Council of the
College of Naturopaths of Ontario

Meeting #23

Draft Agenda

Date: May 26, 2021 (2021/22-01)

Time: 9:00 am to 3:30 pm

Location: Zoom Video Conference Platform[1]

[1] Pre-registration is required.

Excerpt from the Health Professions Procedural Code
Regulated Health Professions Act.

COLLEGE

College is body corporate

2. (1) The College is a body corporate without share capital with all the powers of a natural person.

Corporations Act

(2) The *Corporations Act* does not apply in respect to the College. 1991, c. 18, Sched. 2, s. 2.

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of College

3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.

   4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.
5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

COUNCIL MEETING #23
May 26, 2021
9:00 a.m. to 3:30 p.m.
DRAFT AGENDA

Sect/No.	Action	Item		Page	Responsible
1	**Call to Order and Welcome**				
1.01	Procedure	Call to Order		--	Chair
1.02	Discussion	Meeting Norms		4-6	Chair
1.03	Discussion	"High Five" – Process for identifying consensus		7	Chair
2	**Executive Committee Elections**				
2.01	Election	Council Chair		--	CEO
2.02	Election	Council Vice-Chair			
2.03	Election	Officer-at-Large Public member			
2.04	Election	Officers-at-Large Professional members			
3	**Consent Agenda**[1]				
3.01	Approval	i.	a) Draft Minutes of March 31, 2021		Chair
			b) In-camera Minutes of March 31, 2021[2]		
		ii.	Committee Reports		
		iii.	Information Items		
4	**Main Agenda (9:20 am)**				
4.01	Approval	Review of Main Agenda			Chair
4.02	Discussion	Declarations of Conflict of Interest			Chair
5	**Monitoring Reports**				
5.01	Acceptance	Report of the Council Chair			Chair
5.02	Acceptance	Report on Regulatory Operations			CEO
5.03	Acceptance	Unaudited Financial Statements and Variance Report (Q4)			CEO
6	**Council Governance Policy Confirmation**				
6.01	Discussion	Review/Issues Arising		--	GPRC
		i.	Council-CEO Linkage Policies		
		ii.	Executive Limitations Policies		
		iii.	Ends Policies		
6.02	Discussion	Detailed Review Governance Process Policies (Part 2)		--	
6.03		Proposed New/Amended Policies from GPRC			
	Decision	i.	GP28.00 – Registering Gifts, Benefits & Remuneration		
7	**Regular Business**				
7.01	Decision	Inspection Program Fees			S Armstrong
7.02	Decision	Inspection Program Requirements			S Armstrong
7.03	Decision	Inspection Program Policies			S Armstrong
7.04	Decision	Alternate Dispute Resolution Program Policies			Deputy CEO
7.05	Discussion	Equity, Diversion, and Inclusion Initiatives			CEO
7.06	Decision	Competency Framework Funding Request			CEO
7.07	Decision	Committee Appointments			CEO
8	**Council Education**				
8.01	Information	Program Briefing – ICRC			Deputy CEO
8.02	Information	Program Briefing - Discipline			CEO

[1] Members of Council may request any item in the Consent Agenda to be added to the main agenda.
[2] In-camera minutes are redacted from the materials being released publicly for the Council meeting.

9	**In-Camera (Pursuant to paragraph (d) of section 7(2) of the HPPC)**				
	9.01	Motion	In-camera session to discuss personnel matters.	--	K. Bretz
	9.02	Decision	Implementation of Consultant Recommendation		K. Bretz
	9.03	Motion	To move out of the in-camera session	--	K. Bretz
10	**Other Business**				
	10.01	Decision		--	K. Bretz
11	**Next Meeting**				
	11.01	Discussion	Next Meeting – July 28, 2021	--	K. Bretz
12	**Adjournment**				
	12.01	Decision	Motion to Adjourn	--	K. Bretz

Zoom Meeting
Council of the College of Naturopaths of Ontario

Meeting Norms

General Norms

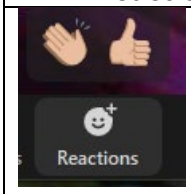
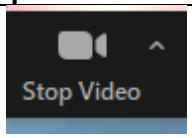
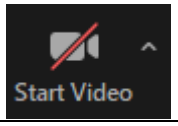
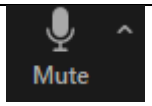
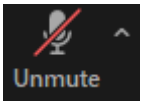
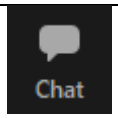
1. We'll listen actively to all ideas
2. Everyone's opinions count
3. No interrupting while someone is talking
4. We will be open, yet honor privacy
5. We'll respect differences
6. We'll be supportive rather than judgmental
7. We'll give helpful feedback directly and openly
8. All team members will offer their ideas and resources
9. Each member will take responsibility for the work of the team
10. We'll respect team meeting times by starting on time, returning from breaks promptly and, avoid unnecessary interruptions
11. We'll stay focused on our goals and avoid getting sidetracked

Additional Norms for Virtual Meetings

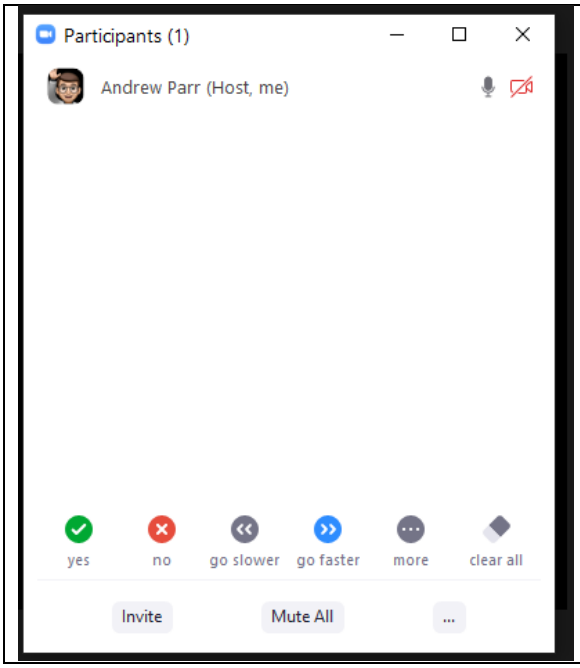
1. No putting the call on hold or using speakerphones
2. Minimize background noise – place yourself on mute until you are called upon to speak and after you have finished speaking
3. All technology, including telephones, mobile phones, tablets and laptops, are on mute or sounds are off
4. If we must take an emergency telephone call, we will ensure that we are on mute and we will stop streaming our video

5. Stay present – webcams will remain on (unless we are on a call or there is another distraction on your end)
6. Stay focused – avoid multi-tasking during the meeting
7. Use reactions (thumbs up, applause) to celebrate accomplishments and people
8. Use the Chat feature to send a message to the meeting host or the entire group.

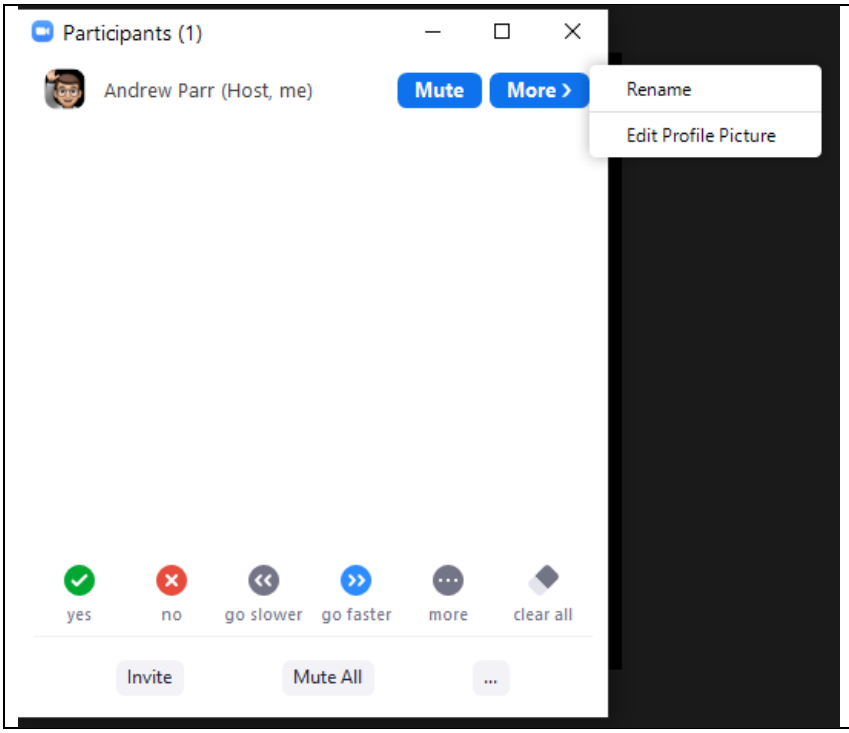
Zoom Control Bar – Bottom of screen

Reactions	Stop or Start Video	Mute/Unmute	
	 	 	

Other Helpful Tips



- Use the Participants button on the bottom control button to see a list of participants.
- On the Participants Menu, you can use the bottoms to send instant message to the Host… yes or no etc. (Not all of these options will appear if you are not the Host)



- Hover over your name on the Participants list to get more options
- You can rename yourself to your proper name
- You can add or change a profile picture.

Zoom Meeting
Council of the College of Naturopaths of Ontario

Using "High Five" to Seek Consensus

Image provided courtesy of Facilitations First Inc.

We will, at times, use this technique to test to see whether the Council has reached a consensus.

When asked you would show:

- 1 finger – this means you hate it!
- 2 fingers – this means you like it but many changes are required.
- 3 fingers – this means I like it but 1-2 changes are required.
- 4 fingers – this means you can live with it as is.
- 5 fingers – this means you love it 100%.

In the interests of streamlining the process, for virtual meetings, rather than showing your fingers or hands, we will ask you to complete a poll.

The College of Naturopaths of Ontario

Council Meeting
March 31, 2021

Teleconference
DRAFT MINUTES

Council		
Present		**Regrets**
Dr. Kim Bretz, ND (5:5)		Ms. Asifa Baig (3:4)
Dr. Shelley Burns, ND (5:5)		
Mr. Dean Catherwood (5:5)		
Mr. Brook Dyson (2:2)		
Ms. Lisa Fenton (5:5)		
Dr. Tara Gignac, ND (4:5)		
Dr. Brenda Lessard-Rhead, ND (Inactive) (5:5)		
Dr. Danielle O'Connor, ND (5:5)		
Ms. Sarah Griffiths-Savolaine (3:3)		
Dr. Jacob Scheer, ND (5:5)		
Dr. Jordan Sokoloski, ND (5:5)		
Dr. George Tardik, ND (5:5)		
Staff Support		
Mr. Andrew Parr, CAE, CEO		
Ms. Erica Laugalys, Director, Registration & Examinations		
Mr. Jeremy Quesnelle, Deputy CEO		
Ms. Monika Zingaro, Administrative Assistant Operations		
Guests		
Ms. Rebecca Durcan, Legal Counsel		

Dr. Jennifer Lococo, ND, Council member elect, District 4		
Ms. Sandi Verrecchia, President, Satori Consulting		

1. Call to Order and Welcome

The Chair, Dr. Kim Bretz, ND, called the meeting to order at 9:00 a.m. She welcomed everyone to the meeting and recognized newly re-elected Council member Dr. Shelley Burns, ND, District 2, and Council members elect Dr. Jennifer Lococo, ND, District 4 and Dr. Jonathan Beatty, ND, District 6. The Chair also noted that the meeting was being live streamed via YouTube to the College's website. As a result, any observers were directed to that feed as opposed to logging into the Zoom meeting.

2. Consent Agenda

2.01 Review of Consent Agenda

The Consent Agenda was circulated to members of Council in advance of the meeting. The Chair asked if there were any items to move to the main agenda for discussion. Dr. Danielle O'Connor, ND, requested to have a brief discussion in relation to the Scheduled Substances Review Committee (SSRC) Chair's Report to receive an update about their communications with the Ministry of Health. The Chair noted this item will be removed from the Consent Agenda and moved into the Main Agenda as Item 9.01 under Other Business.

MOTION:	To approve the Consent Agenda as amended .
MOVED:	Tara Gignac
SECOND:	Danielle O' Connor
CARRIED.	

3. Main Agenda

3.01 Review of the Main Agenda

A draft of the Main Agenda, along with the documentation in support of the meeting had been circulated in advance of the meeting. The Chair asked if there were any items to be added to the agenda, Item 9.01 – Summary of SSRC's Discussion with the Ministry of Health was added.

MOTION:	To approve the Main Agenda as amended.
MOVED:	Jordan Sokoloski
SECOND:	Sarah Griffiths-Savolaine
CARRIED.	

3.02 Declarations of Conflicts of Interest

The Chair reminded the Council members of the updated Declarations of Conflict-of-Interest process. A summary of the Annual Conflict of Interest Questionnaires completed by Council members has been included to increase transparency and accountability initiatives, and to align with the College Performance Measure Framework Report (CPMF) launched by the Ministry of Health.

The Chair declared an updated Conflict of Interest in relation to their speaking engagements with Designs for Health.

4. Monitoring Reports

4.01 Report of the Council Chair

The Report of the Council Chair was circulated in advance of the meeting. The Chair reviewed the report briefly with Council. She welcomed and responded to questions from the Council.

MOTION:	To accept the Report of the Council Chair as presented.
MOVED:	George Tardik
SECOND:	Tara Gignac
CARRIED.	

4.02 Report on Regulatory Operations from the CEO

The Report on Regulatory Operations from the CEO was circulated in advance of the meeting. Mr. Andrew Parr, CEO, provided a detailed overview of the information enclosed in the report, as this is the first one given to Council. He advised this report's timelines have been generated to align with the CPMF cycle and responded to questions that arose during the discussion that followed.

MOTION:	To accept the Report on Regulatory Operations from the CEO.
MOVED:	Shelley Burns
SECOND:	Tara Gignac
CARRIED.	

4.03 Variance Report and Unaudited Financial Statements for Q3

A Variance Report and the Unaudited Financial statements ending December 31, 2020 (Q3) were included in the materials circulated in advance of the meeting. Mr. Parr provided a review of the Variance Report and the Unaudited Statements and highlighted the changes in the report from the previous quarter. He responded to questions that arose during the discussion that followed and informed Council he will clarify the total expenditures percentage with Agnes Kupny, Director of Operations.

MOTION:	To accept the Variance Report and Unaudited Financial statements for the third quarter as presented.
MOVED:	Dean Catherwood
SECOND:	George Tardik
CARRIED.	

5. Council Governance Policy Confirmation
5.01 Review/Issues Arising
5.01(i) Detailed Review – Council-Registrar Linkage Policies
Council members were asked if they had any questions or matters to note with respect to the Governance Process policies based on the reports received. No issues were noted at this time.

5.01(ii) Executive Limitations Policies
Council members were asked if they had any questions or matters to note with respect to the Executive Limitations policies based on the reports received. No issues were noted at this time.

5.01(iii) Ends Policies
Council members were asked if they had any questions or matters to note with respect to the Ends policies based on the reports received. No issues were noted at this time.

5.02 Detailed Review (as per GP08) – Governance Process Policies (Part 1)
Council members were asked if there were any members who wished to discuss the Governance Process Policies (Part 1). Dr. Jordan Sokoloski, ND, provided a detailed overview of the amendments being presented as outlined in the Memorandum included within the Council's package and responded to any questions that arose during the discussion.

MOTION:	To accept the recommendations of the Governance Policy Review Committee.
MOVED:	Brenda Lessard-Rhead
SECOND:	Shelley Burns
CARRIED.	

6. Business
6.01 Executive Committee Elections
The CEO advised Council that at the close of nominations, there were no nominations for the position of Council Vice-Chair. As the by-laws require that this position be filled by a Public member, because the Chair position is currently filled by a Professional member, this position will remain vacant until the regular Executive Committee elections at the end of May.

In addition, at the close of nominations, there was one nomination for the Officer-at-Large (Public member) position. That nomination was for Sarah Griffiths-Savolaine who is hereby declared as elected by acclamation.

6.02 Committee Appointments and COI Declarations
The CEO reminded the Council members that Committee re-appointments are approaching. He referred the Council to the Committee information sheet and invited all Council members to review this while considering which Committees they might like to serve on. It was also noted that at the bottom of information sheet, there is a link to a new on-line portal for their submissions, as well as a copy of the Conflict-of-Interest Declaration form for the coming year. He asked all Council members to complete these forms at their earliest convenience before the next Council meeting at the end of May 2021.

6.03 College Performance Measure Framework Report (CPMF)
The CEO reviewed in detail the CPMF Report distributed to Council in advance of the meeting. He informed the Council that once approved, the report will be submitted to the Ministry of Health and uploaded to the College's website for the public's viewing by end of day. In addition, he responded to any questions or concerns that arose during the discussion that followed.

MOTION:	To approve the College Performance Measure Framework report of the College of Naturopaths of Ontario as presented.
MOVED:	Tara Gignac
SECOND:	Brenda Lessard-Rhead
CARRIED.	

6.04 Operational Plan 2021-2024
A comprehensive briefing note and the Operational Plan document were circulated to the members of the Council in advance of the meeting. The CEO provided a brief review of the plan and highlighted some projects and activities underway for the coming fiscal year. He also responded to any questions or concerns that arose during the discussion that followed.

MOTION:	To accept the Operational Plan for 2021-2024 as presented.
MOVED:	Danielle O'Connor
SECOND:	Sarah Griffiths-Savolaine
CARRIED.	

6.05 Capital and Operating Budgets 2021-2022
A detailed briefing note and the draft budgets were included in the Council materials circulated in advance of the meeting. The CEO highlighted the main components within each budget and responded to any questions or concerns that arose during the discussion that followed.

MOTION:	To accept the Capital and Operating budgets for 2021-2022 as presented.
MOVED:	Brenda Lessard-Rhead
SECOND:	Lisa Fenton
CARRIED.	

7. Business Arising from the Governance Review
7.01 Council and Committee Evaluation Program
The Chair invited Ms. Sandi Verrecchia, President of Satori Consulting, to present for the Council members the intended process for the upcoming Council and Committee evaluations. She went into detail of the timeline that will be followed, for instance, April 30 the survey for all Council and Committee members will go live until May 14, then individual briefings will be held between June 7 - June 25 to present the information gathered from the surveys. In addition, she provided an overview of how the survey will be formatted with sample questions and reminded

Council that all reviews will remain confidential. She also advised all Council members that when taking the survey to allot at least one full hour for completion, and to begin brainstorming feedback and area(s) of improvement(s) for everyone they work with on Council and their Committees to include within the survey. In addition, she also advised Council that great consideration of the members who will be included within this year's evaluation process will be taken, as newer Council and Committee members may result in unfair evaluations due to less time in their given role(s). Lastly, she responded to any questions or concerns that arose during the discussion that followed.

The Chair thanked Ms. Verrecchia for her presentation to Council.

8. In-camera Session (Pursuant to paragraph (d) of section 7(2) of the HPPC)
8.01 Motion to Begin In-camera Session
The Chair called the meeting to move to an in-camera session at 10:25 a.m.

MOTION:	To move to an in-camera session pursuant to paragraph (d) of section 7(2) of the Health Professions Procedural Code as the Council will be discussing personnel matters.
MOVED:	Danielle O' Connor
SECOND:	Brenda Lessard-Rhead
CARRIED.	

9. Other Business
9.01 Summary of SSRC's Discussion with the Ministry of Health (MOH)
Dr. George Tardik, ND, notified the Council members that the MOH informed the SSRC that they have reviewed their 2019 submissions of drug list amendments and followed up with them on three separate occasions with questions, concerns and/or clarifications, to which the Committee provided responses to all.

Mr. Jeremy Quesnelle, Deputy CEO, also notified the Council members that the MOH thanked the College for their responses and will communicate back to the College once their review is completed.

10. Next Meeting
The Chair noted for the Council that the next regularly scheduled meeting is set for May 26, 2021. In addition, noted a new element to the Council meeting, a quick survey to be completed by all members via the link posted in the Zoom's chat box feature.

11. Adjournment
11.01 Motion to Adjourn
The Chair asked for a motion to adjourn the meeting. The meeting adjourned at 11:16 a.m.

MOTION:	To adjourn the meeting.
MOVED:	Tara Gignac
SECOND:	Danielle O' Connor

Recorded by: Monika Zingaro
Administrative Assistant, Operations
March 31, 2021

Minutes Redacted

The Council moved to an in-camera session to discuss materials pursuant to paragraph (2) of section 7(2) of the Health Professions Procedural Code, Schedule 2 of the *Regulated Health Professions Act,1991*. The minutes of that portion of the meeting are also protected under the same authority and have therefore been redacted from the Council meeting materials being disclosed.

Minutes Redacted

The Council moved to an in-camera session to discuss materials pursuant to paragraph (2) of section 7(2) of the Health Professions Procedural Code, Schedule 2 of the *Regulated Health Professions Act,1991*. The minutes of that portion of the meeting are also protected under the same authority and have therefore been redacted from the Council meeting materials being disclosed.

MEMORANDUM

DATE: May 26, 2021

TO: Members of Council

FROM: Andrew Parr, CAE
Chief Executive Officer

RE: Committee Reports

Please find attached the Committee Reports for item 2.01 (ii) of the Consent Agenda. The following reports are included:

1. Audit Committee.
2. Examination Appeals Committee.
3. Executive Committee.
4. Inquiries, Complaints and Reports Committee.
5. Governance Committee.
6. Patient Relations Committee.
7. Quality Assurance Committee.
8. Registration Committee.
9. Scheduled Substances Review Committee.
10. Discipline Committee.
11. Inspection Committee.
12. Governance Policy Review Committee.

In order to increase the College's accountability and transparency, all Committee Chairs were asked to submit a report, even if the Committee had not met during the reporting period. Please note the Discipline/Fitness to Practise Committee Chair was not required to submit a report in order to preserve the independent nature of these Committees; however, the Chair has voluntarily provided a report for Council's information.

AUDIT COMMITTEE CHAIR REPORT
May 2021

This serves as the chair report of the Audit Committee for the period March 1, 2021 to April 30, 2021.

During the reporting period the Audit Committee was not required to undertake any activities, and therefore did not convene.

The Committee is planning to meet mid-May 2021 to begin discussions of the yearly Financial Audit process.

Dr. Elena Rossi, ND
Chair
May 3, 2021

EXAMINATIONS APPEAL COMMITTEE REPORT
May 2021

The Committee meets on an as-needed basis, based on received exam appeals, those that would require deliberation and decision, or needed appeals-related policy review.

The Exam Appeals Committee did not meet in the March 1, 2021 to April 30, 2021 reporting period.

Dianne Delany
Chair
May 2021

EXECUTIVE COMMITTEE REPORT
May 2021

This serves as the Chair report of the Executive Committee for the period March 1, 2021 to April 30, 2021.

During the reporting period the Executive Committee was not required to undertake any activities, and therefore did not convene.

Dr. Kim Bretz, ND
Council Chair
May 2021

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE REPORT
May 2021

Between March 1, 2021 and April 30, 2021, the Inquiries, Complaints and Reports Committee held two regular online meetings – March 4th and April 8th.

In March, 13 matters were reviewed, ICRC members approved 3 Decisions and Reasons and drafted 3 reports.

In April, 16 matters were reviewed, ICRC members approved 2 Decisions and Reasons and drafted 5 reports.

Meetings continue to be well-attended and productive in the online format. The committee continues to see concerns about COVID-related advertising or COVID protocols followed by registrants' clinics. The ICRC also noted an influx of matters related to practising outside the naturopathic scope.

The committee has recently sought prosecutorial viability opinions in some of the more complex matters even though they will not likely be referred for disciplinary action. Typically, this is the step taken prior to sending a matter to discipline, however the committee felt that it needed more clarity from a legal perspective to help make more informed decisions.

One issue of note where guidance was sought is NDs asking pharmacists to change the route of administration of a drug that the ND has prescribed from suppository to oral dosing. This appears to be a work-around solution to the fact that NDs are not authorized to prescribe certain drugs orally.

Dr. Erin Psota, ND
Chair
May 12th, 2021

GOVERNANCE COMMITTEE REPORT
May 2021

The Governance Committee, convenes on an as-needed basis, based on the by-laws.

During the reporting period March 1, 2021 to April 30, 2021, the Committee was not required to undertake any activities, and therefore did not convene.

The Committee is expected to convene early June 2021.

Dr. Gudrun Welder, ND
Chair
May 3, 2021

PATIENT RELATIONS COMMITTEE REPORT
May 2021

The Patient Relations Committee (PRC) had 0 meetings scheduled during the reporting period.

Ongoing Issues/Topics for Discussion

Applications for Funding

There were no new applications for funding for therapy and counselling during this reporting period. There continues to be four active files with a total of $17,029.60 of funding accessed with a total of $2,152.50 being accessed since the last report.

Sam Laldin
Chair
May 2021

QUALITY ASSURANCE COMMITTEE REPORT
May 2021

Meetings and Attendance

Since the date of our last report to Council in March, the Quality Assurance Committee has met on two occasions, both via teleconference; on March 23rd and April 20th, respectively. No concerns regarding quorum have been experienced.

Activities Undertaken

Over the past two meetings, the Committee continued with its regular ongoing review and approval, where appropriate, of new and previously submitted CE category A credit applications.

Additionally, at its **March** meeting, the Committee reviewed and made decisions with respect to 2 CE Reporting deadline extension requests.

The Committee also considered updated information provided by staff on the status of CE reporting for the last reporting period ending September 2020. The Committee noted that there were 11 Registrants who continued to have discrepancies in their CE log reports and decided to grant one further extension to April 30, 2021 to have them completed. Registrants not meeting that deadline would be required to undergo a QAC ordered Peer and Practice Assessment at their own cost.

At its **April meeting,** the Committee also considered information provided by staff on the status of Self-Assessment completion by Registrants for the past reporting period. It was noted that as of April 9th, 997 or 66% of Registrants had completed the Self Assessment. It was also noted that staff would be sending out reminder notices indicating a completion reporting deadline of May 7th.
The Committee also developed a proposed list of potential topics for future Self Assessments, including but not limited to; record keeping, telepractice, scope of practice, delegation and collaboration, billing, informed consent, online/ group programs, and practitioner well-being. It was agreed that staff would begin the process of drafting various Self Assessments and bring them forward for review and approval.

The Committee also considered an update provided by staff on the results of the public/ stakeholder consultation on proposed amendments to the Standard of Practice for Core Competencies as well as staff suggestions with respect to further review of the standard, given

that a new Standards Committee has been established. It was decided that the Committee would review input from the consultation and forward that material, along with the Committee's recommendations, on to that new Committee.

The Committee also discussed the related matter of the Chair and individual Committee members having recently been sent email correspondence by the head of one of the College's stakeholder organizations inquiring about the status of the Committee's review of, and making recommendations on, how the Committee should proceed regarding the consultation feedback. The reply to that organization by the College Council Chair and CEO was also noted. Committee members were reminded that such correspondence to individual Committee members was inappropriate and contrary to the protocol for formal communications between external organizations and the College and that should such be received in the future, it is not to be responded to, but is to be immediately forwarded through the Committee chair to staff for their consideration and any action deemed appropriate.

Issues
None, other than the implications of the ongoing COVID-19 pandemic.

Next Meeting Date
May 25, 2021.

Respectfully submitted by,

Barry Sullivan, Chair,
May 12, 2021

REGISTRATION COMMITTEE REPORT
(May 2021)

At the time of this report, the Registration Committee met on April 21.

Exam Remediation
The Committee continued to set exam plans of remediation, for candidates who have made two unsuccessful attempts of a College examination. Five plans of exam remediation were set during this period, for unsuccessful attempts at the Ontario Clinical Sciences examination.

Danielle O'Connor, ND
Chair
Registration Committee
May 12, 2021

SCHEDULED SUBSTANCES REVIEW COMMITTEE REPORT
May 2021

During the reporting period of March 1, 2021 to April 30, 2021, the SSRC did not meet. Meeting are scheduled based on work flow.

During the reporting period staff of the College met with representatives of the Ministry of Health to review the drug submission made by the Council in 2019. Staff, in conjunction with the Chair of the Committee continued to provide answers and follow up information as request by the MOH regarding the Council's amendments to the schedules of the general regulation made under the *Naturopathy Act, 2007.*

Respectfully submitted by

Dr. George Tardik, ND
Chair
May 2021

The College of Naturopaths of Ontario

DISCIPLINE COMMITTEE REPORT

May 2021

The Discipline Committee (DC) is independent of Council and has no legal obligation to submit bimonthly reports addressing matters of importance to the Committee. However, in the interest of transparency and to acknowledge Committee members' involvement in the discipline process, the Chair is pleased to provide this report to Council.

This report is for the period from 1 March 2021 to 30 April 2021 and provides a summary of the hearings held during that time as well as any new matters referred by the Inquiries, Complaints and Reports Committee (ICRC) of the College. Committee meetings and training are also reported.

Discipline Hearings

CONO vs. Anna Blaszczyk (DC20-03)

On 24 February 2021, the following members of the Discipline Committee were appointed to a panel to hear the above-noted matter referred to the DC by the ICRC on 5 November 2020:

Dr. Tara Gignac, ND - Chair
Dr. Jacob Scheer, ND
Dean Catherwood
Lisa Fenton
Samuel Laldin

The Panel held a one-day uncontested electronic hearing on 19 March 2021 and imposed an order requiring the Registrant to be reprimanded immediately following the hearing of this matter, based on Ms. Blaszczyk's undertaking to resign her certificate of registration.

The Decision and Reasons in this matter was issued by the Panel on 7 April 2021.

CONO vs. Natasha Turner (DC20-02)

On 11 March 2021, the following members of the Discipline Committee were appointed to a panel to hear the above-noted matter referred to the DC by the ICRC on 10 September 2020.

Dr. Jordan Sokoloski, ND - Chair
Dr. Rick Olazabal, ND
Dean Catherwood
Dianne Delany
Lisa Fenton

The hearing of this matter, originally scheduled for 12 April 2021, was deferred at the request of the parties.

New Referrals

No new referrals were made to the Discipline Committee from the ICRC during the reporting period.

Committee Meetings and Training

No committee meetings were held during the reporting period.

Respectfully submitted,

Dr. Jordan Sokoloski, ND - Chair
10 May 2021

INSPECTION COMMITTEE REPORT
March-April 2021

Committee Update

Since the last update to Council, the Inspection Committee had two teleconference meetings on March 17th, and April 28th.

Inspection Outcomes

The Committee reviewed the Inspection Program Requirements Checklists used by the inspectors to record their observations during the inspections, and the Inspector's Reports for 7 premises.

The outcomes were as follows:

- Part I
  - 2 Passes with 2 Recommendations
- Part II
  - 5 Passes with 27 Recommendations, and 7 Conditions

Type 1 Occurrence Reports

There were 5 Type 1 Occurrences reported for this period. Following review of the reports, the Committee had no concerns regarding the actions taken by the Registrants for these occurrences.

Review of the Summary of Type 2 Occurrence Reports

There were no Type 2 Occurrences reported for this period.

Closing Remarks

There was no feedback offered to the Inspection Committee during the public consultation for the amended Inspection Program Requirements. The Committee has made their recommendations to Council for the upcoming meeting. The Committee also discussed and reviewed the public feedback for the Inspection Program Fees consultation, and have made recommendations to Council. We look forward to the start of spring and the positive changes it will bring!

Best of health,

Dr. Sean Armstrong, ND
Chair, Inspection Committee
May 14, 2021

GOVERNANCE POLICY REVIEW COMMITTEE REPORT
May 2021

Meetings and Attendance

Since the date of our last report to Council in March, the Governance Policy Review Committee has met on one occasion, via video-conference, on May 4th. Attendance has been good with no concerns regarding quorum experienced.

Activities Undertaken

At its **May** meeting, the Committee first reviewed and discussed a new Governance Process policy proposed by staff that relates to Council and Committee members' participation in/ involvement with, outside organizations and events.
Suggested changes were made and members agreed to send additional comments to staff pending further review at the next Committee meeting.

The Committee also reviewed and discussed a new Governance Process policy proposed by staff that relates to 'Registering Gifts, Benefits and Remuneration'.
Several changes were made and it was agreed to submit the proposed draft policy to Council for review and approval at their next meeting.
The Committee also reviewed and provided feedback to staff on a related Administrative Policy outlining the process for declaring receipt of gifts and benefits.

The Committee also reviewed the Governance Process Policies (part 2) and considered related Council member feedback in developing proposed amendments to those policies, to be submitted to Council for review and approval as part of their mandated detailed review at their next meeting.

Finally, the Committee considered proposed amendments to the Terms of Reference (TOR) for the Governance Committee that would assign an additional responsibility, for development and maintenance of a program of Equity, Diversity and Inclusion (EDI), to that Committee.
The Committee was also apprised by staff of the Anti- BIPOC Racism Project currently being undertaken by a working group of HPRO member representatives under the auspices of HPRO; the intent of which is to support the development and implementation of EDI programs by it's member health regulatory colleges.
It was agreed that staff would complete a briefing note, including background information and the Council's options for proceeding with this important initiative and that following further review by Committee members, it would be submitted to Council along with the aforementioned TOR amendments for consideration at their next meeting.

Issues
None; other than the continuing implications of the COVID-19 pandemic.

Next Meeting Date
July 6, 2021.

Respectfully submitted by,

Barry Sullivan, Chair,
May 13, 2021

MEMORANDUM

DATE: May 19, 2021

TO: Council members

FROM: Andrew Parr, CAE
Chief Executive Officer

RE: Items Provided for Information of the Council

As part of the Consent Agenda, the Council is provided a number of items for its information. Typically, these items are provided because they are relevant to the regulatory process or provide background to matters previously discussed by the Council.

To ensure that Council members, stakeholders and members of the public who might view these materials understand the reason these materials are being provided, an index of the materials and a very brief note as to its relevance is provided below.

As a reminder, Council members have the ability to ask that any item included in the Consent Agenda be moved to the main agenda if they believe the items warrants some discussion. This includes the items provided for information.

No.	Name	Description
1.	Gray Areas (No. 256)	Gray Areas is a monthly newsletter and commentary from our legal firm, Steinecke Maciura LeBlanc on issues affecting professional regulation. The issues for this past quarter are provided to Council in each Consent Agenda package.
2.	Legislative Update (March, April)	This is an update provided by Richard Steinecke to the members of the Health Profession Regulators of Ontario (HPRO), formerly the Federation of Health Regulatory Colleges of Ontario (FHRCO). The updates identify legislation or regulations pertaining to regulation that have been introduced by the Ontario Government. The updates for the past quarter are provided to Council in each Consent Agenda package.

No.	Name	Description
3	Handbook	A new Per Diems & Expense Claims Handbook has been created which will take effect on June 1, 2021 for volunteers and immediately for Council members.
4	Guidelines	Three Guidelines to reference as noted within Briefing Notes throughout the agenda items. These include the following, *Understanding the Public Interest, Understanding the Rush Analysis Terminology* and *Understanding Transparency.*

Grey Areas
A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION
SML Steinecke Maciura LeBlanc Barristers & Solicitors

Honest, Open and Helpful

by Bernie LeBlanc
May 2021 - No. 256

A challenge for regulators occurs when practitioners do not blatantly refuse to cooperate with an investigation, but still do not provide the requested information or assistance. For example, the practitioner can ask questions to clarify the regulator's request. Or the practitioner can demand disclosure of the basis for the investigation. Or the practitioner can challenge the scope of the request as being overly broad (i.e., a fishing expedition). Or the practitioner can indicate that they will cooperate but explain that they are having difficulties gathering the information and request extensions. Or the practitioner might provide only part of the information requested.

At what point do these responses become a failure to cooperate that is enforceable at discipline? The Ontario Court of Appeal spoke to the issue in *Law Society of Ontario v. Diamond*, 2021 ONCA 255, https://canlii.ca/t/jfhjh. In that case, the regulator sought certain documents that practitioners were required by law to keep. Despite numerous communications, many of the documents were not provided. Seven months after the first request, disciplinary proceedings were commenced alleging non-cooperation. The documents were finally produced about 8 ½ months after the initial request. The hearing proceeded and a finding was made.

The practitioner argued that he had not acted in bad faith. His attempts to understand and clarify the requests did not amount to professional misconduct. He ultimately provided the requested information.

In terms of the standard of review, the Court said:

> … the reviewing court is to apply a standard of correctness to questions of law, while a standard of palpable and overriding error is to be applied to questions of fact and questions of mixed fact and law where the legal principle is not readily extricable ….

The Court held that while the test for assessing a failure to cooperate is a question of law, subject to correctness review, the tribunals and lower court understood the correct test. The issue as to whether the conduct of the practitioner met that test was one of mixed fact and law subject to palpable and overriding error scrutiny.

The Court found that the test for assessing cooperation could be summarized as follows:

> (a) all of the circumstances must be taken into account in determining whether a licensee has acted responsibly and in good faith to respond promptly and completely to the Law Society's inquiries; (b) good faith requires the licensee to be honest, open, and helpful to the Law Society; (c) good faith is more than an absence of bad faith; and (d) a licensee's uninformed ignorance of their record-keeping obligations cannot constitute a "good faith explanation" of the basis for the delay.

The Court held that a practitioner cannot rely upon an honest misunderstanding of their record keeping obligations or their duty to provide an honest, open and helpful response as demonstrating good faith. Practitioners were expected to know these things.

> If a licensee could simply say to the regulator, "I cannot produce the record promptly or

FOR MORE INFORMATION
This newsletter is published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation. If you are not receiving a copy and would like one, please contact: Steinecke Maciura LeBlanc, 401 Bay Street, Suite 2308, P.O. Box 23, Toronto, ON M5H 2Y4, Tel: 416-599-2200 Fax: 416-593-7867,
E-Mail: info@sml-law.com

> completely because I did not know about my record-keeping obligations and made no reasonable effort to find them out", and this response could constitute a "good faith explanation", it would undermine the very purpose of the duty to cooperate. Quite simply, ignorance of one's professional obligations cannot subsist as a demonstration of good faith; they do not go hand in hand.

The Court also did not accept that the omission was insufficiently serious to constitute professional misconduct. The Court said the "conduct constitutes a significant departure from the acceptable standards of the profession".

The Court also rejected the suggestion that a "clear refusal" was required to establish a failure to cooperate. The practitioner argued:

> … that each request made by the Law Society was responded to promptly. While the Law Society may not have liked all of the responses, they were genuine responses that, at their highest, may show some confusion on the part of both of the Law Society and the appellant, but not a failure to cooperate. The appellant argues that this is best demonstrated through the fact that, once the confusion was cleared, all the requested documents were produced. This is said to underscore how everything the appellant did was in good faith.

The Court deferred to the panel's findings that the practitioner's responses were not made in good faith and constituted a "cat and mouse game".

> The reputation of the legal profession rests on the public's confidence that self-regulation is taken seriously by the legal profession. This can only occur where the legal profession has at hand effective and efficient tools by which to achieve accountability among its members. This is fundamental to the health and vibrancy of the legal profession.
>
> Returning to the duty to cooperate, r. 7.1-1 of the *Rules of Professional Conduct* is designed to ensure that there is a complete response and no inordinate delays in investigations by the self-regulated authority. It requires nothing more than prompt and complete responses when requested, which are essential to moving investigations forward. Delays in doing so can only serve to shake the public's confidence in the Law Society's self-regulatory authority …. As the Law Society points out in their factum, the "reputation of the ability of the profession to self-regulate would quickly be diminished if the obligation to cooperate could be subverted by a 'cat and mouse game' (as described by the Hearing Panel), that fell short of a clear refusal."

In light of this decision, regulators can take seven simple steps to enhance the enforceability of honest, open and helpful responses by practitioners:

1. Issue specific requests for the cooperation desired in writing.
2. Do not overreach in one's requests. Seek information that is relevant to the scope of the investigation and which does not create unnecessary burdens on practitioners. It is acceptable to make follow up requests for additional information arising from the information that has already been provided. Follow-up requests are preferable to making overreaching requests at the beginning of the investigation.

3. Set clear deadlines.
4. Follow up missed or incomplete responses with a renewed request for specific cooperation.
5. In replying to any questions for clarification, challenges or counter-proposals by the practitioner, be sure to conclude the response by reiterating the pending request for specific cooperation.
6. Similarly, do not make a commitment to consider an issue without responding immediately after the consideration is completed. Otherwise, the regulator might leave the impression that the request for cooperation is "on hold".
7. In all of this, assert, explicitly and accurately, the practitioner's duty to cooperate.

Prepared by Richard Steinecke

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Bonus Features

Ontario Bills

(www.ola.org)

Bill 269*, Protecting the People of Ontario Act (Budget Measures), 2021* – *(Government Bill, second reading)* Bill 269 reforms the archaic structure of the Ontario Securities Commission by separating the offices of the Chair of the Commission from that of the CEO and separating the Commission, which acts as its board of directors, from the tribunal that will now hear enforcement matters.

Bill 263*, Health Protection and Promotion Amendment Act (Temptation Be Gone), 2021* – *(Private Member's Bill, first reading)* Bill 263 would permit the making of regulations restricting and prohibiting the online sale of high fat, high sodium and high sugar foods.

Proclamations

(www.ontario.ca/search/ontario-gazette)

Ontario College of Teachers Act – February 1, 2021, was the date in which numerous amendments to the governance structure of the College and changes to the sexual abuse provisions came into force. (*Ontario Gazette*, March 20, 2021)

Regulations

(https://www.ontario.ca/laws Source Law - Regulations as Filed)

Laboratory and Specimen Collection Centre Licensing Act; Health Protection and Promotion Act – The regulation exempts persons performing point of care testing for COVID-19 from many of the provisions of the *Act* and regulations but they are required to report positive results to the local medical officer of health. (Ontario Regulations 156/21, 157/21, and 158/21, Filed March 3, 2021)

Pharmacy Act – The registration regulation has been amended to create two new classes of registration: pharmacist (emergency assignment) and pharmacy technician (emergency assignment). (Ontario Regulation 187/21, Filed March 12, 2021)

Audiology and Speech-Language Pathology Act – The registration regulation has been completely updated. (Ontario Regulation 188/21, Filed March 12, 2021)

Emergency Management and Civil Protection Act **and the** ***Reopening Ontario (A Flexible Response to COVID-19) Act*** – Numerous regulations were made relating to the management of the pandemic. Most relate to the nature of restrictions.

Proposed Regulations Registry

(www.ontariocanada.com/registry/)

Dentistry Act and Denturism Act – A combined consultation is being held on proposed amendments to the registration regulation for both Colleges. These amendments include administrative suspensions for failing to provide required information to the College and to clarify the rules for administrative suspensions, revocations and reinstatement of certificates of registration. For denturism, the proposed amendments also include revisions to the approval of denturism programs for registration purposes. Comments are due by April 5, 2021.

Bonus Features

Many of these cases will appear in our blog:
(www.sml-law.com/blog-regulation-pro/)

Hiding Behind a Corporation

Unregistered persons practising a profession through a corporation generally cannot escape prosecution for unauthorized practice. That was the message of the Ontario Court of Appeal in *R. v. Codina*, 2020 ONCA 848 (CanLII), https://canlii.ca/t/jcbs7. Ms. Codina, a disbarred lawyer, was found to have provided immigration advice for compensation without being registered with the immigration consultant's regulatory body. She argued that all clients contracted with her corporation and all fees were paid to the corporation and, thus, she should not personally be convicted.

> The jury heard a great deal of evidence about the operation of Codina International and its employment of various individuals, some of whom were qualified to give advice or provide representation under s. 91. The trial judge, however, appreciated that the operation of Codina International was not the focus of the trial. The appellant's liability turned on what she did and said in respect of the events giving rise to the charges. If she gave advice, she was responsible for that conduct, regardless of how her company was structured or organized its business.
>
> As a matter of law, if the appellant offered advice or provided representation, it was irrelevant to her liability that others operating within Codina International were also providing advice or representation. It was equally irrelevant that the appellant purported to give advice or provide representation in her capacity as a spokesperson, officer or employee of Codina International. The corporate veil offers no protection from personal criminal responsibility for one's own conduct ….

The Court also rejected the argument that it was the corporation, and not the individual, who received the compensation:

> The appellant submits it is unfair to hold the appellant liable for her personal acts even if done in the course of the operation of Codina International, while at the same time imposing liability based on consideration paid only to Codina International. I fail to see any unfairness. If the appellant engaged in the conduct prohibited by s. 91, and directed the payment of the consideration elsewhere, she remains equally responsible for her actions. In any event, it stretches credulity to find any unfairness here. The money went into a bank account totally controlled by the appellant. Clearly, she benefited directly from the consideration paid.

Hiding behind a corporate structure is unlikely to be an effective circumvention strategy for most unauthorized practice cases.

Family Matters

For some professions, such as nursing, professionals are strongly discouraged from involving themselves in the care of family members is because it is difficult to remain objective. In *Hancock v College of Registered Nurses of Manitoba*, 2021 MBCA 20 (CanLII), https://canlii.ca/t/jdp6q, a nurse was disciplined and suspended for two months for this type of conduct. The nurse, despite being warned not to become involved, intervened in the care of her mother-in-law, including communicating with a treating physician and accessing the mother-in-law's records. The hearing panel found that this involvement crossed professional boundaries and failed to respect the privacy of health records.

In upholding the sanction, the Court said:

> The Panel's determination that the appellant lacked insight is reasonably supported by the record. The appellant's lack of insight and failure to accept responsibility distinguishes this case from other cases involving breaches of professional boundaries. The misconduct was serious. It was intentional and involved repeated intrusions into H.L.'s medical record which continued until the conduct was discovered, rather than being a momentary lapse. While the circumstances here are unique in the sense that they involve a family member's medical record accessed with good intentions and after-the-fact consent, the College's policy prohibiting this conduct is clear. The College's policy regarding professional boundaries is intended to prevent conflicts involving a nurse's personal and professional interests in order to ensure client safety.

The appeal involved a number of other legal issues that may be relevant to other regulators, including the following findings:

- There was no undue delay, especially when considering that significant portions of the delay were caused by the nurse of the nurse's representatives.
- Oral reasons recorded in a transcript can meet the requirement for giving reasons for hearing motions.
- Procedural fairness requirements during the investigation and screening stage are less than at the hearing stage and any deficiencies can often be cured by a fair discipline hearing.

This case shows that crossing boundaries and breaching privacy of client records can result in significant consequences, despite the best of intentions.

Publication of Remediation Direction does not make it a Penalty

The Ontario Divisional Court has again affirmed that the posting of remediation orders by the complaints screening committee does not make it a penalty: *Longman v. Ontario College of Pharmacists*, 2021 ONSC 1610 (CanLII), https://canlii.ca/t/jdqps. This reaffirms a similar conclusion in *Geris v. Ontario College of Pharmacists*, 2020 ONSC 7437 (CanLII), https://canlii.ca/t/jc4gk. In the *Longman* case, a pharmacist had participated in a series of errors resulting in the dispensing of a drug to a child who was not authorized by prescription to receive it. The Court held that the reasons given recognized the defence of contributing factors to the errors including an unusual prescription, a computer system not designed to handle complex prescriptions, that others at the pharmacy had also made mistakes contributing to the incorrect dispensing, and that the pharmacist was not the designated manager responsible for policies and procedures. A remedial order was still indicated. The Court said:

> The Applicant submits that the above decisions pre-date the 2017 change in the Code which requires that both cautions and required remediation programs be placed on the public record (ss. 23(2) 7 and 23(5)). He submits that change is sufficient to turn the remedial measures into a penalty or sanction. I disagree. The requirement of publication was implemented to provide transparency to the self regulation process. It was not intended to change the remedial purpose of a caution or required education. Nor has it. Given the ICRC's role, both cautions and educational requirements remain remedial and do not amount to a penalty or sanction.
>
> Nor in the circumstances are the remedial measures imposed by the ICRC unduly harsh. While the Applicant acknowledged his error in respect of the September 16, 2018 refill and expressed remorse concerning it, he failed to recognise his other errors as identified by the ICRC. The remedial measures imposed by the ICRC will benefit both the Applicant's practice and the public. They were neither an error in principle nor clearly unfit.

Public access to the decision does not mean that the remedial nature of the order is altered such that it requires enhanced procedural protections or closer scrutiny.

Court Directed Reconsideration Hearings

Regulators received some guidance on how to conduct re-hearings after being directed to do so by a court in: *Hanif v. College of Veterinarians of Ontario*, 2021 ONSC 1819 (CanLII), https://canlii.ca/t/jdpmt. In that case, the Court set aside one of the disciplinary findings and directed that the matter be returned to the "panel for a reconsideration" of penalty and costs. The matter was re-heard by the original panel (with one person unable to participate given the passage of time) which imposed a different penalty (a one month suspension and terms and conditions) and costs of $65,000. The practitioner appealed the re-hearing outcome. The Court held:

1. There was no appearance of bias in the same panel conducting the re-hearing. In fact, that is precisely what the Court had ordered.
2. The provisions allowing a lesser number of panelists to complete a hearing if a panel member was unable to continue with the hearing applies to the re-hearing proceedings.
3. It is improper for the practitioner to bring motions or raise issues related to the issue of finding as the finding is now final. In fact, there should be cost consequences to the practitioner for persistently doing so.

The Court also held that little weight should be placed on other cases in which supposedly similar conduct may not have been referred to discipline when assessing penalty. The Court said: "…the results of these Complaint Committee cases are simply not comparable to penalty decisions based on a finding of professional misconduct following a contested hearing".

Registration Hearings

For many regulators, registration is a two stage process. Often, there is a written decision or proposal followed by a right to a review of hearing. Where the second stage involves a hearing, is it confined to the issues raised in the written decision or proposal or is a fresh process in which both sides can introduce new issues and evidence?

In *Sbrissa v. Ontario Association of Architects*, 2021 ONSC 2087 (CanLII), https://canlii.ca/t/jdwmt, an architect whose licence had lapsed for non-payment of fees and lack of insurance sought to be given the authority to practice again. While given a licence, the regulator refused to issue a certificate of authorization that permitted them to practise independently. The notice of proposal related to the collapse of a portion of his building and his interactions with the City of Ottawa flowing from the collapse. At the hearing, additional concerns were raised about the applicant's persistent failure to pay fees and the applicant's interactions with regulatory staff.

The Court determined that the hearing was a fresh process that could consider additional issues. However, there had been procedural unfairness in that the applicant had not been notified of them before the hearing began. The Court suggested that the issues could have been considered if an amendment notice of proposal was issued in advance of the hearing. The matter was returned to the regulator.

Regulators should take care to include all concerns in any notice of proposals or reasons for decision that they issue in the first stage of their registration processes. If additional concerns are going to be relied upon, they should be conveyed in advance of the hearing to the applicant.

Reasonable and Probable Grounds

Most regulators must have reasonable and probable grounds in order to appoint an investigator to conduct a formal investigation. However, articulating the reasonable and probable grounds test is difficult. The Supreme Court of Canada has stated that reasonable and probable grounds as "at the point where credibly-based probability replaces suspicion": *Hunter et al. v. Southam Inc.*, [1984] 2 SCR 145, https://canlii.ca/t/1mgc1. Recently, the Ontario Court of Appeal has provided additional guidance in: *Qin v. Ontario Securities Commission*, 2021 ONCA 165 (CanLII), https://canlii.ca/t/jds7p.

Mr. Qin had been subject to an interim order, freezing his assets as the regulator investigated concerns that he and his companies were selling securities without registering under the legislation. Mr. Qin challenged the freeze order in court. In maintaining the freeze order, the court found that there was a serious issue to be heard about Mr. Qin's compliance with the legislation. When the matter was finally heard, the tribunal concluded that Mr. Qin and his companies were not selling securities. Mr. Qin then sued the regulator for malicious prosecution. The regulator brought a motion to dismiss the action on the basis that the earlier court had found there were reasonable and probable grounds for the investigation. If there were reasonable and probable grounds, the action could not succeed.

Thus, the Court of Appeal had to assess whether the earlier court finding that there was a serious issue to be heard was equivalent to the reasonable and probable grounds test. The Court stated that the serious issue to be heard test was a low hurdle and essentially screens out frivolous and vexatious case. The Court concluded that the reasonable and probable grounds test was qualitatively higher:

> The reasonable and probable cause standard invites scrutiny of the record to determine the likelihood or probability, at the time the proceedings were commenced, that the OSC could ultimately establish the allegations….
>
> [Reasonable and probable cause] … requires a determination of whether, objectively viewed, the facts known to the prosecution when it was undertaken, provided reasonable and probable cause to initiate the proceeding. This exercise engages an examination of all of the facts known to the prosecution when it initiated proceedings. Those facts include facts known to the prosecution which could exculpate the would-be targets of the prosecution. Further, as set out above, the totality of the facts known to the prosecution must be measured, not against the "serious issue to be tried" standard, but against the more demanding reasonable and probable cause standard.

This discussion provides a bit more information for regulators on what constitutes reasonable and probable grounds.

Joint Submission Was not "Unhinged"

The Divisional Court of Ontario has again emphasized the stringent nature of the public interest test that applies to discipline panels that consider rejecting a joint submission in the case of *Bradley v. Ontario College of Teachers*, 2021 ONSC 2303 (CanLII), https://canlii.ca/t/jdz7v. In the *Bradley* case, a teacher had agreed to a two-month suspension over the summer months for harassing comments and behaviour towards a colleague. The discipline panel moved the suspension period to the school year because it felt a summer suspension did not adequately recognize the seriousness of the conduct and provided insufficient deterrence. The Court restored the summer suspension that had been set out in the joint submission, saying:

> In this case, the Discipline Committee referred to the *Anthony-Cook* [2016 SCC 43 (CanLII), [2016] 2 SCR 204, https://canlii.ca/t/gv7bk] decision as the guiding authority on the issue of whether it could reject the joint submission on penalty, but it misunderstood the stringent nature of the public interest test and thereby misapplied it. In particular, the Discipline Committee did not find that or articulate any basis for finding that serving the two month penalty in the summer was so "unhinged from the circumstances of the offence and the offender that its acceptance would lead reasonable and informed persons, aware of all the relevant circumstances, including the importance of promoting certainty in resolution discussions, to believe that the proper functioning of the justice system had broken down".
>
> …
>
> Any disciplinary body that rejects a joint submission on penalty must apply the public interest test and must show why the proposed penalty is so "unhinged" from the circumstances of the case that it must be rejected. In this case, the Discipline Committee clearly misunderstood the stringent public interest test, and impermissibly replaced the proposed penalty with its own view of a more fit penalty.

The Court believed the discipline panel had "tinkered" with the joint submission, should not have sought more information in support of the joint submission, and should have shown more regard for the importance of joint submissions.

Prepared by Richard Steinecke

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Bonus Features

Ontario Bills

(www.ola.org)

Bill 283, *Advancing Oversight and Planning in Ontario's Health System Act, 2021* – *(Government Bill, second reading)* Bill 283 creates a regulatory body for personal support workers. It is not a College under the *Regulated Health Professions Act*, rather it is a delegated administrative authority that is less independent of the government. Board/Council members will not be elected by the profession. It is a registration-type scheme, meaning that it is voluntary for practitioners to register with the authority. However, registrants are able to indicate their registration status. It is possible that other new (or even existing) professions could be moved under the umbrella of this authority. It is not intended to be limited to one profession. In addition, physician assistants will be regulated by the College of Physicians and Surgeons of Ontario. Also, applied behaviour analysts will now be regulated under a successor College to the College of Psychologists of Ontario.

Bill 277, *Ministry of Health and Long-Term Care Amendment Act (Supporting Individuals in their Homes and Communities with Assistive Devices for Mental Health), 2021* – *(Private Member's Bill)* – Bill 277 "requires the Minister to ensure that the Assistive Devices Program, or any other similar program established to provide access to assistive devices to support individuals with health needs, includes assistive devices to support individuals with mental health needs and any related data plans required to connect those devices."

Bill 276, *Supporting Recovery and Competitiveness Act, 2021* – (Government Bill, passed first and second reading and referred to the Standing Committee on General Government) Bill 276 is an omnibus bill. Schedule 25 eliminates the Health Professions Regulatory Advisory Council. The amendments to the *Regulated Health Professions Act* and the profession-specific acts seem to have no additional impact other than the removal of the Council. In addition, Schedule 27 adds a new section 29 to the *Statutory Powers Procedure Act* that empowers hearing tribunals, like discipline committees, to make orders preventing the recording and dissemination of recordings and pictures of hearings, such as virtually held hearings.

Bill 269*, Protecting the People of Ontario Act (Budget Measures), 2021* – *(Government Bill, passed third reading and received Royal Assent)* Bill 269 reforms the archaic structure of the Ontario Securities Commission by separating the offices of the Chair of the Commission from that of the CEO and separating the Commission, which acts as its board of directors, from the tribunal that will now hear enforcement matters.

Proclamations

(www.ontario.ca/search/ontario-gazette)

There were no relevant proclamations this month.

Regulations

(https://www.ontario.ca/laws Source Law - Regulations as Filed)

Reopening Ontario (A Flexible Response to COVID-19) Act – The regulation permits a health care practitioner to provide services in a hospital outside of their scope of practice at the direction of the hospital. They will not be accountable under the *Regulated Health Professions Act* for doing so for anything other than incompetence (i.e., it is not professional misconduct). Such activities are not constrained by policies either. In addition, practitioners who are registered outside of the province can provide services in a hospital setting without becoming registered in Ontario. (Ontario Regulation 305/21, Filed April 21, 2021)

Emergency Management and Civil Protection Act **and the** ***Reopening Ontario (A Flexible Response to COVID-19) Act*** – Numerous regulations were made relating to the management of the pandemic. Most relate to the nature of restrictions. Of course the major one was the stay at home order issued on April 7, 2021. Other regulations provide that fully immunized persons can now work in more than one retirement or long-term care homes. There are also a number of provisions relating to work re-deployment of health care providers in hospitals and other settings. One regulation also provides for the transfer of hospital patients to a long-term care home or retirement home without consent.

Proposed Regulations Registry
(www.ontariocanada.com/registry/)

Regulated Health Professions Act – Even as Bill 276 speeds through the Legislature, abolishing the Health Professions Regulatory Advisory Council, there is a consultation on the proposal. The consultation notes that the Minister can still obtain advice through less formal advisory bodies. Comments are due by May 30, 2021. This initiative seems to be part of a pattern as there is current legislation and consultations to eliminate the Citizens' Council and the Pharmacy Council under the *Ontario Drug Benefit Act*.

Bonus Features
Many of these items will appear in our blog:
(www.sml-law.com/blog-regulation-pro/)

Honest, Open and Helpful

Regulators conducting investigations sometimes face situations in which practitioners respond to requests for information with questions of "clarification", challenges to the relevance or necessity of the information, and explanations for why it is difficult for the practitioner to obtain the information. Do such non-substantive responses amount to a failure to cooperate?

In *Law Society of Ontario v. Diamond*, 2021 ONCA 255 (CanLII), https://canlii.ca/t/jfhjh, the Court of Appeal dealt with a disciplinary finding of failure to cooperate in circumstances where the practitioner provided all of the requested information many months after the initial request. The Court held that a failure to cooperate finding should be based on the following considerations:

> … the following considerations emerge from these decisions: (a) all of the circumstances must be taken into account in determining whether a licensee has acted responsibly and in good faith to respond promptly and completely to the Law Society's inquiries; (b) good faith requires the licensee to be honest, open, and helpful to the Law Society; (c) good faith is more than an absence of bad faith; and (d) a licensee's uninformed ignorance of their record-keeping obligations cannot constitute a "good faith explanation" of the basis for the delay.

The Court held that the regulator did not have to establish an outright, subjective, "refusal to cooperate" for a finding of failing to cooperate.

> The reputation of the legal profession rests on the public's confidence that self-regulation is taken seriously by the legal profession. This can only occur where the legal profession has at hand effective and efficient tools by which to achieve accountability among its members. This is fundamental to the health and vibrancy of the legal profession.

The Court upheld the finding based on the panel's findings that the practitioner was playing a "cat and mouse game" with the regulator before finally complying.

For more information on this important decision see: https://www.sml-law.com/resources/grey-areas/recent-issues/.

"This is a helluva way to run a railroad"

Giving full deference to the enormous challenges in managing a once-in-a-century pandemic, one still has to wonder sometimes. The above quote, from 1906, might apply to managing a health care system as well as railroads. On April 20, 2021, without prior notice to key stakeholders, the Chief Medical Officer of Health (CMOH) issued a replacement Medical Directive #2 addressed to "Health Care Providers (Regulated Health Professionals or Persons who operate a Group Practice of Regulated Health Professionals)". Thus, the Directive appeared to be aimed at health practitioners generally, not the hospital sector. The Directive stated: "The following steps are required immediately: All non-emergent and non-urgent surgeries and procedures should be ceased." In the fine print, there was a disclaimer about the provision of other health services but that disclaimer was unclear. The most reasonable reading of the document as a whole was that it was directed at limiting exposure to COVID by drastically reducing the provision of health services in the community. The Directive can be found at:
https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/RHPA_professionals.pdf.

Regulators of health care practitioners were blindsided. Most posted the Directive on their website immediately (as is their custom to support the CMOH during the pandemic), but offered no commentary. Instead, urgent calls were placed to the authorities in an attempt to understand the intent and meaning of the Directive. Were health care practitioners who do not provide non-urgent services to cease all services immediately? Word drifted back from helpful Ministry of Health contacts that the Directive did not really mean what it appeared to say.

Three days later, Ministry of Health officials issued a Question and Answer document stating that "procedures" meant something that "requires surgical nursing support or anaesthetist support or carries a risk of resulting in the use of emergency medical services or other hospital services due to serious intra-operative or post-operative complications." See: https://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/directives/Directive_2_QA.pdf. In other words, the Directive was about conserving hospital resources. Procedures that were unlikely to require use of hospital resources were not restricted.

This unnecessary panic of regulatory partners could have been avoided by a better initial communication rather than sending confusing messages to those trying their best to support the orderly provision of health services during this pandemic.

Deference to Sanction Findings

The Ontario Divisional Court continues to show deference to sanctions (or penalties) imposed by regulators. In *1855456 Ontario In. v. Registrar, Motor Vehicle Dealers Act*, 2002, 2021 ONSC 2905 (CanLII), https://canlii.ca/t/jfg85 the Court dealt with a revocation of registration related to the sale of two vehicles where there were concerns about the accuracy of representations made to the consumers and about the safety of the vehicles.

The Court held that the decision on sanction would stand unless palpable and overriding error was shown. The Court described the degree of deference as follows:

> On the question of penalty, it is well established that in order to overturn a penalty imposed by a regulatory tribunal, it must be shown that the decision-maker made an error in principle or that the penalty was "clearly unfit": *Mitelman v. College of Veterinarians of Ontario*, 2020 ONSC 3039 at para. 18.
>
> Courts in the criminal context have used a variety of expressions to describe a sentence that reaches this threshold, including "demonstrably unfit", "clearly unreasonable", "clearly or manifestly excessive", "clearly excessive or inadequate" or representing a "substantial and marked departure" from penalties in similar cases. This high threshold applies equally in the administrative law context. To be clearly unfit, the penalty must be disproportionate or fall outside the range of penalties for similar offences in similar circumstances. A fit penalty is guided by an assessment of the facts of the particular case and the penalties imposed in other cases involving similar infractions and circumstances, *College of Physicians and Surgeons of Ontario v. Peirovy*, 2018 ONCA 420 at para. 56.

The registrant's main argument was that revocation was excessive given their previous clean record. The Court noted that this consideration was considered by the tribunal "but [it] nevertheless concluded that the two proven breaches involved sufficiently serious misconduct as to warrant revocation".

The fact that the tribunal addressed that argument, albeit briefly, in its reasons assisted the Court in upholding the decision.

Permission for Vexatious Litigants to Commence another Action

As courts become more assertive in restricting vexatious litigants, a new form of legal proceeding is emerging. A court order restraining vexatious litigants typically requires the litigant to obtain permission to commence any further actions. Often that permission needs to be obtained without involving those proposed to be sued, presumably to spare them the further aggravation. Courts are now exploring how it will evaluate such requests from vexatious litigants.

Some guidance has been provided in *Yashcheshen v Law Society of Saskatchewan*, 2021 SKQB 110 (CanLII), https://canlii.ca/t/jfkj4. The litigant had commenced numerous proceedings against the regulator for failing to accommodate her medical disability in the registration process. One of her claims was that the regulator had failed to provide "an alternative to the law school component for admissions to the [admissions process] for persons who cannot obtain a law degree, due to a medical disability".

The Court said that the litigant had to demonstrate two things in order to obtain permission to commence the new proceeding: "An applicant must establish the proposed proceedings are not an abuse of process [citation omitted] and must establish there are reasonable grounds for the proceedings [citation omitted]."

The Court concluded that the proposed proceeding attempted to raise, yet again, arguments that had previously been dismissed by the courts. The Court also concluded that there were no reasonable grounds for proceeding. The causes of actions would not succeed.

It will be rare for vexatious litigants to obtain permission to commence a new action unless it is unrelated to the previous litigation and there is a reasonable prospect of establishing their claim.

Virtual Mischief

While the possibility of taking advantage of opportunities for misbehaviour in virtual proceedings exists, the courts have indicated that they will be dealt with severely. One of the concerns about witnesses testifying virtually is that other people might be present who can influence their testimony. It is for that reason that witnesses are often asked if anyone else is present in the room when they testify.

In *Kaushal v. Vasudeva et al.*, 2021 ONSC 440 (CanLII), https://canlii.ca/t/jcr9v, a party in a civil action was cross-examined on their affidavit in the boardroom of their lawyer. The witness and the lawyer both stated that no one else (other than an interpreter) were present. After the examination was over, it appeared that the virtual computer program was left running. The examining party heard conversation that suggested that the witness's family had also been present during the examination. The interpreter eventually indicated that the family members had been present and had provided assistance to the witness in answering the questions during the examination. While the suggestion was made that the interpreter had been intimidated to providing that information, the witness's lawyer and family members never gave evidence to support the suggestion or to deny that unauthorized persons were in the room. The Court concluded that the family members had been present in the room, contrary to the assurance of the witnesses and legal counsel, that they had provided assistance to the witness during the examination and that the interpreter had not been intimidated to provide false evidence.

The Court concluded that there had not only been interference with the witness, but that there had been a serious abuse of process. The Court struck out not only the evidence provided during the cross-examination, but also the original affidavit. The order likely ended the proceeding.

While this kind of behaviour in a virtual hearing is unlikely to occur frequently, it is reassuring that strong remedies will be imposed. This case forms a precedent for regulators conducting virtual hearings.

College of Naturopaths of Ontario

Per Diem & Expense Claims:

Submission and Processing Handbook

Effective June 1, 2021.

Table of Contents

INTRODUCTION

The College of Naturopaths of Ontario (the College) has instituted a new process for the submission and processing of volunteer claims for per diems and expenses. This handbook has been developed for both volunteers and staff to use to assist in submitting, reviewing and processing of these claims, and to ensure that everyone is aware of what happens at each step.

This handbook and claims process is applicable to Registrants who are appointed to the Council and its Committees, Registrants who are appointed to fulfill in-field roles[1] or Operational Committees and Public Representatives appointed to Council Committees or Operational Committees.

Government appointed Public members will continue to be required to submit their claims to the Health Board Secretariat (HBS) as per the established HBS process.

ACCOUNT SET-UP

All new Council and College-appointed volunteers, including those assigned to Committees and in-field positions are required to complete the following two forms for personal tax credits:

- TD ON Form (current year)
- TD1 Form (current year)

These are available from the Director of Operations of the College and must be completed and returned, along with either a VOID cheque or Account Information from their financial institution to which they would like monies deposited to, before any payment can be made.

A new account creation may take up to five business days to be processed in the College's payroll system. Simultaneously, a new account will be created for the volunteer in Smartsheet for submissions.

SUBMITTING A CLAIM

All Council and College-appointed volunteers, including those assigned to Committees and in-field positions are required to use the new on-line claims submission process outlined in this handbook. Volunteers will no longer be permitted to e-mail or fax their submissions to the College.

To submit a claim, volunteers must first complete an updated Per Diem and Expense Claim form, a copy of which is illustrated as Appendix 1, and will be e-mailed to you. Once completed, the form, along with PDF copies of all necessary receipts, should be saved locally and produced in PDF format.

[1] In-field refers to those volunteers who attend to activities outside of the College, such as examiners, assessors, and inspectors.

For those who are able to, the PDF documents can be merged into a single PDF, although this is not necessary for the processing of the claim. To assist with this process there is a downloadable "app" to your phone (https://acrobat.adobe.com/ca/en/mobile/scanner-app.html). This will allow for you to take a picture of the document, convert it to a PDF and then you will be able to e-mail it to yourself directly from your phone. Volunteers then use the on-line "Volunteer Per Diem and Expense Claims Processing" form and provide the following information:

- Your name, selected from a drop-down menu of contacts. *If your name does not appear, please contact the College staff support person associated with your role to have this information added.*
- Your volunteer role, also selected from a drop-down menu. Please note that some of the items selected will add new field(s) to the form. These may include:
    - Committee member[2],
    - Expert, or
    - Presiding Officer.
- Nature of the Claim, that is, what items are being claimed for reimbursement, selecting as many that apply.
- Claim Upload, this is where you will upload your Expense Claim Form and receipts in PDF.

One form is to be used for each Committee or volunteer role performed, do not combine multiple Committees on one form.

The on-line form that you are completing is a dynamic form that will add fields depending on what you select in the top section. For example, if you enter "Examiner" as the role you are submitting the claim for, specific fields will appear under the Review and Approvals section. If you make a mistake, you can "refresh" your screen to start the submission process over. Once all information is correct, click on submit.

REVIEW PROCESS

The College uses a multipart review process to ensure the accuracy of claims. This process includes those individuals responsible in the program for your role, typically a Coordinator, as well as the Manager or Director responsible for the program area. Once approvals are provided, the Finance Department will review the claim as it is entered into the payroll system and finally, the Director of Operations will audit the claim to ensure that the claim is accurate, and the payment amounts are correct.

Processing and Approval of Claims

Step 1: Initial review

The initial reviewer is the staff support person who works closest with the volunteer (the "claimant") in the role that was performed and for which the claim is being processed. The request for a review is

[2] If you have sat on a Panel of the Discipline or Fitness to Practice Committees, you select Committee member in this field, followed by a Panel member in the next field.

received by an e-mail from "Andrew Parr via Smartsheet (automation@smartsheet.com)" and a link is provided to review the submission. The link opens in a web browser at the bottom of which are two buttons, one for Approved and a second for Approved with Changes.

At this stage, the reviewer is ensuring the following elements of the claim.

- Are the number of days/hours for which a per diem is claimed correct? This ensures that the person is paid the amount that they are owed and that when a person inadvertently claims a preparation day for which they are not entitled, that is corrected.
- Are any claims for meals in keeping with the College's submission rules?
- Are any expenses, such as travel and accommodation supported by receipts where necessary?
- Do the per diem and expenses add up to the amount being claimed?

There are three possible outcomes from this initial review, only one of which can be selected.

1. **Approved**. No changes are required and the claim is approved as it is, in which case the reviewer:
    a. Edits the PDF and adds the accounting codes for the claim, saves the PDF and uploads it back to the approval system in their web browser, and
    b. Clicks on "approved" and the claim is forwarded to the manager or director for second approval.
2. **Approved with changes**. The claim may be approved but changes are required. The initial reviewer will:
    a. Edit the PDF making any necessary changes and adding the accounting codes for the claim;
    b. Add in the comments section on the approval system web browser a summary of the changes being made to the form, saves the PDF and uploads it back to the approval system in their web browser;
    c. Click on "approved with changes" which moves the claim forward to the manager or director for approval; and
    d. Notify the claimant by e-mail of the nature of the changes that have been made. This allows the claimant to call the reviewer to clarify if they have concerns.
3. **Rejected**: Claim rejections are limited to a) the absence of receipts where they are needed, b) the absence of an actual claim form, or c) having more than one activity on any given claim form. To reject a claim, the initial reviewer shall close the web browser without clicking either the Approved or Approved with Changes button and will notify accounting@collegeofnaturopaths.on.ca that the claim has been rejected. The initial reviewer must then e-mail the claimant to notify them that the claim cannot be processed and advise on correcting the issue and the need to resubmit the claim electronically.

Step 2: Second Review and Approval

The second review/approval is completed by the manager or director responsible for the program area. The request for a review is received by an e-mail from "Andrew Parr via Smartsheet (automation@smartsheet.com)" and a link is provided to review the submission. The link opens in a

web browser at the bottom of which are two buttons, one for Approved and a second for Approved with Changes.

At this stage, the reviewer is confirming the following elements of the claim.

- The number of days for which a per diem is claimed correct? This ensures that the person is paid the amount that they are owed and that when a person inadvertently claims a preparation day for which they are not entitled, that is corrected.
- Any claims for meals in keeping with the College's submission rules?
- Are any expenses, such as travel and accommodation are supported by receipts where necessary?
- Do the per diem and expenses add up to the amount being claimed?
- Are the accounting codes added by the Initial Reviewer the correct ones?

As with the initial review, there are three possible outcomes from the second review.

1. **Approved**. The claim is approved as is, in which case the reviewer clicks on "approved" and the claim is forwarded to the Finance Department for processing and payment.
2. **Approved with changes**: The claim may be approved but changes are required. The second reviewer will
    a. Edit the PDF making any necessary changes (including changes to the accounting codes for the claim if that is necessary);
    b. Add in the comments section on the approval system a summary of the changes being made to the form, saves the PDF and uploads it back to the approval system in their web browser, if any additional changes have been made;
    c. Click on "approved with changes" which moves the claim forward to the Finance Department; and
    d. Notify the claimant by e-mail of the nature of the changes that have been made. This allows the claimant to contact the reviewer to clarify if they have concerns.
3. **Rejected**. Claim rejections are limited to a) the absence of receipts where they are needed, b) the absence of an actual claim form, or c) having more than one activity on any given claim form. To reject a claim, the reviewer shall close the web browser without clicking either the Approved or Approved with changes button and notify accounting@collegeofnaturopaths.on.ca that claim has been rejected. The manager or director must then e-mail the claimant to notify them that the claim cannot be processed and advise on correcting the issue and the need to resubmit the claim electronically.

Step 3: Claims Processing

At this stage, the Finance Department will enter all claims into the College's payroll system. In so doing all claims are grouped by volunteer. As a volunteer, this means that if you have submitted several claims in a period, payment is made one time for all claims. Volunteers can see the number of claims processed in any payroll period by looking at the "Hours/Units" portion of their ADP pay stub[3].

[3] This is accessible on-line. If you do not have access, please contact accounting@collegeofnaturopaths.on.ca.

Step 4: Audit

At this stage, the Director of Operations (or their delegate) is checking all the work completed in the earlier steps and ensuring that the payroll has been entered correctly. Once they have confirmed, they check off the audit complete form and enter the date that the payroll is to be completed, i.e. pay day.

As soon as that date is entered, the system will send the volunteer a notification that the claim has been completed and the date the payroll will be completed, and the funds transferred to their bank account. If these funds are not received, volunteers are invited to contact accounting@collegeofnaturopaths.on.ca for follow up.

The Director of Operations will also be responsible for identifying any claims that have been submitted that have not been processed in a timely manner and will alert the staff to take action.

PAYMENT OF CLAIMS

All claims are paid by the College via its payroll system, ADP. All claims are subject to Canada Pension Plan deductions as required by Canada Revenue Agency.

Claims are paid in accordance with the College's payroll cycle, which occurs on either the 15th or last day of each month. To be paid on either of these dates, claims must have been received a minimum of five days prior, that is, either the 10th or the 25th of each month; however, the College endeavours to process claims as quickly as possible.

ACCOUNT CHANGES

For any changes to your:

- Name,
- Address,
- SIN #, and/or
- Banking Information.

Please forward any changes to accounting@collegeofnaturopaths.on.ca. The College's payroll system and applicable Smartsheet will be updated accordingly.

NEXT STEPS

To make this new system work effectively, there are several things that should be done.

Volunteers

Please ensure that you have the most up-to-date claims form and that you can print to PDF and scan to

PDF your receipts.

It is also important that you "whitelist" the e-mail address "Andrew Parr via Smartsheet (automation@smartsheet.com)". You may not be able to do this until you receive your first automated notice. We recommend you check your junk or spam folder until the first message comes in and use that message to mark as "never block sender's domain" as that will allow all Smartsheet messages to be received.

Staff

Please review the guidelines and the rules surrounding claims processing. Please act on the notices that you receive as quickly as possible.

Everyone is invited to review the notifications embedded in the system so that you know what you are looking for. They are set out in Appendix 2.

KEY CONTACTS

The following are your key contacts in the administration of the claims processing system.

General Accounting E-mail Address
accounting@collegeofnaturopaths.on.ca

Monika Zingaro
Administrative Assistant – Operations
416.583.6015
monika.zingaro@collegeofnaturopaths.on.ca

Syed Mehdi
Finance & Administrative Officer
416.583.5995
syed.mehdi@collegeofnaturopaths.on.ca

Agnes Kupny
Director of Operations
416.583.6005
agnes.kupny@collegeofnaturopaths.on.ca

Andrew Parr
Chief Executive Officer
416.583.6013
ceo@collegeofnaturopaths.on.ca

Version 1: May 5, 2021

APPENDIX 1: VOLUNTEER CLAIM FORM

Name: _____

Phone Number: _____

Committee Name: _____

Submission Date: _____

The College of Naturopaths of Ontario

VOLUNTEER EXPENSE CLAIM

1 - Do not use shaded columns.
2 - Attach a scanned copy of original receipts to expense statement.
3 - Note maximum allowances for per diem and expenses per GP18 Honoraria and Expense Policy
4 - No alcohol may be claimed.
5 - Please submit one expense form per meeting/activity.
6 - Please complete expense statement electronically and add your electrconic signature or check the box below

Submit Per Diem and Expenses via Smartsheet

Date	Account Code	Description	Per Diem	Meal B/L/D	Meal $ (No Tax)	KM #	KM $ (No Tax)	Other Exp ($, No Tax)	SubTotal	HST	Total
		PER DIEM									
		Preparation Time									
		Meeting									
		Meeting									
		EXPENSES									
										Sub Total:	

Notes

In submitting the claim, I agree that it is an accurate reflection of my time provided and expenses incurred.

☐ *Check this box if you are completing this form electroncially. By checking this box you are signing this form.*

TOTAL:

Signature: _____ **Date:** _____

If you do not presently have this claim form, please contact your staff liaison for Committee or volunteer role and one will be e-mailed to you. This form was updated in May 2021.

APPENDIX 2: NOTIFICATIONS

In order to provide everyone with enough information, the following are the various notices sent out by the automated system.

Notification on Submission (N1)

Upon submission, the screen will refresh to allow you to enter additional claims, however, at the top of the webpage, you will see a message that says "Success! We've captured your Per diem and Expense Claim."

Notification to First Reviewer (N2)

> Subject: Per Diem and Expense Claim - Initial Review
>
> A per diem and expense claim has been submitted for one of your areas of responsibility. You have been identified as the first reviewer. Your role is to review the claim and review it for accuracy by:
>
> - Checking the dates on the claim.
> - The per diem claimed.
> - Confirming eligibility of any expenses.
> - Ensuring receipts are attached to the claim.
>
> Your choices in response to this are as follows:
>
> - Approve the claim – it will be sent to the manager or director of the program for final approval before being submitted for payment.
> - Approve the claim "with changes" - it will be sent to the manager or director of the program for final approval before being submitted for payment; however, the claimant will be notified that you made changes and the comments you submit will be forwarded. Please be clear, precise and concise with your comments.
> - Reject the Claim (Take no Action in Smartsheet) – if the claim is incorrect to the point that it cannot be amended, or if receipts are not provided, take no action in Smartsheet. E-mail the claimant directly asking that they resubmit the claim with all errors corrected. Copy Monika Zingaro on your e-mail and she will void the claim in Smartsheet.

Notification to Volunteer – Approved

No notification is provided to the volunteer if the claim is approved.

Notification to Volunteer – Approved with Changes (N3)

Subject: Changes made to your Per Diem and Expense Claim

> Dear Volunteer,
>
> Your per diem and expense claim that you submitted has been approved with changes. The changes made to it will be outlined in an e-mail you will receive from the first reviewer.

If you are unclear as to why these changes have been made, or you feel that they have been made in error, please do not hesitate to contact the "first reviewer" notified below.

This claim is continuing in our approval process and has been sent to the manager or director responsible for the program area. You may wish to copy them on any e-mail you send to the first reviewer.

Notification to Second Reviewer – Approved or Approved with Changes (N4)

Subject: Per Diem and Expense Claim Final Review

A per diem and expense claim has been submitted for one of your areas of responsibility. You have been identified as the final reviewer. Your role is to review the claim and review it for accuracy by:

- Checking the dates on the claim.
- The per diem claimed.
- Confirming eligibility of any expenses.
- Ensuring receipts are attached to the claim.

Your choices in response to this are as follows:

- Approve the claim – it will be sent to the Finance Department for payment.
- Approve the claim "with changes" - it will be sent to the Finance Department for payment; however, the claimant will be notified that you made changes and the comments you submit will be forwarded. Please be clear, precise and concise with your comments.
- Reject the Claim (Take no Action in Smartsheet) – if the claim is incorrect to the point that it cannot be amended, or if receipts are not provided, take no action in Smartsheet. E-mail the claimant directly asking that they resubmit the claim with all errors corrected. Copy Monika Zingaro on your e-mail and she will void the claim in Smartsheet.

Notice to Volunteer – Approved with Changes (N5)

Subject: Changes made to your Per Diem and Expense Claim

Dear Volunteer,

Your per diem and expense claim that you submitted has been approved with changes. The changes made to it will be outlined in an e-mail you will receive from the second reviewer.

If you are unclear as to why these changes have been made, or you feel that they have been made in error, please do not hesitate to contact the "second reviewer" identified below.

This claim is continuing in our approval process and has been sent to the Finance Department for payment. You may wish to copy them on any e-mail you send to the second reviewer.

Notification to Volunteer – Approved

No notification is provided to the volunteer if the claim is approved.

Notice to Finance Department – Approved or Approved with Changes (N6)

Subject: Expense Per Diem and Expense Claim Approved

This is an automated notice that a per diem and expense claim from a volunteer has been approved for payment processing. You do not need to take any immediate action; however, this will alert you that when you process payroll, there are claims to be processed.

Notice to Volunteer upon Audit Completion (N7)

Subject: Per Diem and Expense Claim payment

Dear Volunteer,

This message is to alert you that your per diem and expense claim(s) identified below have been entered into the Colleges payroll system. The payroll date is listed below. On that date, you can anticipate that the funds will be deposited into your account.

Agnes Kupny
Director of Operations

Understanding the Public Interest

In carrying out its objects, the College has a duty to serve and protect the public interest (section 3(3) of the Regulated Health Professions Act, 1991 (RHPA).

The term "public interest" is not defined in any legislation or regulation. What is the public interest?

- It is first and foremost a concept.
- It is contextual, the circumstances of decision-making help determine what it is.
- It is an unbiased concern for society.
- Places the benefit to the whole ahead of the benefit to a group, a few, or any one person.

Serving the public interest means ensuring the following.

- The public has access to professions of choice.
- Individuals are treated with sensitivity and respect.
- There are appropriate standards for the profession.
- There are ethical, safe, competent professionals and services.
- The patient interest is placed over professional interest.
- The principle-driven governance and operations are fair, objective, transparent and accountable.

The public interest is also about public protection and safety. Protecting the public from:

- Harm (physical, psychological, financial).
- Dishonesty and disrespect.
- Poor quality care.
- Sexual abuse.
- Breach of laws.
- Ineffective or unnecessary care.

In its deliberations, Council and Committees should consider the following factors.

- Is the decision fair to all parties?
- Is the decision objective, e.g. evidence-based?
- Is the decision impartial, e.g. made without bias?
- Is the decision transparent, e.g. are all of the relevant considerations clearly articulated and in the public domain?

Considerations/Questions to ask oneself during deliberations include:

- Does the matter relate to the College's statutory objects (section 3(1) of the Code)?
- Does the decision further one of the College's four regulatory activities?
- Is the decision being done transparently?
- Who is the primary beneficiary of the initiative?
- Would this better fit into another's mandate (e.g. the educators, the associations)?
- Who would be unhappy with the initiative and why?

- How would it look on the front page of (any local or national newspaper) or on the evening newscast?
- How would our accountability bodies (e.g. the Government of Ontario, Office of the Fairness Commissioner, Health Professions Appeal Review Board) respond?
- Is our decision consistent with the mandate of the College (e.g. to ensure that Ontarians who wish to receive naturopathic services have access to individuals who have the knowledge, skill and judgment to practice safely, ethically and competently) and with other recent similar decisions.

What the public interest is NOT!

- Advancing the profession's self-interest (e.g. increasing fees charged by or earnings of the profession by limiting the number of members through creating barriers to access to the profession, or by expanding the scope of practice of the profession).
- Advancing personal interests of Council members (e.g. getting good PR in the profession in a re-election year).
- Advancing the interests of a small group of patients who feel that the general health care system is not serving them sufficiently (e.g. patients advocating for expanded scope for illness-specific purposes).

UNDERSTANDING THE RISK ANALYSIS TERMINOLOGY

The risk analysis provided to Council as part of its briefing process is becoming more sophisticated. New terminology will begin to be introduced that may be unfamiliar to many Council members and stakeholders. The table below provides information to allow a reader to interpret the information being provided.

RISK CATEGORY	Risk Type	Type Description	Indicators
HAZARD	People	Loss of key people.	Sudden and unforeseen loss of CEO or senior staff due to resignation, retirement, death or illness.
	Property	Damage or destruction.	Property damage due to fire, weather event, earthquake etc.
	Liability	Claims, and cost of defense claims.	Cost of defending a liability claim or awards paid due to a liability claim.
	Net Income Loss	Net Income loss from hazards.	Loss of Net Income (after expenses) from any of the above noted hazard risks.
OPERATIONAL	People	Risks from people selected to run an organization.	Education, professional experience, staffing levels, employee surveys, customer surveys, compensation and experience benchmarking, incentives, authority levels, and management experience.
	Process	Procedures and practices of an organization.	Quality scorecards, analysis of errors, areas of increased activity or volume, review of outcomes, internal and external review, identification of high-risk areas, and quality of internal audit procedures.
	Systems	Technology or equipment owned by an organization.	Benchmark against industry standards, internal and external review, and analysis to determine stress points and weaknesses.
	External Events	Failure of others external to an organization.	Suppliers unable to provide or deliver supplies, or consultants unable to complete projects on time or on budget.

FINANCIAL	Market risk	Currency price, interest rates, commodity price, equity price, and liquidity risk.	Interest rates, savings, and return on investments.
	Credit risk	Risk of people in an organization lent money to defaulting.	If the College were to lend money or credit to Registrants, the risk of defaulting.
	Price risk	Risk of prices of an organization's products or services, price of assets bought or sold by an organization.	Price increases of supplies, consultants, and personnel.
STRATEGIC (external to an organization)	Economic environment	GDP changes, inflation, financial crises, and international trade.	GDP, CPI, and Interest rates.
	Demographics	Changing landscape of people, i.e., aging.	Aging population, lower birth rates.
	Political	Changes in the politics where an organization operates.	Changes in government or government policy, locally, regionally, or nationally.
	Reputation	Damage to the reputation of the organization based on decisions taken or perils encountered.	Confidence and trust of stakeholders, the public, and Registrants.

UNDERSTANDING THE COLLEGE'S COMMITMENT TO TRANSPARENCY

To help protect the public, the College and its Council are committed to transparency. This means providing Ontarians with the tools to make informed decisions, and ensuring that our own decision-making processes are easily understood.

The College and its Council have adopted the Transparency Principles developed by the Advisory Group for Regulatory Excellence (AGRE), a working group of health regulators, as the framework for its decisions.

The following table summarizes the transparency principles adopted by the Council.

Principle	Description
Information to foster trust.	The mandate of regulators is public protection and safety. The public needs access to appropriate information in order to trust that this system of self-regulation works effectively.
Improved patient choice and accountability.	Providing more information to the public has benefits, including improved patient choice and increased accountability for regulators.
Relevant, credible, and accurate information.	Any information provided should enhance the public's ability to make decisions or hold the regulator accountable. This information needs to be relevant, credible, and accurate.
Timely, accessible and contextual.	In order for information to be helpful to the public, it must be; a) timely, easy to find, understandable and, b) include context and explanation.
Confidentiality when it leads to better outcomes.	Certain regulatory processes intended to improve competence may lead to better outcomes for the public if they happen confidentially.
Balance.	Transparency discussions should balance the principles of public protection and accountability, with fairness and privacy.
Greater risk, greater transparency.	The greater the potential risk to the public, the more important transparency becomes.
Consistent approaches.	Information available from Colleges about Registrants and processes should be similar.

The College of Naturopaths of Ontario

Conflict of Interest
Summary of Council Members Declarations 2021-2022

Each year, the Council members are required to complete an annual Conflict of Interest Declaration that identify where real or perceived conflicts of interest may arise.

As set out in the College by-laws, a conflict of interest is:

> ***16.01 Definition***
> For the purposes of this article, a conflict of interest exists where a reasonable person would conclude that a Council or Committee member's personal or financial interest may affect their judgment or the discharge of their duties to the College. A conflict of interest may be real or perceived, actual or potential, and direct or indirect.

Using an Annual Declaration Form, the College canvasses Council members about the potential for conflict in four areas:

Based on positions to which they are elected or appointed;
Based on interests or entities that they own or possess;
Based on interests from which they receive financial compensation or benefit;
Based on any existing relationships that could compromise their judgement or decision-making.

The following potential conflicts have been declared by the Council members for the period April 1, 2021 to March 31, 2022.

Elected or Appointed Positions

Council Member	Interest	Explanation
None		

Interests or Entities Owned

Council Member	Interest	Explanation
Dr. Brenda Lessard-Rhead, ND (Inactive)	Partner, BRB CE Group	BRB CE Group provides continuing education courses for NDs through in-person conferences and on-line webinars and records. The College requires NDs to take continuing education courses and approved courses for credits.

Interests from which they receive Financial Compensation

Council Member	Interest	Explanation
Dr. Kim Bretz, ND	CCNM, Designs for Health, New Roots Herbal (Europe only), and Cytomatrix/Canprev – fee for speaking events	Paid on a per engagementbasis.
Dr. Shelley Burns, ND	Robert Schad Naturopathic Clinic (at CCNM) – PT Faculty	Provides supervision to students of CCNM at theclinic.

Existing Relationships

Council Member	Interest	Explanation
None		

Council Members

The following is a list of Council members for the 2021-22 year and the date the took office for this program year[1], the date they filed their Annual Conflict of Interest Declaration form and whether any conflict of interest declarations were made.

Council Member	Date Assumed Office	Date Declaration Received	Any Declarations Made
Asifa Baig	May 26, 2021		
Dr. Jonathan Beatty, ND	May 26, 2021	May 6, 2021	None
Dr. Kim Bretz, ND	May 26, 2021	April 20, 2021	Yes
Dr. Shelley Burns, ND	May 26, 2021	April 24, 2021	Yes
Dean Catherwood	May 26, 2021	May 17, 2021	None
Brook Dyson	May 26, 2021	May 10, 2021	None
Lisa Fenton	May 26, 2021	May 17, 2021	None

[1] Each year, the Council begins anew in May at its first Council meeting. This date will typically be the date of the first Council meeting in the cycle unless the individual was elected or appointed .

Sarah Griffiths-Savolaine	May 26, 2021	May 13, 2021	None
Dr. Brenda Lessard-Rhead, ND (Inactive)	May 26, 2021	March 31, 2021	Yes
Dr. Jennifer Lococo, ND	May 26, 2021	May 18, 2021	None
Dr. Jacob Scheer, ND	May 26, 2021		
Dr. Jordan Sokoloski, ND	May 26, 2021	May 5, 2021	None
Dr. George Tardik, ND	May 26, 2021	May 18, 2021	None

A copy of each Council members' Annual Declaration Form is available on the College's website.

Updated: May 18, 2021

Report from the Council Chair

This is the Chair's Report (previously known as the President's Report) of the current Council cycle and provides information for the period March 1, 2021 to April 30, 2021.

With an increase in COVID-19 cases and hospitalizations, the College received more information from the Ministry of Health through the new directives directed at all Regulated Health Professions focused on redeployment of health care professionals. This led to continued regular communication with the CEO, as staff tried to interpret and adapt to any new changes that would affect the profession.

We are also in the process of moving through the CEO Performance Evaluation, which is being led by Professional Member, Dr. Brenda Lessard-Rhead, ND (inactive), with a meeting being held on May 14, 2021.

While there remains considerable uncertainty for the future work at the College has continued to be high, I am impressed by the hard work and dedication coming from the staff and our large group of volunteers and Committee Members.

Dr. Kim Bretz, ND
Council Chair
May 2021

The College of Naturopaths of Ontario

Report on Regulatory Operations

Regulatory Activity	May-Jun	Jul-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-Apr	YTD
1.1 Regulatory Activity: Registration							
Registrants (Total)							
General Class							***1531***
In Good Standing	-	-	-	-	-	-	1516
Suspended	-	-	-	-	-	-	15
Inactive Class							***172***
In Good Standing	-	-	-	-	-	-	168
Suspended	-	-	-	-	-	-	4
Life Members	-	-	-	-	-	-	20
Changes in Registration Status							
Suspensions	-	-	21	2	2	11	36
Resignations	-	-	3	1	3	12	19
Revocations	-	-	3	3	2	3	11
Reinstatements	-	-	15	0	1	12	28
Class Changes							0
GC to IN	-	-	7	3	12	22	44
IN to GC (< 2 years)	-	-	1	2	1	4	8
IN to GC (> 2 years)	-	-	0	1	0	0	1
Life Membership Applications							
Approved	-	-	1	0	1	2	4
Not Approved	-	-	0	0	0	0	0
Professional Corporations (Total)							
New applications approved	-	-	4	4	3	2	13
Renewed	-	-	30	25	8	14	77
Revoked	-	-	0	0	0	0	0
Resigned/Dissolved	-	-	0	0	0	0	0
1.2 Regulatory Activity: Entry-to-Practise							
New applications received	-	-	15	40	13	16	84
On-going applications	-	-	-	-	-	27	23
Certificates issued	-	-	13	26	20	11	70
Referred to RC			2	0	2	2	6
Approved	-	-	1	0	1	1	3
Approved – TCLs	-	-	0	0	0	0	0
Approved – Exams required	-	-	0	0	0	0	0
Approved – Education required	-	-	1	0	1	1	3
Denied			0	0	0	0	0

Regulatory Activity	May-Jun	Jul-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-Apr	YTD
1.2 Regulatory Activity: Entry-to-Practise continued							
PLAR Applications							0
New	-	-	0	0	0	1	1
On-going	-	-	0	0	1	1	2
1.3 Regulatory Activity: Examinations							
CSE							
Scheduled	-	-	1	0	1	0	2
Held	-	-	1	0	1	0	2
Candidates	-	-	90	0	27	0	117
BME							
Scheduled	-	-	0	1	0	1	2
Held	-	-	0	1	0	1	2
Candidates	-	-	0	4	0	5	9
Clinical Practical Exam							
Scheduled	-	-	1	1	1	0	3
Held	-	-	1	1	0	0	2
Candidates	-	-	40	37	0	0	77
Therapeutic Prescribing							
Scheduled	-	-	1	0	0	1	2
Held	-	-	1	0	0	0	1
Candidates	-	-	35	0	0	0	35
IVIT							
Scheduled	-	-	0	0	0	0	0
Held	-	-	0	0	0	0	0
Candidates	-	-	0	0	0	0	0
Exam Appeals							
CSE							
*** Granted	-	-	0	0	0	0	0
*** Denied	-	-	0	0	0	0	0
BME							
*** Granted	-	-	0	0	0	0	0
*** Denied	-	-	0	0	0	0	0
Clinical Practical							
*** Granted	-	-	0	0	0	0	0
*** Denied	-	-	0	0	0	0	0
Therapeutic prescribing							
*** Granted	-	-	0	0	0	0	0
*** Denied	-	-	0	0	0	0	0
IVIT							
*** Granted	-	-	0	0	0	0	0
*** Denied	-	-	0	0	0	0	0
Exam Question Development							
*** CSE questions developed	-	-	0	0	0	80	80
*** BME questions developed	-	-	0	0	0	0	0

Regulatory Activity	May-Jun	Jul-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-Apr	YTD
1.4 Regulatory Activity: Patient Relations							
Funding applications							
New applications	-	-	4	0	0	0	4
Funding application approved	-	-			0	0	0
Funding applilcation declined	-	-			0	0	0
1.5 Regulatory Activity: Quality Assurance							
Peer & Practice Assessments							
Scheduled	-	-	0	0	0	3	3
Completed	-	-	0	0	0	3	3
CE Reporting							
Number in group	-	-	0	0	449	0	449
Number received	-	-	0	0	448	0	448
P&P Assessment required	-	-	0	0	0	0	0
QAC Reviews							
Accepted	-	-	0	0	0	0	0
Work Required	-	-	0	0	0	0	0
QAC Referrals to ICRC				1	1	0	2
1.6 Regulatory Activity: Inspection Program							
New premises registered	-	-	7	14	1	7	29
New Premise Inspection							
Part I Scheduled	-	-	9	2	1	2	14
Part I Completed	-	-	9	2	1	2	14
Part II Scheduled	-	-	1	12	0	7	20
Part II Completed	-	-	1	12	0	5	18
New premises-outcomes							
Passed	-	-	20	9	7	2	38
Pass with conditions	-	-	2	1	0	0	3
Failed	-	-	0	0	0	0	0
Secondary Inspections							
Scheduled	-	-	-	-	-	-	0
Completed	-	-	-	-	-	-	0
Second inspections							
Passed	-	-	-	-	-	-	0
Pass with conditions	-	-	-	-	-	-	0
Failed	-	-	-	-	-	-	0
Type 1 Occurrence Reports							
Patient transferred to emergency	-	-	1	8	2	2	13
Patient died	-	-	1	0	0	1	2
Emergency drug administered	-	-	1	0	0	0	1

Regulatory Activity	May-Jun	Jul-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-Apr	YTD
1.7 Regulatory Activity: Complaints and Reports							
New complaints/reports							
Complaints	-	-	2	4	3	2	11
CEO Initiated	-	-	15	4	2	5	26
ICRC Outcomes							
Letter of Counsel	-	-	7	3	1	1	12
SCERP	-	-	0	0	0	0	0
Oral Caution	-	-	2	1	0	1	4
SCERP & Caution	-	-	2	0	0	0	2
No action needed	-	-	2	0	1	1	4
Referred to DC	-	-	1	6	0	0	7
Summary of concerns							
Advertising	-	-	11	5	3	3	22
Failure to comply	-	-			1	2	3
Ineffective treatment	-	-	0	2	1	1	4
Out of scope	-	-	6	3	1	3	13
Record keeping	-	-	1	2	0	0	3
Fees & billing	-	-	3	0	0	1	4
Lab testing	-	-	2	1	0	0	3
Delegation	-	-	0	2	0	0	2
Harassment	-	-	1	0	0	0	1
QA Program comply	-	-	1	1	0	1	3
C&D compliance	-	-	2	0	1	0	3
Failure to cooperate	-	-	2	0	0	1	3
Boundary issues	-	-	1	0	0	0	1
Practising while suspend.	-	-	2	0	1	1	4
Unprofessional, unbecoming conduct	-	-			0	1	1
1.8 Regulatory Activity: Cease & Desist							
C&D Issued	-	-	7	6	2	3	18
C&D Signed	-	-	7	6	1	2	16
Injunctions							0
Sought	-	-	1	0	0	0	1
Approved	-	-	1	0	0	0	1
Denied	-	-	0	0	0	0	0
1.9 Regulatory Activity: Hearings							
Pre-hearing conferences							
Scheduled	-	-	1	0	0	0	1
Completed	-	-	1	0	0	0	1
Discipline hearings							
Contested	-	-	0	1	0	0	1
Uncontested	-	-	5	1	0	1	7
Contested Outcomes							
Findings made	-	-	0	0	1	0	1
No findings made	-	-	5	1	0	0	6
FTP Hearings					0	0	0

Regulatory Activity	May-Jun	Jul-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-Apr	YTD
1.10 Regulatory Activity: Regulatory Guidance							
Inquiries							
E-mail	-	-	336	86	114	90	626
Telephone	-	-	116	93	62	75	346
Top inquiries							
COVID-19	-	-	-	-	20	21	41
Scope of practice	-	-	-	-	20	17	37
Conflict of interest	-	-	-	-	7	14	21
Tele-practice	-	-	-	-	14	13	27
Inspection program	-	-	-	-	7	12	19
Patient visits	-	-	-	-	6	8	14
Advertising	-	-	-	-	10	6	16
Lab testing	-	-	-	-	6	6	12
Notifying patients when moving	-	-	-	-	7	6	13
Fees & billing	-	-	-	-	6	6	12
1.11 Regulatory Activity: HPARB Appeals							
RC Appeals							
Filed	-	-	0	1	0	0	1
Upheld	-	-	0	1	0	0	1
Returned	-	-	0	0	0	0	0
Pending	-	-	0	0	0	0	0
ICRC Appeals							
Filed	-	-	3	0	1	0	4
Upheld	-	-	0	0	0	1	1
Returned	-	-	0	0	0	0	0
Overturned	-	-	0	0	0	0	0
Pending	-	-	0	0	2	2	4
1.12 Regulatory Activity: HRTO Matters							
In progress	1	0	0	0	0	1	2
Decided							0
In favour of applicant	0	0	0	0	0		0
In favour of College	0	0	0	0	0		0

MEMORANDUM

DATE: May 19, 2021

TO: Council members
College of Naturopaths of Ontario

FROM: Agnes Kupny
Director of Operations

RE: Variance Report – Q4 Unaudited Financial Statements

I am pleased to provide this Variance Report and the Unaudited Financial Statements of the College of Naturopaths of Ontario as of March 31, 2021 which represents the fourth quarter of our fiscal year 2020-2021 (year-end).

Statement of Financial Position

The Statement of Financial Position provides a snapshot of the financial standing of the organization at the point in time for which it is dated, in this case, as of March 31, 2021.

At the end of the fiscal year April 1, 2020 to March 31, 2021 the College, as anticipated, finished the year with a deficit of $773,974.

Upon approval of the audited Financial Statements ending March 31, 2021 a request will be made to Council to draw on the Business Continuity Fund to cover this deficit.

In our accounts receivable approximately one third of our Registrants have enrolled in our Pre-Authorized Payment plan which allows for payment of membership dues to be paid over a ten-month period. This is the highest enrollment the College has experienced since offering the program in prior years. The quality of the accounts receivables will be closely monitored during this period.

For additional transparency of the College's finances, a line item called "Deferred Income" has been added to the Statement of Financial Position. It is included under Liabilities and Equity as these are monies (registration fees) that have been received in this fiscal year but apply to the next registration year which falls in the next fiscal period. The College's liabilities are in line with the expectations.

Under Equity only the Patient Relations Fund had a small transaction of $511 deducted for counselling fees. It is also important to note that because of the College ending the year in a deficit, none of the four funds will be in receipt of any top ups or be eligible for any additional allocation of monies at the end of this fiscal year.

Statement of Operations

For your reference the coloured legend is as follows:
Blue- notes actual budget and actual expenditures for Q4 only.
Green- is a calculation of how much was spent in Q4 versus the Q4 budget.
Yellow- historical data from the previous year to illustrate actual expenditures versus the budget.
Purple- this table captures the budget and actual expenditures compounding from quarter to quarter. In this report the table includes data for Q1, Q2, Q3 and Q4.
Pink- illustrates the actual annual budget and the percentage of the budget received or spent to date.

Revenue

Total Year-to-Date revenue received was $2,263,638 which when compared to the Year-to-Date budget of $3,147,310 represents 72% of budgeted revenues. This is an unfavorable variance of $881,672. The primary line items that had the greatest impact to decreased revenue are:

	2020-2021				2019-2020		
Line Item	**Year to Date Revenue**	**Year to Date Budget**	**Variance in $**	**% within the Budget**	**Q4- Actual Revenue**	**Q4- Variance in $**	**Q4- Variance in %**
Registration and Renewals	**1,595,523**	**2,708,755**	**(1,113,232)**	**59%**	**19,347**	**8,649**	181 % over budget
Examination Fees	**197,175**	**256,375**	**(59,200)**	**77%**	**26,500**	**20,000**	408% over budget
Inspection Fees	**35,000**	**80,000**	**(45,000)**	**44%**	**16,250**	**16,250**	1000% over budget
Interest	**4,807**	**65,880**	**(61,073)**	**7%**	**7,178**	**3**	100% within budget

Registration and Renewals- Annual membership fees for Registrants were discounted by 40% for all active and inactive Registrants to provide COVID-19 relief. Small income generated in Q4 is primarily due to issuance fees and Entry to Practice application fees; however, these too would have been lower than originally budgeted.

Examination Fees- Total of 9 candidates completed the jurisprudence exam, 5 candidates completed the Ontario Biomedical exam, and 27 candidates completed the clinical sciences exam. A total of 25 candidates were scheduled to complete the clinical practical exam, which was cancelled due to COVID-19 restrictions. With COVID-19 restrictions in place throughout the year, several exams were cancelled and those that were able to be delivered had restricted capacities.

Inspection Fees- There were three Part 1 inspections and five Part 2 inspections. With COVID-19 restrictions and no inspections taking place in Q1, a total of 31 inspections (combined Part 1

and Part 2) took place in the fiscal year. This is more than 50% less than the budgeted target of completing 64 premises inspections.

Interest- Current investment portfolios continue to underperform versus anticipated for this year. GIC rates in Canada are lower, now in the range of 0.5% to 1.5%.

Expenses

Total Year-to-Date expenses were $3,037,431,810 compared to the Year-to-Date budget of $3,789,065, which is 80% of budget and represents a favorable variance of $751,634 . The primary items that contributed to lower expenses are as follows:

	2020-2021				2019-2020		
Line Item	**Year to Date Expense**	**Year to Date Budget**	**Variance in $**	**% within the Budget**	**Q4-Actual Expense**	**Q4-Variance in $**	**Q4-Variance in %**
Office and General	**137,021**	**313,680**	**(176,659)**	**44%**	**61,320**	**(45,489)**	387% over budget
Consulting Fees-General	**141,905**	**195,000**	**(53,095)**	**73%**	**18,217**	**(9,617)**	212% over budget
Consulting Fees-Assessors	**10,256**	**81,150**	**(70,894)**	**13%**	**35,828**	**(31,328)**	796% over budget
Legal Fees-Complaints	**40,415**	**101,875**	**(61,460)**	**40%**	**7675**	**(7675)**	1000% over budget
Council Fees and Expenses	**94,798**	**209,607**	**(114,809)**	**45%**	**23,883**	**21,466**	53% under budget
Hearings	**20,999**	**51,454**	**(30,452)**	**41%**	**82**	**38,052**	99% under budget
Education and Training	**6,134**	**15,825**	**(9,691)**	**39%**	**0**	**0**	100% within budget

Office and General- No costs were incurred for accommodations, meals or travel due to the cancellation of in person conferences. Copying, courier, janitorial services and general office supplies reduced by over 50% due to office closure. Credit card processing fees were reduced by almost 40% due to the transition to a new vendor. There has also been one staff turnover requiring recruitment for and ETP Coordinator that has been filled. Lastly, costs were saved under licensing fees due to lowered monthly carrying costs with the new vendor. The old client management system and its licensing seized at the end of Q3.

Consulting Fees General- The Drug, Substance and Lab program deferred all of its activities to the following fiscal year resulting in a savings of 20%. There were also savings noted because of only one PLAR Assessment being completed.

Consulting Fees Assessors- Due to COVID-19 the Quality Assurance Program had limited activity in the fiscal year. This resulted in a cost savings of 75% for consulting fees (peer & practice assessors) and an additional 12% in savings was due to a decreased number of inspections conducted under the Inspection Program.

Legal Fees Complaints- Three new files were opened and seven Registrar's Investigator appointments. A total of three complaints have also been closed this quarter. Cost savings in this program were due to lower number of matters in the year vs. budget.

Council Fees and Expenses- In March 2020 when the College transitioned its operations to remote, this resulted in the full fiscal year hosting all committee meetings via Zoom (teleconference) vs in person. Costs were not incurred for accommodations, meals and travel for a total cost savings of 30%. The additional cost savings were in the per diems- Scheduled Substance Review Committee and Exam Appeals Committee had no meetings and Patient Relations met once and the Executive Committee had a decline in Q4 due to transition to new Governance model with increased Council meeting frequency.

Hearings- One uncontested hearing was held over one full day. Cost savings were due to all hearings taking place via teleconference. No costs were incurred for accommodations, meals, room rentals or travel.

Education and Training- Training for Inspections and QA did not take place due to the postponement of assessments as a result of COVID 19. Under operations CPR training was deferred due to COVID-19 restrictions, staff were unable to attend CNAR conference in person and supplementary training for new Alinity database was not required.

Comment on Q4

Considering performance in Q4 (blue columns on the chart provided), both revenue and expenses exceeded the budget for this quarter. Overall, the next results were a loss of $709,081 for the quarter, compared to $702,415 budgeted, an unfavourable variance of 1% for the quarter.

Capital budget

The Capital budget for 2020-21 which was accepted by the Council set out $7,300 for computer equipment and $12,100 for furniture and fixtures for a total of $19,400. No furniture or fixtures were purchased and a total of $3,130.33 was spent on computer equipment. Overall, cost savings from the capital budget was 84%.

This report is a highlight of the overall financial picture of the College for the relevant reporting period. If you have any questions or would like to discuss any aspects of this report, I am happy to do so.

Respectfully submitted,
Agnes Kupny
Director of Operations

The College of Naturopaths of Ontario

STATEMENT OF FINANCIAL POSITION
As of March 31, 2021 (Q4-Year End)
100% of Fiscal Year

ASSETS			
Chequing / Savings			
Bank - Operating Funds	$	923,083.06	
Bank - Savings	$	847,014.05	
Petty Cash	$	700.00	
Total Chequing / Savings			*$ 1,770,797.11*
Accounts Receivable			
Accounts Receivable	$	27,614.76	
Allowance for Doubtful Accounts	$	(32,374.50)	
Ordered DC Costs	$	2,000.00	
Total Accounts Receivable			*$ (2,759.74)*
Other Current Assets			
Prepaid Expenses	$	70,164.08	
Investment in Mutual funds	$	1,573,675.55	
Investment in GIC	$	510,757.10	
Total Other Current Assets			*$ 2,154,596.73*
Fixed Assets			
Computer Equipment	$	69,647.31	
Furniture and Fixtures	$	159,390.70	
Accumulated Amortn - Computers	$	(35,976.61)	
Accumulated Amortn - Furniture	$	(135,680.58)	
Total Fixed Assets			*$ 57,380.82*
TOTAL ASSETS			**$ 3,980,014.92**
LIABILITIES AND EQUITY			
Accounts Payable			
Accounts Payable	$	149,320.32	
Credit cards	$	66.67	
Total Account Payable			*$ 149,386.99*
Other Current Liabilities			
Accrued Liabilities	$	46,802.80	
Deferred Income	$	1,752,441.71	
HST Payable (Refund)	$	173,213.68	
Total Current Liabilities			*$ 1,972,458.19*
Equity			
Retained Earnings	$	417,386.38	
Patient Relations Fund	$	89,192.65	
Business Continuity Fund	$	1,075,385.00	
Investigations and Hearning Fund	$	1,000,000.00	
Succession Planning Fund	$	50,000.00	
Current Earnings	$	(773,794.29)	
Total Equity			*$ 1,858,169.74*
TOTAL LIABILITIES AND EQUITY			**$ 3,980,014.92**

The College of Naturopaths of Ontario

Revenue and Expenses

	2020-21		
	Budget	Y-T-D Actual	YTD as % of Budget
REVENUES			
Registration and member renewal fees	$ 2,708,755	$ 1,595,523	59%
Examination fees	$ 256,375	$ 197,175	77%
Defferred capital funding	$ -	-	-
Incorporation fees	$ 20,300	$ 24,112	119%
Ordered costs recovered	$ 16,000	$ 14,900	93%
Inspection fees	$ 80,000	$ 35,000	44%
Interest	$ 31,680	$ 1,896	6%
Investment Income	$ 34,200	$ 2,911	9%
Government Subsidy		$ 390,771	-
Assessement Fees		$ 1,350	
TOTAL REVENUES	$ 3,147,310	$ 2,263,637	
EXPENSES			
Salaries and benefits	$ 1,608,013	$ 1,581,775	98%
Rent and utilities	$ 293,148	$ 295,548	101%
Office and general	$ 313,680	$ 137,021	44%
Consulting fees			
Consultants - general	$ 195,000	$ 141,905	73%
Consultants - complaints and inquiries	$ 140,000	$ 117,171	84%
Consultants - assessors/inspectors	$ 81,150	$ 10,256	13%
Exam fees and expenses	$ 270,767	$ 225,985	83%
Legal fees			
Legal fees - general	$ 40,500	$ 35,231	87%
Legal fees - complaints	$ 101,875	$ 40,415	40%
Legal fees - discipline	$ 143,000	$ 121,317	85%
Council fees and expenses	$ 209,607	$ 94,798	45%
Hearings (Discipline, Fitness to Practise)	$ 51,451	$ 20,999	41%
Amortization/Depreciation	$ 22,198	$ -	0%
Insurance	$ 31,000	$ 30,712	99%
Equipment maintenance	$ 38,960	$ 40,716	105%
Audit fees	$ 16,300	$ 15,600	96%
Public education	$ 213,791	$ 120,895	57%
Education and training	$ 15,825	$ 6,134	39%
Printing and Postage	$ 2,801	$ 954	34%
TOTAL EXPENSES	$ 3,789,065	$ 3,037,431	
EXCESS OF REVENUES OVER EXPENSES	$ (641,755)	$ (773,794)	

The College of Naturopaths of Ontario

Analysis of Statement of Operations for Q4 commencing January 1, 2021 to March 31, 2021

	Q4						12 MONTH ENDING MARCH 31, 2021					
	Jan-Mar'21 Budget $'s	Jan-Mar'21 Actual $'s	BUDGET FAV (UNFAV) VARIANCE		Jan-Mar'20 Actual $'s	Jan-Mar'20 FAV (UNFAV) VARIANCE	YTD Budget $'s	YTD Actual $'s	BUDGET FAV (UNFAV) VARIANCE		ANNUAL BUDGET	% OF BUDGET REC'D AND/OR SPENT
Revenue			$	%		$			$	%	$	%
Registration and Member Renewals	8,500	24,543	16,043	289%	19,347	8,649	2,708,755	1,595,523	(1,113,232)	59%	2,708,755	59%
Examination Fees	37,500	33,850	(3,650)	90%	26,500	20,000	256,375	197,175	(59,200)	77%	256,375	77%
Deferred Capital Funding	-		-	0%	-	-	-		-	0%	-	0%
Incorporation Fees	2,450	5,981	3,531	244%	3,850	3,850	20,300	24,112	3,812	119%	20,300	119%
Ordered Costs Recovered	4,000	2,750	(1,250)	69%	500	500	16,000	14,900	(1,100)	93%	16,000	93%
Inspection Fees	20,000	11,250	(8,750)	56%	16,250	16,250	80,000	35,000	(45,000)	44%	80,000	44%
Interest	15,120	(563)	(15,683)	-4%	7,178	3	65,880	4,807	(61,073)	7%	65,880	7%
Government Subsidy	-	39,414	39,414	1000%	-	-	-	390,771	390,771	1000%		1000%
Assessment Fees	-	500	500	1000%	-	-	-	1,350	1,350	1000%		1000%
Total Revenue	87,570	117,725	30,155	134%	73,625	49,252	3,147,310	2,263,638	(883,672)	72%	3,147,310	72%
Expenses												
Salaries and Benefits	404,029	381,437	(22,592)	94%	303,656	26,344	1,608,013	1,581,775	(26,238)	98%	1,608,013	98%
Rent and Utilities	73,608	75,226	1,618	102%	70,192	(1,627)	293,148	295,548	2,400	101%	293,148	101%
Office and General	73,911	27,722	(46,189)	38%	61,320	(45,489)	313,680	137,021	(176,659)	44%	313,680	44%
Consulting Fees-General	11,750	77,536	65,786	660%	18,217	(9,617)	195,000	141,905	(53,095)	73%	195,000	73%
Consulting Fees-Complaints and Inquires	33,250	32,235	(1,015)	97%	15,035	(15,035)	140,000	117,171	(22,829)	84%	140,000	84%
Consulting Fees-Assessors/Inspectors	19,800	3,225	(16,575)	16%	35,828	(31,328)	81,150	10,256	(70,894)	13%	81,150	13%
Exam Fees and Expenses	51,810	147,715	95,905	285%	29,997	8,165	270,767	225,985	(44,782)	83%	270,767	83%
Legal Fees-General	11,625	3,212	(8,413)	28%	9,315	6,280	40,500	35,231	(5,269)	87%	40,500	87%
Legal Fees-Complaints	10,400	12,031	1,631	116%	7,675	(7,675)	101,875	40,415	(61,460)	40%	101,875	40%
Legal Fees-Discipline	17,000	28,691	11,691	169%	11,013	23,987	143,000	121,317	(21,683)	85%	143,000	85%
Council Fees and Expenses	39,250	17,325	(21,925)	44%	23,883	21,466	209,607	94,798	(114,809)	45%	209,607	45%
Hearings (Discipline, Fitness to Practice)	5,777	4,103	(1,674)	71%	82	38,052	51,451	20,999	(30,452)	41%	51,451	41%
Amortization/Depreciation	-	-	-	0%	2,004	20,996	22,198	-	(22,198)	0%	22,198	0%
Insurance	-	3,318	3,318	100%	-	-	31,000	30,712	(288)	99%	31,000	99%
Equipment Maintenace	9,690	12,730	3,040	131%	7,573	1,961	38,960	40,716	1,756	105%	38,960	105%
Audit Fees	-	0	-	0%	15,000	1,000	16,300	15,600	(700)	96%	16,300	96%
Public Education	27,397	-	(27,397)	0%	16,978	(4,368)	213,791	120,895	(92,896)	57%	213,791	57%
Education and Training	-	0	-	0%	-	-	15,825	6,134	(9,691)	39%	15,825	39%
Printing and Postage	688	300	(388)	44%	387	(196)	2,801	954	(1,847)	34%	2,801	34%
Total Expenses	789,985	826,806	36,821	105%	628,155	32,916	3,789,066	3,037,432	(751,634)	80%	3,789,065	80%
Total Revenue over Expenses	(702,415)	(709,081)	(6,666)	1%	(554,530)	16,336	(641,756)	(773,794)	(132,038)	21%	(641,755)	

MEMORANDUM

DATE:	May 14, 2021
TO:	Council members
FROM:	Barry Sullivan Chair, Governance Policy Review Committee
AND:	Dr. Jordan Sokoloski, ND GPRC Member
RE:	Review of the Governance Process Policies – Part 2

In keeping with the revised Council Annual Cycle, the May meeting of the Council includes a detailed review of the second part of the Governance Process policies. The Governance Policy Review Committee (GPRC) has operationalized that by considering all policies numbered GP07 and above.

The staff circulated information to Council members in advance of this meeting and a number of questions were posed, which the GPRC considered at its meeting of May 4, 2021.

First and foremost, no substantive feedback was received by the GPRC. Second, several changes were recommended by Council members via the Governance Policy Parking Lot.

GP07 – Cost of Governance

Replace Members with Registrants within the definition of Regulatory work. It would be edited as follows:

> Means all activities associated with regulating ~~members~~ **Registrants** of the profession, including all statutory functions of the College.

GP15 – Linkage with the Public and Registrants

Remove the word “the” in point 1. It would be edited as follows:

> Identifying opportunities to gather information to share with ~~the~~ Council colleagues to assist in policy development; and

GP 21 – Council Debates, Motions and Votes

Add the word “a” and edit the word “it: within Point 10. It would be edited as follows:

> Votes of the Council will usually be carried out by a show of hands and will be recorded as carried or not carried based on the number of votes in favour or opposed and abstentions. Only when **a** Council member who has abstained or opposed a vote requests ~~I t~~ **it** will their name be recorded in the minutes. The CEO as Secretary to the meeting will report to the Chair on the number of votes and the Chair will rule whether the motion has been carried or defeated.

GPRC Recommendation: The GPRC recommends that these changes be accepted and approved with a single motion.

The Council of the College of Naturopaths of Ontario supports the principles of transparency, accountability and openness in its deliberations surrounding the regulatory framework for naturopaths and the Council's management of the College. All decisions must be made in an environment that is free from influence or the perception of influence of individuals or other organizations. As such, Council members and Committee members appointed by the Council, shall publicly declare on the College's Gift Registry, all gifts and benefits they receive as a result of their role with the College.

Definitions	Benefit	Means a service that is given at no cost to the recipient, but which provides assistance, support or reward to the recipient.
	Council member	Means a person appointed to the Council by the Lieutenant Governance in Council or a Registrant elected or appointed to the Council.
	Committee member	Means a person appointed to a Statutory or Council committee by the Council.
	Gift	Means a product that is given at no cost to the recipient, but which provides assistance, support or reward to the recipient.
	Remuneration	Means the provision of unrequested money, or the payment of a fee or stipend to the recipient for the provision of information or for attending a particular event or activity.

Accordingly,

1 Each Council and Committee member must register any gift, benefit or remuneration that they receive from any individual or organization while engaged in regulation or based on their knowledge of regulatory activities with the College.

2 Notwithstanding paragraph 1, the following would not need to be declared.
   a) Any gift or benefit they receive as a corollary when on official College business, e.g., lunch is provided when at a meeting on behalf of the College.
   b) Any gift or benefit they receive from the College for the performance of their duties, including but not necessarily limited to volunteer recognition gifts, per diems or expenses in accordance with GP18, a meal when at a meeting with the College.

3 Declarations of gifts, benefits or remuneration received must be made within seven days of receipt of the gift and on a form prescribed by the Chief Executive Officer (CEO).

4 A summary of all declarations received by the CEO shall be disclosed to the Council and publicly as part of the Consent Agenda of the College Council for the period covering the time since the prior Council meeting.

5 A full summary of all declarations shall be released by the Council via the College's website annually.

6 Any Council or Committee member who is found to have failed to declare a gift of any value may be subject to removal pursuant to section 15.02 of the by-laws.

The College of Naturopaths of Ontario

BRIEFING NOTE
Proposed Schedule 3 (Inspection Program Fee) By-law Changes

PURPOSE: To consider the proposed changes to Schedule 3 of the by-laws as they relate to the Inspection Program fees based on Inspection Committee (IC) recommendations.

OUTCOME Approval

NATURE OF DECISION ❒ Strategic ☑ Regulatory Processes & Actions ❒ Other

PROCESS:

Activity:	Review and discussion of the proposed Inspection Program fee changes.		
Results:	Decision		
Overall Timing:	How much time is allocated on the agenda for this item.		
Steps/Timing:	**1.**	Presentation of the background and proposed changes – IC Chair	5 minutes
	2.	Discussion, Q&A - All	15 minutes
	3.	Motion/Vote - Council	2 minutes

BACKGROUND

In March 2017, Part IV of the General Regulation came into effect authorizing the College to operate an inspection program for all premises where Registrants perform one or both of administering intravenous infusion therapy (IVIT) or compounding for the purposes of IVIT.

The Inspection Program of the College supports continuous quality improvement through the development and maintenance of standards for all premises in which compounding for and/or administration of IVIT are performed. The College recognizes the importance of maintaining competency for certain procedures that are associated with an increased risk and has developed the Inspection Program to ensure the safety and quality of care for the people of Ontario who choose to access these services.

The structure of the program is to inspect premises where compounding for and/or administration of IVIT are performed to ensure that the Inspection Program Requirements, as well as standards, policies and procedures are in place and are being practised by Registrants within the premises.

Consideration of changes to the inspection fees has been included as part of the scheduled review of the Inspection Program (proposed amendments and considerations submitted in separate briefings). The inspection fee is based on a cost recovery[1] basis for all premises undergoing an inspection prior to being authorized to perform IVIT procedures and subsequently, once every 5 years.

The College's inspection program costs include:

[1] Cost recovery is defined as the principle of recovering business expenditures related to an activity.

- per diems for inspectors to prepare for, conduct the inspections and draft an inspection report,
- travel, meals, and accommodation expenses for inspectors when conducting an inspection, and when attending mandatory training,
- per diems for Inspection Committee members,
- travel, meals, and accommodation expenses for Inspection Committee members when attending meetings and training,
- development and delivery of training for Committee members and inspectors,
- postage and printing,
- legal fees, and
- salaries and benefits for staff required to administer the program.

Following a review of the actual costs of the program since its inception in March 2017, The Inspection Committee initiated a public consultation proposing the following amendment to the Inspection Fee (all fees are subject to HST):

1. Reduce the regularly scheduled 5-year inspection fee from $2,500 to $2,000.
2. Reduce the inspection fee for an inspection ordered by the Inspection Committee from $2,500 to $2,000.
3. Change the payment schedule for a new premises from a payment of $1,250 at the time of Part I and a payment of $1,250 at the time of Part II, to a one time payment of $2,500 prior to the Part I inspection.
4. Require a non-refundable Registration Fee of $100 payable at the time a premise submits the form to register as a new IVIT premises. The $100 fee will be applied to the new premise inspection fee. The fee addresses the costs incurred by the College when processing the registration of a new premises.

During the 60-day consultation period (January 8, 2021 to March 9, 2021), feedback was received from one Registrant, and staff provided a clarification response (Attached as Appendix 1).

DISCUSSION POINTS

The proposed changes are indicated in the table below as follows:
~~Deletion~~ Addition

Current Provision	**Proposed Change**	**Rationale/Explanation**
Regularly Scheduled 5-year Inspection $2,500 (payable within 30 days of the date of the invoice)	Regularly Scheduled 5-year Inspection ~~$2,500~~ • $2,000 (payable within 30 days of the date of the invoice)	The Actual costs incurred by the Inspection Program since it began in March 2017 have been reviewed and a reduction of $500 in the inspection fee for a scheduled 5-year inspection is being proposed.
All existing premises required to be inspected within 24 months of the date Part IV of O. Reg 168/15 comes into effect will be invoiced in two equal payments of $1,250 approximately one year apart within the initial 24-month period.	~~*All existing premises required to be inspected within 24 months of the date Part IV of O. Reg 168/15 comes into effect will be invoiced in two equal payments of $1,250 approximately one year apart within the initial 24-month period.*~~	No longer applicable, as the 24-month period has passed.

Inspection ordered by the Inspection Committee $2,500 (payable within 30 days of the date of the invoice)	Inspection ordered by the Inspection Committee ~~$2,500~~ • $2,000 (payable within 30 days of the date of the invoice)	The Actual costs incurred by the Inspection Program since it began in March 2017 have been reviewed and a reduction of $500 in the inspection fee for an ordered inspection is being proposed. This fee and the expenses necessary are the same as the Regularly Scheduled 5-year inspection.
Inspection of a new premises • Part I $1,250 (payable within 30 days of the date of the invoice)	Inspection of a new premises • ~~Part I $1,250~~ $2,500 (payable within 30 days of the date of the invoice)	The Actual costs incurred by the Inspection Program since it began in March 2017 indicates that the $2,500 fee is appropriate. The inspection of a new premises is conducted in two parts, incurring additional expenses as an inspector must attend a premises multiple times (requiring more per diem and travel costs). The original fee was split into 2 equal payments of $1,250. The payment of the full fee prior to Part I of a new premise inspection, reduces the financial risk to the College, since a premise having only had a Part I inspection may perform IVIT until they are notified of a second inspection and then can withdraw from the program without paying the full costs of administering the program.
• Part II $1,250 (payable within 30 days of the date of the invoice)	• Part II $1,250 (payable within 30 days of the date of the invoice) *Applicable to premises invoiced for Part I at $1,250 prior to* [date changes come into effect]	Ensures that premises that have been invoiced for their Part I inspection at $1,250, prior to the date the new fee schedule comes into effect, can be invoiced for their Part II inspection at $1,250.
NA	Registration fee $100.00	The registration fee of $100 is payable at the time a premise submits the form to register as a new IVIT premises. If a premise chooses to cancel their registration, the fee is non-refundable. For a premise that undergoes a Part I inspection, the $100 fee will be applied to the new premise inspection fee. The fee addresses the costs incurred by the College when processing the registration of a new premises.

ANALYSIS

Risk Assessment – The risk assessment is based on the document *Understanding The Risk Analysis Terminology,* a copy of which was included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- Strategic
    - Reputational Risk: Should the proposed amendments not be approved, or the fees be increased, the intention of the fees being made on a cost recovery basis will no longer apply and the College could be seen to be profiting from the Inspection Program.

Privacy Considerations – There are no privacy considerations.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency,* a copy of which was included in the Information Items of the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Relevant, credible, and accurate information: The proposed amendments to Schedule 3 of the by-laws provide an accurate reflection of the current costs of the Inspection Program and the fee amendments reflect the intent for the program to be one of cost recovery.
- Consistent approaches: The registration fee proposed is consistent with the requirements of other Colleges with a similar type of inspection program.

Financial Impact – Financial analysis of the College's Inspection Program costs and the proposed amendments ensure that the costs of administering the program will be recovered resulting in no net financial gain or loss to the College.

Public Interest – The Inspection Program will continue to operate thereby ensuring safe and quality care for Ontarians who choose to access IVIT services.

RECOMMENDATIONS

The Inspection Committee recommends the Council approves the proposed amendments to the Inspection Program fees as included on Schedule 3 of the by-laws.

ACTION ITEMS

Inform Registrants of the changes to Schedule 3 of the by-laws through the News Bulletin, website, email blasts and blog posts.

Sean Armstrong, ND
Chair, Inspection Committee

Mary-Ellen McKenna, ND (Inactive)
Manager, Professional Practice

May 12, 2021

Appendix 1

During the 60-day consultation period (January 8, 2021 to March 9, 2021), feedback was received from one Registrant, as follows:

> "This email is regarding the proposed inspection program fee amendments. One of the proposed amendments is a 50% increase in fees for inspection of new premises, from a total of $2500 to $3750, made in two parts.
>
> While I don't know the breakdown of what it actually costs CONO to do these inspections, as a business owner I believe a 50% increase is excessive. If I were to increase the price of anything in my practice by 50%, such as consultation fees or supplements prices, it would certainly be unacceptable and unjustifiable for patients. The proposed amendment has reduced the cost of inspecting established IVIT clinics to $2000. For inspections of new locations, with the exception of having to pay for an inspector to return to a new IVIT clinic twice, I can't see why the cost would be so significantly different. I have difficulty imagining that it costs CONO $1250 (or if you count the difference in price from a recurring inspection then it would be $1750) to send an inspector back for a second visit.
>
> Furthermore, I would like to make a recommendation that there be a third category of inspection, with a separate pricing structure. The third category should be for established IVIT clinics that are moving to a new location. This happens often, as lease agreements change with landlords (forcing them to leave due to cost), or practices expand and need additional space to provide care. To levy a fee of $3750 to a clinic owner who needs to move their current approved IVIT suite to a new physical space could be prohibitive. Certainly, with greater than 5 years of experience in running a IVIT clinic, owners who are moving to a new location are well aware of the rules, regulations, and expectations for their IVIT space. I would argue that this is a different situation than the two categories currently listed in the inspection program, with its own unique circumstances. As such, I propose that CONO inspects these clinics only once, and reduces their fees to the same price of $2000 that is required for recurring 5-year inspections. If owners fail to meet the requirements, then a second visit with an additional cost can then be applied."

Staff provided the following clarification to the Registrant:

"The proposed fee for a new premises inspection is $2,500, the same as it currently is. The difference is that it will be invoiced as one payment for the full amount rather than $1,250 at the time of Part I and $1,250 at the time of Part II.

The $1,250 fee you are referring to as an increase is the fee for a Part II inspection and will only apply to those premises that were charged the Part I $1,250 + HST fee prior to the new fee schedule coming into effect. There is no increase inspection fee being proposed for a new premises inspection."

The College of Naturopaths of Ontario

BRIEFING NOTE
Proposed Inspection Program Requirements Amendments

PURPOSE: To consider the proposed Inspection Program Requirements amendments based on the Inspection Committee recommendation.

OUTCOME Approval of amendments to the Inspection Program Requirements.

NATURE OF DECISION ☐ Strategic ☑ Regulatory Processes & Actions ☐ Other

PROCESS:

Activity:	Review and discuss the proposed Inspection Program Requirements amendments.		
Results:	Decision		
Overall Timing:	How much time is allocated on the agenda for this item.		
Steps/Timing:	**1.**	Presentation of the background and proposed changes - Chair	10 minutes
	2.	Discussion, Q&A - All	10 minutes
	3.	Motion/Vote - Council	2 minutes

BACKGROUND:

In March 2017, Part IV of the General Regulation came into effect authorizing the College to operate an inspection program for all premises where Registrants perform intravenous infusion therapies (IVIT).

The College's Inspection Program supports continuous quality improvement by developing and maintaining standards for all premises in which compounding for and/or administration of IVIT are performed. The College recognizes the importance of maintaining competency for certain procedures that are associated with increased risk and has accordingly developed the Inspection Program to ensure the safety and quality of care for the people of Ontario who choose to access these services.

The structure of the program is to inspect premises where compounding for and/or administration of IVIT are performed to ensure that the Inspection Program Requirements, as well as standards, policies and procedures, are in place and are being practised by Registrants within the premises.

The Inspection Program Requirements outline the requirements for:

- the physical environment,
- infection control,
- emergency measures,
- equipment and supplies to be stocked and maintained,
- the policies and procedures manual,
- compounding for and administering IVIT procedures,
- record keeping,
- delegation, and

- quality management.

The Inspection Program Requirements apply to an inspection of an existing premises undergoing a scheduled 5-year inspection, and a new premises that will have the inspection conducted in two parts. Part I consists of the requirements that must be in place prior to the premises being authorized to begin performing IVIT procedures. Part II consists of the observation of the performance of compounding for and/or administering IVIT as well as reviewing patient charts and the quality management program.

Inspection Program Requirements Review

A review of the Inspection Program Requirements was conducted by the Inspection Committee as part of the ongoing operations of the College and scheduled to be completed prior to the first round of 5-year inspection being conducted in the fall of 2021. The program requirements were reviewed and compared to current resources from outside agencies, as well as current College regulations, standards of practice, guidelines, and policies. When reviewing external resources, the Committee considered how the requirements for other professions and health care settings apply to IVIT procedures performed by Registrants.

External resources include:

- *National Association of Pharmacy Regulatory Authorities (NAPRA) Model Standards for Pharmacy Compounding of Non-Hazardous Sterile Preparations*
- *USP General Chapter 797 – Pharmaceutical Compounding – Sterile Preparations*
- *Provincial Infectious Diseases Advisory Committee (PIDAC) – Routine Practices and Additional Precautions in All Health Care Settings*
- *Provincial Infectious Diseases Advisory Committee (PIDAC) – Infection Prevention and Control for Clinical Office Practice*

College documents reviewed in the process include:

- *General Regulation*
- *Standard of Practice for Compounding*
- *Standard of Practice for Consent*
- *Standard of Practice for Delegation*
- *Standard of Practice for Emergency Preparedness*
- *Standard of Practice for Infection Control*
- *Standard of Practice for Intravenous Infusion Therapy*
- *Standard of Practice for Record Keeping*
- *Informed Consent Guideline*
- *Managing Risk in Clinical Practice Guideline*
- *Sterile Compounding of Injectables Guideline*
- *AED Policy*
- *Laminar Air Flow Hood Policy*

The Inspection Committee recommended changes based on the above documents to ensure the requirements for compounding and administering IVIT remain current with the practices of other professions and agencies, as well as College regulations, standards of practice, guidelines, and policies.

Public Consultation

As part of the program review a 60-day public consultation was conducted from January 8, 2021 to March 9, 2021. No feedback was received during the consultation period.

DISCUSSION POINTS:

As part of the Inspection Committee's Terms of Reference, the Committee is responsible for providing advice and recommendations to Council regarding the requirements for the College's Inspection Program. The following recommendations are presented for the Council's consideration and approval.

All proposed changes to the Inspection Program Requirements are included in the table below for existing/scheduled 5-year inspections and new (Part I and Part II) inspections. The table also includes those requirements for which there are no recommended changes.

The proposed changes are categorized as follows.

Terminology/Nomenclature

The Council has directed that a number of terms commonly used by the College be changed in order to improve the collective understanding of stakeholders about the role of the College. The following term is being altered by the Council and the proposed changes to the Inspection Program Requirements reflect the Council's direction:

Member to Registrant - The Council has asked that references to Members of the College be altered to Registrants of the College in order to create a better understanding that the College is not beholden to its Members as a professional association would be, but rather, created to regulate the individuals it "registers".

Housekeeping

As is common, when changes are made, there are often minor grammatical issues that are identified, and wording that is inconsistent with related College documents. These changes also add clarity to requirements that may have been unclear for Registrants or moved a requirement into a new section to make it easier for Registrants to implement. Other housekeeping changes include removing redundant requirements. These changes are not substantive, but it is a good practice to make corrections and changes when College documents are being amended.

Alignment with College policies, standards of practice, and guidelines and external resources.

Since the Inspection Program started in 2017 there have been updates to College standards of practice and guidelines that apply to the program, as well as amendments to the sterile compounding requirements set by NAPRA and the *USP General Chapter 797 – Pharmaceutical Compounding – Sterile Preparations*. Proposed changes to the Inspection Program Requirements are based on these documents, and are intended to ensure the Inspection Program reflects current practices ensuring safe and competent procedures are being following in IVIT premises.

All changes are provided in the table attached as Appendix 1. For each proposed change, the table includes the current requirement, the proposed change for the inspection of an existing premises/5-year scheduled inspection, proposed change to a Part I inspection of a new premises, the proposed change to a Part II inspection of a new premises, and the rationale and explanation for the change.

Substantive Changes

The following table highlights the significant proposed changes, indicated as: ~~Deletion~~ or Addition

Current Requirement	Proposed Change to Existing premises/5-year scheduled inspections	Proposed Change to New Premises - Part I	Proposed Change to New Premises - Part II	Rationale/Explanation
1.0 Physical Requirements				
1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).	~~1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).~~	~~1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).~~	NA	Accessibility for persons with disabilities encompasses a wide variety of accommodations beyond physical access to the premises and is beyond the role of the IVIT Inspection Program.
1.3 Emergency Measures				
NA	1.3.4 Notices are posted and readily visible in common areas indicating an AED is on site.	1.3.4 Notices are posted and readily visible in common areas indicating an AED is on site.	NA	New requirement. Aligns with the College's *AED Policy*. Signage allows for anyone in the premises to be aware that an AED is on site and the location.
NA	1.3.5 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	1.3.5 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	2.2.1 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	Allows for the inspector to ensure that the AED is in proper working order.
2.2 Maintenance and Cleaning			**2.1 Maintenance and Cleaning**	
NA	2.2.1 Laminar air flow hood has been certified as recommended by manufacturer.	2.2.1 Laminar air flow hood has been certified as recommended by manufacturer.	2.1.1 Laminar air flow hood has been certified as recommended by manufacturer.	Reflects the requirements for certification as outlined in the College's Laminar Air Flow Hood Policy that it is to be maintained according to the manufacturer's recommendations.
3.0 Drugs and Substances Storage and Inventory ~~and Equipment~~				
NA	3.5 Once a single-use vial has been punctured it must be used within 12 hours.	NA	3.5 Once a single-use vial has been punctured it must be used within 12 hours.	Ensures that single-use vials are used within a safe timeframe after they have been initially punctured.
NA	3.6 Once a multi-dose vial has been punctured, it is not used beyond the manufacturer's beyond-use date or	NA	3.6 Once a multi-dose vial has been punctured, it is not used beyond the manufacturer's	Ensures that multi-dose vials are used within a safe timeframe after they have been initially punctured.

	28 days, whichever is shorter.		beyond-use date or 28 days, whichever is shorter.	
4.0 Policies and Procedures Manual				
The Policies and Procedures Manual contains information, policies, and procedures that address the following.				
4.3 Type 1 and Type 2 Occurrences				
NA	4.3.4 Record keeping for all Type 1 Occurrence, Type 2 Occurrence Tracking (i.e. filed in the patient file as well as in a master file), and Type 2 Occurrence Annual reports.	4.3.4 Record keeping for all Type 1 Occurrence, Type 2 Occurrence Tracking (i.e. filed in the patient file as well as in a master file), and Type 2 Occurrence Annual reports.	NA	Ensures there is a policy and procedure in the manual to file all Type 1 and Type 2 reports.
4.6 Training				
3.1.2 Annual staff training or updating is complete on infection prevention and proper PPE use.	4.6.1 Processes to ensure completion of staff training for: • infection prevention and control, • proper PPE use of personal protective equipment, • proper hand hygiene, • emergency procedures, • waste disposal, • inventory handling and storage, • handling gross blood spills, • cleaning equipment and patient surfaces, and, • other areas as determined by the premises.	4.6.1 Processes to ensure completion of staff training for: • infection prevention and control, • proper PPE use of personal protective equipment, • proper hand hygiene, • emergency procedures, • waste disposal, • inventory handling and storage, • handling gross blood spills, • cleaning equipment and patient surfaces, and, • other areas as determined by the premises.	NA	Ensures that the Policies and Procedures Manual includes thorough processes to train staff in infection prevention and proper PPE use.
6.2 Delivery and Termination of IVIT		NA	**5.2 Delivery and Termination of IVIT**	
8.2.3 Patient is monitored during treatment (at a minimum blood pressure, heart rate,	6.2.12 The patient's vital signs are ~~is~~ monitored during treatment when indicated or for	NA	5.2.12 The patient's vital signs are ~~is~~ monitored during treatment when	Depending on the length of time it takes to administer the iv bag it may not be appropriate to monitor vitals during

respiratory rate or pulse oximeter reading and temperature are recorded).	infusions that take longer than 30 minutes to administer: ~~(at a minimum~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated ~~are recorded)~~.		indicated or for infusions that take longer than 30 minutes to administer: ~~(at a minimum~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated ~~are recorded)~~.	the treatment. Depending on the initial temperature it may not be clinically indicated to monitor during the IVIT.
7.0 General Infection Control Procedures			**6.0 General Infection Control Procedures**	
NA	7.2 Gloves are used for a single task and are never re-used.	NA	6.2 Gloves are used for a single task and are never re-used.	Ensures proper infection control procedures are followed and gloves are never reused.
9.0 Patient Chart Requirements			**8.0 Patient Chart Requirements**	
9.4 Informed Consent			**8.4 Informed Consent**	
NA	9.4.1 Documentation of a discussion regarding consent indicating the patient understands the nature of the intervention, its expected benefits, the material risks and side effects, available reasonable alternatives, the likely consequences of not receiving the intervention, the associated costs, and the right to withdraw consent.	NA	8.4.1 Documentation of a discussion regarding consent indicating the patient understands the nature of the intervention, its expected benefits, the material risks and side effects, available reasonable alternatives, the likely consequences of not receiving the intervention, the associated costs, and the right to withdraw consent.	Proper documentation regarding informed consent is often deficient. This addition, ~~sdds~~adds clarity to include the information that is to be documented and provided to the patient when obtaining informed consent, as stated in the *Standard of Practice for Consent*. Also ensures that Registrants are aware that the requirements are part of an inspection.

ANALYSIS

Risk Assessment – The risk assessment is based on the document *Understanding the Risk Analysis Terminology,* a copy of which is included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- Strategic risk:
    - Political: Where amendments are made to guidance materials of external related organizations it requires analysis to ensure that the College programs remain consistent and up-to-date. By not approving the proposed changes, the College risks not ensuring premises where IVIT procedures are performed are practising according to current standards.
    - Reputation – failure to ensure the College's program is in sync with international and standards of other professions may damage the College's reputation.

Privacy Considerations – There are no privacy considerations.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency,* a copy of which was included in the Information Items of the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Consistent Approaches: the amendments to the program requirements align with other organizations that guide IVIT procedures.
- Timely, accessible, and contextual: Transparency of the proposed changes has been achieved through the 60-day public consultation period undertaken by the College, as well as this briefing being made public, and the Council's discussion being undertaken in an open Council meeting. The proposed changes are presented with the current and proposed changes as well as the context and explanation for the proposed changes.

Financial Impact – There is no financial impact with this recommendation.

Public Interest – The Inspection Program will continue to ensure Registrants are providing IVIT services in accordance with comprehensive, up-to-date requirements ensuring safe and quality care for Ontarians who choose to access IVIT services.

RECOMMENDATIONS

The Inspection Committee recommends the Council approve the amendments to the Inspection Program Requirements.

ACTION ITEMS

The Inspection Program Policies will be updated and posted on the College's website.

Registrants will be informed of the changes to the Inspection Program Requirements through the News Bulletin, website, email blasts and blog posts.

Sean Armstrong, ND
Chair, Inspection Committee

Mary-Ellen McKenna, ND (Inactive)
Manager, Professional Practice

May 12, 2021

Appendix 1

The proposed changes are indicated in the table below as follows:
~~Deletion~~ Addition

Current Requirement	Proposed Change to Existing premises/5-year scheduled inspections	Proposed Change to New Premises - Part I	Proposed Change to New Premises - Part II	Rationale/Explanation
1.0 Physical Requirements				
1.1 General				
1.1.1 Site complies with all applicable building codes including fire safety requirements.	~~1.1.1 Site complies with all applicable building codes including fire safety requirements.~~	~~1.1.1 Site complies with all applicable building codes including fire safety requirements.~~	NA	Fire safety is captured in section 1.1.6.2. Evaluating adherence to building codes is outside of the expertise of IVIT inspectors and is not a necessary component of an IVIT inspection. Removal does not affect the quality and safety of IVIT care being provided at a premise.
1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).	~~1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).~~	~~1.1.3.1 Access for persons with disabilities complies with provincial legislation (*Accessibility for Ontarians with Disabilities Act*).~~	NA	Accessibility for persons with disabilities encompasses a wide variety of accommodations beyond physical access to the premises and is beyond the role of the IVIT Inspection Program.
1.2.1.1 Temperature and ventilation ensures staff and patient comfort.	~~1.2.1.1 Temperature and ventilation ensures staff and patient comfort.~~	~~1.2.1.1 Temperature and ventilation ensures staff and patient comfort.~~	NA	Patient comfort is captures in section 1.1.2. where the inspector can comment on the room temperature and ventilation.
1.1.5.3 The following areas are functionally separate, this may include separate, dedicated rooms or designated areas, depending on the available space: • administration and patient-waiting area/room	1.1.1~~.5.3~~ The following areas are functionally separate, allowing adequate space to ensure patient safety, and that emergency protocols and infection control standards can be met. This may include separate,	1.1.1~~.5.3~~ The following areas are functionally separate, allowing adequate space to ensure patient safety, and that emergency protocols and infection control standards can be met. This may include separate,	NA	Adds clarity

• procedure area/room • clean utility area/room non-sterile storage area/room • compounding area/room • recovery area/room.	dedicated rooms, or designated areas, depending on the available space. • administration and patient-waiting area/room • ~~procedure~~ IVIT administering area/room • clean utility area/room • non-sterile storage area/room • compounding area/room • recovery area/room.	dedicated rooms, or designated areas, depending on the available space. • administration and patient-waiting area/room • ~~procedure~~ IVIT administering area/room • clean utility area/room • non-sterile storage area/room • compounding area/room • recovery area/room.		
1.1.5.1 Layout facilitates safe patient care and patient flow.	1.1.2 Layout of all rooms/areas facilitates safe, comfortable patient care and patient flow.	1.1.2 Layout of all rooms/areas facilitates safe, comfortable patient care and patient flow.	NA	Adds clarity. Includes the need to ensure patients are comfortable including the room temperature and ventilation.
1.1.5.2 Premises is neat, comfortable, clean and free of clutter.	1.1.3 Premises is neat, ~~comfortable,~~ clean and free of clutter.	1.1.3 Premises is neat, ~~comfortable,~~ clean and free of clutter.	NA	The premises being "comfortable" is more applicable to section 1.1.2
1.2.1.5 Openings to the outside are effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means.	1.1.4 Openings to the outside are effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means.	1.1.4 Openings to the outside are effectively protected against the entrance of insects or animals by self-closing doors, closed windows, screening, controlled air current or other effective means.	NA	No change
1.3.1.1 Appropriate compounding area is designated (separate room or low and controlled traffic area with limited access).	1.1.5 The ~~Appropriate~~ compounding ~~designated~~ area/room containing the laminar air flow hood is in ~~(separate room or~~ a low ~~and controlled~~ traffic area with controlled, limited	1.1.5 The ~~Appropriate~~ compounding ~~designated~~ area/room containing the laminar air flow hood is in ~~(separate room or~~ a low ~~and controlled~~ traffic area with controlled, limited	NA	Adds clarity

	access~~)~~.	access~~)~~.		
NA	1.1.6 A sink is readily available in the premises for staff use.	1.1.6 A sink is readily available in the premises for staff use.	NA	Aligns with the College's *Sterile Compounding Guideline*.
1.3.1.2 IV substances are located adjacent to the compounding area and in a controlled access area.	1.1.7 IV drugs/substances are located adjacent to the compounding area, in a low traffic area with controlled, limited access.	1.1.7 The area where IV drugs/substances ~~are~~ will be located is adjacent to the compounding area, in a low traffic area with controlled, limited access.	1.1.1 IV drugs/substances are located adjacent to the compounding area, in a low traffic area with controlled, limited access.	Adds clarity
1.1.2.2 Electrical outlets are available. No overloaded wall-plugs or overloaded extension cords are in use.	1.1.8 Electrical outlets are available. No overloaded wall-plugs or overloaded extension cords are in use.	1.1.8 Electrical outlets are available. No overloaded wall-plugs or overloaded extension cords are in use.	NA	No change
1.2 Infection Control				
1.2.1.2 Floors and walls can be cleaned to meet infection control requirements (eg surfaces are smooth and washable).	1.2.1 Floors, ~~and~~ walls, chairs, examination tables, patient contact surfaces, etc can be cleaned to meet infection control requirements (eg surfaces are smooth and washable).	1.2.1 Floors, ~~and~~ walls, chairs, examination tables, patient contact surfaces, etc can be cleaned to meet infection control requirements (eg surfaces are smooth and washable).	NA	Ensures all patient contact surfaces such as chairs and examination table can be cleaned to meet infection control requirements.
1.2.1.3 In premises access to hand-washing facilities and proper towel disposal.	1.2.2 ~~In premise a~~ Access to hand-washing facilities ~~and~~ with proper towel disposal available to patients and all staff.	1.2.2 ~~In premise a~~ Access to hand-washing facilities ~~and~~ with proper towel disposal available to patients and all staff.	NA	This takes into account that not all premises have a washroom in the premise itself for patients to use but one is available in the building such as in the hallway outside of the premises.
1.2.1.4 Alcohol-based hand cleaner is readily available.	1.2.3 Alcohol-based hand cleaner is readily available throughout the premises for staff and patients.	1.2.3 Alcohol-based hand cleaner is readily available throughout the premises for staff and patients.	NA	Adds clarity that alcohol-based hand cleaner is to be available throughout the premises (rather than potentially in only one location) for both staff and patients.
3.2.3 Tissue boxes are available for staff and patients.	1.2.4 Tissue boxes are available throughout the premises for staff and patients.	1.2.4 Tissue boxes are available throughout the premises for staff and patients.	NA	Adds clarity that tissue boxes are to be available throughout the premises (rather than potentially in only one location) for both staff and patients.

3.2.6 Masks are readily available for patients along with signage for proper use.	1.2.5 Disposable masks are readily available for patients. ~~along with signage for proper use~~.	1.2.5 Disposable masks are readily available for patients. ~~along with signage for proper use~~.	NA	Requirements for all signage moved to as separate requirement in section 1.2.6.
3.2.1 Infection control signs are posted at the entry and at the reception desk.	1.2.6 Infection control signs are prominently posted. ~~at the entry and at the reception desk~~.	1.2.6 Infection control signs are prominently posted. ~~at the entry and at the reception desk~~.	NA	Allows for the premises to determine where the signs are best posted for patients to see.
NA	1.2.7 Infection control signage includes how to prevent the spread of infections (e.g. use of alcohol-based hand sanitizer, use of masks, etc).	1.2.7 Infection control signage includes how to prevent the spread of infections (e.g. use of alcohol-based hand sanitizer, use of masks, etc).	NA	Provides examples of information to include in the infection control signage.
3.2.8 A telephone, in person or online infectious disease screening protocol has been developed and implemented for use when communicating with patients and scheduling appointments.	1.2.8 A telephone, in person or online infectious disease screening protocol ~~has been developed and~~ is consistently implemented ~~for use~~ when communicating with patients and scheduling appointments.	1.2.8 A telephone, in person or online infectious disease screening protocol has been developed ~~and implemented~~ for use when communicating with patients and scheduling appointments.	1.2.1 A telephone, in person or online infectious disease screening protocol ~~has been developed and~~ is consistently implemented ~~for use~~ when communicating with patients and scheduling appointments.	Ensures the process to screen for patients is being used on a consistent basis for existing and Part II inspections. For the Part I inspection, the requirement ensures that a protocol has been developed for use once the premises is authorized to perform IVIT procedures.
3.2.4 Garbage cans are readily available.	1.2.9 Garbage cans are readily available throughout the premises for staff and patients.	1.2.9 Garbage cans are readily available throughout the premises for staff and patients.	NA	Adds clarity that garbage cans are to be available throughout the premises (rather than potentially in only one location) for both staff and patients.
3.2.7 Reception staff can maintain a safe distance (approximately 1 meter) from patients.	1.2.10 Reception staff are protected from possible exposure (e.g. use of personal protective equipment, ~~can~~ maintaining a safe distance ~~(approximately 1 meter)~~ from patients, or protective barriers are in place).	1.2.10 Reception staff are protected from possible exposure (e.g. use of personal protective equipment, ~~can~~ maintaining a safe distance ~~(approximately 1 meter)~~ from patients, or protective barriers are in place).	NA	Ensures protocols are in place to reduce the risk of staff and patient exposure to infectious agents.

3.2.9 A patient segregation area is available when needed.	1.2.11 A patient segregation area is available, when needed.	1.2.11 A patient segregation area is available, when needed.	NA	No changes.
3.2.10 Clean toy and soiled toy bins are used where applicable.	1.2.12 Clean toy and soiled toy bins are used, where applicable.	1.2.12 Clean toy and soiled toy bins are available ~~used~~, where applicable.	NA	Adds clarity
1.3 Emergency Measures				
1.1.6.1 Hallways, stairways and elevators are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.	1.3.1 Hallways, stairways and elevators (where applicable) are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.	1.3.1 Hallways, stairways and elevators (where applicable) are sufficiently wide to allow emergency evacuation of a patient by emergency personnel and their equipment.	NA	Adds clarity
1.1.6.2 The premises is equipped with a fire/smoke alarm system that conforms to local fire codes and fire safety training.	1.3.2 The premise is equipped with ~~a~~ fire~~/smoke~~ alarms, smoke detectors and/or a sprinkler system. ~~that conforms to local fire codes and fire safety training.~~	1.3.2 The premise is equipped with ~~a~~ fire~~/smoke~~ alarms, smoke detectors and/or a sprinkler system. ~~that conforms to local fire codes and fire safety training.~~	NA	Ensures fire safety measures are in place and encompasses premises in a variety of building styles. Assessing fire codes and fire safety training is outside of the expertise of IVIT inspectors and is not a necessary component of an IVIT inspection.
1.1.6.4 Fire exits are clearly marked, and evacuation maps are located in patient areas.	1.3.3 Fire exits are clearly marked, and evacuation maps are prominently displayed ~~located~~ in all patient areas.	1.3.3 Fire exits are clearly marked, and evacuation maps are prominently displayed ~~located~~ in all patient areas.	NA	Adds clarity.
NA	1.3.4 Notices are posted and readily visible in common areas indicating an AED is on site.	1.3.4 Notices are posted and readily visible in common areas indicating an AED is on site.	NA	New requirement. Aligns with the College's *AED Policy*. Signage allows for anyone in the premises to be aware that an AED is on site and the location.
NA	1.3.5 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	1.3.5 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	2.2.1 The AED is fully stocked, the AED pads are not expired, the battery is fully charged, and the unit is fully operational.	Allows for the inspector to ensure that the AED is in proper working order.
1.1.6.5 There is emergency lighting in patient care areas. Emergency lighting	1.3.6 There is emergency lighting in all patient ~~care~~ areas. Emergency	1.3.6 There is emergency lighting in all patient ~~care~~ areas. Emergency	NA	Ensures that emergency lighting is available in all areas where patients

may include but is not limited to a permanently installed emergency system or battery powered portable devices.	lighting may include but is not limited to a permanently installed emergency system or battery powered portable devices.	lighting may include but is not limited to a permanently installed emergency system or battery powered portable devices.		may be, not just in care/treatment rooms.
1.1.6.3 Emergency procedures are clearly displayed.	1.3.7 Emergency procedures are ~~clearly displayed.~~ readily available for staff to use in the event of a patient-related emergency.	1.3.7 Emergency procedures are ~~clearly displayed.~~ readily available for staff to use in the event of a patient-related emergency.		There has been confusion as to whether this was emergency evacuation procedures or emergency procedures to be followed by staff in the event of a patient-related emergency. There is no need for evacuation procedures to be displayed since exits are clearly marked and maps are posted. The change adds clarity and improves safety measures.
1.4.2.2 Crash cart is immediately available.	1.3.8 A crash cart is immediately available and fully stocked.	1.3.8 A crash cart is immediately available and fully stocked.	1.1.1 A crash cart is immediately available and fully stocked.	Ensures that the crash cart is always fully stocked.
2.0 Equipment and Supplies				
2.1 General				
1.1.2.1 All electrical devices are certified by CSA or licensed for use in Canada.	2.1.1 All electrical devices ~~are certified by CSA or licensed for use in Canada~~ meet Canadian electrical safety requirements and contain certification marks, such as CSA, cUL or cETL.	2.1.1 All electrical devices ~~are certified by CSA or licensed for use in Canada~~ meet Canadian electrical safety requirements and contain certification marks, such as CSA, cUL or cETL.	NA	Adds clarity
1.2.1.7 Sharps/biohazard containers are readily available to staff.	2.1.2 Sharps/biohazard containers are ~~readily available to staff~~ puncture-resistant, tamper-resistant, leak-proof with a clearly identifiable biological hazard label.	2.1.2 Sharps/biohazard containers are ~~readily available to staff~~ puncture-resistant, tamper-resistant, leak-proof with a clearly identifiable biological hazard label.	NA	Adds clarity to ensure the proper sharps containers are used.
1.2.1.7 Sharps/biohazard	2.1.3 Sharps/biohazard	2.1.3 Sharps/biohazard	NA	Adds clarity to ensure that sharps containers

containers are readily available to staff.	containers are ~~readily available to staff~~ easily accessible in every "point of use" area and mounted out of the reach of children.	containers are ~~readily available to staff~~ easily accessible in every "point of use" area and mounted out of the reach of children.		are accessible to staff in the areas where they are used (compounding and administering areas) and are safely out of the reach of children.
1.3.2.1 Laminar airflow hood in place	2.1.4 A laminar airflow hood is in place for premises where compounding for IVIT is conducted.	2.1.4 A laminar airflow hood is in place for premises where compounding for IVIT is conducted.	NA	Adds clarity that the LAFH is only required when there is on site compounding for IVIT.
1.3.2.1 Appropriate personal protective equipment (PPE) is available for procedures where applicable.	2.1.5 Appropriate personal protective equipment (PPE) is available for procedures where applicable.	2.1.5 Appropriate personal protective equipment (PPE) is available for procedures where applicable.	NA	No change
NA	2.1.6 Spill kit is readily available to clean gross spills of blood.	2.1.6 Spill kit is readily available to clean gross spills of blood.	NA	The requirement to have a process to clean gross spills of blood has been in place, however, there has not been a requirement to have a spill kit on hand. The process for cleaning blood spills is documented in the Policies and Procedures Manual.
2.2 Maintenance and Cleaning			**2.1 Maintenance and Cleaning**	
NA	2.2.1 Laminar air flow hood has been certified as recommended by manufacturer.	2.2.1 Laminar air flow hood has been certified as recommended by manufacturer.	2.1.1 Laminar air flow hood has been certified as recommended by manufacturer.	Reflects the requirements for certification as outlined in the College's Laminar Air Flow Hood Policy that it is to be maintained according to the manufacturer's recommendations.
1.2.2.2 Equipment used for administering IVIT is maintained and inspected regularly for functionality.	2.2.2 Equipment used for administering IVIT is maintained and inspected regularly for functionality and is recorded in the applicable log.	2.2.2 Maintenance logs are available to record the maintenance and inspection of equipment used for administering IVIT.	2.1.2 Equipment used for administering IVIT is maintained and inspected regularly for functionality and is recorded in the applicable log.	Ensures that there is documentation of the maintenance of equipment used to administer IVIT and allows for the inspection to include a review of the log. For Part I – this ensures a log to record the maintenance of equipment used to

				administer IVIT is in place and ready to be used.
1.3.2.2 Equipment used for compounding for IVIT is maintained and inspected regularly for functionality.	2.2.3 Equipment used for compounding IVIT is maintained and inspected regularly for functionality and is recorded in the applicable log.	2.2.3 Maintenance logs are available to record the maintenance and inspection of equipment used when compounding for IVIT.	2.1.3 Equipment used for compounding IVIT is maintained and inspected regularly for functionality and is recorded in the applicable log.	Ensures that there is documentation of the maintenance of equipment used to compound for IVIT and allows for the inspection to include a review of the log. For Part I – this ensures a log to record the maintenance of equipment used to compound for IVIT is in place and ready to be used.
3.5.2 Approved and appropriate disinfectant products are available for patient surfaces, equipment, and instruments.	2.2.4 Approved and appropriate cleaning and disinfecting products are available for cleaning and disinfecting patient surfaces.	2.2.4 Approved and appropriate cleaning and disinfecting products are available for cleaning and disinfecting patient surfaces.	NA	Adds clarity, is specific to products used on patient surfaces, and ensures the inspector can check that the products are stocked and available for use.
3.5.2 Approved and appropriate disinfectant products are available for patient surfaces, equipment, and instruments.	2.2.5 Approved and appropriate cleaning and disinfecting products are available for cleaning and disinfecting equipment and instruments.	2.2.5 Approved and appropriate cleaning and disinfecting products are available for cleaning and disinfecting equipment and instruments.	NA	Adds clarity, is specific to products used for equipment and instruments, and ensures the inspector can check that the products are stocked and available for use.
NA	2.2.6 Cleaning and disinfecting of patient surfaces, equipment, and instruments is recorded in a cleaning log.	2.2.6 A log is available to record all completed cleaning and disinfecting of patient surfaces, equipment, and instruments.	2.1.4 Cleaning and disinfecting of patient surfaces, equipment, and instruments is recorded in a cleaning log.	New requirements to ensure that cleaning and disinfecting procedures are completed and recorded. Procedures are documented in the Policies and Procedures Manual and ensuring staff is following the procedures is part of the Quality Management Program.
2.3 Items Required on the Crash Cart			**2.2 Items Required on the Crash Cart**	
2.2 • Automated External Defibrillator	1. Alcohol 2. Angiocatheters 3. Atropine i.v. 4. Calcium chloride and/or Calcium	1. Alcohol 2. Angiocatheters 3. Atropine i.v. 4. Calcium chloride and/or Calcium	1. Alcohol 2. Angiocatheters 3. Atropine i.v. 4. Calcium	Nitroglycerin is included on Table 3 of the General Regulation allowing its use in office in emergency

(AED) • Alcohol • Arm board • Basic dressing supplies • Cotton balls • Gauze and bandages • IV tubing, administration sets and angiocatheters • Micropore tape • Non-latex gloves • Non-latex tourniquets • Pocket mask for cardiopulmonary resuscitation • Resuscitation bag with O_2 attachment • Safety engineered needles • Scissors • Smelling salts (amyl nitrate) or essential oil (peppermint) • Syringes 2.3 • Atropine • Calcium chloride and/or Calcium gluconate and/or Calcium glycerophosphate • Dextrose • Diphenhydramine hydrochloride • Epinephrine hydrochloride i.m. • Ipratropium bromide • Magnesium chloride and/or Magnesium sulfate • Saline bags • Oxygen tank with regulator 0-10 L/min with mask or nasal canula	gluconate and/or Calcium glycerophosphate i.v. 5. Dextrose 5% (D5W) and 50% i.v. 6. Diphenhydramine hydrochloride i.v., i.m. 7. Epinephrine hydrochloride i.m. 8. Ipratropium bromide 9. IV tubing and administration sets 10. Magnesium chloride and/or Magnesium sulfate i.v. 11. Micropore tape 12. Nitroglycerin 13. Non-latex gloves 14. Non-latex tourniquets 15. Oxygen tank with regulator 0-10 L/min with mask or nasal canula 16. Pocket mask for cardiopulmonary resuscitation 17. Resuscitation bag with O_2 attachment 18. Safety engineered needles 19. Salbutamol 20. Saline bags 21. Smelling salts (amyl nitrate) or essential oil (peppermint) 22. Syringes	gluconate and/or Calcium glycerophosphate i.v. 5. Dextrose 5% (D5W) and 50% i.v. 6. Diphenhydramine hydrochloride i.v., i.m. 7. Epinephrine hydrochloride i.m. 8. Ipratropium bromide 9. IV tubing and administration sets 10. Magnesium chloride and/or Magnesium sulfate i.v. 11. Micropore tape 12. Nitroglycerin 13. Non-latex gloves 14. Non-latex tourniquets 15. Oxygen tank with regulator 0-10 L/min with mask or nasal canula 16. Pocket mask for cardiopulmonary resuscitation 17. Resuscitation bag with O_2 attachment 18. Safety engineered needles 19. Salbutamol 20. Saline bags 21. Smelling salts (amyl nitrate) or essential oil (peppermint) 22. Syringes	chloride and/or Calcium gluconate and/or Calcium glycerophosphate i.v. 5. Dextrose 5% (D5W) and 50% i.v. 6. Diphenhydramine hydrochloride i.v., i.m. 7. Epinephrine hydrochloride i.m. 8. Ipratropium bromide 9. IV tubing and administration sets 10. Magnesium chloride and/or Magnesium sulfate i.v. 11. Micropore tape 12. Nitroglycerin 13. Non-latex gloves 14. Non-latex tourniquets 15. Oxygen tank with regulator 0-10 L/min with mask or nasal canula 16. Pocket mask for cardiopulmonary resuscitation 17. Resuscitation bag with O_2 attachment 18. Safety engineered needles 19. Salbutamol 20. Saline bags 21. Smelling salts (amyl nitrate) or essential oil	circumstances and should be included on the crash cart. For emergency purposes it is recommended that dextrose is stocked on the crash cart in two concentrations – 5% and 50%. The type of injection (e.g. i.v.) has been added for clarity.

• Salbutamol			(peppermint) 22. Syringes	
2.4 Equipment and Supplies ~~not on Crash Cart but~~ Readily Available			**2.3 Equipment and Supplies ~~not on Crash Cart but~~ Readily Available**	
2.4 • Cold compresses, hot packs • Natural anxiolytic • Non-latex blood pressure cuff • Pulse oximeter • Snacks (crackers, fruit juices) • Stethoscope • Thermometer • Watch (if no wall clock with second hand present in the room) • Lidocaine (topical)	1. Arm board or other support (e.g. pillow with disposable cover) 2. Automated External Defibrillator (AED) 3. Basic dressing supplies 4. Blood pressure cuff 5. Cold compresses, hot packs 6. Cotton balls 7. Gauze and bandages 8. Lidocaine (topical) 9. Natural anxiolytic 10. Non-latex blood pressure cuff 11. Pulse oximeter 12. Scissors 13. Snacks (crackers, fruit juices) 14. Stethoscope 15. Thermometer 16. Watch (if no ~~wall~~ clock with second-hand present in the room)	1. Arm board or other support (e.g. pillow with disposable cover) 2. Automated External Defibrillator (AED) 3. Basic dressing supplies 4. Blood pressure cuff 5. Cold compresses, hot packs 6. Cotton balls 7. Gauze and bandages 8. Lidocaine (topical) 9. Natural anxiolytic 10. Non-latex blood pressure cuff 11. Pulse oximeter 12. Scissors 13. Snacks (crackers, fruit juices) 14. Stethoscope 15. Thermometer 16. Watch (if no ~~wall~~ clock with second-hand present in the room)	1. Arm board or other support (e.g. pillow with disposable cover) 2. Automated External Defibrillator (AED) 3. Basic dressing supplies 4. Blood pressure cuff 5. Cold compresses, hot packs 6. Cotton balls 7. Gauze and bandages 8. Lidocaine (topical) 9. Natural anxiolytic 10. Non-latex blood pressure cuff 11. Pulse oximeter 12. Scissors 13. Snacks (crackers, fruit juices) 14. Stethoscope 15. Thermometer 16. Watch (if no ~~wall~~ clock with second-hand present in the room)	Supports other than an arm board can be used during the administration of IVIT.
3.0 Drugs and Substances Storage and Inventory ~~and Equipment~~				
4.1.1.3 Only drugs/substances listed on Table 2 are stocked for compounding and administering by IVIT.	3.1 Only drugs/substances listed on Tables 2 and 5 of the *General Regulation* are stocked for compounding for	NA	3.1 Only drugs/substances listed on Tables 2 and 5 of the *General Regulation* are stocked for	Includes the drugs that may be compounded for IVIT as listed in the General Regulation can be stocked.

	and/or administering by IVIT.		compounding for and/or administering by IVIT.	
4.1.1.4 Drugs not listed on Table 2 may be stocked if they are being administered through a delegation.	3.2 Drugs/substances not listed on Tables 2 and 5 of the *General Regulation* ~~may be~~ are stocked ~~if they are being~~ for compounding for and/or administering ~~through~~ by IVIT **only** when a delegation is in place.	NA	3.2 Drugs/substances not listed on Tables 2 and 5 of the *General Regulation* ~~may be~~ are stocked ~~if they are being~~ for compounding for and/or administering ~~through~~ by IVIT **only** when a delegation is in place.	Adds clarity that drugs and substances not included on Table 2 and Table 5 of the General Regulation can only be stocked if there is a delegation in place.
4.1.1.5 Only drugs/substances approved for use by the College of Naturopaths of Ontario for IV administration are used.	~~4.1.1.5 Only drugs/substances approved for use by the College of Naturopaths of Ontario for IV administration are used.~~	~~4.1.1.5 Only drugs/substances approved for use by the College of Naturopaths of Ontario for IV administration are used.~~	~~4.1.1.5 Only drugs/substances approved for use by the College of Naturopaths of Ontario for IV administration are used.~~	Captured above in sections 3.1 and 3.2
4.1.1.1 A general drug/substance inventory record is maintained including expiration dates.	3.3 An IVIT ~~general~~ drug/substance inventory record, which includes expiration dates and lot numbers, is maintained and up to date.	3.1 An IVIT ~~general~~ drug/substance inventory record, which includes expiration dates and lot numbers, is available.	3.3 An IVIT ~~general~~ drug/substance inventory record, which includes expiration dates and lot numbers, is maintained and up to date.	Adds clarity that the inspection applies to IVIT drugs and substances. Lot numbers are required to track inventory
4.1.1.2 When applicable, drugs/substances are labelled to indicate the date the seal was broken.	3.4 ~~When applicable,~~ IVIT drugs/substances are labelled to indicate the date they were initially punctured ~~seal was broken~~.	NA	3.4 ~~When applicable,~~ IVIT drugs/substances are labelled to indicate the date they were initially punctured ~~seal was broken~~.	Housekeeping change
NA	3.5 Once a single-use vial has been punctured it must be used within 12 hours.	NA	3.5 Once a single-use vial has been punctured it must be used within 12 hours.	Ensures that single-use vials are used within a safe timeframe after they have been initially punctured.
NA	3.6 Once a multi-dose vial has been punctured, it is not used beyond the manufacturer's beyond-use date or	NA	3.6 Once a multi-dose vial has been punctured, it is not used beyond the manufacturer's beyond-use date	Ensures that multi-dose vials are used within a safe timeframe after they have been initially punctured.

	28 days, whichever is shorter.		or 28 days, whichever is shorter.	
4.1.1.8 Drugs/substances are stored according to manufacturer's recommendations.	3.7 IVIT drugs/substances are stored according to the manufacturer's recommendations, eg room temperature, refrigerated, away from light.	3.2 IVIT drugs/substances are stored according to the manufacturer's recommendations, eg room temperature, refrigerated, away from light.	3.7 IVIT drugs/substances are stored according to the manufacturer's recommendations, eg room temperature, refrigerated, away from light.	Housekeeping change
4.1.1.10 Drugs/substances are organized for easy access in appropriately labelled bins/cupboards.	3.8 IVIT drugs/substances are organized for easy access in ~~appropriately~~ labeled bins, cupboards and shelves, including those in the refrigerator.	3.3 IVIT drugs/substances are organized for easy access in ~~appropriately~~ labeled bins, cupboards and shelves, including those in the refrigerator.	NA	Ensures that all storage spaces including shelves and those in the refrigerator are labeled.
4.1.1.11 Drugs/substances requiring refrigeration are properly stored in a dedicated refrigerator, with the temperature check regularly (eg. use of a thermometer that registers maximum and minimum temperatures and has a visual readout externally).	3.9 IVIT drugs/substances requiring refrigeration are ~~properly~~ stored in a ~~dedicated~~ refrigerator dedicated to injectable drugs/substances only. ~~with the temperature check regularly (eg. use of a thermometer that registers maximum and minimum temperatures and has a visual readout externally).~~	3.4 A dedicated refrigerator is available for the storage of injectable drugs/substances only.	3.8 IVIT drugs/substances requiring refrigeration are ~~properly~~ stored in a ~~dedicated~~ refrigerator dedicated to injectable drugs/substances only. ~~with the temperature check regularly (eg. use of a thermometer that registers maximum and minimum temperatures and has a visual readout externally).~~	Clarifies that the dedicated fridge is only for injectables, and allows for non-IVIT injectables to be stored in the same fridge. The requirement for refrigerator temperature is in a separate requirement.
4.1.1.11 Drugs/substances requiring refrigeration are properly stored in a dedicated refrigerator, with the temperature check regularly (eg. use of a thermometer that registers maximum	3.10 ~~Drugs/substances requiring refrigeration are properly stored in a dedicated~~ The refrigerator used for IVIT drugs/substances is at ~~with~~ the correct temperature (2-8	3.5 ~~Drugs/substances requiring refrigeration are properly stored in a dedicated~~ The refrigerator used for IVIT drugs/substances is at ~~with~~ the correct temperature (2-8	NA	Adds clarity

and minimum temperatures and has a visual readout externally).	°C) ~~check regularly (eg. use of~~ and monitored with a thermometer that ~~registers~~ records maximum and minimum temperatures and ~~has~~ includes an external visual readout ~~externally)~~.	°C) ~~check regularly (eg. use of~~ and monitored with a thermometer that ~~registers~~ records maximum and minimum temperatures and ~~has~~ includes an external visual readout ~~externally)~~.		
NA	3.11 A refrigerator temperature log is maintained and up to date.	3.6 A refrigerator temperature log is available.	3.9 A refrigerator temperature log is maintained and up to date.	Ensures that there is documentation of the refrigerator temperature being monitored and allows for the inspection to include a review of the log. For Part I – this ensures a log to record the refrigerator temperature is in place and ready to be used.
4.1.1.14 Expired or contaminated drugs/substances are stored and labelled to ensure they are not used, and are discarded appropriately (may use the Ontario Medications Return Program).	3.12 Expired or contaminated drugs, substances and equipment are labelled and stored separately from current products, to ensure they are not used ~~and are discarded appropriately~~ before being properly discarded. (May use the Ontario Medications Return Program)	NA	3.10 Expired or contaminated drugs, substances and equipment are labelled and stored separately from current products, to ensure they are not used ~~and are discarded appropriately~~ before being properly discarded. (May use the Ontario Medications Return Program)	Adds clarity.
4.1.1.6 Drugs/substances appropriate for paediatric administration are available if applicable.	~~4.1.1.6 Drugs/substances appropriate for paediatric administration are available if applicable.~~	~~4.1.1.6 Drugs/substances appropriate for paediatric administration are/will be available if applicable.~~	~~4.1.1.6 Drugs/substances appropriate for paediatric administration are available if applicable.~~	There is no need to stock different drugs/substances for paediatric use.
4.1.1.7 Drugs/substances are labeled in accordance with CONO's General Regulation and Standard of Practice for Compounding.	~~4.1.1.7 Drugs/substances are labeled in accordance with CONO's General Regulation and Standard of~~	NA	~~4.1.1.7 Drugs/substances are labeled in accordance with CONO's General Regulation and Standard of~~	It is appropriate to have labelling requirements in the compounding section only when the label is created by the Registrant. All purchased products will be labelled

	~~Practice for Compounding.~~		~~Practice for Compounding.~~	and are not under the control of the Registrant.
4.0 Policies and Procedures Manual				
The Policies and Procedures Manual contains information, policies, and procedures that address the following.				
4.1 Administrative				
11.1.1 Staff person(s) responsible for developing and maintaining the Policies and Procedures Manual is determined.	4.1.1 Staff person(s) responsible for developing and maintaining the Policy and Procedure Manual ~~is determined~~.	4.1.1 Staff person(s) responsible for developing and maintaining the Policy and Procedure Manual ~~is determined~~.	NA	Housekeeping change
11.1.2 Organizational chart.	4.1.2 Organizational chart	4.1.2 Organizational chart	NA	No change
11.1.3 Scope and limitations of the services provided at the premises.	4.1.3 Scope and limitations of the services provided at the premise.	4.1.3 Scope and limitations of the services provided at the premise.	NA	No change
11.2.1 Descriptions for all premises staff that define the scope, responsibilities, and limitations for patient care.	4.1.4 Descriptions for all premises staff who are involved with patients receiving IVIT that define the scope ~~responsibilities~~ and limitations of their duties and responsibilities ~~for patient care~~.	4.1.4 Descriptions for all premises staff who are involved with patients receiving IVIT that define the scope ~~responsibilities~~ and limitations of their duties and responsibilities ~~for patient care~~.	NA	Adds clarity that the scope of the Inspection Program is only for IVIT and the Policies and Procedures Manual content as required in the Inspection Program Requirements should reflect this.
11.2.2 Responsibilities for supervising staff.	~~11.2.2 Responsibilities for supervising staff.~~	~~11.2.2 Responsibilities for supervising staff.~~	NA	This is redundant as section 4.1.4 will include if the scope of a staff member includes supervisory responsibilities.
4.2 Operational Procedures				
11.6.1 Storage, handling, and disposal of combustible and volatile materials.	4.2.1 Storage, handling, and disposal of combustible and volatile materials.	4.2.1 Storage, handling, and disposal of combustible and volatile materials.	NA	No change
11.6.7 Drugs and substances handling and inventory.	4.2.2 IVIT drugs and substances handling and inventory.	4.2.2 IVIT drugs and substances handling and inventory.	NA	Adds clarity that the Policies and Procedures Manual as required in the Inspection Program Requirements is specific to IVIT.
4.1.1.12 Cold chain management is ensured.	4.2.3 Cold chain management - storage and handling of drugs and substances	4.2.3 Cold chain management - storage and handling of drugs and substances	NA	Ensures there is a policy and procedure for staff regarding cold chain management and that it is to include the storage

	requiring a controlled cold temperature.	requiring a controlled cold temperature.		and handling of drugs and substances that require a controlled cold temperature.
11.6.3 Routine maintenance and calibration of equipment.	4.2.4 ~~Routine~~ Appropriately scheduled maintenance and/or calibration of IVIT equipment, and up-dating the maintenance log.	4.2.4 ~~Routine~~ Appropriately scheduled maintenance and/or calibration of IVIT equipment, and up-dating the maintenance log.	NA	Adds clarity that the requirements relate to equipment used for IVIT and that the maintenance log is to be kept up to date.
1.3.2.3 The following documentation for all equipment used when compounding for IVIT is available: • equipment operating manuals, • equipment maintenance contracts, where applicable • maintenance log.	4.2.5 ~~The following~~ Documentation for all equipment used ~~when~~ for administering and compounding for IVIT ~~is available included~~: • equipment operating manuals, where applicable, • equipment maintenance contracts, where applicable, • maintenance log, • inventory list.	4.2.5 ~~The following~~ Documentation for all equipment used ~~when~~ for administering and compounding for IVIT ~~is available included~~: • equipment operating manuals, where applicable, • equipment maintenance contracts, where applicable, • maintenance log, • inventory list.	NA	The list of equipment used when compounding for and administering IVIT should be included in the Policies and Procedures Manual. Other additions are housekeeping changes.
1.3.2.3 The following documentation for all equipment used for compounding IVIT is available: • equipment operating manuals • equipment maintenance contracts, where applicable • maintenance log.	~~1.3.2.3 The following documentation for all equipment used for compounding IVIT is available:~~ • ~~equipment operating manuals~~ • ~~equipment maintenance contracts, where applicable~~ ~~maintenance log.~~	~~1.3.2.3 The following documentation for all equipment used for compounding IVIT is available:~~ • ~~equipment operating manuals~~ • ~~equipment maintenance contracts, where applicable~~ ~~maintenance log.~~	NA	Combined the requirement for compounding and administering equipment documentation into one section (4.2.5).
11.6.5 Patient booking system.	~~4.2.7 Patient booking system.~~	~~4.2.7 Patient booking system.~~	NA	Not necessary to have the type of patient booking system included in the Policies and Procedures Manual.
11.6.6 Obtaining patient informed consent.	~~4.2.8 Obtaining patient informed consent.~~	~~4.2.8 Obtaining patient informed consent.~~	NA	The requirements to document informed consent is included in section 9.4, and the Quality Management

				Program. Not necessary to have a policy and process included in the Policies and Procedures Manual.
11.6.8 Patient preparation for procedures.	4.2.6 Patient preparation for IVIT procedures.	4.2.6 Patient preparation for IVIT procedures.	NA	Adds clarity that the scope of the Inspection Program is only for IVIT and the Policies and Procedures Manual content as required in the Inspection Program Requirements should reflect this.
11.6.9 Response to latex allergies.	4.2.7 Response to latex allergies including accidental exposure in a latex-free clinic.	4.2.7 Response to latex allergies including accidental exposure in a latex-free clinic.	NA	Ensures that all premises ave a policy and procedure to address latex allergies even if they are a latex-free clinic.
11.6.10 Waste and garbage disposal.	4.2.8 Handling and disposal of biomedical and non-biomedical waste. ~~and garbage disposal.~~	4.2.8 Handling and disposal of biomedical and non-biomedical waste. ~~and garbage disposal.~~	NA	Adds clarity and ensures Registrants are aware that processes should be different depending on the type of waste.
4.3 Type 1 and Type 2 Occurrences				
11.3.1 Ensures all staff are aware of the requirements of when and who to report Type 1 and 2 occurrences to.	4.3.1 ~~Ensures~~ All staff are aware of ~~the requirements of when and who to report~~ what Type 1 and Type 2 occurrences are ~~to~~.	4.3.1 ~~Ensures~~ All staff are aware of ~~the requirements of when and who to report~~ what Type 1 and Type 2 occurrences are ~~to~~.	NA	Adds clarity. Other requirements are captured in separate sections.
11.3.2 Ensures all staff are aware of the possible occurrences that can happen and how staff are to ensure they are reported to the College and the designated member and recorded in the patient file.	4.3.2 ~~Ensures~~ All staff are aware of ~~the possible occurrences that can happen and how staff are to ensure they are reported to the College and the designated member and recorded in the patient file~~ when and who they must report Type 1 and Type 2 occurrences to.	4.3.2 ~~Ensures~~ All staff are aware of ~~the possible occurrences that can happen and how staff are to ensure they are reported to the College and the designated member and recorded in the patient file~~ when and who they must report Type 1 and Type 2 occurrences to.	NA	Adds clarity.
11.3.4 Establishes how Type 1 and 2 occurrences are responded to, including the criteria	4.3.3 ~~Establishes~~ How Type 1 and Type 2 occurrences are responded to. ~~including the~~	4.3.3 ~~Establishes~~ How Type 1 and Type 2 occurrences are responded to. ~~including the~~	NA	Emergency response and management is addressed in section 4.4.

to determine if emergency services are required. In an occurrence where emergency services are not required ensure the necessary procedures to provide patient care are included.	~~criteria to determine if emergency services are required. In an occurrence where emergency services are not required ensure the necessary procedures to provide patient care are included.~~	~~criteria to determine if emergency services are required. In an occurrence where emergency services are not required ensure the necessary procedures to provide patient care are included.~~		
NA	4.3.4 Record keeping for all Type 1 Occurrence, Type 2 Occurrence Tracking (i.e. filed in the patient file as well as in a master file), and Type 2 Occurrence Annual reports.	4.3.4 Record keeping for all Type 1 Occurrence, Type 2 Occurrence Tracking (i.e. filed in the patient file as well as in a master file), and Type 2 Occurrence Annual reports.	NA	Ensures there is a policy and procedure in the manual to file all Type 1 and Type 2 reports.
5.2.2 Death occurring within the premises should also be reported to the coroner.	4.3.5 Requirement to report a death occurring within the premises ~~should also be reported~~ to the coroner.	4.3.5 Requirement to report a death occurring within the premises ~~should also be reported~~ to the coroner.	NA	If there has been a death within the premise emergency services will be called and on site. The Registrant is expected to report it to the coroner.
4.4 Emergency Response and ~~Safety Precautions~~ Management				
2.1.1 A risk analysis of the practice is conducted, and documented, based on, at a minimum, the following criteria: • volume of patients • volume of high-risk patients • proximity to a hospital • proximity to an emergency room • acuity of illness of patients • access to emergency services.	4.4.1 A risk analysis for the premises, ~~of the practice is conducted, and documented, based on, at a minimum, the following criteria~~ as outlined in the *Standard of Practice for Emergency Preparedness*, that includes: • volume of patients, • volume of high-risk patients, • proximity to a hospital, • proximity to an emergency room, • acuity of illness of patients, and • access to emergency	4.4.1 A risk analysis for the premises, ~~of the practice is conducted, and documented, based on, at a minimum, the following criteria~~ as outlined in the *Standard of Practice for Emergency Preparedness*, that includes: • volume of patients, • volume of high-risk patients, • proximity to a hospital, • proximity to an emergency room, • acuity of illness of patients, and • access to emergency	NA	Adds clarity to ensure the risk analysis is completed in accordance with the *Standard of Practice for Emergency Preparedness.*

	services.	services.		
11.4.1 Management of patient emergencies.	4.4.2 Management of patient emergencies.	4.4.2 Management of patient emergencies.	NA	No change
11.4.2 Management of emergencies due to fire.	4.4.3 Management of an emergency due to fire.	4.4.3 Management of an emergency due to fire.	NA	No change
11.4.3 Management of emergencies due to power failure.	4.4.4 Management of an emergency due to a power failure.	4.4.4 Management of an emergency due to a power failure.	NA	No change
11.4.4 Management of other emergency evacuations.	4.4.5 Management of other emergencies requiring immediate evacuation.	4.4.5 Management of other emergencies requiring immediate evacuation.	NA	Adds clarity
11.4.5 Emergency situations that require 911 to be called.	4.4.6 Emergency situations that need 911 to be called.	4.4.6 Emergency situations that need 911 to be called.	NA	No change
11.4.6 How to summon additional staff urgently within the premises.	4.4.7 How and when to summon additional staff urgently within the premise.	4.4.7 How and when to summon additional staff urgently within the premise.	NA	Adds clarity
11.5.1 Patient is to be transferred to hospital by an appropriate transportation service in most cases this would be an ambulance.	4.4.8 How a patient in urgent need of transfer is to be transferred to hospital ~~by an appropriate transportation service~~ (in most cases this would be by ambulance).	4.4.8 How a patient in urgent need of transfer is to be transferred to hospital ~~by an appropriate transportation service~~ (in most cases this would be by ambulance).	NA	Adds clarity
11.5.2 The ND most responsible for the patient ensures that essential medical information is sent with the patient.	4.4.9 How the ND most responsible for the patient ~~ensures that~~ sends essential ~~medical~~ information ~~is sent~~ with the patient.	4.4.9 How the ND most responsible for the patient ~~ensures that~~ sends essential ~~medical~~ information ~~is sent~~ with the patient.	NA	Adds clarity
11.5.3 A regulated health professional staff member should accompany the patient during the transfer.	4.4.10 How to ensure a regulated health professional ~~staff member should~~ accompanies the patient during the transfer.	4.4.10 How to ensure a regulated health professional ~~staff member should~~ accompanies the patient during the transfer.	NA	Allows for situations where a non-staff regulated health professional accompanies the patient during transfer, such as EMS.
11.5.4 If the ND most responsible for the patient is not accompanying the	~~11.5.4 If the ND most responsible for the patient is not accompanying~~	~~11.5.4 If the ND most responsible for the patient is not accompanying~~	NA	Section 4.4.9 ensures that essential information regarding the patient is sent to the

patient, he/she must contact the receiving physician/premises immediately, by phone or in person.	~~the patient, he/she must contact the receiving physician/premises immediately, by phone or in person.~~	~~the patient, he/she must contact the receiving physician/premises immediately, by phone or in person.~~		appropriate facility or health care provider. The receiving physician or premises may not be available to contact by phone or in person.
11.5.5 The ND most responsible for the patient must complete a report.	~~11.5.5 The ND most responsible for the patient must complete a report.~~	~~11.5.5 The ND most responsible for the patient must complete a report.~~	NA	The reporting requirement is captured in the Type 1 occurrence reporting requirements.
4.5 Infection Control				
3.1.1 The premises adheres to and maintains documentation for accepted standards of infection control practices pertinent to IVIT. 3.5.1 Written protocols and procedures for cleaning the office setting are available. 11.6.4 Infection control protocols.	4.5.1 Infection control protocols, including cleaning protocols, that ~~Premise~~ adhere to ~~and maintains documentation for~~ accepted standards of infection control practices.	4.5.1 Infection control protocols, including cleaning protocols, that ~~Premise~~ adhere to ~~and maintains documentation for~~ accepted standards of infection control practices.	NA	Housekeeping changes to have all policies and procedures for infection control in one section.
3.5.3 A procedure is in place to decontaminate gross spills of blood.	4.5.2 ~~A procedure is in place~~ Protocol to decontaminate gross blood spills.	4.5.2 ~~A procedure is in place~~ Protocol to decontaminate gross blood spills.	NA	Housekeeping change
NA	4.5.3 Protocols for cleaning the laminar air flow hood.	4.5.3 Protocols for cleaning the laminar air flow hood.	NA	Ensures that infection control procedures include protocols for cleaning the laminar air flow hood for premises that compound on site.
NA	4.5.4 Protocols for hand hygiene when performing IVIT procedures.	4.5.4 Protocols for hand hygiene when performing IVIT procedures.	NA	Ensures that infection control procedures include protocols for hand hygiene specific to IVIT procedures.
NA	4.5.5 A telephone, in person or online infectious disease screening protocol used when communicating with patients and scheduling appointments.	4.5.5 A telephone, in person or online infectious disease screening protocol used when communicating with patients and scheduling appointments.	NA	Ensures the screening process is documented in the Policies and Procedures Manual.
NA	4.5.6 When and how staff are to use personal protective equipment to	4.5.6 When and how staff are to use personal protective equipment to	NA	Ensures the Policies and Procedures Manual includes documentation

	protect themselves and others.	protect themselves and others.		regarding the proper use of PPE.
3.1.4 Referral for post-exposure prophylaxis is recommended for all staff with blood and body fluid exposure.	4.5.7 ~~Referral for post-exposure prophylaxis is recommended for~~ Process to ensure all staff who are exposed to ~~with~~ blood and/or body fluids ~~exposure~~ are referred for post-exposure prophylaxis.	4.5.7 ~~Referral for post-exposure prophylaxis is recommended for~~ Process to ensure all staff who are exposed to ~~with~~ blood and/or body fluids ~~exposure~~ are referred for post-exposure prophylaxis.	NA	Adds clarity
4.6 Training				
3.1.2 Annual staff training or updating is complete on infection prevention and proper PPE use.	4.6.1 Processes to ensure completion of staff training for: • infection prevention and control, • proper PPE use of personal protective equipment, • proper hand hygiene, • emergency procedures, • waste disposal, • inventory handling and storage, • handling gross blood spills, • cleaning equipment and patient surfaces, and, • other areas as determined by the premises.	4.6.1 Processes to ensure completion of staff training for: • infection prevention and control, • proper PPE use of personal protective equipment, • proper hand hygiene, • emergency procedures, • waste disposal, • inventory handling and storage, • handling gross blood spills, • cleaning equipment and patient surfaces, and, • other areas as determined by the premises.	NA	Ensures that the Policies and Procedures Manual includes thorough processes to train staff in infection prevention and proper PPE use.
4.7 ~~Monitoring Quality of Care~~ Quality Management Program				
Processes regarding the Quality Management Program include:				
NA	4.7.1 Formation of a Quality Management Committee and the staff members, who are involved with patients receiving IVIT, comprising the committee.	4.7.1 Formation of a Quality Management Committee and the staff members, who are involved with patients receiving IVIT, comprising the committee.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.

NA	4.7.2 Frequency and reasons for Quality Management Committee meetings.	4.7.2 Frequency and reasons for Quality Management Committee meetings.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.3 Staff review of the Policies and Procedures Manual, at least annually.	4.7.3 Staff review of the Policies and Procedures Manual, at least annually.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
11.7.2 Process to review individual ND performance (procedure selection, patient outcomes, occurrences, etc.).	4.7.4 ~~Process to review individual ND~~ Performance review of naturopath(s) who perform IVIT procedures. ~~(procedure selection, patient outcomes, occurrences, etc.).~~	4.7.4 ~~Process to review individual ND~~ Performance review of naturopath(s) who perform IVIT procedures. ~~(procedure selection, patient outcomes, occurrences, etc.).~~	NA	Adds clarity
NA	4.7.5 Review of staff who are involved in delegated procedures to ensure all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	4.7.5 Review of staff who are involved in delegated procedures to ensure all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	NA	Ensures that the Quality Management Program documented in the Policies and Procedures Manual includes a process to review that delegations are being done according the College's requirements.
1.7.1 Process to review the performance of non-medical staff involved in any of the premise's IVIT related processes and procedures.	4.7.6 ~~Process to review the~~ Performance review of non-medical staff involved in any of the premise's IVIT related processes and procedures.	4.7.6 ~~Process to review the~~ Performance review of non-medical staff involved in any of the premise's IVIT related processes and procedures.	NA	Housekeeping change
NA	4.7.7 Reviewing that staff are aware of and trained in the premise's emergency procedures, including use of the AED.	4.7.7 Reviewing that staff are aware of and trained in the premise's emergency procedures, including use of the AED.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.8 Reviewing that staff are aware of and consistently	4.7.8 Reviewing that staff are aware of and consistently	NA	Ensure there is a thorough Quality Management Program

	use the telephone, in person and online infectious disease screening protocol when communicating with patients and scheduling appointments.	use the telephone, in person and online infectious disease screening protocol when communicating with patients and scheduling appointments.		documented in the Policies and Procedures Manual.
NA	4.7.9 Reviewing that staff are aware of how and when to use personal protective equipment.	4.7.9 Reviewing that staff are aware of how and when to use personal protective equipment.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.10 Reviewing that staff are aware of procedures to follow in the event of exposure to blood or body fluids.	4.7.10 Reviewing that staff are aware of procedures to follow in the event of exposure to blood or body fluids.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.11 Monitoring and evaluating the quality of patient care provided.	4.7.11 Monitoring and evaluating the quality of patient care provided.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.12 Tracking and reviewing patient outcomes.	4.7.12 Tracking and reviewing patient outcomes.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.13 Developing and implementing methods to improve patient care.	4.7.13 Developing and implementing methods to improve patient care.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.14 Identifying and correcting deficiencies in the premise's policies and procedures.	4.7.14 Identifying and correcting deficiencies in the premise's policies and procedures.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.15 Reviewing all Type 1 and Type 2 reporting and record keeping requirements.	4.7.15 Reviewing all Type 1 and Type 2 reporting and record keeping requirements.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
11.7.5 Process to review all Type 1 and 2 occurrences that occurred at the	4.7.16 ~~Process to~~ Reviewing all Type 1 and Type 2 occurrences that	4.7.16 ~~Process to~~ Reviewing all Type 1 and Type 2 occurrences that	NA	Adds clarity

premises, including potential remedial actions that may be taken to prevent future occurrences and mitigate harm to patients.	occurred at the premises, ~~including potential remedial actions that may be taken~~ and developing policies and procedures to reduce the risk of ~~prevent~~ future occurrences ~~and mitigate harm to patients~~.	occurred at the premises, ~~including potential remedial actions that may be taken~~ and developing policies and procedures to reduce the risk of ~~prevent~~ future occurrences ~~and mitigate harm to patients~~.to patients.		
11.7.3 Process to randomly select and review 5-10 patient records to assess quality of care to patients, completeness, and accuracy of entries, and to ensure records adhere to the Standard of Practice for Record Keeping.	4.7.17 ~~Process to randomly~~ Selecting, at least annually, and reviewing 5-10 patient records to assess: • quality of care to patients, • completeness and accuracy of entries, • documentation of informed consent, • appropriateness of treatment, • follow-up to abnormal laboratory test results, and • ~~to ensure records~~ adherence to the *Standard of Practice for Record Keeping*.	4.7.17 ~~Process to randomly~~ Selecting, at least annually, and reviewing 5-10 patient records to assess: • quality of care to patients, • completeness and accuracy of entries, • documentation of informed consent, • appropriateness of treatment, • follow-up to abnormal laboratory test results, and • ~~to ensure records~~ adherence to the *Standard of Practice for Record Keeping*.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.18 Monitoring adherence to infection control practices pertinent to IVIT.	4.7.18 Monitoring adherence to infection control practices pertinent to IVIT.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.19 Monitoring proper cleaning procedures for patient surfaces and IVIT equipment.	4.7.19 Monitoring proper cleaning procedures for patient surfaces and IVIT equipment.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.20 Monitoring maintenance of IVIT and emergency equipment.	4.7.20 Monitoring maintenance of IVIT and emergency equipment.	NA	Ensure there is a thorough Quality Management Program documented in the

				Policies and Procedures Manual.
NA	4.7.21 Monitoring the drug and substance inventory and storage (including cold chain management).	4.7.21 Monitoring the drug and substance inventory and storage (including cold chain management).	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.22 Monitoring labelling and disposal of expired drugs, substances, and equipment.	4.7.22 Monitoring labelling and disposal of expired drugs, substances, and equipment.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.23 Monitoring use of logs for inventory, cleaning, and maintenance.	4.7.23 Monitoring use of logs for inventory, cleaning, and maintenance.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
NA	4.7.24 Reviewing proper handling and disposal of all biomedical and non-biomedical waste.	4.7.24 Reviewing proper handling and disposal of all biomedical and non-biomedical waste.	NA	Ensure there is a thorough Quality Management Program documented in the Policies and Procedures Manual.
11.7.4 Process to review compliance with all policies and procedures in the manual.	~~11.7.4 Process to review compliance with all policies and procedures in the manual.~~	~~11.7.4 Process to review compliance with all policies and procedures in the manual.~~	NA	Too broad a requirement. The recommended additions and changes, clarify and ensure a more thorough Quality Management Program is documented and in place.
4.8 Delegation				
11.6.2 Delegating controlled acts.	4.8.1 ~~Delegating controlled acts.~~ Processes to ensure the criteria for making a delegation as outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	4.8.1 ~~Delegating controlled acts.~~ Processes to ensure the criteria for making a delegation as outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	NA	Adds clarity and allows the inspection to include reviewing procedures that are in place in the event delegations are made.
NA	4.8.2 How to meet the criteria for accepting a delegation as outlined in the *Standard of Practice for Delegation* and Part	4.8.2 How to meet the criteria for accepting a delegation as outlined in the *Standard of Practice for Delegation* and Part	NA	As above with respect to accepting a delegation.

	III of the *General Regulation* are met.	III of the *General Regulation* are met.		
4.9 Miscellaneous				
11.8.1 All forms used at the premises (intake forms, IV treatment form, consent form etc).	4.9.1 All forms used at the premises (intake, IV treatment, consent, Type 1 occurrence report, Type 2 occurrence tracking).	4.9.1 All forms used at the premises (intake, IV treatment, consent, Type 1 occurrence report, Type 2 occurrence tracking).	NA	More examples added
	4.9.2 Templates of all logs including inventory, maintenance, cleaning, refrigerator temperature, etc	4.9.2 Templates of all logs including inventory, maintenance, cleaning, refrigerator temperature, etc	NA	Ensures all logs used at the premises are included in the Policies and Procedures Manual.
11.8.3 Any external policies, as deemed necessary by each individual premises.	4.9.3 Any external policies, as deemed necessary by each individual premises.	4.9.3 Any external policies, as deemed necessary by each individual premises.	NA	No change
5.0 Observation of Compounding IV Bag			**4.0 Observation of Compounding IV Bag**	
5.1 Compounding IV Bags			**4.1 Compounding IV Bags**	
7.1.3 Laminar airflow hood has been turned on at least 30 minutes prior to use.	5.1.1 Laminar airflow hood (LAFH) has been turned on at least 30 minutes prior to use.	NA	4.1.1 Laminar airflow hood (LAFH) has been turned on at least 30 minutes prior to use.	Housekeeping change
NA	5.1.2 LAFH is cleaned with sterile 70% isopropyl alcohol using a non-shedding/lint-free cloth or wipes before and after use.	NA	4.1.2 LAFH is cleaned with sterile 70% isopropyl alcohol using a non-shedding/lint-free cloth or wipes before and after use.	Ensures that the laminar air flow hood is properly cleaned prior to compounding for IVIT.
7.1.1 It is verified that the proper IV prescription is being prepared for the intended patient.	5.1.3 ~~It is~~ Verify ~~that the~~ proper IVIT ~~prescription~~ formula (whether compounded on site or by a compounding pharmacy) ~~is being prepared for~~ and	NA	4.1.3 ~~It is~~ Verify ~~that the~~ proper IVIT ~~prescription~~ formula (whether compounded on site or by a compounding pharmacy) ~~is being prepared~~	Ensures that the ND checks that the formula of the iv bag is the correct one for the patient, whether it is made at a compounding pharmacy or compounded on site.

	the intended patient.		~~for~~ and the intended patient.	
7.1.2 Osmolarity is calculated.	5.1.4 Calculate osmolarity before compounding.	NA	4.1.4 Calculate osmolarity before compounding.	Adds clarity
7.1.5 Proper infection controls and prevention of contamination procedures are followed when working under the laminar airflow hood.	~~7.1.5 Proper infection controls and prevention of contamination procedures are followed when working under the laminar airflow hood.~~	~~7.1.5 Proper infection controls and prevention of contamination procedures are followed when working under the laminar airflow hood.~~	~~7.1.5 Proper infection controls and prevention of contamination procedures are followed when working under the laminar airflow hood.~~	Replaced with more detailed requirements to ensure Registrants are aware the expectations.
7.1.12 Bottles are checked for expiry date, proper concentration, contamination and abnormal appearance.	5.1.5 ~~Bottles are~~ All needed bags, vials and containers are collected and checked for: • beyond use ~~expiry~~ date, to ensure it is current, • ~~proper~~ concentration, • leaks, • defects that could compromise sterility, and • ~~contamination,~~ abnormal appearance – cloudiness, colour, precipitate.	NA	4.1.5 ~~Bottles are~~ All needed bags, vials and containers are collected and checked for: • beyond use ~~expiry~~ date, to ensure it is current, • ~~proper~~ concentration, • leaks, • defects that could compromise sterility, and • ~~contamination,~~ abnormal appearance – cloudiness, colour, precipitate.	Ensures that all injectables are checked for expiry or beyond use date, appearance etc before being used to compound the iv bag. Possible contamination is assessed by checking for leaks, defects and abnormal appearance.
7.1.13 All packages are checked to ensure they are new and not previously opened.	5.1.6 ~~All packages are checked to~~ All needed compounding equipment is collected, checked for the expiration date where applicable and ensured it is new and not previously opened.	NA	4.1.6 ~~All packages are checked to~~ All needed compounding equipment is collected, checked for the expiration date where applicable and ensured it is new and not previously opened.	Ensures that all equipment used for compounding, is checked to insure it is new and not previously opened.
7.1.7 The person compounding under the laminar airflow hood washes their	5.1.7 The person performing the compounding ~~under the laminar~~	NA	4.1.7 The person performing the compounding ~~under the laminar~~	Ensures the person doing the compounding is aware of the proper procedures and the

hands with a suitable antimicrobial at the beginning and when re-entering the aseptic preparation area.	~~airflow hood washes their hands~~ follows proper hand hygiene ~~with a suitable antimicrobial~~ at the beginning, and ~~when re-entering the aseptic preparation area~~ before donning gloves to compound under the laminar air flow hood in accordance with *PIDAC – Infection Prevention and Control for Clinical Office Practice.*		~~airflow hood washes their hands~~ follows proper hand hygiene ~~with a suitable antimicrobial~~ at the beginning, and ~~when re-entering the aseptic preparation area~~ before donning gloves to compound under the laminar air flow hood in accordance with *PIDAC – Infection Prevention and Control for Clinical Office Practice.*	PIDAC document for proper hand hygiene.
7.1.6 Personnel use protective equipment of gloves, gown, and mask, (hair cover and shoe cover are optional).	5.1.8 The person performing the compounding dons a ~~Personnel use protective equipment~~ of mask, gown and gloves at a minimum; (hair, shoe, and beard (when applicable) covers are optional).	NA	4.1.8 The person performing the compounding dons a ~~Personnel use protective equipment~~ of mask, gown and gloves at a minimum; (hair, shoe, and beard (when applicable) covers are optional).	Adds clarity
7.1.8 All bottles, vials or containers are wiped down with alcohol or disinfectant before being brought into the laminar airflow hood. 7.1.10 All items necessary for the preparation should be placed under the hood prior to commencing the compounding.	5.1.9 All bottles, vials, containers, and equipment necessary for compounding ~~the preparation~~ are disinfected with 70% isopropyl alcohol using a non-shedding/lint-free cloth or wipes as they are placed under the LAFH prior to ~~commencing the~~ compounding. ~~are wiped down with alcohol or disinfectant before being brought into~~	NA	4.1.9 All bottles, vials, containers, and equipment necessary for compounding ~~the preparation~~ are disinfected with 70% isopropyl alcohol using a non-shedding/lint-free cloth or wipes as they are placed under the LAFH prior to ~~commencing the~~ compounding. ~~are wiped down with alcohol or disinfectant~~	Ensures all injectables and equipment are properly cleaned and disinfected before being place under the laminar air flow hood.

	~~the laminar airflow hood~~		~~before being brought into the laminar airflow hood~~	
NA	5.1.10 Sterile items that are in sealed containers designed to keep them sterile are removed from the covering as they are introduced into the LAFH without being wiped.	NA	4.1.10 Sterile items that are in sealed containers designed to keep them sterile are removed from the covering as they are introduced into the LAFH without being wiped.	Ensures that Registrants are aware that there is no need to disinfect items that are in sterile packaging as they are introduced into the laminar air flow hood.
7.1.9 All objects are suitably placed in the hood to provide good airflow with minimal obstruction.	5.1.11 All objects are suitably place in the LAFH to provide good airflow with minimal obstruction.	NA	4.1.11 All objects are suitably place in the LAFH to provide good airflow with minimal obstruction.	No change
7.1.15 Bottles are swabbed with alcohol and left for 30 seconds before puncturing.	5.1.12 ~~Bottles are swabbed with alcohol and left for 30 seconds before puncturing.~~ Vial stoppers, ampule necks and intravenous bag septa are wiped with 70% isopropyl alcohol and allowed to dry before entering or puncturing stoppers and septa, or breaking the necks of ampules.	NA	4.1.12 ~~Bottles are swabbed with alcohol and left for 30 seconds before puncturing.~~ Vial stoppers, ampule necks and intravenous bag septa are wiped with 70% isopropyl alcohol and allowed to dry before entering or puncturing stoppers and septa, or breaking the necks of ampules.	Adds clarity
7.1.16 Proper drawing technique is used, (eg. calcium gluconate is added last or a new needle used, 45 degree angle entry into rubber stoppers).	5.1.13 Proper drawing technique is used (e.g. calcium gluconate is added last or a new needle is used, 45° angle with bevel up entry into rubber stoppers).	NA	4.1.13 Proper drawing technique is used (e.g. calcium gluconate is added last or a new needle is used, 45° angle with bevel up entry into rubber stoppers).	Adds clarity
7.1.17 All drugs/substances are added to the bag and	5.1.14 All drugs and substances are added to the iv bag	NA	4.1.14 All drugs and substances are added to the	The requirement to inspect the finished product has been moved

mixed well. Finished product is inspected for visible precipitate	and mixed well. ~~Finished product is inspected for visible precipitate.~~		iv bag and mixed well. ~~Finished product is inspected for visible precipitate.~~	to a separate requirement (5.1.17).
7.1.14 IV bags are checked for leaks, contamination, and abnormal appearance.	5.1.15 Once compounded, the iv bag is checked for leaks, ~~contamination,~~ and abnormal appearance - cloudiness, colour, and precipitate.	NA	4.1.15 Once compounded, the iv bag is checked for leaks, ~~contamination,~~ and abnormal appearance - cloudiness, colour, and precipitate.	Ensures the iv bag is checked for leaks and abnormal appearance after it has been compounded.
7.1.11 Direct contact between a sterile product and any non-sterile product should be avoided.	5.1.16 ~~Direct contact between a sterile product and a non-sterile product is avoided.~~ Gloved hands are disinfected with 70% isopropyl alcohol before re-introduction into the LAFH or after gloves have been in contact with a non-sterile surface during the compounding procedure.	NA	4.1.16 ~~Direct contact between a sterile product and a non-sterile product is avoided.~~ Gloved hands are disinfected with 70% isopropyl alcohol before re-introduction into the LAFH or after gloves have been in contact with a non-sterile surface during the compounding procedure.	Ensures that Registrants are aware of the proper procedure if gloves have been in contact with something that is not sterile if they have left the LAFH and then returned.
3.1.3 All sharps are disposed of in puncture-resistant sharps containers.	5.1.17 All sharps are disposed of in a puncture-resistant, tamper-resistant, leak-proof sharps container.	NA	4.1.17 All sharps are disposed of in a puncture-resistant, tamper-resistant, leak-proof sharps container.	Adds clarity as to the requirements for all sharps containers.
7.1.20 All materials are disposed of properly.	5.1.18 All materials are disposed of properly.	NA	4.1.18 All materials are disposed of properly.	No change
7.1.19 The label used is disposed of in a secure manner, such that any identifying information is destroyed or unreadable.	5.1.19 The iv bag label ~~used~~ is disposed of in a secure manner, such that any identifying information is destroyed or unreadable.	NA	4.1.19 The iv bag label ~~used~~ is disposed of in a secure manner, such that any identifying information is destroyed or unreadable.	Housekeeping change
5.2 Labelling			**4.2 Labelling**	
The iv bag, or a document attached to the bag, is properly labelled with the following:				

• the name of the patient for whom the bag was compounded • an identification number, if applicable	5.2.1 The name of the patient for whom the bag was compounded, or an identification number, ~~if applicable~~	NA	4.2.1 The name of the patient for whom the bag was compounded, or an identification number, ~~if applicable~~	Ensures all labelling requirements align with the *Standard of Practice for IVIT* and the *General Regulation.*
• the member's name and title	5.2.2 The ~~member~~ Registrant's name and title, address, and telephone number	NA	4.2.2 The ~~member~~ Registrant's name and title, address, and telephone number	Housekeeping change.
• the name, address and telephone number of the place where the bag was compounded	5.2.3 The name of the person who compounded the iv bag, and the address and telephone number of the place where the bag was compounded if different from above,	NA	4.2.3 The name of the person who compounded the iv bag, and the address and telephone number of the place where the bag was compounded if different from above,	Housekeeping change.
• the identification of the drugs, substances and any other ingredients used in the compounding, the names and strength and, if available, the manufacturer	5.2.4 ~~identification~~ The names and strength of the drugs, substances and any other ingredients used in the compounding, ~~the names and strength~~ and the manufacturer if available,	NA	4.2.4 ~~identification~~ The names and strength of the drugs, substances and any other ingredients used in the compounding, ~~the names and strength~~ and the manufacturer if available,	Housekeeping change.
• the amount or percentage of each of the drugs, substances and any other ingredients used to make the compounded product and the quantity of the compounded product in the container	5.2.5 The amount or percentage of each of the drugs, substance and any other ingredients used to make the compounded product and the total quantity of the compounded product in the container,	NA	4.2.5 The amount or percentage of each of the drugs, substance and any other ingredients used to make the compounded product and the total quantity of the compounded product in the container,	Housekeeping change.
• the date that the compounded drug was prepared and the date that the	5.2.6 The date that the iv bag ~~compounded drug~~ was:	NA	4.2.6 The date that the iv bag ~~compounded drug~~ was:	All compounded iv bags are to be administered within 12 hours of being prepared. The date the

compounded drug was administered to the patient, • the expiry date of the iv bag, even if the bag is to be used on the same day it is compounded.	• prepared, ~~and the date that the compounded drug was~~ • administered to the patient • and the expiry date. ~~of the iv bag, even if the bag is to be used on the same day it is compounded,~~		• prepared, ~~and the date that the compounded drug was~~ • administered to the patient • and the expiry date. ~~of the iv bag, even if the bag is to be used on the same day it is compounded,~~	bag was prepared, the date it was administered and the expiry date on the label must ensure the 12-hour timeframe is met.
• the directions for the storage of the iv bag,	5.2.7 The directions for storage of the iv bag,	NA	4.2.7 The directions for storage of the iv bag,	No change
• use of the iv bag, including its dose, frequency, route of administration and any special instructions	5.2.8 The directions for use of the iv bag, including ~~its~~ dose, frequency, route of administration and any special instructions, and	NA	4.2.8 The directions for use of the iv bag, including ~~its~~ dose, frequency, route of administration and any special instructions, and	Housekeeping changes
• any cautionary information about the drug or substance.	5.2.9 any cautionary information about the drug or substance.	NA	4.2.9 any cautionary information about the drug or substance.	No change
6.0 Observed IVIT Treatment			**5.0 Observed IVIT Treatment**	
6.1 Pre-treatment Preparation			**5.1 Pre-treatment Preparation**	
8.1.1 Patient is re-assessed including a review of symptoms, medications, supplements, and diagnostic tests.	6.1.1 The patient is ~~re-assessed including a review of~~ questioned regarding any change in their symptoms, medications, and supplements; consideration has been given to possible new contraindications and if additional diagnostic tests are needed.	NA	5.1.1 The patient is ~~re-assessed including a review of~~ questioned regarding any change in their symptoms, medications, and supplements; consideration has been given to possible new contraindications and if additional diagnostic tests are needed.	Adds clarity and more direction as to what the Regsitrant should do prior to starting each IVIT.
8.1.4 Informed consent is obtained,	6.1.2 Informed consent is	NA	5.1.2 Informed consent is	No change

and all patient's questions are answered.	obtained, and all the patient's questions are answered.		obtained, and all the patient's questions are answered.	
8.1.2 Patient is verified for treatment being administered.	6.1.3 The patient is verified for IVIT treatment being administered.	NA	5.1.3 The patient is verified for IVIT treatment being administered.	Housekeeping change
8.1.7 Collect IV equipment: • administration set • alcohol • cotton • gloves • safety engineered needles • tape • tourniquet.	6.1.4 ~~Collect IV~~ Equipment needed to administer IVIT is collected: • administration set • alcohol • cotton • gloves • safety engineered needles • tape • tourniquet.	NA	5.1.4 ~~Collect IV~~ Equipment needed to administer IVIT is collected: • administration set • alcohol • cotton • gloves • safety engineered needles • tape • tourniquet.	Housekeeping change
8.1.8 Collect IV bags and inspect for leaks and cloudy or abnormal appearance	6.1.5 Collect IV bags and inspect for leaks, ~~and~~ cloud~~y~~iness, ~~and abnormal appearance~~ colour and precipitate.	NA	5.1.5 Collect IV bags and inspect for leaks, ~~and~~ cloud~~y~~iness, ~~and abnormal appearance~~ colour and precipitate.	Adds clarity, and ensures a final check of the iv bag before being administered.
8.1.3 Patient is questioned regarding: • use of restroom • fears/anxiety around treatment • history of fainting due to needles • last time they have eaten.	6.1.6 Patient is questioned regarding: • use of restroom, and • ~~fears/anxiety around treatment~~ • ~~history of fainting due to needles~~ • the last time they have eaten.	NA	5.1.6 Patient is questioned regarding: • use of restroom, and • ~~fears/anxiety around treatment~~ • ~~history of fainting due to needles~~ • the last time they have eaten.	Information about the patient's fear or anxiety regarding the IVIT or if they have a history of fainting are captured in the Patient Chart Requirements (9.7.2) and does not need to be asked prior to every IVIT.
8.1.6 Ensure infection control procedures are followed – e.g. wash hands, establish clean field.	6.1.7 ~~Ensure infection control procedures are followed – e.g. wash hands, establish clean field.~~ The person administering the IVIT washes their hands and dons gloves.	NA	5.1.7 ~~Ensure infection control procedures are followed – e.g. wash hands, establish clean field.~~ The person administering the IVIT washes their hands and dons gloves.	Changed from one requirement to two distinct requirements (see below). Ensures that the person administering the IVIT has followed proper hand hygiene protocols.

8.1.6 Ensure infection control procedures are followed – e.g. wash hands, establish clean field.	6.1.8 ~~Ensure infection control procedures are followed – e.g. wash hands, establish~~ Clean and dirty fields are established.	NA	5.1.8 ~~Ensure infection control procedures are followed – e.g. wash hands, establish~~ Clean and dirty fields are established.	Adds clarity that there is a clean and a dirty field.
8.1.9 Appropriate IV equipment is placed in the clean field.	6.1.9 Appropriate ~~IV equipment is~~ items are placed in the clean field.	NA	5.1.9 Appropriate ~~IV equipment is~~ items are placed in the clean field.	Housekeeping change
8.1.5 Pre-treatment vital signs are taken – blood pressure, heart rate, respiratory rate or pulse oximeter reading and temperature	6.1.10 Pre-treatment vital signs are taken: • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature.	NA	5.1.10 Pre-treatment vital signs are taken: • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature.	No change
NA	6.1.11 All relevant pre-treatment information is entered in the patient chart.	NA	5.1.11 All relevant pre-treatment information is entered in the patient chart.	Ensures NDs are aware of the need to chart pre-treatment info.
8.1.10 Administration set is properly set up	~~8.1.10 Administration set is properly set up~~	NA	~~8.1.10 Administration set is properly set up~~	No details of each step of setting up the admin set were previously provided in the Inspection Program Requirements. The following additions include the procedures to follow when setting up the administration set.
NA	6.1.12 The administration set is attached to the IV bag and the line is flushed.	NA	5.1.12 The administration set is attached to the IV bag and the line is flushed.	Procedure to be followed when setting up the administration set.
NA	6.1.13 The drip chamber is set to half full.	NA	5.1.13 The drip chamber is set to half full.	Procedure to be followed when setting up the administration set.
6.2 Delivery and Termination of IVIT		NA	**5.2 Delivery and Termination of IVIT**	
8.2.1 Patient is properly positioned and prepared for injection.	~~6.2.1 Patient is properly positioned and prepared for injection.~~	NA	~~6.2.1 Patient is properly positioned and~~	No details of what steps are expected when positioning the patient and preparing them for

			~~prepared for injection.~~	the injection were previously provided in the Inspection Program Requirements. The following additions include the procedures to follow when preparing the patient for injection.
NA	6.2.1 The patient's arm is properly positioned and supported.	NA	5.2.1 The patient's arm is properly positioned and supported.	Procedure to be followed when preparing the patient for injection.
NA	6.2.2 The tourniquet is applied.	NA	5.2.2 The tourniquet is applied.	Procedure to be followed when preparing the patient for injection.
NA	6.2.3 The appropriate injection site is selected.	NA	5.2.3 The appropriate injection site is selected.	Procedure to be followed when preparing the patient for injection.
NA	6.2.4 The injection site is swabbed with 70% isopropyl alcohol.	NA	5.2.4 The injection site is swabbed with 70% isopropyl alcohol.	Procedure to be followed when preparing the patient for injection.
8.2.2 The IV is inserted and drip started.	~~8.2.2 The IV is inserted and drip started.~~	NA	~~8.2.2 The IV is inserted and drip started.~~	No details of what steps are expected when inserting the IV and starting the drip were previously provided in the Inspection Program Requirements. The following additions include the procedures to follow when the iv is inserted and the drip started.
NA	6.2.5 The angiocatheter or butterfly needle is inserted.	NA	5.2.5 The angiocatheter or butterfly needle is inserted.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.6 The angiocatheter/needle is checked for a back flow of blood (flashback).	NA	5.2.6 The angiocatheter/needle is checked for a back flow of blood (flashback).	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been

				trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.7 The tourniquet is released.	NA	5.2.7 The tourniquet is released.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.8 The administration line is attached.	NA	5.2.8 The administration line is attached.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.9 The angiocatheter/needle is taped and secured.	NA	5.2.9 The angiocatheter/needle is taped and secured.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.10 The IV drip is started and the drip rate set.	NA	5.2.10 The IV drip is started and the drip rate set.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures

				that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.11 The insertion site is monitored during the treatment.	NA	5.2.11 The insertion site is monitored during the treatment.	Procedure to be followed when the iv is inserted and the drip started, which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
8.2.3 Patient is monitored during treatment (at a minimum blood pressure, heart rate, respiratory rate or pulse oximeter reading and temperature are recorded).	6.2.12 The patient's vital signs are ~~is~~ monitored during treatment when indicated or for infusions that take longer than 30 minutes to administer: ~~(at a minimum~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated ~~are recorded)~~.	NA	5.2.12 The patient's vital signs are ~~is~~ monitored during treatment when indicated or for infusions that take longer than 30 minutes to administer: ~~(at a minimum~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated ~~are recorded)~~.	Depending on the length of time it takes to administer the iv bag it may not be appropriate to monitor vitals during the treatment. Depending on the initial temperature it may not be clinically indicated to monitor during the IVIT.
8.2.4 IV drip is terminated, and all materials are properly disposed of.	~~8.2.4 IV drip is terminated, and all materials are properly disposed of.~~	NA	~~8.2.4 IV drip is terminated, and all materials are properly disposed of.~~	No details of what steps are expected when terminating the IV and disposal of materials were previously provided in the Inspection Program Requirements. The following additions include the procedures to follow when terminating the IVIT and disposing of materials.
NA	6.2.13 Once the iv bag has been administered, the angiocatheter/	NA	5.2.13 Once the iv bag has been administered, the angiocatheter/	Procedure to be followed when terminating the IVIT which all IVIT Registrants

	needle and tape are removed.		needle and tape are removed.	have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.14 The agiocatheter/needle is checked to ensure it is intact and there is no breakage.	NA	5.2.14 The agiocatheter/needle is checked to ensure it is intact and there is no breakage.	Procedure to be followed when terminating the IVIT which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.15 Pressure is applied with gauze or a cotton ball once the angiocatheter/ needle is removed.	NA	5.2.15 Pressure is applied with gauze or a cotton ball once the angiocatheter/ needle is removed.	Procedure to be followed when terminating the IVIT which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.16 A bandaid is applied or cotton ball taped down over the insertion site.	NA	5.2.16 A bandaid is applied or cotton ball taped down over the insertion site.	Procedure to be followed when terminating the IVIT which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
NA	6.2.17 All waste is handled and disposed of properly.	NA	5.2.17 All waste is handled and disposed of properly.	Procedure to be followed when disposing of materials, which all IVIT Registrants have been trained in. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.

8.3.3 All sharps are disposed of in a puncture-resistant sharps container.	6.2.18 All sharps are disposed of in a puncture-resistant, tamper-resistant, leak-proof sharps container.	NA	5.2.18 All sharps are disposed of in a puncture-resistant, tamper-resistant, leak-proof sharps container.	Adds clarity as to the requirements for all sharps containers.
NA	6.2.19 The insertion site is observed post-treatment for redness, swelling or hematoma. Treatment is provided as needed.	NA	5.2.19 The insertion site is observed post-treatment for redness, swelling or hematoma. Treatment is provided as needed.	Procedure to be followed when terminating the IVIT which all IVIT Registrants have been trained to perform. The addition to the Inspection Program Requirements ensures that the Registrant is aware that it will be observed as part of the inspection.
8.2.5 Vital signs (blood pressure, heart rate, respiratory rate or pulse oximeter reading and temperature) are taken after treatment.	6.2.20 Post-treatment vital signs are taken: ~~after treatment.~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated.	NA	5.2.20 Post-treatment vital signs are taken: ~~after treatment.~~ • blood pressure • heart rate • respiratory rate or pulse oximeter reading • temperature, when indicated.	Allows for temperature to only be taken when it is clinically indicated.
8.2.6 Appropriate post-treatment instructions are given to the patient including reporting to the ND any serious health events such as shock or convulsions, infections, allergic reactions, and adverse reactions. Also any unscheduled treatments as a result of the IV treatment, that may include visit to a hospital emergency department or another health care practitioner are to be reported.	6.2.21 Appropriate post-treatment instructions are given to the patient, including reporting to the ND any serious health events such as shock or convulsions, infections, allergic reactions, and adverse reactions. Also any unscheduled treatments as a result of the IV treatment, that may include visit to a hospital emergency department or another health care	NA	5.2.21 Appropriate post-treatment instructions are given to the patient, including reporting to the ND any serious health events such as shock or convulsions, infections, allergic reactions, and adverse reactions. Also any unscheduled treatments as a result of the IV treatment, that may include visit to a hospital emergency department or another health	No change

	practitioner are to be reported.		care practitioner are to be reported.	
8.2.7 All relevant information is entered on an IVIT-specific treatment form.	6.2.22 All relevant information is entered on an IVIT-specific treatment form in the patient chart.	NA	5.2.22 All relevant information is entered on an IVIT-specific treatment form in the patient chart.	Adds clarity
8.2.8 Only qualified personnel deliver treatment in accordance with their knowledge, skill, and judgment.	~~8.2.8 Only qualified personnel deliver treatment in accordance with their knowledge, skill and judgment.~~	NA	~~8.2.8 Only qualified personnel deliver treatment in accordance with their knowledge, skill and judgment.~~	Not necessary since the performance of the above procedures allows the inspector to assess the knowledge, skill, and judgment of the person delivering the IVIT.
7.0 General Infection Control Procedures			**6.0 General Infection Control Procedures**	
8.3.1 Universal precautions are followed	~~8.3.1 Universal precautions are followed.~~	NA	~~8.3.1 Universal precautions are followed.~~	Not necessary since other requirements outline the proper infection control procedures and precautions to follow.
8.3.2 Needles, syringes, IV bags, medication, administration tubing and connectors are never re-used.	7.1 When administering IVIT, the following are used for only one patient: • needles, • syringes, • ~~iv~~ bags of IV solution, • ~~medication,~~ • administration tubing and connectors ~~are never reused~~.	NA	6.1 When administering IVIT, the following are used for only one patient: • needles, • syringes, • ~~iv~~ bags of IV solution, • ~~medication,~~ • administration tubing and connectors ~~are never reused~~.	Provides clarity.
NA	7.2 Gloves are used for a single task and are never re-used.	NA	6.2 Gloves are used for a single task and are never re-used.	Ensures proper infection control procedures are followed and gloves are never reused.
8.3.5 Appropriate additional precautions are applied as necessary re: airborne, contact/droplet or contact precautions.	7.3 Appropriate ~~additional precautions are applied as~~ personal protective equipment is used when necessary ~~re:~~ to protect against airborne, contact and droplet	NA	6.3 Appropriate ~~additional precautions are applied as~~ personal protective equipment is used when necessary ~~re:~~ to protect against	Adds clarity regarding the use of personal protective equipment.

	transmission. ~~or contact precautions~~.		airborne, contact and droplet transmission. ~~or contact precautions~~.	
8.3.6 Staff wear appropriate Personal Protective Equipment.	~~8.3.6 Staff wear appropriate personal protective equipment (PPE).~~	NA	~~8.3.6 Staff wear appropriate personal protective equipment (PPE).~~	This requirement is too general. The appropriate use of PPE is captured in other sections with more specific expectations.
3.5.2 Approved and appropriate disinfectant products are available for patient surfaces, equipment, and instruments.	7.4 Approved and appropriate cleaning and disinfectant products are ~~available for~~ used to clean and disinfect patient surfaces, ~~equipment, and instruments~~.	NA	6.4 Approved and appropriate cleaning and disinfectant products are ~~available for~~ used to clean and disinfect patient surfaces, ~~equipment, and instruments~~.	Cleaning and disinfecting patient surfaces has been separated from the requirement for equipment and instruments.
3.5.2 Approved and appropriate disinfectant products are available for patient surfaces, equipment and instruments.	7.5 Approved and appropriate cleaning and disinfectant products are ~~available for~~ used to clean and disinfect ~~patient surfaces,~~ equipment, and instruments.	NA	6.5 Approved and appropriate cleaning and disinfectant products are ~~available for~~ used to clean and disinfect ~~patient surfaces,~~ equipment, and instruments.	Cleaning and disinfecting patient surfaces has been separated from the requirement for equipment and instruments.
NA	7.6 The cleaning and disinfecting log is kept up to date.	NA	6.6 The cleaning and disinfecting log is kept up to date.	Ensures Registrants keep a log and the inspector will be able to check.
8.0 Quality Management			**7.0 Quality Management**	
The following requirements apply to the implementation of the Quality Management Program as laid out in the Policies and Procedures Manual.				
10.1.1 Documentation that a Quality Management Committee has been established and is comprised of all staff providing IVIT related patient care.	~~10.1.1 Documentation that a Quality Management Committee has been established and is comprised of all staff providing IVIT related patient care.~~	NA	~~10.1.1 Documentation that a Quality Management Committee has been established and is comprised of all staff providing IVIT related patient care.~~	Moved to the Policies and Procedures Manual. The Quality Management section addresses how and if the processes were carried out.
NA	8.1 The Quality Management Committee meets in accordance with the Policies and	NA	7.1 The Quality Management Committee meets in accordance with the Policies	Ensures that the Quality Management Committee meets in accordance with the Policies and Procedures Manual.

	Procedures Manual.		and Procedures Manual.	
10.1.2 A process is in place to ensure that all staff review the Policy and Procedure Manual on an annual basis.	8.2 ~~A process is in place to ensure that all~~ Staff reviews the Policies and Procedures Manual ~~on an~~ at least annually ~~basis~~.	NA	7.2 ~~A process is in place to ensure that all~~ Staff reviews the Policies and Procedures Manual ~~on an~~ at least annually ~~basis~~.	Ensures that Quality Management Program includes reviewing that staff have reviewed the Policies and Procedures Manual on an annual basis.
10.2.3 Naturopathic Doctor performance is reviewed including patient selection to ensure appropriateness of treatment.	8.3 Naturopathic doctor(s) performance is reviewed as it relates to IVIT processes and procedures. ~~including patient selection to ensure appropriateness of treatment.~~	NA	7.3 Naturopathic doctor(s) performance is reviewed as it relates to IVIT processes and procedures. ~~including patient selection to ensure appropriateness of treatment.~~	Adds clarity that the Quality Management Program applies to IVIT. The review of appropriateness of treatment is captured in the patient records review section 8.18.
10.2.2 Non-medical staff performance is reviewed as it relates to IVIT processes and procedures.	8.4 Non-medical staff performance is reviewed as it relates to IVIT processes and procedures.	NA	7.4 Non-medical staff performance is reviewed as it relates to IVIT processes and procedures.	No change
NA	8.5 Reviews that staff who are involved in delegated procedures are aware of and have met all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	NA	7.5 Reviews that staff who are involved in delegated procedures are aware of and have met all requirements outlined in the *Standard of Practice for Delegation* and Part III of the *General Regulation* are met.	Ensures delegation procedures are reviewed at least annually as part of the Quality Management Program and are being followed in a premises where delegations occur.
2.1.3 All staff are aware of and trained in the clinic's emergency procedures.	8.6 Reviews that all staff are aware of and trained in the clinic's emergency procedures, including use of the AED.	NA	7.6 Reviews that all staff are aware of and trained in the clinic's emergency procedures, including use of the AED.	This requirement was included in the general emergency preparedness requirements. Inclusion in the Quality Management Program ensures it is reviewed when all other reviews are done and now includes use of the AED.

NA	8.7 Reviews that staff are aware of and consistently use the telephone, in person or online infectious disease screening protocol when communicating with patients and scheduling appointments.	NA	7.7 Reviews that staff are aware of and consistently use the telephone, in person or online infectious disease screening protocol when communicating with patients and scheduling appointments.	Ensures that the Quality Management Program includes a review that staff are following screening protocols.
3.2.5 Personal protective equipment available and used by staff when appropriate.	8.8 Reviews that staff are aware of how and when to use personal protective equipment in order to protect themselves and others.	NA	7.8 Reviews that staff are aware of how and when to use personal protective equipment in order to protect themselves and others.	Ensures that the Quality Management Program includes a review that staff are following procedures related to use of personal protective equipment.
NA	8.9 Reviews that staff are aware of procedures to follow in the event of exposure to blood or body fluids.	NA	7.9 Reviews that staff are aware of procedures to follow in the event of exposure to blood or body fluids.	Ensures that the Quality Management Program includes a review that staff are following procedures related to exposure to blood or body fluids.
10.2.1 The premises has a written quality improvement program in place which: • monitors and evaluates patient care,	8.10 ~~The premises has a written quality improvement program in place which:~~ The quality of patient care provided is monitored and evaluated.	NA	7.10 ~~The premises has a written quality improvement program in place which:~~ The quality of patient care provided is monitored and evaluated.	Housekeeping change
10.2.4 Patient outcomes are tracked and reviewed.	8.11 Patient outcomes are tracked and reviewed.		7.11 Patient outcomes are tracked and reviewed.	No change
10.2.1 The premises has a written quality improvement program in place which: • evaluates methods to improve patient care,	8.12 ~~evaluates~~ Methods to improve patient care are developed and implemented.	NA	7.12 ~~evaluates~~ Methods to improve patient care are developed and implemented.	Ensures the methods are not just developed but also reviews that they are being implemented.
• identifies and corrects	8.13 Deficiencies regarding policies	NA	7.13 Deficiencies regarding policies	Housekeeping change

deficiencies within the premises,	and procedures are identified and corrected~~.~~ ~~deficiencies within the premises~~		and procedures are identified and corrected. ~~deficiencies within the premises~~	
• alerts the designated member to identify and resolve problems.	~~alerts the designated member to identify and resolve problems.~~	NA	~~alerts the designated member to identify and resolve problems.~~	Not necessary, identifying and resolving problems is captured in other requirements, and may not always be the responsibility of the designated member.
NA	8.14 Reviews that staff are familiar with Type 1 and Type 2 occurrences.	NA	7.14 Reviews that staff are familiar with Type 1 and Type 2 occurrences.	Had been included in the Policies and Procedures Manual but not included as part of the Quality Management Program. The addition, ensures that staff reviews what Type 1 and 2 occurrences are.
NA	8.15 Reviews that staff have met the reporting requirements for Type 1 and Type 2 occurrences.	NA	7.15 Reviews that staff have met the reporting requirements for Type 1 and Type 2 occurrences.	Ensures that the Quality Management Program includes a review of the reporting requirements for Type 1 and 2 occurrences.
NA	8.16 Reviews that staff have met the record keeping procedures for Type 1 and Type 2 occurrences that have happened.	NA	7.16 Reviews that staff have met the record keeping procedures for Type 1 and Type 2 occurrences that have happened.	Ensures that the Quality Management Program includes a review of the record keeping requirements for Type 1 and 2 occurrences.
10.2.5 Complications and Type 1 and 2 occurrences are tracked and evaluated.	8.17 ~~Complications and~~ Type 1 and Type 2 occurrences ~~are tracked and evaluated.~~ that have happened are reviewed and the procedures to reduce the risk of future occurrences are reviewed, developed, and implemented.	NA	7.17 ~~Complications and~~ Type 1 and Type 2 occurrences ~~are tracked and evaluated.~~ that have happened are reviewed and the procedures to reduce the risk of future occurrences are reviewed, developed, and implemented.	Ensures that the Quality Management Program includes a review of Type 1 and Type 2 occurrences and that procedures to reduce the risk of future occurrences are reviewed, developed, and implemented.
10.2.6 At least annually, a random selection of 5-10 patient records is	8.18 At least annually, a random selection of 5-10 patient records is	NA	7.18 At least annually, a random selection of 5-10 patient	Housekeeping changes. Deleted requirements are captured in other sections.

reviewed to assess for: • record completion and documentation of informed consent, • completeness and accuracy of entries, • appropriate patient treatment, • when required, reporting requirements are met in a timely manner, • evaluation and follow-up of Type 1 and 2 occurrences, • assessment of incidents requiring transfer to hospital, • abnormal laboratory results follow-up.	reviewed to assess for: • ~~record completion and~~ adherence to the *Standard of Practice for Record Keeping* • documentation of informed consent • completeness and accuracy of entries • appropriateness of ~~patient~~ treatment • ~~when required, reporting requirements are met in a timely manner~~ • ~~evaluation and follow-up of Type 1 and 2 occurrences~~ • ~~assessment of incidents requiring transfer to hospital~~ • follow-up to abnormal laboratory test results.		records is reviewed to assess for: • ~~record completion and~~ adherence to the *Standard of Practice for Record Keeping* • documentation of informed consent • completeness and accuracy of entries • appropriateness of ~~patient~~ treatment • ~~when required, reporting requirements are met in a timely manner~~ • ~~evaluation and follow-up of Type 1 and 2 occurrences~~ • ~~assessment of incidents requiring transfer to hospital~~ • follow-up to abnormal laboratory test results.	
3.1.1 The premises adheres to and maintains documentation for accepted standards of infection control practices pertinent to IVIT.	8.19 ~~Premise adheres to and maintains documentation for~~ Reviews that accepted standards of infection control practices pertinent to IVIT are being followed.	NA	7.19 ~~Premise adheres to and maintains documentation for~~ Reviews that accepted standards of infection control practices pertinent to IVIT are being followed.	Ensures that the Quality Management Program includes a review of the infection control practices relevant to IVIT.
10.3.1 Review of activities related to cleaning, maintenance and storage of equipment	8.20 Reviews ~~of activities related to~~ that cleaning procedures are being followed and	NA	7.20 Reviews ~~of activities related to~~ that cleaning procedures are being followed	Housekeeping change, divides the requirement into two separate requirements since cleaning is a separate

	the cleaning log is properly maintained. ~~maintenance and storage of equipment.~~		and the cleaning log is properly maintained. ~~maintenance and storage of equipment.~~	process from maintenance and storage. Includes a review that the applicable logs are being maintained.
10.3.1 Review of activities related to cleaning, maintenance and storage of equipment	8.21 Reviews ~~of activities related to cleaning. Maintenance and storage of equipment.~~ that IVIT and emergency equipment is being maintained and the maintenance log is properly maintained.	NA	7.21 Reviews ~~of activities related to cleaning. Maintenance and storage of equipment.~~ that IVIT and emergency equipment is being maintained and the maintenance log is properly maintained.	As above
10.4.1 Review of activities related to monitoring drug inventory and proper storage.	8.22 Reviews ~~of activities related to monitoring~~ that drug and substance inventory is monitored, and the inventory log is properly maintained ~~and proper storage~~.	NA	7.22 Reviews ~~of activities related to monitoring~~ that drug and substance inventory is monitored, and the inventory log is properly maintained ~~and proper storage~~.	Housekeeping change, separates the requirement into two requirements to add clarity. Includes a review that the applicable logs are being maintained.
10.4.1 Review of activities related to monitoring drug inventory and proper storage.	8.23 Reviews ~~of activities related to monitoring~~ that drugs and substances are ~~inventory and~~ properly stored, and the refrigerator temperature log is properly maintained.	NA	7.23 Reviews ~~of activities related to monitoring~~ that drugs and substances are ~~inventory and~~ properly stored, and the refrigerator temperature log is properly maintained.	As above
NA	8.24 Reviews that expired drugs, substances and equipment are labelled and properly disposed of.	NA	7.24 Reviews that expired drugs, substances and equipment are labelled and properly disposed of.	Ensures that the Quality Management Program includes a review that expired drugs, substances and equipment are labelled and properly disposed of.
NA	8.25 Reviews that biomedical and non-biomedical waste is being handled and	NA	7.25 Reviews that biomedical and non-biomedical waste is being handled and	Ensures that the Quality Management Program includes a review that procedures for handling and disposing of all

	disposed of properly		disposed of properly	waste are being followed.
10.5.1 A process is in place for the reporting and documentation of Type 1 and 2 occurrences, incompetence or professional misconduct.	~~10.5.1 A process is in place for the reporting and documentation of Type 1 and 2 occurrences, incompetence or professional misconduct.~~	NA	~~10.5.1 A process is in place for the reporting and documentation of Type 1 and 2 occurrences, incompetence or professional misconduct.~~	Changed to more specific quality management requirements for Type 1 and 2 occurrences. Reporting and documentation of incompetence and professional misconduct is outside of the scope of the Inspection Program.
9.0 Patient Chart Requirements			**8.0 Patient Chart Requirements**	
All patient charts must be maintained in accordance with the *Standard of Practice for Record Keeping* and contain the following information.				The following is a list of the information to be included in the patient chart.
9.1 Appointment Record			**8.1 Appointment Record**	
6.1.1 Contains member's name, clinic name, address, and telephone number.	9.1.1 ~~Contains member's~~ Registrant's name, clinic name, address, and telephone number	NA	8.1.1 ~~Contains member's~~ Registrant's name, clinic name, address, and telephone number	Housekeeping and terminology changes
6.1.2 Contains the date and time of the appointment.	9.1.2 ~~Contains the~~ Date and time of the appointment	NA	8.1.2 ~~Contains the~~ Date and time of the appointment	Housekeeping change
6.1.3 Contains the patient's name.	9.1.3 ~~Contains the~~ Patient's name	NA	8.1.3 ~~Contains the~~ Patient's name	Housekeeping change
6.1.4 Indicates the duration of the appointment.	9.1.4 ~~Indicates the~~ Duration of the appointment	NA	8.1.4 ~~Indicates the~~ Duration of the appointment	Housekeeping change
9.2 Patient Financial Record ~~and Patient Receipt~~			**8.2 Patient Financial Record ~~and Patient Receipt~~**	
6.2.1 Treating member's name, clinic name, address, and telephone number are recorded.	9.2.1 Treating ~~Member's~~ Registrant's name, clinic name, address, and telephone number. ~~are recorded~~	NA	8.2.1 Treating ~~Member's~~ Registrant's name, clinic name, address, and telephone number. ~~are recorded~~	Housekeeping and terminology changes
6.2.2 Patient's name and address are recorded on the	9.2.2 Patient's name, ~~and~~ address and telephone	NA	8.2.2 Patient's name, ~~and~~ address and	Ensures that the phone number is added as it is required in the *Standard*

receipt.	number. ~~are recorded on the receipt.~~		telephone number. ~~are recorded on the receipt.~~	*of Practice for Record Keeping*.
6.2.3 Date of service is recorded.	9.2.3 Date of service. ~~is recorded.~~	NA	8.2.3 Date of service. ~~is recorded.~~	Housekeeping change
6.2.4 Fees for naturopathic consultation are billed separately from all other fees.	9.2.4 Fees for naturopathic consultation ~~are~~ (billed separately from all other fees).	NA	8.2.4 Fees for naturopathic consultation ~~are~~ (billed separately from all other fee).	Housekeeping change
6.2.5 Fees for supplements, injectables, etc are listed separately from the naturopathic consultation fee.	9.2.5 Fees for supplements, injectables, etc are ~~listed~~ itemized and separate~~ly~~ from the naturopathic consultation fee.	NA	8.2.5 Fees for supplements, injectables, etc are ~~listed~~ itemized and separate~~ly~~ from the naturopathic consultation fee.	Adds clarity
6.2.6 Receipts are issued for all payments and copies are maintained in the patient financial record.	9.2.6 ~~Receipts are issued for all payments and~~ Copies of the receipts ~~are~~ provided to patient for all payments. ~~are maintained in the patient financial record.~~	NA	8.2.6 ~~Receipts are issued for all payments and~~ Copies of the receipts ~~are~~ provided to patient for all payments. ~~are maintained in the patient financial record.~~	Adds clarity
6.2.7 Financial record includes payment amount, method of payment and balance of the account.	9.2.7 ~~Financial record includes~~ Payment amount, method of payment and balance of the account	NA	8.2.7 ~~Financial record includes~~ Payment amount, method of payment and balance of the account	Housekeeping change
9.3 General Patient Chart Record Keeping Components			**8.3 General Patient Chart Record Keeping Components**	
6.3.1 Patient's name, address, phone number and date of birth are documented.	9.3.1 Patient's name, address, phone number and date of birth. ~~are documented~~	NA	8.3.1 Patient's name, address, phone number and date of birth. ~~are documented~~	Housekeeping change
6.3.3 In the event that more than one health care practitioner is making entries in the patient chart, each	9.3.2 ~~In the event that more than one health care practitioner is making entries in the patient chart,~~	NA	8.3.2 ~~In the event that more than one health care practitioner is making entries in the patient chart,~~	Regardless of how many health care practitioners are making entries, there should always be a signature, registration

practitioner is identified with his or her registration number and signature, along with the date the entry was made.	~~each practitioner is identified with his or her~~ Indication of who made each entry with a signature and registration number (when applicable), and the date the entry was made.		~~each practitioner is identified with his or her~~ Indication of who made each entry with a signature and registration number (when applicable), and the date the entry was made.	number and date for every entry.
6.3.4 Patient name or patient number on each page.	9.3.3 Patient name or patient number on each page.	NA	8.3.3 Patient name or patient number on each page.	No change
6.3.5 All pages are in chronological order, consecutively numbered and dated.	9.3.4 All pages are in chronological order, consecutively numbered and dated.	NA	8.3.4 All pages are in chronological order, consecutively numbered and dated.	No change
6.3.6 A consistent format is used for recording the date.	9.3.5 All dates are recorded in a consistent format.	NA	8.3.5 All dates are recorded in a consistent format.	No change
6.3.7 All entries are made in, at the least, either English or French.	9.3.6 All entries are made in, at the least, either English or French.	NA	8.3.6 All entries are made in, at the least, either English or French.	No change
6.3.8 All written records are legible.	9.3.7 All written records are legible.	NA	8.3.7 All written records are legible.	No change
6.3.9 All written entries are made in indelible ink.	9.3.8 All written entries are made in indelible ink.	NA	8.3.8 All written entries are made in indelible ink.	No change
6.3.10 No highlighter is used over writing.	9.3.9 No highlighter is used over writing.	NA	8.3.9 No highlighter is used over writing.	No change
6.3.11 There are no blank spaces between entries.	9.3.10 Blank spaces are not left between entries.	NA	8.3.10 Blank spaces are not left between entries.	No change
6.3.12 All chart entries are recorded as soon as possible after the patient interactions.	~~6.3.12 All chart entries are recorded as soon as possible after the patient interactions.~~	NA	~~6.3.12 All chart entries are recorded as soon as possible after the patient interactions.~~	This is outside of what an inspector can assess.
6.3.13 When other than generally accepted medical abbreviations are used, a legend of abbreviations or codes is available.	9.3.11 A legend of abbreviations ~~or codes~~ is available when other than generally accepted medical	NA	8.3.11 A legend of abbreviations ~~or codes~~ is available when other than generally accepted medical	Housekeeping change

	abbreviations are used.		abbreviations are used.	
9.4 Informed Consent			**8.4 Informed Consent**	
NA	9.4.1 Documentation of a discussion regarding consent indicating the patient understands the nature of the intervention, its expected benefits, the material risks and side effects, available reasonable alternatives, the likely consequences of not receiving the intervention, the associated costs, and the right to withdraw consent.	NA	8.4.1 Documentation of a discussion regarding consent indicating the patient understands the nature of the intervention, its expected benefits, the material risks and side effects, available reasonable alternatives, the likely consequences of not receiving the intervention, the associated costs, and the right to withdraw consent.	Proper documentation regarding informed consent is often deficient. This addition, sdds clarity to include the information that is to be documented and provided to the patient when obtaining informed consent, as stated in the *Standard of Practice for Consent*. Also ensures that Registrants are aware that the requirements are part of an inspection.
6.3.2 Patient chart contains a signed informed consent form.	9.4.2 ~~Patient chart contains a signed informed consent form~~ Documentation in the form of a notation in the patient record or a consent form that is dated, signed, and witnessed.	NA	8.4.2 ~~Patient chart contains a signed informed consent form~~ Documentation in the form of a notation in the patient record or a consent form that is dated, signed, and witnessed.	Aligns with the *Standard of Practice for Consent* and the *Standard of Practice for Record Keeping*. Also ensures that Registrants are aware that the requirements are part of an inspection.
NA	9.4.3 Any modifications to the consent.	NA	8.4.3 Any modifications to the consent.	Aligns with the *Standard of Practice for Consent*. Also ensures that Registrants are aware that the requirements are part of an inspection.
NA	9.4.4 If consent is withdrawn, the reason(s) why and what was specifically withdrawn.	NA	8.4.4 If consent is withdrawn, the reason(s) why and what was specifically withdrawn.	Aligns with the *Standard of Practice for Consent*. Also ensures that Registrants are aware that the requirements are part of an inspection.
9.5 Required Electronic ~~Medical~~ Naturopathic Record Components			**8.5 Required Electronic ~~Medical~~**	Housekeeping change

			Naturopathic Record Components	
6.4.1 The system provides a visual display of the recorded information.	9.5.1 ~~The system provides~~ A visual display of the recorded information can be provided.	NA	8.5.1 ~~The system provides~~ A visual display of the recorded information can be provided.	Housekeeping change
6.4.2 The system provides a means of accessing the record of each patient by the patient's name.	9.5.2 The ~~system provides a means of accessing the~~ record of each patient can be accessed by the patient's name or other unique identifier.	NA	8.5.2 The ~~system provides a means of accessing the~~ record of each patient can be accessed by the patient's name or other unique identifier.	Housekeeping change
6.4.3 The system is capable of printing promptly the recorded information in chronological order for each patient.	9.5.3 The ~~system is capable of printing promptly the~~ recorded information can be printed promptly in chronological order for each patient.	NA	8.5.3 The ~~system is capable of printing promptly the~~ recorded information can be printed promptly in chronological order for each patient.	Housekeeping change
6.4.4 Confidentiality and privacy is maintained (such as through password protection, encryption).	9.5.4 ~~Confidentiality and privacy is maintained~~ Protections against unauthorized or inappropriate access are in place (e.g. password protection, encryption).	NA	8.5.4 ~~Confidentiality and privacy is maintained~~ Protections against unauthorized or inappropriate access are in place (e.g. password protection, encryption).	Aligns with the *Standard of Practice for Record Keeping*.
6.4.5 The system maintains an audit trail that: • records the date and time of each entry for each patient, • preserves the original content of the record if changed or updated, • identifies the person making	9.5.5 The system maintains an audit trail that: • records the date and time of each entry for each patient, • preserves the original content of the record if changed or updated, • identifies the person making	NA	8.5.5 The system maintains an audit trail that: • records the date and time of each entry for each patient, • preserves the original content of the record if changed or updated,	No change

each entry or amendment, • is capable of printing each patient record separately.	each entry or amendment, and • is capable of printing each patient record separately.		• identifies the person making each entry or amendment, and • is capable of printing each patient record separately.	
9.6 Required Naturopathic ~~Medical~~ Records Components			**8.6 Required Naturopathic ~~Medical~~ Records Components**	
6.5.1 The chief complaint(s) is clearly stated, the symptoms are adequately described, the duration of symptoms noted, and a functional inquiry is performed.	9.6.1 The chief complaint(s) ~~is clearly stated the symptoms are adequately described, the duration of symptoms noted, and a functional inquiry is performed.~~	NA	8.6.1 The chief complaint(s) ~~is clearly stated the symptoms are adequately described, the duration of symptoms noted, and a functional inquiry is performed.~~	Aligns with the *Standard of Practice for Record Keeping*.
6.5.2 The family history is documented.	9.6.2 Health, family and social history ~~is documented~~.	NA	8.6.2 Health, family and social history ~~is documented~~.	Aligns with the *Standard of Practice for Record Keeping.*
6.5.3 Allergies are identified and documented.	9.6.3 Allergies ~~are identified and documented~~.	NA	8.6.3 Allergies ~~are identified and documented~~.	Housekeeping change
8.3.4 Patients are screened for Methicillin Resistant Organisms and infectious diseases. Screening may include history taking and questioning the patient. Questioning can include but should not be limited to determining patients who are high risk, who know they have been determined to carry MRO in the past or who have had an MRO infection in the past.	9.6.4 Patient's ~~are screened for~~ history regarding exposure to and infection from methicillin resistant organisms (MROs). ~~and infectious diseases. This may include history taking and questioning of the patient.~~	NA	8.6.4 Patient's ~~are screened for~~ history regarding exposure to and infection from methicillin resistant organisms (MROs). ~~and infectious diseases. This may include history taking and questioning of the patient.~~	Patient screening can imply that laboratory testing is required which is not the case. The patient's history regarding MROs should be documented in the patient chart.
6.5.4 Assessment includes one or more	9.6.5 Assessment ~~includes~~ is	NA	8.6.5 Assessment ~~includes~~ is	Housekeeping change

of the following: • patient's health history, • physical exam with positive/negative findings documented, • lab tests and other diagnostic investigations that are clinically relevant.	formulated from information from one or more of the following: • patient's health history, • physical exam with positive/negative findings documented, • lab tests and other diagnostic investigations that are clinically relevant.		formulated from information from one or more of the following: • patient's health history, • physical exam with positive/negative findings documented, • lab tests and other diagnostic investigations that are clinically relevant.	
6.5.5 Blood tests performed in the office are only those listed in the *General Regulation* made under the *Naturopathy Act* (BTA Bioterrain Assessment, glucose, live blood cell analysis, haemoglobin $A_{1c,}$ mononuclear heterophile antibodies (monospot), free fatty acids, blood group – ABO and RhD).	9.6.6 Blood tests performed in the office are only those listed in the General Regulation made under the Naturopathy Act (BTA Bioterrain Assessment, glucose, live blood cell analysis, haemoglobin $A_{1c,}$ mononuclear heterophile antibodies (monospot), free fatty acids, blood group – ABO and RhD).	NA	8.6.6 Blood tests performed in the office are only those listed in the General Regulation made under the Naturopathy Act (BTA Bioterrain Assessment, glucose, live blood cell analysis, haemoglobin $A_{1c,}$ mononuclear heterophile antibodies (monospot), free fatty acids, blood group – ABO and RhD).	No change
6.5.6 Non-blood tests performed in the office are only those listed in *Regulation 683* made under the *Laboratory and Specimen Centre Collection Licencing Act* (ascorbic acid/Vitamin C, BTA Bioterrain Assessment, human chorionic gonadotrophin, indican, Koenisberg, oxidative testing, routine urinalysis by	9.6.7 Non-blood tests performed in the office are only those listed in Regulation #683 made under the Laboratory and Specimen Centre Collection Licencing Act (ascorbic acid/Vitamin C, BTA Bioterrain Assessment, human chorionic gonadotrophin, indican, Koenisberg,	NA	8.6.7 Non-blood tests performed in the office are only those listed in Regulation #683 made under the Laboratory and Specimen Centre Collection Licencing Act (ascorbic acid/Vitamin C, BTA Bioterrain Assessment, human chorionic gonadotrophin, indican,	No change

dipstick, Sulkowich, rapid strep test and vaginal pH).	oxidative testing, routine urinalysis by dipstick, Sulkowich, rapid strep test and vaginal pH).		Koenisberg, oxidative testing, routine urinalysis by dipstick, Sulkowich, rapid strep test and vaginal pH).	
6.5.7 Laboratory tests ordered from an allowed laboratory are only those listed in *Regulation 683* made under the *Laboratory and Specimen Centre Collection Licencing Act.*	9.6.8 Laboratory tests ordered from an allowed laboratory are only those listed in Regulation 683 made under the *Laboratory and Specimen Centre Collection Licencing Act.*	NA	8.6.8 Laboratory tests ordered from an allowed laboratory are only those listed in Regulation 683 made under the *Laboratory and Specimen Centre Collection Licencing Act.*	No change
6.5.8 A review of medications, remedies and supplements is documented.	9.6.9 Review of medications, remedies, and supplements. ~~is documented~~	NA	8.6.9 Review of medications, remedies, and supplements. ~~is documented~~	Housekeeping change
6.5.9 An assessment of the information collected and a diagnosis are documented.	9.6.10 An assessment of the information collected and a diagnosis. ~~are documented~~	NA	8.6.10 An assessment of the information collected and a diagnosis. ~~are documented~~	Housekeeping change
6.5.10 The proposed treatment plan is fully documented.	9.6.11 ~~The~~ Proposed treatment plan. ~~is fully documented~~	NA	8.6.11 ~~The~~ Proposed treatment plan. ~~is fully documented~~	Housekeeping change
NA	9.6.12 Name, strength, dosage, frequency, and method of administration for all drugs and substances included in the treatment plan.	NA	8.6.12 Name, strength, dosage, frequency, and method of administration for all drugs and substances included in the treatment plan.	Aligns with the *Standard of Practice for Record Keeping*.
6.5.11 Relevant communications with or about the patient are documented.	9.6.13 Relevant communications with or about the patient. ~~are documented~~	NA	8.6.13 Relevant communications with or about the patient. ~~are documented~~	Housekeeping change
6.5.12 The particulars of any referral made is documented.	9.6.14 ~~The particulars of any~~ Relevant referral information, where applicable. ~~made is documented~~	NA	8.6.14 ~~The particulars of any~~ Relevant referral information, where applicable. ~~made is documented~~	Aligns with the *Standard of Practice for Record Keeping*.
6.5.13 Prior to the procedure the IVIT	~~6.5.13 Prior to the procedure the IVIT~~	NA	~~6.5.13 Prior to the procedure the~~	Captured in the consent section 9.4.1

protocol along with risks, benefits, alternatives, potential complications and side effects, and costs were discussed with the patient/substitute decision maker and documented	~~protocol along with risks, benefits, alternatives, potential complications and side effects, and costs were discussed with the patient/substitute decision maker and documented~~		~~IVIT protocol along with risks, benefits, alternatives, potential complications and side effects, and costs were discussed with the patient/substitute decision maker and documented~~	
6.5.14 Relevant subjective and objective information obtained during re-assessments is documented.	9.6.15 Relevant subjective and objective information obtained during re-assessments. ~~is documented~~	NA	8.6.15 Relevant subjective and objective information obtained during re-assessments. ~~is documented~~	Housekeeping change
6.5.15 Any amendments to a written chart is initialled, dated and indicates what change was made.	9.6.16 Amendments to a written chart is initialled, dated and indicates what change was made.	NA	8.6.16 Amendments to a written chart is initialled, dated and indicates what change was made.	No change
6.5.16 Amendments are only made in the form of additions and not erasures or overwriting.	9.6.17 Amendments are ~~only~~ made in the form of additions and not erasures or overwriting.	NA	8.6.17 Amendments are ~~only~~ made in the form of additions and not erasures or overwriting.	Housekeeping change
6.5.17 A patient chart is never re-written.	~~9.6.18 A patient chart is never re-written~~	NA	~~9.6.18 A patient chart is never re-written~~	This is outside of what an inspector can assess.
9.7 Required Information Related to the Delivery of Intravenous Treatment			**8.7 Required Information Related to the Delivery of Intravenous Treatment**	
8.1.3 Patient is questioned regarding: • fears/anxiety around treatment	9.7.1 Whether or not the patient has fears/anxiety around IVIT treatment	NA	8.7.1 Whether or not the patient has fears/anxiety around IVIT treatment	Housekeeping change
8.1.3 Patient is questioned regarding: • history of fainting due to needles	9.7.2 Whether or not the patient has a history of fainting due to needles	NA	8.7.2 Whether or not the patient has a history of fainting due to needles	Housekeeping change
6.7.6 An IVIT specific form containing the	9.7.3 An IVIT specific form	NA	8.7.4 An IVIT specific form	

following information:	containing the following information:		containing the following information:	
6.7.1 Name and strength of all drugs administered	9.7.3.1 Name and strength of all drugs/substances administered.	NA	8.7.3.1 Name and strength of all drugs/substances administered.	Housekeeping change
NA	9.7.3.2 Formula of iv bag	NA	8.7.3.2 Formula of iv bag	Ensures that the information required on the iv bag label is also included in the patient chart.
6.7.2 Dosage and frequency	9.7.3.3 Dosage and frequency.	NA	8.7.3.3 Dosage and frequency.	No change
6.7.3 Date of administration	9.7.3.4 Date of administration.	NA	8.7.3.4 Date of administration.	No change
6.7.4 Method of administration	~~6.7.4 Method of administration~~	NA	~~6.7.4 Method of administration~~	No need to explicitly state this since this section is the information included on the IVIT specific form.
• infusion site	9.7.3.5 infusion site	NA	8.7.3.5 infusion site	No change
• butterfly size	~~butterfly size~~	NA	~~butterfly size~~	Not necessary, this information will be included with the catheter size.
• catheter size	9.7.3.6 catheter size	NA	8.7.3.6 catheter size	No change
• osmolarity	9.7.3.7 osmolarity	NA	8.7.3.7 osmolarity	No change
• start time	9.7.3.8 start time	NA	8.7.3.8 start time	No change
• end time	9.7.3.9 end time	NA	8.7.3.9 end time	No change
• drip rate	9.7.3.10 drip rate	NA	8.7.3.10 drip rate	No change
• vital sign **(**blood pressure, heart rate, respiratory rate or pulse oximeter reading and temperature) before, during and after treatment	9.7.3.11 vital sign **(**blood pressure, heart rate, respiratory rate or pulse oximeter reading, and temperature when applicable) before, during and after treatment	NA	8.7.4.11 vital sign **(**blood pressure, heart rate, respiratory rate or pulse oximeter reading, and temperature when applicable) before, during and after treatment	Housekeeping change
• documentation of patient monitoring during IVIT in addition to vitals	9.7.3.12 ~~documentation of patient~~ monitoring of patient during IVIT in addition to vitals	NA	8.7.3.12 ~~documentation of patient~~ monitoring of patient during IVIT in addition to vitals	Housekeeping change
6.7.5 How treatment was tolerated	9.7.3.13 how treatment was tolerated	NA	8.7.3.13 how treatment was tolerated	No change

• reactions noted • follow up to reactions	9.7.3.14 any adverse reactions to the IVIT and follow up to reactions as needed	NA	8.7.3.14 any adverse reactions to the IVIT and follow up to reactions as needed	Housekeeping change
• post treatment instructions for the patient.	9.7.3.15 post-treatment instructions for the patient (when applicable).	NA	8.7.3.15 post-treatment instructions for the patient (when applicable).	Housekeeping change
9.8 Record Keeping for Type 1 and Type 2 Reports			**8.8 Record Keeping for Type 1 and Type 2 Reports**	
NA	9.8.1 All Type 1 occurrence reports are filed in the patient file and a master file.		8.8.1 All Type 1 occurrence reports are filed in the patient file and a master file.	Ensures that any Type 1 occurrence reports that have been made are properly filed and the inspector can check during the inspection.
	9.8.2 All Type 2 occurrence tracking forms are filed in the patient file and a master file.		8.8.2 All Type 2 occurrence tracking forms are filed in the patient file and a master file.	Ensures that any Type 2 occurrences have been tracked and recorded and the inspector can check during the inspection. No need to check for the annual Type 2 occurrence report as the College keeps those records.
9.9 Delegation Charting			**8.9 Delegation Charting**	
The documentation of accepting or receiving a delegation includes:	9.9.1 The documentation when a Registrant makes ~~accepting or receiving~~ a delegation includes:	NA	8.9.1 The documentation when a Registrant makes ~~accepting or receiving~~ a delegation includes:	Record Keeping requirements for delegation are included in the *Standard of Practice for Delegation* and the *General Regulation*. There are different requirements when making or accepting a delegation.
6.6.1 the date and the specific activities that were delegated,	9.9.1.1 The date of the delegation. ~~and the specific activities that were delegated,~~	NA	8.9.1.1 The date of the delegation. ~~and the specific activities that were delegated,~~	Ensures that the delegation is specific to a patient and when the delegation occurred.
6.6.1 the date and the specific activities that were delegated,	9.9.1.2 The ~~date and the specific activities that were delegated,~~ particulars of the delegation.		8.9.1.2 The ~~date and the specific activities that were delegated,~~ particulars of the delegation.	Aligns with the wording used in the *General Regulation*, to ensure the specific activities of the delegation are documented.

6.6.5 any applicable conditions,	9.9.1.3 Any applicable conditions.	NA	8.9.1.3 Any applicable conditions.	No change
6.6.8 the communication plan to deal with the management of any adverse events that may occur.	9.9.1.4 The communication plan to deal with the management of any adverse events that may occur as a result of the delegation.	NA	8.9.1.4 The communication plan to deal with the management of any adverse events that may occur as a result of the delegation.	Aligns with the *General Regulation*.
6.6.2 the name, registration number and discipline of the delegator,	9.9.1.5 The name and registration number ~~and discipline~~ of the delegator.	NA	8.9.1.5 The name and registration number ~~and discipline~~ of the delegator.	The requirement applies to when a naturopath makes a delegation, so there is no need to state their discipline.
6.6.3 the name, registration number (if applicable) and training of the delegatee	9.9.1.6 The name~~, registration number (if applicable) and training~~ of the delegatee.	NA	8.9.1.6 The name~~, registration number (if applicable) and training~~ of the delegatee.	Aligns with the *General Regulation*.
6.6.7 informed consent specific to the delegation	9.9.1.7 Informed consent specific to the delegation.	NA	8.9.1.7 Informed consent specific to the delegation.	No change
The documentation of accepting or receiving a delegation includes:	9.9.2 The documentation when a Registrant accepts ~~or receiving~~ a delegation includes:	NA	8.9.2 The documentation when a Registrant accepts ~~or receiving~~ a delegation includes:	Record Keeping requirements for delegation are included in the *Standard of Practice for Delegation* and the *General Regulation*. There are different requirements when making or accepting a delegation.
6.6.1 the date and the specific activities that were delegated,	9.9.2.1 The date of the delegation. ~~and the specific activities that were delegated,~~	NA	8.9.2.1 The date of the delegation. ~~and the specific activities that were delegated,~~	Ensures that the delegation is specific to a patient and when the delegation occurred.
6.6.1 the date and the specific activities that were delegated,	9.9.2.2 The ~~date and the specific activities that were delegated,~~ particulars of the delegation.	NA	8.9.2.2 The ~~date and the specific activities that were delegated,~~ particulars of the delegation.	Aligns with the wording used in the *General Regulation*, to ensure the specific activities of the delegation are documented.
6.6.5 any applicable conditions,	9.9.2.3 ~~any applicable~~ The conditions, if any, under which the delegation occurred.	NA	8.9.2.3 ~~any applicable~~ The conditions, if any, under which the delegation occurred.	Aligns with the *Standard of Practice for Delegation* and the *General Regulation.*
6.6.2 the name, registration number	9.9.2.4 The name, registration	NA	8.9.2.4 The name, registration	No change

and discipline of the delegator,	number and discipline of the delegator.		number and discipline of the delegator.	
NA	9.9.2.5 The education and qualifications related to the delegated procedure of the delegator.	NA	8.9.2.5 The education and qualifications related to the delegated procedure of the delegator.	Addition to align with the *Standard of Practice for Delegation*.
6.6.3 the name, registration number (if applicable) and training of the delegatee	9.9.2.6 The name, ~~registration number (if applicable) and training~~ of the delegatee.	NA	8.9.2.6 The name, ~~registration number (if applicable) and training~~ of the delegatee.	Aligns with the *General Regulation*.
6.6.6. the period of time the delegation remains in force	9.9.2.7 The period of time the delegation remains in force.	NA	8.9.2.7 The period of time the delegation remains in force.	No change
6.6.7 informed consent specific to the delegation	9.9.2.8 Informed consent specific to the delegation.	NA	8.9.2.8 Informed consent specific to the delegation.	No change

The College of Naturopaths of Ontario

BRIEFING NOTE
Proposed Inspection Program Policies Amendments

PURPOSE: To consider the proposed Inspection Program Policies amendments based on the Inspection Committee recommendation.

OUTCOME Approval of the Inspection Program Policies amendments.

NATURE OF DECISION ❒ Strategic ☑ Regulatory Processes & Actions ❒ Other

PROCESS:

Activity:	Review and discussion of the proposed Inspection Program Policies amendments		
Results:	Decision		
Overall Timing:	How much time is allocated on the agenda for this item.		
Steps/Timing:	**1.**	Presentation of the background and proposed changes – Manager, Professional Practice	5 minutes
	2.	Discussion, Q&A - All	5 minutes
	3.	Motion/Vote - Council	1 minute

BACKGROUND:

The Inspection Committee is responsible for developing the appropriate policies and procedures governing the Inspection Program. The Committee annually reviews the policies and is bringing the proposed amendments to the Council for review and approval.

DISCUSSION POINTS:

The following amendments to the Inspection Program Policies (attached) are being proposed.

<u>Terminology/Nomenclature</u>

The Council has directed that a number of terms commonly used by the College be changed in order to improve the collective understanding of stakeholders about the role of the College. The following terms are being amended to reflect the Council's direction:

- Member to Registrant - The Council has asked that references to Members of the College be altered to Registrants of the College in order to create a better understanding that the College is not beholden to its Members as a professional association would be, but rather, created to regulate the individuals it "registers".
- Registrar to CEO - The Council has directed that references to the Registrar (and Registrar & CEO) be altered to Chief Executive Officer (CEO). A "registrar" position is typically associated with educational institutions and the use of the term by the College adds to the confusion of the College in this regard.
- Public Representative - In the changes made to the by-laws previously, the Council added an ability to appoint members of the public to its Committees. The terminology introduced at

that time created confusion with Public Members appointed by the Ontario Government to the Council. Introducing a defined term “Public Representative” is intended to add clarity.

Housekeeping

As is common, when a review is undertaken, there are often minor grammatical issues that are identified, and wording that is inconsistent with related College documents. These changes are not significant, but it is a good practice to make corrections when College documents are being amended.

Substantive Amendments

Additional, more substantive proposed amendments are provided in the following table. For each amendment, the table includes the current wording, the proposed amendment, and the rationale for the amendment.

Current wording	**Proposed Amendment**	**Rationale**
Composition of the Committee	Composition of the Committee	
The composition of the IC is specified in the by-laws of the College. The Committee shall be appointed by the Council of the College and shall be comprised of at least three and not more than five members, including: At least one (1) professional member who is a member of the Council At least one (1) public member who is a member of the Council; At least one but not more than three professional members who are not members of the Council and who have met the standard of practice for both Intravenous Infusion Therapy and Prescribing as established in the *General Regulation*.	The composition of the IC is specified in the by-laws of the College. ~~The Committee shall be appointed by the Council of the College and shall be comprised of at least three and not more than five members, including:~~ ~~At least one (1) professional member who is a member of the Council~~ ~~At least one (1) public member who is a member of the Council;~~ ~~At least one but not more than three professional members who are not members of the Council and who have met the standard of practice for both Intravenous Infusion Therapy and Prescribing as established in the *General Regulation*.~~	By not including the details of the composition of the Inspection Committee in the policies, any changes made in the by-laws do not also require a change in the policies. This reduces the need for staff to present amendments to the Committee, and subsequently to the Council for review and approval.
Responsibilities of the Committee	Responsibilities of the Committee	
As outlined in Part IV of the *General Regulation* and the Terms of Reference, the IC may do only one or more of the following: • develop, maintain and review the Inspection Program Requirements; • develop appropriate policies and procedures governing the inspection	As outlined in Part IV of the *General Regulation* and the Terms of Reference, the IC may do only one or more of the following: • advise on and recommend to Council the requirements for, and policies and procedures relating to the Inspection Program of the College	Updated to ensure consistency with the current Terms of Reference for the Inspection Committee.

program for review and approval by the Council; • ensure appropriate individuals are appointed and trained to perform inspections; • ensure adequate inspections are undertaken and completed in a timely way using appropriate tools and mechanisms, • determine, after reviewing inspection reports and other material referred to in Part IV of the *General Regulation,* whether the outcome for a premises is a pass, pass with conditions, or fail, • specify the conditions that shall be attached to each "pass with conditions", • deliver written reports as required; • ensure the IVIT Premises Register is maintained; • direct the Registrar to refer a member to the Quality Assurance Committee, if the result of an inspection report made by the Committee finds that a member's knowledge, skill or judgment is unsatisfactory; • direct the Registrar to refer a member to the Inquiries, Complaints and Reports Committee, if the result of an inspection report made by the College finds that a member may have committed an act of professional misconduct or may be incompetent or incapacitated.	• annually review all program policies and related procedures and report to the Council on the outcome of the review and make any recommendations for amendments, ~~develop, maintain and review the Inspection Program Requirements;~~ • ~~develop appropriate policies and procedures governing the inspection program for review and approval by the Council;~~ • ensure appropriate individuals are appointed and trained to perform inspections; • bi-annually review relevant regulations made under the *Naturopathy Act, 2007*, including but not necessarily limited to Part IV of the *General Regulation,* • ensure adequate inspections are undertaken and completed in a timely way using appropriate tools and mechanisms, • determine, after reviewing inspection reports and other material referred to in Part IV of the *General Regulation*: ○ whether the outcome for a premises is a pass, pass with conditions, or fail, ○ specify the conditions that shall be attached to each "pass with conditions", ○ deliver written reports as required; • ~~ensure the IVIT Premises Register is maintained;~~ ○ direct the ~~Registrar~~ Chief Executive Office to refer a ~~member~~ Registrant to the	

	Quality Assurance Committee, if the result of an inspection report made by the Committee finds that a ~~member's~~ Registrant's knowledge, skill or judgment is unsatisfactory; ○ direct the ~~Registrar~~ Chief Executive Office to refer a Registrant ~~member~~ to the Inquiries, Complaints and Reports Committee, if the result of an inspection report made by the College finds that a Registrant ~~member~~ may have committed an act of professional misconduct or may be incompetent or incapacitated.	
Registering an Existing Premises	~~Registering an Existing Premises~~	
For premises where procedures are being performed on the day Part IV of the *General Regulation* comes into force the designated member is required to register the premises with the College by completing the Registering an IVIT Premises form. These premises are considered to be existing premises. Written notification must be provided no later than 60 days from the date Part IV of the *General Regulation* comes into force.	~~For premises where procedures are being performed on the day Part IV of the *General Regulation* comes into force the designated member is required to register the premises with the College by completing the Registering an IVIT Premises form. These premises are considered to be existing premises.~~ ~~Written notification must be provided no later than 60 days from the date Part IV of the *General Regulation* comes into force.~~	No longer applicable, as the 60-day period has passed.
Registering a New Premises	Registering a New Premises	
For premises not performing IVIT on the day Part IV of the *General Regulation* came into effect and where members are intending to perform procedures the designated member must	For premises ~~not performing IVIT on the day Part IV of the *General Regulation* came into effect and~~ where Registrants ~~members~~ are intending to perform procedures the Dedesignated	No longer require wording to include premises that were performing IVIT prior to the day Part IV of the General Regulation came into effect, as this no longer applies. Proposed amendments add

provide written notification of the new premises to the College by completing the Registering an IVIT Premises form. New premises must undergo Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients. An existing premises that moves to a new location must register as a new premises and undergo Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients.	Registrant ~~member~~ must provide written notification of the new premises to the College by completing the Registering an IVIT Premises form. New premises must undergo Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients. An ~~existing~~ already registered premises that moves to a new location must register as a new premises and undergo Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients.	clarity that only new premises and registered premises providing IVIT that are moving to a new location, are required to register prior to be authorized to perform IVIT.
Initial Inspection Timelines for Existing Premises	~~Initial Inspection Timelines for Existing Premises~~	
All existing premises will be inspected by the College within 24 months of the date Part IV of the *General Regulation* comes into force.	~~All existing premises will be inspected by the College within 24 months of the date Part IV of the *General Regulation* comes into force.~~	No longer applicable, as the 24-month period has passed.
Timelines for New Premises	Timelines for New Premises	
Part II of the inspection will occur within approximately 6 months of the completion of Part I.	Part II of the inspection will occur within approximately 6 months of the successful completion of Part I.	Adds clarity.
Delegation	Delegation	
A member may not delegate the compounding of or the intravenous administration of a prescribed substance at a premises that has failed an inspection.	A Registrant ~~member~~ may not make or accept a delegation ~~the~~ for compounding ~~of~~ or ~~the~~ administration by intravenous injection ~~administration~~ of a ~~prescribed~~ substance at a premises that has failed an inspection.	Adds clarity. When a premises fails an inspection Registrants cannot perform IVIT by accepting a delegation, nor can they make a delegation to someone at the premises. Ensures that the Registrant does not work around an outcome of a fail and continue to perform IVIT.
Inspection Fees	Inspection Fees	
All premises that are subject to an inspection must pay a fee of $2,500 to the College as per Schedule 3 of the by-laws.	All premises that are subject to an inspection must pay the inspection~~a~~ fees ~~of $2,500~~ to the College as per Schedule 3 of the by-laws.	By not including the inspection fee amount, any future changes to fees made in the by-laws do not require a change in the policies. This

The inspection fee will be invoiced to the designated member who must pay the required amount within 30 days of the date of the invoice.	The inspection fee will be invoiced to the premises. The Ddesignated Registrant ~~member who must~~ is required to submit payment ~~the required amount~~ within 30 days of the date of the invoice. The premises registration fee stated in Schedule 3 of the by-laws is payable on receipt of the Registering an IVIT Premises form.	reduces the need for staff to present amendments to the Committee, and subsequently to the Council for review and approval. Includes the new registration fee and that it is payable at the time the Registrant submits the Registering an IVIT Premises form.
Invoicing of fees	Invoicing of fees	
For all existing premises at the date Part IV of the *General Regulation* comes into force the $2,500 fee will be invoiced in two equal instalments of $1,250 approximately one year apart within the initial 24 month period.	~~For all existing premises at the date Part IV of the *General Regulation* comes into force the $2,500 fee will be invoiced in two equal instalments of $1,250 approximately one year apart within the initial 24 month period.~~	The fee payment for requirements premises existing at the time Part IV of the General Regulation no longer applies, as the 24-month period has passed.
For all subsequent inspections the full $2,500 fee will be invoiced upon notification that the premise has been selected for an inspection. The subsequent inspection may be conducted within the regular 5-year cycle or as deemed necessary or advisable by the College.	For all ~~subsequent~~ regularly scheduled 5-year inspections the ~~full $2,500~~inspection fee as stated in Schedule 3 of the by-laws will be invoiced upon notification to the Designated Registrant that the premise has been selected for an inspection. ~~The subsequent inspection may be conducted within the regular 5-year cycle or as deemed necessary or advisable by the College.~~	The amount of the inspection fee is removed for reasons stated above. The timing of the “subsequent inspection” is not necessary in this section.
For a new premises the $2,500 fee will be invoiced in two equal payments of $1,250. The first $1,250 will be invoiced upon notification to the designated member that the inspector has been assigned to conduct Part I of the inspection. The second $1,250 will be invoiced upon notification to the designated member that the inspector has been assigned to	For a new premises the ~~$2,500~~ inspection fee as stated in Schedule 3 of the by-laws will be invoiced ~~in two equal payments of $1,250. The first $1,250 will be invoiced~~ upon notification to the Ddesignated Registrant ~~member~~ that the premises has been selected for an inspection. ~~inspector has been assigned to conduct Part I of the~~	Updates the new premises fees in accordance with the Schedule 3 by-law amendments. Removes invoicing and timing of invoicing that no longer apply.

conduct Part II of the *inspection.*	~~inspection. The second $1,250 will be invoiced upon notification to the designated member that the inspector has been assigned to conduct Part II of the inspection.~~	
The second instalment of the inspection fee for an existing premises that has not undergone an inspection will not be invoiced if it is withdrawn from the Inspection Program prior to being invoiced for the second instalment.	~~The second instalment of the inspection fee for an existing premises that has not undergone an inspection will not be invoiced if it is withdrawn from the Inspection Program prior to being invoiced for the second instalment.~~	
An existing premises that has undergone an inspection and withdraws from the Inspection Program will be invoiced for the second instalment regardless of when the premises is withdrawn.	~~An existing premises that has undergone an inspection and withdraws from the Inspection Program will be invoiced for the second instalment regardless of when the premises is withdrawn.~~	
Refunds	Refunds	
Inspection fees that have been paid will not be refunded to a premises that withdraws from the Inspection Program even if the premises has not undergone an inspection.	Inspection fees that have been invoiced and/or paid will not be refunded to a premises that withdraws from the Inspection Program even if the premises has not undergone an inspection.	Inspection fees will be invoiced at the time a premises is notified that it has been selected for an inspection, and will not be refunded even if the premises chooses at this time to stop performing IVIT procedures. It is possible that the Designated Registrant may continue to provide IVIT until they are required to undergo an inspection, and then stop doing IVIT to avoid an inspection and paying the fee. They may choose to stop IVIT at the premises, however they will still be required to pay the inspection fee.
Non-payment of fees	Non-payment of fees	
If payment is not received within the 30 days the designated member's	If payment is not received within the ~~30 days~~required timeframe the D~~d~~esignated	Allows for all payments to be made in accordance with the timeframes outlined in the by-

registration may be suspended for failure to pay fees.	Registrant's ~~member's~~ registration may be suspended for failure to pay fees.	laws. By not including the number of days for each type of payment, any future changes made in the by-laws do not require a change in the policies. This reduces the need for staff to present amendments to the Committee, and subsequently to the Council for review and approval.
Withdrawal from Inspection Program	Withdrawal from Inspection Program	
When a premises closes or ceases to perform IVIT procedures the designated member of that premises must notify the College in writing no later than 30 days following the date the premises closed or ceased to perform these services. If a premises has been notified that it has been selected for an inspection and then chooses to close or cease to perform IVIT procedures the inspection will not be conducted as long as the Cease to Perform IVIT Form is received by the College no later than 14 days after notification of the inspection.	When a premises closes or ceases to perform IVIT procedures the Dd~~d~~esignated Registrant ~~member~~ of that premises must notify the College in writing no later than 30 days following the date the premises closed or ceased to perform these services. If a premises has been notified that it has been selected for an inspection and then chooses to close or cease to perform IVIT procedures the inspection will not be conducted as long as the Cease to Perform IVIT Form is received 14 days prior to the inspection. ~~by the College no later than 14 days after notification of the inspection.~~	Allows a premises more time to withdraw from the Inspection Program and stop performing IVIT. A longer timeframe allows arrangements for patients to continue IVIT at another premises.
Selection of an Existing Premises	Selection of an Existing Premises	
Existing premises will be selected for an initial inspection within 24 months of the date Part VI of the *General Regulation* comes into force. Following the initial inspection, premises will be selected to undergo an inspection once every 5 years or more often if, in the opinion of the College, it is necessary or advisable to do so.	~~Existing premises will be selected for an initial inspection within 24 months of the date Part VI of the *General Regulation* comes into force.~~ Following the initial inspection, premises will be selected to undergo an inspection once every 5 years or more often if, in the opinion of the College, it is necessary or advisable to do so.	No longer applicable, as the 24-month period has passed.

Selection of a New Premises	Selection of a New Premises	
New premises will be inspected as soon as is practicable and no longer than 180 days after receiving the Registering an IVIT Premises form.	New premises will be inspected as soon as is practicable and no longer than 180 days after receiving the Registering an IVIT Premises form and the premises registration fee.	Includes the new requirement to pay the registration fee.
Notification of Selection	Notification of Selection	
The designated member for a premises will receive written notification that the premises has been selected for an inspection along with the name of the inspector.	The Dd~~d~~esignated Registrant ~~member~~ for a premises will receive written notification that the premises has been selected for an inspection ~~along with the name of the inspector~~. Notification will occur via email (as well as fax or mail) and as such every Designated Registrant must provide the College an active email address.	Includes how the Designated Registrant will be notified that they have been selected for an inspection, and that they must ensure the College has their current email address.
Deferral Requests	Deferral Requests	
The designated member for a premises that is selected for an inspection may seek a deferral only under special circumstances such as if they are on parental leave, are on a leave-of-absence, are seriously ill, or if there are other extenuating circumstances. The designated member must submit the deferral request to the College within 14 days of the premises being notified of its selection for an inspection. The request may be accompanied by a letter from a regulated health care practitioner or other supporting documentation verifying the circumstances for his or her inability to attend the inspection.	The Dd~~d~~esignated Registrant ~~member~~ for a premises that is selected for an inspection may seek a deferral only under special circumstances such as if they are on parental leave, are on a leave-of-absence, are seriously ill, or if there are other extenuating circumstances. The Dd~~d~~esignated Registrant ~~member~~ must submit the deferral request to the College within 14 days of the premises being notified of its selection for an inspection unless there are extenuating circumstances that affect the Registrant's ability to submit the application earlier. The request may be accompanied by a letter from a regulated health care practitioner or other supporting documentation verifying the circumstances for ~~his or her~~ their inability to attend the inspection.	Allows the Designated Registrant to submit a deferral request after 14 days of being notified of an inspection, in special circumstances.
Setting a date and time	Setting a date and time	

The inspection shall occur during office hours.	~~The inspection shall occur during office hours.~~	Allows the inspector and the Designated Registrant to schedule the inspection at a mutually convenient time, including outside of regular office hours.
Effective Date	Effective Date	
A report that a premises has passed, passed with conditions or failed an inspection is effective on the date it was received by the designated member or one or more of the Members performing procedures at the premises.	A report that a premises has passed, passed with conditions or failed an inspection is effective on the date it was received in accordance with section 39 of the *Regulated Health Professions Act, 1991* by the D~~d~~esignated Registrant ~~member or one or more of the Members performing procedures at~~ for the premises.	Adds clarity by including the "deemed delivered" clause in the RHPA. **39**(1) A notice or decision to be given to a person under this Act, the *Drug and Pharmacies Regulation Act* or a health profession Act may be given by mail or by fax. 2007, c. 10, Sched. M, s. 11. **When notice or decision given by mail received** (2) If a notice or decision is sent by mail addressed to a person at the person's last known address, there is a rebuttable presumption that it was received by the person on the fifth day after mailing. 2007, c. 10, Sched. M, s. 11. **When notice or decision given by fax received** (3) If a notice or decision is sent by fax to a person at the person's last known fax number, there is a rebuttable presumption that it was received by the person, (a) on the day it was faxed, if faxed after midnight and before 4 p.m.; or (b) on the following day, if faxed at any other time.

ANALYSIS

Risk Assessment – The risk assessment is based on the document *Understanding the Risk Analysis Terminology,* a copy of which is included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- *Operational*
  - Process: Process risk comes from the Committee, in their review, ensuring that all of the necessary practices and procedures for update have been identified and properly amended.
- Strategic
  - Reputational: Confidence and trust in the organization comes from ensuring that its practices and procedures are accurate, consistent and up-to-date.

Privacy Considerations – There are no privacy considerations.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency,* a copy of which was included in the Information Items of the Consent Agenda. Only those items that have been identified will be addressed..

- Information to foster trust: Updating the policies and making them publicly available will allow the public and the profession to access the necessary information in order to trust that this process works effectively.
- Relevant, credible, and accurate information: Ensuring that the Inspection Program Policies are consistent with other College policies and resources may increase trust in the processes of the College.

Financial Impact – There is no financial impact with this recommendation.

Public Interest – The Inspection Program will continue to operate thereby ensuring safe and quality care for Ontarians who choose to access IVIT services.

RECOMMENDATIONS

The Inspection Committee recommends the Council approves the amendments to the Inspection Program Policies.

ACTION ITEMS

The Inspection Program Policies will be updated and posted on the College's website.

Sean Armstrong, ND
Chair, Inspection Committee

Mary-Ellen McKenna, ND (Inactive)
Manager, Professional Practice

May 12, 2021

Intent/Purpose	To provide comprehensive policies governing the Inspection Program of the College of Naturopaths of Ontario (the College).	
Definitions	Inspector	A person appointed by the College to carry out an inspection under the Ontario Regulation 168/15 (the *General Regulation*) on behalf of the College.
	Designated Registrant	A Registrant[1] who is designated to deliver and accept information on behalf of a specified premises as per Section 30 of the *General Regulation*.
	Premises	Any place where a Registrant performs or may perform a procedure.
	Procedure	(i) Any procedure by which any two or more drugs or substances listed in Table 2 or Table 5, in any combination, are mixed, reconstituted, or by any other means made into a customized therapeutic product by a Registrant for the purpose of administration by intravenous injection to a patient, and includes the labeling of such a customized therapeutic product, or (ii) the administration of a customized therapeutic product described in (i) by intravenous injection to a patient by a Registrant .
	Adverse Drug Reaction	A harmful and unintended response by a patient to a drug or substance or combination of drugs or substances that occurs at doses normally used or tested in humans for the diagnosis, treatment or prevention of a disease or the modifications of organic function.
General	Regulations	All aspects of the Inspection Program will be managed in accordance with the *Health Professions Procedural Code,* and the Ontario Regulation 168/15. Members of the Inspection Committee (IC) and Professional Practice department staff will act in accordance with these policies, regulations and the applicable procedures manuals.
	Composition of the Committee	The composition of the IC is specified in the by-laws of the College.
	Quorum	Pursuant to section 12.06 of the By-laws of the College quorum for meetings shall be three (3) members of the Committee unless the Committee is composed of three (3) members, in which case, the quorum for such a Committee shall be two (2) members, at least one of which shall be either a Public member of the Council or a

[1] The Council of the College of Naturopaths of Ontario has directed that the College refer to individuals registered with the College as "Registrants". "Registrant", as it is used in this policy has the same meaning as "member" as defined in section 1(1) of the *Health Professions Procedural Code*.

Public Representative.

In cases of urgency as determined by the Chair of the Committee, the public member requirement for the purposes of quorum may be waived.

Bias/Conflict of Interest

Pursuant to the College's by-laws, no member of a Committee can have a real or perceived bias or conflict of interest. If an IC member has a conflict of interest or bias, whether it is real or perceived, they must declare it and should excuse themselves from any discussions and votes pertaining to the matter whenever the matter is tabled.

Committee members must be objective and impartial with respect to the outcome of the matter coming before them for decision. Committee members may be disqualified because of an actual bias or conflict of interest or because of circumstances that give rise to a reasonable apprehension of bias or conflict of interest, even though an actual bias does not exist.

Responsibilities of the Committee

As outlined in Part IV of the *General Regulation* and the Terms of Reference, the IC may do only one or more of the following:

- advise on and recommend to Council the requirements for, and policies and procedures relating to the Inspection Program of the College
- annually review all program policies and related procedures and report to the Council on the outcome of the review and make any recommendations for amendments, ensure appropriate individuals are appointed and trained to perform inspections;
- bi-annually review relevant regulations made under the *Naturopathy Act, 2007*, including but not necessarily limited to Part IV of the *General Regulation,*
- ensure adequate inspections are undertaken and completed in a timely way using appropriate tools and mechanisms,
- determine, after reviewing inspection reports and other material referred to in Part IV of the *General Regulation*:
  - whether the outcome for a premises is a pass, pass with conditions, or fail,
  - specify the conditions that shall be attached to each "pass with conditions",
  - deliver written reports as required;
  - direct the Registrar to refer a Registrant to the Quality Assurance Committee, if the result of an inspection report made by the Committee finds that a

Registrant's knowledge, skill or judgment is unsatisfactory;

- direct the Registrar to refer a Registrant to the Inquiries, Complaints and Reports Committee, if the result of an inspection report made by the College finds that a Registrant may have committed an act of professional misconduct or may be incompetent or incapacitated.

	Participation	As outlined in Section 26(1) of the *General Regulation*, all premises where a procedure is or may be performed by a Registrant in connection with their practice are subject to an inspection by the College.
	Non-compliance	Failing to comply with any duty or requirement of Part IV of the *General Regulation* may be considered professional misconduct, as outlined in Section 36 of the Professional Misconduct Regulation.
	Annual Policy and Standards Review	The IC will review the program policies and the Inspection Program Requirements, on an annual basis.
	Inspector's Honoraria and Expenses	Inspectors are entitled to an honorarium of $75 for inspection preparation, $150 to conduct the inspection and $75 for drafting the Inspection Report. Reimbursement for expenses will be in accordance with GP 18.04 Per Diems and Expenses.
Inspection Program General	Designated Registrant	All premises in which procedures are performed must have a Designated Registrant at all times. The designated Registrant must be a Naturopathic Doctor registered with the College who has met the standards of practice for Intravenous Infusion Therapy and Prescribing.
	Designated Registrant Responsibilities	The Designated Registrant is the main contact person for a premises, and is responsible for communicating with the College and the payment of fees regarding the premises and any inspections thereof. The Designated Registrant ensures that the premises and all staff who perform procedures there meet the responsibilities and requirements outlined in the College's Inspection Program documents and Part IV of the *General Regulation*.
	Registering a New Premises	For premises where Registrants are intending to perform procedures the Designated Registrant must provide written notification of the new premises to the College by completing the Registering an IVIT Premises form. New premises must undergo

	Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients. An already registered premises that moves to a new location must register as a new premises and undergo Part I of the inspection and receive an outcome of a pass or pass with conditions prior to offering the administration of IVIT or compounding for IVIT to patients.
Ceasing to Offer Procedures at a Premises	If a premises closes or ceases to perform compounding for IVIT and/or administration of IVIT, the Designated Registrant must notify the College by completing the Cease to Perform IVIT Procedures form within 30 days of the changes.
Resumption of Procedures at a Premises	If a premises re-opens or resumes performing procedures, the premises will be considered to be a new premises and will be required to undergo and pass or pass with conditions Part I of an inspection prior to offering IVIT services to patients. (Part II of the inspection will occur within approximately 6 months of the completion of Part I.)
Inspection Frequency	All premises where a Registrant performs or may perform a procedure are subject to an inspection by the College once every 5 years, following the first inspection or more often if, in the opinion of the College, it is necessary or advisable to do so.
Timelines for New Premises	New premises in which Registrant are intending to perform procedures will undergo Part I of the inspection within 180 days of the College receiving written notification from the Designated Registrant . Part II of the inspection will occur within approximately 6 months of the successful completion of Part I.
Policies and Procedures Manual	All premises in which procedures are performed must have a Policies and Procedures Manual which includes, at a minimum, the information outlined in the Inspection Program Requirements. The Designated Registrant is responsible for ensuring the manual is created and kept current, and that all staff reviews the manual on an annual basis.
Naturopathic Doctors' Qualifications	Registrants who are performing procedures at a premises must hold a valid certificate of registration in the General class with the College of Naturopaths of Ontario, and must have met the

	standards of practice for Intravenous Infusion Therapy and Prescribing. All Registrants of the College are expected to maintain valid Health Care Provider level CPR certification.
Other Regulated Health Professionals' Qualifications	All regulated health professionals (RHPs) who provide IVIT-related care at the premises must be adequately trained and appropriately registered with their regulatory body.
Other Staff Qualifications	All additional staff other than NDs or members of another regulated health profession, who may be involved in IVIT-related patient care, must have the appropriate qualifications and training to perform their assigned duties safely and competently.
Delegation	A Registrant may not make or accept a delegation for compounding or administration by intravenous injection of a substance at a premises that has failed an inspection. When making or accepting a delegation the Registrant must meet the criteria outlined in Part III of the *General Regulation* and the *Standard of Practice for Delegation*.
Inspection Fees	All premises that are subject to an inspection must pay the inspection fees to the College as per Schedule 3 of the by-laws. The inspection fee will be invoiced to the premises. The Designated Registrant is required to submit payment within 30 days of the date of the invoice. The premises registration fee stated in Schedule 3 of the by-laws is payable on receipt of the Registering an IVIT Premises form.
Invoicing of fees	For all regularly scheduled 5-year inspections the inspection fee as stated in Schedule 3 of the by-laws will be invoiced upon notification to the Designated Registrant that the premise has been selected for an inspection. For a new premises, the inspection fee as stated in Schedule 3 of the by-laws will be invoiced upon notification to the Designated Registrant that the premises has been selected for an inspection.
Refunds	Inspection fees that have been invoiced and/or paid will not be refunded to a premises that withdraws from the Inspection Program even if the premises has not undergone an inspection.

	Non-payment of fees	If payment is not received within the required timeframe the Designated Registrant's registration may be suspended for failure to pay fees.
	Withdrawal from Inspection Program	When a premises closes or ceases to perform IVIT procedures the Designated Registrant of that premises must notify the College in writing no later than 30 days following the date the premises closed or ceased to perform these services. If a premises has been notified that it has been selected for an inspection and then chooses to close or cease to perform IVIT procedures the inspection will not be conducted as long as the Cease to Perform IVIT Form is received 14 days prior to the inspection.
	Type 1 and Type 2 Occurrence Reporting	Type 1 and Type 2 occurrences must be reported in accordance with Sections 24 and 25 of the *General Regulation*. Reports shall be submitted to the College using the applicable form. Type 2 occurrence reports are to be submitted to the College no later than May 1 of each year and shall be for the reporting period of March 2 of the previous year to March 1 of the current year.
	Type 1 Occurrence Report Requirements	All Type 1 occurrence reports must include the following information: i. which Type 1 occurrence happened, ii. the initials, age, and sex of the patient, iii. contact information of the Registrant making the report, iv. names of all staff involved in providing care for the patient, v. the name(s) of any witness to the event (if applicable), vi. the time, date and location of the event, vii. a description of the incident and any actions taken, or treatment provided, viii. the outcome of the event, and ix. any other information relevant to the incident.
	Follow up on Occurrence Reports	Type 1 occurrences will be reviewed by the IC to determine what, if any, further action is required. A summary of Type 2 occurrences will be provided to the IC and Council on an annual basis for statistical and planning purposes.
Pre-Inspection	Selection of an Existing Premises	Following the initial inspection, premises will be selected to undergo an inspection once every 5 years or more often if, in the opinion of the College, it is necessary or advisable to do so.

Selection of a New Premises	New premises will be inspected as soon as is practicable and no longer than 180 days after receiving the Registering an IVIT Premises form and the premises registration fee.
Notification of Selection	The Designated Registrant for a premises will receive written notification that the premises has been selected for an inspection. Notification will occur via email (as well as fax or mail) and as such every Designated Registrant must provide the College an active email address.
Deferral Requests	The Designated Registrant for a premises that is selected for an inspection may seek a deferral only under special circumstances such as if they are on parental leave, are on a leave-of-absence, are seriously ill, or if there are other extenuating circumstances. The Designated Registrant must submit the deferral request to the College within 14 days of the premises being notified of its selection for an inspection unless there are extenuating circumstances that affect the Registrant's ability to submit the application earlier. The request may be accompanied by a letter from a regulated health care practitioner or other supporting documentation verifying the circumstances for their inability to attend the inspection.
Review of Deferral Requests	All deferral requests will be reviewed by the IC on an individual basis. Deferrals are granted based on the validity and severity of the situation or illness that may prevent the Designated Registrant from submitting the necessary forms or attending the inspection.
Required Forms Submitted by the Designated Registrant	When a premises is notified that it has been selected for an inspection, the College will provide the Designated Registrant with the Pre-inspection Information and Registrant Declaration of a Conflict of Interest forms that must be completed and returned to the College within, at least 14 days.
Assignment of an Inspector	The Chief Executive Officer, or their delegate, will assign an inspector based on the information provided in the Registering an IVIT Premises form and the Declarations of a Conflict of Interest from the Designated Registrant and the inspectors. No Registrant of the College who, to the knowledge of the Chief Executive Officer, or their delegate has sat on a panel of the Discipline Committee and has heard allegations against a Registrant at the selected premises will be assigned as an inspector for that premises.

		No inspector who, to the knowledge of the Chief Executive Officer, or their delegate has a conflict of interest with a Registrant , other health care practitioner or staff member who provide IVIT-related patient care at the premises will be assigned as an inspector for that premises.
	Conflict of Interest Criteria	A conflict of interest exists where a reasonable person would conclude that the inspector's professional, personal or financial relationship to one or more of the staff or health care practitioners providing IVIT related patient care at the premises being inspected may affect their judgment or the discharge of their duties to the College. A conflict of interest may be real or perceived, actual or potential, direct or indirect.
	Setting a date and time	The assigned inspector will contact the Designated Registrant to arrange a date and time for the inspection, which should occur within approximately 30 days. The inspector will notify the College of the inspection date for each of the premises they are responsible for conducting. For existing and Part II new premises inspections, the Designated Registrant shall make every effort to ensure that the inspection is conducted on a day when there are patients scheduled for IVIT treatments and compounding for IVIT will be performed.
Inspection	Inspector Authority	An inspector appointed by the College may enter and inspect a premises where administration of IVIT and/or compounding for IVIT are performed by a Registrant , at reasonable times, upon producing information identifying them as an inspector.
	Access to Premises	On the day of the inspection, the Designated Registrant will ensure that the inspector has access to all appropriate areas of the premises, and that all documentation relevant to the performance of procedures is made available, including but not limited to appointment books, accounts, reports, and patient records.
	Denial of Access	If an inspector is denied entry or access to a premises, all Registrants must cease to perform procedures at that premises until an inspection has taken place.
	Inspection components	An inspection of a premises may include some or all of the following: • a review of the physical layout, equipment, storage of drugs and substances being compounded and administered by IVIT, infection control and relevant

emergency procedures in accordance with the Inspection Program Requirements,
- a review of patient records and other documentation related to patient care,
- observation of the administration of IVIT and/or compounding for IVIT procedures being performed in accordance with the Inspection Program Requirements and standards of practice,
- a review of any reports made to the College regarding Type 1 and Type 2 occurrences at the premises,
- a review of the Policies and Procedures Manual,
- a review of any other material that is deemed relevant to the inspection.

	Observation of a procedure	As part of an inspection, the inspector may directly observe a Registrant performing a procedure on a patient. Before the observation occurs, the inspector will identify themself to the patient, explain the purpose of the observation, and inform the patient that the information obtained may be used in proceedings under Part IV of the *General Regulation* or any other proceeding under the Act, answer any questions that the patient asks and obtain the patient's written consent.
	Patient Consent	Written patient consent is necessary in order to allow the inspector to directly observe a treatment. Consent is obtained by the inspector so that the purpose for the observation can be fully explained to the patient. If a patient does not consent, direct observation of that patient's treatment cannot occur.
	Immediate Reporting of Unsafe Practices	If the inspector has reason to believe that there is a significant risk to patients due to the current compounding and/or IVIT practices at the premises they shall report this to the College immediately. The College will call an emergency meeting of the IC to determine if it is advisable to order the premises to stop performing procedures.
	Exit Interview	At the end of the inspection, the inspector will meet with the Designated Registrant to discuss the findings and anticipated content of the inspector's report, and to answer any questions the Designated Registrant may have. The inspector will also provide the Designated Registrant with the Post-inspection Questionnaire.
Post Inspection	Inspector's Report	Following the inspection, the inspector will complete the Inspector's Report form to include their observations, comments and recommendations regarding the inspection and will provide it

	to the College within approximately 14 days of the completion of the inspection.
Inspection Outcome	After an inspection of a premises the IC will determine whether the outcome of the inspection is a pass, a pass with conditions, or a fail. The IC will utilize the Inspection Outcome Decision Pathway when determining the outcome. The IC will also consider the inspection results provided by the inspector, the Inspector's Report, any information or submissions made by any Registrant(s) practising at the premises and any other information that is directly relevant to the inspection.
Inspection Committee Report	Any Inspection Committee Report regarding an inspection of a premises where procedures are performed will include the outcome of the inspection as a pass, pass with conditions, or fail. Where a premises passed with conditions, the conditions will be stated. Where Inspection Program Requirements are partially met and do not warrant a condition being placed on the premises, the IC may make recommendations in the report.
Notice of Outcome	The College will provide the Designated Registrant with the Inspection Committee Report, within a reasonable time after the inspection is completed.
Registrant Submissions	A Registrant may make a submission to the College within 14 days of the date the Inspection Committee Report is received if the outcome is a pass with conditions or a fail.
Confirmation or Change of Decision	The IC may elect to re-inspect the premises after receiving a written submission, but will do one of the following within 60 days of receiving a submission, regarding the inspection outcome: 1. confirm its finding that the premises passed with conditions or failed, 2. make a report and find that the premises passed with conditions, 3. make a report and find that the premises passed the inspection.
Effective Date	A report that a premises has passed, passed with conditions or failed an inspection is effective on the date it was received in accordance with section 39 of the *Regulated Health Professions Act, 1991* by the Designated Registrant for the premises.
Restrictions on Performing Procedures	A Registrant shall not perform a procedure on a patient in a premises that has failed an inspection until:

1. the IC delivers a report indicating that following a subsequent inspection the premises passed or passed with conditions, or
2. the IC substitutes a finding that the premises passed or passed with conditions after considering the written submission, if any.

A Registrant shall not perform a procedure on a patient in a premises that has passed with conditions except in accordance with the conditions set out in the report until:

1. the IC delivers a report indicating that the premises passed a subsequent inspection, or
2. the IC substitutes a finding that the premises passed the inspection, after considering the written submission, if any.

Follow-up / Additional Inspections

Premises that fail an inspection or pass with conditions may be subject to one or more further inspections within a reasonable time after the IC delivers its report. A follow-up inspection may occur at the request of a Registrant or Designated Registrant , or at any time at the discretion of the College, if it determines that it is necessary or advisable to do so.

The IC will determine if a follow-up inspection is necessary on a case-by-case basis. If a premises fails an inspection, or passes with conditions that limit the performance of procedures due to patient safety concerns, an additional inspection may be required in order to ensure the issues have been rectified prior to the premise being allowed to resume performing procedures.

A follow-up inspection may also be deemed to be necessary if the College has reason to believe that a premises is not complying with the conditions set out in the Inspection Committee Report.

Inspection Program Feedback

Registrant Feedback

The Designated Registrant has the opportunity to provide feedback regarding the inspection process by completing the Post-inspection Questionnaire . The form should be returned to the College within 14 days of the inspection.

Inspector Feedback

Inspectors will be asked to provide feedback about the inspection process by completing and submitting the Inspector’s Feedback form. Feedback will be requested annually prior to inspector training or at the time an inspector completes their term of service.

Use of Feedback

The College will review all Registrant and inspector feedback received and make any changes and improvements to the program and inspector training that are indicated. Information received regarding the inspectors will be communicated to the individual inspector if advisable.

Inspectors	Inspector Qualifications	Inspectors will be one of the following: A naturopath who is registered with the College of Naturopaths of Ontario and has met the standards of practice for Intravenous Infusion Therapy and Prescribing, OR A member of another regulated health profession who is in good standing with their regulatory body and who is authorized, under the applicable legislation, to perform the controlled acts of compounding and administering a substance by intravenous injection.
	Inspector Training	All Inspectors will be fully trained by the College on the Inspection Program and the inspection process.
	Inspector Criteria - NDs	A Registrant will be eligible for appointment as an inspector if the Registrant : • is registered in the General class OR in the Inactive class for less than 2 years, • has met the standards of practice for IVIT and Prescribing, • has actively performed IVIT and compounding for IVIT within the last 2 years, • is not in default of payment of any fees or costs to the College, • is not the subject of any disciplinary or incapacity proceeding, • has not had a finding of professional misconduct, incompetence or incapacity against them in the proceeding five years, • is not currently nor has been a member of the College's staff at any time within the preceding one year, • is not currently nor has been a member of the Council or a Committee of the College within the preceding one year.
	Inspector Criteria - Other Regulated Health Care Professionals	A member of another regulated health profession will be eligible for appointment as an inspector if the member: • is registered in the equivalent of the General class OR the Inactive class for less than 2 years, • has the appropriate training in administering by intravenous injection and compounding, • has actively performed intravenous injections and compounding for intravenous injection within the last 2 years, • is not the subject of any disciplinary, or incapacity proceeding,

- has not had a finding of professional misconduct, incompetence, or incapacity against him/her in the proceeding five years,
- is not currently nor has been a member of the College's staff at any time within the preceding one year,
- is not currently nor has been a member of a Committee of the College within the preceding one year.

Inspector Appointment

The term of an inspector is approximately three years from the date they are appointed.

An inspector may request a deferral of their appointment or a leave of absence for up to one year, as long as they provide the IC with satisfactory reasons for the request.

When the inspector's three-year appointment nears its completion, the inspector may apply for re-appointment.

An individual who has served as an inspector for three consecutive terms is ineligible for re-appointment until a full year has passed since they last served as an inspector.

Inspector Application

An individual may apply or re-apply to the College to become an inspector by submitting a current CV/resume and a cover letter outlining the reasons(s) they are interested in being appointed or re-appointed as an inspector. The College may request that the Registrant submit any other relevant documentation.

Considerations

When appointing inspectors, the College will consider the following:

- need for inspectors,
- the individual's geographical location,
- any relevant experience,
- additional professional qualifications, expertise and/or specialty,
- languages spoken,
- communication skills, and
- interview evaluation.

Inspector Disqualification

An inspector will be discharged if they:

- breach one of the qualifications required to become an inspector as outlined in this policy,
- breach confidentiality of any information learned through an inspection,
- fail to properly or honestly meet the duties and responsibilities of the position for which they have been appointed.

Completion of Appointment	An inspector will be considered to have completed their appointment and thanked for their services if they, having made arrangements with the College for the completion of any outstanding inspections, does any of the following: • resigns in writing, • completes their term of service and is not re-appointed, or • completes three consecutive terms.

BRIEFING NOTE
Alternative Dispute Resolution Program Policies

PURPOSE: Presentation to the Council of the Alternative Dispute Resolution (ADR) Program Policies and Eligibility Policy for the creation of an ADR Program.

OUTCOME Approval of the Alternative Dispute Resolution Program Policy.

NATURE OF DECISION ☐ Strategic ☑ Regulatory Processes & Actions ☐ Other

PROCESS:

Activity:	Discussion		
Results:	Consideration and a Decision		
Overall Timing:	15 minutes		
Steps/Timing:	**1.**	Deputy CEO to provide overview of ADR Program Policies	5 minutes
	2.	Questions from Council and answers	5 minutes
	3.	Motion and Vote	5 minutes

BACKGROUND:

In July 2020 the Council of the College of Naturopaths of Ontario approved its *Governance Report: A Mandate for Change* and *Governance Report Implementation Plan.* Section e. of the Implementation Recommendations notes the development of an ADR program for the College, including the necessary policies and procedures to be presented to the Council for approval.

ADR is considered an alternative to the formal complaint process and involves the Complainant and Registrant working together with a facilitator to create a resolution to everyone's satisfaction. It provides an opportunity to resolve low risk complaints in a manner that protects the public interest while allowing for both the Complainant and Registrant to actively participate in shaping an appropriate outcome.

Section 25.1 of the Health Professions Procedural Code authorizes the use of ADR in certain circumstances and outlines particulars with regards to confidentiality, ratification of resolutions and timing.

Staff of the College in consultation with several other Colleges, legal counsel and investigations and mediation professionals have drafted the necessary materials for the College to implement its own ADR program including an ADR Policy, Guide to ADR and template notification letters, contracts and mediator agreements. The ADR Program Policies were provided to the ICRC who discussed the process and provided feedback and suggestions.

DISCUSSION POINTS:

The draft ADR Program Policy (attached) establishes the ADR program for the College and outlines the applicable rules and processes for the implementation of the program. Below are a few highlights/summaries of the information contained therein.

Participation: In order to be eligible for ADR, the complaint must meet the eligibility criteria, no exclusion criteria can apply, both the Complainant and Registrant must agree that they wish to participate, and the CEO must review and refer the matter to the ADR Process.

Confidentiality: All aspects of the discussions/mediation between a Complainant and Registrant are confidential. Staff of the College are not involved in the mediation discussions but rather are provided with regular status updates to ensure that timelines are met. Only once an agreement between the Complainant and Registrant has been reached is it provided to a panel of the ICRC for review and acceptance.

Timelines: As outlined in the Health Professions Procedural Code ("the Code") a matter referred for ADR must be resolved within 120 days. This includes an initial 60-day period and an additional 60-day opportunity for a resolution to be reached.

Prior History: Any matter resolved using ADR does not form a part of a Registrant's formal prior history as defined in subsection 26(2) of the Code; however, as noted in case law all relevant information available to the College may be provided to a Panel when considering a complaint/report. As such ADR outcomes would be provided to a Panel when considering future complaints/reports about a Registrant.

Ratification: Where an agreement is reached, both the Complainant and Registrant must sign the proposed resolution. The Code permits the CEO to accept the resolution or to refer the matter to a panel of the ICRC for review and acceptance. The ADR policies reflect the wording of the Code (as the Council cannot overrule the statutory authorities); however, an operating policy or formal delegation will be put in place such that all ADR agreements are to be reviewed by a panel of the ICRC. When considering a proposed ADR agreement, the review will be undertaken from the perspective of reasonableness, risk and the public interest.

Costs: The costs of the program include the retention of trained mediators/facilitators to conduct meetings with the parties. These costs are intended to be in place of investigator costs that are currently budgeted as a part of the Complaints Program.

Eligibility: In order for a matter to be eligible for ADR it must meet all of the Inclusion Criteria which includes:

- the College must receive a Formal Complaint,
- both the Registrant and Complainant must agree to participate in ADR,
- none of the exclusion criteria can apply, and
- the CEO must accept and make the referral to the ADR process.

Exclusions: A matter is not eligible for ADR if:

- The allegations involve sexual abuse or incapacity;
- The Registrant has a prior discipline history;
- The Registrant is currently under a investigation on a separate matter;
- A similar complaint or report was filed with regards to the Registrant within the preceding 2 year;
- The allegations relate to:
    - Professional Boundaries;
    - A criminal matter;

- Inappropriate or incompetent care (including performing authorized acts unsafely);
- Practising outside of the scope of practice;
- Failing to comply with an order of the College;
- Practising while suspended; and/or
- Fraud.

Role of ICRC: Where a matter is referred to ADR by the CEO and an outcome is agreed to by both the Complainant and Registrant, the agreement shall be referred by the CEO to a panel of the ICRC in accordance with section 25.1(4)(b) of the Code for review and acceptance to ensure it is in accordance with the public interest. Once an agreement has been accepted by a panel of the ICRC, per subsection 25.1(5)(a) of the Code it is considered to be a full and final resolution of the matter.

ANALYSIS

Risk Assessment – The risk assessment is based on the document *Understanding the Risk Analysis Terminology,* a copy of which was included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- Operational risk:
  - Process risk - as the program will be reliant on staff identifying applicable matters and explaining the pros and cons of the process to the parties, it is imperative to ensure that the staff have the skills needed to meet program needs.
  - External events - The ADR program is also reliant on internal and external reviews/facilitation being conducted in a timely matter in order to meet necessary statutory timelines.
- Strategic risks:
  - Reputational risks - as ADR outcomes are confidential they may raise questions regarding the College's Transparency initiatives and ideas of the College "protecting its own" by not conducting investigations on ADR files. This is mitigated by the public availability of the Program policies and the list exclusions from the program.

Privacy Considerations – There are no privacy concerns.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency*, a copy of which is included in the Information Items of the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Information to foster trust – the ADR Program policies will be made publicly available to foster trust among the public and the Registrants that the right matters can be settled by mediation.
- Improved patient choice and accountability – Patients who make complaints do not always want the matters to go to a full investigation or hearing. The ADR Program gives some patients more choice and more say in the outcomes.
- Timely, accessible and contextual – The Program may provide for more timely outcomes and outcomes that are more suited to the context of the complaint.
- Confidentiality when it leads to better outcomes – the confidentiality provisions surrounding ADR will lead to better outcomes as Complainants and Registrants can participate willingly and without prejudice in ADR.
- Greater risk, greater transparency – The ADR policies improve transparency because they are public and the exclusions are very clear in terms of what is or is not eligible for ADR.
- Consistent approaches – By establishing the ADR program, the College moves into a consistent approach with other regulatory Colleges.

Financial Impact – Currently low risk matters that do not require investigator appointments cost approximately $800 per file on average. The cost of similar matters resolved via ADR will likely cost the College anywhere from $1,500 – $2,000 per file as they will require the appointment of facilitators.

Public Interest – The public interest assessment is based on the document Understanding the Public Interest, a copy of which is included in the Information Items of the Consent Agenda. Only those relevant factors have been identified and addressed.

- The ADR policies establish a careful set of checks and balances to ensure that different elements of the organization can view potential settlements. First, the CEO has to agree that the matter can be referred to ADR based on the Council's program policy. Second, if an agreement is made, all parties must sign that they have come to that agreement. Third, the ICRC will be asked to review the settlement which allows another perspective on the matter and will ensure consistency, reasonableness and take into account risk consideration with regards to the public interest in outcomes made by ADR.
- Given the exclusions from what is eligible for ADR, there should be no fear on the part of the public that serious misconduct or high-risk activities are being removed from the complaints process.
- The public interest is also served by having appropriate outcomes from complaints, regardless of how those outcomes might be achieved. ADR, like right touch regulation, accomplishes the appropriate outcomes with the consent of all parties to the complaint.

RECOMMENDATIONS
That the Council approve the ADR Program Policy as presented.

Respectfully Submitted

Jeremy Quesnelle
Deputy CEO

May 2021

Intent/Purpose	To provide comprehensive policies governing the Alternative Dispute Resolution (ADR) program of the College of Naturopaths of Ontario (the College).	
Definitions	Acknowledgement & Undertaking	Means an agreement by a Registrant to the College to do certain things, or to refrain from doing certain things.
	ADR Mediator	Means an independent ADR practitioner retained by the College for the purpose of facilitating resolution of a complaint in accordance with s.25.1 of the Code.
	Alternative Dispute Resolution	Means the mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute as set out in section 1(1) of the *Health Professions Procedural Code, Schedule 2* of the *Regulated Health Professions Act, 1991* (RHPA) (the *Code*).
	CEO	Means the Chief Executive Officer of the College appointed under section 9(2) of the Code and who performs the duties of "registrar" as set out in the Code.
	Code	Means the Health Professions Procedural Code which is Schedule 2 of the RHPA.
	College	Means the College of Naturopaths of Ontario as established under the *Naturopathy Act, 2007* and governed by the *Regulated Health Professions Act, 1991*.
	Formal Complaint	Means a complaint that meets the following requirements: 1. The complaint must be in writing or recorded on a tape, film, disk or other medium. 2. The Complainant must be identified. 3. The Registrant must be identifiable. 4. The complaint must identify some conduct or actions that are of concern. 5. The Complainant must intend the matter to be a complaint.
	HPARB	Means the Health Professions Appeal and Review Board, as established under the Code.
	Incapacity	Means that the Registrant is suffering from a physical or mental condition or disorder that makes it desirable in the interest of the public that the Registrant's certificate of registration be subject to terms, conditions or limitations, or that the Registrant no longer be permitted to practise, as set out in subsection 1(1) of the Code.

	Incompetence	Means that a Registrant's professional care of a patient displayed a lack of knowledge, skill or judgment of a nature or to an extent that demonstrates that the Registrant is unfit to continue to practise or that the Registrant's practice should be restricted, as set out in subsection. 52(1) of the Code.
	Inquiries, Complaints and Reports Committee (ICRC)	Means the statutory committee of the College established pursuant to paragraph 3 of section 10(1) of the Code and which investigates registrant-specific concerns (e.g., professional misconduct, incompetence, incapacity).
	RHPA	Means the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18, as amended from time to time.
General	Legislation	In accordance with section 25 of the Code, a Formal Complaint may be referred to an ADR process by the CEO if the matter is eligible and with consent of both the Complainant and the Registrant. All Formal Complaints will be managed in accordance with the Code.
	Confidentiality	Members of the ICRC and ICRC support staff will act in accordance with these policies and the ICRC Procedures Manual. ICRC members and any persons retained by the College to facilitate ADR have a statutory duty of confidentiality, set out in section 36 of the RHPA which provides that every person employed, retained or appointed for the purposes of the administration of the RHPA shall preserve secrecy with respect to all information that comes to their knowledge in the course of their duties and shall not communicate any information to any person except to the extent the information is available to the public under the RHPA or in connection with the administration of the RHPA or as otherwise permitted by the Act. All communications that are a part of an alternative dispute resolution process, including but not necessarily limited to the mediator's notes and records shall remain confidential and be deemed to have been made without prejudice to the parties in any proceeding.
	Bias/Conflict of Interest	No member of a panel and/or ADR Mediator can have a real or an appearance of conflict of interest. Where an appearance of or real conflict of interest exists, the individual must declare it to staff and ICRC members and will excuse themselves from the discussions. Panel members and/or ADR Mediators must be impartial and disinterested in the outcome of the matter coming before them for decision. An individual may be disqualified because of actual or perceived conflict of interest.

Formal Complaints	Informal Resolution of Pre-Complaint Matters	Prior to the filing of a Formal Complaint, potential complainants may contact the College with questions or to seek clarification. At no time will staff encourage or discourage the making of a Formal Complaint. Staff shall provide information about the complaint process and any potential for an informal resolution (e.g., suggesting communication between the Registrant and the potential Complainant) so that the person can make an independent determination. If the person indicates that they wish to make a Formal Complaint, staff shall provide all reasonable assistance to the person. Where there is a serious risk of significant harm and a Formal Complaint is not filed, the matter will be brought to the attention of the CEO. Staff must be neutral and impartial at all times. This means not saying or doing anything that suggests that the staff person supports or does not support the filing of a complaint. Once a Formal Complaint has been filed, staff shall not take any action that might be construed as trying to facilitate a resolution of the matter. In order for a matter to be referred to an ADR process, it must meet all of the eligibility criteria outlined below.
	Notice of Receipt to the Complainant	Staff will provide the Complainant notice of receipt of the Formal Complaint on behalf of the CEO as outlined in section 25.(5) of the *Code.* Should the matter be eligible for ADR, staff will provide the Complainant with additional information about the ADR process and inquire as to whether the Complainant wishes to undertake an ADR process. The Complainant shall be provided at least 7 days to decide whether to undertake an ADR.
	Notice of Complaint to Registrant	Staff will provide the Registrant notice of the Formal Complaint on behalf of the CEO as outlined in section 25.(6) of the *Code.* Where the Complainant agreed to undertake an ADR process, the Registrant will be provided with information and the opportunity to decide whether to participate in an ADR process.
	Written Agreement to Participate	Where both parties agree to participate in ADR, both parties shall complete and return to the College an agreement to participate.
	Approval of Eligibility	The Formal Complaint and the agreements to participate will be provided to the CEO for consideration for referral to an ADR process in accordance with section 25.1(1) of the Code.

ADR Administration	Mediator	The person who is appointed to act as the ADR Mediator shall not participate in any other manner with regards to the complaint and/or related discipline proceedings.
	Timelines	Where a matter is referred to ADR by the CEO a resolution must be completed and submitted for ICRC ratification within 60-days of the referral. Should a resolution not be agreed upon within the time limit, the ICRC may proceed with its investigation of the complaint; however, the ADR Mediator may continue the facilitation if they believe there is a reasonable prospect of a resolution being reached. The ICRC adopt a resolution that is reached within 120-days of the referral; however, it may not adopt any resolution reached after that time frame.
	Prior History	Complaints resolved through ADR and adopted by a panel of the ICRC do not constitute Prior History as defined in subsection 26(2) of the Code. However, the fact and details, including but not limited to the resolution of the ADR outcome, will be provided to future panels in the event of a subsequent complaint or report.
	Discontinuing ADR	An ADR process may be discontinued at any time upon request of either the Complainant or the Registrant or, if in the opinion of the ADR Mediator, it becomes evident that either party is not acting in good faith or a resolution is unlikely.
	Right to Appeal	Agreed upon ADR resolutions do not constitute a decision of the ICRC made pursuant to s.26(1) of the Code and as such there is no right of appeal the HPARB by either the Complainant or Registrant.
	Agreement Ratification	Both the Registrant and Complainant must sign any agreement outlining the proposed resolution. The agreement shall be referred to the CEO who may, in turn, refer it to a panel of the ICRC in accordance with section 25.1(4)(b) of the Code for review and acceptance to ensure it is in accordance with the public interest. Once an agreement has been accepted by either the CEO or a panel of the ICRC, per subsection 25.1(5)(a) of the Code, it is considered to be a full and final resolution of the matter.
	Monitoring	Staff of the College will be responsible for monitoring that the terms of the agreement are completed by the Registrant and/or Complainant.
	Costs	Any costs associated with the ADR Mediator are paid by the College.
Eligibility	Eligibility Criteria	In order for a matter to be referred to an ADR process it must meet all of the criteria outlined below: • A Formal Complaint has been submitted to the College;

	• Both the Complainant and Registrant must agree to participate in the ADR Process; • All of the allegations in the complaint are eligible for ADR; and • None of the exclusion criteria apply.

Exclusions	A matter cannot be referred to an ADR if any of the following situations apply:
	• The allegations involve sexual abuse or incapacity concerns;
	• The ICRC has already issued a decision and reasons or made a referral to the Discipline Committee with regards to the Formal Complaint;
	• The Registrant has a prior discipline history with the College;
	• The Registrant has been the subject of a similar complaint or report filed within the preceding 2 years;
	• The Registrant is currently under investigation for any other issue;
	• The Formal Complaint includes concerns relating to:
	  ○ Violation of professional boundaries;
	  ○ A criminal matter;
	  ○ Inappropriate or incompetent patient care;
	  ○ Practicing outside of the scope of practice;
	  ○ Failure to perform an authorized act safely and competently;
	  ○ Failure to abide by an order of the College;
	  ○ Practicing while suspended;
	  ○ Intentional dishonesty or fraud.

BRIEFING NOTE
Equity, Diversity, and Inclusion

PURPOSE: To discuss equity, diversity, and inclusion issues and to determine any future initiatives and strategies to be undertaken by the College.

OUTCOME Discussion, Initiatives, Strategies

NATURE OF DECISION ❒ Strategic ☑ Regulatory Processes & Actions ❒ Other

PROCESS:

Activity:	Overview presentation, discussion.		
Results:	Identification of importance and setting direction.		
Overall Timing:	30 minutes		
Steps/Timing:	1.	CEO to provide a brief overview	5 minutes
	2.	General discussion	10 minutes
	3.	Q&A	10 minutes
	4.	Consensus and/or Motion	5 minutes

BACKGROUND:

Over the past several years, issues with respect to systemic racism, inequality, and exclusion of certain sectors within society have come to the forefront.

In response to these issues, key movements have emerged, seeking to draw attention to these problems, to inform and enact change. These include the MeToo and Black Lives Matter movements, and other less structured but equally important movements to stop racist activities towards Indigenous peoples and the Asian community.

Since 2018, the College has been working with the Canadian Centre for Diversity and Inclusion to provide education and training on the issues of diversity, inclusion, and unconscious bias.

While the intent of this education and training is to prevent biased or discriminatory regulatory decision-making at the Council and Committee levels, no other initiatives have been undertaken by the Council or the College on the broader issues of EDI (equity, diversity, and inclusion).

Health Professions Regulators Ontario, the “federation” of the Health Regulatory Colleges, has initiated a project that is designed to assist the Colleges in developing processes to identify and correct discriminatory practices within the regulatory framework.

The initiative is called the “Anti-BIPOC Racism Working Group Project” and focuses on anti-discrimination activities as well as on equity, diversity, and inclusion activities. Although the title includes BIPOC (Black, Indigenous, People of Colour), the initiatives would be intended to address EDI in ‘all forms for all people’.

DISCUSSION POINTS:

The Ontario Human Rights Code

Under the Ontario Human Rights Code (OHRC), discrimination is illegal and subject to a matter being brought before the Human Rights Tribunal of Ontario. Under the OHRC, there are 10 grounds upon which a person might claim discrimination:

- Age,
- Creed,
- Disability,
- Family and Marital Status,
- Gender Identity and Gender Expression,
- Race and related grounds,
- Receipt of public assistance,
- Record of offences,
- Sex, and
- Sexual Orientation.

Ontario's Human Rights Code does not consider an individual's behavior outside of certain protected social areas. In other words, it does not address societal behavior generally. The following social areas are protected from discriminatory behavior.

- Accommodation (housing),
- Contracts,
- Employment,
- Goods, services, and facilities, and
- Membership in unions, trade, and professional associations.

The HRTO process is a reactive one, much the same as the College's complaints and investigations process. Something must happen for action to be taken. Action is a reaction to an external force.

Unconscious Bias

Unconscious bias is a bias that an individual does not recognize that they possess and is therefore much harder to account for. Unconscious bias training is intended to help individuals identify their own biases so that their impact can be countered.

If not addressed, unconscious bias can be a "key" to unlocking the door to discrimination. For example, if an individual has a bias against a specific culture or race, they are less likely to see individuals from this culture or race in a positive or even neutral way. This will impact their regulatory decision making and could result in the rules not being applied equally.

Equity, Diversity, and Inclusion (EDI)

EDI may very well be the next step in what we can only hope is the evolutionary process of our global society. The principles of EDI, while very straightforward and simple, speak to fixing a society that is damaged and addressing a system that is inherently discriminatory.

Equity – every individual in our society and in this world is equal, regardless of any of the grounds set out by the Ontario Human Rights Code and similar codes around the world.

Diversity – every individual is unique and the differences among us are what make the human race great. Diversity is embraced.

Inclusion – all cultures, creeds, genders, etc. are included and their participation in all elements of our society is required to expand perspectives, understanding and acceptance.

Embracing EDI as an organization is a commitment to intentionally and purposefully stamping out discrimination of any kind in the systems and processes under our control.

EDI Initiatives from the HPRO Working Group

Attached to this briefing is a document given to the Board of Directors of HPRO about the Anti-BIPOC Racism Working Group Project. The following are the anticipated project outcomes to be generated by this Working Group.

1. Action Plan – a high-level action plan to direct current and future EDI initiatives among members of HPRO.
2. EDI Self-assessment Checklist and Reporting Tool – to enable HPRO members to evaluate themselves on key domains that contribute to the effective delivery of key statutory functions and key organizational aspects in the context of EDI best practices.
3. Staff training and EDI Toolkit – the toolkit will include common HR policies, recruitment practices, complaints procedures and templates, sample policies and guidelines for EDI, as well as two half-day training sessions for staff, Councils and volunteers.

HPRO's Working Group has indicated that most of this work will be informed by the Canadian Centre for Diversity and Inclusion (CCDI).

Potential EDI initiatives

Before contemplating any initiatives the College might take around EDI, it is important to place EDI in context. In this regard, the College needs to be concerned with EDI in the following ways:

1. Its regulatory rules, policies, and procedures within the regulatory framework such that:
    a. We identify and amend any that are or appear to be inherently or systematically racist, discriminatory, or biased.
    b. We properly train all volunteers and staff involved in the application of the framework to ensure that they are not applying them in a racist, discriminatory, or biased manner.
2. Its processes for recruitment, assessment, appointment, and training of volunteers to ensure that our practices promote equity, diversity, and inclusion.

It is important for racialized communities and those who have been and continue to experience discrimination that they see themselves as supported within our organization. As such, the College needs to emphasize its desire to be diverse, equitable and inclusive of all peoples both from within the naturopathic profession and the public at large.

There are several potential initiatives that the College might contemplate at this time.

First, is to prepare to receive the materials that are identified as outcomes from the HPRO Working Group and identify with whom the responsibility for acting on the HPRO outcomes will rest. Here, there are two options:

a) Create a new Council EDI Committee that will be responsible for acting on and reporting back to the Council on College EDI initiatives (see draft Terms of Reference attached); or
b) Add these responsibilities to the Governance Committee which is presently responsible for overseeing the development and implementation of a comprehensive volunteer program (see draft amendments to the Governance Committee Terms of Reference, attached).

Secondly, the Council itself may want to articulate a commitment to equity, diversity, and inclusion. As the Council typically speaks through policy, a Governance Process policy may be appropriate. Responsibility for developing this policy could be given to the Committee the Council determines in the previous item, the Governance Policy Review Committee, or both.

ANALYSIS

Risk Assessment – The risk assessment is based on the attached document *Understanding the Risk Analysis Terminology*. Only those risks that have been identified will be addressed.

- Operational risks:
    - People – There is a risk associated with selecting individuals to run the organization, including volunteers. Selecting individuals with the requisite experience, with skills that are suited for their roles and who have the judgement to address and avoid discriminatory or racist behavior is critical.
    - Process – The intent of this process is to identify policies and procedures within the College that are systematically racist or discriminatory. It cannot be assumed that processes that are discriminatory or biased were created with that intention. Care has to be taken when amending processes to ensure that one set of biases or discriminatory approaches is not replaced with another.
- Strategic risks:
    - Reputation – Reputational risk is likely the largest single risk associated with this matter. First, it is important that any action the College undertakes is done in good faith with the intention of identifying barriers and effecting change. Initiatives that are seen as “window dressing” or “lip service” will not bode well for the College’s reputation. Second, the outcomes of any review and our initiatives must also be made public and be seen to be real and meaningful. Finally, a failure to act on a matter as important today as this might also be damaging to the College’s reputation. It might convey we do not believe that there is racism in our regulatory processes or that the matter is not of great importance.

Privacy Considerations – There are no privacy considerations associated with this matter.

Transparency – The transparency assessment is based on the document *Understanding the College’s Commitment to Transparency*, a copy of which is included in the Information Items within the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Information to foster trust – this briefing, the Council’s discussion, and any initiatives the College might undertake work to provide information and to foster trust among the public.
- Relevant, credible, and accurate information.
- Timely, accessible, and contextual – the briefing and the proposed initiatives work towards this goal. They will endeavour to make the College more accessible; the initiatives are timely and based within the context of what is happening in our world today.
- Consistent approaches: by relying in part on and implementing the work to come from the HPRO Working Group, the Council is embarking on an approach that will be consistent with the approaches of other Colleges.

Financial Impact – The financial impact will be dependent on whether the Council decides to act at this time. Initial work will involve either an existing or newly created committee resulting in the payment of per diems.

Public Interest – The public interest assessment is based on the document *Understanding the Public Interest*, a copy of which is included in the Information Items of the Consent Agenda. Only those relevant factors have been identified and addressed.

It is a matter of societal and public interest that not only the College be free of any discrimination, racism, or bias, but that the College be representative of the public that it serves and as such, that it be an equitable, diverse, and inclusive organization.

RECOMMENDATIONS

No specific recommendations are being provided. The College dialogue on the topic is likely the first step in what may be a long process and the Council itself needs to provide direction as to any actions it might want to undertake.

Andrew Parr, CAE[1]
Chief Executive Officer
May 2021

[1] With special thanks to the members of the Governance Policy Review Committee for their assistance in reviewing this important briefing.

Health Profession Regulators of Ontario

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Meeting: Management Committee

Date: January 15, 2021

Agenda Item: HPRO Priorities – HPRO Working Groups – Anti-BIPOC Racism WG Activities

Decision: To homologate the decision of the Board, confirmed by email on January 28, 2021, to formally record this decision in HPRO's minutes. The text of the email from WG Chair Judy Rigby to Board Members follows.

> *Dear Fellow Board Members:*
>
> *On behalf of the HPRO Anti-BIPOC Racism WG I want to thank you for supporting our work, this very important project and this urgent request.*
>
> *We are providing the attached Briefing Note to confirm what was verbally agreed to in calls and emails with members of the Management Committee this week. For the record, could you please reply to me and copy Beth Ann with an email to say "APPROVED" so that we have documentation of the Board's decision at this time. At our next Board meeting – date soon to be confirmed – we will ratify the Board's decision to proceed.*
>
> *Additionally we are providing the following documents for your information and that you can share with your staff, Council/ Board and Committees:*
>
> - *Project Status Update*
> - *Project Funding*
> - *Grant Application Deliverables*
>
> *We will let you know as soon as we hear back from the Federal Government about our funding application, and we will continue to keep you apprised as our work progresses, providing you with resources that you can share with your staff and Council/Board and Committee members along the way.*
>
> *Do not hesitate to contact me if you have any questions.*
>
> *Again, many thanks to you for supporting this project and allowing us to be as nimble as possible.*
>
> (Attachments noted in the email text follow.)

Time will also be available on the agenda for a brief verbal update on the project.

Decision:	Approval of $40,000 to be spent from net assets internally restricted for strategic initiatives for the work of the HPRO Anti-BIPOC Racism working group, including: • $22,625 to retain consultants to advance and scope out the work of the HPRO Anti-BIPOC Racism Working Group (WG), and • up to a maximum of $17,375 to support the immediate actions of the WG in communications, research, education and project plan development.
Public Interest Rationale:	In Ontario, every person should have the ability to reach their full health potential regardless of their colour, culture, or ethnic origin. HPRO and its member organizations acknowledge the historical and ongoing harm caused by racism, both systemic and overt, against Black, Indigenous and People of Colour in Canada. Change is necessary to eliminate existing racial inequities and best serve and protect the public. Health profession regulators play a critical role in driving that change. As individual organizations, regulatory bodies, and key stakeholders in the health system, we advocate for, and are committed, to actioning essential change to eliminate racism and strive for diversity, equity and inclusivity that is embodied in Ontario's Human Rights Code.
Background:	• MC struck the Anti-BIPOC Racism Working Group (WG) at its June 26th meeting to provide direction on how HPRO can support its members to identify systemic racism and implement tangible and coordinated actions, in the immediate, medium and longer- term, to eradicate BIPOC racism and build a culture, systems, and practices that allow diversity, equity, and inclusion to thrive. • Agreement that the WG's deliverables should be outcomes that all HPRO members commit to actioning through a Project Charter (PC) that is evidence based and outcome driven. The WG identified that the work effort required subject matter knowledge in diversity, equity and inclusion (DEI) and research, education and facilitation expertise. • December 2020 the WG carried out 3 activities towards fulfilling its purpose, the costs associated with it constitute the approval of spending for $22,625:

Category	**Activity**	**Cost ***
Education - HPRO Board	Engaged Dr. Javeed Sukhera to present on Bias and EDI-B	$1,000
External funding	Retained a project consultant to develop an anti-racism initiatives proposal that is eligible for Community Support, Multiculturalism, and Anti-Racism Initiatives Program (CSMARI) government funding.	$4,000
Project Charter Development – Scope, Deliverables, Outcomes and Activities	Received proposals from two HPRO member recommended consultants experienced in DEI, conducting environmental scans and project charter development. Proposal 1 $6,000; Proposal 2 $17,625. Recommend awarding contract to Dr. Javeed Sukhera, MD based on his credentials, familiarity with health professionals, HPRO and member organizations, such	$17,625

	as CPSO and the College of Dietitians of Ontario, expertise in Anti-Racism and Equity, Diversity, Inclusion and Belonging, and skills and experience in research, facilitation, education, training and project planning skills. *(See Considerations #3 re: Procurement Policy)*	

Considerations:

1. HPRO funds of $50,084 are available at December 31, 2020 in Net Assets Internally Restricted for Strategic Initiatives to support the WG's request of $40,000 to remain nimble in its work.
2. In addition, Net Assets Unrestricted for use at the Board's discretion and approval at December 31, 2020 is $239,030. This is approximately $116,500 in excess of the requirement to keep no less than 6 months of budget operating revenue to be accessed in the event of an unexpected loss of regular income and/or to satisfy liabilities in the event of the winding down of HPRO available (HPRO Reserve and Surplus Funds Policy D-12). The $116,500 can be allocated to any of HPRO's strategic initiatives.
3. With respect to obtaining only 2 proposals for Project Charter development, HPRO's procurement policy D-13 states that for contracts in excess of $10,000 "If three quotes are not possible to obtain due to the nature of the product or service, approval for moving forward must be granted by the Management Committee or President and Treasurer on behalf of the Management Committee." Due to the need to expedite this activity and to select a consultant with the requisite credentials, knowledge, skills and proven track record in DEI, the Management Committee after reviewing both proposals approved the exemption to move forward with Dr. Sukhera's.
4. Identifying Anti-BIPOC Racism and DEI as an HPRO strategic priority will ensure Board accountability to support Colleges in their individual EDI journeys, recognizing the complexity of the issue and the purpose of HPRO "Advancing excellence in public safety through collaboration".

FORMED A WORKING GROUP

Confirmed by the Management Committee in June 2020 with volunteers from 11 HPRO Colleges

Deborah Adams, CRPO (Registrar)	Kevin McCarthy, CNO
Kelly Dobbin, CMO (Registrar)	Brian O'Riordan, CASLPO (Registrar)
Naakai Garnett, CMTO	Judy Rigby, CDTO (Registrar) – WG Chair
Linda Gough, CMRITO (Registrar)	Dr. Saroo Sharda, CPSO
Danielle Lawrence, CKO	Melisse Willems, College of Dietitians of Ontario (Registrar)
Tim Mbugua, COTO	Beth Ann Kenny, HPRO Support

DRAFTED A PURPOSE FOR THE WG THAT ALIGNS WITH HPRO PURPOSE

To support active commitment of all 26 member organizations to identify systemic racism and implement tangible and coordinated actions, in the immediate, medium, and long- term, to eradicate BIPOC racism and build a culture, systems and practices that allow diversity, equity and inclusion to thrive.

DRAFTED A PUBLIC INTEREST RATIONALE THAT FULFILLS A PORTION OF CPMF REPORTING REQUIREMENTS

In Ontario, every person should have the ability to reach their full health potential regardless of their colour, culture, or ethnic origin. HPRO and its member organizations acknowledge the historical and ongoing harm caused by racism, both systemic and overt, against Black, Indigenous and People of Colour in Canada. Change is necessary to eliminate existing racial inequities and best serve and protect the public. Health profession regulators play a critical role in driving that change. As individual organizations, regulatory bodies, and key stakeholders in the health system, we advocate for, and are committed, to actioning essential change to eliminate racism and strive for diversity, equity and inclusivity that is embodied in Ontario's Human Rights Code.

KEY WORK TO-DATE

Since August 2020, the WG has met five times. Key work to-date is highlighted below:

- **Toolkit**: currently, identified resources are being catalogued and made accessible to the WG and College leadership; will be added to throughout the project
- **Education**: received presentations from CASLPO on their DEI initiatives, including environmental scan, literature review, and open dialogue webinar for College registrants; more being planned
- **Legislative Mandate**: identified legislative alignment – *Ontario Anti-Racism Act*
- **Partnerships Identified**: Fairness Commissioner, other regulatory bodies, Ontario Human Rights Commission, national health profession regulatory body collaboratives, HPRO Communications Committee, HPRO Commitment to Cultural Safety and Humility WG
- **Project Funding:**
  - HPRO = $40,000
  - Individual Colleges = $0 (in kind contributions only)
  - Federal Government funding =$88,000 (to be confirmed – *see Anti-BIPOC Racism Funding Document*)
- **Project Charter/Workplan**: outlined overall plan and potential resources required, including financial needs for expertise as laid out in a federal grant application; modules to include:
  - Overall action plan (including overarching principles and goals)
  - EDI Self-Assessment Checklist and Reporting Tool (to support CPMF work)
  - Staff Training and EDI Toolkit

It is recognized that there will be no "one size fits all" solution and that guidance/resource documents and education and training opportunities will be beneficial for all HPRO members. The WG sees this project as an opportunity to engage all colleges and to work together to advance this important issue. Future work will be modular, both to focus the work and in recognition of the resources available to individual colleges.

Financial/Human Resource Needs Identified – Federal Government Grant Application Submitted

An external funding application has been submitted to the federal government's Canadian Heritage Community Support, Multiculturalism, and Anti-Racism Initiatives Program.

- The funding request is to support HPRO's commitment to take significant action in combatting anti-racism at the regulatory level per guidance provided by Ontario's Anti-Racism Directorate
- 19-month project, is to build internal equity, diversity and inclusion (EDI) capacity within the 26 regulatory bodies in Ontario responsible for the regulation of health care professionals
- Project deliverables[1]:
  (a) Developing the Project Charter
  (b) Creating an HPRO member organization EDI Self-Assessment Checklist and Reporting Tool
  (c) Staff Training and EDI Toolkit (the "Toolkit")
- Funding model is as follows:

Source	**Federal Gov't**	**HPRO**	**Individual Colleges**	**Total**
Cash	$88,000[2]	$20,000 (50% of the $40,000 approved to date)	$0	$108,000
In-kind (time commitment)	$0	$10,800 Anti-BIPOC Racism WG support – B.A. Kenny 1.5 days/month for 19 months	$159,400 WG members 11 members for 1 day/month for 19 months; plus Staff support 1 person/College for 4 days in total (over 19 months), e.g., document review, responding to surveys and environmental scan	$170,200

[1] See excerpt from grant application (Anti-BIPOC Racism Project Funding Grant – Deliverables) for more details
[2] Grant application submitted; not guaranteed

1) *Action Plan*

At the outset of the project, HPRO intends to develop a high-level Action Plan to direct current and future EDI initiatives among members. The Action Plan will be structured as follows:

- Background and purpose
- How/why the Plan was developed
- Vision and Mission Statements
- Overarching principles and goals
    - Activities, timelines and accountability
    - Reporting and evaluation

2) *EDI Self-Assessment Checklist and Reporting Tool*

An EDI self-assessment checklist and reporting tool will be designed for HPRO members to evaluate themselves on key domains that contribute to the effective delivery of the key statutory functions and key organizational aspects in the context of EDI best-practices. The checklist will be supplemented by a guidance document explaining how to conduct the assessment providing examples of standards or best-practices for each domain as well as the measures and evidence that may indicate where gaps exist. Colleges will use the tool to identify the planned improvement action required, measure their progress and improve their EDI performance.

Areas covered by the checklist will reflect regulators' core statutory functions[1] and key organizational aspects in governance and operations core activities: entry-to-practice, registration, standard setting (professional and practice), fitness to practice, complaints and discipline, and quality assurance (i.e. continuing competency). All aspects of College operations will be covered by the checklist including: policies, procedures, forms, governance, staff training, procedures, and registrant communications.

As part of the project, the Diversity Consultant (see below) will help all participating colleges map their "current state" to the checklist above. This will help to highlight areas that may require attention and serve as a baseline to compare future self-assessments.

3) *Staff Training and EDI Toolkit (the "Toolkit")*

A multipronged Toolkit will include common human resources policies, recruitment practices, complaints procedures and templates, samples of policies and guidelines (e.g. onboarding policies, fair, equitable registration processes and investigating further any applicants' previous history re. complaints, racism or inequity, professional misconduct or standards of the profession, including governance, etc.).

The content of the Toolkit will be greatly informed by recommendations made by the Canadian Centre for Diversity and Inclusion (CCDI)[2] in this regard. This report suggests that "[t]he purpose of this toolkit is to give you the framework for creating a diversity and inclusion strategy document that can be easily customized to suit your own organization". This definition is especially salient as it is the goal of this project – to give the 26 HPRO members the opportunity to tailor the content developed in this project to suit their own needs. This report also emphasizes the importance of an action plan "for everyone in your organization to understand what needs to be done to help you move you toward becoming a more inclusive organization".

Also scheduled, are two, half-day training sessions with regulatory college staff, Council and volunteers. The first will explore best practices in the area of equality, diversity and inclusion with specific attention paid at recognizing and managing unconscious bias, both at a systemic and individual level. The second session will be provided to senior leadership/staff on how to implement the EDI Self-Assessment Checklist and Reporting Tool and EDI Toolkit within their own organizations. The overarching goals of the training modules is to assist organizations in uncovering unconscious bias and creating a strategic framework for becoming a more inclusive organization. Both sessions will be recorded such that they are available on-demand to HPRO members.

[1] Per the *Ontario Regulated Health Professions Act (1991);* all Colleges have Objects which they are responsible for. All of these Objects will be included as part of the self-assessment review. See Section 3: Regulated Health Professions Act, 1991, S.O. 1991, c. 18 (ontario.ca)

[2] See: "Locking in your leadership: Toolkit for developing a diversity and inclusion strategy". 2014. *Canadian Centre for Diversity and Inclusion*. : 20200130-locking-in-your-leadership-toolkit-for-developing-a-di-strategy.pdf (ccdi.ca)

Section	Committee	Page
Governance Process	Governance Committee (CC04.04)	1
		Create Date: November 5, 2013

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Accountability and Authority	The Governance Committee (formerly the Nominations and Elections Committee) is a non-statutory committee of the Council of the College of Naturopaths of Ontario and is established pursuant to section 12.02 and section 10 of the bylaws and the *Committee Principles* policy (GP06).
Limitations	The Governance Committee shall only exercise the authority, and fulfill the duties and responsibilities authorized in the bylaws and by these Terms of Reference.
Responsibilities	The Governance Committee shall: • Review and make a final ruling on any disputes regarding a Registrant's eligibility to vote in an election (s.10.07 of the bylaws); • Review and make a determination on the acceptability of the biography and personal statement submitted by a candidate for election (s. 10.13 of the bylaws); • Upon the request of the CEO, assist the CEO in the supervision and administration of elections of candidates for the Council (s. 10.16 of the by-laws); • Upon a referral from the Council, shall hold an inquiry into the validity of the election of a Council member and shall make a report and recommendations to the Council; • Working with the CEO, develop and maintain a comprehensive volunteer program for Council and Committee members that is acceptable to Council and that: o Provides for a process of recruitment and application for elections and/or appointments to Council and its Committees. o Provides for a competency-based framework for election and/or appointment to Council and its Committees. o Provides for an induction program for the assessment of candidates for Council and Council Committees. o Provides for orientation and training of new Council and Committee members appointed by Council. o Provides for an evaluation process for Council and Committee members. o Provides for a feedback process for all volunteers. o Provides for a volunteer recognition program for serving Council and Committee members. • Working with the CEO and senior staff, develop and maintain a program of equity, diversity and inclusion that ensures that: o Appropriate policies are developed, approved by the Council and implemented that reflect the values of the Council and its commitment to equity, diversity, inclusion and an environment that is free of bias, discrimination and racism. o All recruitment of volunteers to work with the College is one that is based on equity and diversity and includes every individual who is qualified to participate. o Training for all volunteers includes addressing critical issues surrounding equity and inclusion, in particular but not limited to anti-discrimination and anti-bias training.

DATE APPROVED	REVIEW DATE	RESPONSIBLE
January 16, 2014	January 27, 2021	Council

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- Reviewing the College's regulatory framework and processes to ensure that they are equitable to all individuals within society.

Composition and Appointment	The Governance Committee shall be appointed by Council and shall be comprised of at least three (3) but as many members as the Council deems appropriate,, including: • One (1) or more Council members; • one (1) or more Registrants who are not Council members and who are not seeking election to the Council in the year on which they sit on the Committee; and • Any number of Public Representatives as defined in the by-laws. The Council shall appoint the Chair of the Governance Committee.
Term of Office	The members of the Governance Committee shall be appointed annually by Council for approximately one (1) year, or until such time as the Council has made further appointments.
Meetings	The Governance Committee shall meet at the call of the Chair. In the event that the Chair of the Committee is unable to preside at the meeting, the Chair may designate an acting Chair from among the Committee members, or where the Chair has not done so, an acting Chair for the meeting shall be selected from among the Committee members by the Committee.
Quorum	Pursuant to section 12.06 of the By-laws of the College of Naturopaths of Ontario, quorum for meetings of the Governance Committee shall be three members of the Committee, at least one of which shall be a Public member or a Public Representative as defined in the by-laws. In cases of urgency as determined by the Chair of the Committee, the Public member/Public Representative requirement for the purposes of quorum may be waived.
Reports	The Committee shall provide a report of its activities annually to the Council, as well as when requested from time to time, subject to any requirements of *the Regulated Health Professions Act, 1991*. The Chair shall also submit a quarterly report to the Council addressing matters of importance to the Committee.

DATE APPROVED	REVIEW DATE	RESPONSIBLE
January 16, 2014	January 27, 2021	Council

Accountability and Authority	The Equity, Diversity and Inclusion Committee is a non-statutory committee of the Council of the College of Naturopaths of Ontario and is established pursuant to section 12.02 and section 10 of the bylaws and the *Committee Principles* policy (GP06).
Limitations	The Equity, Diversity and Inclusion Committee shall only exercise the authority, and fulfill the duties and responsibilities authorized in the bylaws and by these Terms of Reference.
Responsibilities	Working closely with the CEO and senior staff, the Equity, Diversity and Inclusion Committee shall develop and maintain a program of equity, diversity and inclusion that ensures that: • Appropriate policies are developed, approved by the Council and implemented that reflect the values of the Council and its commitment to equity, diversity, inclusion and an environment that is free of bias, discrimination and racism. • All recruitment of volunteers to work with the College is one that is based on equity, diversity and includes every individual who is qualified to participate. • Training for all volunteers includes addressing critical issues surrounding equity and inclusion, in particular but not limited to anti-discrimination and anti-bias training. • Reviewing the College's regulatory framework and processes to ensure that they are equitable to all individuals within society.
Composition and Appointment	The Equity, Diversity and Inclusion Committee shall be appointed by Council and shall be comprised of at least three (3) but as many members as the Council deems appropriate,, including: • One (1) or more Council members; • One (1) or more Registrants who are not Council members; and • Any number of Public Representatives as defined in the by-laws. The Council shall appoint the Chair of the Equity, Diversity and Inclusion Committee.
Term of Office	The members of the Equity, Diversity and Inclusion Committee shall be appointed annually by Council for approximately one (1) year, or until such time as the Council has made further appointments.
Meetings	The Governance Committee shall meet at the call of the Chair. In the event that the Chair of the Committee is unable to preside at the meeting, the Chair may designate an acting Chair from among the Committee members, or where the Chair has not done so, an acting Chair for the meeting shall be selected from among the Committee members by the Committee.
Quorum	Pursuant to section 12.06 of the By-laws of the College of Naturopaths of Ontario, quorum for meetings of the Governance Committee shall be three members of the Committee, at least one of which shall be a Public member or a Public Representative as defined in the by-laws.

In cases of urgency as determined by the Chair of the Committee, the Public member/Public Representative requirement for the purposes of quorum may be waived.

Reports

The Committee shall provide a report of its activities annually to the Council, as well as when requested from time to time, subject to any requirements of *the Regulated Health Professions Act, 1991*.

The Chair shall also submit a quarterly report to the Council addressing matters of importance to the Committee.

BRIEFING NOTE
Competency Development Project

PURPOSE: To obtain approval of the Council to spend up to $65,000 to develop a competency framework for the College Council and Committees.

OUTCOME Approval

NATURE OF DECISION ❒ Strategic ❒ Regulatory Processes & Actions ☑ Other Financial

PROCESS:

Activity:	Discussion		
Results:	Direction provided.		
Overall Timing:	20 minutes		
Steps/Timing:	**1.**	CEO to provide background and outline of proposal.	7 minutes
	2.	Questions and answer	10 minutes
	3.	Motion	3 minutes

BACKGROUND:

In its *Governance Report: A Mandate for Change*, the Council identified that in the future, Council members should have the competencies necessary to fulfill the role.

The Council has been presented with a preliminary outline of competencies necessary for the role which were developed, in part based on a working group from Health Profession Regulators Ontario (HPRO) and in part based on independent research.

While some additional work has been conducted to refine these competencies, it has become increasingly clear that the competency framework should be developed by experts in this particular area of study. In doing so, the framework would have greater credibility among stakeholders and the Government.

The Directors College (TDC), which is a part of the DeGroote School of Business of McMaster University, has a program through which it certifies directors for public boards. It is a comprehensive educational program that provides graduates with the “C.Dir.” designation. Such a program would need to be based on a competency framework for directors of public boards that would inform the curriculum for the courses leading to the designation.

Although the College is a not-for-profit entity, there would be considerable overlap in the competencies necessary for the Council when compared to directors on a public board. There would, however, be a set of skills beyond those and others that are more specific to health regulation.

Based on preliminary discussions with TDC, there is interest on their part in supporting the health regulatory Colleges in the development of a competency framework that is based in part

on the program at TDC, but also reflects additional competencies that might be specific to not-for-profit organizations and health regulators.

The need for some formal competency framework for health regulatory Colleges has been highlighted in the College Performance Measure Framework (CPMF) from the Ministry of Health which seeks information in this area. Reports submitted to the CPMF process at the end of March 2021 indicate that a few Colleges have taken steps in this area, although a small number of those have what might be considered a robust framework for articulating and assessing the competencies of potential Council members.

To date, the College has been working with HPRO to attempt to initiate a project to develop the competency framework. A project which would ideally be funded through HPRO. Talks have been underway since late November 2020 and progress is very slow.

DISCUSSION POINTS:

Proposal from The Directors College

The Directors College (TDC) has made the following proposal.

Phase 1: TDC will compare the competencies developed thus far by the 26 Colleges against the competency framework developed and currently being updated for TDC which informs curriculum development for TDC, DeGroote Schools of Business.

Phase 2: A shortened list of competencies would be selected and presented to a peer group of Board Directors, as well as a group of Council members from a small group of the Colleges for input to produce a final agreed upon list.

Outcomes: The project will provide the following:

1. A final list of competencies including clear definitions with behavioral examples for each.
2. A competency assessment grid with suggestions for assessments that could be undertaken to assess each competency.

Costs: $55,000 - $65,000

Health Professions Regulators Ontario (HPRO)

The College has been working in conjunction with HPRO in order to obtain funding and broad support among the Colleges. Unfortunately, HPRO is slow to respond and is focusing on other more “topical” areas. It is unclear if a decision may be made to support this initiative and when such a decision may be forthcoming.

Other Colleges

In the interim, several other Colleges have expressed an interest in participating in this project and being part of a small team of Registrars/CEOs to oversee the project. This includes providing financial support for the project if we undertake it outside of the HPRO framework.

Next Steps

If Council approves the funding, the CEO will reach out directly to the Registrars/CEOs of the other 25 health regulatory Colleges to seek support for the project. Participating Colleges would be asked to agree to fund the project equally among participating Colleges. Of course, the College would pay its share of the project.

Subsequently, the CEO will coordinate activities with TDC, including funding the project as needed and invoice the Colleges for their portion of the costs.

ANALYSIS

Risk Assessment – The risk assessment is based on the document *Understanding the Risk Analysis Terminology,* a copy of which is included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- Operational risk:
    - People – Operationally, people risk relates to the education, experience and skills of individuals who run an organization. The Council and its Committees make many regulatory decisions, set the direction for the organization and provide a critical oversight function. Having the right people on the Council and its Committees means having individuals who have the competence to fulfill the roles. That is what the outcome of this project will be.
    - Process – Once a competency framework is developed, a process for assessing competencies will be required. This project will provide the framework and recommendations on how to accomplish that assessment.
- Strategic risk:
    - Political – Politically, the College is subject to the oversight of the Ministry of Health (MOH). The MOH has operationalized is College Performance Measure Framework which measures the ability of the Colleges to select the right people for the Council and the Committees and is based on transparent criteria. This project will move the College forward in this regard.
    - Reputation – Having a clearly articulated set of competencies that are applied fairly, equitably and consistently will improve the reputation of this and all Colleges if adopted across the group. By ensuring the people at the Board table have the necessary skills, the College is better equipped to fulfill its role,

Privacy Considerations – There are no privacy considerations.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency*, a copy of which is included in the Information Items of the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Information to foster trust – The fact that the College and HPRO are undertaking initiatives in this area should foster greater trust in the College. Once completed and implemented, the trust levels should improve further as the College can be clear that it has the right people on the Board and committee tables to do the job.
- Consistent approaches – Whether it is through HPRO or this College, the intent is to work towards a single set of Council competencies that are applied consistently across all of the Colleges.

Financial Impact – As noted above, the full costs of the project, if funded by this College, would be a maximum of $65,000. It is anticipated that the actual amount would be lower as other Colleges are expected to want to be a part of this initiative.

Public Interest – The public interest assessment is based on the document *Understanding the Public Interest*, a copy of which is included in the Information Items of the Consent Agenda. Only those relevant factors have been identified and addressed.

- The public interest is served by good governance of the Colleges. Good governance is accomplished, in part, based on the competencies of the individuals who sit on the Council. It is impossible to recruit individuals with the correct skills if we have not articulated what those skills are.

RECOMMENDATIONS
It is recommended that the Council approve an expenditure of up to $65,000, with the intent of obtaining financial support from other Colleges, in the event that HPRO cannot fund this project.

Andrew Parr, CAE
Chief Executive Officer
May 2021

BRIEFING NOTE
Committee Appointments

PURPOSE: The Council is asked to appoint volunteers to the Statutory and Council Committees of the College.

OUTCOME Decision

NATURE OF DECISION ❒ Strategic ☑ Regulatory Processes & Actions ❒ Other

PROCESS:

Activity:	Presentation and discussion.		
Results:	Decision on appointments		
Overall Timing:	25 minutes		
Steps/Timing:	**1.**	CEO will present the briefing and the list of appointments.	10 minutes
	2.	Council questions and discussion.	10 minutes
	3.	Motion	5 minutes

BACKGROUND:

The Council has two sets of Committees, the Statutory Committees as set out in the Health Professions Procedural Code and the Council Committees as established in the College's by-laws and the Council Governance Process policies (GP06-Committee Principles).

Committee appointments are made for approximately one year or until the appointments are considered by Council. The last large group of appointments were made in April 2020.

The Council must appoint a variety of individuals to the Committees, including Council members, or in some instances Public members (appointed by the Government) or both, and Public Representatives.

All existing Committee members were asked to consider whether they wish to continue in their current roles, add new ones or change to new Committees, and an on-line form was provided to capture everyone's preferences.

The College also launched a recruitment campaign for new volunteers.

DISCUSSION POINTS:

At the time of preparing this briefing, a number of individuals, including some Council members, had still not provided any information about whether they wish to continue in a volunteer capacity. As a result, a list of proposed appointments will be provided to the Council separately a day or two prior to the meeting date.

The following table summarizes the minimum number of required appointments by Committee to guide the Council's deliberations.

Committee	Council member	Public member	Registrant (Council)	Registrant (non-Council)	Public Reps	Total needed
Statutory Committees						
Discipline/FTP	--	2	1	Any	Any	5
ICRC	--	1	-	1	Any	3
QAC	--	1	1	1	Any	3
Patient Rels	1	--	--	1	Any	3
Registration	--	1	--	1	Any	3
Council (Non-statutory) Committees						
Audit	1	--	--	1	--	3
Exam Appeals	1	--	--	1	--	3
Governance	1	--	--	1	Any	3
GPRC	1	--	--	Any	Any	2
Inspection	1	--	--	1	Any	3
Standards	1	--	--	2	Any	3
SSRC	1	--	--	1	Any	5

Having considered the requirements, whether they are set out in the Code or the College by-laws, a number of conclusions can be drawn.

- Public member representation on Statutory Committees is a significant challenge for the College as we need five Public members on Statutory Committees and presently have only five Public members on Council. It is a foregone conclusion that each Public member must be on at least 1 Committee.
- As a corollary, Public members must be appointed first and foremost to the Statutory Committees.
- The Committee requirements establish a need for 14 Council members. There are presently only 13 available for appointment.

Fortunately, while the College has 22 volunteers available to it, of which 15 are NDs. Many of these individuals have been serving for some time and many have also offered to expand their work to meet the needs of the College.

From among the Council members, seven have offered to sit on multiple Committees. This will assist the Council in meeting the minimum requirements set out above.

It should be noted that the College took a decision recently to remove from its website a list of Committee members. This was due to two factors. First, an external communication having been sent to members of one Committee which may have been seen to be attempting to influence those discussions. Second, the College has heard of some volunteers feeling ostracized from other organizations because they volunteer for the College. In the interest of maintaining our volunteer base and protecting our volunteers from any potential harassment, the list will not be made public pursuant to paragraph (d) of section 7(2) of the Code.

Notwithstanding the fact that the list itself will not be released publicly, there is no need for Council to go in camera for these discussions as it is unlikely that the Council will speak to individual appointments other than Council members.

ANALYSIS

Risk Assessment –The risk assessment is based on the document *Understanding the Risk Analysis Terminology,* a copy of which is included in the Information Items of the Consent Agenda. Only those risks that have been identified will be addressed.

- Operational risk:
    - People – While another matter before the Council focuses on competencies of those who work for the College, the risk embodied with this item is whether the College has a sufficient number of people to staff up its Committees.
    - External events – The College and the profession continue to be impacted by COVID-19 which makes decisions on long term volunteering difficult.
- Strategic risk:
    - Demographics – It is assumed based on anecdotal evidence that many of the potential volunteers do not participate because of the demographics of the profession. The profession is predominantly female and sizeable portion of them are at the stage of their life where their focus is also on family.

Privacy Considerations – The briefing is being made public; however, the list of Committee volunteers will not be released publicly to protect the privacy of the volunteers and based on the matter being a personnel matter of the College.

Transparency – The transparency assessment is based on the document *Understanding the College's Commitment to Transparency*, a copy of which is included in the Information Items of the Consent Agenda. Only those transparency principles that are relevant have been identified and addressed.

- Timely, accessible and contextual – release of the briefing materials and the discussion of appointments in open Council provides timely information as well as providing it in the context of the issues.
- Balance – balancing public protection and accountability against fairness and privacy is a significant consideration behind the decision to not release the names of Committee appointees publicly.

Financial Impact – The financial impact of this item is marginal and only effects the budget in terms of the number of per diems and other expenses paid to volunteers.

Public Interest – The public interest assessment is based on the document *Understanding the Public Interest*, a copy of which is included in the Information Items of the Consent Agenda. Only those relevant factors have been identified and addressed. The public interest is served by having discussions in public although lists of names is not being released. The public benefits from these appointments as they are primary means through which the regulatory framework can be operationalized.

RECOMMENDATIONS

The Council will be asked to appoint a list of individuals, to be provided at a later date closer to the meeting, to the Committees of the College.

Andrew Parr, CAE
Chief Executive Officer
May 2021

BRIEFING NOTE
Educational Briefing - Complaints and Reports Processes

BACKGROUND

The College of Naturopaths of Ontario is established by under the *Naturopathy Act, 2007* and the *Regulated Health Professions Act, 1991*. Its duty, as set out in the legislation is to serve and protect the public interest. Its mandate is to support patients' rights to receive safe, competent, and ethical naturopathic care.

The College achieves its mandate by performing four key functions.

1. **Registering Safe, Competent, and Ethical Individuals -** The College establishes requirements to enter the practise of the profession, sets and maintains examinations to test individuals against these requirements, and register competent, ethical and qualified individuals to practise naturopathy in Ontario.

2. **Setting Standards –** The College sets and maintain standards of practice that guide our Registrants to ensure they provide safe, ethical and competent patient care and guide patients to understand the standard of care that they can expect from a naturopath.

3. **Ensuring Continuing Competence –** The College creates and manages a variety of continuing education and professional development programs to help assure the provision of safe, competent and ethical naturopathic care.

4. **Providing Accountability through Complaints and Discipline –** The College holds Ontario naturopaths accountable for their conduct and practice by investigating complaints and concerns and determining appropriate solutions, including disciplining naturopaths who have not upheld the standards.

Some elements of the College's role, such as setting standards and ensuring continuing competence, are proactive insomuch as they attempt to prevent issues from arising by setting minimum standards and ensuring a competent profession. Other elements of the College's role, such as registering individuals and holding naturopaths accountable, are reactive, that is, they are initiated only after an event occurs. The event may be a request to sit an exam or to become registered or a complaint that has been filed against a Registrant.

When we do our job well, we have set rules that ensure safe care that benefits patients; we have registered the right people who are qualified and committed to providing safe, ethical and competent care; we have ensured that our Registrants maintain their knowledge, skill and judgement; and we have held those who may have faltered to be accountable for their decisions and actions.

Other elements that will arise within the regulatory framework include "right touch regulation", using the approach that is best suited to the situation to arrive at the desire income of public protection, and risk-based regulation, focusing regulatory resources on areas that present the greatest risk of harm to the public. Both of these will be further elaborated upon in later briefings.

The focus of this briefing is on the Complaints and Reports program and processes of the College.

Complaints and Reports Program

The Complaints and Reports Program is the primary method by which the College responds to concerns about the practice, conduct or health of a Registrant in instances where they may have failed to meet the standards of the profession. These concerns can be raised by formal complaints, reports filed by regulated health professionals, employers or other organizations or as the result of investigations initiated by the College's CEO. The formal process for investigation of a complaint is outlined in the *Regulated Health Professions Act,* and is further explained below. Each step of the complaints and reports process is designed to ensure fairness to both the person filing the complaint, and the ND named in the complaint. Although the College investigates all complaints received, the RHPA does permit the ICRC to take no action if it considers it to be frivolous, vexations, made in bad faith, moot or otherwise an abuse of power.

The Inquiries, Complaints and Reports Committee is responsible for overseeing the investigation of inquiries, concerns or reports regarding the conduct and/or competence of Registrants. An investigation may include appointing formal investigators to obtain records, interviewing parties or witnesses, collecting any relevant documentation.

The Inquiries, Complaints and Reports Committee is composed of Naturopathic Doctors, appointed public members and representatives of the public. The Committee works in panels of no less than three people, one of which must be a public member.

A panel of the ICRC, after investigating a complaint or report, may do any one or more of the following:

- Take no action if the conduct and/or actions meet reasonable and acceptable standards of practice, or if there is insufficient information for the Committee to take action.
- Provide advice, guidance and recommendations to the Registrant.
- Require the Registrant to complete a specified continuing education or remediation program (SCERP).
- Require the Registrant to appear before a panel to be cautioned about his/her practice or conduct.
- Refer the matter to the Discipline Committee to hear specified allegations of professional misconduct or incompetence.
- Refer the Registrant to another panel of the ICR Committee for investigation of possible mental or physical health concerns that might interfere with the Registrant's ability to practise.

The ICRC does not have the authority to order monetary compensation, process anonymous complaints or investigate complaints about health care providers other than Ontario NDs.

Complaint Process

Given the importance of the Complaints Program to the College's mandate and to the Registrants against whom allegations may be made, the Complaints Process can be complex and depending on the nature and complexity can take a great deal of time. The *Regulated Health Professions Act* requires that investigations of complaint be completed within 150 days of it being filed with the College. Should more time be necessary the College is required to send a notification to the Health Professions Appeal and Review Board, as well as both the complainant and Registrant, every 30 days explaining the reason for the delay and the anticipated date of completion.

The Complaints and Reports process begins when the College receives information that a Registrant has committed acts of professional misconduct and/or incompetence. This can be in the form of a formal complaint, which can be filed at any time and by any person including but not limited to: patients, other health professionals, Registrants or any member of the public. All complaints must be submitted to the College in writing or recorded in video or audio format. Complaints shouldinclude:

- The name of the naturopathic doctor.
- The Complainants name and contact information.
- Details of the problem or concern, including specific places, dates and issues that occurred, etc.)
- The names of other individuals or witnesses who may be able to provide the College with more information.
- Any other information that may help the ICRC process the complaint.

Outside of a formal complaint sometimes information is brought to the attention of the College from a variety of other sources. This information might include a criminal case being reported in the newspaper or information provided by an employer or insurance company who may choose not to file a formal complaint or go through the complaints process. In these situations the CEO will consider the information and College staff will verify the information if possible. If there are reasonable and probable grounds to believe that a Registrant has committed acts of professional misconduct or is incompetent and the CEO determines that action is needed, with the approval of the ICRC,the CEO may appoint an investigator to look into the matter and file a Report with the ICRC.

The following is a general outline of the stages of a Complaint/Report process. As a part of its transparency initiatives, the College publishes anonymized summaries of outstanding complaint and report investigations on its website.

Stage 1: Notice of Complaint/Report

Within 14 days of receipt of a complaint or a report, the College issues a notice of complaint/report and provides a copy to the Registrant in question. The Registrant may make a written submission to the ICRC within 30 days of the date of the notice.

Stage 2: Additional comments from complainant (Complaints ONLY)

The Registrant's response is provided to the complainant who may provide comment. Should new information or allegations be raised in the response, the information will again be provided to the Registrant for comment.

Stage 2a: Interim Order

In extreme situations after receiving a complaint or appointing an investigator, a Panel of the ICRC may make an interim order to suspend or impose terms, conditions or limitations on a Registrant's certificate of registration if it believes that the Registrant's conduct is likely to expose patients to harm or injury. If an interim order is being contemplated, the Registrant will typically receive notice about the intention to impose and interim order and provided an opportunity to respond. In certain circumstance, a Panel of the ICRC may impose an interim order without notice where it believes that urgent intervention is required. Where an interim order is made, the information is posted on the public register.

Stage 3: Review by ICRC

Once all documentation and relevant information has been collected from the parties and possible witnesses, the matter is reviewed by a panel of the ICRC. The Panel conducts a thorough review of the information and considers whether there are any additional documents that should be obtained or any other witnesses who should be approached and interviewed.

Stage 3a. Expert Opinion

Where standards of practice within the profession are an issue, the Panel may retain a knowledgeable member of the profession to provide an expert opinion. Similarly, experts in document analysis, DNA, mental health or other disciplines may be required in some cases.

Stage 3b: Formal Investigation (Complaints ONLY)

In some circumstances the Panel may request that the CEO appoint a formal investigator, who has the power to:

- Enter the Registrant's place of practice and examine records or equipment and, where necessary, copy or remove them;
- Summons witnesses or documents; and
- Obtain a search warrant.

Stage 4: Decisions and Reasons

Once the investigation is completed the ICRC deliberated on the potential outcomes of the complaint/report. A written decision and the reasons for the decision are provided to both the complainant and the Registrant except where the matter has been referred to the Discipline Committee or to another panel of the ICRC to conduct health inquiries.

Stage 5: Implementation of the Outcomes

The College monitors compliance with all ICRC outcomes. If a Registrant fails to comply with a decision of the ICRC, the CEO of the College, with the approval of the ICRC may appoint an investigator to inquire into the Registrant's actions and the reasons for non-compliance.

Decisions

As noted above a panel of the ICRC, after investigating a complaint or report, may do any one or more of the following:

Take no action
if the conduct and/or actions meet reasonable and acceptable standards of practice, or if there is insufficient information to support the allegations, the Committee may decide to take no action.

Issue a Letter of Counsel
A Letter of Counsel if a communication of the ICRC's expectations for corrective action on behalf of the Registrant, and may include advice, guidance and recommendations to review particular standards or publications.

Oral Cautions

An Oral Caution requires the Registrant to appear before a panel of the ICRC to be cautioned about their practice or conduct. The RHPA requires the details of all Oral Cautions to be listed on the Public Register.

Specified Continuing Education or Remediation Program (SCERP)

A SCERP requires the Registrant to successfully complete an educational or remediation program specified by the ICRC. SCERPS may include educational training, self-directed learning, inspections and or assessments. The RHPA requires the details of all SCERPs to be listed on the Public Register.

Discipline Committee Referrals

Where the allegations are sufficiently serious and information exists to support the allegations, a Panel of the ICRC may refer the matter to the Discipline Committee to hear specified allegations of professional misconduct or incompetence. All referrals to the Discipline Committee including the Specified Allegations are listed on the Scheduled Hearings page of College's website and posted on the Public Register.

Health Inquiry Referrals

Where a penal of the ICRC investigating a complaint or report believes that the Registrant may have a physical or mental condition which prevents them from providing safe, ethical and competent care, they may refer the matter to another panel of the ICRC for investigation of possible mental or physical health concerns that might interfere with their ability to practise. The Health Inquiry Panel may require an independent medical examination of the Registrant. If the Registrant is considered to be incapacitated, the panel may refer the matter to the Fitness to Practice Committee who may suspend, attach specific limitations or revoke a certificate of registration. Information about incapacity proceedings and decisions regarding a Registrant's capacity are not published publicly. However, if their ability to practice has been restricted, that information is made available on the public register.

Reviews by HPARB

Either the complainant or Registrant may request any of the decisions, except for a Referral to the Discipline or Fitness to Practice Committee, be reviewed by the Health Professions Appeal and Review Board (HPARB). The Board is an independent body established by the provincial government and is made up on non health care professionals. Following a review HPARB may:

- Confirm the Committee's decision;
- Refer the matter back to the Committee;
- Require the Committee to take a specific action;
- Make recommendations to the Committee.

Importance of this Program

The College's Complaints and Report program is a critical aspect of self-regulation and maintaining the trust of the public. It can be a lengthy and costly process as each complaint and report is thoroughly investigated, reviewed, and considered. Each matter is unique and as such there is complexity in the administration of the ICRC's functions.

The Complaints and Reports Program is the primary method by which the College responds to concerns about the practice, conduct or health of a Registrant in instances where they may have failed to meet the standards of the profession and ensures that Registrants provide safe, competent and ethical care.

Respectfully submitted,

Jeremy Quesnelle
Deputy CEO

May 2021

BRIEFING NOTE
Educational Briefing - Discipline Processes

BACKGROUND

The College of Naturopaths of Ontario is established by under the Naturopathy Act, 2007 and the Regulated Health Professions Act, 1991. Its duty, as set out in the legislation is to serve and protect the public interest. Its mandate is to support patients' rights to receive safe, competent, and ethical naturopathic care.

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Other elements that will arise within the regulatory framework include "right touch regulation", using the approach that is best suited to the situation to arrive at the desire income of public protection, and risk-based regulation, focusing regulatory resources on areas that present the greatest risk of harm to the public. Both of these will be further elaborated upon in later briefings.

The focus of this briefing is on the discipline program and processes of the College. It is presented as a natural follow on the Complaints and Reports program and processes.

Discipline Program

The Discipline Program is the primary vehicle through which the College holds Registrants accountable for their conduct and competence. The Discipline Program involves a minimum of three parties.

1. The College of Naturopaths of Ontario – as the regulatory authority, the College has the responsibility to set out specific allegations against a Registrant and to present the evidence in support of those allegations as part of its prosecution of the Registrant. The College is represented by the Chief Executive Officer and by General Council of the College. "The prosecution."
2. One (or more) Registrants of the College – as the individuals who are regulated, Registrants are a party to the Discipline Program as they have the right to defend themselves against the allegations set out by the College. The Registrants are typically (though not always) represented by Legal Counsel and together, they are "The defence."
3. Discipline Committee (a Panel thereof) – the Discipline Committee of the College is independent of the College (although many Council members will sit on the Committee). It will be made up of a minimum of three and a maximum of five individuals, two of which must be Public members (individuals appointed to the Council by the Government), and one of which must be a Professional member from the Council. The remaining two individuals may be any of Public members, professional members of the College (Registrants) or Public Representatives appointed by the Council as set out in the by-laws. The Panel is "The Jury."

Notwithstanding the imagery evoked by the terms "Prosecution", "Defence" and "Jury", the matter is not a criminal proceeding but rather, a civil one. In a disciplinary matter brought before a panel of the Discipline Committee, the College is responsible for presenting sufficient evidence to "prove" its case. The burden of proof is "on the balance of probabilities", that is, having weighed the evidence, that the Registrant is more likely than not to have committee acts of professional misconduct or demonstrated incompetence. This is different than a criminal matter where the burden of proof is "beyond a reasonable doubt".

A discipline hearing is conducted in a formal quasi-judicial setting in the College's Council Chamber (or virtually) with all parties present. Evidence is presented under oath and witnesses are called before the Panel and subject to examination and cross-examination.

If the "prosecution" can prove the allegations, the Panel of the Discipline Committee will make a finding of either professional misconduct or incompetence, or both. The Panel will issue a decision and reasons for that decision and they will set out a penalty in the form of an order from the Panel. The Panel may order any one or more of the following as part of its penalty:

- a reprimand;
- impose restrictions on the Registrant's registration, called terms, conditions or limitations;
- require the Registrant to complete a specified education and remediation program;
- suspend the Registrant's Certificate of Registration for a period of time;
- revoke a Registrant's Certificate of Registration.

In addition to the penalty that can be imposed by the Panel, the Panel may also impose "costs" on the Registrant, that is, the Panel can order that the Registrant reimburse the College for part of its costs of the investigation, its legal costs and hearing costs. Where a finding of professional misconduct has been made that relates to sexual abuse, the Panel can also order the member to reimburse the College for funding provided to patients for counseling in sexual abuse.

Both the Registrant and the College have the right to appeal a Discipline Committee decision to the Superior Court of Justice.

Discipline Process

Given the importance of the Discipline Program to the College's mandate and to the Registrants against whom allegations may be made, the Discipline Process is quite complex and can take a great deal of time. Due process requires that the Registrant have sufficient time to mount a defence of the allegations while the College has an obligation to both the public and the Registrant to ensure that the process is timely.

The discipline process begins when the Inquiries, Complaints and Reports Committee (ICRC) refers specified allegations of professional misconduct and/or incompetence to the Discipline Committee for a hearing. The ICRC will make such a referral only after they have completed a fulsome investigation into either a complaint filed against a Registrant or an inquiry initiated by the CEO. The ICRC will have considered, among other things, the public interest, the risk of harm posed to the public and the likelihood of success within the discipline program. The ICRC is required to be very specific in the allegations referred to the Discipline Committee and once made, additional allegations cannot be raised as part of the discipline program.

The following is a general outline of the stages of a disciplinary matter involving a Registrant of the College. As a part of its transparency initiatives, the College ensures that the public is aware of the status of each matter being brought before the Discipline Committee.

Stage 1: Notice of Hearing and Disclosure

Legal Counsel for the College will, based on the referral of the specified allegations, draft the Notice of Hearing. Once signed by the CEO, the Notice of Hearing, Rules of Procedure of the Discipline Committee, and the Disclosure (which is all of the information the College has that is relevant to the allegations) will be sent to the Registrant or the Registrant's Legal Counsel, if one is appointed.

Stage 2: CEO and Legal Review

The CEO of the College is purposefully not directly involved in matters under investigation by the ICRC. This ensures that when a matter is referred by the ICRC to the Discipline Committee, the CEO who is responsible, along with Legal Counsel, for taking the matter before the Discipline Committee does so with a fresh look and without any potential bias.

In this stage, the CEO and Legal Counsel will review the allegations, the evidence in support of the allegations, witness statements and expert opinions to determine how the College wishes to proceed with the Discipline Hearing.

Also in this stage, Legal Counsel will prepare a memorandum to the CEO setting out the range of penalties that might be imposed in the matter and the case law from other regulatory authorities that support the range of penalties. Legal Council will also begin drafting an Agreed Statement of Fact (ASF) and Joint Submission on Penalty (JSP) for use later in the process.

Stage 3: Pre-Hearing Conference (PHC)

In accordance with the Rules of Procedure of the Discipline Committee, a Pre-hearing Conference (PHC) is held. The PHC is chaired by an independent person familiar with discipline proceedings before regulatory bodies.

At the PHC, the College presents an overview of its case and the Registrant or their Legal Counsel presents their defence. The PHC Chair will review the evidence and advise the parties about the strengths of their cases and areas where they may be weak. The Chair will also, based on their experience in discipline matters, provide the parties with advice as to whether the case might lead to a finding against the Registrant.

The parties also often engage in discussions surrounding whether a settlement is possible. A settlement occurs when the Registrant agrees to some or all of the allegations against them and when both the College and the Registrant can agree on a penalty. A settlement is seen as serving the public interest as it will result in an admission by the Registrant, an agreement on penalty and remediation and potentially limits on the Registrant's practice, either temporary or permanent.

Legal counsel for the College will present to the PHC Chair and the Registrant a draft Agreed Statement of Facts (ASF) and Joint Submission on Penalty (JSP) at the PHC in an attempt to facilitate settlement.

Stage 4: Setting a Hearing Date

Following the PHC and based on the outcome of on-going settlement discussions, both parties will ask the Chair of the Discipline Committee to appoint a panel to hear the matter and to set the date(s) for a hearing.

Although the Notice of Hearing is publicly released and the referral information about the matter are both posted to the College's website, the Discipline Committee has not yet been involved while the preliminary stages are completed.

The Discipline Committee Chair will canvass members of the Committee to ensure that no one who has a conflict of interest with the Registrants against whom the allegations are made is potentially appointed to the Panel. The Chair will then appoint a Panel as well as a Panel Chair.

Stage 5: The Hearing

At this stage, the panel appointed by the Chair of the Discipline Committee will be convened for one or more days during which they will be presented with evidence in support of the allegations by the College and with the defense case for the Registrant. A hearing has the following components:

a. Presentation of the case by the College and the defense by the Registrant.
b. Verbal decision and reasons on the allegations by the panel.
c. If a finding of professional misconduct or incompetence is made, submissions by the College and Registrant on penalty.
d. Verbal decision and reasons on penalty.
e. Submissions on costs by the College and Registrant.

In an uncontested, single day hearing the College and the Registrant present the ASF, the fact relating to the allegations against the Registrant as well as a JSP on penalty and proposed costs. More information about the settlement process is provided below.

In a contested hearing, the panel typically issues initial verbal decisions. If a finding of professional misconduct or incompetence is made, the panel will ideally proceed as soon as time permits to hear submissions on penalty. If the College is also seeking costs, these submissions will occur after the

submissions on penalty as costs are not part of the penalty. After hearing these submissions, the panel will usually (although not in every case) issue a verbal decision on penalty and, if applicable, costs.

Stage 6: Decision and Reasons

After the hearing has concluded, the Panel will draft the written Decision and Reasons. This document, once finalized, is formally issued by the Panel to the College, the Registrant and the Complainant (if applicable) and is also released publicly by the College on its website and through The Canadian Legal Information Institute (CanLII), a subsidiary of the Federation of Law Societies of Canada.

If either the Registrant or the College does not agree with the Decision and Reasons as issued by the Discipline Panel, either may appeal the outcome to the Superior Court of Justice for Ontario.

Stage 7: Implementation

If the Panel finds that the Registrant had committed acts of professional misconduct or incompetence, and imposes a penalty, and assuming there is no appeal of the Decision and Reasons, the College will implement any penalty imposed by the Panel.

The penalty, which must be completed within a set period of time, typically includes one or more of the following:

- Revocation of their certificate of registration or a suspension from practising the profession for a period of time;
- A reprimand of the Member by the Panel;
- Applying a term, condition or limitation on the Member's certificate of registration which may include the following;
    - Taking one or more continuing education courses related to matters relevant to the findings against the Member;
    - One or more meetings with Experts in areas of the practice of the profession related to the findings against the Member;
    - One or more meetings with Experts in regulation;
    - One or more inspections on the Member's practice and files to review matters related to the findings against the Member;
- A fine of not more than $35,000 payable to the Minister of Finance.

Reaching a Settlement

There are a number of reasons why one or both parties to a hearing may wish to reach a settlement, some of which are:

- Witnesses to the matter, including patients, may decide they no longer wish to testify;
- Information received during the process may bring doubt upon the credibility of a witness;
- Expert testimony may not be as strong as initially anticipated or new information brings the credibility of the Expert themselves into question;
- The costs of proceeding to a full hearing outweigh the potential benefits for either side in terms of likely outcomes.

The parties can reach a settlement at any time before or even during a hearing; however, the closer the settlement occurs to the start of a contested hearing the more likely the College is to be seeking higher costs (as the costs to the College have increased).

An offer to settle the matter is typically made either just prior, during or immediately following the Pre-Hearing Conference. The College will often make an initial offer to the Registrant and their legal counsel

by drafting an Agreed Statement of Facts (ASF) and a draft Joint Statement on Penalty and Costs (JSOC). In most circumstances, a negotiation follows these offers where either side indicates its willingness to agree to or withdraw allegations, agree to penalties and agree to costs for the process.

Allegations- allegations may be withdrawn because the College does not have sufficient evidence (witnesses, experts, documentation) to obtain a finding from a Panel of the Discipline Committee or the allegation is not crucial to the overall matter at hand.

Penalties – penalty discussions are always based on the case law from other regulatory bodies in matters that are similar. It is highly improbable that another case exists that exactly matches the matter before the Discipline Committee; however, through a series of similar cases, a range of penalties can typically be derived. If both sides can agree on the range and the seriousness of the case to be brought before a panel, then the likelihood of agreeing on penalty is increased.

In any penalty discussion, the College is considering four principles. First, specific deterrence to ensure that the Registrant does not repeat the allegations to which they are agreeing. Second, general deterrence to provide information to the profession on the whole as to what happens when regulations and standards are breached. Third, the ability to remediate the Registrant through education and training to improve compliance and outcomes in the future. Fourth, whether the penalty will allow the public to have confidence in the ability of the College to regulate its Registrants in the public interest. The College will also consider aggravating and mitigating factors, that is, factors that affect the decision including the parties involved, the circumstances of the matter, agreeing to settle among many others.

Costs – while the courts have made several rulings on the validity of cost awards (up to 66% of the costs of a contested hearing, provided the costs have been well documented and are reasonable), cost discussions in an uncontested matter are detailed. The College documents all of its costs throughout the process; however, when making an "offer" as to the costs, some costs have to be estimated on how long the settlement discussions will take and how close to or into an actual hearing the process will go. Once again, costs are considered in the context of other rulings by regulatory bodies; however, the range is usually more broad and dependent on the organization involved. The CEO will also consider facts presented, in good faith, by the Registrant, in particular when it involves potential hardship imposed on the Registrant.

Any settlement must be acceptable to the Panel of the Discipline Committee. Again, the courts have consistently ruled that panels must accept any joint proposal on penalty unless the panel can reasonably conclude that the penalty is beyond the range for such cases, either too harsh or too lenient and that the settlement will undermine public confidence in the regulatory body and process. Not included among the reasons for rejecting a joint proposal on penalty is that a panel simply does not like or agree with the penalty itself.

Importance of this Program

The importance of the Discipline Program and related processes cannot be overstated. It is a critical aspect of self-regulation and maintaining the trust of the public. It can be a very lengthy process as it requires a great deal of careful thought on the part of all three (or more) parties.

It is the role of the College to proceed on these matters and to do so with the intent to serve and protect the public interest. There is no satisfaction derived from successfully prosecuting a Registrant just as there is no embarrassment of not being successful. The College's role is to present the evidence that is available to it. The Panel's role is to weigh that evidence and the credibility of witnesses and experts and to render a decision.

Respectfully submitted,

Andrew Parr, CAE
CEO

May 2021

Materials Redacted

Page redacted pursuant to paragraph (2) of section 7(2) of the Health Professions Procedural Code. The materials include personnel related materials that are personal information to the individual to whom they pertain.

The Council will be moving to an in camera session to discuss these materials pursuant to paragraph (2) of section 7(2) of the Health Professions Procedural Code

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