College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Council briefing package

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College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario
THE STANDARD OF CARE.

Council

June 3, 2020 at 1:00 p.m. via ZOOM

Agenda

1:00 p.m.	**1. Agenda**	
1:05 p.m.	**2. Minutes of the meeting of March 11 and 12, 2020**	Information
	3. Strategic Issues	
1:10 p.m.	**3.1 2019 Annual Report** 3.1.1 Annual Report 3.1.2 Audited 2019 Annual Financial Statements Geoff Clute, Hilborn LLP	Direction
1:30 p.m.	**3.2 RPN scope of practice: revised Controlled Acts regulation for submission to government**	Discussion
1:45 p.m.	**3.3 By-Law amendments to combine the membership of the Discipline and Fitness to Practise committees**	Discussion
	4. Reports	
2:00 p.m	**4.1 Executive Director Update**	Information
2:30 p.m	**4.2 Executive Committee meetings** • March 11, 2020 • May 21, 2020	Information

Information Item

Finance Committee meeting, May 21, 2020

Next scheduled meetings:

September 16 and 17, 2020
December 2 and 3, 2020

Minutes

Present

C. Evans, Chair
F. Cardile
D. Cutler
S. Douglas
C. Egerton
A. Fox
G. Fox
D. Graystone
R. Henderson (Thursday)
T. Holland
C. Hourigan
A. Jewell
M. Klein-Nouri
D. Lafontaine
C. Manning
J. Petersen
L. Poonasamy
D. A. Prillo
S. Robinson
G. Rudanycz
M. Sheculski
N. Thick
D. Walia
J. Walker
C. Ward
H. Whittle
R. Woodfield

Regrets

T. Dion
R. Henderson (Wednesday)
D. LiChong
K. Patterson
T. Perlin
D. Thompson
A. Vidovic
K. Wagg
T. White
C. Woodbury

Guest

R. Steinecke, Legal Counsel

Staff

A. Coghlan
J. Hofbauer, Recorder
D. Jones
E. Horlock
B. Knowles
K. McCarthy
S. Mills
C. Stanford
C. Timmings

Agenda

The agenda had been circulated.

Motion 1

Moved by D. Cutler, seconded by C. Egerton,

> That the agenda for the March 11 and 12, 2020 Council meeting be approved as circulated.

CARRIED

Minutes

Minutes of the Council meeting of December 4 and 5, 2019 had been circulated.

Motion 2

Moved by R. Woodfield, seconded by N. Thick,

> That the minutes of the Council meeting of December 4 and 5, 2019 be approved as circulated.

CARRIED

Strategy 2021-2024

Council members had received the draft 2021-2024 Strategic Plan: *Strategy 2021-2024.*

A. Coghlan and C. Evans highlighted the process for developing the new strategic plan, including the extensive input of Council through three workshops. Members of CNO's Leadership Team described how the four pillars of the plan will work together.

A. Coghlan outlined how CNO plans to be ready to start implementing the plan in 2021. She noted that clear and measurable criteria for success will be developed.

In discussing approval of the plan, Council was asked if they believe that the plan positions CNO to meet its new purpose: *To protect the public by promoting safe nursing practice.* It was noted that the new plan is designed to strengthen CNO's focus on proactively supporting nurses in providing safe care as well as remediating when there are concerns about a nurse. It will also enhance CNO's capacity to influence system changes to support safe nursing practice.

Motion 3

Moved by M. Sheculski, seconded by S. Robinson,

> That Council approve the new CNO Strategic Plan, Strategy 2021-2024, attachment 1 to the briefing note, to come into effect January 1, 2021.

CARRIED

Council was informed that a version of the plan is being prepared for the public.

Council discussed the ongoing relevance of CNO's current mission and vision given the new purpose statement.

Motion 4

Moved by C. Manning, seconded by G. Fox,

> That Council approve the sunsetting of the current CNO Mission and Vision by December 31, 2020.

CARRIED

Proposal to combine the membership of the Discipline and Fitness to Practise committees

Council members received a briefing note highlighting the changing workloads of the Discipline and Fitness to Practise committees. It was noted that the legislation and adjudicative processes and skills required for both committees are similar.

It was confirmed that having a larger pool of members for both committees is in the public interest. It supports maintenance of competence in adjudication, provides additional members for future leadership positions and allows for a larger pool from which to book hearings for both committees.

Motion 5

Moved by N. Thick, seconded by D. Walia,

> That Council approve in principle that beginning in June 2020, the membership of the Discipline and Fitness to Practise Committees will be increased by cross-appointing members, such that every member of the Discipline Committee will become a member of the Fitness to Practise Committee and every member of the Fitness to Practise Committee will become a member of the Discipline Committee.

CARRIED

Follow-up Action

Draft By-Laws to June 2020 Council
Executive Director and CEO

RPN Scope of Practice: Proposed amendments to the Controlled Acts Regulation

In December, Council confirmed that the safeguards included in the Controlled Acts regulation were enough to support safe initiation of the added controlled acts by RPNs.

Motion 6

Moved by D. A. Prillo, seconded by M. Klein-Nouri,

> That Council approve for notice and circulation, proposed changes, as shown in Attachment 1 to the briefing note, to Part III, Controlled Acts of Ontario Regulation 275/94: General, as amended, made under the *Nursing Act, 1991*.

CARRIED

Follow-up Action

Circulate proposed regulation amendments
Final approval of regulations on June 2020 Council agenda
Executive Director and CEO

RN prescribing

Government has the regulation amendments approved by Council in March 2019. To be ready for government approval of the regulation changes, CNO needs to amend the register by-law to allow CNO's register – Find a Nurse – to clearly identify those RNs authorized to prescribe medications.

In reviewing the draft by-law amendment, it was clarified that Article 44.1.06 identifies the additional information that will be included on the register.

Motion 7

Moved by T. Holland, seconded by G. Rudanycz,

> That Council approve for notice and circulation the addition of paragraph 39 (below), specifying register information related to RN prescribing, to Article 44.1.06 of By-Law No. 1: General:
>
> *If a member holds a certificate of registration as a RN in the general class and is authorized to prescribe a drug designated in the regulations under the Act, a notation of that fact.*

CARRIED

Circulate proposed by-law amendments
Final approval of by-laws on June 2020 Council agenda
Executive Director and CEO

Nursys Canada

B. Knowles highlighted CNO's collaborative work to implement Nursys Canada – a system to support regulators across Canada sharing regulatory information about registrants. Initial development is a collaborative project between CNO, the British Columbia College of Nursing Professionals and the National Council of State Boards of Nursing.

Once the initial project is complete, the data from Nursys Canada will be available to all Canadian nursing regulators. Additional work is needed for other Canadian nursing regulators to enter their registrant information into the system. Nursys Canada is designed enhance public safety in a time of increasing mobility.

Statutory committee reports

C. Evans noted the critical public safety function performed by statutory committees. She also noted that under the *Health Professions Procedure Code,* these committees are required to report annually to Council.

Council members had received written reports. Committee chairs highlighted key trends.

Patient Relations

C. Evans highlighted the report of the Patient Relations Committee, focusing on work done to meet its mandate to prevent the sexual abuse of patients. Several web-based tools that had been developed for nurses and employers were shared with Council.

It was noted that there is a communication plan to promote these resources with nurses and employers. CNO is also working with educators on integrating the relevant competencies and resources into the curriculum.

Inquiries, Reports and Complaints Committee

C. Evans highlighted the report of the Inquiries, Reports and Complaints Committee (ICRC). She noted that the committee has experienced a continuing significant increase in the number of investigations ordered. The move to 4 panels was designed to address the significant growth in workload. In 2019, ICRC moved to receiving all committee materials through MeetX, which has enhanced efficiency and supported members in preparing for meetings.

Council was informed that ICRC has been exploring new remedial opportunities, including piloting a competency assessment and remediation process, where appropriate. ICRC has also begun accepting undertakings from nurses entering CNO's Nurses' Health Program.

Discipline Committee

T. Holland highlighted the report of the Discipline Committee. She noted that, following a 43% increase in referrals of matters to the committee between 2017 and 2018, there has been another 17% increase in referrals between 2018 and 2019.

T. Holland highlighted the work done to develop a competency and attribute-based approach to applying for leadership positions within the Discipline Committee: decision writer, panel and pre-hearing chair.

Fitness to Practise

N. Thick highlighted the report of the Fitness to Practise Committee. She reported that the committee has experienced a 47% decline in new referrals between 2018 and 2019. This change was also reflected in the number of matters the committee addressed in 2019.

Quality Assurance

M. Sheculski highlighted the report of the Quality Assurance Committee. She reported that over 90% of the nurses who participated in practice assessment in 2019 were successful and exited the program. She identified the status of the remaining nurses.

Registration

J. Petersen highlighted the report of the Registration Committee. She reported that in 2019, the Committee addressed over 1,500 applicants. In 82% of the matters, the committee identified that the applicant met the registration requirement. The requirement that was reviewed most frequently was fluency in English or French.

C. Evans thanked the Chairs and committees for the important work undertaken to support safe nursing practice.

Strategic Performance report

It was noted that, while Council has approved a new strategic plan, its current plan does not expire until the end of 2020. To support Council in its accountability for monitoring achievement of the current strategic plan, it received highlights of achievements and a report on the Key Performance Indicators (KPIs).

C. Evans highlighted the change in the KPI related to Council and committee functions being supported through technology.

K. McCarthy highlighted the major accomplishments in 2019 to support CNO meeting its strategic objectives. He also identified lessons learned in relation to key performance indicators, which will inform the identification of indicators to monitor achievement of Strategy 2021.

There was discussion about several of the KPIs and the opportunities to leverage CNO's data and resources to enhance performance.

Governance Work Group Report

Richard Steinecke, Legal Counsel, joined the meeting.

C. Evans introduced the report of the Work Group, noting the achievements related to Governance that had occurred to date. In December 2019, Council supported replacing the

Election and Appointments Committee (EAC) with an interim Nominating Committee. This continues Council's approach to implementing the components of its governance vision that can be implemented prior to legislative change.

The Governance Work Group presented draft terms of reference for the interim Nominating Committee. They were based on the terms of reference for the future Nominating Committee, expanded to include ongoing EAC roles required under the current legislation.

Motion 8

Moved by D. Cutler, seconded by N. Thick,

> That Council approve the Terms of Reference for the interim Nominating Committee as they appear in attachment 1 of the Governance Work Group report.

CARRIED

By-Law

By-Law changes needed to implement the interim Nominating Committee were presented to Council.

C. Evans informed Council of a consideration that had yet to be addressed: what would be the most appropriate approach to ensuring there was a mechanism to address the role of the EAC between June of 2020 and when the interim Nominating Committee is appointed in the fall of 2020. The Governance Work Group is recommending that this role be added to the Executive Committee for the short term. Those transitional provisions are included in the draft by-law.

Motion 9

Moved by R. Woodfield, seconded by M. Klein-Nouri,

> That Council approve the addition of article 24.08 (as shown in attachment 2 of the report of the Governance Work Group) to article 24 of *By-Law No.1: General*, to take effect as of the end of the Council meeting in June 2020.
>
> That, on the date on which Council first appoints the interim Nominating Committee, the following changes be made to *By-Law No.1: General*:
>
> - Article 24 (*including article 24.08 noted above*) be repealed and replaced with articles 24.01 – 24.03 (as shown in attachment 2 of the report of the Governance Work Group); and
> - The term "Election and Appointments Committee" be replaced by the term "Nominating Committee" throughout the by-law, including Schedule 1.

CARRIED

Executive Director update

A. Coghlan informed Council about:

- organizational leadership and facilities change to support CNO in its capacity to move towards implementing Strategy 2021 - 2024;
- the pilot of CNO's public outreach strategy;
- the government plan to grant College's the ability to award BScN degrees and the implications for CNO regulations;
- the national strategy related to Nurse Practitioner practice and the work that will be done at CNO; and
- CNO's approach to addressing Covid 19.

Executive Committee

Council had received, for information, the minutes of the Executive Committee meeting of February 20, 2020.

Finance Committee.

H. Whittle highlighted the report of the Finance Committee meeting of February 20, 2020. She highlighted the unaudited financial statements for the year ended December 31, 2019.

Motion 10

Moved by H. Whittle, seconded by C. Egerton,

> That Council approve the unaudited financial statements for the year ended December 31, 2019.

CARRIED

The Finance Committee had received the report of the Sub-Committee on Compensation. Changes were recommended to CNO's Compensation Principles.

Motion 11

Moved by H. Whittle, seconded by T. Holland,

> That Council approve the proposed revised Compensation Principles as they appear in attachment 4 to the Finance Committee report.

CARRIED

The Finance Committee recommended changes to the Terms of Reference of the Sub-Committee.

Motion 12

Moved by H. Whittle, seconded by A. Jewell,

> That Council approve the proposed revised Terms of Reference for the Sub-Committee on Compensation as they appear in Attachment 6 to the Finance Committee's report.

CARRIED

Council was informed that the Finance Committee met with the auditor, including an in-camera session and continued discussions about terms of reference for a future Finance Committee.

Electronic Voting for the Executive Committee

In December, Council had agreed to move forward with electronic voting for the Executive. Amendments to Schedule 1 to By-Law No. 1: General were prepared to enable electronic voting.

Motion 13

Moved by A. Jewell, seconded by N. Thick,

> That Council approve the amendments to Schedule No. 1 to By-Law No. 1: *Process for Election of Council Officers and Other Members of the Executive Committee*, as they appear in attachment 1 to this briefing note.

CARRIED

Adjournment

Council adjourned at 2:00 p.m. to reconvene at 9:00 a.m. on Thursday, March 12, 2020.

Thursday, March 12, 2020

Appointment of scrutineers

G. Fox, Chair of the Election and Appointments Committee randomly selected three Council members to serve as scrutineers for the election of the Executive Committee.

Motion 14

Moved by N. Thick, seconded by D. Lafontaine,

> That the scrutineers for the 2020 election of the Executive Committee be: R. Henderson, D. Prillo and M. Sheculski.

CARRIED

Election of the Executive Committee

G. Fox chaired the election of the Executive Committee.

She announced the nominations received for officers:

President:
- S. Robinson
- H. Whittle

Vice-President, RN
- N. Thick

Vice President, RPN
- A. Fox

G. Fox called for nominations from the floor. None were forthcoming.

Motion 15

Moved by C. Egerton, seconded by R. Woodfield,

> That nominations for the election of Council officers be closed.

CARRIED

Council members were sent electronic ballots and voted. G. Fox informed Council that S. Robinson was elected President.

G. Fox informed Council that D. Thompson had been nominated as a public member of Council. G. Fox called for nominations from the floor.

When no nominations came forward, G. Fox shared the recommendation of the Election and Appointments Committee (EAC). EAC is proposing that decision about the second public member on the Executive be deferred until June Council. By show of hands, Council supported this proposal.

G. Fox announced the 2020-2021 Executive Committee:

S. Robinson, President
A. Fox, Vice-President, RPN
N. Thick, Vice-President, RN
Diane Thompson, public member.

Council was informed that there will be another call for nominations for the additional public member on the Executive Committee in advance of Council in June.

Motion 16

Moved by D. Prillo, seconded by D. Lafontaine,

That the ballots for the election of the 2020-2021 Executive Committee be destroyed.

CARRIED

Appointment of statutory committee chairs

The Executive recommended the chairs of statutory committees. Given Council's support for merging the membership of the Discipline and Fitness to Practise committees, one chair is being recommended for those two committees.

Motion 17

Moved by G. Fox, seconded by G. Rudanycz,

That the 2020-2021 statutory committee chairs be:

Discipline	T. Holland
Fitness to Practise	T. Holland
Quality Assurance	M, Sheculski
Registration	J. Petersen

CARRIED

Appointment of members of statutory committees

G. Fox highlighted the report of the Election and Appointments Committee. She identified that new Council members are recommended to committees based on vacancies, their background and time availability. Recommended non-Council committee members were selected based on candidates meeting the needed competencies and attributes.

Motion 18

Moved by N. Thick, seconded by D. Lafontaine,

> That Council and committee members be appointed to statutory committees, effective June 4, 2020, in accordance with the list of committee appointments presented by the Election and Appointments Committee (attached to the minutes); and
>
> That C. Hourigan's appointment to the Discipline Committee take effect immediately.

CARRIED

Sub-committee on Compensation

The Finance Committee recommended reappointment of a sub-committee member and the Executive recommended its chair.

Motion 19

Moved by M. Sheculski, seconded by F. Cardile,

That Joe Nunes:

- be reappointed to the Sub-Committee on Compensation until June 2023; and
- be appointed as the 2020-2021 Chair of the Sub-Committee on Compensation.

CARRIED

Confirmation of committee appointment

The Executive had made a committee appointment to support ongoing effectiveness.

Motion 20

Moved by C. Manning, seconded by N. Thick,

> That the appointment of Shana (Hana) Anjema to the Inquires, Complaints and Reports Committee (ICRC) until June 2021 be confirmed.

CARRIED

Next meeting

Council will meet again on June 3 and 4, 2020.

Adjournment

At 11:00, it was

Motion 21

Moved by D. Walia, seconded by M. Klein-Nouri,

That Council conclude.

CARRIED

_____

Chair

Attachment 1

2020-2021 Committee Members
(Term begins June 4, 2020)

Executive Committee
Sandra Robinson, RN, President
Ashley Fox, Vice-President, RPN
Naomi Thick, Vice President, RN
Diane Thompson, PM
Election of 2nd public member deferred

Inquiries, Complaints and Reports Committee
Sandra Robinson, NP, Chair
Shana Anjema, RN*
Frank Cardile, PM
Samantha Diceman, RPN*
Cheryl Evans, RN
Ashley Fox, RPN
Ryan Henderson, RN
Kristin Kennedy, RN*
Michelle Lewis, RN*
Candace Ngungu, RN*
Judy Petersen, PM
Mary Ellen Renwick, RN*
Maria Sheculski, PM
Sherry Simo, RPN*
Katharina Skrzypek, RN*
Kathleen Tabinga, RPN*
Naomi Thick, RN
Diane Thompson, PM

Discipline Committee
Terry Holland, RPN, Chair
Margarita Cleghorne, RPN*
Dawn Cutler, RN
Jacqueline Dillon, RPN*
Tanya Dion, RN
Sylvia Douglas, PM
David Edwards, RPN*
Cathy Egerton, PM
Carly Gilchrist, RPN*
Shaneika Grey, RPN*
Max Hamlyn, RPN*
Neil Hillier, RPN
Carly Hourigan, PM
Carolyn Kargiannakis, RN*
Karen LaForet, RN*
Bonnie MacKinnon, RN
Mary MacNeil, RN*
Linda Marie Pacheco, RN*
Honey Palalon, RN*
Tania Perlin, PM
Lalitha Poonasamy, PM
Desiree-Ann Prillo, RPN
Heather Riddell, RN*
George Rudanycz, RN
Martin Sabourin, RN
Michael Schroder, NP*
Heather Stevanka, RN*
Sherry Szucsko-Bedard, RN*
Devinder Walia, PM
Jane Walker, RN
Chris Woodbury, PM

* Appointed committee member

Fitness to Practise Committee
Terry Holland, RPN, Chair
Sylvia Douglas, PM
Cathy Egerton, PM
Jennifer Farah, RPN*
Kerry Gartshore, RPN
Fotyne Georgopoulos, RPN*
Jane Matthews, RN*
Andrea Norgate, RN*
Fern**ando** Tarzia, RN*
Patricia Sullivan, RN
Jody Whaley, RPN*
Colleen Wilkinson, RN*
Chris Woodbury, PM
Joseé Wright, RN

* Appointed committee member

Quality Assurance Committee
Maria Sheculski, PM, Chair
Katie Condon, RPN*
Zaheeda Hamza, RN*
Monica Klein-Nouri, RN
Dale Lafontaine, PM
Diane Morin-LeBlanc, RN*
Lalitha Poonasamy, PM
Desiree-Ann Prillo, RPN
Devinder Walia, PM
Heather Whittle, NP

Registration Committee
Judy Petersen, PM, Chair
Linda Bishop, RPN*
Cathy Egerton, PM
Carrie Heer, NP*
Connie Manning, RPN
Maureen Ralph, RN*
Diane Thompson, PM
Andrea Vidovic, RN

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Innovating with Evidence

2019 Annual Report

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2019 Annual Report

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Welcome to CNO

We are the College of Nurses of Ontario (CNO) and we protect the public by promoting safe nursing practice.

What do we do?

WE SET THE REQUIREMENTS FOR BECOMING A NURSE IN ONTARIO

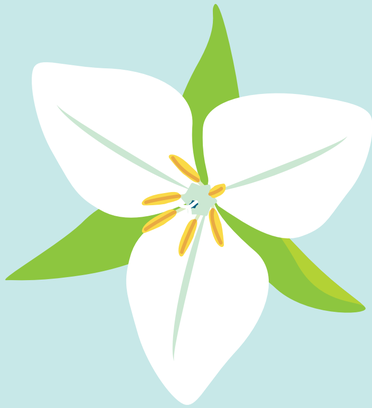
WE INFORM NURSES OF THEIR ACCOUNTABILITIES, AND TELL YOU WHAT YOU CAN EXPECT FROM NURSES

WE RESPOND TO YOUR CONCERNS ABOUT NURSES' CONDUCT, COMPETENCE AND HEALTH

WE ENSURE NURSES ENGAGE IN CONTINUOUS QUALITY IMPROVEMENT THROUGHOUT THEIR CAREERS

Nurses in Ontario

121,488
REGISTERED NURSES (RNs)



59,967
REGISTERED PRACTICAL NURSES (RPNs)

3,864
NURSE PRACTITIONERS (NPs)

More than 185,000 nurses

For more statistics about nurses and nursing, visit **www.cno.org/stats**

As of December 31, 2019

Executive Director & CEO's message

Just as nurses use evidence in their practice every day, CNO is committed to ensuring we use evidence to inform our regulatory work. In 2019, we used what we learned from the **Long-Term Care Homes Public Inquiry** to strengthen our processes. Some of these initiatives are highlighted in this report, and you can find many more at **www.cno.org**.

We also spent 2019 gathering evidence to inform future planning. Our current strategic plan ends in December 2020, so our Council and staff worked together to envision possibilities for CNO's future contributions to patient safety. Safety is everyone's responsibility. While nurses are key in our system of safety, they are by no means the only part. We look forward to sharing our strategic plan later this year.

At the time of writing this, we are adapting to respond to COVID-19. We know the public can count on nurses to use the best available evidence to keep patients safe. CNO is here to protect the public by promoting safe nursing practice. ✦

ANNE COGHLAN RN, MScN
EXECUTIVE DIRECTOR & CEO CNO

President's message

Global best practices in governance and Ontario's health care system continue to evolve, so regulators like CNO need to evolve as well. We initiated a radical paradigm shift in our governance structure and processes, to ensure we are regulating nurses in the best way possible to protect the public (see page 8 for more information).

Pending government approval, we'll be ready to implement these changes. We've also been sharing our vision with national and provincial regulators who are eager to learn from our experiences and look to us as leaders in this area. In fact, many have since initiated changes to improve their own governance structures.

In changing the way we govern, CNO will be more efficient in making decisions, and ultimately more effective in enhancing your trust in nursing care. ✦

CHERYL EVANS RN, MScN
COUNCIL PRESIDENT JUNE 2018 - JUNE 2020 CNO

Find more on our Council at:
www.cno.org/council

Read about CNO's committees at:
www.cno.org/committees

For Discipline Decisions, visit:
Find a Nurse and **www.cno.org**

Three highlights from 2019

01 Reducing risk

Developing interventions against patient harm

It's rare but real: some health care providers do set out to harm patients. Why does this happen and how can we prevent it? To answer these questions, we explored trends among health care providers who harm patients. Using evidence, we learned that some of these atrocious acts can be both detected — and prevented.

We started by conducting extensive literature reviews on health care serial killers, sexual abuse and other forms of harm. We studied all sexual abuse reports CNO received between 2000 and 2017. We interviewed international experts and examined the evidence about preventing patient harm.

While there is no formula for recognizing health care providers who intend to harm patients, we discovered there are risk factors and common characteristics. For example, we found similarities in types of victims and care settings, among others.

Common characteristics can be used as warning signs — especially when there is more than one. For instance, health care serial killers often make their colleagues anxious and act suspicious before being caught for poor nursing practices. When this suspicion is raised, they may change jobs.

Based on the evidence, we developed interventions for detecting nurses who harm patients. We already use some of these interventions, such as a new tool to assess risk when we receive a concern about a nurse. We've created other practice resources for nurses, educators and employers, too.

Stakeholders in Canada and around the globe are looking to us so they can learn more. So we're taking every opportunity we can to share this information. After all, we all have a role to play in reducing the risk.

See more of our research results at: **www.cno.org/SAP** and **www.cno.org/pir**. ✦

ALLEGED SEXUAL ABUSE MOST COMMON AREAS OF PRACTICE:

28% MENTAL HEALTH

11% GERIATRICS

8% HOME CARE

CHARACTERISTICS OF A HEALTH CARE SERIAL KILLER:

1. MENTAL HEALTH DISORDER
2. MAKES COLLEAGUES ANXIOUS
3. MAY POSSESS UNAUTHORIZED MEDICATIONS AT HOME/WORKPLACE
4. MAY CHANGE EMPLOYERS FREQUENTLY

WE SHARED WHAT WE LEARNED WITH:

- → PROVINCIAL, NATIONAL AND INTERNATIONAL HEALTH CARE REGULATORS
- → NATIONAL NURSING REGULATORS
- → THE LEGAL COMMUNITY

DISCIPLINE PANELS ARE MADE UP OF MEMBERS OF THE PUBLIC AND NURSES

NURSE MANAGERS TESTED OUR NEW REPORTING GUIDE TO ENSURE IT'S CLEAR AND EASY TO UNDERSTAND

THE GUIDE HELPED THEM MAKE THE RIGHT DECISIONS ABOUT WHETHER OR NOT TO REPORT A NURSE

02 Patient safety first

> We published a new online Reporting Guide to help employers, nurse colleagues and anyone else working with a nurse, better understand when and how to submit a report.

Clarifying questions about nursing practice

Patient safety is the focus of everyone involved in patient care. This means not only nurses, but also those who employ and work with them.

CNO learned many things from the Long-Term Care Homes Public Inquiry. For one, we needed to clarify what concerns about a nurse's behaviour or care to report to CNO.

In 2019, we published a new online **Reporting Guide** to help employers, nurse colleagues and anyone else working with a nurse, better understand when and how to submit a report to CNO. The guide outlines nurses' professional accountabilities for reporting, and legal obligations to report certain nursing conduct and concerns.

To test these changes, we piloted the Reporting Guide and form with employers and used their feedback to improve them. Now the form has more areas to list multiple incidents, for example, so we can get a more accurate picture of what's going on. As well, users can submit the form electronically on **www.cno.org**. Going forward, we'll provide more resources to help people understand when to report.

We also believe transparency is key to patient protection. That's why we're making more of a nurse's employment history available to the public. Now, you can find the past three years of a nurse's employment history (up from one) on our public Register, **Find a Nurse**. ✦

03 Good governance

> By enhancing our processes, we're raising the bar for regulatory excellence in Ontario.

Improving our processes to enhance public trust

Every year, CNO's Council (board) and committees make decisions about nursing care with the public's best interest in mind. But how can we do this even better?

Last year, we submitted legislative changes to the Ontario government that will make us more effective in public protection. These changes include reducing the number of directors on our board to improve communication and decision-making, and appointing nurse board members based on their competence. We're also changing the words we use to describe ourselves to make our roles clearer. For example, we'll use "board" instead of "Council" and "Registrar" instead of "Executive Director."

We have new requirements for nurses who want to join our committees. They ensure that decisions about patient safety are made by qualified individuals.

In 2019, we asked people who used the new requirements to tell us about their experience. With their feedback, we refined our processes even more. We simplified the application itself by reducing the number of questions and making it easier to complete, for instance. As well, we promoted our.committee work as a way of contributing to public protection. All of this resulted in almost double the number of nurses applying for committees, compared to the previous year.

We also developed new resources for members of the public and nurses who want to understand more. For one, we created an educational video to give them an idea of what it's like to serve on our Council.

By enhancing our processes, we're raising the bar for regulatory excellence in Ontario. Ultimately, that translates into more public trust in nursing care — across the board.

Read more information about our **Governance Vision**. ✦

CNO's future board

12 members

EQUAL # OF PUBLIC MEMBERS AND NURSES

EVERY 3 YEARS, AN EXTERNAL EXPERT WILL EVALUATE OUR BOARD AND GOVERNANCE PROCESSES TO ENSURE WE STAY ON TRACK

WE CONTINUE TO COLLABORATE WITH THE CITIZEN ADVISORY GROUP TO ENCOURAGE PUBLIC PARTICIPATION IN CNO DECISIONS

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

College of Nurses of Ontario | 101 Davenport Rd. Toronto ON | cno.org

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Agenda Item 3.1.2

Direction Note – June 2020 Council

Audited Financial Statements for the Year-Ended December 31, 2019

Contact for Questions or More Information

Stephen Mills, Chief Administrative Officer

Direction to Executive

That the audited financial statements for the year ended December 31, 2019 be approved.

Background

The Finance Committee met on May 21st and reviewed the attached audited financial statements. CNO's audit partner, Blair MacKenzie attended the meeting and highlighted the statements. The Finance Committee had an in-camera session with Blair – without staff in attendance. Following the in-camera session, the Finance Committee decided to recommend that Council approve the statements.

The manager of CNO's audit, Geoff Clute, will attend Council to highlight the statements.

Attachments:

1. 2019 Audited Financial Statements

COLLEGE OF NURSES OF ONTARIO

FINANCIAL STATEMENTS

DECEMBER 31, 2019

HILBORN LLP

HILBORN LLP

Independent Auditor's Report

To the Council of the College of Nurses of Ontario

Opinion

We have audited the financial statements of the College of Nurses of Ontario (the "College"), which comprise the statement of financial position as at December 31, 2019, and the statements of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2019, 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.

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the College in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Other Information

Management is responsible for the other information. The other information comprises the information included in the annual report but does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not and will not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information identified above when it becomes available and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

When we read the annual report, if we conclude that there is a material misstatement therein, we are required to communicate the matter to those charged with governance.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of the 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.

In preparing the financial statements, management is responsible for assessing the ability of the College to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the College or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the financial reporting process of the College.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

Independent Auditor's Report (continued)

Auditor's Responsibilities for the Audit of the Financial Statements (continued)

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit 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 internal control of the College.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the ability of the College to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the College to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

We also provide those charged with governance with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

Toronto, Ontario
Date to be determined

Chartered Professional Accountants
Licensed Public Accountants

COLLEGE OF NURSES OF ONTARIO

Statement of Financial Position

December 31	2019 $	2018 $
ASSETS		
Current assets		
Cash	**49,246,911**	27,317,736
Investments (note 3)	**21,192,321**	25,052,067
Amounts receivable	**22,664**	170,969
Prepaid expenses	**1,026,225**	527,996
	71,488,121	53,068,768
Investments (note 3)	**12,180,199**	14,069,355
Capital assets (note 4)	**7,296,739**	7,663,073
Intangible assets (note 5)	**342,191**	414,646
Defined benefit asset (note 6)	**-**	264,725
	19,819,129	22,411,799
	91,307,250	75,480,567
LIABILITIES		
Current liabilities		
Accounts payable and accrued liabilities (note 8)	**13,357,019**	9,631,430
Deferred membership and examination fees	**43,275,243**	42,313,328
	56,632,262	51,944,758
Defined benefit liability (note 6)	**796,546**	-
	57,428,808	51,944,758
NET ASSETS		
Invested in capital and intangible assets	**7,638,930**	8,077,719
Unrestricted	**26,239,512**	15,458,090
	33,878,442	23,535,809
	91,307,250	75,480,567

The accompanying notes are an integral part of these financial statements

Approved on behalf of the Council:

President

Vice-President

Vice-President

COLLEGE OF NURSES OF ONTARIO

Statement of Operations

Year ended December 31	2019 $	2018 $
Revenues		
Membership fees	**49,602,126**	36,115,990
Credential evaluations, endorsements and transcripts	**4,470,315**	3,107,090
Examinations	**1,899,655**	2,161,560
Investment income	**1,237,451**	688,126
Other	**268,201**	260,087
	57,477,748	42,332,853
Expenses		
Employee salaries and benefits	**29,007,869**	26,053,508
Consultants (note 7)	**5,249,356**	5,840,668
Legal services	**2,697,549**	2,912,249
Equipment, operating supplies and other services	**5,138,391**	4,137,741
Taxes, utilities and amortization	**1,510,277**	1,448,000
Examination fees	**1,483,634**	1,658,750
Non-staff remuneration and expenses	**809,340**	745,864
	45,896,416	42,796,780
Excess of revenues over expenses (expenses over revenues) for year	**11,581,332**	(463,927)

The accompanying notes are an integral part of these financial statements

COLLEGE OF NURSES OF ONTARIO

Statement of Changes in Net Assets

Year ended December 31

	Invested in capital and intangible assets $	Unrestricted $	2019 Total $
Balance, beginning of year	8,077,719	15,458,090	**23,535,809**
Excess of revenues over expenses for year	-	11,581,332	**11,581,332**
Amortization of capital assets	(1,103,409)	1,103,409	
Loss on disposal of capital assets	(1,826)	1,826	**-**
Amortization of intangible assets	(136,962)	136,962	**-**
Purchase of capital assets	738,901	(738,901)	**-**
Purchase of intangible assets	64,507	(64,507)	**-**
Defined benefit costs - remeasurements and other items	-	(1,238,699)	**(1,238,699)**
Balance, end of year	7,638,930	26,239,512	**33,878,442**

	Invested in capital and intangible assets $	Unrestricted $	2018 Total $
Balance, beginning of year	8,270,251	16,192,177	24,462,428
Excess of expenses over revenues for year	-	(463,927)	(463,927)
Amortization of capital assets	(1,042,830)	1,042,830	-
Loss on disposal of capital assets	(13,528)	13,528	-
Amortization of intangible assets	(123,197)	123,197	-
Purchase of capital assets	882,920	(882,920)	-
Purchase of intangible assets	104,103	(104,103)	-
Defined benefit costs - remeasurements and other items	-	(462,692)	(462,692)
Balance, end of year	8,077,719	15,458,090	23,535,809

The accompanying notes are an integral part of these financial statements

COLLEGE OF NURSES OF ONTARIO

Statement of Cash Flows

Year ended December 31	2019 $	2018 $
Cash flows from operating activities		
Excess of revenues over expenses (expenses over revenues) for year	**11,581,332**	(463,927)
Adjustments to determine net cash provided by (used in) operating activities		
Amortization of capital assets	**1,103,409**	1,042,830
Amortization of intangible assets	**136,962**	123,197
Loss on disposal of capital assets	**1,826**	13,528
Interest not received during the year capitalized to investments	**(619,075)**	(362,121)
Interest received during the year previously capitalized to investments	**213,718**	88,970
Pension benefits funding	**(1,320,318)**	(1,185,147)
Pension benefits expense	**1,142,890**	1,010,646
	12,240,744	267,976
Change in non-cash working capital items		
Decrease in amounts receivable	**148,305**	19,118
Decrease (increase) in prepaid expenses	**(498,229)**	120,146
Increase in accounts payable and accrued liabilities	**3,725,589**	2,536,202
Increase in deferred membership and examination fees	**961,915**	24,333,503
	16,578,324	27,276,945
Cash flows from investing activities		
Purchase of investments	**(23,683,606)**	(40,452,643)
Proceeds from disposal of investments	**29,837,865**	17,467,000
Purchase of capital assets	**(738,901)**	(882,920)
Purchase of intangible assets	**(64,507)**	(104,103)
	5,350,851	(23,972,666)
Net change in cash	**21,929,175**	3,304,279
Cash, beginning of year	**27,317,736**	24,013,457
Cash, end of year	**49,246,911**	27,317,736

The accompanying notes are an integral part of these financial statements

December 31, 2019

Nature and description of the organization

The College of Nurses of Ontario (the "College") was incorporated as a non-share capital corporation and continued as such under the Nursing Act, 1991. As the regulatory body of the nursing profession in Ontario, the major function of the College is to administer the Nursing 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**

(i) **Membership fees**

Membership fees are recognized as revenue in the fiscal year to which they relate. The membership year of the College coincides with that of the fiscal year of the College, being January 1 to December 31. Membership fees received in advance of the fiscal year to which they relate are recorded as deferred membership fees.

(ii) **Services**

Revenue from credential evaluations, endorsements, transcripts and examinations is recognized when the service is rendered. Examination fees received in advance of the date the examination is held are recorded as deferred examination fees.

(iii) **Investment income**

Investment income comprises interest from cash and investments.

Revenue is recognized on the accrual basis. Interest on investments is recognized over the terms of the investments using the effective interest method.

(b) **Investments**

Investments consist of fixed income investments whose term to maturity is greater than three months from date of acquisition. Investments that mature within twelve months from the year-end date are classified as current.

December 31, 2019

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 the commencement of the utilization of the assets, on a straight-line basis at rates designed to amortize the cost of the capital assets over their estimated useful lives. The annual amortization rates are as follows:

Building	2 1/2%
Building improvements	6 2/3%
Office furniture	10%
Office equipment	20%
Computer hardware	20%

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 recognized in 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.

(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 straight-line 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	20%

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

(d) **Intangible assets (continued)**

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, 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 recognized in 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) **Employee future benefits**

Defined benefit component of a pension plan

(i) A defined benefit liability is recognized in the statement of financial position to the extent that the defined benefit obligations exceed the fair value of plan assets.

Components of the total cost of a defined benefit component of a pension plan, excluding remeasurements and other items, are recognized in income in the year incurred.

Remeasurements and other items incurred during the year are recognized directly in the statement of changes in net assets.

(ii) Defined benefit obligations are measured using an actuarial valuation report prepared for funding purposes.

(iii) Defined benefit obligations are actuarially determined using the projected benefit method prorated on services and management's best estimates of retirement age, mortality, discount rates to reflect the time value of money, future salary and benefit levels and other actuarial assumptions.

(iv) Plan assets are measured at fair value.

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

(e) **Employee future benefits (continued)**

Defined benefit component of a pension plan (continued)

(v) Plan assets and defined benefit obligations are measured at December 31.

(vi) The components of the total cost of a defined benefit component of a pension plan for a year are comprised of:

- current service cost;
- finance cost; and
- remeasurements and other items.

Current service cost for the year is the actuarial present value of benefits attributed to employees' services rendered during the year, reduced to reflect employee contributions.

Finance cost for the year is the net interest on the defined benefit liability calculated by multiplying the defined benefit liability at the beginning of the year by the discount rate used in determining the defined benefit obligation at the beginning of the year. Finance cost for a defined benefit asset is a credit.

Remeasurements and other items are comprised of:

- the difference between the actual return on plan assets and the return calculated using the discount rate used in determining the defined benefit obligation at the beginning of the year;
- actuarial gains and losses;
- the effect of any valuation allowance in the case of a net defined benefit asset;
- past service costs; and
- gains and losses arising from settlements and curtailments.

(vii) Actuarial gains and losses can arise in a given year from:

- the difference between the actual defined benefit obligations at the end of the year and the expected defined benefit obligations at the end of the year; and
- changes in actuarial assumptions.

December 31, 2019

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

(e) **Employee future benefits (continued)**

Defined contribution component of a pension plan

(i) Components of the total cost of a defined contribution component of a pension plan are recognized in income in the year incurred.

(ii) The components of the total cost of a defined contribution component of a pension plan for a year are comprised of:

- current service cost;
- past service costs;
- interest cost on the estimated present value of any contributions required in future years related to employee services rendered during the current year or prior years; and
- a reduction for the interest income for the year on any unallocated plan surplus.

Current service cost for the year is comprised of the contributions required to be made in the year in exchange for employee services rendered during the year and the estimated present value of any contributions required to be made in future years related to employee services rendered during the year.

(f) **Related party transactions**

A party is considered to be related to the College if such party or the College has the ability to, directly or indirectly, control or exercise significant influence over the other's financial and operating decisions, or if the College and such party are subject to common control or common significant influence. Related parties may be individuals or other entities.

Transactions with related parties in the normal course of business are initially recorded at their exchange amount, which is the amount of consideration established and agreed to by the related parties.

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

(g) **Financial instruments**

(i) **Measurement of financial assets and liabilities**

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

The College subsequently measures all of 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, investments and amounts receivable.

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

(ii) **Impairment**

At the end of each year, 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.

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

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

(ii) **Impairment (continued)**

Any impairment of the financial asset is recognized in 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 the 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.

Significant estimates include those used when accounting for employee future benefits, amortization and accruals related to professional conduct and certain legal matters.

2. 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	X			X	
Investments	X			X	
Amounts receivable	X				
Accounts payable and accrued liabilities		X			

The College manages its exposure to the risks associated with financial instruments that have the potential to affect its operating and financial performance in accordance with its risk management policy. The objective of the policy is to reduce volatility in cash flow and earnings. The Council monitors compliance with risk management policies and reviews risk management policies and procedures on an annual basis.

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:

	2019 $	2018 $
Cash	49,246,911	27,317,736
Investments	33,372,520	39,121,421
Amounts receivable	22,664	170,969
	82,642,095	66,610,126

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

The College manages its exposure to credit risk of investments through an investment policy which restricts the types of eligible investments.

December 31, 2019

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

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 liquidity of the College is monitored by management to ensure sufficient cash is available to meet liabilities as they become due.

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.

Interest rate risk

Interest rate 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 market interest rates.

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.

3. **Investments**

	2019 $	2018 $
Current	21,192,321	25,052,067
Long-term	12,180,199	14,069,355
	33,372,520	39,121,422

	2019 $	2018 $
Effective interest rates	1.85% - 2.92%	1.80% - 2.92%
Maturity dates	Jan 2020 to Nov 2021	Jan 2019 to Jun 2021

4. **Capital assets**

	Cost $	Accumulated Amortization $	2019 Net $
Land	3,225,009	-	3,225,009
Building	6,835,907	5,590,750	1,245,157
Building improvements	3,923,184	3,191,247	731,937
Office furniture	2,344,693	2,153,202	191,491
Office equipment	1,127,271	1,111,642	15,629
Computer hardware	4,769,226	2,881,710	1,887,516
	22,225,290	14,928,551	7,296,739

	Cost $	Accumulated Amortization $	2018 Net $
Land	3,225,009	-	3,225,009
Building	6,744,448	5,420,995	1,323,453
Building improvements	3,923,184	3,051,324	871,860
Office furniture	2,342,620	2,096,000	246,620
Office equipment	1,133,674	1,090,386	43,288
Computer hardware	4,322,452	2,369,609	1,952,843
	21,691,387	14,028,314	7,663,073

During the year, amortization in the amount of $1,103,409 was provided for in respect of capital assets (2018 - $1,042,830).

During the year, capital assets with a net book value of $1,826 (cost of $204,998 and accumulated amortization of $203,172 (2018 - $13,528 (cost of $303,148 and accumulated amortization of $289,620)) were disposed of for no proceeds resulting in a loss of $1,826 being recognized (2018 - $13,528).

5. **Intangible assets**

	Cost $	Accumulated Amortization $	2019 Net $
Computer application software	4,095,159	3,752,968	342,191

	Cost $	Accumulated Amortization $	2018 Net $
Computer application software	4,055,984	3,641,338	414,646

During the year, amortization in the amount of $136,962 was provided for in respect of intangible assets (2018 - $123,197).

During the year, intangible assets with a net book value of nil (cost and accumulated amortization of $25,332) (2018 - nil (cost and accumulated amortization of $75,733)) were disposed of for no proceeds resulting in neither a gain nor loss being recognized.

6. **Defined benefit asset (liability)**

(a) **Description of plan**

The College maintains a registered pension plan for its employees, which comprises defined benefit and defined contribution components. The defined benefit component provides benefits based on years of service and a base pensionable earnings year which is automatically updated each January 1 to the year three years prior to the current year. The policy of the College is to fund the registered pension plan in the amount that is required by governing legislation and determined by the actuary of the pension plan.

The most recent actuarial valuation of the pension plan for funding purposes was as of June 30, 2019.

Total cash payments for pension benefits for 2019, consisting of cash contributed by the College to its funded registered pension plan, were $1,320,318, comprised of normal and special payments of $24,785 and $143,884, respectively, to the defined benefit component and $1,151,649 to the defined contribution component (2018 - $1,185,147, comprised of normal and special payments of $40,207 and $121,748, respectively, to the defined benefit component and $1,023,192 to the defined contribution component).

During the year the College amended the defined benefit component of the plan whereby it ceased benefit accruals for all members of the defined benefit component effective June 30, 2019. The defined benefit obligation was adjusted in the amount of $121,608, to reflect this plan amendment at December 31, 2018 to represent the period in which management made the decision to amend the plan. Effective July 1, 2019, the defined benefit component of the plan is being funded only by the College.

Effective December 31, 2019, the College is winding-up the registered pension plan. The settlement on wind-up will be recognized in the year the expenditure towards the settlement is made or an obligation for a fixed or determinable amount has been entered into in respect of settling the registered plan pension.

6. **Defined benefit asset (liability) (continued)**

(a) **Description of plan (continued)**

Effective January 1, 2020, members of the registered pension plan as of December 31, 2019 can either join a new defined contribution pension plan is sponsored by the College, that has equivalent terms and conditions as the defined contribution component of the current registered pension plan, or join the Healthcare of Ontario Pension Plan.

(b) **Defined benefit component of plan**

i) **Funded status of defined benefit component of plan**

	2019 $	2018 $
Plan assets at fair value	5,075,307	4,578,568
Defined benefit obligation	5,871,853	4,313,843
Defined benefit asset (liability)	(796,546)	264,725

ii) **Components of defined benefit costs**

	2019 $	2018 $
Current service cost	8,280	18,237
Finance cost	(17,039)	(30,783)
	(8,759)	(12,546)
Remeasurements and other items		
- difference between the actual return on plan assets and the return calculated using the discount rate used in determining the defined benefit obligation at the beginning of the period	(388,695)	584,300
- actuarial loss	1,627,394	-
- plan amendment	-	(121,608)
	1,238,699	462,692
Defined benefit costs	1,229,940	450,146

6. **Defined benefit asset (liability) (continued)**

(b) **Defined benefit component of plan (continued)**

iii) **Assets of defined benefit component of plan at fair value**

	2019 $	2018 $
Balance, beginning of year	4,578,568	5,032,476
Actual return on plan assets	614,675	(335,633)
Employer's contributions - regular	24,785	40,207
Employer's contributions - special	143,884	121,748
Employees' contributions	11,199	17,574
Benefits paid	(297,804)	(297,804)
Balance, end of year	5,075,307	4,578,568

	2019 %	2018 %
Plan assets consist of:		
Equity securities	-	62
Debt securities	-	32
Cash	-	6
	-	100

iv) **Defined benefit obligation**

	2019 $	2018 $
Balance, beginning of year	4,313,843	4,479,560
Current service cost	19,479	35,811
Interest cost	208,941	217,884
Actuarial loss	1,627,394	-
Benefits paid	(297,804)	(297,804)
Plan amendment	-	(121,608)
Balance, end of year	5,871,853	4,313,843

6. **Defined benefit asset (liability) (continued)**

(b) **Defined benefit component of plan (continued)**

v) **Actuarial assumptions**

The significant actuarial assumptions used in measuring the accrued pension obligation and the defined benefit costs are as follows:

	2019 %	2018 %
Defined benefit obligation as of December 31:		
Discount rate	5.00	5.00
Rate of compensation increase	3.75	3.75
Defined benefit costs for years ended December 31:		
Discount rate	2.30	5.00
Rate of compensation increase	3.75	3.75

(c) **Defined contribution component of plan**

	2019 $	2018 $
Defined contribution costs recognized, net of forfeitures	1,151,649	1,023,192

7. **Related party transactions**

The College has as a related party, Nurses' Health Program (Ontario) / Programme de santé pour infirmières (Ontario) ("NHP"), by virtue of the College having representation on the board of directors of NHP, participating in its policy-making processes and providing all funding to NHP, all of which enables the College to exercise significant influence over the financial and operating decisions of NHP.

The purpose of NHP is to provide for the establishment and operation of a voluntary program for nurses to support their recovery from substance use and/or mental health disorders so they may safely return to practice thereby protecting the public and promoting professional accountability, to raise nurses awareness of the program through collaboration with and among the nurses' regulatory college, professional associations, unions, employers and other organizations; and such other complementary purposes not inconsistent with the above-mentioned purposes.

NHP 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.

The College has no economic interest in NHP.

During the year, the College provided funding to NHP in the amount of $1,074,227 (2018 - $44,798) which is recorded in consultants expense in the statement of operations. As at December 31, 2019, the College has a balance payable of $422,286 (2018 - $44,978) due to NHP which is recorded in accounts payable and accrued liabilities in the statement of financial position.

8. **Accounts payable and accrued liabilities**

	2019 $	2018 $
Trade payables and accrued liabilities	6,069,354	3,499,643
Accrued liabilities - professional conduct	2,580,200	1,882,940
Government remittances	4,285,179	4,203,869
Contribution payable to Nurses' Health Program (Ontario)	422,286	44,978
	13,357,019	9,631,430

9. **Subsequent events**

Subsequent to the year end, the global pandemic of the virus known as COVID-19 led the Canadian Federal government, as well as provincial and local governments, to impose measures, such as restricting foreign travel, mandating self-isolations and physical distancing and closing non-essential businesses. Because of the high level of uncertainty related to the outcome of this pandemic, it is difficult to estimate the financial effect, if any, on the College. No adjustments have been made in the financial statements as a result of these events.

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College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Agenda Item 3.2

Discussion Note – June 2020 Council
RPN Scope of Practice: revised Controlled Acts Regulation for submission to Government

Contact for Questions

Kevin McCarthy, Director of Strategy

For Discussion

That Council approve proposed changes, as shown in Attachment 1 to the briefing note, to Part III, Controlled Acts of Ontario Regulation 275/94: General, as amended, made under the *Nursing Act, 1991* for submission to the Minister of Health.

Public Interest Rationale

The implementation of these regulations will allow patients, in community settings, to receive more timely care by eliminating the need for an RPN to obtain an order before providing these aspects of care.

Question for Council

In March 2020 Council approved draft regulation changes for notice and circulation (60-day consultation).[1] Does the feedback received change Council's perspective that the proposed regulation is in the public interest?

Background

In June 2019, CNO received a letter from Ontario's Minister of Health requesting that CNO make the necessary regulatory amendments to authorize RPNs to perform the following procedures without first obtaining an order:

- irrigating, probing, debriding and packing a wound

[1] Subsection 95(1.4) of the Health Professions Procedural Code under the *Regulated Health Professions Act, 1991* requires all regulations made by Council to be circulated for at least 60-days.

- venipuncture to establish peripheral intravenous access and maintain patency using a solution of normal saline (0.9 per cent), in circumstances in which the individual requires medical attention and delaying the venipuncture is likely to be harmful to the individual
- assisting with health management activities that require putting an instrument beyond the labia majora and, assessment that requires putting an instrument, hand or finger beyond the labia majora
- assessing an individual or assisting an individual with health management activities that requires putting an instrument or finger beyond an artificial opening into the patient's body

All nurses are accountable for their own practice, for being aware of the limits of their competence and from refraining from providing care when not competent. Currently, RPNs are providing these aspects of care when an order is provided. This means that this regulation, once implemented, will result in a change in RPN authority rather than a change in RPN practice.

Should this regulation move forward, the need for an order will remain unchanged in a hospital setting. The *Public Hospitals Act* requires that there be an order for any treatment by an RN or RPN. Thus, this change will only occur in community settings.

The timeline below outlines the key activities that have led to development of the draft regulation that you are considering today.

Summary of Literature Review:
Council reviewed the results of a comprehensive literature review in June 2018. While there were limitations to this review (e.g. most of the literature referenced is about nurses in general, difficult to find studies that fully reflect the RPN role in Ontario), the literature suggests there are relevant roles for RPNs related to the proposed activities. In addition, the literature referred to factors that support safe nursing practice. This information was instrumental in Council moving forward with developing regulation amendments that were based on evidence.

Stakeholder Consultations, 2019:

A key focus of the work conducted to date has been to determine if existing regulatory mechanisms are sufficient to ensure public protection or if additional requirements are necessary. In the Fall of 2019, CNO engaged in stakeholder consultations to explore this issue with those who would be most impacted by the changes. Stakeholders included community employers, clinical experts, CNO's Employer Reference Groups (Multi-Sector and Long-Term Care), educators, including CNO's Academic Reference Group, unions and associations (RPNAO, RNAO, NPAO, Ontario Personal Support Workers Association, Ontario Hospital Association, Retirement Home Regulatory Authority, and Home Care Ontario).

These stakeholder consultations confirmed that existing regulatory mechanisms do support safe care and will support the safe implementation of these changes. However, a need to raise awareness of these existing resources was identified. CNO's current standards, guidelines and resources articulate the requirements of all nurses to ensure competence before providing care and accountabilities for assessment and follow-up once care has been provided.

A comprehensive communications plan will be developed to draw nurses and other key stakeholders to our existing resources. A focus will be on raising awareness of the document 'RN and RPN Practice: The Client, The Nurse and The Environment' to assist employers and nurses in establishing role clarity within their practice settings. The information shared in this document identifies accountabilities for RNs and RPNs and outlines factors to be considered when assigning the appropriate care.

Circulation and summary of feedback

Attachment 1 shows relevant sections of the current Controlled Acts Regulation (Ontario Regulation 275/94, s. 15 & 15.1), with proposed additions highlighted in yellow. These revisions were circulated to nurses and key stakeholders on March 13, 2020 with a request for feedback by May 11, 2020.

CNO received 3,150 survey responses:

- 174 NP
- 1,399 RN
- 1,273 RPN
- 151 members of the public, and
- 153 other

When asked, “Do you support the regulation change?”

- 50.9% responded no (1,607)
- 43.2 %responded yes (1,364)
- 5.8% (184) were unsure

84.1% of RPNs who responded supported the regulation change.

79.5% of RNs who responded did not support the change.

When asked, “Is the proposed regulation change in the public interest?”

- 46% of respondents said no (1,470)
- 43.2 % of respondents said yes (1,363)
- 10.2% of respondents were unsure (322)

77.3% of RPNs who responded indicated that the proposed regulation change is in the public interest.

72.4% of RNs who responded stated that it is not in the public interest.

151 members of the public responded to the survey. Of those, 86% of the members of the public who responded did not support the change. However, when these changes were shared with Council’s Public Advisory Group in the fall of 2019 there was broad support. The members of the group are well versed in the regulatory role and CNO council consults with them frequently. The advisory group’s November 2019 Report includes feedback on the RPN scope changes.

Thematic Analysis

A thematic analysis of the survey feedback was conducted by two CNO staff who independently reviewed feedback to identify common themes and conferred to ensure consistency of themes identified. Themes are summarized in attachment 3 and fall into the following categories:

Themes in support of the regulation:

- More timely access to patient care and continuity of patient care
- RPNs’ ability - with the right supports, they can attain the necessary competence to initiate these procedures
- RPNs are already competently providing this care under the authority of an order

Themes in opposition to the regulation:

- RPNs lack knowledge, skill and judgment to perform these procedures

- Risk to patient safety related to certain procedures (e.g. wound care, specifically debriding, and venipuncture)
- Cost-savings is the motivator for this change

To date, we have received two letters from key stakeholders – the Ontario Nurses Association (Attachment 4) and the Registered Nurses' Association of Ontario (Attachment 5). However several key stakeholders provided feedback through the survey, including RPNAO (weRPN) (Attachment 6)

Next Steps:

- Should Council approve the proposed regulation, it will be submitted to the Minister of Health by the end of June 2020.
- After submission to the Minister, the regulation undergoes the Ministry's internal review. The Minister has the power to alter Council's proposed regulation before it is approved by the government. The regulation will not take effect until it is approved by the Ontario government.
- CNO will move forward with a communications plan that will focus on raising awareness among all nurses and stakeholders about regulatory mechanisms that support safe nursing practice (e.g. RN and RPN Practice: The Client, The Nurse and The Environment, Authorizing Mechanisms, Decisions About Procedures and Authority).

Attachments:

1. Draft Proposed Controlled Acts amendments
2. Practice Background
3. Summary of key themes in response to circulation of the proposed regulation
4. Letter from Ontario Nurses Association
5. Letter from Registered Nurses' Association of Ontario
6. Feedback from the Registered Practical Nurses' Association of Ontario (weRPN)

Attachment 1

Below is the proposed regulation change that will enable RPNs to initiate these activities in the absence of an order. Changes are highlighted in yellow:

Nursing Act, 1991

ONTARIO REGULATION 275/94

GENERAL

Consolidation Period: From January 1, 2020 to the e-Laws currency date.

Last amendment: 473/19.

This is the English version of a bilingual regulation.

15.1 (1) For the purposes of clause 5 (1) (a) of the Act, a registered practical nurse in the general class may perform a procedure set out in subsection (2) if he or she meets all of the conditions set out in subsection (3). O. Reg. 387/11, s. 1.

(2) The following are the procedures referred to in subsection (1):

1. With respect to the care of a wound below the dermis or below a mucous membrane, any of the following procedures:
   i. cleansing,
   ii. soaking,
   iii. irrigating,
   iv. probing,
   v. debriding,
   vi. packing,
   vii. dressing.

2. Venipuncture to establish peripheral intravenous access and maintain patency, using a solution of normal saline (0.9 per cent), in circumstances in which,
   i. the individual requires medical attention, and
   ii. delaying venipuncture is likely to be harmful to the individual.

3. A procedure that, for the purpose of assisting an individual with health management activities, requires putting an instrument,
   i. beyond the point in the individual's nasal passages where they normally narrow,

ii. beyond the individual's larynx, or
iii. beyond the opening of the individual's urethra.

4. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument or finger,

i. beyond the individual's anal verge, or
ii. into an artificial opening into the individual's body.

5. A procedure that, for the purpose of assessing an individual or assisting an individual with health management activities, requires putting an instrument, hand or finger beyond the individual's labia majora.

6. Treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgment, insight, behaviour, communication or social functioning. O. Reg. 387/11, s. 1; O. Reg. 473/19, s. 2.

Attachment 2

What is a controlled act?

- A controlled act is a procedure that poses a significant risk to the public if performed by an unqualified person. All of the controlled acts are set out in Section 36 of the Regulated Health Professions Act. The controlled acts that nurses can perform are set out in the Nursing Act.

What is an order?

- An order is a prescription made by a regulated health professional for a procedure, treatment, drug or intervention for a particular client. A RN or RPN requires an order when: a procedure falls under a controlled act authorized to nursing or when required by other legislation such as the Public Hospitals Act. Or, orders may be required by organizational policy.

What is initiation?

- Initiation allows RNs and RPNs to independently decide to perform certain controlled acts in the absence of an order when conditions are met. In order for nurses to be able to initiate controlled acts, they need to be specific in regulations.

What do these changes mean?

The changes will enable RPNs to initiate components of certain controlled acts which they currently are able to perform with an order, as follows.

Authorizing RPNs to initiate irrigation, probing, debriding and packing a wound

- What is this?
  - Irrigation, probing, debriding and packing are activities associated with complex wound care
- What is the current situation?
  - RPNs are authorized to initiate cleansing, soaking and dressing a wound – they need an order for irrigation, probing, debriding and packing a wound
- What is the Minister proposing?
  - That CNO amend regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate irrigation, probing, debriding and packing a wound

Authorizing RPNs to initiate venipuncture to establish peripheral intravenous access and maintain patency using a solution of normal saline (0.9 per cent), in circumstances in which the individual requires medical attention and delaying the venipuncture is likely to be harmful to the individual.

- What is this?
    - Venipuncture establishes access to a vein (for example, for fast fluid replacement)
- What is the current situation?
    - Currently, RPNs can perform venipuncture with an order
- What is the Minister proposing?
    - That CNO amend regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate venipuncture to establish peripheral intravenous access and maintain patency, in certain circumstances

Authorizing RPNs to initiate assistance with health management activities that require putting an instrument beyond the labia majora and, initiate activities that for the purpose of assessing an individual, require putting an instrument, hand or finger beyond the labia majora.

- What is this?
    - This relates to RPNs initiating a procedure that, for the purpose of assisting or assessing an individual, requires putting an instrument, hand or finger beyond the individual's labia majora
- What is the current situation?
    - For the purpose of assisting an individual with health management activities, RPNs can initiate putting a hand or finger beyond the labia majora, but they must have an order to put an instrument beyond the labia majora.
    - For an RPN to perform any of the above activities for *assessment* purposes they currently require an order.
- What is the Minister proposing?
    - That CNO amend the regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate putting an instrument beyond a client's labia majora for assistance or putting an instrument, hand or finger beyond a client's labia majora for assessment purposes

Authorizing RPNs to initiate assessing an individual or assisting an individual with health management activities that requires putting an instrument or finger beyond an artificial opening into the client's body

- What is this?
    - Examples of procedures that involve putting an instrument or finger beyond an artificial opening into the client's body are cleaning a colonoscopy stoma or suctioning an established tracheostomy site
- What is the current situation?
    - Currently, RPNs can initiate activities related to openings in the client's body (for example, beyond the anal verge) – but not an artificial opening. They can perform procedures that require putting and instrument or finger beyond an artificial opening into the client's body when an order is provided.
- What is the Minister proposing?
    - That CNO amend the regulation 275/94 under the *Nursing Act, 1991* to allow RPNs to initiate putting an instrument or finger beyond an artificial opening into the client's body

How will the public be protected?

RPNs already have the authority to initiate components of some controlled acts, as described above. Regulatory mechanisms are in place to support protection of the public. Before initiating any controlled act, regulations under the *Nursing Act, 1991* require all RPNs and RNs to:

- have the knowledge, skill and judgment to perform the procedure safely, effectively and ethically
- have the knowledge, skill and judgment to determine whether the individual's condition warrants performance of the procedure
- determine that the individual's condition warrants performance of the procedure, having considered:
    - the known risks and benefits to the individual of performing the procedure
    - the predictability of the outcome of performing the procedure
    - the safeguards and resources available in the circumstances to safely manage the outcome of performing the procedure
    - other relevant factors specific to the situation
- accept accountability for determining that the individual's condition warrants performance of the procedure

Attachment 3 – Summary of key themes

The following summarizes key themes from qualitative feedback submitted via the survey as well as written responses from organizations.

Themes in support of the regulation:

- **More timely access to patient care and continuity of patient care**

Stakeholders noted that the proposed changes would reduce wait times and improve access to care. The changes would also contribute to continuity of care, allow for more timely access to procedures and better patient care in community settings. For example, it was noted that delays in obtaining an order to initiate treatment negatively impacts patient care:

> *"I work in the community and have the knowledge, skills and judgement to complete these tasks and determine when certain procedures should be initiated. However, awaiting an order delays the treatment, sometimes for days!! This is often detrimental to the patient- ask anyone who's ever tried to get an order on a Saturday afternoon."*

- **RPNs' ability - with the right supports, they can attain necessary competence**

The feedback suggested that RPN education provides the foundational knowledge, skill and judgement for RPNs upon which competence to initiate these procedures can be built. Stakeholders emphasized that as long as RPNs have the necessary competence and with the right supports such as education and mentorship, an order is not needed to perform these procedures safely.

> *"With increased education and training I, as an NP, have no concerns in enabling RPN's to perform these controlled acts in the establishment of practicing to one's full scope."*

> *"It's my belief RPN's can develop the competence for those particular tasks listed in this article. RPN's know their limits and will consult when necessary. RPN's have the ability to manage outcomes to those tasks as well. Therefore I believe it's reasonable to have the RPN scope expand to add the medical procedures listed."*

- **RPNs are already competently providing this care under the authority of an order**

Stakeholders stated that RPNs are currently performing these procedures competently in practice. As noted below, depending on the practice setting, many of these procedures are already being performed safely under the authority of an order or medical directive:

"In many instances where "standing orders" are already in place RPNs perform these tasks without consulting a physician or advanced practitioner."

Themes in opposition to the regulation:

- **RPNs lack knowledge, skill and judgment to perform these procedures**

The majority of stakeholders who did not support the proposed regulation were concerned with the proposed changes due to RPNs' lack of foundational education as well as not having the necessary knowledge, skill and judgement, particularly critical thinking skills which can jeopradize patient safety. Furthermore, it was noted that due to complexity of these procedures, they should remain within the RN scope of practice.

"The RPN does not have the ability to act on his/her judgment alone related to lack of education skill and abilities."

"RPNs may be taught how to complete the task but do they have the required judgement skill and knowledge to troubleshoot and determine when such tasks are appropriate."

- **Risk to patient safety related to certain procedures (e.g. wound care, specifically debriding, and venipuncture)**

Stakeholders expressed concern with certain procedures that could cause risk to patient safety. Concern was raised in particular related to debridement of a wound and venipuncture. It was emphasized that additional advance training and, possibly, certification is required in these areas. They stated that RPNs do not have the advance knowledge to properly make an informed decision on how to treat and debride a wound. Many suggested that debridement should be left to RNs and other practitioners who are specialized and certified in wound care.

"Debridement is a skill that requires education, mentorship, validation of skill and ongoing practice to achieve and maintain competency; probing a wound can cause serious, irreparable harm to patients without understanding the anatomy and structures adjacent to wound openings - puncturing a lung or bowel is serious."

- **Cost-savings is the motivator for this change**

Stakeholders stated that these changes were motivated by cost-savings to the healthcare system and not in the interest of the public. They commented that it is a way to add more responsibility to RPNs for less pay and ultimately to replace RNs with RPNs for cost-savings reasons:

"Patient safety should come before cost savings. These proposed changes feel like they are a way to get RN work from RPNs at a savings to the employer but a huge risk to the population."

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May 7, 2020

VIA EMAIL

Ms. Anne Coghlan
Executive Director and Chief Executive Officer
College of Nurses of Ontario Council
101 Davenport Road
Toronto, ON M5R 3P1

Mr. Kevin McCarthy
Director, Strategy
College of Nurses of Ontario Council
101 Davenport Road
Toronto, ON M5R 3P1

Ms. Cheryl Evans
Council President
College of Nurses of Ontario Council
101 Davenport Road
Toronto, ON M5R 3P1

Dear Ms. Coghlan, Mr. McCarthy & Ms. Evans,

Re: Proposed Regulation Changes Expanding the Scope of Practice for Registered Practical Nurses (RPNs)

I am writing to express ONA's position regarding the College of Nurses of Ontario's (CNO) proposed Regulation expanding the scope of practice for Registered Practical Nurses (RPNs). ONA is concerned that the draft Regulation is not evidence-based and that approving the Regulation without comprehensive consultation may lead to reduced patient outcomes.

ONA strongly believes that both RNs and RPNs have a legitimate place in our health care system. Both contribute a great deal to the needs of their patients. However, RPNs practice appropriately with patients with less complex health needs and stable and predictable outcomes. A proposal that may force RPNs to care for unstable patients with unpredictable outcomes poses a risk to patient safety. As CNO itself points out in its three factor framework guideline, while RNs and RPNs study from the same body of nursing knowledge, RNs study for a longer period of time, which equips them with greater foundational knowledge in clinical practice, decision-making, critical thinking and leadership. As a result, the level of autonomous practice of RNs is greater than that of RPNs.

The proposed Regulation will primarily affect the care of patients in long-term care and community settings. We know that patients in these settings are more complex and have greater acuity levels than in the past. In addition, these practice settings are relatively unsupported, often short staffed and face challenges ensuring continuity of care. Therefore, it is essential that the scope of practice for RNs and RPNs is accurate and appropriate for these patients.

Allowing an RPN to make decisions about a newly authorized procedure, without the critical thinking skills and guidance of an RN, could result in negative outcomes for patients. RPNs rely on the enhanced critical thinking and leadership of RNs. An RN assesses a patient's complexity and the individual RPN's level of knowledge, skill and judgment, to determine whether it is appropriate to delegate an intervention to the RPN. Allowing RPNs to initiate controlled acts independently assumes not only that they have the practical skills and knowledge to ensure competency but that they possess the analytical and critical thinking skills to determine when an intervention is necessary and within their scope.

We are specifically opposed to RPNs independently initiating venipuncture in order to establish a peripheral intravenous line. If a patient's condition has deteriorated to the point they are in need of this procedure, that patient is, by definition, unstable. According the three factor framework, a client who is unstable is more likely to fall within the scope of an RN. Similarly, extending an RPN's scope to include packing and debridement of wounds also raises concerns for patient safety. RPNs do not have the critical thinking skills and training to provide this type of intensive wound care. These are only two examples of the proposed expanded scope for RPNs that raise issues of patient safety.

Any proposal to expand RPN scope of practice into traditional RN scope must be informed by the best available evidence, including peer-reviewed research and advice from clinicians and experts. ONA has reviewed the Briefing Notes presented to CNO Council in June 2018, September 2019 and December 2019. This material makes it clear that the expanded RPN scope is not supported by strong research. In fact, the opposite is true. The summary of the literature review states, **"It is important to note that there is <u>not</u> a significant amount of literature related to RPNs."** (June 2018 Council Briefing Notes, p. 152). A decision as important and as risky as expanding RPN scope cannot be based on incomplete research.

A review of the role of RPNs (or "Licensed Practical Nurses") in other provinces shows that no other province except British Columbia allows RPNs to perform any of the proposed procedures without an order.

It is essential not only that any proposed RPN scope be evidence-based but that it be undertaken based on a comprehensive consultation process. However, the Council Briefing Notes demonstrate that ONA and the Registered Nurses Association of Ontario expressed strong opposition to the proposal because of concerns regarding patient safety. These concerns were not closely examined or discussed in any detail. In addition, clinical experts expressed specific worries with allowing wound debridement and more general concerns regarding role confusion. Again, these concerns were not thoroughly explored or resolved.

It is clear to ONA that CNO's proposal to expand RPN scope is not evidence-based and does not include a careful and measured consultation with nursing experts and stakeholders, including ONA. This consultation must not be rushed or completed during a time when nursing stakeholders are preoccupied with an unprecedented pandemic. Patient safety requires no less.

Sincerely,

ONTARIO NURSES' ASSOCIATION

Vicki McKenna, RN
President

C: ONA Board of Directors

Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario

May 25, 2020

Cheryl Evans, Council President
Anne Coghlan, Executive Director and Chief Executive Officer
College of Nurses of Ontario
101 Davenport Road
Toronto, ON M5R 3P1

Dear Cheryl and Anne,

Re: Expanding RPN scope of practice and RN prescribing

The Registered Nurses' Association of Ontario (RNAO) welcomes the opportunity to provide feedback to the College of Nurses of Ontario (CNO) on its proposed new regulation to expand the Registered Practical Nurse (RPN) scope of practice to include independent initiation of the following controlled acts:

- Irrigate, probe, debride and pack a wound below the dermis or below a mucous membrane;
- Venipuncture to establish peripheral intravenous access and maintain patency using a normal saline solution when the client requires medical attention and delaying venipuncture is likely harmful to the client;
- Put an instrument, hand or finger beyond the labia majora when assessing or assisting with health management activities; and
- Put an instrument or finger beyond an artificial opening into the client's body for the purpose of assessing or assisting with health management activities.[1] [2]

As we have already expressed to the CNO, RNAO does not support the proposed regulation summarized above and believes the proposed changes to the RPN scope will result in damaging shortfalls related to:

1. Protection of patient safety
2. Requisite knowledge, skills and judgment required for procedures not in the RPN skill set
3. Decision-making influenced by client factors under CNO's three-factor framework (complexity, predictability and risk of negative outcomes).[3]

RNAO's concern regarding substantial scope of practice expansion for RPNs to initiate these controlled acts was echoed in 2018 by Helena Jaczek, then minister of health, when she requested a hold on CNO's advancement on this matter until comprehensive, evidence-based, and expert-advised consultation was complete.[4] [5] Once again, two years later, these same four controlled acts are being proposed by CNO for RPN initiation in this regulation change, after so recently being disallowed by government.[6]

It is important to note that the current scope of RPN practice, based on a previous regulation change, allows for RPNs to perform the above intrusive procedures with an order from an appropriate provider.[7] Moreover, the RPN scope has consistently been expanded in particular, over the past three to four years, to include performance of controlled acts, and now initiation of these acts, whereas there has been complete stagnation in scope expansion for RNs evident in the *Nursing Act, 1991* and regulation,[8] [9] since the move to the BScN entry requirement for RNs in 2005, when RN education moved from three to four years.[10] [11] [12]

Of critical concern is that expanding the RPN scope to authorize independent initiation of these controlled acts effectively renders the Registered Nurse (RN) and RPN scope identical. That the CNO takes this move is objectionable considering that RPNs have a two year college degree and RNs a four year baccalaureate. As we have discussed in repeated occasions with CNO staff, RNAO insists that these changes jeopardize the safety of Ontarians, will add to already existing role confusion and tensions, and grossly undermine the enhanced knowledge and critical thinking of RNs.

According to the CNO three-factor framework referenced in *RN and RPN Practice: The client, the nurse, and the environment*, complex patients with less predictability and less stable environments are cared for by RNs.[13] CNO further explains:[14]

> RNs and RPNs study from the same body of nursing knowledge. RNs study for a longer period of time, allowing for greater foundational knowledge in clinical practice, decision-making, critical thinking, leadership, research utilization and resource management. As a result of these differences, the level of autonomous practice of RNs differs from that of RPNs.
>
> The complexity of a client's condition influences the nursing knowledge required to provide the level of care the client needs. A more complex client situation and less stable environment create an increased need for consultation and/or the need for an RN to provide the full range of care requirements.

Based on this framework, RPNs should not care for highly complex, unstable clients who are at risk for deterioration – therefore, initiation of the proposed procedures such as venipuncture and wound debridement should never be required of an RPN. Furthermore, RPN initiation of these controlled acts also implies urgency when an RN is not available which would rarely if ever be the case.

As RNAO strongly expressed in the May 8, 2020 meeting requested by CNO to discuss our concerns, it is RNAO's perception that CNO is skewing their regulatory decision making in favour of expanding RPN scope, without clear evidence of population health needs nor the requisite RPN knowledge, judgment and skills. Indeed, CNO is doing so contradicting its own framework mentioned above. Simultaneously, RNAO is keenly aware that CNO has actively attempted to contract RN scope of practice in spite of solid evidence of population need and high

capacity of RNs, (i.e., initiation of RN psychotherapy), and also has proceeded extremely slowly with RN scope expansion (i.e., RN prescribing).[15] [16]

As evidence for this perception, in 2014 the CNO acted to remove initiation of psychotherapy from the RN scope of practice despite the facts that: RNs had been consistently and ably carrying out this practice for approximately ten years, there is high population need, and it is clearly within the knowledge, skill and judgment of the RN. Furthermore, while, five regulatory bodies immediately enabled their professionals to initiate psychotherapy (occupational therapists, physicians, psychologists, registered psychotherapists, and social workers), CNO was the only regulatory body attempting to take away from RNs a long standing practice[17] This act of initiation for RNs was only fully reinstated without barriers in 2019 following a two year exemption period and considerable evidence-based advocacy on the part of RNAO that triggered a letter to CNO by Eric Hoskins, then minister of health.[18] [19] [20]

Further adding to this view, in the case of RN prescribing, the CNO has deliberated this scope change for the last eight years.[21] Once again in 2020, RNAO is providing feedback for how to proceed with this expanded scope in a timely way. At this time, we note that CNO is still not prepared to embrace the expansion of RN practice through continuing education for practicing RNs, as well as through the basic undergraduate nursing curriculum to be fully incorporated as part of the RN scope of practice for all graduating RNs.[22] CNO's stubbornness in regards to RN prescribing despite the robust evidence from other countries – such as United Kingdom and New Zealand – is difficult to comprehend. This position contradicts the evidence gathered by CNO itself and it is not good for patients, health organizations and the public.

This grave imbalance in CNO's approach to proposed regulatory changes related to RN and RPN scope is disheartening and shocking. RNAO would like to address this matter as a major concern directly with the CNO Council, and is asking for an urgent meeting to that effect. CNO's actions – favouring scope expansion for RPNs while presenting barriers to enhancing the RN role or even taking steps to narrow it – creates an unclear distinction between the two roles. Any blurring of the roles makes it difficult for employers and the public to understand and adequately utilize these two categories of nurses, and leads to tensions between RNs and RPNs. On the contrary, it is RNAO's view that both RN and RPN categories should be respected and fully utilized within their scopes of practice and both types of nursing education should be valued.

Such role confusion already leads to inappropriate utilization of regulated professionals, imbalanced workload and missed opportunities for expanded service delivery.[23] Furthermore, the role blurring may also discourage each category from practicing to their full extent and hinder the retention of RNs in practice settings that employ RPNs.[24]

RN and RPN category role confusion and blurring also raises the troubling question in the minds of students, the public and policymakers as to why a four-year university degree is required in the first place, when a two-year college graduate can perform almost at the same level of acuity,

complexity and initiation. Since there are substantial personal and societal costs to have a four year baccalaureate program, as compared to a two year program, this undervaluing of the baccalaureate degree is deeply worrisome. Indeed, the quality and level of RN undergraduate education must in no way be diminished and in fact must be enhanced to ensure sustained expanded RN scope, for example, by including RN prescribing in undergraduate nursing education. Having RNs graduate with this competency will enhance access to health services for Ontarians.

It should be noted that these moves by the CNO constitute a process of de-skilling of nursing care, as the requirement to perform complex procedures is approved for professionals with half the years of education that were previously required. There is a broad literature providing evidence of the harm to patients and society resulting from deskilling of nurses' work.[25] [26] [27]

Finally, the trends we have reviewed in this letter beg the question of what is CNO's understanding of its role regulating three different categories of nurses and how it intends to perform that role in the go forward. It should be clear from this letter that the professional association representing RNs and NPs in Ontario has serious concerns about how the College is performing its regulatory role.

In conclusion, RNAO is strongly opposed to the proposed RPN scope regulation change and maintains it is not in the public's best interest. We therefore recommend that CNO *does not* move forward to the Ministry of Health in June 2020 with the proposed new changes to RPN scope of practice.

We reiterate our request to meet with the CNO Council on our growing concerns about the imbalance in CNO's approach to proposed regulatory changes related to RN and RPN scope. Please let us know if you are open to such a meeting.

We thank you for the opportunity to provide feedback and trust you will continue to seek consultation with RNAO in regards to this matter.

Warm regards,

Doris Grinspun, RN, MSN, PhD, LLD(hon), Dr(hc), FAAN, O.ONT.
Chief Executive Officer, RNAO

Angela Cooper Brathwaite, RN, MN, PhD

President, RNAO

CC: CNO Council
Hon. Doug Ford, Premier of Ontario
Hon. Christine Elliott, Minister of Health
Helen Angus, Deputy Minister of Health
Sean Court, ADM, Strategic Policy and Planning Division, MOH
Allison Henry, Director, Health Workforce Regulatory Oversight Branch, MOH
Michelle Acorn, Provincial Chief Nursing Officer, MOH

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Attachment 6 – RPNAO (WeRPN) - Survey Feedback.

1. Wound Care: Currently many RPNs have the knowledge, skill and judgement to perform wound care procedures with an order. Some are wound care experts. However, when clients require wound care beyond cleansing, soaking, and dressing, the RPN, in community settings, is required to contact an RN for an order to initiate these procedures. In many cases the RN provides the order without personally assessing the wound, whereby the RPN is in effect initiating the additional procedures based on his or her own knowledge, skill, and judgement. In this situation, the RN "initiation" is substantively administrative in nature, rather than clinically based. In other cases, the RPN may not be able to contact the RN for an order because the RN is not able to personally assess the wound or is unavailable, potentially denying the client the care that he or she needs, or resulting in a deterioration of the client's wound that can lead to additional treatment that might include hospital admission. In practice, when RPNs are unable to access another health professional (MD, NP, RN) to obtain an order in a timely fashion, it can impact patient outcomes and the proposed changes will help address this issue.

2. Venipuncture: Initially when this regulation was enacted RPNs did not initiate venipuncture. Currently Ontario's RPNs routinely initiate venipuncture with an order and have the knowledge, skill, and judgement to initiate venipuncture when a client's condition rapidly deteriorates and the patient requires immediate access to IV fluids. The proposed amendment would ensure equitable and timely access to this essential emergency care in particular in rural and remote areas where RPNs may be the only available nurse and the client may not have timely access to a physician or NP to obtain an order

3. Assessing (Labia Majora): For the purpose of assisting an individual with health management activities, the current regulation permits an RPN to initiate a procedure that requires putting a hand or finger beyond the individual's labia majora. The regulation does not permit an RPN to initiate a procedure that, for the purpose of assessing an individual, requires putting a hand or finger beyond the individual's labia majora. The act of assessing precedes the actions of implementation in the nursing process. To permit implementation without permitting assessment is counterintuitive in many circumstances.

4. Assessing (Artificial Opening): For the purpose of assisting an individual with health management activities, the current regulation permits an RPN to initiate a procedure that requires putting a hand or finger beyond the individual's labia majora or anal verge. The regulation does not allow an RPN to initiate a procedure that requires putting an instrument or a finger beyond an artificial opening into a client's body. This restriction prohibits RPNs from initiating a number of procedures for the purpose of assisting an individual with health

management activities, such as cleaning the ostomy stoma of a home care client. The current regulation unduly restricts the RPN's scope of practice, delays or denies timely and effective patient care, and increases the number of home care clients who are unnecessarily readmitted to hospital.

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO
THE STANDARD OF CARE.

Agenda Item 3.3

Discussion Note – June 2020 Council

By-Law to combine the membership of the Discipline and Fitness to Practise Committees

Contact for Questions or More Information

Stephen Mills, Chief Administrative Officer

For Discussion

That the amendments to By-Law No. 1: General, as they appear in column 2 of attachment 1 to the briefing note, be approved, to come into effect on June 4, 2020.

Background

In March 2020, Council approved in principle that the membership of the Discipline and Fitness to Practise committees be merged

The Discipline and Fitness to Practise committees play vital roles in protecting the public. The decision to merge the membership was based on:

- the changing workloads of the two committees; and
- the similarity of the adjudicative processes and the needed skills.

A detailed briefing note and the annual reports of the Discipline and Fitness to Practise committees supported decision making.

Staff were asked to prepare by-law amendments to implement the change that Council adopted.

Attachment 1 is a table showing the by-law amendments proposed to implement Council's decision, including the rationale for the proposed amendments. The amendments were drafted by legal counsel. Attachment 2 shows the changes integrated into the current Articles in the By-Law.

Attachments:

1. Table of by-law amendments
2. Revised articles

Proposed by-law revisions to combine membership of adjudicative committees

Column 1 Current by-law	Column 2 Proposed revision	Column 3 Rationale
19 Discipline Committee **19.01** The Discipline Committee shall be composed of i) not fewer than five or more than six elected councillors each of whom was elected as an RN; ii) not fewer than two or more than three elected councillors each of whom was elected as an RPN; iii) not fewer than seven or more than eleven public councillors; iv) not fewer than six or more than nine RNs who are appointed committee members; and v) not fewer than three or more than six RPNs who are appointed committee members.	**19 Discipline Committee** **19.01** The Discipline Committee shall be composed of i) not fewer than ~~five or more than~~ six elected councillors each of whom was elected as an RN; ii) not fewer than~~ two or more than~~ three elected councillors each of whom was elected as an RPN; iii) not fewer than seven ~~or more than eleven~~ public councillors; iv) not fewer than ~~six or more than~~ nine RNs who are appointed committee members; and v) not fewer than ***four*** ~~three or more than six~~ RPNs who are appointed committee members.	Proposed membership numbers for both committees are identical. For nurse members, numbers were based on minimum number for both committees, added together. Since public members are currently cross appointed to Discipline and Fitness to Practise, the minimum number for Discipline was used. To give flexibility to address changing workloads, especially with non-Council nurse appointees, the maximums were deleted from committee memberships.

Proposed by-law revisions to combine membership of adjudicative committees

Column 1 Current by-law	Column 2 Proposed revision	Column 3 Rationale
20. Fitness to Practise Committee **20.01** The Fitness to Practise Committee shall be composed of i) not fewer than one or more than three elected councillors each of whom was elected as an RN; ii) not fewer than one or more than two elected councillors each of whom was elected as an RPN ; iii) not fewer than three or more than seven public councillors; iv) not fewer than three or more than six RNs who are appointed committee members; and v) not fewer than one or more than three RPNs who are appointed committee members.	**20. Fitness to Practise Committee** 20. 01 The Fitness to Practise Committee shall be composed of i) not fewer than ***six*** ~~one or more than three~~ elected councillors each of whom was elected as an RN; ii) not fewer than ***three*** ~~one or more than two~~ elected councillors each of whom was elected as an RPN ; iii) not fewer than ~~three or more than~~ seven public councillors; iv) not fewer than ***nine*** ~~three or more than six~~ RNs who are appointed committee members; and v) not fewer than ***four*** ~~one or more than three~~ RPNs who are appointed committee members.	As above
New Article	***29.05.1 Each member appointed to the Discipline Committee shall automatically also be appointed to the Fitness to Practise Committee and each member appointed to the Fitness to Practise Committee shall automatically also be appointed to the Discipline Committee.***	To ensure that the committee appointments made in March that will come into effect on June 4 reflect Council's intent – that all members serve jointly on Discipline and Fitness to Practise. Note: In future, the slates will include everyone and this may not be needed. Legal counsel did note that it does provide assurances that, if someone is left off one of

Proposed by-law revisions to combine membership of adjudicative committees

Column 1 Current by-law	Column 2 Proposed revision	Column 3 Rationale
		the slates by mistake, they will still be cross appointed.
New Article	***29.1.04.1 A member of the Discipline or Fitness to Practise Committees who ceases to be a member of one of those committees shall immediately cease to be a member of both of those committees.***	Article 29 re. Removal of Committee members The intent of the by-law changes is for all members to serve on both committees. If someone is removed or ceases to be on one of the committees, this article requires that she or he be removed from both committees. This will allow the vacancy to be filled for both committees and to maintain the pool of members.
New Article	***30.06.1 If the same person chairs both the Discipline and Fitness to Practise committees, and the person ceases to be the chair of either one of those committees under article 30.06, that person shall immediately cease to be the chair of both of those committees.***	New article identifying that if the Chair is removed as Chair of one committee, and the chair is the same for both committees, they are also removed from the other.

Attachment 2
Proposed By-Law Amendments to merge the membership of the Discipline and Fitness to Practise committees.

19. Discipline Committee

19.01 The Discipline Committee shall be composed of

i) not fewer than ~~five or more than~~ six elected councillors each of whom was elected as an RN;

ii) not fewer than ~~two or more than~~ three elected councillors each of whom was elected as an RPN;

iii) not fewer than seven ~~or more than eleven~~ public councillors;

iv) not fewer than ~~six or more than~~ nine RNs who are appointed committee members; and

v) not fewer than ***four*** ~~three or more than six~~ RPNs who are appointed committee members.

20. Fitness to Practise Committee

20.01 The Fitness to Practise Committee shall be composed of

i) not fewer than ***six*** ~~one or more than three~~ elected councillors each of whom was elected as an RN;

ii) not fewer than ***three*** ~~one or more than two~~ elected councillors each of whom was elected as an RPN ;

iii) not fewer than ~~three or more than~~ seven public councillors;

iv) not fewer than ***nine*** ~~three or more than six~~ RNs who are appointed committee members; and

v) not fewer than ***four*** ~~one or more than three~~ RPNs who are appointed committee members.

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29. Appointments to Committees

29.01 Deleted June 2013

29.02 Having regard for the composition requirements of each committee and following any protocol approved by Council, the Election and Appointments Committee shall

i) at the March Council meeting present a slate of candidates for each statutory committee; and

ii) at the June Council meeting, present a slate of candidates for the members of the Conduct Committee and the Finance Committee.

(Amended December 2019)

29.03 The Election and Appointments Committee will present the slates to Council for its consideration and, subject to any amendment by Council, ratification.

(Amended December 2019)

29.04 Once ratified each member on the slate shall be deemed to have been appointed to that committee by Council and the term of office of each appointed committee member shall begin on the effective date of the member's appointment as specified by Council.

(Amended June 2013)

29.05 Unless specifically provided otherwise, any eligible person may be re-appointed to a committee.

29.05.1 ***Each member appointed to the Discipline Committee shall automatically also be appointed to the Fitness to Practise Committee and each member appointed to the Fitness to Practise Committee shall automatically also be appointed to the Discipline Committee.***

29.06 Where for any reason the Council fails to appoint a new committee at the time or times provided for in this by-law, the existing members of the committee shall continue to serve as the committee provided that a quorum exists.

29.1 Removal of Committee Members

(Article 29.1 added September 2008)

29.1.01 A member of a committee who is a councillor may be removed from the committee, with or without cause, by a two-thirds majority vote of the councillors present at a Council meeting duly called for that purpose.

(Amended March 2013)

29.1.02 A member of a committee who is an appointed committee member may be removed from the committee, with or without cause, by resolution of the Executive Committee at a meeting called for that purpose.

(Amended March 2013)

29.1.03 A member of a committee who is neither a councillor, nor an appointed committee member[1] may be removed from the committee, with or without cause, by resolution of the Executive Committee at a meeting called for that purpose.

(Amended March 2013)

29.1.04 An appointed committee member who has been removed from all committees ceases to be an appointed committee member.

29.1.04.1 ***A member of the Discipline or Fitness to Practise Committees who ceases to be a member of one of those committees shall immediately cease to be a member of both of those committees.***

29.1.05 The decision of the Executive Committee under Article 29.1.02 or 29.1.03 is not subject to review or appeal.

(Added March, 2013)

30. Committee Chairs

30.01 Save and except where the by-laws specifically provide otherwise, the chair of each statutory committee shall be a councillor.

(Amended March 2009)

30.02 No person shall be eligible to serve as a chair of a committee for more than two consecutive terms.

30.02.1 Deleted - March 2009.

30.03 The President shall be the chair of the Executive Committee and of the Inquiries, Complaints and Reports Committee.

(Amended March 2009)

30.04 The two Vice-Presidents shall co-chair the Finance Committee in such manner as they agree upon or, failing agreement, as determined by the Finance Committee.

(Moved March 2009)

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[1] For example – members of the Sub-Committee on Compensation would fall into this category.

(Amended March 2012)

30.05 Save and except where the by-laws specifically provide otherwise, the chair of every committee, other than the Executive Committee, Inquiries, Complaints and Reports Committee and Finance Committee, shall be appointed by Council on the recommendation of the Executive Committee and shall be a member of the committee.

(Approved March 2009)

30.06 A chair of a committee, other than the Executive Committee, Inquiries, Complaints and Reports Committee and the Finance Committee, shall cease to be chair upon the receipt by the Executive Committee of a requisition signed by at least a two-thirds of the members of the committee.

(Amended March 2009)

30.06.1 ***If the same person chairs both the Discipline and Fitness to Practise committees, and the person ceases to be the chair of either one of those committees under article 30.06, that person shall immediately cease to be the chair of both of those committees.***

30.07 Where the position of chair of any committee, other than the Executive Committee, Inquiries, Complaints and Reports Committee or the Finance Committee, becomes vacant for any reason, the Executive Committee shall appoint an interim chair who shall serve until a new chair can be appointed by Council in accordance with Article 30.05.

(Approved March 2009)

30.08 Nothing in this Article prevents the interim chair from being appointed as the chair under Article 30.05.

(Approved March 2009)

30.09 Where one of the positions of co-chair of the Finance Committee becomes vacant, the remaining co-chair shall act as the chair of the Committee until a new Vice-President is elected.

(Approved March 2009)

30.10 Time spent as chair as a result of an appointment to fill a vacancy whether as a result of the appointment by the Executive Committee or Council shall not be included for the purposes of Article 30.02.

(Numbering change March 2009)

Executive Committee
March 11, 2020

Minutes

Present		
C. Evans, Chair	J. Petersen	H. Whittle
A. Fox	C. Ward	

Staff		
A. Coghlan	J. Hofbauer, Recorder	K. McCarthy

Purpose

This special meeting was held to make recommendations about the Chair of the Discipline and Fitness to Practise committees.

Committee Chairs

In February, the Executive had identified its recommendations for Chairs of the Quality Assurance and Registration Committees.

The Executive noted that Council supported the merging of the membership of the Discipline and Fitness to Practise committees. It had been agreed that, if this was the decision, there would be one chair.

The Executive received a briefing note with information about the individuals who had volunteered to serve as chairs of the individual and combined committees.

All members unanimously supported recommending to Council that T. Holland chair both the Discipline and Fitness to Practise committees.

_____
Chair

Executive Committee
May 21, 2020 at 11:00 a.m. via ZOOM

Minutes

Present		
C. Evans, Chair	J. Petersen	H. Whittle
A. Fox	C. Ward	
Guests		
S. Robinson	N. Thick	D. Thompson
Staff		
A. Coghlan	J. Hofbauer, Recorder	K. McCarthy
		A. McNabb

Orientation

C. Evans welcomed S. Robinson, N. Thick and D. Thompson for orientation. She highlighted the role of the Executive and how the committee functions both at its meetings and at Council.

C. Evans noted that the Executive is CNO's Patient Relations Committee. An orientation to the role of the Patient Relations Committee will be provided in the future.

A. Coghlan highlighted the staff support for the Executive.

Agenda

The agenda had been circulated and was accepted on consent.

Minutes

Minutes of the Executive Committee meetings of February 20, 2020 and March 11, 2020 had been circulated.

Motion 1

Moved by H. Whittle, seconded by J. Petersen,

That the minutes of the Executive Committee meetings of February 20, 2020 and March 11, 2020 be approved as circulated.

CARRIED

Executive Director update

A. Coghlan updated the Executive on CNO's activities in response to the COVID 19 pandemic. She noted that focus in the initial phase of closure has been on essential services in support of public safety.

As part of CNO's focus on supporting the health care system in meeting patient needs, CNO has attempted to minimize the time that nurse members of Council and committees are engaged in CNO processes.

CNO is gradually adding activities, with a focus on key statutory functions. A basic planning assumption is that CNO will continue to work mostly remotely until at least the end of August.

Committee Appointments

The Executive received information on statutory committee vacancies and new public members.

Motion 2

Moved by H. Whittle, seconded by C. Ward,

That the following be the statutory committee appointments for new public members:

- Karen Goldenberg, Bill Irwin, Ian McKinnon and Natalie Montgomery to the Discipline Committee and to the Fitness to Practise Committee
- Bill Irwin and Karen Goldenberg to the Registration Committee
- Stephen Eaton to the Inquiries, Complaints and Reports Committee
- Ian McKinnon to the Quality Assurance Committee.

CARRIED

June Council meeting

C. Evans noted that June Council will be a ZOOM meeting and will address only essential matters. The goal is for Council to function as efficiently and effectively as possible and to meet the transparency requirements for open Council meetings. It was identified that meeting management will become clearer as planning progresses.

The Executive had received and approved the agenda for the June Council meeting.

RPN scope of practice: revised Controlled Acts regulation for submission to government

A. McNabb, Strategy Consultant, joined the meeting. The Executive had received a preliminary Council briefing note about this issue. Since the deadline for feedback was recent, there will be added analysis provided in the final Council briefing note.

It was suggested that background about the evidence that informed Council's previous decisions be included. It was identified that evidence could include the advice of Council's public advisory group.

It was also pointed out that the Minister of Health requested that Council make this change – Council's focus has been to ensure that safeguards are in place to ensure safe practice.

A. McNabb left the meeting.

By-Law Amendments to combine the membership of the Discipline and Fitness to Practise committees

The Executive received and supported a draft Council briefing.

Conclusion

C. Evans expressed appreciation to the outgoing members of the Executive for their leadership and support.

At 12:30 p.m., on completion of the agenda and consent, the Executive Committee concluded.

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Signature

College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Information Note: Finance Committee Meeting of May 21, 2020

Contact for Questions or More Information

Stephen Mills, Chief Administrative Officer

The Finance Committee met on May 21, 2020. This information note provides a brief review of the key matters discussed at the meeting and shares the quarterly unaudited financial statements for the three months ended March 31, 2020. A full report of the Finance Committee's May meeting will come to Council in September, together with a report of the August meeting.

Financial Statements

Blair MacKenzie, CNO's audit partner from Hilborn$_{LLP}$ was a guest at the meeting. He highlighted the 2019 audited financial statements and met in private with the committee. Approval of the 2019 audited financial statements was recommended to June Council.

The committee reviewed the unaudited quarterly financial statements for the three months ending March 31, 2020 (attached). It was noted that the surplus to date of $3.6M is $1.4M more than the budgeted surplus for this quarter of $2.2M. S. Mills highlighted major reasons for the variances. He noted that COVID-19 has resulted in delays in project costs – for example the renovation of CNO's building and to delays in hiring staff to fill budgeted positions.

Auditor Appointment

The Finance Committee's recommendation regarding appointment of the auditor for 2020 will be presented to Council in September.

Committee's Year-End Self-Monitoring

The committee conducted its annual review of its detailed self-monitoring tool. The committee confirmed that over the four meetings of the 2019-2020 committee, it fulfilled its terms of reference.

Attachment:

Quarterly Financial Statements for the three months ended March 31, 2020.

Attachment 1

COLLEGE OF NURSES OF ONTARIO FINANCIAL STATEMENTS

FOR THE THREE MONTHS ENDED MARCH 31, 2020 (Unaudited)

College of Nurses of Ontario
Statement of Financial Position ($)
As at March 31

	2020 March	2019 March	2019 December
ASSETS			
Current assets			
Cash	5,384,744	6,758,385	49,246,911
Investments	55,442,325	36,931,777	21,192,321
Sundry receivables	47,571	4,563	22,664
Prepaid expenses	1,176,961	884,927	1,026,225
	62,051,601	44,579,652	71,488,121
Investments	10,069,147	14,169,022	12,180,199
Capital assets			
Furniture and fixtures	2,300,024	2,300,024	2,300,024
Equipment - non computer	1,127,271	1,133,674	1,127,271
Computer equipment	4,928,404	4,708,498	4,769,226
Building	6,835,907	6,744,448	6,835,907
Building improvements	3,923,184	3,923,184	3,923,184
Land	3,225,009	3,225,009	3,225,009
Art	44,669	44,669	44,669
	22,384,468	22,079,505	22,225,289
Less: Accumulated amortization	(15,312,609)	(14,349,770)	(14,928,550)
	7,071,858	7,729,735	7,296,739
Intangible Assets	4,095,159	4,058,729	4,095,159
Less: Accumulated amortization	(3,786,968)	(3,676,962)	3,752,968
	308,191	381,767	342,191
Accrued pension asset	-	264,725	-
	79,500,797	**67,124,901**	**91,307,250**
LIABILITIES			
Current liabilities			
Accounts payable and accrued liabilities	6,192,048	4,715,773	13,357,018
Deferred membership and examination fees	35,066,832	34,447,717	43,275,243
	41,258,880	39,163,490	56,632,261
Accrued pension liability	796,546	-	796,546
	42,055,426	39,163,490	57,428,807
NET ASSETS			
Net assets invested in capital assets	7,380,049	8,111,502	7,638,930
Unrestricted net assets	30,065,322	19,849,909	26,239,513
	37,445,371	27,961,411	33,878,443
	79,500,797	**67,124,901**	**91,307,250**

College of Nurses of Ontario
Statement of Operations ($)
Three Months Ended March 31

	2020 Year to Date March			2019 Year to Date March			2020 Budget	
	Budget	Actual	Variance Fav/(Unfav)	Budget	Actual	Variance Fav/(Unfav)	Remaining	Approved
REVENUES								
Membership fees	12,585,402	12,826,782	241,380	12,299,742	12,658,133	358,391	37,435,698	50,262,480
Application assessment	1,154,475	1,155,300	825	876,525	869,375	(7,150)	3,194,325	4,349,625
Verification and transcripts	20,275	17,085	(3,190)	19,225	22,040	2,815	39,165	56,250
Interest income	379,522	403,809	24,287	253,185	360,528	107,343	715,894	1,119,703
Examination	448,400	458,210	9,810	412,840	404,960	(7,880)	1,457,790	1,916,000
Other	113,560	122,277	8,717	109,020	113,041	4,021	232,973	355,250
Total Revenues	**14,701,634**	**14,983,463**	**281,829**	**13,970,537**	**14,428,077**	**457,540**	**43,075,845**	**58,059,308**
EXPENSES								
Employee salaries and expenses	8,776,982	7,660,133	1,116,849	7,878,824	7,177,662	701,162	29,466,697	37,126,830
Contractors and consultants	982,056	1,442,224	(460,168)	867,647	735,389	132,258	7,525,158	8,967,382
Legal services	665,500	443,672	221,828	559,356	521,026	38,330	2,230,728	2,674,400
Equipment, operating supplies and other services	1,083,938	882,131	201,807	838,406	676,758	161,648	4,502,805	5,384,936
Taxes, utilities and depreciation	491,809	483,565	8,244	438,108	414,538	23,570	1,483,671	1,967,236
Exam fees	329,538	362,359	(32,821)	313,906	319,475	(5,569)	1,096,544	1,458,903
Non-staff remuneration and expenses	201,189	142,452	58,737	188,607	157,628	30,979	689,263	831,715
Total Expenses	**12,531,012**	**11,416,536**	**1,114,476**	**11,084,854**	**10,002,476**	**1,082,378**	**46,994,866**	**58,411,402**
Excess of revenues over expenses/(expenses over revenues)	**2,170,622**	**3,566,927**	**1,396,305**	**2,885,683**	**4,425,601**	**1,539,918**	**(3,919,021)**	**(352,094)**
Opening net assets		**33,878,443**			**23,535,809**			
Closing net assets		**37,445,370**			**27,961,410**			

College of Nurses of Ontario
Statement of Changes in Net Assets ($)
Three Months Ended March 31

	2020			2019
	Invested in Capital and Intangible Assets	Unrestricted	Total	December
Balance, beginning of period	**7,638,930**	**26,239,513**	**33,878,443**	**23,535,809**
Excess of (expenses over revenues)/revenues over expenses	(418,059)	3,984,987	3,566,928	11,581,332
Purchase of capital assets	159,178	(159,178)	-	-
Defined benefit pension plan - remeasurements and other items	-	-	-	(1,238,699)
Balance, end of period	**7,380,049**	**30,065,322**	**37,445,371**	**33,878,442**

College of Nurses of Ontario
Statement of Cash Flows ($)
Three Months Ended March 31

	2020 March	2019 March
Cash flows from operating activities		
Excess of revenue over expense for the period	3,566,927	4,425,601
Adjustments to determine net cash provided by/(used in) operating activities		
Amortization of capital assets	384,059	321,457
Amortization of intangible assets	34,000	35,624
Interest not received during the year capitalized to investments	(257,747)	(298,678)
Interest received during the year previously capitalized to investments	197,096	164,455
Funding of pension benefits	(130,995)	(345,394)
Pension benefit expense	130,995	345,394
	3,924,335	**4,648,459**
Changes in non-cash working capital items		
(Increase) decrease in amounts receivables	(24,907)	114,341
(Increase) in prepaid expenses	(150,736)	(356,929)
(Decrease) in accounts payables and accrued liabilities	(7,164,971)	(4,863,591)
(Decrease) in deferred membership fees	(8,208,410)	(7,865,611)
	(11,624,689)	(8,323,331)
Cash flow from investing activities		
Purchase of investment	(43,078,300)	(15,683,596)
Proceeds from disposal of investments	11,000,000	3,838,440
Purchase of capital assets	(159,178)	(388,119)
Purchase of intangible assets	-	(2,745)
	(32,237,478)	(12,236,020)
Net decrease in cash and cash equivalents	(43,862,167)	(20,559,351)
Cash and cash equivalents, beginning of year	49,246,911	27,317,736
Cash and cash equivalent, end of year	**5,384,744**	**6,758,385**