure will result in a better or increased public safety and protection.

2. Will the burden imposed by regulation be greater than the benefits of regulation?

This questions intends to reveal if the cost of regulating is in proportion to the risk.

Regulation should NOT be used if the burden is greater than the benefit or if the cost of regulation is disproportionate to the risk. Look for alternatives, such as posting information on the website or creating non-regulatory tools; collaborating with stakeholders; or reconsider the need to intervene at all.

## Evidence Base, Planning of Further Work and Implementation

1. What regulatory option are you recommending to introduce?

Refer to the College's Definitions guide. Indicate what you are leaning towards recommending.

2. What information and data are already available?

3. What further information needs to be gathered? How will this be done, and by when?

4. How do you plan to engage with those who will be affected by this policy proposal?

   Refer to the College's guide to public consultation. Describe what consultations, including inter-departmental, were or will be carried out. Describe how you engaged or plan to engage with those who will be affected by your policy proposal. Explain the purpose of consultation and outline a plan for consultation, including who should and should not be consulted.

5. Are there any areas of uncertainty that could impact the final decision?

   Any areas of uncertainty must be discussed openly and assessed for their impact on the final decision. Make sure the decision-making process was robust enough and can withstand external scrutiny.

6. Is any particular communication or information activity foreseen? If so, what, and by when?

7. How are you planning to implement and evaluate the proposed policy option?

   It is essential to have a clear implementation plan (including implementation date) for delivering your proposed policy option. There should be a clear understanding of expected outcomes and benefits as well as challenges, if relevant. This is even more important when a proposed policy intersects with other regulations, policies or projects. Your plan should also clearly reflect the importance of evaluation: how do you plan to assess that the policy remains relevant and needed and whether the policy has been a success.

## Attachments

List all attachments, if any

## Submitted by:

# Briefing Note for Council

**Subject:** Infection Prevention and Control (IPAC)

## Summary

Council requested information regarding IPAC standards and the College's role and responsibilities in establishing, enforcing and identifying breaches in IPAC practices.

## Background

The College plays an important role in protecting the public from potential disease transmission through the enforcement of provincial IPAC standards. It is a general core competency of Canadian midwives to "limit the spread of disease by using appropriate infection control measures" (CMRC *Canadian Core Competencies for Midwives*). The College does not therefore act in isolation on this important issue.

Governing Legislation

The *Health Protection and Promotion Act* (*HPPA*) is the governing legislation that gives boards of health their legal mandate for the provision of public health programs and services, including the prevention of disease transmission. Public health programs are delivered across the province by 36 public health units. One of their important roles is to respond to public complaints or concerns regarding IPAC practices of premises such as physician's offices and midwifery clinics.

Ministry of Health and Long-Term Care

Under the authority of the *HPPA*, the Ministry of Health and Long-Term Care (MOHLTC), Population and Public Health Division is responsible for creating regulatory documents known as *Ontario Public Health Standards* (OPHS). These standards specify mandatory health programs and services provided by boards of health. MOHLTC also develops protocols to provide direction to health boards on how to operationalize the specific requirements within the OPHS. Two such protocols are *Infection Prevention and Control Practices Complaint Protocol (2015),* and *Infection Prevention and Control Lapse Disclosure Guidance Document (2016)*. These protocols set out the minimum expectations to be carried out by medical officers of health and their delegate public health inspectors.

As set out in the *IPAC Complaint Protocol*, when a local public health unit receives a complaint with respect to IPAC practices of a premise, the unit investigates the identified premise and its IPAC practices. When the premise involves a regulated health professional, the public health unit also contacts the respective regulatory College(s).

Public Health Investigations

The public health investigation evaluates practices against the IPAC standard of care documents published by the Provincial Infectious Disease Advisory Committee (PIDAC) and Public Health Ontario (PHO). The health inspector uses the *PHO Checklist for Infection Prevention and Control (IPAC) CORE Elements in Clinical Office Practice* and the *PHO Checklist for Reprocessing of Medical Equipment/Devices in Clinical Office Practice* to determine if deviations from IPAC standards are occurring. Any deviations are then ranked as low, medium or high risk. Through this process, the public health inspector may identify breaches or lapses in IPAC practices.

An IPAC breach is the identification of a practice that falls below the PIDAC standard of care but where the medical officer of health or designate (public health inspector) does not believe would result in an infectious

disease transmission to the premise's clients, attendees or staff. A lapse, however, is defined as a deviation from PIDAC standards of care that the medical officer of health or designate believes on reasonable and probable grounds has or may result in infectious disease transmission to the premise's clients, attendees or staff through exposure to blood, body fluids and/or potentially infectious lesions. Lapses are considered high risk and require public disclosure though the posting of reports on the public health unit's website. Furthermore, boards of health are required to provide bi-annual summary reports of lapses to the Ministry of Health and Long-Term Care.

In cases where medical officers of health or designates have reasonable and probable grounds to believe that a premise or practice presents an immediate health hazard to the public, the officer has the authority to issue a written order to require a person to take or refrain from taking any action, such as refraining from using medical instruments that may have been improperly sterilized. In some cases, the officer may even order the premise to be closed until such time that the inspector deems the premise safe.

Colleges' Roles during Public Health Investigations

Colleges are notified by public health either prior to an inspection or shortly after it has been conducted. Public health inspectors will enter a premise "unannounced" and therefore the Colleges do not inform the member(s) in advance. The Colleges' role is to monitor the investigation, provide general information about the health profession and its practices, and to act under the authority of the *Regulated Health Professions Act (RHPA)*, when necessary.

The CMO takes public health inspections seriously. After monitoring several investigations in the past two years, and consulting extensively with other Colleges, the CMO has developed a process that is consistent with other Colleges and demonstrates our cooperation with public health.

Finally, the CMO can rely on an exception to the confidentiality provision in s.36 of the RHPA to disclose information about infection control concerns to public health that are raised through the CMO complaints or reports process.

## Key Considerations

Some Colleges, such as the Royal College of Dental Surgeons of Ontario (RCDSO), create College specific IPAC standards that differ from PIDAC standards. The CMO considers this approach to be problematic for several reasons. Firstly, public health uses the PIDAC standards. Therefore a finding of a breach or a lapse could be made in a public health investigation, regardless of the standard set by the College. Secondly, the College standard may in fact hold members to a lower standard that could put the public at risk, especially over time as Colleges may not have the resources to regularly revise standards in accordance with changing evidence. Not only is this approach confusing to members of the profession, but it could place the College's reputation at risk by not setting standards that adequately protects the public.

The PIDAC standards are considered best practice standards. The CMO acknowledges that the current PIDAC standards require substantial time and resources to meet them. The CMO has requested stakeholder status in the development and revision of all IPAC related documents published by PHO, including the PIDAC standards. This would permit the CMO to participate in the development of IPAC standards that affect midwifery practice and address key areas that are midwifery specific, such as IPAC practices in the homebirth setting.

Additional ways of communicating to members about IPAC standards

Staff is considering developing guiding materials outlining the expectations of meeting IPAC standards as well as the College's role in a Public Health IPAC investigation. We will also provide links to relevant

resources that have been developed by other organizations, including the Association of Ontario Midwives, to support members in their continued learning and achievement of IPAC standards.

## Recommendations

None

## Implementation Date

N/A

## Attachments

1. Memo to Registrars re: IPAC Lapse investigation Process Update August 9, 2016
2. MOHLTC, Population and Public Health Division "Roles and Responsibilities in Community Health Care Settings During Potential Infection Prevention and Control Lapse Investigations" July 1 2016.
3. Infection Prevention and Control Practices Complaint Protocol
4. Infection Prevention and Control Lapse Disclosure Guidance Document
5. PHO Community IPAC Lapse Algorithm
6. PHO Checklist for Reprocessing of Medical Equipment/Devices in Clinical Office Practice
7. PHO Checklist for Infection Prevention and Control (IPAC) CORE Elements in Clinical Office Practice

## Legislative and Other References

1. *Health Protection and Promotion Act (HPPA*)
2. *Regulated Health Professions Act (RHPA)*
3. *Independent Health Facilities Act (IHFA)*
4. Ontario Public Health Standards and Protocols

## Submitted by:

Kelly Dobbin, Registrar & CEO

**Ministry of Health**
**and Long-Term Care**

Chief Medical Officer of Health
21st Floor, 393 University Avenue
Toronto ON M7A 2S1

Telephone: 416 212-3831
Facsimile: 416 325-8412

**Ministère de la Santé**
**et des Soins de longue durée**

Médecin hygiéniste en chef
393 avenue University, 21e étage
Toronto ON M7A 2S1

Téléphone : 416 212-3831
Télécopieur : 416 325-8412

Ontario

AUG 0 9 2016

# MEMORANDUM

**TO:** Registrars and Executive Directors
Health Regulatory Colleges

**RE: Infection Prevention and Control Lapse Investigation Process Updates**

---

Dear Colleagues,

I am writing to inform you of new documents, and recent procedure changes, supporting infection prevention and control (IPAC) lapse investigation processes by Ontario public health units.

## Roles and Responsibilities Resource Development

The following two resources have been developed to support health units and other partners in responding to community infection prevention and control lapses:

- *Roles and Responsibilities in Community Health Care Settings During Potential Infection Prevention and Control Lapse Investigations: Information for Public Health Units and Stakeholders* – developed by the Ministry of Health and Long-Term Care (MOHLTC), in collaboration with Public Health Ontario (PHO), the College of Physicians and Surgeons of Ontario and public health units to provide guidance on roles and responsibilities, current inspection practices, and contact information for use during lapse investigations.

- *Community IPAC Lapses Algorithm* -- developed by PHO to support the risk assessment process that may occur during IPAC lapse investigations.

Both documents are intended for use in conjunction with the Infection Prevention and Control Practices Complaint Protocol, 2015, and any other relevant supporting documents.

.../2

**Changes to Infection Prevention and Control Lapse Investigation Reporting Requirements**

New public disclosure requirements have been added in the Infection Prevention and Control Standard of the *Ontario Public Health Standards*, 2008. Further details are provided in the:

- *Infection Prevention and Control Practices Complaint Protocol, 2015*;
- *Infection Prevention and Control in Personal Services Settings Protocol, 2015, and*
- *Infectious Diseases Protocol, 2015.*

The disclosure requirements relate to all IPAC lapses that become known through complaints, referrals, or communicable disease surveillance in the following settings:

- Personal services settings;
- Settings not routinely inspected by the health unit; and
- Settings in which the lapse is linked to the conduct of a regulated health professional.

Disclosure is not required for complaints or referrals regarding health hazards in the environment.

Under these new provisions, health units are required to post Initial and Final Reports of investigations of IPAC lapses which come to the attention of health units through complaints, referrals from regulatory colleges or through communicable disease surveillance. A new *Infection Prevention and Control Lapse Disclosure Guidance Document, 2015* provides operational details along with a template for required reports, which will standardize the information provided to the public.

The new reporting requirements do not change expectations for inspection or investigation practices, or the overall roles and responsibilities of health units and regulatory colleges.

The new requirements have been put in place to improve public access to information about IPAC lapses which become known through complaints, referrals or surveillance. The new reporting requirements are effective as of October 14, 2015. Please see Appendix A for a list of links to the online versions of these documents.

**Routine Inspections of Personal Services Settings/ Facilities Offering Personal Services**

Under the *Infection Prevention and Control in Personal Services Settings Protocol, 2015,* public health units are required to inspect personal services settings at least once a year. Additional inspections may be required depending on the nature of the service(s) provided.

.../3

The protocol applies to personal services settings which are premises as defined by the *Health Protection and Promotion Act* that offer personal services where there is a risk of exposure to blood and/or body fluids. This includes services such as, but not limited to: hairdressing and barbering; tattooing; body piercing; nail services; electrolysis; and various other aesthetic services. The protocol applies to **any** person delivering personal services, including regulated health professionals.

In some cases, personal services are being offered in regulated health facilities, such as Out-of-Hospital Premises or Independent Health Facilities. However, personal services must be inspected by public health units, regardless of the type of facility in which they are offered. If you have not already made your local public health unit aware that you are offering personal services, or if you are unsure as to whether your facility requires inspection, please contact your local public health unit as soon as possible.

Please communicate these new requirements and resources to your members to ensure that health unit staff can undertake these responsibilities with full collaboration from all stakeholders.

On behalf of the MOHLTC, I would like to thank you for your continued commitment to preventing IPAC lapses in Ontario.

Sincerely,

David C. Williams, MD, MHSc, FRCPC
Chief Medical Officer of Health

Attachments

HLTC2976IT-2016-150

## Appendix A: Resource Links

- Infection Prevention and Control Practices Complaint Protocol, 2015
  - Available at: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_complaint.pdf
- Infection Prevention and Control in Personal Services Settings Protocol, 2015
  - Available at: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_personal_services.pdf
- Infectious Diseases Protocol, 2015
  - Available at: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infectious_diseases.pdf
- Infection Prevention and Control Lapse Disclosure Guidance Document, 2015
  - Available at: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/ipac_lapse_disclosure_gd.pdf

# ROLES AND RESPONSIBILITIES IN COMMUNITY HEALTH CARE SETTINGS DURING POTENTIAL INFECTION PREVENTION AND CONTROL LAPSE INVESTIGATIONS

INFORMATION FOR PUBLIC HEALTH UNITS AND STAKEHOLDERS

This document has been created to provide public health units and other stakeholders with an overview of **key** roles and responsibilities and contact information for all those who may be involved in investigation of a potential infection and control lapse in a community health care setting[1]. It should be noted that these roles and responsibilities may vary depending on the context of the situation. Current inspection practices are also provided for background information. This document was developed following broad consultations with Public Health Ontario, the College of Physicians and Surgeons of Ontario, and public health units.

This document should be used in conjunction with the *Infection Prevention and Control Practices Complaints Protocol, 2015* (or as current) and any other applicable protocols/ guidance documents. This information is current as of **July 1, 2016**; should any changes to procedure be made, this document will be revised and redistributed by the Ministry of Health and Long-Term Care (MOHLTC).

For definitions and other key information, including licensing, confidentiality, and closure of facilities, please see Appendix 1. For public health unit contact information, please see Appendix 2.

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| **Ministry of Health and Long-Term Care (MOHLTC) – Population and Public Health Division (PPHD)** | ▪ No direct role (i.e. would not inspect clinic/practice on a routine basis)<br>▪ May support/ coordinate teleconferences if needed (e.g. investigation involves more than one public health unit, or in the case of a significant event)<br>▪ Create regulatory documents such as the | ▪ Not involved in inspecting clinics or regulated health professionals' practices<br>▪ Investigations, including inspections, are implemented by Boards of Health via 36 public health units<br>▪ MOHLTC can be involved in co-ordinating if more than one public health unit is involved in | ▪ Health units should contact the Public Health Division if they need assistance or clarification with policy questions at any time during potential lapses.<br>▪ Health units should contact the Public Health Division if they believe there is potential for media | Infectious Diseases Policy and Programs Section, idpp@ontario.ca<br><br>Or directly:<br>Caroline Marshall<br>Strategy and Policy Advisor<br>416-325-8923<br>caroline.marshall@ontario.ca |

[1] Community health care settings include those where a regulated health professional offers regulated health services; it does not include hospitals, long-term care homes, or personal service settings.

[2] For legislative authority, please see 'Applicable Legislation' in Appendix 1.

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| | Ontario Public Health Standards that provide direction on board of health requirements<br>▪ May be consulted during investigations for coordination, policy interpretation, etc. (see When to Involve) | investigation | coverage of/ during the investigation. | |
| **MOHLTC – Independent Health Facilities (IHF) Branch** | ▪ No direct role (i.e. would not inspect clinic/ practice routinely)<br>▪ Licenses and oversees IHFs in Ontario. May take licensing action if there is a risk to patient health and safety.<br>▪ Licensing action may be taken based on information provided to the IHF program area from other assessing bodies such as College of Midwives of Ontario (CMO), College of Physicians and Surgeons of Ontario (CPSO), public heath units (PHUs). This information can come in the form of a letter, email, inspection/assessment report etc. | ▪ Not involved in inspecting independent health facilities directly<br>▪ Requests quality assessments from CPSO/CMO as applicable<br>▪ Liaises with CPSO, PHU and/or CMO to request and organize inspections/ investigations | ▪ Notify as soon as possible if an IHF is involved<br>▪ If the PHU is not certain whether a facility is an IHF, they can contact the IHF program area directly at the telephone number or email address provided. | ▪ Phone (General Intake Line): 613-548-6637<br>▪ IHFP@ontario.ca |

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| **Public Health Ontario (PHO)** | ▪ Provision of scientific and technical advice to support PHU lapse investigations<br>▪ Laboratory coordination of samples and further testing (e.g. genetic sequencing) | ▪ No routine role in clinic inspections but may provide field support to PHUs as requested to inform the risk assessment process (e.g. provision of technical guidance) | ▪ PHUs may request support to inform the risk assessment process<br>▪ PHUs should connect with the Lab outbreak coordinator early in an investigation to discuss supports required | **Requests for support should be directed to:**<br>Claudine D'Souza<br>Nurse Consultant<br>647-260-7626<br>epir@oahpp.ca<br>or<br>Infection Prevention and Control<br>ipac@oahpp.ca<br><br>**Public Health Ontario Laboratory Customer Service Line:** 416-235-6556 or 1877-604-4567 |
| **College of Physicians and Surgeons of Ontario (CPSO)** | ▪ Responsible for oversight and licensing of physicians and surgeons in Ontario<br>▪ Responsible for oversight, and inspection of certain types of facilities (Out-of-Hospital Premises<br>▪ Responsible for assessment of IHFs and reporting findings to the MOHLTC IHF Program<br>o Assessments may involve inspections, review of reports, etc.<br>▪ Investigate as part of quality assurance and complaints process | ▪ Inspect Out of Hospital Premises<br>▪ Assess Independent Health Facilities<br>o Assessments may involve inspections, review of reports, etc.<br>▪ Can assess Individual member's practice as necessary | ▪ Notify appropriate area (facilities or member-specific complaints) as early as possible<br>▪ If unsure about oversight, contact the OHP area to determine if facility is under CPSO's regulation<br>▪ Public health unit/ CPSO may choose to conduct joint investigation where possible/ reasonable | **Regarding CPSO-regulated facilities:**<br>Shandelle Johnson, Manager<br>Practice Assessment & Enhancement<br>Dept., Quality Management Division<br>Phone: (416) 967-2600 ex.401 \| Toll Free: 1-800-268-7096 \| Fax: (416) 967-2605 \|<br>Email: sjohnson@cpso.on.ca or OHP@cpso.on.ca<br><br>**Regarding CPSO members individually:**<br>Denitha Breau, Manager<br>Investigations and Resolutions<br>416-967-2600 ext 766<br>1-800-268-7096 ext 766<br>Email: DBreau@cpso.on.ca<br><br>**CPSO** does not have an after-hours intake line; however, e-mails may be monitored. |

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| **Other regulatory colleges** | ▪ Responsible for oversight and licensing of their respective regulated health professions in Ontario | ▪ Varies by college | ▪ Notify as soon as possible<br>▪ Note that colleges require complaints to be submitted in written or recorded format, but can provide information over the phone<br>▪ Some colleges may have the capacity to be involved in investigations, while others may not | **College of Nurses of Ontario:**<br>Main line: 416 928-0900<br>Toll-free in Ontario: 1 800 387-5526<br>*For questions about nursing practice standards and related issues:*<br>Practice Line: Ext. 6397<br>*To report a nurse's conduct, learning more about disciplinary processes:*<br>Professional Conduct: Ext. 6988<br><br>**College of Midwives of Ontario:**<br>Professional Conduct<br>*For inquiries relating to, the care or conduct of a midwife, unauthorized practice, workplace issues and expectations of the profession.*<br>Phone: 416.640.2252 ext. 223<br>email: regaffairs@cmo.on.ca<br>Complaints Process<br>*For inquiries relating to the complaints process and discipline:*<br>Phone: 416.640.2252 ext. 224<br>email: iandh@cmo.on.ca<br><br>**College of Pharmacists of Ontario:**<br>Practice Consultants<br>*For questions about regulations, by-laws or pharmacy practice standards and related issues:*<br>email: pharmacypractice@ocpinfo.com<br>phone: 416-962-4861 ext. 2236<br>Complaints & Discipline<br>*For information on how to report a concern about a pharmacist, pharmacy* |

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| | | | | *technician or pharmacy, or the complaints & discipline process*.<br>email: complaints@ocpinfo.com<br>phone: 416-962-4861 ext. 2274<br><br>**Royal College of Dental Surgeons of Ontario:**<br>*Practice Advisory Service*<br>416-934-5614<br>1-800-565-4591<br>practiceadvisory@rcdso.org<br>*Complaints Information*<br>416-961-6555<br>toll-free: 1-800-565-4591<br>fax: 416-961-5814 Attn: Complaints<br>e-mail: complaints@rcdso.org<br><br>**College of Dental Hygienists of Ontario:**<br>Tel:416-961-6234, ext. 242<br>Toll Free:1-800-268-2346,<br>ext. 242<br>Fax:416-961-6028<br>E-mail:<br>psingh@cdho.org<br><br>**College of Traditional Chinese Medicine of Ontario**<br>Tel : 416.238.7359<br>Fax : 416.214.0879<br>E-mail: info@ctcmpao.on.ca<br><br>For other regulatory colleges, please consult their respective websites. |

| Organization | Roles and Responsibilities during an investigation[2] | Current Inspection Practices (if applicable) | When to Involve Organization in Investigation | Contact Information |
|---|---|---|---|---|
| **Public Health Unit (PHU)** | ▪ Responsible for investigating complaint/lapse/ referral or follow-up of reportable diseases independently **or** as a joint investigation with an appropriate regulatory college<br>▪ Responsible for providing guidance regarding areas for IPAC improvement and, if deemed necessary, issuance of orders under the Health Protection and Promotion Act (HPPA)<br>▪ Responsible for public reporting of IPAC lapses where applicable | ▪ Inspect clinics/practices based on complaint/ referral/ reportable disease surveillance | ▪ Typically complaint/referral/reportable disease investigations are originally submitted to the health unit<br>▪ If not, notify as soon as possible<br>▪ May participate in joint investigations with regulatory colleges if agreed upon between the college and health unit<br>▪ If a college cannot/ does not undertake an investigation, the health unit must continue to undertake their own investigation. | ▪ Varies by health unit – see Appendix 2 or visit this website: http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx<br>▪ Request on call communicable disease inspector/nurse/manager |

# APPENDIX 1: DEFINITIONS

## FACILITY DEFINITIONS

**Out-of-Hospital Premises** (OHPs), where services are provided under different levels of anesthesia and sedation, are overseen by the College of Physicians and Surgeons of Ontario (CPSO). Some OHPs are also IHFs. OHPs are facilities where college members are performing procedures outside a hospital using the following:

- General anesthesia
- Parenteral sedation
- Regional anesthesia
- Local anesthesia for:
    - Tumescent procedures involving administration of dilute, local anesthetic
    - Surgical alteration or excision of lesion or tissue for cosmetic purposes
    - Injection or insertion of permanent fillers, autologous tissue, synthetic devices for cosmetic purposes
    - Nerve blocks for management of chronic pain
    - Acts in the opinion of CPSO in those set out above that are performed for a cosmetic purpose

**Independent Health Facilities** (IHFs) are facilities where patients receive services in respect of which facility fees are charged to and paid by the Ministry, or places designated by the Minister to be an IHF. Examples of OHIP-insured services offered at IHFs include (but are not limited to) diagnostic imaging, sleep medicine, pulmonary function, dialysis, eye surgery, abortion, and plastic surgery, and birth centres. Endoscopy services are currently unlicensed IHF services. IHFs are **not**: places where patients receive services provided in a hospital or hospital satellite facility; places where patients receive services in a private medical facility not licensed under the IHFA e.g. physician's office; places where patients receive uninsured services i.e. cosmetic surgery; medical laboratories e.g. where blood tests are performed; blood and specimen collection centres.

The MOHLTC IHF program area and College of Physicians and Surgeons of Ontario (CPSO) and the College of Midwives of Ontario (CMO) jointly manage a Quality Assurance (QA) Program for services provided in IHFs. The MOHLTC IHF program area is responsible for licensing, while assessments and Clinical Practice Parameters and Facility Standards (CPPs) are developed by CPSO/ CMO.

## INSPECTIONS/ QUALITY ASSESSMENTS

### IHFs

The MOHLTC IHF program area and College of Physicians and Surgeons of Ontario (CPSO) and the College of Midwives of Ontario (CMO) jointly manage a Quality Assurance (QA) Program for services provided in IHFs. Framework for QA program is legislated under the *Independent Health Facilities Act, 1990* (IHFA). Each IHF is required to have a Quality Advisor, who must be a physician/midwife. CPSO/CMO develops Clinical Practice Parameters and Facility Standards (CPPs) against which the facilities are assessed; CPPs reflect generally accepted professional standards.

Medical and technical assessors are trained and appointed by the CPSO/CMO to conduct on-site assessments and report their findings to the Registrar; CPSO/CMO then reports to the Director of IHFs. The Director is authorized to take licensing action as appropriate in accordance with IHFA and regulations.

IHFs are assessed approximately once every five years with 225 assessments conducted in a fiscal year.

- The Director may request more frequent assessments, for example:
  - in connection with a quality-related complaint.
  - where significant issues were identified in a previous assessment.
  - where there has been a change in ownership or services provided.
- The Director may request that an assessment be routine, announced or unannounced.

### OHPs

Facilities wishing to perform services covered under the OHP Regulation may not begin offering services until they pass an inspection-assessment by CPSO. If a premise meets all expectations and receives a "Pass", it will be re-assessed in 5 years, or earlier if the premises decides to add additional procedures or if the College receives disconcerting information about the premise. If the premise does not meet one or more of the OHPIP standards and receives a "Pass with Conditions" or a "Fail", it will be offered an opportunity to come into compliance with the standards. In some cases, minor changes may be required to come into compliance and the Premises Inspection Committee (PIC) will review those changes and issue a "Pass". In other circumstances, a re-assessment will be required in order for the premises to receive a "Pass". Assessments may involve any of the following:

- Inspection, examination or tests regarding any equipment, instrument, materials or any other thing that may be used in the performance of a procedure.

- Examination and copying of books, accounts, reports, records or similar documents that are, in the opinion of the College, relevant to the performance of a procedure in the practice of the member.
- Inquiries or questions to be answered by the member which are relevant to the performance of a procedure on a patient.
- Direct observation of a member in his or her practice, including direct observation by an assessor of the member performing a procedure on a patient.

## OTHER FACILITIES WHERE REGULATED HEALTH PROFESSIONALS PROVIDE REGULATED SERVICES

In facilities that are not considered IHFs or OHPs, such as a family physician's office or chiropractor's office, regulatory colleges may investigate the practices of a college member, but have no jurisdiction over the facility itself.

Public health units (PHUs) are responsible for responding to complaints in any facility, but do not have routine inspection responsibilities in community health facilities.

## CLOSURE OF FACILITIES

**CPSO does not have the authority to close an OHP** but has authority over its members that perform procedures within a facility. Therefore, if an OHP fails an inspection the CPSO has the authority to restrict any of its members from performing any of the procedures in that facility that would be captured under the OHP Regulation. This essentially may close the facility if all physicians are restricted from working there.

**Medical Officers of Health or a public health inspector have the power to close a facility if certain conditions are met.** Under the *Health Protection and Promotion Act, 1990*, "[a] medical officer of health or a public health inspector… by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard." R.S.O. 1990, c. H.7, s. 13 (1). This may include the closure of a facility. Prior to issuing such an order, the medical officer of health or public health inspector must be of the opinion, upon reasonable and probable grounds, "(a) that a health hazard exists in the health unit served by him or her; and (b) that the requirements specified in the order are necessary in order to decrease the effect of or to eliminate the health hazard." R.S.O. 1990, c. H.7, s. 13 (2).

**Medical Officers of Health may also place requirements or restrictions on a person's actions where they present an immediate risk of an outbreak of a communicable disase in the health unit served by the medical officer of health.** Under the *Health Protection and Promotion Act, 1990*, "[a] medical officer of health… by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a communicable disease. R.S.O. 1990, c. H.7, s. 22 (1). Prior to issuing such an order, the medical officer of health must be of the opinion, upon reasonable and probable grounds, "(a) that a communicable disease exists or may exist or that there is an immediate risk of an outbreak of a communicable disease in the health unit served by the medical officer of health; (b) that the communicable disease presents a risk to

the health of persons in the health unit served by the medical officer of health; and (c) that the requirements specified in the order are necessary in order to decrease or eliminate the risk to health presented by the communicable disease. R.S.O. 1990, c. H.7, s. 22 (2); 1997, c. 30, Sched. D, s. 3 (1).22.

**IHF closure**

Under the *Independent Health Facilities Act*, the Director of IHFs may take licensing action if some or all of the services have been identified as being prejudicial to patient health and safety or prejudicial with an immediate threat to patient health and safety. There are different options for licensing action depending on whether the concerns are related to the entire IHF or some but not all services. The licensee may request a hearing before the Health Services Appeal and Review Board (HSARB). This may delay proposed licensing action which would allow for the IHF to continue providing services pending the result of the hearing. If the Director has taken licensing action, although a hearing may be requested, the ministry will not pay the technical fees associated with the services removed from the licence. Licensees are encouraged to work with the CPSO/CMO to address the deficiencies noted in the assessment report and the Director may consider lifting any licensing action or proposed licensing action.

## CONFIDENTIALITY

Depending on the type of investigation, complaint or assessment in which the lapse is identified, CPSO may have restrictions on the amount of information that can be shared.

Section 36 of the Regulated Health Professions Act, limits the amount of information that the CPSO can share. Should the CPSO form the view that disclosure to public health unit(s) is necessary to facilitate whatever actions the public health unit deems necessary for eliminating or reducing a significant risk of serious bodily harm to those persons who may be treated at the premises, the CPSO will then share this information. This is done on a case by case basis with extensive consultation with the CPSO legal department and the various College Committees.

If CPSO and a health unit conduct a joint investigation, a copy of the CPSO inspection/assessment will be provided to the health unit from the OHP program. With regard to IHFs, if an assessment report is needed, the ministry may choose to provide the report to the health unit.

Public health units are encouraged to share information with any involved regulatory colleges upon approval from their own legal counsel.

Bill 21, Safeguarding Health Care Integrity Act, 2014, proposes to add the Health Protection and Promotion Act to the Regulated Health Professions Act, 1991, which would facilitate communication between regulatory colleges and the public health sector. The bill has passed its third reading, received royal assent, and will be proclaimed in force in the near future.

## APPLICABLE LEGISLATION

- *Regulated Health Professions Act, 1991;* sets out the governing framework for the regulated health professions in Ontario. Available at: http://www.ontario.ca/laws/statute/91r18
- Regulatory college by-laws and professional codes of conduct
- *Independent Health Facilities Act, 1990;* legislation applying to all IHFs in Ontario. Available at: http://www.ontario.ca/laws/statute/90i03
- Other practice- or College-specific acts as applicable (e.g. *Traditional Chinese Medicine Act, 2006)*
- *Health Protection and Promotion Act, 1990*; sets out the powers and responsibilities of medical officers of health (MOHs) and boards of health. Available at*:* https://www.ontario.ca/laws/statute/90h07
- *Ontario Public Health Standards and Protocols*. *2008 (or as current)*; the standards function as the guidelines for the provision of mandatory health programs and services by the Minister of Health and Long-Term Care, pursuant to Section 7 of the Health Protection and Promotion Act, R.S.O. 1990, c. H.7. Available at:http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/intro.aspx

## COMPANION DOCUMENTS:

- *Infection Prevention and Control Practices Complaints Protocol*, *2008 (or as current)*
  - Available at: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/infection_prevention_complaint.pdf
- PIDAC best practices documents
  - Available at: http://www.publichealthontario.ca/en/BrowseByTopic/InfectiousDiseases/PIDAC/Pages/PIDAC_Documents.aspx
  - Includes *Infection Prevention and Control for Clinical Office Practice*, June 2013, available at: http://www.publichealthontario.ca/en/eRepository/IPAC_Clinical_Office_Practice_2013.pdf

# APPENDIX 2: PUBLIC HEALTH UNIT CONTACT INFORMATION

Information is current as of October 1, 2015. For the most recent available information, please see http://www.health.gov.on.ca/en/common/system/services/phu/locations.aspx

- **Algoma Public Health Unit**
  Tel : 705-942-4646
  Toll : 1-866-892-0172
- **Brant County Health Unit**
  Tel : 519-753-4937
- **Chatham-Kent Health Unit**
  Tel : 519-352-7270
- **Durham Region Health Department**
  Tel : 905-668-7711
  Toll Free : 1-800-841-2729
- **Eastern Ontario Health Unit**
  Tel : 613-933-1375
  Toll : 1-800-267-7120
- **Elgin-St. Thomas Health Unit**
  Tel : 519-631-9900
  Toll : 1-800-922-0096
- **Grey Bruce Health Unit**
  Tel : 519-376-9420
  Toll : 1-800-263-3456
- **Haldimand-Norfolk Health Unit**
  Tel : 519-426-6170
- **Haliburton, Kawartha, Pine Ridge District Health Unit**
  Tel : 905-885-9100
  Toll : 1-866-888-4577
- **Halton Region Health Department**
  Tel : 905-825-6060
  Toll : 1-866-442-5866
  TTY : 905-827-9833
- **City of Hamilton**
  Tel : 905-546-3500
- **Hastings and Prince Edward Counties Health Unit**
  Tel : 613-966-5500
- **Huron County Health Unit**
  Tel : 519-482-3416
  Toll : 1-877-837-6143
- **Kingston, Frontenac and Lennox & Addington Public Health**
  Tel : 613-549-1232
  Toll : 1-800-267-7875
- **Lambton Public Health**
  Tel : 519-383-8331
  Toll : 1-800-667-1839
- **Leeds, Grenville and Lanark District Health Unit**
  Tel : 613-345-5685
- **Middlesex-London Health Unit**
  Tel : 519-663-5317
- **Niagara Region Public Health Department**
  Tel : 905-688-3762
  Toll : 1-800-263-7248
- **North Bay Parry Sound District Health Unit**
  Tel : 705-474-1400
- **Northwestern Health Unit**
  Tel : 807-468-3147
  Toll : 1-800-830-5978
- **Ottawa Public Health**
  Tel : 613-580-6744
  Toll : 1-866-426-8885
  TTY : 613-580-9656
- **Oxford County Public Health**
  Tel : 519-539-9800
  Toll : 1-800-755-0394
- **Peel Public Health**
  Tel : 905-799-7700
- **Perth District Health Unit**
  Tel : 519-271-7600
- **Peterborough County-City Health Unit**
  Tel : 705-743-1000
  TTY : 705-743-4700
- **Renfrew County and District Health Unit**
  Tel : 613-735-8653
  Toll : 1-800-267-1097
- **Simcoe Muskoka District Health Unit**
  Tel : 705-721-7520
  Health Connection (Toll free) 1-877-721-7520
- **Sudbury and District Health Unit**
  Tel : 705-522-9200
- **Porcupine Health Unit**
  Tel : 705-267-1181

- **Thunder Bay District Health Unit**
  Tel : 807-625-5900
  Toll : 1-888-294-6630 (807 area only)
- **Timiskaming Health Unit**
  Tel : 705-647-4305
- **Toronto Public Health**
  Tel : 416-338-7600
- **Region of Waterloo, Public Health**
  Tel : 519-575-4400
  TTY: 519-575-4608
- **Wellington-Dufferin-Guelph Public Health**
  Tel : 519-822-2715
  Toll : 1-800-265-7293
- **Windsor-Essex County Health Unit**
  Tel : 519-258-2146
- **York Region Public Health Services**
  Tel : 905-895-4511
  Toll : 1-800-361-5653 (Health Connection Line)

# Infection Prevention and Control Practices Complaint Protocol, 2015

Ontario

## Preamble

The Ontario Public Health Standards (OPHS) are published by the Minister of Health and Long-Term Care under the authority of the *Health Protection and Promotion Act* (HPPA) to specify the mandatory health programs and services provided by boards of health.[1, 2] Protocols are program and topic specific documents which provide direction on how boards of health must operationalize specific requirement(s) identified within the OPHS. They are an important mechanism by which greater standardization is achieved in the province-wide implementation of public health programs.

Protocols identify the minimum expectations for public health programs and services. Boards of health have the authority to develop programs and services in excess of minimum requirements where required to address local needs. Boards of health are accountable for implementing the standards including those protocols that are incorporated into the standards.

## Purpose

This protocol has been developed to provide direction to boards of health with respect to reporting, investigating and responding to infection prevention and control (IPAC) complaints in all settings that are not included under one of the following protocols listed below:

a) For complaints specific to health hazards in the environment please refer to the *Identification, Investigation, and Management of Health Hazards Protocol, 2008* (or as current) under the Health Hazards Prevention and Management Standard;

b) For complaints specific to personal services settings, please refer to the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current).

Examples of settings covered by this protocol include, but are not limited to:

a) Temporary dwellings established for temporary or seasonal workers;

b) Schools (all levels);

c) Child care centres (as defined in the *Child Care and Early Years Act, 2014*) and unlicensed child care facilities;[3]

d) Recreational facilities (including sports clubs);

e) Community centres; and

f) Facilities in which regulated health professionals operate.

# Reference to the Standards

**Table 1: identifies the OPHS standards and requirements to which this protocol relates.**

| Standard | Requirement |
|---|---|
| Infectious Diseases Prevention and Control | Requirement #9: The board of health shall ensure that the medical officer of health or designate receives reports of complaints regarding infection prevention and control practices and responds and/or refers to appropriate regulatory bodies, including regulatory colleges, in accordance with applicable provincial legislation and in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current). In addition, if an infection prevention and control lapse is identified, the board of health shall post an Initial and a Final Report online on the board of health's website, in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current).<br><br>Requirement #10: The board of health shall ensure that the medical officer of health or designate receives reports of and responds to complaints regarding infection prevention and control practices in settings for which no regulatory bodies, including regulatory colleges, exist, particularly personal services settings. This shall be done in accordance with the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) and the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current). In addition, if an infection prevention and control lapse is identified, the board of health shall post an Initial and a Final Report online on the board of health's website, in accordance with the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current) and the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current).<br><br>For the purposes of sections 9 and 10, a "regulatory college" means the college of a health profession or group of health professions established or continued under a health professions Act named in Schedule 1 to the *Regulated Health Professions Act.* |

# Operational Roles and Responsibilities

## 1) General

The board of health shall:

a) Have an on-call system for receiving and responding to IPAC practices complaints on a 24 hours per day, 7 days per week (24/7) basis.

b) Develop and maintain written policies and procedures for responding to IPAC practices complaints. The policies and procedures shall address, but not be limited to:
   i) Steps for managing a complaint investigation;

ii) Communication with the premises involved in the complaint; provincial and/or federal agencies providing oversight or support (including regulatory colleges if applicable); and/or the public (if necessary).

## 2) Investigation of Complaints Regarding Infection Prevention and Control Practices

The board of health shall:

a) Initiate an investigation of all complaints within 24 hours of receiving the complaint(s) to determine the risk of communicable and/or infectious disease transmission and to determine the appropriate board of health response. The board of health investigation shall include, but not be limited to, a review of communicable disease surveillance data available to the board of health to assess any epidemiological link of a communicable and/or infectious disease to the premises named in the complaint.

b) Determine, given the information available, whether a communicable disease transmission risk is, or may be, linked to the professional conduct of a regulated health professional governed by a regulatory college (e.g., nurse, physician). The board of health shall, in that event:
   i) Contact the regulatory college directly and provide any relevant information about the member(s) and the reported non-adherence to IPAC practices for follow up by the regulatory college;
   ii) Provide information to the complainant about how to contact the regulatory college himself or herself, if applicable; and
   iii) Consider a collaborative approach with the regulatory college in any ongoing assessment of the complaint and any subsequent investigation deemed necessary.

c) Conduct an assessment which shall focus on identifying if an IPAC lapse has occurred in the premises named in the complaint.
   i) The assessment of the complaint may include, but not be limited to:
      - Determining whether previous complaints or concerns have been reported to the board of health and what actions, if any, were taken;
      - Visiting the premises named in the complaint for the purpose of conducting a risk assessment;
      - Interviewing staff of the premises directly involved in the practice under assessment, including identification of any prior history of complaints;
      - Observing IPAC practices;
      - Reviewing relevant documentation, which includes policies, procedures, records, and logs (e.g., reprocessing practices); and
      - Reviewing evidence/previous experience to determine whether a previous IPAC lapse or premises named in the complaint has been associated with previous communicable and/or infectious disease transmission.
   ii) Information obtained during the assessment shall be evaluated based on:
      - The implementation of appropriate IPAC practices, where applicable;
      - The extent to which routine IPAC practices have been adhered to; and
      - Adherence to best practices for reprocessing recommended in the premises named in the complaint.

d) Advise the regulatory college if the board of health's assessment indicates that an IPAC lapse has been identified in the premises named in the complaint and is linked to the conduct of a regulated health professional.

e) Undertake responsive actions if the board of health's assessment indicates that an IPAC lapse has been identified in the premises named in the complaint. The responsive actions may include, but not be limited to:
   i) Recommending the implementation of appropriate IPAC procedures in accordance with current best practices;
   ii) Providing education to ensure adherence to current best practices;
   iii) Ordering corrective action based on the findings of the investigation, up to and including having the medical officer of health or public health inspector issue written orders under the HPPA;[2]
   iv) Advising the owner/operator of the premises under investigation of his/her responsibility to take corrective action and the consequences of failing to do so;
   v) Developing a risk-communication strategy for notification of identified cases in collaboration with the affected premises;
   vi) Engaging in formal look-back case-finding studies where the initial investigation raises concerns about a communicable and/or infectious disease outbreak related to improper IPAC practices; and
   vii) Scheduling a re-inspection(s) to ensure corrective action has been undertaken and that there is adherence to current IPAC practices.

f) Maintain a record of all complaints received, any investigation and/or referral action undertaken, and responsive actions undertaken.

g) Report cases of reportable diseases through the integrated Public Health Information System (iPHIS) or any other method specified by the ministry.

## 3) Reporting of Infection Prevention and Control Lapses

If an IPAC lapse has been identified in a setting that is not routinely inspected by the board of health or is linked to the conduct of a regulated health professional, the board of health shall post an Initial and a Final Report online in accordance with the *Infection Prevention and Control Lapse Disclosure Guidance Document, 2015* (or as current).[4]

# Glossary

**Infection Prevention and Control (IPAC) Lapse:** A lapse is defined as a deviation from IPAC standard of care, based on current IPAC standard of care documents from the Provincial Infectious Diseases Advisory Committee (PIDAC), Public Health Ontario (PHO), or the ministry, where available, that the medical officer of health or designate believes on reasonable and probable grounds has or may result in infectious disease transmission to the premises' clients, attendees or staff through exposure to blood, body fluids and/or potentially infectious lesions.

**Regulatory College:** The college of a health profession or group of health professions established or continued under a health professions Act named in Schedule 1 to the *Regulated Health Professions Act.*[5]

## References


1. Ontario. Ministry of Health and Long-Term Care. Ontario Public Health Standards. Toronto, ON: Queen's Printer for Ontario; 2008 [revised 2015 October]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf.
2. *Health Protection and Promotion Act,* R.S.O. 1990, c. H.7. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm.
3. *Child Care and Early Years Act, 2014* S.O. 2014, c. 11. Available from: http://www.ontario.ca/laws/statute/14c11.
4. Ontario. Ministry of Health and Long-Term Care, Public Health Division. Infection prevention and control lapse disclosure guidance document. Toronto, ON: Queen's Printer for Ontario; 2015. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guidance/ipac_lapse_disclosure_gd.pdf.
5. *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm.

Catalogue No. 019467 ISBN: 978-1-4606-5011-0 (PDF) October 2015 © Queen's Printer for Ontario 2015

Ministry of Health and Long-Term Care

# Infection Prevention and Control Lapse Disclosure Guidance Document

**This document is in support of the Infection Prevention and Control Practices Complaint Protocol, 2008 (or as current), the Infectious Diseases Protocol, 2008 (or as current), and the Infection Prevention and Control in Personal Services Settings Protocol, 2008 (or as current) under the Ontario Public Health Standards.**

Population and Public Health Division
Ministry of Health and Long-Term Care

March 2016

Ontario

# Table of Contents

# 1. Introduction

The Ontario Public Health Standards (OPHS) specify the minimum public health programs and services that all boards of health are required to provide.[1] The OPHS are published by the Minister of Health and Long-Term Care under section 7 of the *Health Protection and Promotion Act* (HPPA).[1, 2]

The OPHS are supported by incorporated protocols that further delineate expectations for carrying out the standards' requirements.[1] The *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current), the *Infectious Diseases Protocol, 2008* (or as current), and the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) are part of the Infectious Diseases Prevention and Control Program Standard.[3, 4, 5]

The purpose of the *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current) is to provide direction to boards of health with respect to reporting, investigating and responding to infection prevention and control complaints.[3] The purpose of the *Infectious Diseases Protocol, 2008* (or as current) is to provide boards of health with direction with respect to the prevention and management of infectious diseases of public health importance.[4] The purpose of the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) is to provide direction to boards of health to minimize the risk of contracting blood-borne and other types of infections for both clients and personal services workers during the delivery of personal services.[5]

This guidance document was created to assist and direct boards of health with the disclosure of identified infection prevention and control (IPAC) lapses as required in the OPHS and Protocols.[1] This guidance document pertains only to public disclosure of IPAC lapses and does not address other public health activities related to the management or investigation of IPAC lapses.

The *Infection Prevention and Control Practices Complaint Protocol, 2008* (or as current), the *Infectious Diseases Protocol, 2008* (or as current), and the *Infection Prevention and Control in Personal Services Settings Protocol, 2008* (or as current) require boards of health to follow the protocols in accordance with this Guidance Document.[3, 4, 5] "In accordance with" means that the requirements in this guidance document are mandatory activities for boards of health to undertake under the OPHS.[1]

## 1.1 Disclaimer

This guidance document is not intended to provide legal advice or to be a substitute for the professional judgement of staff employed by local boards of health or legal counsel. Professional staff employed by local boards of health should consult with their manager and/or legal counsel, as appropriate. Where there is conflict between this guidance

document, the *Infection Prevention and Control Practices Complaint Protocol*, the *Infectious Diseases Protocol*, and the *Infection Prevention and Control in Personal Services Settings Protoctol*, the OPHS, the HPPA or its regulations, the *Infection Prevention and Control Practices Complaint Protocol*, the *Infectious Diseases Protocol*, the *Infection Prevention and Control in Personal Services Settings Protocol*, OPHS, HPPA or its regulations, as the case may be, shall prevail.[3, 4, 5, 1, 2]

# 2 Identifying a Lapse

## 2.1 Definition

A lapse is defined as a deviation from IPAC standard of care, based on current IPAC standard of care documents from the Provincial Infectious Diseases Advisory Committee (PIDAC), Public Health Ontario (PHO), or the Ministry of Health and Long-Term Care ("the ministry"), where available, that the medical officer of health or designate believes on reasonable and probable grounds has or may result in infectious disease transmission to the premises' clients, attendees or staff through exposure to blood, body fluids and/or potentially infectious lesions.

If breaches in IPAC are identified but the medical officer of health or designate does not believe that the breach would result in an infectious disease transmission to the premises' clients, attendees or staff, the definition of a lapse has not been met and there is no need for a public report. The flow chart in Appendix A of this Guidance Document identifies when an Initial or Final Report of a lapse identified via complaint or referral is required to be publicly posted.

## 2.2 Scope of requirements

The disclosure requirements relate to all IPAC lapses that become known through complaints, referrals, or communicable disease surveillance in the following settings:

- Personal services settings;
- Settings not routinely inspected by the board of health; and
- Settings in which the lapse is linked to the conduct of a regulated health professional.

This does not include complaints or referrals regarding health hazards in the environment.

# 3 Initial Report

An Initial Report must be completed and posted online by a board of health if a medical officer of health or designate becomes aware of and identifies an IPAC lapse. The lapse could be identified as a result of a complaint, communicable disease surveillance, or referral from a regulatory college, other medical officer of health or the ministry. To prepare an Initial Report, complete the "Initial Report" section of the template provided in Appendix B.

## 3.1 Content of the Initial Report

As per the template provided, each **Initial Report** must contain:

a) The date the medical officer of health or designate identified the IPAC lapse*;

b) How the medical officer of health or designate became aware of the IPAC lapse (e.g., complaint, communicable disease surveillance, referral from a regulatory college, other medical officer of health or the ministry);

c) The type of premises;

d) The name and address of the premises;

e) Summary description of the IPAC lapse identified;

f) Referral to a regulatory college (if applicable);

g) A brief description of the corrective measures to be taken;

h) The date(s) any order or directive was issued to the owner/operator (if applicable); and

i) How to contact the board of health for more information.

The **summary description** should contain a concise (4-5 sentences maximum) description of the service or concern related to the lapse. If more than one IPAC lapse is identified, the board of health shall summarize the lapses that require corrective measures and indicate those lapses that present the greatest risk to clients, attendees or staff of the premises.

The **brief description of corrective measures** should contain a concise description of the corrective measures required to correct the lapse, including the type of corrective measure(s) (e.g., following best practices for use of equipment, including cleaning, disinfection and sterilization; removal of equipment), the method assisting the realization of corrective measures (e.g., education, verbal or written order) and the extent of the

* If a lapse is traced to a premises from a case of a disease, this date refers to the date that the link to the premises was confirmed.

corrective measure(s) needed (e.g., minimal changes, moderate changes, extensive changes).

Note that no personal information as defined in the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA) or personal health information as defined in the *Personal Health Information Protection Act* (PHIPA) should be disclosed in an Initial Report.[6, 7] When in doubt about whether information constitutes either personal information or personal health information, the board of health should consult with its own legal counsel, as appropriate.

## 3.2 Process for Posting the Initial Report

Within two weeks of identification of the IPAC lapse that does not involve patient notification, the board of health shall post the Initial Report on the board of health's website in a location that is easily located by the public. To complete the Initial Report, fill in a copy of the reporting template which is available by contacting the ministry at OPHS.Protocols.moh@ontario.ca. A sample of the template is included in Appendix A as reference. The template can be formatted by users to match the visual style of board of health websites.

If an investigation involves, or is expected to involve, patient notification, boards of health should refrain from posting Initial Reports until preliminary patient notification has occurred. Any subsequent patient contact and/ or testing is considered part of the investigation, and as such, the Final Report should not be posted until all aspects of the investigation have been completed.

As more information becomes available during the course of an investigation, the Initial Report must be updated to ensure transparency of the most relevant and current information. The date of revision must also be indicated on the report. In determining an appropriate time frame for doing so, the board of health should consider the urgency of the new relevant information, and whether a potential risk to the public exists if there is a delay in updating the public report(s).

The Initial Report must be available online until a Final Report is completed. Archived reports must be available from the board of health upon request. All posted reports shall be compliant with relevant legislation including the *Accessibility for Ontarians with Disabilities Act* (AODA), the *French Language Services Act* (FLSA) (if applicable), MFIPPA and PHIPA.[8, 9, 6, 7]

# 4 Final Report

A Final Report shall be completed and posted by the board of health once the recommended corrective measures have been completed. Please note that the same template is used for the Initial and Final Reports with the difference being that the Final Report requires completion of the "Final Report" section of the template.

# 4.1 Content of the Final Report

A **Final Report** must contain the information outlined above, for the Initial Report, as well as:

a. A brief description of corrective measures taken; and

b. The date all corrective measures were confirmed to be completed.

The **brief description of corrective measures taken** should be updated to describe the corrective measures that were used to correct the lapse, including the type of corrective measure(s) (e.g., following best practices for use of equipment including cleaning, disinfection and sterilization; removal of equipment), the method assisting the realization of corrective measures (e.g., education, verbal or written order) and the extent of the corrective measure(s) needed (e.g., minimal changes, moderate changes, extensive changes).

Note that no personal information as defined in MFIPPA or personal health information as defined in PHIPA should be disclosed in a Final Report.[6, 7] When in doubt about whether information constitutes either personal information or personal health information, the board of health should consult with its own legal counsel, as appropriate.

# 4.2 Process for Posting the Final Report

Within two weeks of the confirmation that all corrective measures were taken, the board of health shall replace the Initial Report posted on the board of health's website with the Final Report. The Final Report must be posted in the same location as the Initial Report was and must be easily located by the public. To complete the Final Report, fill in the remaining sections of the accessible PDF template used for the Initial Report.

If any information is found to have been incorrect at the time when it was noted, the Final Report shall be updated. The date of revision must also be indicated on the report. All posted reports must be compliant with relevant legislation including the AODA, the FLSA (if applicable), MFIPPA and PHIPA. [8, 9, 6, 7]

Boards of health shall make full investigation reports available upon request subject to applicable law (e.g, MFIPPA and PHIPA). [6, 7] To accomplish this, boards of health shall establish and implement a policy to ensure that the public can access full investigation reports upon request (see preamble below).

# 5 Content of the Website

The board of health shall include the following preamble on the web page on which reports are posted. The board of health is encouraged to consult with its legal counsel

regarding the adequacy of this preamble and whether any additional legal disclaimers are required from their perspective.

Boards of health subject to French language requirements must ensure that this preamble is posted in both English and French (available in the French version of this Guidance Document).

## 5.1 Preamble

"This website contains reports on premises where an infection prevention and control lapse was identified through the assessment of a complaint or referral, or through communicable disease surveillance. It does not include reports of premises which were investigated following a complaint or referral where no infection prevention and control lapse was ultimately identified.

These reports are not exhaustive, and do not guarantee that those premises listed and not listed are free of infection prevention and control lapses. Identification of lapses is based on assessment and investigation of a premises at a point-in-time, and these assessments and investigations are triggered when potential infection prevention and control lapses are brought to the attention of the local medical officer of health.

Reports are posted on the website of the board of health in which the premises is located. Reports are posted on a premises-by-premises basis, i.e., will correspond with one site only. Should you wish to view a full investigation report for any posted lapse, please contact [insert appropriate contact information]."

# 6 Reporting to the Ministry

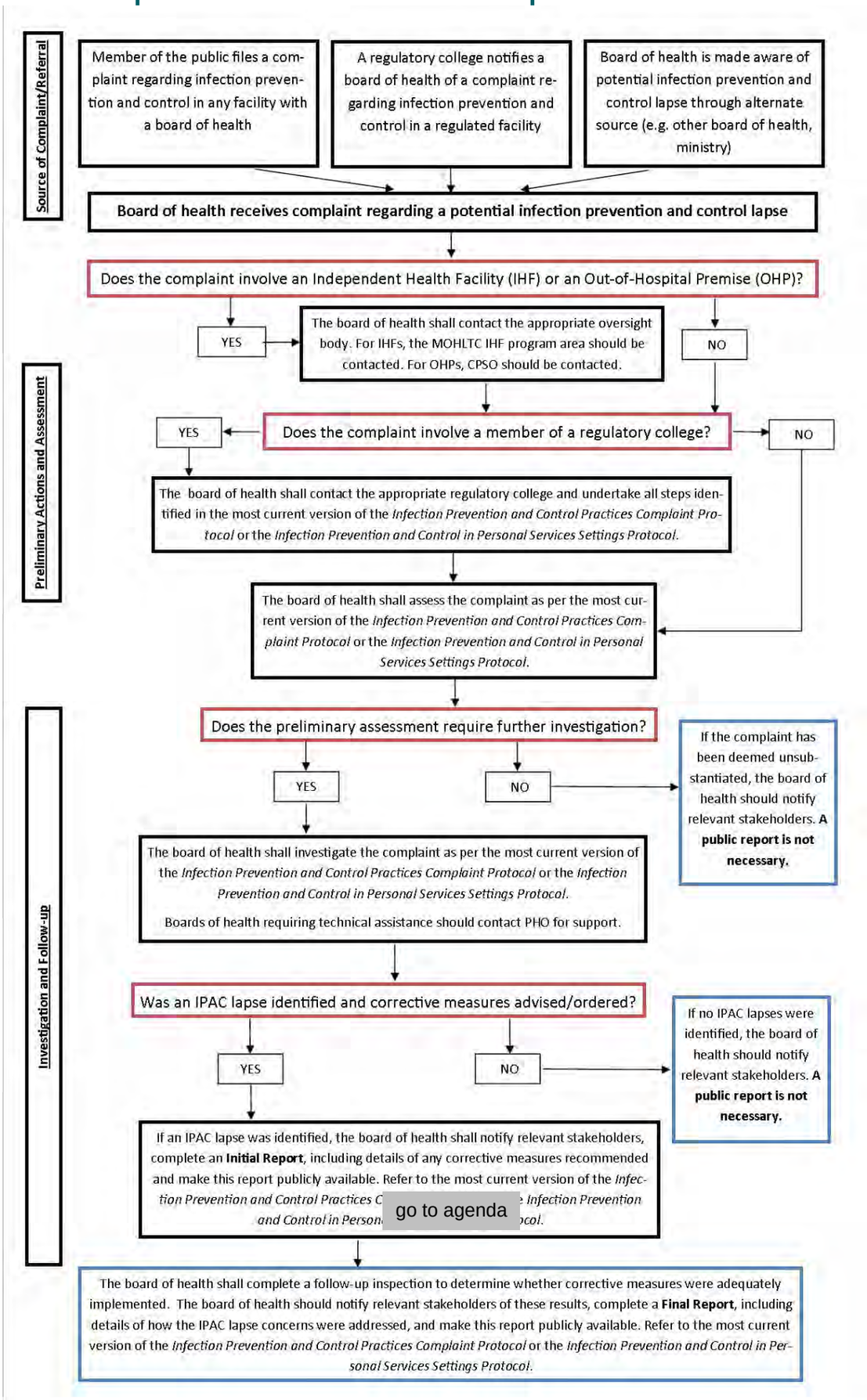
Boards of health shall submit IPAC Lapse Summary Reports to the ministry semi-annually. Direction on report content and submission instructions will be provided by the Public Health Division.

# 7 References


1. Ontario. Ministry of Health and Long-Term Care. Ontario public health standards. Toronto, ON: Queen's Printer for Ontario; 2008 [revised October 2015]. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/default.aspx?/index.html.
2. *Health Protection and Promotion Act*, RSO 1990, c H.7. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90h07_e.htm.
3. Ontario. Ministry of Health and Long-Term Care. Infection prevention and control practices complaint protocol, 2015. Toronto, ON: Queen's Printer for Ontario; 2015. Available from:

http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/infdis.aspx.
4. Ontario. Ministry of Health and Long-Term Care. Infectious diseases protocol, 2015. Toronto, ON: Queen's Printer for Ontario; 2015. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/infdis.aspx
5. Ontario. Ministry of Health and Long-Term Care. Infection prevention and control in personal services settings protocol, 2015. Toronto, ON: Queen's Printer for Ontario; 2015. Available from:http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/infdis.aspx.
6. *Municipal Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. M.56. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90m56_e.htm.
7. *Personal Health Information Protection Act*, S.O. 2004, c. 3, Sched. A. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_04p03_e.htm.
8. *Accessibility for Ontarians with Disabilities Act*, S.O. 2005, c. 11. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_05a11_e.htm.
9. *French Language Services Act*, R.S.O. 1990, c. F.32. Available from: http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_90f32_e.htm.

# Appendix A: Flow of Information and When to Post an IPAC Lapse Identified via a Complaint or Referral



# Appendix B: Sample Initial and Final Report Template

Please note that this is a sample of the required Initial and Final Report Template that must be posted once an IPAC lapse has been identified. When posting, please use a copy of the template which is available by contacting the ministry at OPHS.Protocols.moh@ontario.ca.

This copy below is for information purposes only.

Please do not include any personal information or personal health information on this Template. If you have any question about whether information constitutes personal health information or personal information, please consult your legal counsel.

## Sample: Public Health Unit Infection Prevention and Control Lapse Report

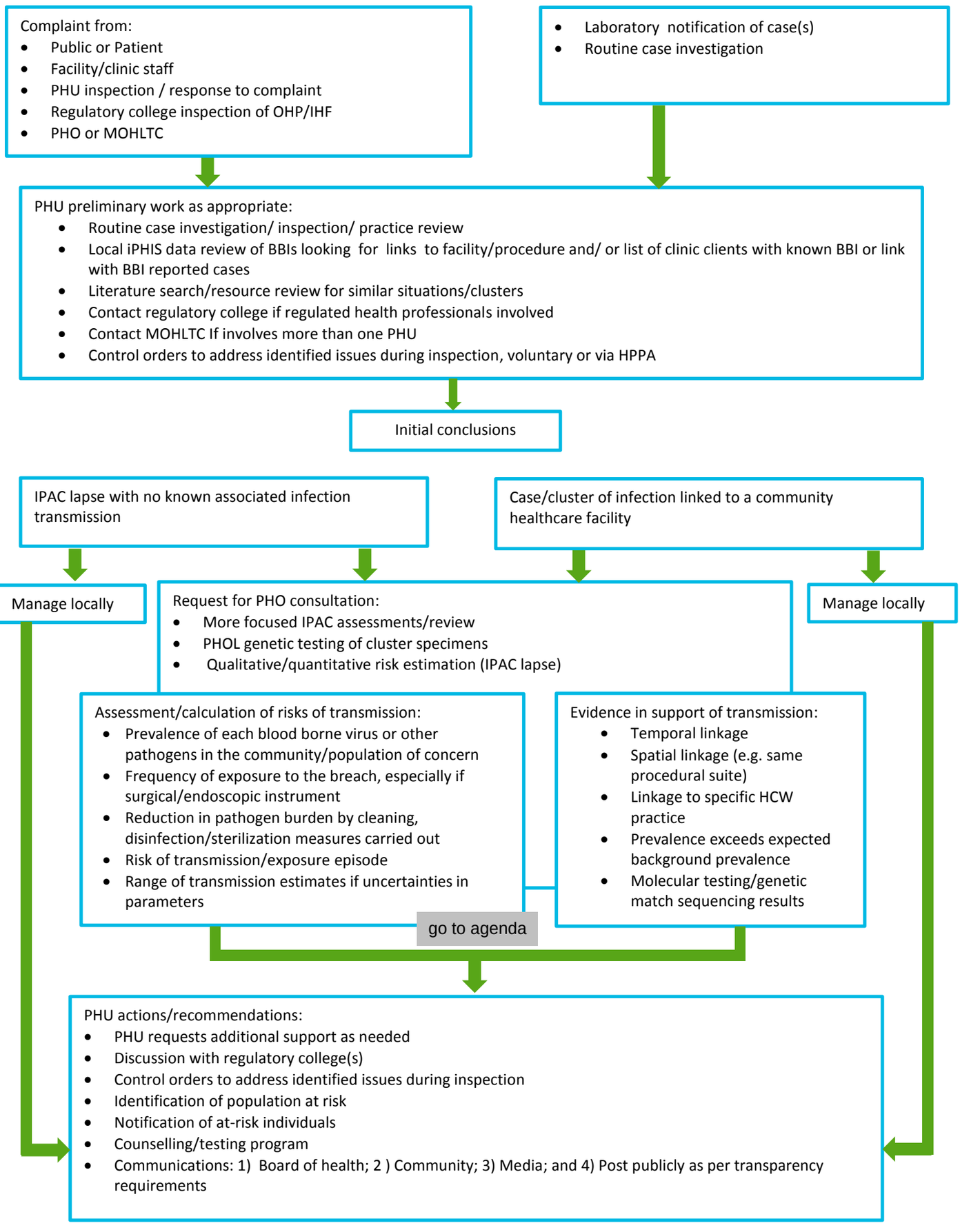
| PUBLIC HEALTH UNIT INFECTION PREVENTION AND CONTROL LAPSE REPORT | |
|---|---|
| **Initial Report** | |
| Premise/facility under investigation<br>(name and address) | |
| Type of premise/facility:<br>(E.g. clinic, personal services setting) | |
| Date Board of Health became aware of IPAC lapse | |
| Date of Initial Report posting | |
| Date of Initial Report update(s) (if applicable) | |
| How the IPAC lapse was identified | |
| Summary Description of the IPAC Lapse | |
| **IPAC Lapse Investigation** | |
| Did the IPAC lapse involve a member of a regulatory college? | |
| If yes, was the issue referred to the regulatory college? | |
| Were any corrective measures recommended and/or implemented? | |
| Please provide further details/steps | |
| Date any order(s) or directive(s) were issued to the owners/operators<br>(if applicable) | |
| **Initial Report Comments and Contact Information** | |
| Any Additional Comments<br>(Do not include any personal information or personal health information) | |
| **If you have any further questions, please contact:** | |
| Name | |
| Title | |
| E-mail address | |
| Phone number | |
| **Final Report** | |
| Date of Final Report posting: | |
| Date any order(s) or directive(s) were issued to the owner/operator<br>(if applicable) | |
| Brief description of corrective measures taken | |
| Date all corrective measures were<br>confirmed to have been completed | |
| **Final Report Comments and Contact Information** | |
| Any Additional Comments<br>(Do not include any personal<br>information or personal health information) | |
| **If you have any further questions, please contact:** | |
| Name | |
| Title | |
| Email address | |
| Phone number | |

Catalogue No. 019469 ISBN 978-1-4606-5013-4 (PDF) March2016 © Queen's Printer for Ontario

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

# Community IPAC Lapses Algorithm



Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

Abbreviations for Community IPAC Lapses Algorithm:

| | |
|---|---|
| BBI | Blood borne infections |
| HPPA | Health Protection and Promotion Act |
| HCW | Health Care Worker |
| ICRT | Infection Control Resource Team |
| IHF | Independent Health Facility |
| IPAC | Infection Prevention and Control |
| iPHIS | Integrated Public Health Information System |
| MOHLTC | Ministry of Health and Long-Term Care (Ontario) |
| OHP | Out-of-Hospital Premise |
| PHO | Public Health Ontario |
| PHOL | Public Health Ontario Laboratory |
| PHU | Public Health Unit |
| RICN | Regional Infection Control Network |

go to agenda

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

# Checklist for Reprocessing of Medical Equipment/Devices in Clinical Office Practice

**When to use this document:** This checklist was developed as a tool to assist public health units and others during IPAC lapse investigations and can be used to conduct inspections, audits and reviews of IPAC programs.

**Disclaimer:** Public Health Ontario (PHO) has developed this *Checklist for Reprocessing of Medical Equipment/Devices in Clinical Office Practice* and its content, based on the Provincial Infectious Disease Advisory Committee's (PIDAC's) *Infection Prevention and Control for Clinical Office Practice, June 2013*. This document is intended to support a review or audit of public health practices and does not replace best clinical practices or legislative requirements. PHO is not responsible for any losses or damages arising from the use of this document or its contents, including for any purposes to inform any decision or determination, clinical or otherwise, regarding inspections, findings, outcomes or recommendations.

Location name: _____

Location address: _____

Date of visit: _____

Reason for inspection: _____

Name of inspector: _____

Location contacts (name, title and phone numbers): _____

| | |
|---|---|
| **Leg. Req. = Legislated Requirement:** | Must be compliant with the relevant Act or regulation (e.g. *Occupational Health and Safety Act*). |
| **High Risk:** | Immediate health hazard exists. Stop practice and correct immediately. The act or failure to act immediately may lead to the transmission of infection or risk of illness or injury. Practices that cannot be corrected immediately must be stopped until the health hazard is observed to have been eliminated. An Order may be warranted/issued. |
| **Medium Risk:** | Signifies practices that must be corrected. Timelines for compliance or agreement on alternate process determined during inspection. |
| **Inform and Educate (I/E):** | Provide information regarding best practices, mandatory legislated practice requirements etc. This may also include just-in-time education. |

**NOTE: These categorizations represent the minimum risk level. Based on good judgement and circumstance, public health units may increase the risk category.**

Unless otherwise indicated, the reference used for the development of this checklist is PIDAC's *Best Practices for Cleaning, Disinfection and Sterilization of Medical Equipment/Devices (May 2013)*. This document is referred to as **PIDAC CDS** throughout this checklist. Specific sections are cited as to where the information may be found within the document.

| 1 | Policies and Procedures | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection |
|---|---|---|---|---|---|---|---|---|
| 1.1 | There is a written policy that says medical equipment/devices that cannot be cleaned and reprocessed according to the recommended standards are not purchased or are designated single-use. | | **I/E** | | | | **For items 1.1 and 1.2 -** Refer to: PIDAC CDS – See section on *Purchasing and Assessing Medical Equipment/Devices and/or Products for Disinfection or Sterilization Processes* | |
| 1.2 | There are written policies and procedures for all aspects of reprocessing that are based on current recognized standards/recommendations. These are reviewed regularly and /or as new information becomes available. | | **I/E** | | | | Newly purchased, non-sterile critical and semi-critical medical equipment/devices must first be inspected and reprocessed according to their intended use.<br>CSA Group. CSA Z314.8-14: Decontamination of reusable medical devices. Toronto, ON: CSA Group; 2014<br>CSA Group. CSA-Z314.0-13 Medical device reprocessing - general requirements. Toronto, ON: CSA Group; 2013. | |
| 1.3 | There is a policy and procedure for the recall of improperly reprocessed equipment that includes notification of IPAC, assessment of patient risk and notification of patients, other facilities and/or regulatory bodies, if indicated. | | **I/E** | | | | Refer to: PIDAC CDS – See section on *Recalls* | |
| 1.4 | There is a policy that requires scheduled preventative maintenance of cleaning and sterilization equipment, with written documentation that this has occurred. | | **I/E** | | | | | |

| 1 | Policies and Procedures | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection |
|---|---|---|---|---|---|---|---|---|
| 1.5 | There is a policy and procedure for quality monitoring and documentation of the reprocessing process (e.g. biological indicators, chemical indicators). | | **I/E** | | | | | |
| 1.6 | The health care setting has written policies regarding single-use medical equipment/devices. | | **I/E** | | | | Refer to: PIDAC CDS – See section on *Single-Use Medical Equipment/Devices* | |
| 1.7 | There is a policy outlining the process for removing faulty medical equipment/devices/ instruments until repaired or replaced. | | **I/E** | | | | | |

| 2 | Education and Training | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection |
|---|---|---|---|---|---|---|---|---|
| 2.1 | Staff assigned to reprocess medical equipment/devices/ instruments have completed education and training in reprocessing. Education should include theoretical and practical components. | | **High** | | | | **For items 2.1 to 2.3** – Refer to: PIDAC CDS – See section on *Education and Training* | |
| 2.2 | Staff assigned to reprocess medical equipment/devices/ instruments receive device-specific reprocessing instructions from the device manufacturer to ensure proper cleaning and high-level disinfection or sterilization. | | **High** | | | | See 2.1 Notes/Resources | |
| 2.3 | There are ongoing audits with documentation of competency of staff involved in reprocessing medical devices. | | **Med.** | | | | See 2.1 Notes/Resources<br><br>Competency requirements include ongoing education and training | |

| 3 | Single Use Items | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 3.1 | Single-use items including needles are not reprocessed. | | **High** | | | | Critical and semi-critical medical equipment/devices labelled as single-use are not reprocessed and re-used unless the reprocessing is done by a licensed reprocessor.<br><br>Refer to: PIDAC CDS – See section on *Single-Use Medical Equipment/Devices* | |

| 4 | Physical Space | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 4.1 | Medical equipment/ devices/instruments are cleaned in a designated area that is *physically separate* from direct care areas and from where clean, disinfected or sterile items are handled or stored. | | **Med.** | | | | The reprocessing work area is physically separated from clean areas by walls or if not possible, partitions or other barriers may be used; Walls or partitions should be cleaned regularly and be constructed of materials that can withstand cleaning and disinfection.<br><br>Refer to: PIDAC CDS – See section on *Environmental Requirements for Reprocessing Areas*.<br><br>If physical barriers are not feasible e.g. family practice office, IPAC principles related to separation of clean and dirty are followed (also see 4.2) | |
| 4.2 | There is a one-way work flow from dirty to clean to prevent cross-contamination. | | **High** | | | | **For items 4.2 to 4.4** – Refer to: PIDAC CDS – See section on *Reprocessing Endoscopy Equipment/Devices: Physical Space* | |
| 4.3 | There is a sink sufficient in size and depth for cleaning medical equip/devices/instruments in the reprocessing area. | | **Med.** | | | | See 4.2 Notes/Resources | |

| 4 | Physical Space | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 4.4 | There is sufficient cleanable, non-porous counter space to handle the volume of work. | | **Med.** | | | | See 4.2 Notes/Resources | |
| 4.5 | There is a dedicated hand hygiene sink and/or ABHR in the reprocessing area. | | **Med.** | | | | Do not use a hand washing sink for equipment cleaning<br><br>Refer to: PIDAC CDS – *Appendix C: Recommendations for Physical Space for Reprocessing* | |
| 4.6 | There is a puncture-resistant sharps container at point-of-use. | **Leg.** | **High** | | | | Refer to PIDAC CDS – as above<br><br>Health Care and Residential Facilities, O. Reg. 67/93. Available from: https://www.ontario.ca/laws/regulation/930067 | |
| 4.7 | There is an eye-wash station. | **Leg.** | **High** | | | | Refer to: PIDAC CDS – *Appendix C: Recommendations for Physical Space for Reprocessing* | |
| 4.8 | There is a regular schedule for environmental cleaning in the reprocessing area that includes written procedures and clearly defined responsibilities. | | **High** | | | | Refer to: PIDAC CDS – See section on *Environmental Cleaning in Sterile Processing Departments*<br><br>CSA Group. CSA Z314.0-13: Medical device reprocessing – general requirements. Toronto, ON: CSA Group; 2013. | |

| 5 | Personal Protective Equipment (PPE) | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 5.1 | PPE is available and readily accessible in appropriate sizes at point of care. | **Leg.** | **High** | | | | **For items 5.1 and 5.2**:<br>Refer to: PIDAC CDS – See section on *Personal Protective Equipment* | |
| 5.2 | PPE (gloves, gowns, mask, eye protection) is worn for procedures (e.g. instrument cleaning) that are likely to result in splashes or sprays of blood or other body fluids. | | **High** | | | | See 5.1 Notes/Resources | |

| Cleaning, Disinfection and Sterilization | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **6** | **Chemical Products for Reprocessing** | **Leg. Req.** | **Risk** | **C** | **NC** | **N/A** | **Notes/Resources** | **Inspection Notes (to be completed by individuals conducting visits/inspection)** |
| 6.1 | Chemical products used for disinfection/ sterilization<br>• Have a drug identification number (DIN) from Health Canada;<br>• Are prepared and used according to manufacturer's instructions for dilution, temperature, water hardness, use, shelf life and storage conditions;<br>• Are labelled with expiry date;<br>• Are stored in a manner that reduces risk of contamination;<br>• Are compatible with reprocessing equipment and instruments being reprocessed, according to manufacturer's instruction. | | **High** | | | | **For 6.1 to 6.5** – Refer to: PIDAC CDS – See section on *Methods Of Disinfection For Semicritical Medical Equipment/Devices – Liquid Chemical Disinfection* | |
| 6.2 | Disinfectants are not used past expiry date. | | **Med.** | | | | See 6.1 Notes/Resources | |
| 6.3 | High-level disinfectant test strips specific to the product are checked for efficacy when each test strip bottle is opened. | | **Med.** | | | | See 6.1 Notes/Resources | |
| 6.4 | Efficacy of high-level disinfectant is monitored daily before first use with test strips and a log is kept of the results. | | **High** | | | | See 6.1 Notes/Resources | |
| 6.5 | Disinfectant test strip bottles are dated when opened and discarded when expired. | | **Med.** | | | | See 6.1 Notes/Resources | |

| 7 | Cleaning of Semi-critical and Critical Medical Equipment/Devices | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 7.1 | Contaminated medical equipment/devices are kept separate from clean items. | | **High** | | | | **For 7.1 to 7.10** – Refer to: PIDAC CDS – See section on *Disassembly, Inspection and Cleaning of Reusable Medical Equipment/Devices* | |
| 7.2 | Gross soil is removed from medical equipment/devices at point-of-use, prior to cleaning. | | **High** | | | | See 7.1 Notes/Resources | |
| 7.3 | If cleaning cannot be done immediately, the medical equipment/device is kept moist in a transport container by using a product specifically intended for this use and in accordance with manufacturer's instructions. | | **Med.** | | | | See 7.1 Notes/Resources | |
| 7.4 | Medical equipment/devices are cleaned manually with an enzymatic solution. | | **Med.** | | | | See 7.1 Notes/Resources | |
| 7.5 | Cleaning equipment (e.g. brushes) is disposable or thoroughly cleaned and disinfected with a high-level disinfectant or sterilized between uses. | | **Med.** | | | | See 7.1 Notes/Resources | |
| 7.6 | Reusable cleaning items (e.g. brushes) are discarded if worn or damaged. | | **Med.** | | | | See 7.1 Notes/Resources | |
| 7.7 | Ultrasonic washers, if used, are tested for efficacy at least weekly or according to manufacturer's recommendations. | | **High** | | | | See 7.1 Notes/Resources<br><br>Also, refer to: CSA Group. Z314.8-14 Decontamination of reusable medical devices. Toronto, ON: CSA Group; 2014. Section 7.3.4.4 | |
| 7.8 | Ultrasonic washers receive documented preventative maintenance. | | **I/E** | | | | See 7.1 Notes/Resources<br><br>If weekly performance testing parameters are being met, advise regarding importance of regular preventative maintenance | |
| 7.9 | Medical equipment/devices are dried prior to high-level disinfection or sterilization (e.g. with lint-free cloth). | | **Med.** | | | | See 7.1 Notes/Resources | |

| 7 | Cleaning of Semi-critical and Critical Medical Equipment/Devices | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 7.10 | Detergent or enzymatic cleaning solution is discarded after each use. | | **Med.** | | | | See 7.1 Notes/Resources | |

| 8 | High-level Disinfection (HLD) | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 8.1 | Semi-critical medical equipment/devices receive at minimum HLD according to equipment/device manufacturer's and disinfectant manufacturer's instructions for time, temperature and concentration. | | **High** | | | | **For items 8.1 to 8.5** – Refer to: PIDAC CDS – See section on *Disinfection of Reusable Medical Equipment/Devices – High-Level Disinfection(HLD)* | |
| 8.2 | A log is kept of medical equipment/devices that receive HLD which includes: date/time of HLD, length of contact time with disinfectant and person performing HLD. | | **High** | | | | See 8.1 Notes/Resources | |
| 8.3 | Medical equipment/devices are totally submerged in disinfectant for the time specified by the disinfectant manufacturer. | | **High** | | | | See 8.1 Notes/Resources | |
| 8.4 | Medical equipment/devices are thoroughly rinsed with sterile, filtered or tap water depending on the intended use of the instrument and dried if not being used immediately. | | **High** | | | | See 8.1 Notes/Resources | |
| 8.5 | The disinfectant container is washed, rinsed and dried when the solution is changed. | | **Med.** | | | | See 8.1 Notes/Resources | |

| 9 | Sterilization | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 9.1 | Critical instruments/items are either disposable or sterilized using an approved sterilization process. | | **High** | | | | **For items 9.1 to 9.8** – Refer to: PIDAC CDS – See section on *Sterilization of Reusable Medical Equipment/Devices* | |
| 9.2 | Items are packaged according to the manufacturer's instructions. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.3 | Chemical indicators (CI) are placed appropriately in and/or on each package, if not part of the pouch/pack wrap. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.4 | Items are placed in the sterilizer according to sterilizer manufacturer's instructions. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.5 | Sterilizer mechanical printout is checked and signed for each cycle by the person sterilizing the instrument. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.6 | Sterilizer is tested with a biological indicator (BI) each day the sterilizer is used. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.7 | If dynamic air removal-type sterilizer is used, an air-detection PCD (Bowie-Dick test pack) is used. | | **High** | | | | See 9.1 Notes/Resources | |
| 9.8 | Records are kept to document that all sterilization parameters have been met (e.g. BIs, CIs, time/temperature/pressure readings). | | **High** | | | | See 9.1 Notes/Resources<br>A device is not used if any of the monitoring parameters suggest inadequate processing. | |
| 9.9 | Sterilized items are not used until the CI(s) are checked. | | **High** | | | | See 9.1 Notes/Resources<br>Refer to: PIDAC CDS – See section on *Routine Monitoring of Sterilizers* | |
| 9.10 | Loads containing implantable items are held until results of BI are available. | | **High** | | | | See 9.1 Notes/Resources | |

| 9 | Sterilization | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 9.11 | If a failed chemical indicator is found, the contents of the package are reprocessed before use. | | High | | | | See 9.1 Notes/Resources CSA Group. CSA Z314.3-14: Effective sterilization in health care settings by the steam process. Toronto, ON: CSA Group; 2014.<br><br>Refer to: PIDAC CDS – See section on *Continued Monitoring and System Failures* | |

| 10 | Storage | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 10.1 | Sterile items are stored in their sterile packaging until time of use. | | High | | | | Refer to: PIDAC CDS – See section on *Storage and Use of Reprocessed Medical Equipment/Devices* | |
| 10.2 | Packaged, sterilized instruments are stored securely in a manner that keeps them clean, dry and prevents contamination. | | High | | | | See 10.1 Notes/Resources<br><br>Event-related sterility. | |
| 10.3 | Medical equipment/devices which have been reprocessed can be differentiated from equipment/devices which have not been reprocessed (e.g. colour coding). | | High | | | | Refer to: PIDAC CDS – See section on *Transportation and Handling of Contaminated Medical Equipment/Devices*<br><br>See also: CSA Group. CSA Z314.8-14: Decontamination of reusable medical devices. Toronto, ON: CSA Group; 2014 | |

| 11 | Other Considerations | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 11.1 | There is a process for receiving and disseminating medical equipment/device alerts and recalls originating from manufacturers or government agencies. | | Med. | | | | Refer to: PIDAC CDS – See section on *Continued Monitoring and System Failures*<br><br>See also: CSA Group. CSA Z314.0-13: Medical device reprocessing – general requirements. Toronto, ON: CSA Group; 2013 | |

| 12 | Record Keeping | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection |
|---|---|---|---|---|---|---|---|---|
| 12.1 | A written log of test results is maintained. | | **High** | | | | A log is kept of chemical indicator monitoring results. A record is kept of each sterilization/HLD cycle<br><br>Information to be recorded: Load control label (sterilizer/AER number, load number and date of sterilization/HLD); recording chart/printout of physical parameters of the sterilization/HLD cycle; load contents; person responsible for the sterilization/HLD cycle<br><br>Refer to: PIDAC CDS – See sections on *Sterilization of Reusable Medical Equipment/Devices;* and, *Appendix E: Sample Program Audit Tool for Endoscope Reprocessing*<br><br>See also: CSA Group. CSA Z314.0-13: Medical device reprocessing – general requirements. Toronto, ON: CSA Group; 2013<br><br>Additional resource: IPAC Canada Endoscopy audit tool, 9.10 and 9.11, pg. 14) | |

**Please print and sign.**

| | |
|---|---|
| **Owner/Operator (print name):**<br><br>**Signature:** | **Date:** |
| **Person conducting visit (print name):**<br><br>**Signature:** | **Date:** |

Public Health Ontario acknowledges the financial support of the Ontario Government.

Public Health Ontario | Santé publique Ontario

PARTNERS FOR HEALTH | PARTENAIRES POUR LA SANTÉ

# Checklist for Infection Prevention and Control (IPAC) CORE Elements in Clinical Office Practice

**When to use this document:** This checklist was developed as a tool to assist public health units and others during IPAC lapse investigations and can be used to conduct inspections, audits and reviews of IPAC programs.

**Disclaimer:** Public Health Ontario (PHO) has developed this *Checklist for Infection Prevention and Control (IPAC) CORE Elements in Clinical Office Practice* and its content, based on the Provincial Infectious Disease Advisory Committee's (PIDAC's) *Infection Prevention and Control for Clinical Office Practice, June 2013*. This document is intended to support a review or audit of public health practices and does not replace best clinical practices or legislative requirements. PHO is not responsible for any losses or damages arising from the use of this document or its contents, including for any purposes to inform any decision or determination, clinical or otherwise, regarding inspections, findings, outcomes or recommendations.

Location name: _____

Location address: _____

Date of visit: _____

Reason for inspection: _____

Name of inspector: _____

Location contact (name, title and phone number): _____

| | |
|---|---|
| **Leg. Req. = Legislated Requirement:** | Must be compliant with the relevant Act or regulation (e.g. *Occupational Health and Safety Act*). |
| **High Risk:** | Immediate health hazard exists. Stop practice and correct immediately. The act or failure to act immediately may lead to the transmission of infection or risk of illness or injury. Practices that cannot be corrected immediately must be stopped until the health hazard is observed to have been eliminated. An Order may be warranted/issued. |
| **Medium Risk:** | Signifies practices that must be corrected. Timelines for compliance or agreement on alternate process determined during inspection. |
| **Inform and Educate (I/E):** | Provide information regarding best practices, mandatory legislated practice requirements etc. This may also include just-in-time education. |

**NOTE: These categorizations represent the minimum risk level. Based on good judgement and circumstance, public health units may increase the risk category.**

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 1 | Reception/Waiting Area | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 1.1 | There is appropriate infection prevention and control signage at the entrance of the clinic and at the reception desk. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *4. Routine Practices, D. Booking, Reception and Placement.* | |
| 1.2 | There is a process for managing patients with suspected febrile respiratory infections, diarrhea and vomiting, rash and eye infections to prevent transmission to others. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *4. Routine Practices, D. Booking, Reception and Placement.* | |
| 1.3 | There is 70% - 90% alcohol-based hand rub (ABHR) and masks available at reception, with signage for appropriate use. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *4. Routine Practices, B. Hand Hygiene Products.*<br><br>ABHR for hand hygiene has a minimum concentration of 60% alcohol but a concentration of 70% is preferable to be effective against Norovirus. | |
| 1.4 | There are tissue boxes available. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *D. Booking, Reception and Placement, 2. Respiratory Etiquette* and See *Appendix E* for a sample sign for reception areas, *Cover Your Cough*.<br><br>Waste recepticles should be available for immediate disposal of tissues after use. Access to ABHR for immediate hand hygiene after disposal of tissues.<br><br>If tissues are not available, other avoidance measures (e.g., sneeze into sleeve) may be used. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 1 | Reception/ Waiting Area | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 1.5 | Furniture, items and touch surfaces are cleaned and disinfected (e.g. chairs, toys, books). | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *7. Control of the Environment, A. Cleaning the Environment, 2. Surfaces and Finishes.* | |

| 2 | Policies and Procedures | Leg. Req. | Risk | C | NC | N/A | Notes/Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 2.1 | There are written Infection Prevention and Control (IPAC) policies and procedures that are based on the most current best practices. | | **Med.** | | | | For Items 2.1 to 2.3:<br>Refer to: *PIDAC's Best Practices for Infection Prevention and Control Programs in Ontario, May, 2012*. See section *9. IPAC Program Functions, B. Policies and Procedures.*<br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*.<br>Policies and procedures may include but are not limited to the following areas:<br>• Routine Practices such as hand hygiene, risk assessment and appropriate selection and use of PPE<br>• Environmental cleaning and waste management<br>• Requirements for education and training of staff and physicians<br>• Healthy workplace and occupational health policies such as work restrictions when ill and management of exposures to blood and body fluids<br>Policies and procedures may vary depending on the size of the clinical setting and the complexity of services provided. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 2 | Policies and Procedures | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 2.2 | Policies and procedures are reviewed and updated as required on a regular basis. | | **I/E** | | | | See 2.1 Notes/Resources | |
| 2.3 | Staff members have access to the IPAC policies and procedures and are familiar with their use. | | **I/E** | | | | See 2.1 Notes/Resources | |
| 2.4 | IPAC and Occupational Health and Safety policies and procedures are followed by all staff including physicians. | | **I/E** | | | | Refer to: *PIDAC's Best Practices for Infection Prevention and Control Programs in Ontario, May, 2012*. See section *4. Occupational Health and Safety (OHS).* | |

| 3 | Education | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 3.1 | Regular education (including orientation and continuing education) and support is provided in clinical office practices to help staff consistently implement appropriate infection prevention and control (IPAC) practices. | **Leg.** | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *2. Staff Education and Training.*<br><br>Persons with knowledge of IPAC should be active participants in the planning and implementation of IPAC educational programs. | |
| 3.2 | There is a process for recording and reporting of attendance at staff education and training. | **Leg.** | **I/E** | | | | Refer to: *PIDAC's Routine Practices and Additional Precautions in All Health Care Settings, November, 2012*. See section on *2. Staff Education and Training.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

For Sections 4.1 to 7.2 please refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May 2012*

| 4 | General Environmental Cleaning including Products | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 4.1 | Surfaces, furnishings, equipment and finishes are smooth, non-porous, seamless and cleanable (e.g. no unfinished wood or cloth furnishings). | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *7. Control of the Environment, A. Cleaning the Environment, 2. Surfaces and Finishes.*<br>Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012*. See section on *Surfaces in Health Care Settings and Finishes in Health Care Settings (Walls, Flooring).* | |
| 4.2 | There is written procedure for immediate containment, cleaning and disinfection of spills of blood and body fluids. | | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment*<br>*A. Cleaning the Environment,* 8. Cleaning *up Body Fluid Spills.*<br>Refer to: *Environmental Cleaning Toolkit Videos* - Cleaning a Blood Body Fluid Spill. | |
| 4.3 | There are procedures for cleaning each area of the clinic. If cleaning is contracted out, the cleaning contractor has procedures in place for cleaning each area of the clinic. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment*<br>*A. Cleaning the Environment, 6. End of Day Cleaning* and *7. Scheduled Cleaning.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 4 | General Environmental Cleaning including Products | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 4.4 | Chemical products used for environmental cleaning:<br>• Have a drug identification number (DIN) from Health Canada<br>• Are prepared and used according to manufacturer's instructions for dilution, temperature, water hardness, use, shelf life and storage conditions;<br>• Are labelled with expiry date;<br>• Are stored in a manner that reduces risk of contamination. | | **High** | | | | Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012*. See Section *1. Principles of Cleaning and Disinfecting Environmental Surfaces in a Health Care Environment, D. Cleaning Agents and Disinfectants.* | |

| 5 | Environmental Cleaning/ Reception Area | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 5.1 | Routine cleaning and disinfection of touch surfaces and floors is done at least daily. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment.*<br>*A. Cleaning the Environment, 6. End of Day Cleaning* and *7. Scheduled Cleaning.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 6 | Environmental Cleaning/Health Care Environment i.e. areas where direct care is provided | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 6.1 | Health care environment areas and high touch surfaces are cleaned and disinfected daily. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment.*<br>*A. Cleaning the Environment, 1. General Principles of Environmental Cleaning.*<br>Refer to: PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012. See Section on *Frequency of Contact with Surfaces.*<br>Clinical component is the area involved in patient care. This is comprised of the clinical areas of the office, including examination rooms, procedure rooms, bathrooms and diagnostic and treatment areas. Areas designated in the clinical component are cleaned with a detergent and then disinfected with a hospital-grade disinfectant. 'High-touch' surfaces may require more frequent cleaning. | |
| 6.2 | Surfaces/items that come into direct contact with the patient's body fluids (e.g. urine or blood), are cleaned and disinfected between patients. | | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment A. Cleaning the Environment, 3. Principles of Cleaning and Disinfection* and *8. Cleaning up Body Fluid Spills.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 6 | Environmental Cleaning/Health Care Environment i.e. areas where direct care is provided | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 6.3 | Horizontal surfaces of exam table are cleaned and disinfected between patients (even when paper is used) and when visibly soiled. Where paper is used on exam tables, it must be changed between patients. | | **Med.** | | | | Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012.* See section *D. Cleaning Agents and Disinfectants- Using Disinfectants.*<br><br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *7. Control of the Environment*<br>*A. Cleaning the Environment,1. General Principles of Environmental Cleaning-*<br>*Clinical component;* 5. *Cleaning Between Patients;* and *Table 1: Frequency of cleaning items in the clinical practice setting.*<br><br>Clean and disinfect using an approved surface cleaner and a hospital-grade low-level disinfectant (These products are also available as a one-step cleaner/disinfectant).<br><br>Avoid using spray bottles to apply products as aerosols are a safety risk.<br><br>Change cleaning cloths, mop heads and disinfectant solution in buckets frequently. DO NOT double-dip cleaning cloths. | |
| 6.4 | Treatment area is cleaned and disinfected between clients/patients. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *7. Control of the Environment, A. Cleaning the Environment.*<br><br>Areas designated in the clinical component are cleaned with a detergent and then disinfected with a hospital-grade disinfectant. 'High-touch' surfaces may require more frequent cleaning. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 7 | Environmental Cleaning/Other Environment (office, storage of supplies, hallways etc.) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 7.1 | Routine cleaning of touch surfaces within other environments, is done at least weekly. | | I/E | | | | Refer to: *PIDAC's Routine Practices and Additional Precautions in All Health Care Settings, November, 2012*. See *Appendix E: PIDAC'S Routine Practices Fact Sheet for All Health Care Settings.* | |
| 7.2 | Clean or sterile medical supplies are not stored under sinks, nor on counters adjacent to sinks where they can become contaminated. | | High | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *4. Routine Practices, B. Hand Hygiene, 5. Hand Washing Sinks.* | |
| 7.3 | Waste disposal meets provincial regulations and local bylaws, with attention to sharps and biomedical waste. | Leg. | High | | | | Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012*. See *Table 2: Disposal Streams for Biomedical and General Waste* and *Collection of Waste.*<br><br>Segregate waste at the point where it was generated into either plastic bag or rigid container with a lid.<br><br>Do not double-bag waste unless the first bag becomes stretched or damaged, or when waste has spilled on the exterior.<br><br>Close waste bags when three-quarters full and tie in a manner that prevents contents from escaping.<br><br>Biomedical waste is to be stored in a secure (locked) dedicated area that is clearly marked with a biohazard symbol.<br><br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *7. Control of the Environment.*<br><br>*A. Cleaning the Environment, 12. Waste* and *13. Sharps.*<br><br>Refer to: CSA Group. Z317.10-09 (R2014): Handling of waste materials in | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 7 | Environmental Cleaning/Other Environment (office, storage of supplies, hallways etc.) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| | | Leg. | High | | | | health care facilities and veterinary health care facilities. Toronto, ON: CSA Group; 2014. | |

| 8 | Routine Practices/ Additional Precautions (Hand hygiene, PPE) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 8.1 | There is the ability to perform hand hygiene at the point of care using ABHR or liquid soap and water if hands are visibly soiled. | | High | | | | Refer to: *PIDAC's Best Practices for Hand Hygiene in All Health Care Settings, April 2014*. See Sections on *What is Hand Hygiene?; Alcohol - based hand rub vs. soap and water; Alcohol Based Hand Rub (ABHR); Hand Washing Sinks and Soap Formulations and Product Selection C., Placement of ABHR Dispensers.*<br><br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *4. Routine Practices, B.Hand Hygiene, 2. Hand Hygiene Products.*<br><br>This becomes semi-critical for *PIDAC moment #2 of hand hygiene*. Of importance: 1) ABHR for hand hygiene has a minimum concentration of 60% alcohol but a concentration of 70% is preferable to be effective against Norovirus; 2) ABHR is available in each examination room or where patient care is provided; 3) There are dedicated hand hygiene sinks with liquid soap available in each clinic; 4) Bottles of ABHR and liquid soap are not to be "topped up" when partially full or empty, but replaced with new bottles of product. **Bar soap is not acceptable**. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 8 | Routine Practices/ Additional Precautions (Hand hygiene, PPE) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| | | | High | | | | ABHR dispensers should be available immediately adjacent to the entrance to every client care area (e.g., outpatient clinic room) unless contraindicated by guidelines from the Ontario Fire Marshall's Office. | |
| 8.2 | Effective hand hygiene requirements are in place: no artificial nails or nail enhancements and preferably no polish. Any polish must be fresh and not chipped. Nails are short (i.e. not more than 2mm beyond fingertip). | | I/E | | | | Refer to: *PIDAC's Best Practices for Hand Hygiene in All Health Care Settings, April 2014*. See Section *II Best Practices, 5. Impediments to Effective Hand Hygiene*.<br><br>Measures include: 1) Nails must be kept clean and short; 2) Nail polish, if worn, must be fresh and free of cracks or chips; 3) Artificial nails or nail enhancements must not be worn; 4) Rings are not worn, preferably; 5) Hand and arm jewellery, including watches, are must be removed or pushed up above the wrist by staff caring for clients before performing hand hygiene. | |

| 9 | Personal Protective Equipment (PPE) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 9.1 | PPE such as gowns, gloves, masks, and eye protection, is available at point of care. | Leg. | High | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *1. Legislation Relating to Infection Prevention Control Practices in the Clinical Office - The Occupational Health and Safety Act (OHSA)* and *4. Routine Practices, C. Personal Protective Equipment (PPE)*. | |
| 9.2 | PPE such as gowns, gloves, masks, and eye protection are selected based on risk assessment and worn appropriately. | | High | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *4. Routine Practices, C. Personal Protective Equipment (PPE)* and section *5. Additional Precautions.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 9 | Personal Protective Equipment (PPE) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| | | | High | | | | Staff are educated and trained on principles and components of Routine Practices as well as additional transmission-based precautions (Additional Precautions) and assessment of the risk of infection transmission and the appropriate use of PPE, including safe application, removal and disposal. | |

| 10 | Medical Equipment/Devices used to provide Patient Care | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 10.1 | Non-critical items are cleaned and low-level disinfected between uses. | | Med. | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See *Appendix B: Reprocessing Decision Chart.*<br><br>Refer to: CSA Group. CAN/CSA - Z314.0-13: Medical device reprocessing - General requirements. Toronto, ON: CSA Group; 2013.<br><br>Medical equipment that comes into contact with the patient's intact skin requires low-level disinfection (LLD) after each use. Equipment and surfaces must be thoroughly cleaned prior to LLD. Examples of items that require LLD include stethoscopes, blood pressure cuffs, oximeters, baby scales, ECG. | |
| 10.2 | Reprocessed medical equipment/devices is/are stored in a clean, dry location in a manner that minimizes contamination or damage. | | High | | | | Refer to: CSA Group. CSA Z314.0-13: Medical device reprocessing - General requirements. Toronto, ON: CSA Group; 2013. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 10 | Medical Equipment/Devices used to provide Patient Care | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 10.3 | Newly purchased, non-sterile critical and semicritical medical equipment/devices are inspected and reprocessed prior to use, according to their intended use as per manufacturer's recommendations. | | **High** | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See section *A. Purchasing and Assessing Medical Equipment/Devices and/or Products for Disinfection or Sterilization Processes.* | |
| 10.4 | Critical and semi-critical medical equipment/devices labelled as single-use are not reprocessed and re-used unless the reprocessing is done by a licensed third party reprocessor. | | **High** | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See section *P. Single-Use Medical Equipment/Devices.* | |
| 10.5 | Semi-critical items shared between patients such as tonometers, other ophthalmologic equipment that touch the eye (mucous membrane), vaginal specula and other semi-critical items that come into contact with mucous membranes or non-intact skin must undergo high level disinfection between patient uses. | | **High** | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See *Table 1: Spaulding's Classification of Medical Equipment/Devices and Required Level of Processing/ Reprocessing* and *Appendix B: Reprocessing Decision Chart.*<br>Examples of high level disinfectants include 2% glutaraldehyde, 6% hydrogen peroxide, 0.2% peracetic acid, etc.<br>Alcohol is a low level disinfectant and is not sufficient.<br>Always follow manufacturer's directions for reprocessing. | |
| 10.6 | All **critical** items e.g. suture removal equipment, are either **SINGLE PATIENT USE** (disposable) **or sterilized** between uses. | | **High** | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See *Table 1: Spaulding's Classification of Medical Equipment/Devices and Required Level of Processing/ Reprocessing Section P: Single-Use Medical Equpiment/Devices – Sharps* and Section *2. Best Practices A. Purchasing and Assessing Medical Equipment/Devices and/or Products for Disinfection or Sterilization Processes.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 10 | Medical Equipment/Devices used to provide Patient Care | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| | | High | | | | | Instruments that enter a sterile body site, including the vascular system are classified as critical and require cleaning followed by sterilization. Other examples of these instruments include surgical instruments and biopsy instruments.<br>Needles must be single-use and must not be reprocessed. | |
| 10.7 | At point-of-use, upon opening the reprocessed medical equipment/device, the integrity of the packaging and the equipment/device is checked; results of chemical monitors, if present, are validated; and equipment/devices are reassembled, if required. | | | | | | Refer to: *PIDAC's Best Practices for Cleaning, Disinfection and Sterilization in All Health Care Settings, May 2013*. See section *Q: Storage and Use of Medical Equipment/Devices - Using Sterile Equipment/Devices.* | |

**NOTE: If any reusable critical or semi-critical medical devices/equipment is being reprocessed within the clinical office, also complete Medical Device Reprocessing tab**

| 11 | Medication Room/Area | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 11.1 | There are facilities for hand hygiene in the medication room/area. These include either a dedicated hand hygiene sink and/or alcohol based hand rub (ABHR). | | High | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *B: Hand Hygiene, 5. Hand Washing Sinks.*<br>Refer to: *PIDAC's Routine Practices and Additional Precautions in All Health Care Settings, November, 2012*. See section *on Hand Hygiene, Alcohol-based Hand Rub (ABHR).*<br>Refer to: *PIDAC's Best Practices for Hand Hygiene in All Health Care Settings, April 2014*. See section *9. Hand Hygiene Considerations in Facility Design, A. Hand Washing Sinks.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 11 | Medication Room/Area | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 11.2 | The medication preparation area is a dedicated area that is separate from areas that may potentially be contaminated with blood and body fluids. | | **High** | | | | For 11.2- 11.6:<br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.*<br><br>See section *6. Medications, Vaccines and Skin Antisepsis item C. Refrigerators* and *Appendix H: Checklist for Safe Medication Practices.*<br>If a dedicated/separate area is not available, prepare medication in a clean area away from splashes e.g. not near hand hygiene sink or where specimens are being handled. | |
| 11.3 | There is a dedicated medication/vaccine refrigerator. | | **High** | | | | See 11.2 Notes/Resources and refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *6. Medications, Vaccines* and *Skin Antisepsis, C. Refrigerators* and *D. Vaccines.*<br><br>For more information about vaccine storage and handling, refer to the Ontario Ministry of Health and Long Term Care's (2012) *Vaccine Storage and Handling Guidelines.* | |
| 11.4 | There is a dedicated patient specimen refrigerator. | | **High** | | | | See 11.2 Notes/Resources | |
| 11.5 | Food is not stored with either medication/vaccines or specimens. | | **High** | | | | See 11.2 Notes/Resources | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 12 | Injectable Medication Vials or Solutions | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 12.1 | Single-dose injectable medications are used once on a single patient and discarded immediately. | | **High** | | | | For 12.1-12.5:<br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *6. Medications, Vaccines and Skin Antisepsis A. General Principles* and section *B. Safe Administration of Injectables- item 2. Single Dose Vials* and *Appendix H: Checklist for Safe Medication Practices.*<br>The use of SINGLE USE vials is always preferred. | |
| 12.2 | Rubber stoppers (diaphragm/septum) of vials are scrubbed with either 70% alcohol prep pad or 70% alcohol pumped onto a cotton ball prior to entry into the vial in preparation for administration. Stopper is allowed to dry before inserting a new needle into the vial. | | **High** | | | | Refer to: PHO's Updated guidance on the use of multidose vials.<br>See 12.1 Notes/Resources | |
| 12.3 | Product monograph is followed and referred to for further clarification regarding correct storage (e.g. refrigeration, keep away from light), handling, preparation, and directions for administration. | | **High** | | | | See 12.1 Notes/Resources | |
| 12.4 | Unopened vials and other products are discarded according to the manufacturer's expiration dates. | | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *6. Medications, Vaccines and Skin Antisepsis - A. General Principles.* | |
| 12.5 | Leftover contents of vials (single-dose or multidose) are never pooled. | | **High** | | | | See 12.1 Notes/Resources | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 13 | Multidose vials | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 13.1 | Multidose vials have been replaced with single-dose vials wherever possible. | | I/E | | | | For 13.1 – 14.4 Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *6. Medications, Vaccines and Skin Antisepsis, 3. Multidose Vials* and *Appendix H: Checklist for Safe Medication Practices.* | |
| 13.2 | If a multidose vial is used, it must be used for a single patient whenever possible and labelled with the patient's name. | | Med. | | | | See 13.1 Notes/Resources | |
| 13.3 | The multidose vial is labelled with the date it was first used, to facilitate discarding at the appropriate time. | | High | | | | See 13.1 Notes/Resources | |
| 13.4 | All needles are SINGLE PATIENT USE ONLY. | | High | | | | See 13.1 Notes/Resources | |
| 13.5 | All syringes are SINGLE PATIENT USE ONLY. | | High | | | | See 13.1 Notes/Resources | |
| 13.6 | Multidose vials are never entered with a used needle OR used syringe. | | High | | | | See 13.1 Notes/Resources | |
| 13.7 | The multidose vial is accessed on a surface that is clean and where not dirty, used or potentially contaminated items are placed or stored. | | High | | | | See 13.1 Notes/Resources | |
| 13.8 | Once medication is drawn up, the needle is IMMEDIATELY withdrawn from the vial. A needle is NEVER left in a vial to be attached to a new syringe. | | High | | | | See 13.1 Notes/Resources | |
| 13.9 | The multidose vial is discarded immediately if sterility is compromised or questioned. | | High | | | | See 13.1 Notes/Resources | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 13 | Multidose vials | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 13.10 | Opened multidose vials are discarded according to the manufacturer's instructions or within 28 days, whichever is shorter. | | **High** | | | | See 13.1 Notes/Resources<br>NOTE: Exceptions can be considered for multidose vials intended for single patient e.g. allergy shots, if the manufacturer's instructions state the vial can be used for longer than 28 days, provided all other above recommendations are followed and the vial must only be used for a single patient. | |

| 14 | Aseptic technique is always practised for percutaneous injection | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 14.1 | Hand hygiene is performed immediately prior to handling and administration of injectable products (e.g. vials, needles, syringes). | | **High** | | | | Refer to: *PIDAC's Best Practices for Hand Hygiene In All Health Care Settings, April 2014.* See section *II. Best Practices, 3. Indications and Moments for Hand Hygiene during health care activities*<br>Critical risk related to PIDAC moment #2 of hand hygiene (i.e. before aseptic procedure). | |
| 14.2 | Alcohol containers are labelled and are not topped up. | | **Med.** | | | | Refer to: *PIDAC's Best Practices for Hand Hygiene In All Health Care Settings, April 2014.* See *Appendix C: PIDAC's Hand Hygiene Fact Sheet for Health Care Settings – Factors that Reduce the Effectiveness of Hand Hygiene*. | |
| 14.3 | Skin should be prepped with 70% alcohol prior to injection. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *6. Medications, Vaccines and Skin Antisepsis, G. Antiseptic Agents for Skin Antisepsis.* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 14 | Aseptic technique is always practised for percutaneous injection | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 14.4 | Preferably disposable single use alcohol prep pads are used to prepare the skin for injection. Seventy (70 %) alcohol pumped onto cotton balls at time of use is permitted. | | **I/E** | | | | Refer to: United States Pharmacopeial Convention. USP Compounding Compendium. Rockville, MD: United States Pharmacopeial Convention; 2014. USP 797 Pharmaceutical Compounding – sterile preparations; p. 57.<br><br>Cotton balls are stored in a clean covered container. | |

| 15 | Vaccines (if applicable) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 15.1 | Cold chain is maintained according to PHAC Canadian Immunization Guide and MOHLTC Vaccine Storage and Handling Guidelines. | | **High** | | | | For 15.1- 15.4 Refer to the following:<br><br>National Advisory Committee on Immunization; Public Health Agency of Canada. Canadian immunization guide [Internet]. Evergreen ed. Ottawa, ON: Her Majesty the Queen in Right of Canada; 2015. Part 1: key immunization information 2013 – storage and handling of immunizing agents. . Available from: http://www.phac-aspc.gc.ca/publicat/cig-gci/p01-08-eng.php<br><br>Ontario. Ministry of Health and Long-Term Care. Vaccine storage and handling guidelines [Internet]. Toronto, ON: Queen's Printer for Ontario; 2012. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/guide_vaccine_storage.pdf<br><br>Ontario. Ministry of Health and Long-Term Care. Vaccine storage and handling protocol, 2016 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2016. Available from: http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/vaccine_storage_handling.pdf | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 15 | Vaccines (if applicable) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 15.2 | Temperatures of refrigerators and freezers used to store vaccines are checked twice daily and recorded as per recommended public health protocols. | | **High** | | | | See 15.1 Notes/Resources | |
| 15.3 | Vaccines are kept refrigerated at a temperature between 2°C and 8°C (unless otherwise specified by the manufacturer) and are stored according to manufacturer's instructions (e.g. kept frozen at a temperature of -15°C or colder, protected from light, refrigerated). | | **High** | | | | See 15.1 Notes/Resources<br><br>See Public Health Agency of Canada. Immunization competencies for health professionals. Ottawa, ON: Her Majesty the Queen in Right of Canada; 2008. Section 7, Storage an dhandling of immunization agents; p. 18. Available from: http://www.phac-aspc.gc.ca/im/pdf/ichp-cips-eng.pdf<br><br>If vaccine is to be refrigerated, it is not stored in refrigerator doors. If refrigerator temperatures are less than 2°C or greater than 8°C (unless otherwise specified by the manufacturer for a particular vaccine), report immediately to the public health unit for assessment of vaccine potency. | |
| 15.4 | There is an alarm on the medication/ vaccine refrigerator to warn when the temperature falls outside the recommended range and a protocol is in place to follow-up regarding break in cold chain. | | **I/E** | | | | See 15.1 Notes/Resources | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 16 | Sharps Safety Program | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 16.1 | Sharps containers must be: 1) clearly labelled as sharps containers, preferably with a Biohazard symbol, or colour-coded according to the employer's safe work practices; 2) puncture-resistant; 3) tamper-proof; 4) closable; contained sharps must not be able to fall out with normal use; 5) leakproof on both sides and bottom; 6) not filled past the fill line, usually at the 3/4 mark. | **Leg.** | **High** | | | | For 16.1- 16.7 Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *7. Control of the Environment, 13. Sharps,* and *14. Sharps Containers*<br><br>Refer to: CSA Group. CAN/CSA-Z316.6-14: Sharps injury protection - Requirements and test methods - Sharps containers. Toronto, ON: CSA Group; 2014. | |
| 16.2 | Sharps containers are available at point of use for direct disposal, to minimize handling or transportation of used sharps. | | **High** | | | | See 16.1 Notes/Resources | |
| 16.3 | Sharps containers are securely stored for timely, safe removal once full, according to local legislated biomedical waste by-laws. | **Leg.** | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *7. Control of the Environment*<br>*A. Cleaning the Environment, 12. Waste* | |
| 16.4 | Sharps/needles/syringes must be safety-engineered medical sharps (SEMS). | **Leg.** | **High** | | | | See 16.1 Notes/Resources<br><br>Refer to: *Occupational Health and Safety Act (OHSA);* Needle Safety, O. Reg. 474/07. Available from: https://www.ontario.ca/laws/regulation/070474<br><br>A SEMS is a hollow-bore needle that is designed to eliminate or minimize the risk of a skin puncture injury to the worker, and is licensed as a medical device by Health Canada. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 16 | Sharps Safety Program | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 16.5 | There is a policy or procedure in place to prevent the transmission of blood-borne pathogens (i.e. hepatitis B, hepatitis C and HIV) that includes an immunization policy for hepatitis B vaccination and a record of documented immunity to hepatitis B by serology. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *10. Administrative Controls* and item, *B. Staff Immunization.*<br><br>Refer to: Ontario Hospital Association; Ontario Medical Association. Blood-borne diseases surveillance protocol for Ontario hospitals. Revised March 2015 [Internet]. Toronto, ON: Ontario Hospital Association; 2015. Available from: https://www.oha.com/Services/HealthSafety/Documents/Blood%20Borne%20Diseases%20Protocol%20-%20Reviewed%20and%20Revised%20March%202015.pdf<br><br>If there are no policies, recommend Hepatitis B vaccine for clinic staff given potential for needle stick injury. | |
| 16.6 | There is a blood-borne pathogen post-exposure management policy or procedure that incorporates worker education and facilitation of timely access to a medical assessment for appropriate post-exposure prophylaxis PEP if indicated (e.g. HIV PEP medications). Reporting of sharps injuries to the Workers' Safety and Insurance Board (WSIB) is required* and to the Ministry of Labour, as appropriate.<br><br>*Dependent on size of employer | | **Med.** | | | | Refer to: *PIDAC's Routine Practices and Additional Precautions in All Health Care Settings, November, 2012.* See section *C. Occupational Health and Hygiene Issues - Post - Exposure Follow Up*<br><br>Refer to: CSA Group. CSA-Z314.0-13: Medical device reprocessing - general requirements. Toronto, ON: CSA Goup; 2013. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 16 | Sharps Safety Program | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 16.7 | There are written measures and procedures to prevent and manage injuries from sharp objects. | **Leg.** | **High** | | | | See 16.1 Notes/Resources<br>Refer to: CSA Group. CAN/CSA-Z314.0-13 Medical device reprocessing - general requirements. Toronto, ON: CSA Group; 2013.<br>Refer to: Health Care and Residential Facilities, O. Reg. 67/93. Available from: https://www.ontario.ca/laws/regulation/930067 | |

| 17 | Specimen Handling | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 17.1 | There is a policy or procedure for appropriate handling of all blood and body fluids. This includes blood specimens obtained through venipuncture and urine specimens either provided on site or brought in to a clinic. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *A. Cleaning the Environment, 8. Cleaning up Body Fluid Spills.* | |
| 17.2 | Tourniquets are non-latex and are single use. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See Section *C. Personal Protective Equipment (PPE), 1. Gloves-Types of Gloves* and *Appendix I: Recommended Minimum Cleaning and Disinfection Level and Frequency for Medical Equipment.*<br>Refer to: PHO's *Just Clean Your Hands* Hand Care Program. See *Appendix B: Common Irritants to Skin Health (not all inclusive).* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 17 | Specimen Handling | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 17.3 | For urine samples, there is a safe process for handling specimens and disposal. Urine is never disposed of in a hand hygiene sink. | | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *7. Control of the Environment*<br>*A. Cleaning the Environment, 12. Waste-Waste Streams and Disposal Requirements.*<br>Urine specimen containers can be discarded in the following ways:<br>a) Preferred: Specimen containers can be emptied into a toilet with gloved hands and the empty containers disposed of as general waste (i.e. green or black bag).<br>b) Alternative: Full urine containers that are tightly sealed can be disposed of into a yellow medical waste bag. Waste in a yellow bag is biomedical waste and needs to be disposed of by a biomedical waste disposal company.<br>**Not recommended:** Urine should not be put down sinks in the patient exam room. Sinks in patient exam rooms should be used only for washing hands. | |
| 17.4 | There is a designated storage area for specimens separate from cleaning supplies. | | **I/E** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015.* See section *5. Hand Washing Sinks* and section *B. Clinical Office Design/ Renovations, Storage/ Utility Area(s).* | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 17 | Specimen Handling | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 17.5 | Appropriate PPE is worn by staff when handling blood or other body fluids (e.g. urine). | | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *4. Routine Practices, C. Personal Protective Equipment (PPE).*<br><br>Appropriate PPE shall be used when handling blood or other body fluids based on risk assessment.<br><br>Recommendations:<br><br>9. Gloves should be worn if it is anticipated that hands will be in contact with blood, body fluids, secretions or excretions.<br><br>10. A gown should be worn if it is anticipated that arms and/or clothing will be in contact with blood, body fluids, secretions or excretions.<br><br>11. Facial protection should be worn if it is anticipated that the mucous membranes of the eyes, nose and/or mouth will be in contact with blood, body fluids, secretions or excretions. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 18 | Lancets and Glucometers (If applicable) | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 18.1 | Lancets are SINGLE USE ONLY. | | **High** | | | | For 18.1 to 18.3 Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*<br>See section *6. Medications, Vaccines and Skin Antisepsis, B. Safe Administration of Injectables - I. Point-of-Care Testing.*<br>As of September 26, 2014, blood monitors must meet the guidelines outlined in Health Canada. Notice –September 26, 2014: New requirements for medical device license applications for lancing devices and blood glucose monitoring system [Internet]. Ottawa, ON: Health Canada; 2014.<br>For questions or clarification on the content of the Notice, please contact: Device Evaluation Division, Medical Devices Bureau, Therapeutic Products Directorate, Health Canada, 2934 Baseline Road, Tower B, Ottawa, ON, K1A 0K9, Telephone: 613-954-0297, Fax: 613-957-9969, E-mail: MDB Enquiries@hc-sc.gc.ca<br>Licensing for lancing devices and blood glucose meters can be confirmed by searching on Health Canada's Medical Devices Active Licence Listing. | |
| 18.2 | Lancet hubs (holds the lancet) are SINGLE USE ONLY. | | **High** | | | | See 18.1 Notes/Resources | |
| 18.3 | Glucometers (blood glucose monitoring devices) are not shared between patients unless the device is designed for multi-patient use and cleaned and disinfected after use with each patient, as per manufacturer's recommendation. | | **High** | | | | See 16.1 Notes/Resources<br>If the manufacturer does not specify how the device should be cleaned and disinfected, then the device cannot be shared. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 19 | Blood Collection Devices | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 19.1 | SINGLE USE blood collection tube holders are PREFERRED. If blood tube holders are reused, they **MUST** be designed for **multi-patient use** and cleaned and disinfected after each use with a low level disinfectant (LLD), following the manufacturer's instructions for re-use. | | **High** | | | | Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May, 2012*. See *Appendix G: Recommended Minimum Cleaning and Disinfection Level and Frequency for Non-critical Client/ Patient/Resident Care Equipment and Environmental Items.*<br><br>*PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See Section *8. Reprocessing Medical*<br><br>*Equipment, C. Single-Use Medical Devices.*<br>Refer to: *Top Five High Risk Practice Recommendations and Occupational Health and Safety Responsibilities.* | |

| 20 | Occupational Health and Safety | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 20.1 | Responsible physicians in this setting understand their duties and responsibilities as employers and supervisors under Ontario's *Occupational Health and Safety Act (OHSA)* to ensure workers know about hazards and dangers by providing information, instruction, supervision on how to work safely (e.g. appropriate handling of chemicals) and training and access to appropriate PPE based on risk assessment of exposure. | **Leg.** | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *1. Legislation Relating to Infection Prevention and Control Practices in the Clinical Office- A. The Occupational Health and Safety Act (OHSA).*<br><br>Refer to: Ontario. Ministry of Labour. A guide to the Occupational Health and Safety Act. Revised March 20, 2015 [Internet]. Toronto, ON: Queen's Printer for Ontario; 2015. Available from: https://www.labour.gov.on.ca/english/hs/pubs/ohsa/ | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 20 | Occupational Health and Safety | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 20.2 | There is a healthy workplace policy which includes a clear expectation that staff do not come into work when ill with symptoms of infection. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *10. Administrative Controls - A. Healthy Workplace Policies* and *Section D. Infections in Health Care Providers.*<br><br>It is incumbent on a physician to protect individuals within his or her clinical office practice. This responsibility is not restricted to patients, but rather, includes clinical office staff and other visitors as well. Infectious agents are not only spread person-to-person, but can also be spread indirectly through inanimate objects known as fomites. The waiting room of a clinical office practice may also be a source for many communicable diseases. As such, protective mechanisms must be in place, not only in direct patient management but in handling of the clinical office environment as well.<br><br>All clinical office settings should establish a clear expectation that staff do not come into work when ill with symptoms of infection. This includes not working when acutely ill with signs and symptoms likely due to a transmissible infection, such as fever, cough, influenza-like symptoms, runny nose, sore throat, vomiting, diarrhea, rash or conjunctivitis.<br><br>If the decision is made that the health care provider must work (weighing the risks and benefits of working against not providing patient care), scrupulous hand hygiene and appropriate PPE (e.g., wear a mask if you have a cold) is essential to minimize the possibility of transmission of infection. | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 20 | Occupational Health and Safety | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 20.3 | Staff members are immunized appropriately. | | **Med.** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *D. Occupational Health and Safety Issues, 3. Communicable Disease Status.*<br><br>Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *10. Administrative Controls-Healthy Workplace Policies, B. Staff Immunization.*<br><br>Ideally all immunizations recommended for adults are recorded, such as measles, mumps, rubella (MMR), varicella, diphtheria, tetanus and acellular pertussis vaccines.<br><br>Although not mandated through legislation, hepatitis B vaccination is strongly recommended due to the risk of blood-borne pathogen exposure. Health care workers should have a record of vaccination and a record of sufficient antibodies to protect against infection (i.e. greater than 10U/L). Annual influenza vaccination is also strongly advised. | |
| 20.4 | Disposable sharps shall be disposed of in an appropriate puncture-resistant sharps container at point-of-use, prior to transportation. | **Leg.** | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *7. Control of the Environment*<br><br>*A. Cleaning the Environment, 13. Sharps* and *14. Sharps Containers.*<br><br>Refer to: Health Care and Residential Facilities, O. Reg. 67/93. Available from: https://www.ontario.ca/laws/regulation/930067 | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

| 20 | Occupational Health and Safety | Leg. Req. | Risk | C | NC | N/A | Notes/ Resources | Inspection Notes (to be completed by individuals conducting visits/inspection) |
|---|---|---|---|---|---|---|---|---|
| 20.5 | There is a policy that prohibits eating/drinking, food storage, smoking, application of cosmetics or lip balm, and handling contact lenses in the reprocessing area.<br><br>No food, drink, tobacco or cosmetics is consumed, applied or kept in areas where infectious materials, hazardous chemicals or hazardous drugs are used, handled or stored. | **Leg.** | **High** | | | | Refer to: Health Care and Residential Facilities, O. Reg. 67/93. Available from: https://www.ontario.ca/laws/regulation/930067 | |
| 20.6 | All chemical products (e.g. cleaning and disinfecting agents) are labelled according to WHMIS requirements. | **Leg.** | **High** | | | | Refer to: *PIDAC's Infection Prevention and Control for Clinical Office Practice, April 2015*. See section *1. Legislation Relating to Infection Prevention and Control Practices in the Clinical Office, B. The Workplace Hazardous Materials Information System (WHMIS).*<br><br>Refer to: Workplace Hazardous Materials Information System (WHMIS), R.R.O. 1990, Reg. 860. Available from: https://www.ontario.ca/laws/regulation/900860 | |
| 20.7 | Material Safety Data Sheets (MSDS) for cleaning/disinfecting products are readily available and up to date. | **Leg.** | **High** | | | | Refer to: *PIDAC's Best Practices for Environmental Cleaning for Prevention and Control of Infections, May 2012*. See section *E. Other Considerations-Chemical Safety.*<br><br>Refer to: Workplace Hazardous Materials Information System (WHMIS), R.R.O. 1990, Reg. 860. Available from: https://www.ontario.ca/laws/regulation/900860<br><br>MSDS should be no more than 3 years old and updated as new product information is available | |

| Legend: |
|---|
| Leg Req: Legislated Requirement |
| C: Compliant |
| NC: Not Compliant |
| N/A: Not Applicable |

**Please print and sign:**

| | |
|---|---|
| **Owner/Operator (print name):**<br><br>**Signature:** | **Date:** |
| **Person conducting visit (print name):**<br><br>**Signature:** | **Date:** |

Public Health Ontario acknowledges the financial support of the Ontario Government.

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# QUALITY ASSURANCE COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

## Committee Members

| | |
|---|---|
| Chair | Jan Teevan, RM |
| Professional | Lilly Martin, RM, Isabelle Milot, RM, Jan Teevan, RM |
| Public | Gemma Salamat, Philip Playfair |
| Non-Council | Mylene Shields, RM, Tia Sarkar, RM |

## Committee Meetings
May 10, 2017

## Panel Meetings/Hearings
n/a

## Trainings
May 10, 2017 – Quality Assurance Committee Training Refresher

## Items

1. **Self-Assessment Questionnaire (SAQ) and SAQ Guideline**
   In December 2015, staff recommended that the SAQ be put on hold until the questionnaire could be adequately evaluated. In February 2016, QAC agreed to put SAQ on hold for 2015/2016 and directed staff to research alternatives. Staff conducted research and focus groups and proposed a revised SAQ and SAQ Guideline at the May 10, 2017, meeting.

   Staff proposed that the revised SAQ focus largely on a specific professional event or situation summary. The QAC also decided to revise the SAQ Guideline to align with the changes in the questionnaire. This included removing the requirement to report on SAQ completion following a member's first two years of registration and every three years thereafter, with simply requiring all members to complete an SAQ by October 1, 2018. This SAQ and Guideline is an interim solution to fulfil the requirements set out in the RHPA and a broader SAQ proposal is included in the Quality Assurance Program (QAP) Report. The QAC approved the proposed temporary Self-Assessment Questionnaire (SAQ) and SAQ Guideline (see attached).

2. **Quality Assurance Program Findings, Recommendations and Skeleton Framework**
   In 2015, staff began a preliminary review of the Quality Assurance Program (QAP) and began revising its Quality Assurance regulation. At the September 2016 QAC meeting, staff was directed to develop a proposal for a revised QAP by spring 2017. To gather

evidence for this proposal, 4 focus groups were held with general and inactive registrants to determine how they feel the current requirements meet the mandate of the QAP. The focus group findings were combined with current research evidence to develop a report and a QAP skeleton (see attached). The QAC reviewed and provided suggestions and feedback on the QAP Skeleton Framework.

Staff intends to present a final version of the QAP to Council for approval in December 2017. However, implementing the new QAP will occur after the new Quality Assurance Regulation has passed and all other recommendations (guidelines and educational video) are ready for members and both the front end and back end of the database are fully functional.

Johanna Geraci, Quality Assurance Manager, will present on the QAP Findings, Recommendations and Skeleton Framework at the June 28, 2017, Council meeting.

**Formal Motions to Council**
n/a

**Attachments:**
1. Self-Assessment Questionnaire (SAQ)
2. SAQ Guideline
3. QAP Findings and Recommendations
4. QAP Skeleton Framework

Respectfully Submitted,

Jan Teevan, Chair

# Self-Assessment Questionnaire

This Self-Assessment Questionnaire (SAQ) will take approximately 1-2 hours to complete. Once you complete the SAQ, log in to the Member Portal, click on Quality Assurance Program, then click on SAQ Declaration of Completion – click 'submit' and ensure that you keep a copy of your completed SAQ in your files for ten (10) years.

You are not required to submit the completed SAQ to the College, however, should you ever be assessed as part of the College's peer and practice assessment program, you will be required to provide the appointed assessor with your completed questionnaires.

## PERSONAL PROFILE

| | |
|---|---|
| **NAME** | |
| **REGISTRATION NUMBER** | |
| **DATE OF COMPLETION** | |

## I. REGULATORY ASSESSMENT

The following list highlights the key legislation that midwives in Ontario should be familiar with. Use the tick box to indicate your familiarity with the legislation. The legislation can be accessed via www.ontario.ca

| | **LEGISLATION** |
|---|---|
| | Regulated Health Professions Act, 1991 |
| | Health Care Consent Act, 1996 |
| | Public Hospitals Act, 1994 |
| | Midwifery Act, 1991 (Bill 56) |
| | Sexual Abuse Amendment to the RHPA (Bill 100) |
| | Health Insurance Act, 1990 |
| | Laboratory and Specimen Collection Centre Licensing Act, 1990 |
| | Ontario Drug Benefit Act, 1990 |
| | Child and Family Services Act |
| | Coroners Act |
| | Vital Statistics Act |
| | Controlled Drugs and Substances Act |
| | Personal Health and Information Protection Act |
| | Accessibility for Ontarians with Disabilities Act |
| | Health Protection and Promotion Act, 1990 |

## II. SITUATION SUMMARY

The following asks you to summarize a recent professional event or situation and to reflect on your response to it. This may be a situation where an error was averted or when something went particularly well.

DESCRIBE THE SITUATION:

DESCRIBE YOUR ACTIONS IN RELATION TO THE SITUATION:

What was your response to the situation?

Why did you respond this way?

What worked well about your response?

What did not work well about your response?

What will you do differently the next time the situation occurs?

Other reflections relevant to the situation:

## III. DETERMINE YOUR PRIORITIES

Based on your situation summary prioritize your continuing professional development goals and how they will be achieved.

To determine what your goals are and how to accomplish them – ask yourself:

- What do I want to accomplish?
- Why do I want to accomplish this goal?
- Who or what is involved?
- Where will this occur?
- When will I be finished?
- Which requirements must be addressed and which barriers must I consider?

Now that you have completed the SAQ, log in to the Member Portal to submit the SAQ Declaration of Completion to the College. Remember to retain a copy of your completed SAQ in your files. Thank you for taking the time to consider these issues as part of the College's Quality Assurance Program.

# Guideline on Self-Assessment Questionnaire

The Self-Assessment Questionnaire (SAQ) is a tool for members to reflect on their practice. Reflecting on a recent professional event or situation can identify areas of strength and areas for improvement that inform continuing education and professional development needs.

The College will notify members required to complete the SAQ via email. SAQ due dates are also indicated by logging in to the CMO Member Portal. Members can download and print a copy of the questionnaire through the Member Portal. A fillable PDF is also available.

The SAQ consists of three sections:

I. **Regulatory Assessment**: highlights key legislation pertaining to the practice of midwifery in Ontario.
II. **Situation Summary**: asks members to isolate a recent professional event or situation and to reflect on their response to it.
III. **Determining Priorities**: asks members to prioritize continuing professional development goals and how they will be achieved based on the case summary.

The situation summary is a new component of the SAQ, and is designed to help members understand how they have responded to a professional situation, identifying areas of strength and areas for improvement. The situation summary can be about any aspect of your professional practice; it does not have to be specific to clinical care. Members are then asked to determine their learning needs based on the situation to establish clear learning objectives and indicators for how the member will know when their learning goal has been achieved.

Upon completion of the SAQ, members must submit the online Declaration of Completion. Submitting the Declaration of Completion requires members to check off the declaration box on the Self-Assessment Questionnaire section of the Member Portal and click the *Submit* button. It is the member's responsibility to retain a copy of their completed SAQ in their files on for ten (10) years.

**Action**

Members are required to:

- ❑ Submit the online Declaration of Completion by the due date. **Do not send the completed SAQ to the CMO**.

- ❑ Retain the completed SAQ in your files for ten (10) years from the date of completion, in accordance with the Quality Assurance Regulation.

# QUALITY ASSURANCE PROGRAM: FINDINGS AND RECOMMENDATIONS

College of Midwives of Ontario

# 1. Quality Assurance Program

## Introduction

The Quality Assurance Program (QAP) is mandated under the Regulated Health Professions Act (RHPA), 1991 and is defined as "a program to assure the quality of the practice of the profession and to promote continuing evaluation, competence and improvement among the members" (s. 1(1)). Because the intent is to be supportive rather than punitive, the overall impact of an effective QAP is generally believed to be much more significant than that of the whole of the complaints and discipline/fitness to practise activities of the College. The components of the CMO's QAP can be found under the Quality Assurance Regulation made under the *Midwifery Act, 1991* (O. Reg. 335/12).

The Quality Assurance Program is comprised of the following components:

1. Provision of clinical information
2. Continuing education and professional development (CE/CPD)
3. Peer case reviews (PCR)
4. Quality of care evaluations (QCE)
5. Self-assessments (SAQ)
6. Peer and practice assessments

## Background

The CMO's current program is written in the General Regulation and each General and Supervised Registrant with the CMO is required to report annually on 6 PCRs, 3 QCE Action Records and 3 CE/CPD activities. Midwives who are registered in the General class for less than 11 months are eligible to pro-rate some, or all, of their activities. In 2015, the requirement for completing an approved activity in Fetal Health Surveillance (FHS) every 3 years was implemented and is embedded in the CE/CPD requirements. The SAQ is required of registrants every 3 years and upon returning to the profession after a leave.

The QCE Action Record is designed to collect information that will assist practices and midwives to improve the quality of their care. The policy requires that midwives provide the QCE to all clients at or within 6 months of discharge from care. According to the QCE guideline, the returned QCEs should be reviewed on a regular basis. The questionnaire has 29 questions divided up into 6 parts: prenatal care, labour and birth care, postpartum care, continuity of care, informed choice and consultation and transfer of care.

PCRs are designed to be educational and should be conducted in a confidential and non-punitive environment. Each PCR must have a minimum of 4 midwives from at least 2 different practice groups. Registrants must report on 6 PCRs every year but two of these can be replaced by interprofessional case reviews.

The College describes CE/CPDs as activities that maintain or improve a registrant's knowledge, skills or judgment related to the practice of midwifery. Approved activities include taking

courses, preceptorships and writing articles for publication. Two PCRs, beyond the 6 required, also can be used as a CE/CPD. Registrants must report on three CE/CPDs each year. In addition, every 3 years, a registrant must complete an approved activity in Fetal Health Surveillance (FHS) that can be used as one of their CE/CPD activities for that year.

It is important to note that any activity that meets a registration requirement of the College (i.e. NRP, CPR or ES) or is part of a Quality Assurance Program (i.e., the six PCRs) is not eligible as an activity under this regulation [sic].

The SAQ is an 11-page questionnaire designed to fulfill the regulation's requirement for self-assessment. In 2015, the Quality Assurance Committee (QAC) directed staff to put the SAQ on hold until a more relevant way of self-assessment could be developed. Currently, a shortened questionnaire is planned for recirculation to fulfill the College's obligations under the regulation until the revised QAP in its entirety, that includes a method of self-assessment, is implemented.

## Compliance with QAP

The data on compliance with the QAP since 2010 are provided in Table 1. The table looks at the registrants who were required to submit (i.e. General registrants not exempt). The data are limited by numerous factors but the table provides a general overview of the number of registrants who submitted completed QAPs during any given reporting year.

Table 1: Compliance data

| Date | Number of eligible registrants | Number of compliant | Number of non-compliant & incomplete | Percentage compliance |
|---|---|---|---|---|
| **2010** | 417 | 350 | 67 | 84% |
| **2011** | 461 | 391 | 70 | 85% |
| **2012** | 494 | 428 | 66 | 87% |
| **2013** | 537 | 490 | 47 | 91% |
| **2014/15** | 590 | 531 | 59 | 90% |
| **2016** | 640 | 618 | 22 | 96% |

The current components of the QAP were written into regulation in 1994 and have remained essentially the same with a few minor changes. It is time to apply the current evidence with regard to promoting *continuing evaluation, competence and improvement* to the CMO's QAP. The evidence shows that one of the essential considerations in competency-based programs for professionals is consideration for local contexts, professional cultures and the needs of the practitioners (Austin and Gregory, 2015). In support of this, the CMO held focus groups with registrants to understand, from their perspective, what was working and what wasn't working in

their required QAP activities so a revised program could combine these registrant-identified needs and professional culture with the existing literature.

### Focus Groups

In total, 4 group interviews (focus groups) were held in November 2016. Three focus groups (Guelph, Ottawa and Toronto) were held in-person. The focus group in Thunder Bay was held over the phone. Each focus group had between 5-8 members and lasted between 68 – 88 minutes. Focus group questions were specific to the current QAP. In general – the purpose of the focus groups was to understand what works and doesn't work about the current QAP. All participants were registered with the CMO. Most practitioners were General Registrants and worked in urban practices but there was representation from Inactive registrants and rural registrants. Most participants were in practices of 8 or more midwives and worked full-time in shared care arrangements.

Participants did not really understand that the QAP was a mechanism for them to maintain competence and saw it as a CMO strategy to check in on them. However, participants generally felt that CE/CPD and PCRs met the goals of the QAP and the QCEs did not. The following section combines the findings from the focus groups with published research, discusses discrete categories of the current and proposed new QAP, and makes recommendations about how the goals might be achieved.

## Discussion

### Current requirements

#### Quality of Care Evaluation (QCE) Action Records

There is research to show that positive changes can occur in a practitioner's clinical knowledge, and communication and collaboration skills when they receive feedback from multiple sources (e.g. intraprofessional and interprofessional colleagues and clients (Austin & Gregory, 2015)). This technique is generally used as a way of assessing a practitioner's competence rather than a way to maintain or improve competence. Since the QCE captures the feedback from only one source (clients), the improvements that can be found with multi-source feedback cannot be applied to this component of the QAP. In fact, the findings from the focus groups show that participants generally felt that there was very little to learn from the QCEs that supported the goal of the QAP. "*I find getting the evaluations is helpful, but finding something from the evaluations to give to the College is not*". Participants believed there was value in gaining client feedback and some thought it was essential for midwives to gather client feedback, "I think it's almost not negotiable to hear from our clients – we need to hear from our clients." The general held view of participants however was that reporting on the QCE did not meet the goals of the QAP and that submitting actionable items should not be a College requirement. Participants also agreed that most of the information they collected from clients on the QCE is positive and there is little that comes back that is helpful to reflect on individual practice, "it's helpful for generic group practice improvements or a pat on the back but I don't see the benefit of it for an

individual midwife because there is no way you can really capture that". In addition to the above concerns noted, participants also expressed the following:

- the anonymous nature of the form means you may not even know who the feedback is for
- the form is old and in need of updating
- the QCEs provide very little new information

The responses from participants support the findings from an evaluation the College did on the QCE questionnaire conducted in 2011 by a consultant Michael Murray, PhD. Overall, Murray found that the questionnaire had

> *shortcomings both from a local practice improvement perspective and a College perspective. It also seemed to be a clinician-directed questionnaire. Analysis showed that the results of the QCE are extremely positive but with little variation. This lack of variation in responses suggests that the form itself may not be a valid way of measuring clients views of their midwives' care.*

This points to the QCE as an invalid tool for capturing the information it was designed to capture as well as a regulatory requirement that is not fulfilling the goal of the QAP to *promote continuing evaluation, competence and improvement* among registrants.

### Recommendations

1. QCE be removed from the QAP as a CMO requirement
2. The intent of the QCE, as a form of quality assessment measurement, be included in the professional standards for midwives
3. Registrants be informed that the College's QCE is not a valid tool for capturing client feedback
4. Registrants be encouraged to continue to collect feedback from clients as part of best practice but that these not be developed, implemented or evaluated by the College

### Peer Case Reviews (PCR)

PCRs were almost universally supported by participants. There was a sense from some participants that PCRs were part of the professional identity of midwives, "it's so ingrained in our culture – we grew up as midwives doing it. For the next generation if it wasn't required [if] they had other options – would they do it? I think it would be a loss." The benefits, including networking, mentorship, sharing midwifery best practices and self-reflection were reported by most participants suggesting that they can be events that add to the ongoing learning of registrants in numerous ways. This is supported in a small body or research that shows that learning and quality of care outcomes were improved among midwives who participated in small, peer group learning (Engels, Verheijen, Fleuren, Mokkink, & Frol, 2003). Travaglia and Debono (2009) found that formalized case reviews (such as morbidity and mortality rounds) can facilitate practitioner learning through candid discussions about events and potential solutions to mistakes. Systematic approaches to these kinds of reviews, however, are more likely to provide better learning outcomes for participants (Joseph, Garrubba, Melder, & Loh, 2015).

Some participants criticized peer reviews for their tendency towards providing support to midwives rather than as a place to discuss challenging clinical care. Others felt that support was an important part of the activity…

> *I think there is a very therapeutic aspect to it that we don't talk about or value but when there's a bad outcome and you have an emergency peer review that ability of midwives to hold that space it huge – like I don't think we can quite put words on how valuable that is in a profession where you feel vulnerable and where bad outcomes are quite traumatic*

Participants also spent time discussing the number of PCRs that are required and how this leads to registrants focusing on the quantity of PCRs rather than the quality. One participant said this about choosing charts to review without any preparation "…it's like oh my god – its peer review, I've got to rush around trying to get something, it's just a practicality. Your life gets so busy – you know you've got to do it but it usually catches us on the hop."

Another participant said "when there's a case that seems to be prepared and well-presented – like it makes sense. But that is infrequent. Most of the time it's a last-minute presentation and we're all guilty of it". This suggests that rather than critically evaluating care, the PCRs can be a requirement that midwives simply want to complete without effort, or "a chore" that does not meet the goals of the QAP. In addition, participants mentioned barriers to PCRs that included the sheer number of participants (at times over 40 for some practice groups) and the logistics of conducting them such as organizing them and their administrative and financial costs.

Another barrier to learning for participants was the uncertainty around the confidentiality of PCRs. There was concern that the clinical care discussed might not be considered confidential and the belief by some that the very important cases often don't make it to PCR for fear that they might be reported to the College. Despite these concerns, participants believed PCRs should remain in the QAP because of the benefits that they impart.

### Recommendations

1. Describe for registrants the intent of PCRs
2. Develop clear guidance around the confidentiality of PCR and who can attend (e.g. midwives, students, general, inactive, Aboriginal clause, out of province)
3. Provide clear guidance around how to conduct peer reviews (perhaps more like M&M rounds-adopt best practice from other discipline for conducting them such as:
    a. Limiting numbers of registrants in attendance
    b. Criteria to measure the review against
    c. How to prepare them. This can include research that shows the following contribute to more rigorous reviews of client care in a peer reviewed forum such as what happened, was there a breach of standards, what can be done to prevent a recurrence, what are the key lessons for the organization or individual
4. Consider requiring that all midwives present a peer review every reporting period (feeds into self-assessment).
5. Encourage inter and intraprofessional case reviews
6. Consider the potential barriers for some practices in attending PCRs

- organizing them
- time to prepare for them
- Is it possible to do them by webinar? How secure would a web format be?

### Continuing Education/Continuing Professional Development

Continuing Education and Continuing Professional Development are two distinct terms; the former refers to the continuation of educational activities after the completion of formal education and the latter refers to outcomes focussed activities that are often self-directed (Austin & Gregory, 2015). This is an important distinction to make when discussing this part of the QAP.

Participants, in general, enjoyed participating in CE/CPDs and many appreciated the flexibility of the current program that approves of everything from reading a journal article to attending a conference. Other participants felt there should be stricter rules around the type of CE/CPD because "…midwives tend to study what they like – not necessarily what they need" and "why is a one-hour webinar worth as much as a 3-day conference?" While the flexibility may be appreciated, it is not in keeping with the current evidence that shows lectures and other didactic techniques have little to no effect on improving practitioner behavior whereas participation in interactive activities, such as clinical simulations and case-based learning, have been shown to have moderate-to-high beneficial effects (Austin & Gregory, 2015). A systematic review, that includes research on midwives, reported similar findings showing that interactive activities are important in improving practitioner behavior; though this does not necessarily mean client outcomes are affected (Elliott, Murrell, Harper, Stephens, & Pellowe). While there was a desire by some participants to retain the right to employ print-based, didactic forms of learning, the current evidence does not support this as a solitary activity for improving knowledge.

Research shows that competent practice requires both technical skills and non-technical skills (Kodate, Ross, Anderson, & Flin, 2012). The seven basic non-technical skills discussed by Flin & O'Connor (2008) are situation awareness, decision-making, communication, teamwork, leadership, managing stress and coping with fatigue. Since skills such as communication are essential to practice and are often cited as areas of concern for the College, a QAP that acknowledges the contribution of these skills to midwifery practice warrants consideration.

In terms of the number of activities required by the College, there is no evidence to support 3 activities as an appropriate or inappropriate number. In fact, there is evidence showing that there is little, to no, benefit from setting a specific number of CE/CPD hours in terms of affecting positive change in clinician behaviour (Austin & Gregory, 2015). Like the CMO, common practice among Ontario regulators is to set a required number of hours or points for CE/CPD for compliance with QAP - thereby quantifying the commitment to ongoing learning. The College of Pharmacists of Ontario is unique in electing to use learning objectives without specifying numbers of hours or credits.

Currently, the QAP requires that all registrants participate, without necessarily completing, a Fetal Health Surveillance activity every 3 years. Allowing registrants to individually participate in an online module poses problems by contradicting the research showing that didactic or print-based continuing education material has little to no effect on changing clinician behaviour. A

2011 systematic review found that communication, team training and emergency response are essential in FHS training which suggests that an online module, in isolation, may result in little to no improvement in FHS knowledge and skills (Pehrson, Sorensen, & Amer-Wahlin, 2011). Additional problems are posed by the 3-year time frame. The Society of Obstetricians and Gynaecologists of Canada (SOGC) recommends regularly updating FHS skills and proposes that all care providers participate in an interdisciplinary, FHS course update every few years (Liston, Sawchuck, & Young, 2007). Pehrson et al. (2011) found that knowledge of FHS is retained at 6 months post-training but that clinical skills may start to diminish prior to 6 months. So, while there is no widely accepted time frame within which organizations recommend updating FHS, the current 3-year requirement is arbitrary and adds to the numerous reporting deadlines that focus group participants were frustrated by.

## Recommendations

1. Use the title CE/CPD to describe the components of the QAP with the details, such as PCRs, an acceptable activity within the CE/CPD
2. Get QAC feedback about using discrete learning goals as outcomes measurements rather than hours and points as input measurements OR move to a credit-based system to encourage midwives to adopt more multi-modal continuing education activities*
3. Remove the 3-year FHS requirement from the QAP and can be captured (if necessary) in the proposed registration regulation under “condition of general certificate of registration”
4. Communicate with the AOM about learning needs of registrants so CE/CPD courses can be developed to meet membership needs.
5. Require non-technical CE/CPD activities with guidelines about how to do that
6. Registrants design their CE/CPD activities based on their self-assessment reducing the prescriptive nature of the current QAP

## Self-Assessment

The College’s Self-Assessment Questionnaire (SAQ) was put on hold by the QAC because they felt it was labour intensive and did not lead to adequate self-assessment and reflection. Focus group participants also did not find the SAQ a valuable tool and did not feel it met the goals of the QAP. One participant said, “I have not learned from it, it is just a task I have to do to be registered as a midwife”. Another participant spoke on behalf of the focus group by commenting, “I think it would be the minority in the room that did not mind the SAQ”. In addition to not meeting the goals of the QAP, participants also were concerned about how the College might use information contained in the SAQ. One participant described her hesitance about the SAQ

> *Maybe that comes from the culture of our profession and relationship with the College where, you know, it’s been very regulated and almost punitive so that's what the College*

* To be determined by QAC

*represents to us. And when you are also asking us to self-reflect we are like "ooooh". It seems scary*

Another participant simply said "…in the SAQ you are kind of making stuff up but in a more thoughtful way."

What the current research says about self-assessment is that when practitioners self-identify their own learning needs, it can lead to more engagement in their continuing professional development activities. It is not, however, easy to self-reflect with research to show that the ability to self-assess may be the worst in practitioners who are the least competent (Austin & Gregory, 2015). Motycka, Rose, Ried, & Brazeau (2010) (Motycka, Rose, Ried, & Brazeau)recommend that this challenge may be partially addressed using external feedback.

### Recommendations

1. Develop an SAQ that is guided using objective measures of performance
2. Attach SAQ to learning goals
3. Self-assess both technical and non-technical skills
4. Ensure that self-assessment gets at personal practitioner needs as well as public and system needs
5. Consider how members could use BORN reports to reflect on practice (could be points in CE/CPD) – optional rather than mandatory

### Reporting

Focus group participants were frustrated by how many different College activities they had to report on and submit, and that deadlines seemed to always be changing. Examples given were Active Practice Reports (APR), Continuing competency documentation (Emergency Skills (ES), Neonatal Resuscitation (NRP) and CPR) and 5 discrete QAP activities (including Fetal Health Surveillance and SAQ). Numerous participants did not understand the need for the different reporting deadlines finding remembering them onerous and confusing when dates and requirements seemed to change a lot over the past few years. In the words of one member, "I see [QAP], to be honest, as a necessary evil I have to remember to do because there are so many other different reports we have to do….it does seem to be another workload."

Some participants said they liked reporting on QAP every year and some said they did not. The benefits of yearly reporting for participants is that they know what they must do every year and then just go about doing it. What participants did not like about yearly reporting was that it could be challenging to meet the goals of the QAP. The "life of a midwife", specifically being on-call, posed barriers to planning and attending some QAP activities. In support of this, a yearly reporting cycle is shown to be inadequate for most professionals to achieve their own learning goals and that longer cycles, from 2-5 years, may be better by providing practitioners time to reflect on learning needs and achieve their learning goals (Austin & Gregory, 2015).

Participants discussed wanting to report their QAP to the College thinking that this accountability would be a motivator to complete it and some felt there was no point in the QAP if it wasn't necessary to report it. However, numerous participants described reporting as a psychological and physical barrier to completing the QAP. Regarding PCRs, one participant felt that “the most frustrating part is not the actual peer review, it's the documentation”. Registrants report on their activities by listing them in the database where a staff member checks each entry for completeness. This takes a great deal of time and resources.

Portfolios are the way numerous health care regulators require of their registrants. They can be formal or informal and can be used to house the professional history of the practitioner. In addition to being an ongoing record, portfolios are often the beginning of the registrant’s ongoing learning starting with a guided self-assessment, the development of a learning plan that identifies learning needs and eventually reflecting on how well the activities met their learning needs. Austin and Gregory (2015) suggest that portfolios can be an effective way to assess practice improvement and professional judgement. When discussed with participants, some liked the idea of portfolios and some felt it would be much more work that they did not want to have to do. Others liked the notion of a portfolio as a place to organize things and reduce the administrative burden of tracking and submitting multiple certificates of completion (CPR, NRP, ESW), APR and QAP activities.

> *I am a fan of things that are not in addition to the things that I already have to do. That is where we tend to fall down as midwives and is why things like peer reviews tend to get forgotten about and left and then all of a sudden you are scrambling because it’s not - and we've had a lot of changes in terms of when we're reporting and how we're reporting and all of that and some of the changes have been great but the fewer things I have to remember the better. So, if every October we do everything - our renewal - our QAP - our self-reflection - whatever - once done - all in one place - we're much more likely to remember it as a profession than if in July we report on this, and October do this and one every 5 years do this.*

### Recommendations

1. Implement a portfolio based reporting system allowing registrants to house all College required documentation including (e.g. QAP activities, continuing competencies)
2. Coordinate registrants’ requirements to report on activities college-wide and use portfolio to do so
3. Increase the reporting cycle from every year to every 2-3 years*
4. Get rid of pro-rating (to focus on outcomes rather than inputs) as the flexibility in the program will make this unnecessary
5. Self-assessment guiding the QAP will be in line with registrants reporting cycle (not due at different times)
6. QAP reporting will be done using a declaration of completion

* To be discussed by QAC

7. Registrant's will be randomly assessed with a certain percentage going on to have their QAP checked for completion
8. Develop a system of who reports and when in the 3-year cycle
9. Revise the database portfolio to reflect these changes.
10. Develop document about the QAP, the regulations where it lives, its intent and its outcomes (stressing that it is for the good of registrants – not just a CMO mechanism for keeping tabs)

### Who will report

The current regulation requires that registrants in the General and Supervised classes must participate in the QAP. The proposed legislation requires that General, Supervised and Inactive registrants submit a QAP. With this new requirement, the AOM was concerned that it was unfair to midwives who had temporarily left the profession for things like sick leave or parental leave. Another potential challenge with requiring Inactive registrants to report was noted by focus group participants who stated that Inactive registrants have a difficult time meeting their PCR requirements. An important consideration is the difference between an Inactive registrant who is on short term leave from practice and an Inactive registrant who maintains registration for purposes other than clinical midwifery. As such - the College needs to carefully consider how to promote ongoing learning and competence in Inactive registrants who are non-clinicians as well as in Inactive registrants who are providing clinical care at some time during their reporting period.

### Members in Type 1 Alternate Practice Arrangements (APA1)

QAP requirements for members working in an APA1 are approved by College staff and exclude the QAC from exercising their powers under the RHPA to approve exemptions from any or all components of the program; "Upon application by a member, the Committee may grant an exemption to the member from any of the requirements of the program because of illness, maternity leave or any other circumstance the Committee considers appropriate." O. Reg. 335/12, s. 4. (*This Part applies only to members who hold a certificate of registration for the general or supervised practice class. O. Reg. 335/12, s. 2.*)

### Recommendations

- Consider having two streams where
  - General, Supervised and Inactive **with** intention to practice fulfill CE and CPD guided by self-assessment
  - Inactive **without** intention to practice fulfill CPD only.
- Articulation of an argument supporting value of QAP for Inactive registrants
- Develop a process for non-compliance among inactive members
- All members working in APAs will be referred to QAC for consideration if they cannot complete QAP requirements
- If APAs remain or if the practice contexts change – consider *contexts of practice* so registrants practicing in rural/remote regions, for example, might need something different (e.g. more interprofessional activities)

### Exemptions and non-compliance

The Quality Assurance department has a process for managing cases where registrants do not submit their QAP as well as for registrants who apply for an exemption from the QAP.

Recommendation

1. Maintain the current process for QAP non-compliance
2. Revise the risk framework for considering QAP exemptions and non-compliance to consider a longer reporting period (threshold for accepting non-compliance may be lower) and the increased flexibility in activities.

### Implementation

There was a lot of confusion among the participants about aspects of the QAP. The most concerning was the lack of understanding regarding the intent of the QAP, the requirements around confidentiality of peer reviews and self-assessments, and what the College does with the information gathered from the QAP. These concerns highlight the lack of knowledge about, and engagement in the QAP that is currently felt by numerous participants and is perhaps reflective of the larger registrant population. As one participant said…

> *If you are thinking about how to get midwives engaged in the QAP program you have to look at what the QAP is giving back to midwives because right now the QAP program is work… people don't think of peer review and think "oh I'm so glad that QAP made me come to peer review". They aren't thinking "oh I'm so glad I have this opportunity to fill out my self-assessment form-good thing we have a QAP program". … I would say if you are looking for ways to engage with members about the QAP - its making that link in their mind - I think it's more of a campaign of the goal and of the "we want you to be great midwives and here are all the things", make it more about the benefits we are getting out of it, not so much about the work.*

### Recommendation

1. Develop a QAP guidebook providing clear and detailed instructions/guidelines on the QAP including who it applies to, its purpose, components, how to complete it, submit it and outcomes of non-compliance. It will also provide guidance about confidentiality as it relates to the components of the program.
2. Implement the revised QAP when the following conditions have been met
    - new QA regulation has passed
    - all supporting documents for the QAP have been developed
    - the database has been tested and is fully functional
3. Develop a video (PowerPoint presentation) for the College website explaining the new QAP so members have continuous access to information about what the changes are, how to work with the new QAP, negotiating the QAP portion of the database and the expectations.
4. Share findings with membership

### Regulations

The regulations should reflect a revised QAP that is based on member feedback and current evidence. Rather than add the details that are in the current regulation – the regulation should be flexible or broad enough to allow the Quality Assurance Committee (QAC) to approve revisions to the programs to keep in line with emerging evidence, best practice and local contexts.

## Conclusion

It is important to make a QAP that meets the needs of registrants within the mandate of the RHPA but also to consider the College resources required to manage such a program. A new database has streamlined the process but more changes will need to be made on behalf of the database, staff and the registrants to successfully implement a revised QAP. Once approved by Council, the revised QAP will need an implementation and evaluation plan. The evaluation plan will be developed alongside implementation and will include surveying registrant's during the first reporting cycle to determine its accessibility, and then again after the first reporting cycle to determine its value.

# Bibliography


Austin, Z., & Gregory, P. (2015). *Professional Quality Assurance and Competency Assessment: A Scoping Review.* College of Physiotherapists of Ontario (CPO).

Elliott, S., Murrell, K., Harper, P., Stephens, T., & Pellowe, C. (n.d.). *A comprehensive systematic review of the use of simulation in the continuing education and training of qualified medical, nursing and midwifery staff.* JBI Database of Systematic Reviews and Implementation Reports 6.12 (2011): 538-587., 6(12), 538-587.

Engels, Y., Verheijen, N., Fleuren, M., Mokkink, H., & Frol, R. (2003). The effect of small peer group continuing quality improvement on the clinical practice of midwives in the Netherlands. *Midwifery, 19*, 250-258.

Flin, R., & O'Connor, P. (2008). *Safety at the Sharp End: A Guide to Non-Technical Skills.* Ashgate Publishing, Ltd.

Irving, A. (2014, October). Policies and Procedures for Healthcare Organizations: A Risk Managment Perspective. *Patient Safety and Quality Healthcare*.

Joseph, C., Garrubba, M., Melder, A., & Loh, E. (2015). Best practice for conducting morbidity and mortality reviews: A literature review . *The Quarterly: the Royal Australasian College of Medical Administration*.

Kodate, N., Ross, A., Anderson, J., & Flin, R. (2012). *Non-Technical Skills (NTS) for Enhancing Patient Safety; Achievements and Future Directions.*

Motycka, C., Rose, RL., Ried, D., & Brazeau, G. (2010). *Self-Assessment in Pharmacy and Health Science Education and Professional Practice.* American Journal of Pharmaceutical Education. 74(5) 1-7

Travaglia, J., & Debono, D. (2009). *Mortality and morbidity reviews: a comprehensive review of the literature.* University of New South Wales, Centre for Clinical Governance Research.

# QAP Skeleton

The Quality Assurance Program (QAP) will be designed for members registered in both the General, Supervised Practice and Inactive Class. This skeleton draft was developed for members in the General Class and members in the Inactive Class who have practiced or have intention to practice, at some point during the reporting cycle (the term "General Registrant" and "member" will be used to capture both groups in this document). This skeleton draft was revised after the May 2017 Quality Assurance Committee meeting based on feedback and recommendations from the Committee.

## Current Plan for the Quality Assurance Program

Introduction to the Quality Assurance Plan which will be reported every 3 years
The current outline is adapted from the Ontario College of Pharmacists with permission.

1. Self-assess and identify learning needs

Registrants will use this self-assessment to identify learning goals based on identified areas for growth and document learning goals.

2. Plan learning objectives

Registrants will write about how they are going to meet their learning goals using a template that includes expected dates for completion.

3. Complete and document objectives

Registrants will document what they completed and when they completed it

4. Self-reflect

Registrants will reflect on what was learned and how it has been, or will be incorporated into their practice and profession.

5. Declaration of Completion OR submit QAP activities

All registrants will submit a QAP declaration of completion confirming completion of their required QAP activities OR all the QAP requirements completed during the reporting period (QAC could not decide on how registrants should report).

## Step 1: Self-Assessment

General registrants will use a self-assessment questionnaire to identify learning goals based on identified areas for growth. The self-assessment will be based on the professional standards document currently being developed by the College (e.g. professional knowledge and practice, person-centred care, collaborative care). Members will be asked to answer questions honestly by reflecting on their practice over the previous reporting cycle and identify areas where they may need to update their knowledge or skills.
QAC did not determine how this questionnaire will rate registrants' knowledge – this will be determined when a new questionnaire is developed. Table 1a (below) provides examples of

questions with no rating system. Table 1b provides measures for the midwife and includes a rating system. None of these have been decided up by QAC

**Table 1a**

The following tables provides examples of the types of questions that could be asked of General registrants in their self-assessment. The following tables are based on an assessment manual and toolbox (European Reference Networks (ERN), 2016)

| Sample Questions | Comment |
|---|---|
| **Professional Knowledge and Practice** | |
| I have current knowledge of the changes in technology that have taken place in the midwifery profession | |
| I am competently providing emergency management of all aspects of maternal and newborn care | |
| I am aware of the Core competencies are possess the skills needed to carry them out competently | |
| **Person-centred care** | |
| I provide clients with relevant and current information about the process and outcome of their care | |
| I provide clients with information about how to file a complaint or raise concerns about their care | |
| I ensure all clients are aware of, and have access to, their medical records | |
| I evaluate and respond to client feedback | |

**Table 1b**

| Measure | Rating | | | Comment |
|---|---|---|---|---|
| **Practice environment** | 1 | 2 | 3 | |
| I have a system for gathering and evaluating client feedback about my care | | X | | |
| Midwifery equipment is cleaned, sterilized and transported in accordance with midwifery standards | | X | | |
| Client records are stored in accordance with health records policies/CMO standards | | | X | |

## Step 2: Plan

After completing the self-assessment questionnaire, members will choose areas that need to be improved up based on their assessment. They will also identify areas of identified strength (this is important to do and more research is being done to determine how this might be used by the member-an possible example is given below in Table 2c). Members will then complete a learning plan based on these identified gaps. In the learning plan, members will be asked to demonstrate how they will meet their learning objectives and dates for expected completion. Each year, one learning objective must be met. The member can also include other learning objectives that were not identified in the self-assessment such as a situation that came up at a peer case review, a client interaction, or a breakdown in communication with a client or other health care provider. There will be some guidance to help members identify whether their identified areas for improvement are related to a technical or non-technical skills (i.e. leadership, teamwork, decision-making and situation awareness that complement technical skills and contribute to safe and efficient task performance) that need improvement. Members will also be encouraged to ask a trusted peer to assist with this exercise. For example - is it the technical aspects of Fetal Health Surveillance (such as identifying a late deceleration) or is their learning need more about decision-making (such as acting on the late deceleration or asserting themselves in a potential emergency.

**Table 2a**

| Learning objective | Why this is a learning objectives (explain) | How this might be addressed |
|---|---|---|
| Emergency Skills<br>I need to increase my confidence in managing obstetrical emergencies | I take Emergency Skills every 2 years but am still not confident in some emergency situations. I have a difficult time making decisions in high stress situations. | • I have taken ALARM for the past few years and will take the AOM ESW because it is designed for midwives.<br>• I will find a workshop on decision-making for health care providers.<br>• I will read 3 papers on decision-making in high stress situations. |

**Table 2b**

| Learning objective | Why this is a learning objectives (explain) | How this might be addressed |
|---|---|---|
| The practice has a system but I am unable to ask for help | I find work is getting more stressful because I don't ask for help, I am not sleeping when I should be and this affects my off-call time. | • To attend an AOM webinar on work-life balance.<br>• To write a practice protocol on safe limits of sleeplessness that will involve researching the best evidence |

**Table 2c**

| Identified strength | Why this is a strength | How I might use this |
|---|---|---|
| I am well versed in the College standards and midwifery regulations/legislation | My colleagues come to me for clarification about standards. I feel confident applying the standards to the care I provide | • Continue to use it in practice<br>• Support practice partners when they don't know.<br>• Consider how to become a College assessor or Council member |

## Step 3 and 4: Complete and document objectives

After completing their learning objectives, members will document the details of their activities, their learning, and a reflection of the learning. *The following format is based on the "Portfolio for Midwives" with permission granted from the New Zealand College of Midwives.*

**Professional Reflection**

| **Learning Objective**<br>Your reasons for attending this course or undertaking this activity and what you hoped to gain from it |
|---|

| **Description or title of educational or activity**<br><br>**Date:**<br>**Location:**<br>**Length of time:** |
|---|

| **Summary of content**<br>Briefly describe the aspects of the activity or topic that were relevant and important to you.<br>Were your objectives met? |
|---|

| **The learning outcomes and implications for practice**<br>Describe briefly how this learning will be or has been incorporated into your practice, the strategies you will use or have used to bring about change or disseminate his information and the benefits you anticipate or have seen in your practice |
|---|

## Peer Case Review

Peer Case Reviews (PCR) and Interprofessional case reviews also will be required as part of a members' QAP. In addition to specifying a minimum number of PCRs required per year or per reporting period (the QAC has not determined a number for this yet), guidance around conducting PCRs, confidentiality and any other requirements regarding conducting the PCRS. An example guidance is below:

*It is expected that PCRs be conducted in accordance with a methodology. There are numerous resources that can be used to provide guidance to members about conducting peer case reviews. An example is given below from a 2017 literature review providing a list of questions that can be considered for PCRs:* (Joseph, Garrubba, & Melder, 2017, p. 3)

1. What happened?
2. Was there was a breach of a standard of care or an error, why did it happen?
3. What can be done to prevent a recurrence?
4. What went wrong (or right)?
5. How did it go wrong (or right)?
6. Why did it go wrong (or right)?
7. What could we do differently in future?
8. What are the key lessons for the practice, birth center, hospital?

PCR

### Peer Case Review Reflective activity

**Note**: *QAC could ask members to fill out a brief reflective activity (as shown here) for PCRs/Interprofessional reviews or just require attendance. The QAP could also provide this kind of format for members to reflect without making it a requirement. There are issues of confidentiality and documentation so these factors will dictate what can and cannot be included.*

| **Date:**<br>**Intraprofessional/Interprofessional** |
|---|

| **The learning outcomes and implications for practice**<br>Describe briefly how this learning will be or has been incorporated into your practice |
|---|

## Step 4: Declaration of Completion

All members will submit a QAP declaration confirming completion of their required QAP activities OR continuing professional development and continuing education based on the completion of the QAP requirements **OR** they will submit the full documentation (QAC has yet to determine). The declaration or report of activities will be required at the end of their reporting cycle (i.e. every 3 years). Table 3 (below) is an example of what information might be included in a declaration based on a 3-year reporting cycle where 2 PCRs (as an example) are required every year. If a full report is decided on – then members would be required to submit the finalized documents that they will have completed during their reporting cycle.

| **Compulsory Activities** | **Year 1** (October 1, 2019-September 30, 2020) | **Year 2** (October 1, 2020-September 30, 2021) | **Year 3** (October 1, 2021-September 30, 2022) | **Year 4** (October 1 2019-September 30 2020) |
|---|---|---|---|---|
| **Self-assessment** | Required | Not needed | Not needed | Required |
| **Peer Case Reviews** | 2 | 2 | 2 | 2 |
| **Learning objectives** | 1 | 1 | 1 | 1 |

**Declaration**
**I have met my learning objectives and completed all components of my Quality Assurance Program for this reporting cycle**

**Signature** _____ **Date** _____

## Bibliography

(ERN), European Reference Networks. (2016). Assessment Manual and Toolbox for European Reference Networks . *Optional Criteria for the Assessment of Healthcare Providers*.

Joseph, C. W., Garrubba, M. L., & Melder, A. M. (2017). Informing best practice for conducting morbidity and mortality reviews: a literature review. *Australian Health Review*.

# REGISTRATION COMMITTEE
# REPORT TO COUNCIL – JUNE 2017

**Committee Members**

| | |
|---|---|
| **Chair** | Isabelle Milot, RM |
| **Professional** | Carron Canning, RM, Isabelle Milot, RM |
| **Public** | Gemma Salamat, Jennifer Lemon |
| **Non-Council** | Mylene Shields, RM, Alexandra Nikitakis, RM |

**Committee Meetings**

Past

- May 24, 2017 – ¼ day teleconference

Upcoming

- September 13, 2017
- November 8, 2017

**Panel Meetings/Hearings**

- Two Panel files at one meeting on April 5, 2017 as follows:
    - Applications for re-registration from former members who had previously resigned

Upcoming

- Two applications for registration– dates pending:
    1. Former supervised practice member
    2. AIT application from former member

**Training**

- No training has been held since the last report to Council. Training is being planned for the Registration Committee meetings in the Fall.

**Items**

At its recent meeting, the Registration Committee reviewed:

<u>An update on the Office of the Fairness Commissioner</u>

On April 12, 2017 the Deputy Minister of Citizenship and Immigration announced the appointment of Grant Jameson as the new Commissioner to the Office of the Fairness Commissioner (OFC). Mr. Jameson replaces Melissa Thomson who had been acting as the Interim Fairness Commissioner.

In addition, Bill 27, the Burden Reduction Act, 2016 received royal assent on March 22, 2017. Bill 27 includes amendments to the Fair Access to Regulated Professions and Compulsory Trades Act (FARPACTA), which will change the OFC's governance and reporting structure. The mandate of the OFC remains the same and the OFC will continue to work with regulators to assess and advise on ensuring fair, objective, impartial and transparent registration practices among regulated professions and trades. During the transition to its new structure, the OFC will focus on concluding assessments underway and working with the College as needed.

CMO's Jurisprudence Course Implementation

The completion of a jurisprudence course set and approved by the College's Registration Committee is a non-exemptible registration requirement, and is outlined in the College's Registration Regulation. The Registration Committee agreed to set the date for implementation of this requirement as July 1, 2017.

All applicants to the College of Midwives of Ontario must be familiar with the laws, regulations and standards that apply to midwives in Ontario and must demonstrate that by completing the College's Jurisprudence Course. This entry-to-practice requirement applies to all applicants wishing to become registered as a midwife in Ontario as of July 1, 2017.

The Jurisprudence Course may be completed up to one year before applying to the College.

The College's Jurisprudence Course is offered online and consists of a handbook (available on the College's website) to be reviewed, and an e-Learning module with exam questions.

The e-Learning module and exam is open-book, and is divided into 11 lessons which can be completed in any order. While there are no limits to the number of attempts an applicant can take to successfully complete the exam questions, all questions must be answered successfully to complete the Jurisprudence Course.

Proposed Changes to the Policy on Continuing Competencies

Please see motion below and attached briefing note and materials.

**CMO Membership Stats – May 31, 2017**

| **Total Registered Members** | **854** |
|---|---|
| General | 628 |
| General (with new registrant conditions) | 69 |
| Supervised | 4 |
| Transitional (Supervised) | 0 |
| Inactive | 153 |
| | |
| | |
| Included in above: | |
| New Registrations - Inactive Certificate | 0 |
| New Registrations - Transitional Certificate | 0 |
| New Registrations - Supervised / GWC | 0 |
| New Registrations - General via AIT | 0 |
| Re-registrations | 0 |
| Deceased | 1 |
| Resignations | 1 |
| Revocations | 0 |
| Suspensions | 0 |

**Formal Motions to Council**

The Committee recommends that:
Council approve the proposed changes to the Policy on Continuing Competencies.

**Attachments:**

Briefing note and attachments – Revisions to the *Policy on Continuing Competencies*

Respectfully Submitted,

Isabelle Milot, RM, Chair

# Briefing Note for Council

**Subject:** Revisions to the *Policy on Continuing Competencies*

**Summary:** Council should consider updating the current *Policy on Continuing Competencies* to no longer accept courses without a practical component as evidence of continuing competency in cardiopulmonary resuscitation (CPR), neonatal resuscitation (NRP), or emergency skills (ES).

## Background

The College's Registration Regulation states that it is a non-exemptible requirement that all applicants must provide satisfactory evidence of competency in NRP, CPR, and ES to become registered. In addition, all members are required to provide satisfactory evidence of continuing competency in NRP every year and CPR and ES every two years. Current members that are practising (i.e. not Inactive) must provide evidence of being current in their certifications as part of the membership renewal process each year as of October 1st.

In June 2011, the Registration Committee made the recommendation to the College's Executive Committee to accept the CPR Healthcare Provider course offered by CPRToday, an American online course, to fulfill the CPR continuing competency requirement. The Executive Committee approved the recommendation and thereafter the Registration Department accepted CPRToday as evidence of competency in cardiopulmonary resuscitation upon initial registration and as continuing competency for maintaining registration.

In December 2015, the 3 separate continuing competency policies were consolidated into 1 policy to make it easier for the public and midwives to access the information. In addition, accepted courses for NRP, CPR and ES were listed within the new policy. The Quality Assurance Committee (QAC) also developed and approved criteria for approving continuing competency courses to help guide the decision-making around assessing courses and including them in the policy.

The College was advised that the Heart and Stroke Foundation of Canada does not recognize online CPR courses and that these courses are not recognized by any Canadian CPR provider. The Canadian guidelines, developed by the Heart and Stroke Foundation, all require an in-person, hands-on component.

During their May 2017 meeting, the Registration Committee reviewed the current *Policy on Continuing Competencies* considering the feedback from the Heart and Stroke Foundation and the criteria developed by the QAC for approving continuing competency courses. The Registration Committee decided to adopt the criteria for approving courses developed by the QAC. It addition, the Committee decided to approve a revision to the policy, requiring all continuing competency courses accepted by the College have a theoretical and practical component, consistent with the criteria for approving courses. In addition, the Registration

Committee made minor grammatical edits to the policy. Lastly, the Committee proposes removing FirstAid4U from the list of accepted CPR courses since it is a Canadian Red Cross Training Partner, so they deliver the Canadian Red Cross Program, which is already listed as an accepted course.

## Key Considerations

- Although the *Policy Continuing Competencies* was approved with an online CPR course listed as an accepted course and the Registration Department has continued to accept it, there is no evidence to support the effectiveness of such training
- No other midwifery regulator in Canada accepts online CPR as evidence of competency/continuing competency in CPR
- The Registration Committee's review of CPRToday concluded that this course is not sufficient to meet the intent of the current policy. However, this has not been communicated to the profession.

## Recommendations

The following recommendations are submitted:

1. Decide that only courses with a theoretical and practical component be accepted as evidence in competency and continuing competency
2. Thus, only Health Care Provider level CPR courses successfully completed in-person will be accepted as competency/ continuing competency in cardiopulmonary resuscitation. This will be applicable to all applicants, as well as current members based on the implementation plan.
3. Approve the proposed changes to the *Policy on Continuing Competencies* as presented.

## Implementation Date

It is recommended that this change be implemented shortly after the June Council meeting, as soon as August 1, 2017. All members providing proof of continuing competency and the course was taken as of August 1, 2017, must take a course with a practical component.

This timeframe will allow ample communication to the membership regarding this change and can be coordinated with membership renewal communication. This implementation date and process also takes into consideration that the College is currently receiving applications for initial registration from recent graduates from the Midwifery Education Programs and the International Midwifery Pre-Registration Program. An implementation date of August 1, 2017 will allow sufficient time to communicate to potential applicants that all applications received on or after August 1, 2017 must take a course with a practical component in order to be accepted by the College as evidence of competency.

## Attachments

1. Draft *Policy on Continuing Competencies*
2. QAC Criteria for Approving Courses
3. Course details regarding CPR Today's Health Care Provider course
4. Course details regarding FirstAid4U CPR course

## Legislative and Other References

1. Section 7 of the Registration Regulation, Issuance – general and supervised practice classes
2. Section 12 of the Registration Regulation, Conditions – general certificate

**Submitted by:** Registration Committee

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# Policy on Continuing Competencies

Midwives must successfully complete a College of Midwives of Ontario (CMO) approved course in **obstetric emergency skills, neonatal resuscitation and cardiopulmonary resuscitation** at initial registration and regularly thereafter. The CMO approves each course based on an objective set of criteria. Courses not listed in this policy must be pre-approved by the CMO in order to be accepted as evidence of continuing competency.

**Deleted:** Quality Assurance Committee (QAC)

All midwives registered in the general class must provide the CMO with evidence of successful completion by the registration renewal date of October 1st.

A midwife who is an instructor in obstetric emergency skills, neonatal resuscitation or cardiopulmonary resuscitation will meet the continuing competency requirement for the particular course of instruction with evidence of current instructor status in that course. They ~~She or he~~ must also show evidence of having assessed or having been assessed within the required timeframe: within the previous year for neonatal resuscitation, or within the previous two years for obstetric emergency skills or cardiopulmonary resuscitation courses.

**Comment [NG1]:** Gender inclusive language

## CMO Requirements and Approved Courses

All courses must have a theoretical and practical component.

**Comment [NG2]:** As recommended by the Registration Committee.

### Every Year

**Neonatal Resuscitation**

**Every year**, midwives shall provide evidence of continuing competency in **neonatal resuscitation.**

Currently accepted course:

- Neonatal Resuscitation Programme (NRP) delivered through the Canadian Paediatric Society (CPS)

**Comment [NG3]:** Correct spelling of course name

### Every Two Years

**Obstetrical Emergency Skills**

**Every two years**, midwives shall provide evidence of continuing competency in **obstetric emergency skills**. The standard is successful completion of a course that meets or exceeds the Association of Ontario Midwives (AOM) Emergency Skills Workshop (ESW). To meet this standard in a course other than the ESW, successful

completion of all of the obstetric emergency skills included in the ESW is required. The minimum required emergency skills are **antenatal, intrapartum and postpartum haemorrhage**, **abnormal fetal heart rates, malpresentation and cord prolapse, shoulder dystocia, emergency breech birth, emergency twin birth.**

Currently accepted courses:

- Emergency Skills Workshop (ESW) (Association of Ontario Midwives, Midwives Association of Manitoba, Association of Alberta Midwives, Regroupement les Sages-Femmes du Québec).
- Midwifery Emergency Skills Program (MESP) (Association of Midwives of British Columbia)
- Obstetric Emergency Skills courses administered by a recognized Canadian Midwifery Education Program or Bridging Program.
- Advances in Labour and Risk Management (ALARM), (Society of Obstetricians and Gynecologists of Canada)
- Managing Obstetrical Risk Efficiently (MORE$^{OB}$)[1] (Salus Global$^{TM}$)

**Cardiopulmonary Resuscitation**

**Every two years**, midwives shall provide evidence of continuing competency in cardiopulmonary resuscitation at the level of Health Care Provider (HCP).

The standard is successful completion of a course that meets or exceeds the following currently accepted courses:

- BLS for Healthcare Providers (C) (Heart and Stroke Foundation of Canada)
- CPR/AED Level HCP (Canadian Red Cross)
- CPR HCP (Lifesaving Society)
- CPR HCP (St. John Ambulance)
- ~~CPR HCP (First Aid 4U)~~
- ~~CPR today~~

Deleted: me

Deleted: me

**Comment [NG4]:** FirstAid4U is a Canadian Red Cross Training Partner, so they deliver the Canadian Red Cross Program and thus can be removed from the list.

**Comment [NG5]:** This is an online course. Registration Committee recommend that the CMO no longer accept online CPR courses and thus remove this from the list of acceptable CPR courses

Username:

Password:

Forgot password?
New to CPRToday? Sign Up Now

LOG IN

Need your CPR certification but hate to sit through another mind-numbing 6-hour class? With CPRToday! nationally-validated, fully-accredited online courses you can earn your CPR, First Aid, AED, and Bloodborne Pathogens certification at your convenience and have your certificate and wallet card today.

Click to use Flash

CLICK HERE FOR LARGER VIDEO

CPRToday! is quick, inexpensive and completely **risk-free.** Ours is the only program that:

- Is nationally accredited; accepted in all 50 states, Canada, and worldwide
- Is JCAHO, ILCOR, ECC, and OSHA 1910.1030(g)(2) compliant
- Meets International Guidelines Conference on Cardiopulmonary Resuscitation standards
- Includes most recent ARC and AHA/ILCOR Guidelines (October 15, 2015)
- Includes "compression-only" bystander-initiated CPR techniques (ILCOR 2008, 2010)
- Does not require hands-on skills testing
- Includes instant 2-year certification from your own printer (see yours now)
- Does not require additional fees for practical exam
- Includes 60-day unlimited course access from any internet-connected device
- Includes unlimited access to your certificate and wallet card
- Is endorsed by CNN, & featured in USA Today, The New York Times, and eHow
- Is accepted in more places than any other online certification - GUARANTEED!

What a wonderful service you have here. I'll be sure to use your services again. Thank you!

**Raymond Washington**
*Emeryville, CA*

For a limited time all new clients receive an **introductory 20% discount** when enrolling in any of our courses. Simply use code WELCOME or click here to join over half-million satisfied clients from around the world and register today! This offer is for individual registrations only and may not be combined.


**Ready to join 556,337 satisfied clients?**

Sign up in under 1 minute ▸

Not quite ready to register? No problem - take any of our courses absolutely free!

Let your Facebook friends know about CPRToday! and help us spread the word.
Thank you :)

Sign up in under 1 minute ▸

**Not quite ready to register? No problem - take the course for free now!**

## Healthcare Provider Course

Includes Adult & Pediatric CPR, AED, and Bloodborne Pathogens

take this course now completely free




**Course Duration**

- Approximately 60-90 minutes
  Please note: it is strongly recommended that you read entire course before taking the exam. However, we understand that many of our clients are trained professionals who simply need a quick refresher. If you are familiar with the material you can proceed directly to the exam immediately after registration in which case you may be certified within a few minutes.

**Lesson 1: Introduction**

- Brief history of CPR
- Mechanics of Artificial Life Support
- Fundamentals of human physiology (circulatory system) and CPR applications
- What is expected during an emergency (including EMS response)

**Lesson 2: Adult CPR**

- Definitions
- Scene assessment and appropriate response
- C-A-B's of Adult CPR for 1 rescuer
- C-A-B's of Adult CPR for 2 rescuers

**Lesson 3: Child CPR**

- Definitions
- Scene assessment and ap go to agenda esponse
- C-A-B's of Child CPR for 1 rescuer
- C-A-B's of Child CPR for 2 rescuers

**Lesson 4: Infant CPR**

- Definitions
- Scene assessment and appropriate response
- C-A-B's of Infant CPR for 1 rescuer
- C-A-B's of Infant CPR for 2 rescuers

**Lesson 5: Bloodborne Pathogens**

- Introduction & Definitions
- Bloodborne Pathogens Viruses
- Transmission and Occupational Exposure
- Universal Precautions and Transmission Prevention
- Post-exposure Procedures

**Lesson 6: Automated External Defibrillator (A.E.D.)**

- Definitions
- Mechanics of A.E.D.
- Proper A.E.D. usage

**Final Exam**

- Interactive review and test of your grasp of the course material (unlimited attempts until you pass)

**Certification** [preview]

- Healthcare Provider Wall Certificate:

- BLS: Adult CPR, Child CPR and Infant CPR
- Bloodborne Pathogens
- A.E.D. Training

- Healthcare Provider Certification Wallet Card:
  - BLS: Adult CPR, Child CPR and Infant CPR
  - Bloodborne Pathogens
  - A.E.D. Training
  - includes a convenient, full-color CPR pocket reference chart

**Ready to join over half a million satisfied clients?**

Sign up in under 1 minute ▸

Not quite ready to register? No problem - take the course for free now!

**Comprehensive Basic Life Support Program**

Includes Adult & Pediatric CPR, Universal First Aid, AED, and Bloodborne Pathogens

take this course now completely free


(Includes Standard and Healthcare Professional Certification)

**Course Duration**

- Approximately 60-90 minutes
  Please note: it is strongly recommended that you read entire course before taking the exam. However, we understand that many of our clients are trained professionals who simply need a quick refresher. If you are familiar with the material you can proceed directly to the exam immediately after registration in which case you may be certified within a few minutes.

**Lesson 1: Introduction**

- Brief history of CPR
- Mechanics of Artificial Life
- Fundamentals of human physiology (circulatory system) and CPR applications
- What is expected during an emergency (including EMS response)

go to agenda

**Lesson 2: Adult CPR**

- Definitions
- Scene assessment and appropriate response
- C-A-B's of Adult CPR for 1 rescuer
- C-A-B's of Adult CPR for 2 rescuers

**Lesson 3: Child CPR**

- Definitions
- Scene assessment and appropriate response
- C-A-B's of Child CPR for 1 rescuer
- C-A-B's of Child CPR for 2 rescuers

**Lesson 4: Infant CPR**

- Definitions
- Scene assessment and appropriate response
- C-A-B's of Infant CPR for 1 rescuer
- C-A-B's of Infant CPR for 2 rescuers

**Lesson 5: Basic First Aid**

- Introduction to First Aid safety with emphasis on injury prevention
- 12 common emergency situations and corresponding First Aid procedures



**Lesson 6: Bloodborne Pathogens**

# First Aid 4U is a Red Cross Training Partner

First Aid 4U is a multi-award winning Red Cross training partner for First Aid and CPR Courses and is one of the fastest growing First Aid and CPR training companies in Canada.

An Ontario based First Aid and CPR training provider for businesses, groups, associations and individuals, First Aid 4U offers WSIB approved First Aid and CPR training courses throughout Ontario. Corporations, schools and groups can book on-site training sessions while individuals and small groups can register for one of our many public courses at one of our professional training facilities throughout Ontario. No Private company in Canada has more training facilities or offers more public courses than First Aid 4U.

## First Aid 4U offers the following Red Cross certification courses:

- Standard First Aid & CPR (http://www.firstaid4u.ca/en/course-info/workplace-standard-first-aid-cpr/)
- Emergency First Aid & CPR (h[go to agenda]v.firstaid4u.ca/en/course-info/workplace-emergency-first-aid-cpr/)
- Workplace First Aid & CPR (http://www.firstaid4u.ca/en/wsib-compliance/)
- Wilderness Standard First Aid & CPR (http://www.firstaid4u.ca/en/wilderness-remote-first-aid/)
- Childcare First Aid & CPR (http://www.firstaid4u.ca/en/babysitter-course/)

- CPR level A, C and HCP (http://www.firstaid4u.ca/en/course-info/cpraed-levels/)
- AED (defibrillator) training (http://www.firstaid4u.ca/en/defibrillators-save-lives/)
- Recertification courses (http://www.firstaid4u.ca/en/course-info/recertification/)

## Find A Course Near You (http://www.firstaid4u.ca/en/contact/location-finder/)

---


(http://www.firstaid4u.org/en/all-courses/)


(http://shop.firstaid4u.org)

## Latest Reviews

go to agenda

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

# CRITERIA FOR APPROVING COURSES

The CMO approves the professional courses that are required as continuing competencies for midwives registered in Ontario. This document sets out the criteria that will be considered by the Quality Assurance Committee (QAC) when approving courses.

## Content and instruction

1. The objectives of the course meet the CMO's expectations for course content [1]

   ○ Yes
   ○ No

   Comments

2. Theoretical and practical components are used

   ◉ Yes
   ○ No

   Comments

3. The course is relevant to a Canadian healthcare context

   ○ Yes
   ○ No

   Comments

4. Instructors receive standardized training in delivering the course

   ○ Yes
   ○ No

   Comments

5. Participants demonstrate their knowledge and skill acquisition

   ○ Yes
   ○ No

   Comments

[1] The CMO recognizes the expertise housed in the organizations developing and delivering the courses. The CMO expects that organizations research and develop appropriate curriculum that responds to the changing needs of the health care environment. Should the CMO perceive that public interest is not being served by an approved course, the CMO will engage in discussions with the organizations to address any perceived gaps, oversights or questions of scope.

**Administration**

1. The course is developed and administered by an institution or organization with a formal governance structure and system of accountability

Yes
No

Comments

2. Midwifery representation is permitted in the organization overseeing the course

Yes
No

Comments

3. Evidence of successful completion is provided to participants

Yes
No

Comments

4. There is a mechanism in place for evaluating and updating the course

Yes
No

Comments

Recommendation for approving the course overall

Yes

No

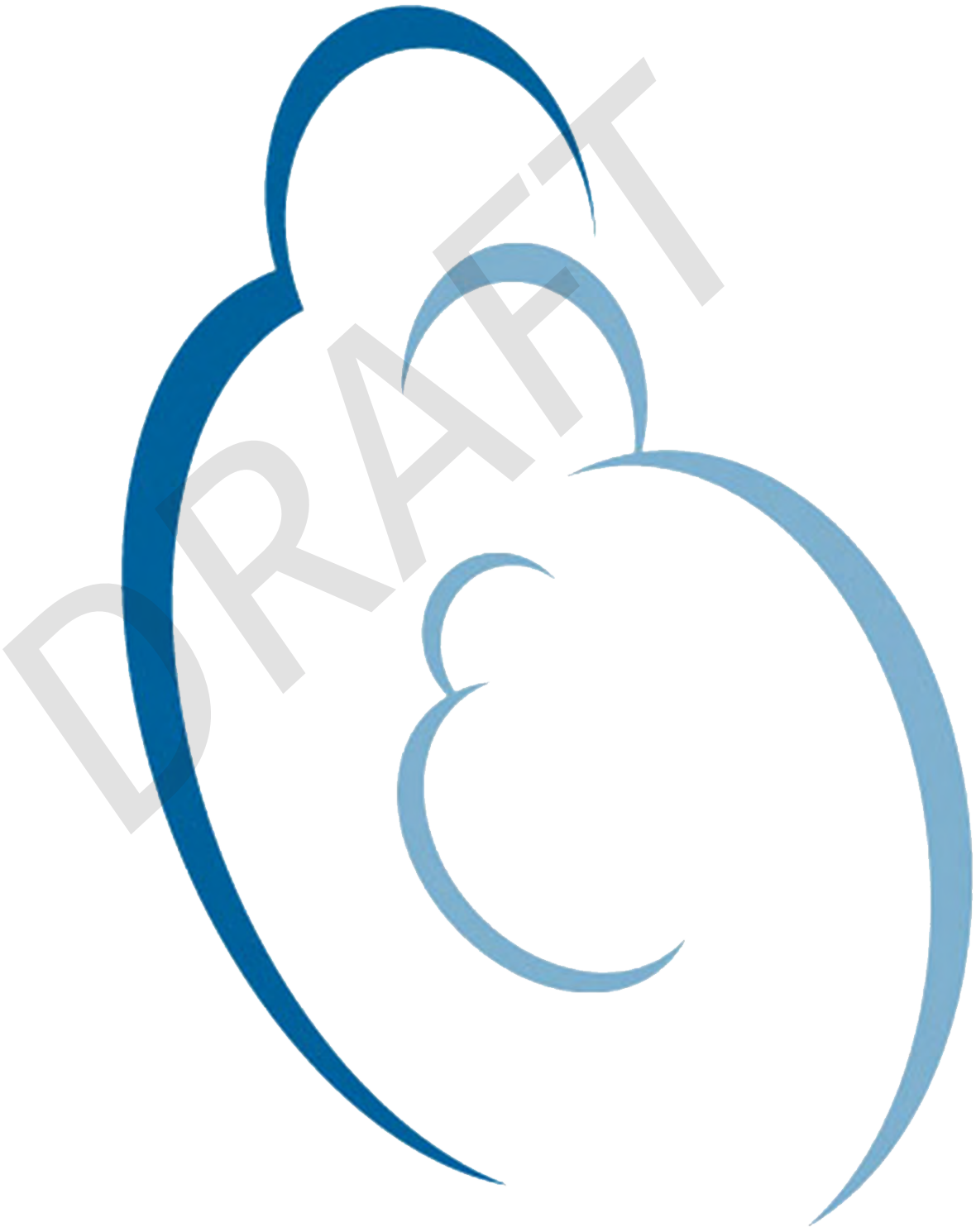
| | |
|---|---|
| Quality Assurance Committee (QAC) Approval Date | |

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

DRAFT

# 2016-2017 ANNUAL REPORT

## The College of Midwives of Ontario


DRAFT

# 2016-2017

## The College of Midwives of Ontario
## Annual Report
## Table of Contents

# Message from the President

Nine years ago I walked into my very first College of Midwives of Ontario Council meeting as an elected professional council member. I was immediately impressed with the caliber of the College Council and staff: how devoted they were to the mandate; how well they worked together; how thorough and thoughtful their debates, discussions and decisions were; and how much they could accomplish in a short amount of time.

As I move on from my role on Council, I see how this ongoing devotion, cooperation, thoughtfulness, and ambition has increased the College's respect among health regulators. Throughout the ongoing evolution of midwifery, the College has ensured the profession is firmly rooted and valued within the health care system by protecting the public interest.

The College has continually adapted both its own internal structure, and how it regulates midwifery to stay responsive to the changing needs of midwifery clients and midwives, modernization within the Ministry of Health and health care system, and the best practices for regulatory excellence. To this end, the College has committed to adjusting and improving its organizational structure, moving away from prescriptive standards and towards risk-based regulation, reviewing the scope of practice, remodeling its Quality Assurance Program, and enhancing accountability and transparency.

I am immensely proud of these successes and credit the commitment and hard work of each and every College Council and staff member, past and present. I am truly honoured to have worked with and, more importantly, learnt from each and every one of these individuals.

When I joined the College of Midwives of Ontario Council in 2008, I brought my deep passion and devotion to the core philosophy of midwifery care in Ontario. We know that this model is internationally respected, and proven to lead to excellent health outcomes and greater satisfaction, serving the public's interest. Now as my time at the College has come to end, I promise this philosophy of care is alive and well, and that protecting the public interest by ensuring high quality midwifery care is the driving force of the decisions the College of Midwives of Ontario makes.

**Barbara Borland, RM**

**President**

# Message from the Registrar & CEO

I am pleased to present the 2016-2017 Annual Report of the College of Midwives of Ontario. It has been a demanding and exciting year for both Council and the staff of the College. The sense of forward momentum we had at the end of last year has not only continued, but accelerated, and this report gives a full picture of the scope and complexity of work that the College undertook over the past twelve months.

Our principles of accountability, transparency, integrity, proportionality, and innovation guide our work at the College, and are evident throughout the report in the highlights from Council, committees and program areas. In addition, several important themes emerge as we reflect on the year's work. The College made significant efforts to improve its effectiveness, consistency, and fairness of decision-making and program delivery; and to share more meaningful and relevant information with members, stakeholders and the public as we progress.

In this past year, Council and staff worked together to make changes to the regulatory framework of midwifery in Ontario, and important changes to the Professional Misconduct Regulation and to the General Regulation (Quality Assurance) were approved by Council in March 2017. Together, we embarked on a significant journey to transform the way we approach regulation in general. Our systematic review of policies and processes has only just begun but is already producing results in our ongoing Standards of Practice review.

The staff of our Policy, Registration, Quality Assurance and Professional Conduct departments dutifully supported the important work of Council and their statutory committees and panels and delivered high quality programs supporting applicants and members and, of course, protecting the public. Their unwavering commitment to delivering efficient, effective and fair programs is commendable and very much appreciated. To better meet the changing needs of our members, we improved our IT systems and internal processes, and enhanced our custom-built database and member portal with integrated online Council elections, online payments and tax receipts.

Throughout all this we worked closely with the Ministry of Health and Long-Term Care, other regulators, the Association of Ontario Midwives, the Midwifery Education Program and many others to ensure that we remained on track in both our planning and our policy-making. It continues to be an honour to work in partnership with Council, College staff, members, stakeholders and the public in our shared goal of ensuring high quality midwifery care in Ontario.

Our heartfelt appreciation is owed to Barbara Borland, with whom I've worked closely over the years and who is concluding her 9th consecutive year on Council and 5th year as president. Barb guided the College in its senior staffing transition in 2013 and, since then, has provided me with the support one would expect of a skilled and caring midwife. Thank you, Barb, for your leadership and guidance.

**Kelly Dobbin, RM, MA, MSc**

**Registrar & CEO**

# MEET YOUR COUNCIL

This year the College of Midwives said farewell to a couple of our Council Members. The College and Council would like to take this opportunity to thank Joan A. Pajunen for her hard work and dedication to the College. A special thank you is owed to outgoing Council President Barbara Borland who has given so much during her nine years on Council. We are very grateful for her contribution.

Barbara Borland, RM
**Council President**
**Professional Member**

Caroline Brett
**Public Member**

Carron Canning, RM
**Professional Member**

Rochelle Dickenson
**Pubic Member**

Tiffany Haidon, RM
**Vice President - Professional**
**Professional Member**

Claudette Leduc, RM
**Professional Member**

Jennifer Lemon
**Vice President- Public**
**(Elected in October)**
**Public Member**

Lilly Martin, RM
**Professional Member**

Isabelle Milot, RM
**Professional Member**

Wendy Murko, RM
**Professional Member**

Joan A. Pajunen
**Public Member**
**Term end: May 2016**

Philip Playfair
**Public Member**

Gemma Salamat
**Public Member**

Jan Teevan, RM
**Professional Member**

Fern Sager
**Public Member**
**Term: October 2016 - December 2016)**



## Non-Council Committee Members:

### April 2016 - December 2016

Heather Brechin, RM
Diane Parkin, RM (finished October 2016)
Tia Sarkar, RM
Mylene Shields, RM
Edan Thomas, RM

### December 2016 - March 2017

Heather Brechin, RM
Christi Johnston, RM
Alexandra Nikitakis, RM
Lisa Nussey, RM
Tia Sarkar, RM
Mylene Shields, RM
Edan Thomas, RM

# STRATEGIC FRAMEWORK 2017-2020



Every three years, Council undertakes a review of the College's strategic priorities as well as its vision, mission and core principles to ensure they are relevant. The College's 2017-2020 strategic plan was created in 2016 and new strategic framework for the College was approved by Council at their March 2017 meeting.

The Strategic Framework paves the way forward for the College. It builds a stronger sense of common purpose, direction and a shared understanding of what we will achieve as an organization in collaboration with our partners and stakeholders.

## Our Mission

Regulating midwifery in the public interest.

## Our Vision

Inspiring trust and confidence in midwifery by leading in regulatory excellence.

## Our Strategic Priorites

- Modernization of Legislation & Regulation
- Implementation of Risk-Based Regulation
- Public Participation & Engagement

# Strategic Framework

## Our Guiding Principles

**Accountability**
We make fair, consistent and defensible decisions.

**Proportionality**
We allocate resources proportionate to the risk posed to our regulatory outcomes.

**Transparency**
We act openly to enhance accountability.

**Innovation**
We translate opportunity into organizational value.

**Integrity**
We act with respect, fairness and honesty.

## Outcomes We Are Expected To Achieve

1. Clients and the public can be confident that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice, and exercise clinical and professional judgment to provide safe and effective care.
2. Clients and the public can be confident that midwives maintain boundaries between professional and non-professional relationships.
3. Clients and the public can be confident that midwives practise the profession with honesty and integrity, and regard their responsibility to the client as paramount.
4. Clients are safeguarded from sexual abuse from midwives.
5. Clients can expect midwives to facilitate their choice and autonomy in decision-making.
6. Clients and the public can be confident that midwives demonstrate accountability by complying with legislative and regulatory requirements.
7. Clients and the public can expect midwives to practise free of a condition that prevents them from providing safe care.
8. Clients and the public trust that the College of Midwives of Ontario regulates in the public interest.

# Council Highlights

## Legislation and Regulations Governing the Profession:

In 2016, the College started a comprehensive review of all legislation and regulations that define and inform the practice and regulation of midwifery. This work was undertaken to ensure we are responsive and effective in fulfilling our public interest mandate.

The proposed changes aim to improve the client experience in the health care system by removing barriers to the delivery of safe, timely and quality midwifery care, and to increase the effectiveness and efficiency of our programs.

One proposed change that applies to all College regulations is that regulations be written at a high level of generality, focusing on overarching requirements that can be applied flexibly to a rapidly changing environment. This approach allows us to adapt to changing circumstances and find a good balance between ensuring accountability and enhancing innovation.

The General Regulation (including the Quality Assurance Regulation) and the Professional Misconduct Regulation were approved for an official submission to the Ministry at our March Council meeting. We look forward to framing our rationale for scope of practice, drugs and lab changes while working closely with the Ministry and other stakeholders as we move forward.

## Delivering Risk-Based Regulation:

In 2016 the College committed to delivering an over-arching program of change which will fundamentally reshape our approach to regulation. Traditional prescriptive, "rules-based" regulation is being replaced by risk-based regulation. This radical restructuring positions us to be able to deliver responsive and effective regulation within a rapidly changing regulatory and healthcare landscape.

Risk-based regulation is geared to achieving the right outcomes, and focuses our resources upon the areas of greatest risk to clients and members of the public. By applying the right level of regulation, we also support practitioner flexibility without constraining their clinical and professional judgment.

Regulating in a new way, focusing on risks and outcomes rather than compliance with detailed rules, has been a significant change. We have been deliberately ambitious in the scope of our regulatory transformation. Throughout 2016 we have pressed ahead with successfully implementing core aspects of risk-based regulation.

# Council Highlights

## Risk-Based Regulation Highlights

**Regulatory outcomes:** The ultimate goal of the College's regulatory activity is to work with the objects set out in the Regulated Health Professions Act (RHPA). We have defined the desired regulatory outcomes we expect to achieve, and these outcomes are outlined in our Strategic Framework (page 9 of this report.)

**Risk Register:** In order to ensure consistency in the way risks are identified, we have come up with a set of risks to our regulatory outcomes, which are outlined in our Risk Register. Our universal register ensures that each risk is accurately identified in a consistent way and that we have a comprehensive picture of our risk exposures across all core areas of regulatory activity. The Risk Register is a critical element of our new regulatory approach.

**Risk Appetite:** Once we had a clear idea of the risks we face, we considered our 'risk appetite', i.e. how much risk to the achievement of our outcomes we are prepared to accept? Using available data and information we decided which risks we should prioritize and tackle. We also decided which risks we will not deal with - understanding that resources are finite and that zero risk is unattainable.

**Streamlining:** We have undertaken a targeted review of all College policy areas and decision-making tools. Where the review concluded that changes were required, we submitted changes. We have also identified instances where we can provide more information through formal channels of communication instead of using formal regulatory tools.

**Policy Making:** We developed a rigorous approach to policy making to ensure that policy decisions are based on a proper evaluation of risk, solid evidence, and a thorough analysis of options and impacts. This process ensures that regulatory tools are not adopted as the default solution but rather introduced to mitigate risk when other non-regulatory options are unable to deliver the desired results. Our new decision-making tool will be posted to the website in 2017.



We are now moving from the development phase of these reforms into a period of intensive implementation; keenly aware that there remains much to do, particularly in the area of data collection and analysis, and building fit for purpose IT systems. In the next couple of years, we will see an emerging picture of the strengths and challenges of our new strategic approach to regulation. As a responsible regulator, we will continuously assess and evaluate our regulatory framework to ensure that we continue to respond to emerging challenges in a timely manner to be able to achieve the right outcomes in the public interest.

# Council Highlights

## Standards Review

Throughout 2016, we at the College have been working on a professional standards document that will articulate the expectations of midwifery professionalism. This document focusses on high level principles and will strengthen midwifery practice by providing guidance around clinical decision-making and professional judgment.

When midwifery was officially recognized and regulated in Ontario in 1993, there were few documents that could provide guidance to midwives practising in the province. It became our responsibility to put this guidance in place. Documents, like Standards, were developed not only to guide midwifery practice but also to demonstrate to the public and other health care providers what midwives were authorized to do. This has resulted in College standards that can be prescriptive; limiting midwives' abilities to use their professional judgment.

Twenty-three years later, Ontario midwives can find standards of practice in guidelines, community standards and peer-reviewed journals. Midwives can also use resources developed by the Association of Ontario Midwives, the Society of Obstetricians and Gynecologists of Ontario, and the Canadian Pediatric Society. With the profession now firmly rooted in the provincial health care system, and the presence of established organizations committed to high quality midwifery, it is time to replace our prescriptive standards with a document focussed on professional standards of behaviour.

In October 2016, Council approved the development of this new document and struck a working group of professional and public members to participate in the process. The first draft of the professional standards is scheduled to go out for member consultation in the summer of 2017.

.



# 2016-2017 COMMITTEE REPORTS

# Executive

The Executive Committee acts for Council between Council meetings and has all the powers of Council regarding any matter requiring immediate attention, other than the power to make, amend and revoke regulations and bylaws. It is also responsible for the College's governance, and acts as the Finance and Audit Committee.

In 2016-17, the Committee developed and implemented systems to strengthen its governance and increased fiduciary and risk oversight responsibilities.

The Committee designed a Council member competency matrix to build a Council on the basis of the competencies each individual brings to the table, ensuring that the whole of Council possesses the broad expertise needed to oversee and direct the College. To accomplish this, the Committee will first identify the knowledge and skills needed in Council, then identify "gaps" in incumbent members. With this information, a competency matrix will be created in 2017 in which current and prospective Council members will be matched against each needed skill. The matrix will be reviewed and updated regularly by the Executive Committee to ensure that it is aligned with the evolving strategic needs of the College.

This year the Committee piloted a tool to conduct auditor assessments. After the completion of the pilot, the tool was approved for use. Each year, the Committee will conduct an Annual Assessment, with a Comprehensive Audit Assessment occurring approximately every five years. Assessments are conducted to align with best practices as laid out under the Enhanced Audit Quality Initiative put forward by the Chartered Professional Accountants of Canada. This process allows the Committee to produce quality improvement recommendations for the external auditor annually, recommend the auditor for tender or reappointment periodically, as well as to note any concerns.

# Executive

This past year, the College initiated its collaboration with the Healthcare Insurance Reciprocal of Canada (HIROC) to complete the Risk Assessment Checklist program. This program, developed and administered by HIROC, is a web-based, self-assessment program that aims to improve the College's internal processes and systems. The program consists of checklists, or risk modules, for each of the high-cost/high-frequency risks identified from HIROC's extensive claims database. Each risk module is comprised of the most impactful, evidence-based mitigation strategies the Colleges should implement to effectively address the respective risk. The program also allows subscribers to track and benchmark progress over time. The Risk Assessment Checklist Program follows a three-year cycle, involving a step by step completion of the modules, and it will be overseen by the Executive Committee and other relevant statutory committees.



## 2016-2017 Committee members:

**April 2016 - October 2016**

Chair: Barbara Borland, RM

Professional Council Members:
Tiffany Haidon, RM
Wendy Murko, RM

Public Council Members:
Rochelle Dickenson
Jennifer Lemon

**October 2016 - March 2017**

Chair: Barbara Borland, RM

Professional Council Members:
Tiffany Haidon, RM
Claudette Leduc, RM

Public Council Members:
Rochelle Dickenson
Jennifer Lemon

# Registration

Registration of applicants is one of the key functions of the College, and it is the responsibility of the Registration Committee to ensure all applicants meet requirements for entry to practise. The Committee determines whether further training or supervision is required to meet those requirements, or if any terms, conditions, or limitations should be imposed. These requirements ensure that midwives have the knowledge, skills and judgment to practise midwifery in Ontario.

The Registration Committee also reviews class change applications to determine appropriate individualized requalification programs for members wishing to change from the Inactive to General class, and who do not otherwise meet the requirements for a General certificate of registration.

At the College, we continually explore new ways to ensure that the registration process remains efficient, fair, objective, impartial, transparent and accessible.

As part of our annual activities, the Registration Department filed the College's 2016 Annual Fair Registration Practices Report with the Office of the Fairness Commissioner and the Health Professions Database report with the Ministry of Health and Long-Term Care.

The College coordinated successful administrations of the Canadian Midwifery Registration Examination with 82 candidates sitting in Toronto and Sudbury in 2016.

In 2016, the College finalized a Jurisprudence Course handbook on the ethical and legal framework within which midwives practise in Ontario. This handbook accompanies a new Jurisprudence Course, which will become a registration requirement for all applicants starting in July of 2017.

The Registration Committee reviewed the first draft of proposed changes to the Registration Regulation and conducted initial consultations with key stakeholders. In collaboration with our Registration Department, the Registration Committee has initiated a review of all current registration policies and procedures, and we are reviewing some of our registration requirements. The purpose of this work is to identify gaps and streamline processes to develop up-to-date regulatory tools. This corresponds with our risk-based approach to regulation and the desired outcomes of fair, objective, impartial and transparent registration practices.

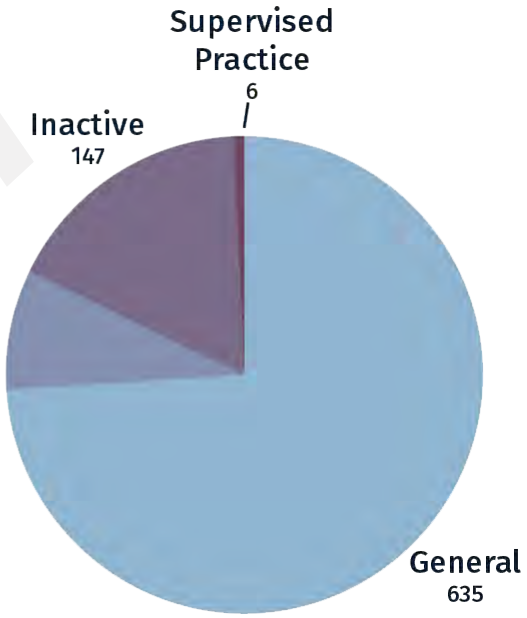
There were no appeals to the Health Professions Appeal and Review Board in this fiscal year.

# Registration

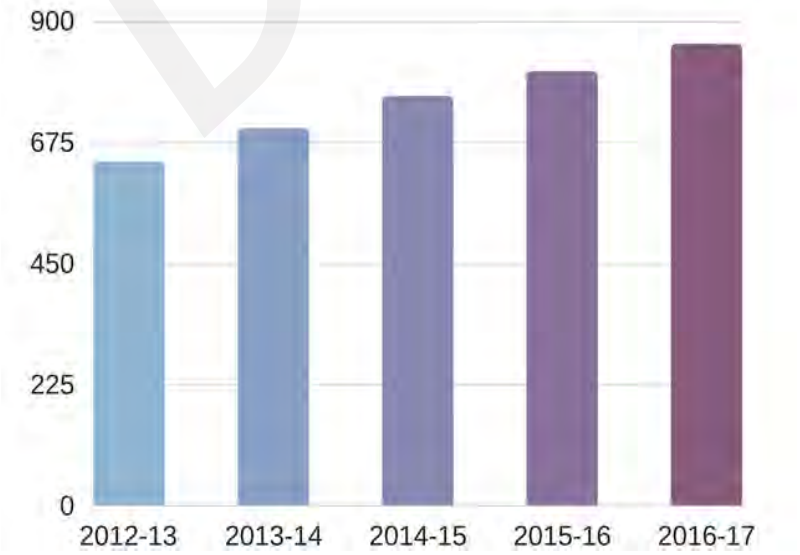
## By the Numbers

A total of **858** midwives were registered in Ontario as of March 31st, 2016.

- **635** General
- **70** General with New Registrant Conditions
- **6** Supervised Practice
- **147** Inactive




Registered midwives over the last five years.




| Fiscal Year (April 1 to March 31) | Total Registrants (as of March 31) |
|---|---|
| 2016-2017 | 858 |
| 2015-2016 | 807 |
| 2014-2015 | 761 |
| 2013-2014 | 701 |
| 2012-2013 | 639 |

# Registration

## Changes made to the Public Register respecting class and status between April 1 2016 and March 31 2017:

**352** total changes. The Registration Department handles an average of **29** class or status changes per month.

**22** members resigned their membership, **3** members were suspended for non-payment of fees and **4** members had their registration revoked for non-payment of fees.

**8** registration panels were held, addressing:

- **2** issues of active practice shortfalls in relation to class change,
- **1** clinical experience shortfall at initial application,
- **5** re-entry to practise.

In the 2016-17 fiscal year, **75** new members were registered:

- **65** were graduates from Ontario's Midwifery Education Programs,
- **6** were graduates from the International Midwifery Pre-registration Program at the Chang School of Continuing Education at Ryerson University,
- **4** former members re-registered with the College after having previously resigned.

# 2016-2017 Committee members:

**April 2016 - December 2016**
Chair: Gemma Salamat

Professional Council Members:
Carron Canning, RM
Isabelle Milot, RM

Public Council Members:
Joan. A. Pajunen (finished May 2016)

Non-Council Members:
Mylene Shields, RM

Barbara Borland, RM *ex-officio*

**December 2016 - March 2017**
Chair: Caroline Brett

Professional Council Members:
Carron Canning, RM
Isabelle Milot, RM

Public Council Members:
Jennifer Lemon
Gemma Salamat

Non-Council Members:
Mylene Shields, RM
Alexandra Nikitakis, RM

Barbara Borland, RM *ex-officio*

# Fitness to Practise

The Fitness to Practise Committee is mandated to protect the public from members who cannot practise safely or competently because of mental or physical incapacity. If a midwife is found to be incapacitated, their certificate may be revoked, suspended or have specific terms, conditions and limitations attached to it for a given length of time.

There were no Fitness to Practise Committee proceedings or referrals in the 2016-17 fiscal year.



## 2016-2017 Committee members:

**April 2016 - December 2016**
Chair: Lilly Martin, RM

Professional Council Members:
Claudette Leduc, RM
Jan Teevan, RM

Public Council Members:
Philip Playfair
Gemma Salamat

Non-Council Members:
Diane Parkin, RM

Barbara Borland, RM ***ex-officio***

**December 2016 - March 2017**
Chair: Lilly Martin, RM

Professional Council Members:
Claudette Leduc, RM
Jan Teevan, RM

Public Council Members:
Rochelle Dickenson (began March 2017)
Jennifer Lemon (began March 2017)
Philip Playfair
Gemma Salamat

Barbara Borland, RM ***ex-officio***

# Discipline

The Discipline Committee receives referrals from the Inquiries, Complaints and Reports Committee (ICRC) regarding alleged professional misconduct and/or incompetence.

A panel appointed by the Committee hears evidence regarding each case and decides whether an allegation should be dismissed, or whether a member has committed professional misconduct or is incompetent. If the member is found guilty, the panel orders an appropriate penalty. Holding midwives accountable for providing safe, quality care is an important part of maintaining public confidence in self-regulation.

The Committee conducts hearings in accordance with the Regulated Health Professions Act (RHPA) and has established rules of procedures that govern the hearings process. The College publishes discipline hearing summaries in accordance with the requirements of the RHPA and the College's bylaws. Committee decisions are available online at the College's website.

There were no Discipline Committee proceedings or referrals in the 2016-17 fiscal year.



## 2016-2017 Committee members:

**April 2016 - December 2016**
Chair: Lilly Martin, RM

Professional Council Members:
Claudette Leduc, RM
Jan Teevan, RM

Public Council Members:
Philip Playfair
Gemma Salamat

Non-Council Members:
Diane Parkin, RM

Barbara Borland, RM ***ex-officio***

**December 2016 - March 2017**
Chair: Lilly Martin, RM

Professional Council Members:
Claudette Leduc, RM
Jan Teevan, RM

Public Council Members:
Rochelle Dickenson (began March 2017)
Jennifer Lemon (began March 2017)
Philip Playfair
Gemma Salamat

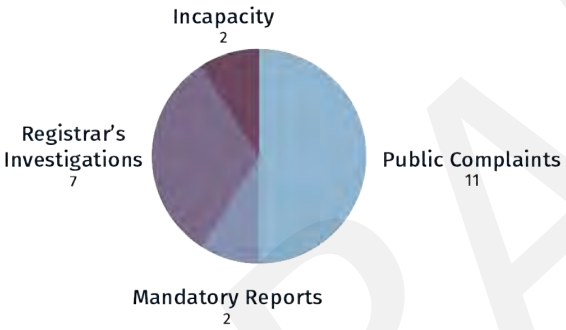
Barbara Borland, RM ***ex-officio***

# Inquiries, Complaints & Reports

The Inquiries, Complaints and Reports Committee (ICRC) oversees investigation matters related to formal complaints and information the College receives through mandatory and other reports. The Committee makes dispositions in accordance with legislation, including referrals to the Discipline Committee for allegations of professional misconduct and/or incompetence. The ICRC can also make referrals to the Fitness to Practise Committee regarding allegations of incapacity.

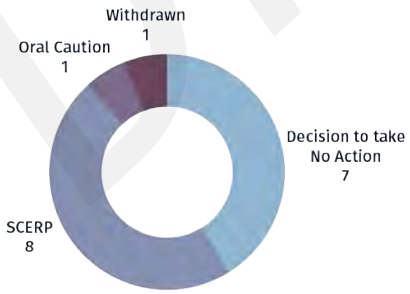
During the complaints process, the Committee is responsible for keeping the complainant and the registrant informed and strives to reach a conclusion within 150 days of confirming the issues relevant to the complaint. Every complaint and report about midwifery care is carefully considered. The committee regularly reviews how the investigation and resolution processes can be revised to better protect the public.

There were a total of **22** new cases opened in 2016-17:




**11** cases were public complaints;
**2** cases were mandatory reports;
**7** cases were Registrar's Investigations;
**2** cases were incapacity inquiries.

In 2016-17, **17** cases were closed. The ICRC decisions breakdown as follows:




**1** matter was withdrawn;
**7** decisions to take no action;
**8** decisions for a specified continuing education or remediation program (SCERP);
**1** decision for an oral caution.

There were no appeals to the Health Professions Appeal and Review Board in this fiscal year.

# Inquiries, Complaints & Reports

## Inquiries, Complaints and Reports Committee Highlights

The two main priorities for the committee were implementing a Risk Assessment Framework and proposed changes to the Professional Misconduct Regulation.

The ICRC Risk Assessment Framework was implemented this year to guide panels in their assessment of complaints and reports; enabling transparent, consistent and fair decision making. The accompanying Risk Analysis Tool lists issues that a complaint may consist of and categorizes the risk they pose to clients and the public interest. The tool also summarizes the possible outcomes based on the identified category of risk.

The College has had a Professional Misconduct Regulation in effect since being established in 1993. It was last revised in 2008, receiving government approval in 2009. This year's review of the regulation focussed on clarifying the wording and ensuring consistency in language with other health colleges' Professional Misconduct Regulations. Following a 70-day consultation with the membership and stakeholders, the regulation changes were approved by Council and are now ready for formal submission to the Ministry of Health.

# 2016-2017 Committee members:

**April 2016 - December 2016**
Chair: Rochelle Dickenson

Professional Council Members:
Tiffany Haidon, RM
Wendy Murko, RM

Public Council Members:
Caroline Brett
Jennifer Lemon
Joan A. Pajunen (finished May 2016)

Non-Council Members:
Heather Brechin, RM
Edan Thomas, RM

Barbara Borland, RM *ex-officio*

**December 2016 - March 2017**
Chair: Wendy Murko, RM

Professional Council Members:
Carron Canning, RM
Tiffany Haidon, RM

Public Council Members:
Caroline Brett
Rochelle Dickenson
Jennifer Lemon

Non-Council Members:
Heather Brechin, RM
Edan Thomas, RM
Lisa Nussey, RM

Barbara Borland, RM *ex-officio*

# Quality Assurance

The Quality Assurance Committee monitors and oversees the Quality Assurance Program (QAP), including peer and practice assessment, and the development of standards, policies and guidelines for Council's approval.

The QAP is designed to ensure that the knowledge, skill and judgment of Ontario midwives remains current throughout their careers, and that they continue to provide safe, effective, appropriate and ethical midwifery care to their clients.

## Quality Assurance Program Member Focus Groups

In November 2016, the College held member focus groups in several locations across the province (Toronto, Ottawa, Thunder Bay & Guelph) to discuss and evaluate the current QAP. We also engaged rural and remote midwifery practice groups to better understand the challenges our members practising in rural and remote environments face in meeting QAP reporting requirements.

Participants thought the continuing education and Peer Case Review requirements met the goals of the QAP but that the Quality of Care Evaluations and the Self-Assessment Questionnaire (SAQ) did not meet those goals. This feedback will inform the upcoming changes to the QAP.

## Assessments

One assessment took place as a result of QAP non-compliance from the previous reporting year (2014-2015).

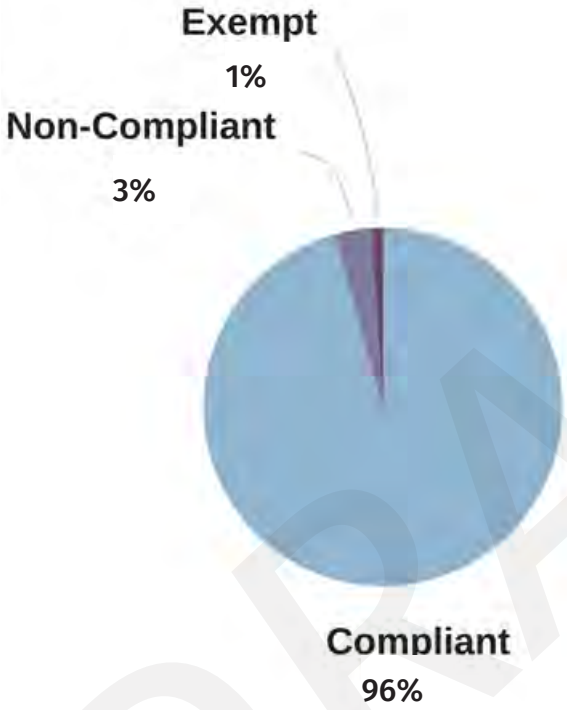
## Regulations, Standards and Policies

The Committee made the following amendments to regulations, standards and policies:

- Reviewed and proposed changes to the Quality Assurance Regulation
- Approved a new approach to developing and reviewing standards (shown on page 12 of this report)
- Revised the Policy on Continuing Education in Fetal Health Surveillance (FHS)
- Rescinded the Practice Assessment Workbook (PAW) Policies and Procedures document

# Quality Assurance

## Quality Assurance Program Reporting




**Compliant:** Compliance with the QAP was one of the highest rates of compliance the College has seen at 96%

**Non-Compliant:** QAP non-compliance cases were reviewed by a panel of the Committee and resulted in no further action.

**Exempt:** A panel of the Committee can exempt a member from reporting on some or all of the QAP requirements based on extenuating circumstances. The panel reviewed and approved six exemption applications.

**Note:** Members in the Inactive Class of registration are not currently required to report on QAP activities.



# 2016-2017 Committee members:

April 2016 - March 2017

Chair:
Jan Teevan, RM

Professional Council Members:
Lilly Martin, RM
Isabelle Milot, RM

Public Council Members:
Philip Playfair
Gemma Salamat

Non-Council Members:
Mylene Shields, RM
Tia Sarkar, RM

Barbara Borland, RM ***ex-officio***

# Client Relations

The Client Relations Committee (CRC) is responsible for overseeing programs that aim to continuously improve the professional relationship between midwives and their clients. This includes:

- Developing education requirements and guidelines for registrants as they relate to the prevention of sexual abuse;
- Developing guidelines for the conduct of registrants with their clients;
- Ensuring measures are in place to prevent and deal with sexual and other forms of client abuse;
- Promoting public understanding of the College's sexual abuse prevention program;
- Administering a funding program, which provides therapy and counselling for clients who were sexually abused by a College registrant.

In September 2016, a report from the Minister's Task Force on the Prevention of Sexual Abuse of Patients and the Regulated Health Professions Act (RHPA), 1991 was released. The Committee monitored the related government recommendations regarding processes that regulatory colleges should have in place to prevent and respond to sexual abuse complaints.

The Committee also monitored Bill 87, the Protecting Patients Act. If passed, resulting amendments to the sexual abuse provisions of the RHPA will require changes to Committee programs and the development of further guidance and resources for the membership and public.



## 2016-2017 Committee members:

**April 2016 - December 2016**
Claudette Leduc, RM

Professional Council Members:
Carron Canning, RM
Tiffany Haidon, RM
Wendy Murko, RM

Public Council Members:
Rochelle Dickenson

Barbara Borland, RM *ex-officio*

**December 2016 - March 2017**
Chair: Carron Canning, RM

Professional Council Members:
Claudette Leduc, RM
Tiffany Haidon, RM
Wendy Murko, RM

Public Council Members:
Rochelle Dickenson

Non-Council Members:
Christi Johnston, RM

Barbara Borland, RM *ex-officio*



# FINANCIAL STATEMENTS

# *Hold for Financial Statements*

# The College of Midwives of Ontario


21 St Clair Ave E., Suite 303
Toronto, Ontario, M4T 1L9

Toll Free: 1 844 640 2252
Phone: 1 416 640 2252
Fax: 1 416 640 2257

Email : admin@cmo.on.ca
Website: www.cmo.on.ca
Twitter: @cmo_osfo
Facebook: facebook.com/cmo.on.ca