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

THE STANDARD OF CARE.

# Council briefing package

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

THE STANDARD OF CARE.

**Council**
Wednesday, December 7 and Thursday, Dec. 8, 2022 via Zoom

# Agenda

Council's Governance Principles
Council's Annual Plan
Council's Team Norms

## Wednesday, December 7, 2022
## 1:00 p.m. – 5:00 p.m.

| | | |
|---|---|---|
| 1:00 p.m. | **1. Land Acknowledgement** | |
| 1:05 p.m. | **2. Agenda** | Decision |
| 1:10 p.m. | **3. Minutes of September 2022 Council meeting** | Decision |
| | **4. Strategic Issues** | |
| 1:15 p.m. | 4.1 Strategic Plan 2021-2024 - update | Information & Discussion |
| 2:15 p.m. | 4.2 Registration<br>• Background<br>• Modernizing Applicant Assessment - update<br>• Implementation of the Registration Regulation: Temporary class and reinstatements<br>• Overview of Bill 106<br>• Jurisprudence examinations | Information & Discussion |
| 3:15 p.m. | **Break** | |
| 3:30 p.m. | 4.3 Modernizing Practice Standards, Code of Conduct | Decision |
| 4:15 p.m. | 4.4 Nursing Education Program Approval | Decision |
| | **5. Reports** | |
| 4:30 p.m. | 5.1 Chief Executive Officer's Update | Information & Discussion |
| 4:50 p.m. | 5.2 Executive Committee meeting of November 17, 2022 | Information & Discussion |
| 5:00 p.m. | Recess | |

**Thursday, December 8, 2022**
**9:00 a.m. to 2:30 p.m.**

## Council Agenda

| | | |
|---|---|---|
| | **6. Information Presentation(s)** | |
| 9:00 a.m. | 6.1 Quality Assurance Program Transformation | Information & Discussion |
| 9:30 a.m. | **5. Reports (continued)**<br>5.3 Finance Committee meeting of November 17, 2022<br>• Unaudited Financial Statements for the nine months ended September 30, 2022<br>• 2023 Operating and capital budgets | Decision |
| | **7. Council operations and governance** | |
| 11:30 a.m. | 7.1 Board evaluation<br>• Watson attending | Information & Discussion |
| 12:00 | **Break** | |
| 1:00 p.m. | 7.2 By-Laws re. Statutory Committee membership | Information & Discussion |
| 1:30 p.m. | 7.3 Dates of Council meetings | Decision |
| . | **8. Discussion agenda items added by Council members** | |
| | **9. Reflection on the team norms** | |
| . | **10. Date of next meeting**<br>Wednesday, March 8 and Thursday, March 9, 2023 | |
| 2:30 p.m. | **11. Conclusion** | |

**Information Items:**
Nurse Practitioner Entry to Practice Competencies

Council is individually and collectively committed to regulating in the public interest according to the following principles:

## Accountability

- We make decisions in the public interest
- We are responsible for our actions and processes
- We meet our legal and fiduciary duties as directors

## Adaptability

- We anticipate and respond to changing expectations and emerging trends
- We address emerging risks and opportunities
- We anticipate and embrace opportunities for regulatory and governance innovation

## Competence

- We make evidence-informed decisions
- We seek external expertise where needed
- We evaluate our individual and collective knowledge and skills to continuously improve our governance performance

## Diversity

- Our decisions reflect diverse knowledge, perspectives, experiences and needs
- We seek varied stakeholder input to inform our decisions

## Independence

- Our decisions address public interest as our paramount responsibility
- Our decisions are free of bias and special-interest perspectives

## Integrity

- We participate actively and honestly in decision-making through respectful dialogue
- We foster a culture in which we say and do the right thing
- We build trust by acting ethically and following our governance principles

## Transparency

- Our processes, decisions and the rationale for our decisions are accessible to the public
- We communicate in a way that allows the public to evaluate the effectiveness of our governance

Approved by Council, September 2016

2022-2023

# ANNUAL PLAN FOR COUNCIL

## December 2022

- 2023 Budget
- Board evaluation report
- By-Laws re. statutory committee membership
- Dates of Council meetings
- Registration
    - Modernizing applicant assessment
    - Update on Temporary class and reinstatements
    - Overview of Bill 106
    - Jurisprudence examination
- Modernizing Practice Standards: Code of Conduct
- Nursing education program approval: Comprehensive and preliminary reviews
- Strategic Plan: 2021-2024
- Quality Assurance Program update

## MARCH 2023

- 2023 statutory committee annual reports
- Election of the Executive Committee
- Modernizing Applicant Assessment
- Jurisprudence Examination
- Nursing education program approval (new program)
- Quality Assurance Program
- Strategic Plan: 2021-2024
- Statutory committee appointments

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## JUNE

2023

- *2022 Annual Report*
- 2022 audited financial statements
- Nursing education program approval

## SEPTEMBER

2023

- Dates of Council meetings in 2024

# DECEMBER

2023

- 2024 Budget

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# Team Norms

As members of Council, we are committed to:

- **Being engaged, participating in Council discussion and decision-making**
- **Acknowledging and building on each other's contributions**
- **Fostering consensus**
- **Being comfortable raising dissenting views, respecting dissenting views**
- **Supporting decisions made by Council**
- **Respecting each other and the agenda**
- **Avoiding side discussions or off-line debate**
- **Being succinct**
- **Being open-minded**
- **Being genuine**
- **Being fully attentive**
- **Being kind to each other**

Adopted by Council
September 2021

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

THE STANDARD OF CARE.

**Council**
September 28 and 29, 2022

# Minutes

## Present

N. Thick, Chair
A. Arkell
J. Armitage
T. Crowder
R. Dunn
S. Eaton (Thursday)
D. Edwards
T. Fukushima
Z. Hamza
T. Hands
N. Hillier
M. Hogard
C. Hourigan
A. Jahangir
R. Kaur
M. Krauter
S. Larmour
R. Lastimosa Jr.
S. Leduc
D. May
I. McKinnon (Wednesday)
E. Mutia
F. Osime
L. Poonasamy
M. E. Renwick
J. Petersen
M. Sheculski
P. Sullivan-Taylor
D. Thompson

## Regrets

P. Ankamah
S. Douglas
S, Eaton (Wednesday)
K. Gartshore
M. MacDougall
I. McKinnon (Thursday)

## Guests

A. Bromstein
J. Butterfield
C. Evans
R. Steinecke

## Staff

V. Adetoye
S. Crawford
F. Garvey
J. Hofbauer, Recorder
C. Gora
E. Horlock
B. Knowles
K. McCarthy
S. Mills
A. M. Shin
C. Timmings

## Land Acknowledgement

N. Thick shared a Land Acknowledgment.

## Agenda

N. Thick noted that the agenda had been circulated

## Motion 1

Moved by A. Jahangir, seconded by R. Lastimosa Jr.,

> That the agenda for the Council meeting of September 28 and 29, 2022 be approved as circulated.

CARRIED

## Minutes

Minutes of the Council meeting of June 8, 2022 had been circulated.

## Motion 2

Moved by D. Edwards, seconded by M. E. Renwick,

> That the Minutes of the Council meeting of June 8, 2022 be approved as circulated.

CARRIED

Confidential minutes of the closed Council session of June 8, 2022 had been circulated to Council members.

## Motion 3

> That the confidential Minutes of the closed Council session of June 8, 2022 be approved as circulated.

CARRIED

## NURSYS Canada

S. Mills provided an update about NURSYS Canada, a platform being developed to allow Canadian nursing regulators to share information about registrants. He highlighted how implementation of NURSYS will support CNO's regulatory role and public safety.

He reported on the collaborative work undertaken by CNO and the BC College of Nurses and Midwives, partnered with the National Council of State Boards of Nursing. Council was informed that a pilot site with data from CNO and the BC College is planned to go live later this year.

The plan is to open the platform to other nursing regulators in late 2023 and they will be onboarded as they are ready to proceed. It was identified that some regulators may require more time to prepare than others.

## Financial Overview

As part of ongoing education and to support Council members in their role in ensuring CNO's ongoing financial viability, S. Mills presented a financial overview. He highlighted CNO's status as a not-for-profit corporation, noted the role of various parties in ensuring CNO's ongoing fiscal viability, highlighted financial statements and described CNO's surplus/deficit cycle.

N. Thick clarified that Council's duty in making any decisions, including financial, is to support CNO's ability to fulfil its purpose.

## Council Evaluation

J. Butterfield from Watson's joined the meeting.

Council had received a briefing note, including a proposed Council Evaluation Policy. J. Butterfield noted that the policy has been developed based on research, consultation, and best practice. It is specific to Council's stewardship role as CNO's board of directors and reflective of the information discussed at Council's professional development session on evaluation. She noted that the policy includes provisions for its review and updating at least every three years.

## Motion 4

Moved by J. Petersen, seconded by A. Arkell,

> That Council approve the Council Evaluation Policy as it appears in attachment 2 to the briefing note.

CARRIED

## Follow-up Action

Conduct Council evaluation.
Include Council evaluation on December 2022 Council agenda.
Executive Director and CEO

## Report of the Nominating Committee

C. Evans, Chair of the Nominating Committee, joined Council to present the final report of the 2021-2022 Nominating Committee. A report had been circulated to Council.

K. McCarthy presented an overview of Council's governance vision, highlighting evidence of its ongoing validity, and noting the steps that Council has taken to implement the vision. He noted the key role that a competency-based Nominating Committee will play, supporting the board in making competency-based board and committee appointments. He noted that, to be ready to fully implement the vision when legislative changes come into effect, Council has implemented a Nominating Committee.

C. Evans highlighted the report of the Nominating Committee. She reminded Council of its recommendations made in March regarding appointment of statutory committee members and in June about the members of the Finance Committee.

## Nominating Committee members

C. Evans highlighted the process used by the Nominating Committee to recommend the Council members for the 2022-2023 Nominating Committee.

She noted that the mix of ongoing and incoming members provides the competencies needed for the Nominating Committee to fulfil its Terms of Reference.

### Motion 5

Moved by S. Leduc, seconded by D. Ballantyne,

> That A. Jahangir, RN and S. Douglas, public member, be appointed to the Nominating Committee.

CARRIED

## Council vacancy

C. Evans reminded Council that since there has not been legislative change, the Nominating Committee has roles related to Council elections. This includes recommending to Council how to address a Council vacancy. It was noted that the committee's recommendation is based on the options in by-law.

### Motion 6

Moved by J. Petersen, seconded by P. Sullivan-Taylor,

> That, in accordance with Article 55.02 of By-Law No. 1: General, the RN/NP Council member position in the Northwestern electoral district remain vacant until the newly elected RN/NP Council member joins Council in June 2023.

CARRIED

## Terms of Reference

The Nominating Committee reviewed its Terms of Reference and is proposing changes to support ongoing efficiency and effectiveness.

### Motion 7

Moved by A. Jahangir, seconded by D. May,

> That the proposed revised Terms of Reference for the Interim Nominating Committee, as they appear in attachment 2 to the Nominating Committee's report to Council, be approved.

CARRIED

C. Evans noted that the Nominating Committee debriefed on the appointments process. A change made to the Nominating Committee competencies was shared with Council.

## Conduct Committee

Council members received a briefing note with recommendations from the Executive and Nominating Committee regarding the members of the 2022-2023 Conduct Committee.

## Motion 8

Moved by M. Hogard, seconded by A. Arkell,

That Council appoint the following as the 2022-2023 Conduct Committee: M. E. Renwick, Chair, D. Edwards, T. Hands, J. Petersen and D. Thompson.

CARRIED

C. Evans left the meeting.

## Dates of Council meetings

Council members received a briefing with recommended dates.

## Motion 9

Moved by M. Sheculski, seconded by R. Kaur,

That Council approve the following meeting dates for 2023:

- Wednesday and Thursday, March 8 and 9, 2023 and
- Wednesday and Thursday, June 7 and 8, 2023.

CARRIED

In December, Council will approve the dates for meetings in September and December 2023.

## Recess

Council recessed to resume at 9:00 a.m. on Thursday, September 29, 2022.

## Thursday, September 29, 2022

### Council's Response to Minister Jones' Directive

A. Bromstein, Legal Counsel, A. McNabb and E. Tilley joined the meeting.

S. Crawford and C. Timmings highlighted CNO's ongoing work to register nurses with the knowledge, skill, and judgement to practice safely in Ontario. The actions CNO has taken, including responding to directives from the Minister of Health, collection and analysis of data and partnering with stakeholders in the system were highlighted

### Proposed Amendments to the Registration Regulation

E. Tilley reviewed the proposed changes to the Registration Regulation in detail. She noted that there are three changes related to the Temporary Class:

- broadening the education requirement to successful completion of any registered nurse (RN) or registered practical nurse (RPN) program approved in any jurisdiction,
- enabling someone in this class to take the approved registration exam twice (e.g., two exam failures would result in the certificate of registration being revoked), and
- giving the Executive Director discretion related to the timeframe to revoke a Temporary Class certificate of registration (e.g., so the Executive Director can give more time to allow individual IENs the opportunity to meet education gaps then get registered in the General Class).

She highlighted the change related to the reinstatement:

- giving the Executive Director discretion related to the amount of time a nurse, who previously worked in the province, can be out of practice.

She noted that removing some specifics from regulation and moving them to Executive Director discretion allows CNO to respond to changing evidence, public expectations and systems needs.

Council discussed the balance of enhancing access to registration for qualified candidates with the need to have policies and practices in place to ensure public safety.

### Motion 10

Moved by A. Jahangir, seconded by R. Dunn,

> That Council approve Ontario Regulation 275/94 (General), as amended, under the *Nursing Act, 1991* as it appears in attachment 1 to the briefing note. The Registrar and President are authorized to sign any Government proposed form of the changes that implement the intent of the changes approved by Council.

CARRIED

A. Bromstein left the meeting.

## Follow-up Action

Submit regulation amendments to Minister of Health for approval.
Executive Director and CEO

## Nursing Education Program approval

Council had received a decision note, including the outcomes of the nursing education program reviews and recommendations regarding program approval.

N. Thick noted the importance of Council's role in approving nursing education programs. She identified at that this meeting, all programs will be reviewed.

K. Dilworth, Manager of Education Program shared a presentation on the program approval process, including highlighting the score card used to assess programs.

Annual reviews of nursing programs

S. Leduc declared a conflict of interest and left the meeting.

## Motion 11

Moved by M. Hogard, seconded by A. Jahangir,

> That the annual monitoring review status of nursing programs, listed in Attachment 1 to the briefing note, be approved.

CARRIED

S. Leduc returned to the meeting.

Comprehensive reviews of nursing programs

## Motion 12

Moved by J. Armitage, seconded by A. Arkell,

> That the comprehensive review status of nursing programs, listed in Attachment 2 to the briefing note, be approved.

CARRIED

New nursing programs

## Motion 13

Moved by N. Hillier, seconded by R. Lastimosa Jr.,

> That the preliminary review status of new nursing programs, listed in Attachment 3 to the briefing note, be approved.

CARRIED

## Follow-up Action

Inform nursing education programs of their approval status
Update program approval information on cno.org
Executive Director and CEO

## Modernizing Standards

Council members had received a briefing note highlighting the process to revise the Code of Conduct and including the most recent draft Code of Conduct.

C. Tancioco highlighted the work, including the stakeholder consultation and Council engagement, undertaken to date to modernize the Code of Conduct.

It was noted that CNO is planning further broad consultation on the draft Code of Conduct that had been circulated to Council.

A final draft of the Code, including feedback from stakeholders and Council, will be presented to Council in December, for decision. It was noted that plans for implementation include a future effective date to allow for education and collaboration with system partners.

## Executive Committee

Council members had received notes of the Executive's decision of August 16 and 17, 2022, approving Council's response to Minister Jones' directive. N. Thick reported that the Executive had responded on Council's behalf under Section 12(1) of the *Health Professions Procedural Code.*

Council had received the draft minutes of the Executive Committee meeting of August 25, 2022. N. Thick noted that the meeting had focused on input into the board evaluation professional development session and planning for the Council meeting.

R. Steinecke, Legal Counsel, joined the meeting.

N. Thick highlighted the action taken by the Executive, with the input from staff and legal counsel, to support CNO's ongoing regulatory operations.

Council had received a briefing highlighting proposed revisions to Article 13 of Part 1 of By-Law 1, to establish the Deputy Registrar's role. It was noted that this is required to allow the Executive Director and CEO to appoint a Deputy Registrar.

R. Steinecke clarified the unique legislative role of the Registrar and the rationale for specific clauses in the draft by-law.

N. Thick clarified that a 2/3 majority is required to pass a by-law revision.

## Motion 14

Moved by D. Thompson, seconded by J. Petersen,

> That Council approve the amendments to By-Law No. 1, Part 1, Article 13 as they appear in attachment 1 to the briefing note.

CARRIED

R. Steinecke left the meeting.

## Follow-up Action

Amend and publish the By-Laws
Executive Director and CEO

## Strategic Planning

Council had received a briefing note, providing background on the development and implementation of CNO's 2021-2024 Strategic Plan. N. Thick highlighted Council's role, as CNO's board of directors, in developing and monitoring the strategic plan in collaboration with staff.

S. Crawford, S. Mills and C. Timmings highlighted how CNO is mapping and measuring achievement of the three outcomes and the four pillars of the Strategic Plan. An integrated road map showing the implementation plans and dependencies over the next three years and metrics for each outcome were shared. It was noted that a dashboard is being developed to support Council in its monitoring of the strategic plan.

S. Crawford identified that the work to implement and measure the strategic plan is integrated across CNO. It was confirmed that as implementation proceeds, targets and additional metrics may be identified.

## Chief Executive Officer's Update

S. Crawford introduced her Chief Executive Officer update, noting that her reporting will focus on CNO leadership, engagement and emerging opportunities – what is happening in the environment and on the horizon.

She noted that during her transition into the CEO role, she has witnessed a strong commitment to CNO's purpose across the organization.

She also confirmed significant engagement, collaboration and consultation supporting Council's and CNO's leadership in regulatory change. She highlighted the interest of other jurisdictions in Council's leadership in supporting access to registration for qualified applicants.

She reported that CNO innovations support regulatory change and transformation provincially, nationally and internationally. For example, a growing number of Canadian nurse regulators are licensing CNO's nursing education program approval process.

## Finance Committee report

Council had received a report of the Finance Committee meeting of August 25, 2022. P. Sullivan-Taylor highlighted the report.

She informed Council that the Finance Committee had reviewed the unaudited financial statements for the six-months ended June 30, 2022 in detail and the accompanying confidential Management Discussion and Analysis document. The six-month operating surplus is approximately $2.3M, a $4.4 M favourable variance from the budgeted deficit of $2.1M.

## Motion 15

Moved by P. Sullivan-Taylor, seconded by A. Arkell,

> That Council approve the unaudited financial statements for the six-months ending June 30, 2022.

CARRIED

P. Sullivan-Taylor noted that the Finance Committee received a briefing on the budget development process. She reminded Council that the Finance Committee will be presenting a draft budget in December.

Council had received notice of a proposed by-law revision. The proposed revision is needed to align with the recently revised Terms of Reference and is reflective of recent changes to higher level by-laws.
N. Thick reminded Council that a 2/3 majority is required to approve a by-law.

## Motion 16

Moved by P. Sullivan-Taylor, seconded by E. Mutia,

That Article 26 of By-Law No. 1: General be rescinded and replaced with:

26.01 The Finance Committee advises Council on the financial affairs of the College. Specifics regarding the Finance Committee's authority, role and membership is set out in its Terms of Reference, as approved by Council.

CARRIED

## Next Meeting

Council will meet again on December 7 and 8, 2022. It was noted that the meeting will be remote.

## Adjournment

At 3:05 p.m., on conclusion of the agenda, it was,

Moved by R. Lastimosa Jr., seconded by A. Jahangir,

That Council adjourn.

CARRIED

_____
Chair

COLLEGE OF NURSES OF ONTARIO
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**Agenda Item 4.2**

# Information Note – December 2022 Council

# Jurisprudence Examination

## Contact for Questions or More Information

Kevin McCarthy, Director, Strategy

## Background

CNO's Jurisprudence Examinations are one of eight entry-to-practice registration requirements for nursing applicants. These exams assess an applicant's knowledge and understanding of the laws, regulations, CNO by-laws and practice standards that govern the nursing profession in Ontario. The current Jurisprudence Examinations (JE) were launched in January 2013 following Council's approval.

### *Legislative framework*

Ontario Regulation 275/94 made under the *Nursing Act, 1991* states that *"the applicant must, within five years before the day that the applicant is issued the certificate of registration, have successfully completed the examination in nursing jurisprudence that is approved by Council for applicants for the issuance of a certificate of registration"*.

### *Current Jurisprudence Examinations*

All applicants wishing to register in the General, Temporary or Special Assignment classes must successfully pass the Registered Nurse/ Registered Practical Nurse Jurisprudence Examination. Applicants wishing to register as a Nurse Practitioner must pass the Registered Nurse (Extended Class) Jurisprudence Examination. Reinstating members may be required to write the jurisprudence examination if they have not been registered in the past 5 years.

The current exams are an online, multiple-choice question, "open-book" exam, which means that applicants can access and use paper, electronic, or online resources (e.g., laws, regulations, CNO's practice standards) while writing the exam. Applicants have unlimited writes to successfully complete this requirement.

### *Need for Change*

The changing health care environment needs an exam that better supports learning, is agile to changing nursing regulation and focuses on risk areas that are evident through professional conduct inquiries and investigations. The current exams are focussed on knowledge assessment but do not ensure a supportive learning experience for all applicants. To align with

Outcome 1 in the Strategic Plan and with CNO's modernization of applicant assessment, there is a desire to deliver an exam that is fit for purpose and encourages applicant learning through an interactive, user-friendly and adaptive learning model. Furthermore, CNO's new Quality Assurance (QA) Technology Platform will provide an opportunity to deliver a new learning format and facilitate a supportive assessment approach that prepares all applicants for nursing in Ontario.

***Proposed New Jurisprudence Exams***

Insights and evidence gathered from a jurisdictional scan (national and province-specific), literature review and consultation with stakeholders and subject matter experts informed CNO's vision for a new approach. The new Jurisprudence Exams will consist of online learning modules and testing components designed to support applicant learning and assess knowledge attained. The exams will continue to reflect entry-level nursing practice and legal nursing responsibilities and accountabilities.

The proposed new online learning modules for the RN/RPN and NP jurisprudence exams will focus on five chapters. Robust analytics methodology and validation survey with stakeholder engagement was conducted to determine focused content. Chapters will cover:

1. Nursing Regulation
2. Nursing Scope of Practice
3. Professional Accountability and Responsibility
4. CNO Practice Standards
5. Quality Assurance and Continuing Competence.

At the end of each interactive chapter, the applicant will be assessed on their knowledge and application of learned content.

## Next Steps

- Leverage the new Quality Assurance Technology Platform and Learning Management System (LMS) to design and deliver the new learning modules and exams
- In March 2023, Council will be asked to consider and approve the new Jurisprudence Exams as an entry to practice registration requirement
- CNO will conduct analysis to determine the cost implications to administer the new exams. Where there is a need to increase or decrease the applicant fee for the jurisprudence exams, there will be a bylaw change that comes to Council in March 2023 for decision
- Establish and communicate clear timelines in early 2023 on the launch of the new Jurisprudence Exams and support applicants and stakeholders through the transition.

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Agenda Item 4.3

# Decision Note – December 2022 Council

# Standards Modernization: Code of Conduct

## Contact for Questions or More Information

Kevin McCarthy, Director of Strategy

## Decision for consideration:

That Council approve the draft *Code of Conduct* (Code), as it appears in Attachment 1 of this decision note, as a practice standard of the profession of nursing, effective Monday, June 5th 2023.[1]

## Public Interest Rationale

Modern standards act as a proactive contributor to inform the public, employers and nurses of nursing accountabilities in safe nursing practice, thereby reducing client harm.

## Strategic Outcome

Modernizing practice standards supports CNO's mandate to protect the public and set standards of practice and conduct. This also supports the implementation of CNO's Strategic Plan 2021-2024. Specifically, modernized practice standards advance CNO's strategic outcome so that *nurses' conduct will exemplify understanding and integration of CNO standards for safe practice*.

Informed by evidence, the objectives of this initiative are to ensure practice standards are:

- accessible (clear and easy-to-understand),
- defensible (evidence-informed, measurable), and
- relevant (reflect contemporary practice to prevent risk, informed by stakeholders, and meet stakeholder needs).

## Background

From 2020 to present, discussions with Council began on Standards Modernization. This included discussions on the following topic areas:

[1] Subject to Council approval, this date enables CNO to post the *Code of Conduct* before it takes effect so stakeholders can review it and plan for implementation. The June 5th, 2023 date also enables CNO to develop additional knowledge resources to support implementation.

- An overview of the objectives of modern standards,
- Key findings from the profession, other stakeholders, literature and regulators (e.g., understanding why and how stakeholders use practice standards),
- Evidence reflecting best practices in regulation and practice standard development (e.g., targeting risk, principle-based standards),
- An overview of a framework and,
- Key features of a modern standard.

In September 2022, Council was informed that the Code would be modernized first given its importance as the central practice standard. Council received an update on the Code's revisions to date, including a summary of evidence which identified additional gaps within the Code. This included a literature review, jurisdictional scans, regulatory data, extensive stakeholder consultation and external legal consultations. The evidence informed a preliminary draft Code shared with Council in September 2022.

**Stakeholder Consultation Summary**

CNO conducted extensive stakeholder engagement to obtain diverse perspectives at a client, nursing and/or system level[2] on the draft Code shared with Council in September 2022. Since then, CNO continued to engage with stakeholders. This included inviting stakeholders, such as employers, academics, associations and unions, to participate in individual interviews, focus groups or complete the Code's public consultation survey and participate in future work to modernize practice standards and develop additional resources for their respective communities.

CNO analyzed feedback from these sources. The survey was open from September 12 to September 30, 2022. Stakeholders were invited to participate through several channels: including targeted email invitations to a random sample of 12,000 nurses and organizations servicing vulnerable communities[3]; and *The Standard* which was emailed to all registrants and social media. In total, 783 stakeholders completed the survey comprising of:

- 723 nurses
- 42 other individuals (e.g., former nurses, members of the public, other regulated health professionals)

[2] Examples of stakeholder groups include but are not limited to: Alliance Ontario, Black Nursing Communities of Practice (e.g., academics with expertise in anti-black racism), Citizen's Advisory Group (e.g., comprising of diverse clients), Indigenous Communities (e.g., Indigenous Primary Health Care Council), LGBTQ2+ Communities (e.g., Queer Ontario, 519 Health), Mental Health & Addiction Communities (e.g., Centre for Addictions and Mental Health, Ontario Shores), Nurse Advisory Group (e.g., comprising of nurses working in rural/remote Ontario and with Francophone communities) and Senior & Elder Communities (e.g., Advantage Ontario, Ontario Retirement Communities Association).

[3] Examples of organizations include the First Nations Health Authority, Ontario Council of Agencies Serving Immigrants, Queer Ontario, Black Health Alliance, Muslim Family and Child Services of Ontario, Community Living Ontario, and Centre for Internationally Educated Nurses.

- 18 organizations (e.g., 9 colleges and universities, 3 health professional regulators, 3 nursing unions and 1 nursing association)

Overall, feedback on the Code was positive. For example, the survey asked stakeholders if there was anything unclear under each section of the Code. Between 89-94% of stakeholders answered “no” for each section. The survey also asked stakeholders if each section in the Code was applicable to the nursing profession. Between 93-97% of stakeholders answered “yes” for each section. Key themes emerging from the feedback include:

- Clarifying definitions (e.g., culturally safer, cultural humility, offences),
- Integrating key concepts (e.g., empathy, advocacy),
- General support for new principle focused on diversity, equity and inclusion,
- Importance of developing resources to support the Code’s application for various stakeholders including nurses, public and employers (e.g., online educational resources, digital communications, case studies) and,
- Additional feedback unrelated to the Code content (e.g., challenges nurses are currently facing within the healthcare system, employer issues, human resource shortages).

## A Modernized Code of Conduct

After analyzing all feedback, the Code now reflects:

- Revised, clearer principles to support reorganization of statements
- A new principle focused on providing inclusive, culturally safe care by practising cultural humility
- Revised, clearer terminology
- Enhanced integration of key concepts throughout the Code (e.g., empathy and advocacy)
- Action-oriented or measurable statements
- Enhanced alignment with professional misconduct regulation (e.g., clarity around acts of professional misconduct such as cooperating with CNO, misappropriation)
- Direct, embedded links to other practice standards.

## Next Steps

1. Implement the *Code of Conduct*:
    a. Develop resources to support application of the Code
    b. Engage stakeholders (e.g., share with stakeholders in a variety of communication methods)
2. Modernize other practice standards in 2023
3. Implementing a cyclical review process of practice standards

### Attachments

1. Attachment 1- DRAFT Code of Conduct

Practice Standard


# Code of Conduct

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

THE STANDARD OF CARE.

# CONTENTS





**Mission**: Regulating nursing in the public interest

**Vision**: Leading in regulatory excellence

**Purpose:** To protect the public by promoting safe nursing practice

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Ce fascicule existe en français sous le titre : *Code de conduite,* n° 59040

# What is the Code of Conduct?

The College of Nurses of Ontario (CNO) protects the public by promoting safe nursing practice. One way we do this is by developing standards of practice for all nurses in Ontario.

The Code of Conduct (Code) is a practice standard describing the accountabilities all nurses registered in Ontario have to clients, employers, colleagues and the public. It explains what people can expect from nurses. The Code also describes what nurses must do to maintain professionalism, competence and ethical behaviour to deliver safe client care. All nurses (Registered Nurses, Registered Practical Nurses, and Nurse Practitioners) are expected to uphold this practice standard, regardless of their role, title or responsibility.

To maintain public trust and confidence in the nursing profession's integrity and care, the Code outlines safe and ethical practice requirements based on current evidence. The Code is also informed by legislation, such as the *Ontario Human Rights Code* and recommendations in the *Truth and Reconciliation Commission of Canada: Calls to Action (2015)*.

The Code puts clients at the centre of **nursing care** and includes principles of diversity, equity and inclusion to ensure client care is safe, compassionate, equitable and discrimination free.

Throughout the Code, we use the word "**client**" broadly, to include individuals, substitute decision-makers, families, caregivers, groups, communities and populations who receive nursing care.

Nurses are expected to use the Code along with other CNO practice standards. The Code applies to any method a nurse uses to deliver health care services, such as in-person, virtually or by telephone.

CNO considers the Code in regulatory processes and in reviewing the practice of nurses such as in Quality Assurance and Professional Conduct processes. Nursing practice is considered in its working context and circumstances.

A glossary of **bolded** terms is provided at the end of this document.

# Principles of the Code

The Code consists of six principles:

1. Nurses respect clients' dignity.
2. Nurses provide inclusive and culturally safe care by practicing cultural humility.
3. Nurses provide safe and competent care.
4. Nurses work respectfully with the health care team.
5. Nurses act with integrity in clients' best interest.
6. Nurses maintain public confidence in the nursing profession.

Each principle is supported by a set of statements of core behaviours all nurses are accountable for. All principles have equal importance and work together to describe the conduct, behaviour, and professionalism necessary for safe and ethical nursing practice in Ontario.

1

# Nurses respect clients' dignity

PRINCIPLE

In this principle, nurses work together with clients with respect and sensitivity to client needs. To do this, nurses are expected to model the following core behaviours:

**1.1** Nurses treat clients with respect, empathy and compassion.

**1.2** Nurses prioritize clients' health and well-being in the **therapeutic nurse-client relationship**.

**1.3** Nurses act in clients' best interests by respecting their care preferences, choices and decisions.

**1.4** Nurses respect clients' rights and involve and support clients in making care decisions.

**1.5** Nurses listen and respond to clients' concerns by collaborating with clients and any person or community the client wants involved in their care.

**1.6** Nurses maintain clients' privacy and dignity, regardless of where the client receives care or of its mode of delivery. This includes after the nurse-client relationship ends.

**1.7** Nurses communicate to clients, clearly and timely, the care details they propose to offer.

**1.8** Nurses obtain **informed consent** from clients, or from their **substitute decision-makers** when clients are unable to do so, as set out in CNO's *Consent* guideline and the *Health Care Consent Act, 1996*.

**1.9** Nurses identify when their own personal beliefs conflict with a client's care plan, and provide safe, compassionate and timely care to those clients, until other arrangements are in place.

2

PRINCIPLE

# Nurses provide inclusive and culturally safe care by practicing cultural humility

In this principle, nurses demonstrate cultural humility through **self-reflection** and evaluating their own behaviour. They advocate for equitable and culturally safe care that is free from discrimination. This includes understanding how personal attributes and societal contexts, such as disabilities, sexual identity, anti-Indigenous and anti-Black racism, influence client care. To achieve this principle, nurses are expected to model the following core behaviours:



### Self-reflection

**2.1** Nurses self-reflect on and identify how their privileges, biases, values, belief structures, behaviours and positions of power may impact the therapeutic nurse-client relationship.

**2.2** Nurses do not act on any stereotypes or assumptions they may have about clients.

**2.3** Nurses seek feedback from clients, the health care team, and others to evaluate their own behaviour and culturally safe practice.

### Creating safer health care experiences

**2.4** Nurses recognize that many identity factors and **personal attributes**, including those identified in the *Ontario Human Rights Code*, may impact a client, their lived experience and perspective on health care.

**Continued >**

2

PRINCIPLE

**2.5** Nurses assess and strive to meet clients' language, cultural and communication needs in ways clients understand.

**2.6** Nurses ask clients if they are open to sharing their lived experiences.

**2.7** Nurses address clients by their preferred name, title and pronoun.

**2.8** Nurses actively listen to and seek to understand the client's lived experiences.

**2.9** Nurses assess clients to determine their risk for **health inequities** and take steps to ensure the best client outcomes.

**2.10** Nurses give care that focuses on clients' resilience and strengths. Nurses work with clients to achieve their health and wellness goals.

**2.11** Nurses take proper action to prevent discrimination and when they observe or identify discrimination against a client.

**2.12** Nurses participate and advocate for culturally safe and inclusive practice environments.

### Training and education

**2.13** Nurses continually seek to improve their ability to provide clients culturally safe care.

**2.14** Nurses undertake continuous education in many areas, including Indigenous health care, **determinants of health**, cultural safety, **cultural humility** and anti-racism.



The subheadings in Principle two and statements 2.1, 2.6, 2.9 and 2.11 are adapted from BCCNM's *Indigenous Cultural Safety, Cultural Humility, and Anti-Racism* practice standard (British Columbia College of Nurses and Midwives, 2022).

PRINCIPLE 3

# Nurses provide safe and competent care

In this principle, nurses work within the limits of their legal scope of practice, education, experience, knowledge, skill and judgment to ensure safe and competent nursing care. To do this, nurses are expected to model the following core behaviours:

**3.1** Nurses identify themselves to clients consistent with CNO's public register, using their name, title (RN, RPN, NP) and their role within the health care team.

**3.2** Nurses recognize and work within the limits of their legal **scope of practice** and their knowledge, skill and judgment.

**3.3** Nurses identify when clients' therapeutic needs are outside of their legal scope of practice or individual competence and support clients to seek services from the proper health care professionals.

**3.4** Nurses seek and use the best available evidence to inform their practice.

**3.5** Nurses conduct research ethically, including placing client well-being above all other research objectives.

**3.6** Nurses use their knowledge, skill and judgment when giving nursing care. Nurses modify client care plans, together with clients and the health care team.

**3.7** Nurses respond and are available to clients in their care.

**Continued >**

3

PRINCIPLE

**3.8** Nurses give timely nursing care. When timely care is not possible, nurses explain to clients the reasons for delay and take steps to avoid or limit client harm.

**3.9** Nurses advocate for and support clients in accessing timely health care that meets clients' needs.

**3.10** Nurses are accountable for engaging in safe **medication practices** as set out in CNO's *Medication* practice standard, including having proper legal authority and requisite knowledge, skill and judgment.

**3.11** Nurses are accountable for maintaining, and keeping clear, complete, accurate and timely **documentation** as set out in CNO's *Documentation* practice standard. Nurses do not document false or misleading information.

**3.12** Nurses in **independent practice** conduct **appropriate business practices** as set out in CNO's *Independent Practice* guideline, including accurate record keeping, informing clients of fee components and charging fitting and reasonable fees.

**3.13** Nurses discontinue nursing services if the client requests it. Nurses arrange timely alternative or replacement services or provide clients a reasonable opportunity to arrange alternative services.

PRINCIPLE 4

# Nurses work respectfully with the health care team to best meet clients' needs

In this principle, nurses are accountable to one another and are expected to build and maintain respectful relationships with the **health care team.** To do this, nurses are expected to model the following core behaviours:

**4.1** Nurses self-reflect on how their privileges, biases, values, belief structures, behaviours and positions of power may impact relationships with health care team members.

**4.2** Nurses identify and do not act on any stereotypes or assumptions they may have about health care team members.

**4.3** Nurses address health care team members by their preferred name, title and pronoun.

**4.4** Nurses recognize many identity factors and personal attributes, including those identified in the *Ontario Human Rights Code*, may impact a health care team member, their lived experience and perspective on nursing and health care.

**4.5** Nurses demonstrate professionalism and treat all health care team members with respect in all contexts, including on **social media**.

**4.6** Nurses collaborate and communicate with the health care team in a clear, effective, professional and timely way to provide safe client care.

**Continued >**

**4.7** Nurses do not physically, verbally, emotionally, financially, or sexually harass or abuse health care team members.

**4.8** Nurses support, mentor and teach health care team members.

**4.9** Nurses assess the learning needs of health care team members they are teaching, supervising and/or assigning. Nurses determine whether individuals have the proper knowledge, skill and judgment to perform safe nursing care.

**4.10** Nurses delegate nursing care so it upholds the expectations outlined in the *Nursing Act, 1991*. Nurses do not direct health care team members to perform nursing care they are not adequately educated for or competent to perform.

**4.11** Nurses provide and accept feedback from the health care team to support positive client outcomes and effective team performance.

**4.12** Nurses contribute to a safe organizational culture.



4

PRINCIPLE

5

PRINCIPLE

# Nurses act with integrity in clients' best interest

In this principle, nurses are honest and fair practitioners who strive to build a trustworthy, therapeutic, nurse-client relationship. To do this, nurses are expected to model the following core behaviours:

**5.1** Nurses fairly divide and advocate for resources. Nurses objectively arrange care, based on health-related needs.

**5.2** Nurses protect the privacy and confidentiality of clients' **personal health information** as set out in CNO's *Confidentiality & Privacy – Personal Health Information* practice standard and the *Personal Health Information Protection Act, 2004*.

**5.3** Nurses do not share clients' personal health information, unless for therapeutic reasons and only in compliance with laws and standards of practice governing privacy and confidentiality.

**5.4** Nurses do not act as attorneys for personal care or as substitute decision-makers for their clients in accordance with the *Health Care Consent Act, 1996*.

**5.5** Nurses identify, prevent and do not practice in situations that cause a **conflict of interest**. If a conflict of interest exists or arises at any point during the therapeutic nurse-client relationship,nurses explore alternative services with clients.

**5.6** Nurses place their professional responsibilities ahead of their **personal gain**.

**5.7** Nurses initiate, establish and maintain professional **boundaries** with clients and terminate the nurse-client relationship as set out in CNO's *Therapeutic Nurse-Client Relationship* practice standard.

**Continued >**

**5.8** Nurses do not physically, verbally, emotionally, financially or sexually abuse, harass or neglect their clients as set out in CNO's *Therapeutic Nurse-Client Relationship* practice standard and the *Regulated Health Professions Act, 1991*.

**5.9** Nurses strive to protect clients from any type of harm, neglect or abuse. This includes taking action to stop and refrain from unsafe, incompetent, unethical or unlawful practice.

**5.10** Nurses are **truthful** in their professional practice.

**5.11** Nurses identify moral or ethical situations and proactively address conflict, dilemmas and/or distress of clients in their care.

**5.12** Nurses promote healthy relationships with clients, their caregivers, advocates and members of the health care team by managing and resolving conflict for best client care.



5 PRINCIPLE

6

PRINCIPLE

# Nurses maintain public confidence in the nursing profession

In this principle, nurses promote dignity and respect for the nursing profession by portraying professionalism and showing leadership. To do this, nurses are expected to model the following core behaviours:

**6.1** Nurses understand and practice in compliance with relevant laws and **standards of practice** and do not breach them.

**6.2** Nurses are accountable for their own decisions, actions, omissions and related outcomes.

**6.3** Nurses take accountability for their errors and learn from them.

**6.4** Nurses **report** any error, unsafe behaviour, unethical conduct or system issue to relevant individuals, including employers, CNO and other regulatory colleges, whether or not harm has occurred.

**6.5** Nurses participate and advocate for improving the quality of their practice setting to support safe client care.

**6.6** Nurses do not steal, misuse, abuse or destroy the property of their clients, health care team or employers.

**6.7** Nurses self-reflect on health and seek help if their health affects their ability to practice safely.

**Continued >**

**6.8** Nurses do not practice when impaired by any substance.

**6.9** Nurses self-reflect, identify learning needs in their practice and engage in continuous learning to improve their competence.

**6.10** Nurses participate in and keep records of their participation in CNO's Quality Assurance Program.

**6.11** Nurses do not publicly communicate health care statements that contradict the best available evidence.

**6.12** Nurses do not engage in any acts of professional misconduct or incompetence.

**6.13** Nurses cooperate with CNO, including cooperation in investigations and offering complete and accurate information.



PRINCIPLE 6

**Appropriate business practices:** Reasonable actions that nurses in independent practice carry out for client safety. This includes, but is not limited to, record keeping, setting reasonable fees, getting professional liability protection, using accurate advertising and developing proper staffing policies.

**Boundaries:** The points when a relationship changes from professional and therapeutic to unprofessional and personal. Therapeutic nurse-client relationships put clients' needs first. Crossing a boundary means a nurse is misusing their power and trust in the relationship to meet personal needs or is behaving in an unprofessional manner with the client. Crossing a boundary can be intentional or unintentional. See CNO's *Therapeutic Nurse-Client Relationship* practice standard.

**Client:** An individual, family, group, community or population receiving nursing care, including, but not limited to, "patients" or "residents."

**Conflict of interest:** When a nurse's personal interests improperly influence their professional judgment or conflict with their duty to act in clients' best interest. This includes financial and non-financial benefit, whether direct or indirect.

**Cultural humility:** An unending process where health care providers engage in self-reflection and self-critique to minimize power differentials between them and their clients. It helps clinicians build skills to understand a client's cultural context through the client's perspective and emphasizes the importance and value of others' perspectives and cultures (Zinan et al., 2021; Virkstis et al., 2021).

**Cultural safety:** Effective client care by a health care provider who has undertaken a process of reflection on their own cultural identity and recognizes the impact of their own culture on their practice. It addresses issues of inequality rooted in historical and structural violence and discrimination leading to power differences and imbalances. Instead, it focuses on safe systems, clinical settings and interactions (Gower et al., 2022; Withall et al., 2021).

**Determinants of health:** The broad range of personal, social, economic and environmental factors determining individual and population health. The main determinants of health include income and social status, employment and working conditions, education and literacy, childhood experiences, physical environments, social supports and coping skills, healthy behaviours, access to health services, biology and genetic endowment, gender, culture or race/racism (Government of Canada, 2022).

**Documentation:** Health records, which may be in a variety of forms (for example, paper, electronic, audio), used to reflect the client's needs or goals, the nurses' inactions, actions and decisions, communication with other health care providers and the outcomes and evaluation of those inactions, actions or decisions.

**Health care team:** Members of the intraprofessional and/or interprofessional team and/or community supporting client care. This also includes students, new learners, Indigenous and traditional healers.

**Health inequities:** Differences in health status or in the distribution of health resources among different population groups, arising from the social conditions in which people are born, grow, live, work and age. (World Health Organization, 2018)

**Independent practice:** Nurses in independent practice are self-employed (for example, operating their own economic enterprise) for the purposes of offering nursing services and/or operating their own nursing business.

**Informed consent:** As described under the *Health Care Consent Act*, a person's consent is informed if the person receives information about a treatment that a reasonable person in the same circumstances would require to make a decision and if the person receives responses to their requests for additional information about the treatment.

The information must include the treatment's nature, expected benefits, material risks and side effects; alternative courses of action; and likely consequences of not having the treatment.

**Medication practices:** Client-centred practices of the most safe and effective medication therapy. Practices may include but are not limited to the following activities: administration, prescribing, dispensing, medication storage, inventory management and disposal of medications.

**Nursing care:** Nursing care given to a client, which includes, but is not limited to, assessment, planning, delivery, monitoring, evaluation and care coordination.

**Personal attributes:** Qualities or characteristics unique to a person. As reflected in the *Ontario Human Rights Code*, this includes citizenship, race, place of origin, ethnic origin, colour, ancestry, disability, age, creed, sex/pregnancy, family status, marital status, sexual orientation, gender identity, gender expression, receipt of public assistance (in housing) and record of offences (in employment). Personal attributes also include political affiliation, income and social status.

**Personal gain:** Advantage or benefit, financial or otherwise, a nurse receives. A personal gain can be monetary (cash, gifts, or rewards) or give the nurse other personal advantages. A personal gain includes the nurse's family's interests, charitable causes or organizations the nurse supports. It does not include a nurse's salary or benefits.

**Personal health information:** As reflected in the *Personal Health Information Protection Act, 2004*, including any identifying information about clients' physical or mental health or their family's health history.

**Quality Assurance Program:** A CNO program in which nurses demonstrate their commitment to continuing competence and quality improvement of their knowledge, skill, and judgment through assessing themselves, their practice and peers. CNO's Quality Assurance Program is mandated by the *Regulated Health Professions Act, 1991*.

**Report:** The legal and organizational requirement to disclose safety issues related to health care professionals' individual practice, or issues impacting practice settings. Examples of legal reporting requirements include reporting to proper authorities any health care team member whose actions or behaviours toward clients are unsafe or unprofessional according to applicable legislation, including, but not limited to, the *Fixing Long-Term Care Homes Act, 2021*, *Child, Youth and Family Services Act, 2017* and the *Public Hospitals Act, 1990*. Another example is reporting a regulated health professional's sexual abuse of a client to the registrar of the proper regulatory college according to the *Regulated Health Professions Act, 1991*. An example of an organizational reporting requirement is reporting medication near-misses.

**Resilience:** The process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional or behavioral flexibility and adjustment to external and internal demands. Some factors contribute to how well people adapt to adversities, predominant among them:

- the ways individuals view and engage with the world
- the availability and quality of social resources
- specific coping strategies (APA Dictionary of Psychology, 2022)

**Self-reflection:** An intentional and continuous process nurses engage in to critically think about their practice. Reflecting on practice daily helps nurses identify strengths and any learning needs. See CNO's Quality Assurance program for more information.

**Scope of practice:** The expectations and limitations of nurses' duties and responsibilities. Nurses are legislated, educated and authorized to perform roles, responsibilities and functions, as reflected in the controlled acts authorized to nurses in the *Regulated Health Professions Act, 1991* and in Section 3 and 4 of the *Nursing Act, 1991*, and those acts' regulations. The scope of practice is further defined in Section 3 of the *Nursing Act, 1991*: "The practice of nursing is the promotion of health and assessment of, the provision of, care for and the treatment of, health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means in order to attain or maintain optimal function."

**Social media:** Community-based online communication tools (websites and applications) used for interaction, content sharing and collaboration. Types of social media include blogs or microblogs (personal, professional, or anonymous), discussion forums, message boards, social networking sites and content-sharing websites.

**Standards of practice:** Expectations for how a competent nurse should perform. Standards of practice describe nurses' expected behaviour and contribute to public protection.

**Substitute decision-maker:** Person, identified by the *Health Care Consent Act, 1996*, who makes a treatment decision for someone who cannot make their own decision. See CNO's *Consent* guideline for more information.

**Therapeutic nurse-client relationship:** A professional relationship between a nurse and a client, which focuses on meeting the client's health needs. There are five components to the nurse-client relationship: trust, respect, professional intimacy, empathy and power.

**Truthfulness:** Speaking or acting without intending to deceive. Truthfulness also refers to giving accurate information. Intentional omissions are as untruthful as false information.

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

THE STANDARD OF CARE.



# Code of Conduct

## Practice Standard

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THE STANDARD OF CARE.

**AGENDA ITEM 4.4**

# Decision Note – December 2022 Council

# Nursing Education Program Approval

## Contact for Questions

Katie Dilworth, Manager, Education Program

## Decisions for Consideration[1]

**Decision 1:**

That the comprehensive review status of the Ontario Tech University nursing programs be approved, as listed in Attachment 1 to this decision note.

**Decision 2:**

That the preliminary review status of new nursing programs at Confederation College and Lambton College be approved, as listed in Attachment 2 to this decision note.

## Public Interest Rationale

Program Approval is a mechanism that allows for rigorous assessment of entry level nursing education programs to ensure their graduates the have knowledge, skill, and judgment to practice safely. The *Nursing Act, 1991* includes a requirement that in order to be eligible for registration, applicants must:

> "successfully complete a program that was specifically designed to educate and train persons to be practising" nurses and that the "program was approved by Council or a body approved by Council for that purpose" [Subsections 2(1)1i, 3(1)1i, and 4(1)2i of Ontario Regulation 275/94].

Approving nursing education programs is an important part of the Council's accountability to protect the public.

[1] Due to the type of approval being sought (comprehensive or preliminary) decisions have been divided into two separate categories.

## Background

### Program Approval

In accordance with the Program Approval Framework approved by Council, all entry level nursing programs, including practical nurse diploma (PN), baccalaureate nursing (BScN or BN) and nurse practitioner (NP), come to Council consideration for annual or comprehensive approval using the Program Approval Framework.

Two programs from Ontario Tech University are presented for comprehensive review approval at this time (see attachment 1). Comprehensive review occurs once every seven years when all nine indicators in the Program Approval Framework are evaluated (see attachment 3). CNO is transitioning to the new Program Approval process. All schools will have their initial comprehensive review by 2025.

### New Nursing Programs:

All new nursing programs must receive preliminary approval before admitting students which includes a detailed review of the program's curriculum. Preliminary approval includes the same rigorous curriculum review as in the comprehensive review. Full approval for all new nursing programs, including meeting the other indicators, occurs the year after the initial cohort graduates. Two new baccalaureate programs from Confederation College and one from Lambton College are presented for preliminary approval by Council (see attachment 2).

## Next Steps:

Following Council's decisions CNO will provide:

- A letter to each of the Nursing Programs addressing the program's approval status and the upcoming dates for the next annual or comprehensive reviews as well as:
  - A Program Approval report outlining the results of a program's comprehensive review; or
  - A Program Approval report outlining the results of the preliminary program review.

Each program's approval status will then be posted on CNO's website.

### Attachments:

**1**: Comprehensive approval of two nursing programs in Ontario: Detailed Review Scoring
**2:** Preliminary approval of three new nursing Programs in Ontario: Detailed Review Scoring
**3:** Program Approval Scoring Methodology

# Attachment 1 – Comprehensive approval of nursing programs in Ontario: Detailed Review Scoring

**Baccalaureate Nursing Programs:** Comprehensive Reviews[1]

| Institution | Nursing Program | Mandatory Indicator 4: Curriculum | Mandatory Indicator 2: Client & Student Safety | Indicator 7: First-time Pass Rate | Total Approval Score >=75% | Approval Status Recommendation |
|---|---|---|---|---|---|---|
| Ontario Tech University | Bachelor of Science in Nursing Collaborative Program | Met | Met | Partially Met | 91.5 | Approved |
| | Bachelor of Science in Nursing – RPN Bridge Program | Met | Met | Met | 100 | Approved |

[1] Based on a program's evidence, each indicator is evaluated against a rubric (see Attachment 3) that determines whether the indicator is met, partially met, or not met. A 'partially met'' or 'not met' Indictor score will not impact approval recommendation if the indicator is not mandatory and the program continues to meet a total score of 75%.

## Attachment 2 – New Baccalaureate Programs: Detailed Review Scoring

**New Baccalaureate Nurse Programs:** Preliminary Review

| Institution | Nursing Program | CNO Program Category | Indicator 4: Curriculum | Approval Status Recommendation |
|---|---|---|---|---|
| Confederation College | Honours Bachelor of Science in Nursing | Direct-Entry Full | Met | Preliminary Approval |
| | Registered Practical Nurse (RPN) to Honours Bachelor of Science in Nursing | Pre-health specified | Met | Preliminary Approval |
| Lambton College | Honours Bachelor of Science – Nursing | Direct-Entry Full | Met | Preliminary Approval |

# Attachment 3 – Program Approval Scoring Methodology

Nursing education programs are evaluated based on the three standards (Structure, Curriculum and Outcomes) and the associated 9 indicators. A comprehensive review enables a score to be calculated for each indicator, standard and overall for each program leading to entry-to-practice.

## 1. Program Approval Scorecard Overview

Nursing program approval is based on the total program score achieved on the program approval scorecard (see Table 1 next page).

## 2. Mandatory Indicators

Two indicators have been defined as “mandatory” from a regulatory perspective and need to be fully met for the program to receive an Approved status. The mandatory indicators include:

- Client and student safety; and
- Entry-to-practice (ETP) competencies integrated into the curriculum.

## 3. First-time pass rates on registration exams (rolling 3-years of aggregate data)

Schools are scored based on their exam results which contributes to their overall approval score. Exam results are scored based on the following rubric:

The first-time pass rate used for program approval purposes is calculated based on the total number of first-time writers that pass the registration exam over a three-year period expressed as a percentage. Using three years of data provides a larger denominator of students for the calculation and helps to mitigate single-year result variations – both commonly seen in smaller programs.

| CNO NURSING EDUCATION PROGRAM APPROVAL SCORECARD | |
|---|---|
| **Structure Standard (Total weight 25%)** | |
| **Indicator[1] (Sub-indicator)** | **Weight** |
| 1. Nursing program governance | **6** |
| 1a. Nursing program governance structure | 2 |
| 1b. Curriculum review structure | 2 |
| 1c. Annual review of program outcomes | 2 |
| **2. Client and student safety (mandatory indicator)** | **13** |
| 2a. Orientation of student and faculty to clinical setting | 2 |
| 2b. Student supervision in all clinical placements | 3 |
| 2c. Regular evaluation of student performance in clinical setting which includes documented assessments and mechanisms for remediation as required. | 3 |
| 2d. Processes are in place to manage safety incidents involving clients and students. | 5 |
| 3. Qualified Faculty | **6** |
| 3a. Faculty who are RN, RPN and NP's have current certificate of registration in Ontario | 2 |
| 3b. Regular process to evaluate teaching | 4 |
| Sub-total – Structure Indicators | **25%** |
| **Curriculum Standard (Total weight 40%)** | |
| **4. Curriculum incorporates entry-to-practice competencies and foundational standards (mandatory Indicator)** | **25** |
| 5. Clinical learning opportunities support learners to attain and demonstrate acquisition of program objectives | **10** |
| 6. Processes in place to communicate expectations for the student placement to preceptor for the integrated practicum. | **5** |
| Sub-total – Curriculum Indicators | **40%** |
| **Outcome Standard (Total weight 35%)** | |
| 7. Registration exam scores – 1st time pass rates (3-year cumulative total) | **7** |
| 8. Recent graduates' ratings of their preparation to practice safely, competently and ethically [2] | **18** |
| 9. Preceptor ratings of student's readiness to practice | **10** |
| Sub-Total -Outcome Indicators | **35%** |
| **All Standards and Indicators (Total weight 100%)** | **100%** |

[1] Based on a program's evidence, each indicator is evaluated against a rubric that determines whether the indicator is met (has met indicator criteria), partially met (has partially met indicator criteria), or not met (has not met indicator criteria). A partially met Indictor score will not impact approval recommendation if the indicator is not mandatory and the program continues to meet a total score of 75%.

[2] Collection of outcome Indicators 8 and 9 commenced in 2021. Program approval outcome indicators' scores are based on a rolling 3-years of aggregate data, these indicators will be part of annual assessments presented to Council in the future.

For each program, one of four approval statuses are granted:

| Status | Criteria |
|---|---|
| Approved | Granted when the program meets a score of 75% and the mandatory indicators for program approval are met. Graduates from a program with this status are considered graduates of an approved nursing program and eligible for registration in Ontario. |
| Approved with Conditions | Granted when the program does not meet the score of 75% OR does not meet the mandatory indicators. Graduates from a program with this status are considered graduates of an approved nursing program and are eligible for registration in Ontario. Programs that receive conditional approval status are required to develop an action plan to address the gaps based on the recommendations and schedule provided by CNO. |
| Preliminary Approval | Granted to a new program with curriculum that meets required criteria. For full approval, programs receiving preliminary approval must undergo a comprehensive review in the academic year following the first class of graduates. Graduates from programs with this status are considered graduates of an approved nursing program and are eligible for registration in Ontario. |
| Not Approved | The program fails to meet the score of 75% OR does not meet the mandatory indicators over a number of consecutive years and does not demonstrate improvement in meeting the requirements. Graduates of a program with this status are not eligible for registration in Ontario. |

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

**Executive Committee**
**November 17, 2022**

# Minutes



## Present

N. Thick, Chair
R. Kaur
F. Osime
P. Sullivan-Taylor
M. Sheculski

## Staff

S. Crawford
J. Hofbauer
J. Jabbour
K. McCarthy

## Guests

Jane Butterfield
Alicia Williams

## Agenda

The agenda was circulated in advance. Members agreed to add supporting engagement in the recruitment for the election of the 2023-2024 Executive Committee to the agenda.

With that change, the agenda was approved on consent.

## Minutes

Draft minutes of the Executive Committee meeting of August 25, 2022 had been circulated.

## Motion 1

Moved by P. Sullivan-Taylor, seconded by R. Kaur,

> That the minutes of the Executive Committee meeting of August 25, 2022 be approved as circulated.

CARRIED

## By-laws re. committee membership

The Executive, in its role in facilitating effective committee functioning, reviewed a draft Council briefing note proposing revisions to by-laws related to statutory committee membership structure.

The purpose of the proposal is to provide all statutory committees the flexibility to adapt committee membership to meet changing workloads. It was noted that the proposed amendments had been reviewed by legal counsel.

During the review, two additional revisions were identified. It was suggested that the Council briefing be revised to address these changes more clearly:

- the reduction of the minimum public members on the Inquiries, Complaints and Reports to reflect the current number of public members available to serve on ICRC; and
- the proposed removal of quorum provisions for ICRC from by-law.

The proposed change in the minimum number of public members on ICRC is not a change in the committee membership, rather it aligns the by-law with the current structure which reflects the number of public members appointed to Council and able to serve on ICRC.

K. McCarthy confirmed that staff will revise the briefing note and circulate it to the Executive by email for review.

## Debrief on September Council

The Executive debriefed on Council's first hybrid meeting. Everyone agreed that the meeting went remarkably well.

It was identified that those in attendance enjoyed the opportunity to get to know one another but having zoom available as an option for participation meant more Council members were able to participate. It was confirmed that N. Thick's engagement of members in the room and on zoom supported engagement and aligned with Council's norms.

It was also confirmed that there were some learnings about the sound and how best to work in chambers, which will support future hybrid meetings.

The Executive discussed strategies to support participation of Council members in decision-making.

## Adding discussion items to the Council agenda

It was noted that it became clear from discussion at the September Council that many Council members did not know how to add items to the Council agenda. N. Thick had followed up and sent the information about adding discussion items to the Council agenda to Council members.

The Executive received a briefing about the process. If requests are received before the deadline, the item(s) will be added to the Council agenda and the Executive will be informed.

## December Council meeting planning

The December 2022 Council meeting will be virtual. The Executive received an annotated agenda.

The Executive noted the important role that Council has in monitoring the strategic plan. It was suggested that the update on the Strategic Plan be the first strategic item on the agenda for the afternoon of December 7th and that the time be extended. Additional adjustments to the order of agenda items were proposed to support that change.

The agenda for the afternoon of December 7th is lengthy and includes several substantive items. The Executive suggested that Council members be asked to be available until 2:30 p.m. on December 8th, to allow for movement of items from the previous day, if needed.

## Motion 2

Moved by P. Sullivan-Taylor, seconded by F. Osime,

> That the agenda for the December 7 and 8, 2022 Council meeting be approved for posting, with the changes identified by the Executive Committee.

CARRIED

The Executive discussed strategies to encourage engagement in the up-coming election of the Executive Committee. The Executive was informed that a call for candidates will go out shortly after the December Council meeting. It was suggested that the President spotlight the opportunity at the December Council meeting.

It was confirmed that the Executive, as Council's governance committee, does have accountability for ensuring that there are candidates for election. If a second call is needed, it can be sent to Council from the President to encourage engagement.

## Council dates

The Executive received proposed dates for Council in September and December 2023. It was agreed to recommend those dates to Council.

## Board Evaluation

Jane Butterfield and Alicia Williams from Watson joined the Executive. The Executive had received a briefing with the preliminary analysis of evaluation feedback. Following the meeting, final analysis will be completed with a full report to Council in December.

There was discussion about the strengths and areas for improvement identified in the preliminary analysis. Watson noted the plan for the PD session includes continuing education on evaluation, a presentation of the results and then small group sessions to prioritize the areas for further work.

Watson confirmed that the report will not be specific about actions and accountabilities for follow up. The report will identify opportunities for further work and options. It will be Council's role to determine priorities, supported by the Executive as Council's governance committee.

Watson flagged that the evaluation framework for 2023 is a light evaluation – focused on specific areas. Based on the evaluation report, Council may identify specific areas where a deeper probe is needed.

The Executive confirmed that to maintain transparency they will not review the final report in advance of it being shared with Council.

Jane Butterfield and Alicia Williams left the meeting.

## Next meeting

N. Thick reminded the Executive that they will meet again the afternoon of February 9, 2023. J. Hofbauer, R. Jabbour and K. McCarthy left the meeting.

## Executive Session

The Executive Committee met in private with S. Crawford, CNO's Chief Executive Officer.

COLLEGE OF NURSES OF ONTARIO
ORDRE DES INFIRMIÈRES ET INFIRMIERS DE L'ONTARIO

THE STANDARD OF CARE.

**Agenda Item 6.1**

# Information Note – December 2022 Council

# Quality Assurance Program Transformation

## Contact for Questions or More Information

Kevin McCarthy, Director, Strategy

Anne Marie Shin, Director, Professional Practice

## Public Interest Rationale

The Quality Assurance (QA) Program is CNO's commitment to the public that every practicing nurse in Ontario is engaged in continuous improvement. QA is a key regulatory function that is designed to proactively strengthen the quality of nursing practice and, as such, supports the achievement of CNO's Strategic Plan outcome that nurses' conduct will exemplify understanding and integration of CNO standards for safe practice.

The purpose of this note is to provide an overview of QA as a regulatory function, how it operates at CNO and to highlight the program transformations for next year.

## Background

The *Regulated Health Professions Act, 1991* requires CNO to establish and administer a QA Program that assists nurses to maintain competence and continually evaluate their practice. CNO's program was introduced in 1997 and has evolved over the years.

The QA Committee is one of CNO's statutory committees and is responsible for administering and monitoring nurses' participation and compliance with all aspects of the QA Program. The Committee is composed of nurses and public members. Peer Coaches[1] support the Committee by reviewing and assessing nurses' QA activities according to set evaluation criteria and write a report for the QA Committee. The Committee then reviews the Peer Coach reports and makes decisions about a nurse's participation in the QA Program.

There are three main components to CNO's QA Program:

QA Everyday (Self-Assessment)

- All nurses registered in the General or Extended class are required to engage in Self Assessment, which includes daily practice reflection, developing an annual Learning Plan and actively updating their knowledge and skills to maintain their continued competence. Nurses attest that they completed their Self-Assessment during Annual Membership Renewal.

[1] Peer Coaches, referred to as Peer Assessors in the *Regulated Health Professions Act, 1991*, are practicing nurses employed and trained by CNO. They review QA Assessment activities using established criteria and write a report for the QA Committee. Peer Coaches also provide coaching support to nurses selected for QA Assessment.

- The self-reflection video is a resource for nurses. It supports the QA Everyday concept that reflection is not just a yearly event, but something that is done by nurses daily.

QA Assessment

- Each year, CNO randomly selects and notifies a limited number of practicing nurses from the General and Extended classes to participate in QA Assessment. The purpose of QA Assessment is to assess a nurse's knowledge, skill and judgment. Nurses are required to complete and submit a Learning Plan along with additional QA activities by a specific deadline. Nurses in the Extended class complete an additional activity because of their expanded scope.
- Peer Coaches review and assess submissions using established criteria and write a report for the nurse and the QA Committee. Nurses' QA activities are either assessed as satisfactory, needs more information, or unsatisfactory.
- QA Committee reviews reports and makes decisions about the nurses selected for QA Assessment. Nurses who are evaluated as satisfactory by the QA Committee then successfully exit the program. Those who need more information are asked to resubmit their QA activities and can access optional coaching support from a Peer Coach.

Remediation

- Nurses who have not satisfactorily completed the QA Assessment activities are directed by QA Committee to complete remediation. This involves additional learning activities, mandatory coaching with a QA Peer Coach and further assessment of their knowledge, skill or judgment in order to meet the "satisfactory" standard.

The QA program is designed to support nurses. This supportive approach has been emphasized and enhanced through the pandemic. An enhancement to QA Assessment introduced in 2021 was optional coaching support with a Peer Coach. Peer Coaches are trained to help nurses identify their learning needs, goals, and provide strategies to meet those objectives. This approach has provided an opportunity for nurses participating in QA Assessment to have more meaningful engagement with CNO.

## Transformation

Under the direction and support of Council, CNO has been working to modernize and enhance the QA program. Work to develop a new evidence informed QA model occurred throughout 2017 with Council approval of the model occurring in December of that year. The occurrence and impacts of the pandemic required CNO to have a modified approach to QA over the past three years.

One of the primary objectives of the QA Program is to expand the reach and engagement of all current registrants in the QA Program with a future plan to have each registrant in Ontario participate in QA Assessment every five to seven years. To achieve this and continue to meet the requirements outlined in legislation (RHPA and *Nursing Act*), starting next year there will be a new QA process, including the implementation of a new QA learning management system (LMS). This new QA system will house various supportive assessment activities, e-learning modules and resources for nurses selected to participate in QA Assessment. In addition, a new selection framework based on areas of public or client risk will be implemented. The framework will provide an evidence informed approach to support the selection of nurses participating in QA Assessment.

The focus for 2023 will be to pilot the LMS, tools, resources and operations. Change management activities are underway to communicate the new program changes and to engage

stakeholders. An evaluation will be conducted to inform the program's ability to scale up and identify the operational capacity requirements over the next few years.

In March 2023, Council will be provided details on the QA Assessment soft launch scheduled for Spring 2023. At that meeting, Council will have the opportunity to review and approve the new risk-based selection framework for QA Assessment.

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**Agenda Item 5.3**

# Report of the November 17, 2022 Finance Committee Meeting

## Contact for questions or more information

Stephen Mills, Chief Administrative Officer

The Finance Committee met on November 17, 2022. Draft minutes of the meeting are attached (Attachment 1).

## Financial Statements

The unaudited financial statements for the nine months ended September 30, 2022 (Attachment 2) and the confidential and privileged Management Discussion and Analysis (MD&A) were reviewed.

The year-to-date operating surplus of $4.2M is a $7.2M favourable variance from the $3.0M budgeted deficit. The unrestricted net assets, or accumulated operating surplus, on September 30th is $38.3M. It was noted that, barring unforeseen circumstances, the year-end operating surplus is expected to be higher than the nine-month results.

After a thorough review and discussion of the statements and the accompanying confidential MD&A, the Finance Committee recommends:

> **That Council approve the unaudited financial statements for the nine-month period ending September 30, 2022.**

## Report of the Sub-Committee on Compensation

The report of the Sub-Committee on Compensation[1] had been circulated to the Finance Committee. Following a thorough discussion of the challenges CNO has been experiencing in attraction and retention of qualified staff and a review of information regarding changes in CNO's employment market, the Sub-Committee advised the Finance Committee that:

> **The 2023 compensation program included in the budget is congruent with the Compensation Principles approved by Council and best practices in human resources.**

[1] The Sub-Committee on Compensation is an independent, expert group that advises the Finance Committee on staff compensation and on Council and committee stipend expenses. Its members are appointed based on competencies. Members are Craig Halket, Chair (member of the Finance Committee), Bob Canuel and Joe Nunes.

## 2023 Budget

The Finance Committee discussed in detail the 2023 draft operating and capital budgets, with projections to the end of 2026 (Attachment 3).

In summary, the draft 2023 operating budget includes new resources to support meeting regulatory effectiveness, changing expectations for regulators, and continue implementation of *Strategy 2021-2024*.

The draft budget estimates an operating deficit of $10.3M which is the result of:
budgeted revenues increasing to $63.7M and
budgeted expenses increasing to $74.0M, which includes a $3.0M budget for projects.

The proposed operating budget includes additional staffing to meet the expectations for regulatory operations, including new expectations with changes to the registration regulations, new standards set by government regulations under Bill 106, and enhancements to hearings support. There are also additional resources in technology in order to maintain CNO's cyber security posture, support new systems such as the new Quality Assurance platform, the Nursys in Canada environment, and components of systems in support of CNO's Strategic Plan. Some of the costs for the Nursys in Canada environment are recovered from other regulators, contributing to a small increase in revenue.

The proposed capital budget for 2023 is $0.9M.

The need for CNO to maintain its financial well-being to allow it to respond to unanticipated expectations or changes in the environment was confirmed. The operating budget and projections predict that CNO's accumulated surplus at the end of 2023 will be 4.6 months of the operating expense budget, declining to 2.3 months by the end of 2024. The latter is below the established minimum accumulated operating surplus benchmark of 3 months of the operating expense budget.

In February 2023, the Finance Committee will have the unaudited year end statements for 2022 and will be able to update its predictions for the accumulated surplus for 2023 and 2024. At that time, the committee will consider whether to propose fee changes to Council and the options they will recommend, if needed.

After an extensive discussion, the Finance Committee is confident that the budget provides the funds required for CNO to meet its regulatory mandate and further its strategic objectives. It is also confident that the budget and projections support CNO's ongoing fiscal well-being.

The Finance Committee recommends:

**That Council approve the 2023 operating and capital budgets.**

## Attachments

1. Draft minutes of the Finance Committee meeting of November 17, 2022
2. Financial statements for the nine months ended September 30, 2022
3. Draft 2023 Operating and Capital Budgets

**Finance Committee**
November 17, 2022 at 1:00 p.m. by Zoom

# Minutes



## Present

R. Kaur, Chair
C. Halket
F. Osime
M. Sheculski
P. Sullivan-Taylor
N. Thick

## Regrets

N. Hillier

## Staff

V. Adetoye
S. Crawford
J. Hofbauer
M. Kelly, Recorder
S. Mills

## Chair

R. Kaur chaired the meeting.

## Agenda

The agenda had been circulated and was approved on consent.

## Minutes

Minutes of the Finance Committee meeting of August 25, 2022 had been circulated.

## Motion 1

Moved by P. Sullivan-Taylor, seconded by F. Osime,

> That the minutes of the Finance Committee meeting of August 25, 2022 be accepted as presented.

CARRIED

## Financial Statements

V. Adetoye highlighted the unaudited financial statements for the nine months ended September 30, 2022. The statement of financial position depicts a decrease in assets when compared to December 2021 as it represents the cost of operations for the first nine months of 2022.

In reviewing the statement of operations, V. Adetoye noted that at the end of the third quarter there was a surplus of $4.2M, which is $7.2M more than the budgeted deficit of $3.0M. She

highlighted the reasons for this surplus, with the most notable contributor being employee-related costs, with a favourable variance of $4.8M. It was noted that the main contributor to this variance relates to salaries, primarily due to a higher vacancy rate observed in 2022. Some of this underspend was partially offset by the use of contractors and consultants. In response to a question, V. Adetoye confirmed that this variance is anticipated to grow by the end of the year. It was noted that steps have been taken in developing the 2023 budget to mitigate the risk of this being repeated, including reflecting the changes observed in vacancy rates in 2022.

It was noted that, because of the variances, CNO's unrestricted net assets at the end of September are $38.3M.

V. Adetoye highlighted that the total registration transactions for RN's and RPN's at the end of September represent a 3% increase when compared to the budget. The committee discussed various utilizations for this data including sharing the results with the Ministry to help attract nurses to practice in Ontario. S. Mills confirmed that as part of the Strategic Plan and improving the quality of our data, CNO is able to share data with others in a mutually beneficial manner with the goal of obtaining a comprehensive data set. This has both provincial and national interest and benefits.

The Committee reviewed and discussed the confidential Management Discussion and Analysis document. V. Adetoye highlighted various projects and initiatives that are outlined in the document.

## Motion 2

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

> That it be recommended that Council approve the unaudited financial statements for the nine months ended September 30, 2022.

CARRIED

## Report of the Sub-Committee on Compensation

The Finance Committee received a written report of the Sub-Committee on Compensation, together with draft notes of their last meeting.

C. Halket noted that the Sub-Committee had a robust discussion pertaining to the attraction and retention efforts of CNO to help address the challenges experienced by the highly competitive job market. The Sub-Committee was supportive of proposed adjustments to both the 2023 salary ranges and salary range administration that was put forward by management. They believe these proposed changes will support CNO's competitive position in its direct market.

The Sub-Committee was informed that CNO is undertaking work to develop a job competency framework which will provide a foundation for succession planning. C. Halket noted that the Sub-Committee will discuss this in more detail at their next meeting.

The Sub-Committee advised the Finance Committee that CNO's compensation program and policies are congruent with the Compensation Principles approved by Council and best practices in human resources.

## 2023 Operating and Capital Budgets

Members of the Finance Committee received the 2023 draft operating and capital budgets along with projections through 2026.

S. Mills reviewed the business context of the budget, highlighting CNO's portfolio management approach and stage gate methodology when budgeting for projects. He also noted that key elements of the Strategic Plan are beginning to operationalize, and this will continue into 2023. Regulatory changes are also anticipated to take effect in 2023, and CNO will need to be agile in their approach to implement these changes.

S. Mills noted that at the end of 2022, the accumulated operating surplus is forecasted to be $37.5M, which is 7.8 months of operating expense coverage and over the guideline set by the Finance Committee. CNO experienced an unexpectedly high vacancy rate in 2022, which had the secondary effect of deferring project work and the use of external resources. Both of these factors attributed to the higher-than-expected surplus. These considerations have been addressed in the proposed 2023 budget, and if approved, the operating expense coverage will decrease to 6.1 months in January 2023 and will continue to decline in the following years. If projections are on target, the operating coverage is expected to decline to 2.3 months by the end of 2024.

The 2023 budget estimates an increase in revenue by 8.5% to $63.7M as a result of estimated increases in registration numbers, an increase in interest income, and a marginal increase in application assessments. The proposed 2023 budget also includes a 12.1% increase in operating expenditures to $74.0M, with the major contributors being additional staff, compensation changes, cost inflation, and increased technology costs for items such as cloud services. These are partially offset by lower project expenditures and slightly lower legal costs. Overall, 2023 is projected to result in an operating deficit of approximately $10.3M.

Capital expenditures are expected to decrease in 2023, with a proposed budget of $0.9M. The Space Redesign building renovations will be completed in 2022, as such, investments in building improvements will be minimal. More of CNO's computing workload has also migrated to the cloud which has resulted a lower budget for technology hardware acquisitions.

S. Mills highlighted the projections from 2024 to 2026. In 2024, it is estimated that CNO will incur an annual operating deficit of $13.1M, which is expected to result in 2.3 months of operating expense coverage at year end. It was noted that, if no action is taken, this is expected to further decline to -0.2 months in 2025 and -2.8 months in 2026. Depending on actual results for 2022, a fee increase may be recommended for 2024. The Finance Committee will discuss this again in February at which time there will be more accurate information about the 2022 year-end results.

There was discussion about the increased budget for staffing in 2023, especially considering the significant favourable variance in the 2022 salary budget. S. Mills noted that CNO is budgeting

differently for salaries in 2023, recognizing the higher vacancy rates experienced in 2022. Steps will be taken to monitor vacancies more closely and provide resources to support recruitments moving forward.

The Committee suggested that the budget presentation to Council should clearly quantify the additional staff requests and link these to the strategic plan, operational requirements and addressing work volumes in various regulatory and business areas. The Committee confirmed that the compensation provisions in the budget reflect the advice of the Sub-Committee on Compensation.

Following extensive discussion, the committee confirmed that the 2023 draft budget allows CNO to carry out key regulatory functions, meet strategic objectives and maintain its long-term fiscal well-being.

## Motion 3

Moved by N. Thick, seconded by P. Sullivan-Taylor,

That approval of the 2023 operating and capital budgets be recommended to Council.

CARRIED

## Self-Monitoring Tool

The Committee reviewed the Self-Monitoring tool and confirmed that they had met their accountability for the meeting. The Committee noted that they feel well supported in their decision-making process based on the level of detail provided in the meeting materials, leaving them with confidence in their recommendations.

## Upcoming meetings

The Finance Committee will meet the morning of February 9, 2023 and the afternoon of May 18, 2023.

## Conclusion

At 3:53 p.m., on completion of the agenda, the Finance Committee meeting concluded.



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Chair

**College of Nurses of Ontario**
**Statement of Financial Position ($)**
**As at September 30**

| | 2022 September | 2021 September | 2021 December |
|---|---|---|---|
| **ASSETS** | | | |
| Current assets | | | |
| Cash | 20,323,476 | 33,474,230 | 64,142,000 |
| Investments | 21,136,887 | 16,443,460 | 11,268,734 |
| Sundry receivables | 117,032 | (47,199) | 219,028 |
| Prepaid expenses | 644,665 | 808,999 | 1,227,453 |
| | 42,222,059 | 50,679,490 | 76,857,216 |
| Investments | 14,959,282 | 9,237,957 | 14,508,491 |
| Capital assets | | | |
| Furniture and fixtures | 3,468,376 | 2,300,024 | 2,139,393 |
| Equipment - non computer | 1,596,546 | 1,357,470 | 1,448,638 |
| Computer equipment | 6,825,794 | 7,276,842 | 6,653,730 |
| Building | 6,835,907 | 6,835,907 | 6,835,907 |
| Building improvements | 7,525,119 | 4,690,093 | 2,789,091 |
| Land | 3,225,009 | 3,225,009 | 3,225,009 |
| Art | 44,669 | 44,669 | 44,669 |
| Construction in progress | - | - | 3,972,310 |
| | 29,521,420 | 25,730,012 | 27,108,747 |
| Less: Accumulated amortization | (16,669,962) | (17,083,840) | (15,433,624) |
| | 12,851,458 | 8,646,172 | 11,675,123 |
| Intangible Assets | 4,305,949 | 4,212,653 | 4,212,653 |
| Less: Accumulated amortization | (4,087,277) | (3,971,284) | (4,011,173) |
| | 218,673 | 241,369 | 201,480 |
| | **70,251,472** | **68,804,988** | **103,242,310** |
| **LIABILITIES** | | | |
| Current liabilities | | | |
| Accounts payable and accrued liabilities | 6,099,060 | 7,590,917 | 15,557,474 |
| Deferred registration and examination fees | 12,769,612 | 12,622,236 | 40,511,419 |
| | 18,868,672 | 20,213,152 | 56,068,894 |
| | 18,868,672 | 20,213,152 | 56,068,894 |
| **NET ASSETS** | | | |
| Net assets invested in capital assets | 13,070,131 | 8,887,541 | 11,876,603 |
| Unrestricted net assets | 38,312,669 | 39,704,295 | 35,296,813 |
| | 51,382,800 | 48,591,836 | 47,173,416 |
| | **70,251,472** | **68,804,988** | **103,242,310** |

**College of Nurses of Ontario**
**Statement of Operations ($)**
**Nine Months Ended September 30**

| | 2022 Year to Date September | | | 2021 Year to Date September | | | 2022 Budget | |
|---|---|---|---|---|---|---|---|---|
| | Budget | Actual | Variance Fav/(Unfav) | Budget | Actual | Variance Fav/(Unfav) | Remaining | Approved |
| **REVENUES** | | | | | | | | |
| Registration fees | 38,899,366 | 39,853,700 | 954,334 | 37,558,937 | 38,744,487 | 1,185,550 | 12,218,300 | 52,072,000 |
| Application assessment | 4,399,625 | 4,398,875 | (750) | 3,912,400 | 4,574,689 | 662,289 | 900,875 | 5,299,750 |
| Verification and transcripts | 61,170 | 122,105 | 60,935 | 39,500 | 78,230 | 38,730 | (54,255) | 67,850 |
| Interest income | 351,786 | 768,714 | 416,928 | 522,759 | 557,475 | 34,716 | (273,571) | 495,143 |
| Examination | 481,200 | 515,640 | 34,440 | 1,647,620 | 2,166,170 | 518,550 | 96,360 | 612,000 |
| Other | 21,383 | 192,727 | 171,344 | 162,803 | 115,987 | (46,816) | (7,977) | 184,750 |
| **Total Revenues** | **44,214,530** | **45,851,761** | **1,637,231** | **43,844,019** | **46,237,038** | **2,393,019** | **12,879,732** | **58,731,493** |
| **EXPENSES** | | | | | | | | |
| Employee salaries and expenses | 33,973,898 | 29,138,206 | 4,835,692 | 29,223,372 | 26,676,306 | 2,547,066 | 16,311,383 | 45,449,589 |
| Contractors and consultants | 3,108,300 | 3,228,139 | (119,839) | 2,894,702 | 3,358,632 | (463,930) | 1,008,136 | 4,236,275 |
| Legal services | 2,536,084 | 1,912,255 | 623,829 | 2,064,599 | 1,899,822 | 164,777 | 1,500,745 | 3,413,000 |
| Equipment, operating supplies and other services | 3,258,947 | 3,115,599 | 143,348 | 3,338,749 | 2,841,117 | 497,632 | 2,175,025 | 5,290,624 |
| Taxes, utilities and depreciation | 1,510,893 | 1,501,870 | 9,023 | 1,472,306 | 1,427,591 | 44,715 | 546,228 | 2,048,098 |
| Exam fees | 134,580 | 142,976 | (8,396) | 1,314,832 | 1,806,648 | (491,816) | 47,324 | 190,300 |
| Non-staff remuneration and expenses | 465,032 | 411,391 | 53,641 | 327,930 | 350,506 | (22,576) | 220,017 | 631,408 |
| **Total Base Operating Expenses** | **44,987,734** | **39,450,436** | **5,537,298** | **40,636,490** | **38,360,622** | **2,275,868** | **21,808,858** | **61,259,294** |
| Project Expenses | 2,187,964 | 2,191,941 | (3,977) | 4,714,753 | 2,022,556 | 2,692,197 | 2,532,120 | 4,724,061 |
| **Total Expenses** | **47,175,698** | **41,642,377** | **5,533,321** | **45,351,243** | **40,383,178** | **4,968,065** | **24,340,978** | **65,983,355** |
| **Excess of (expenses over revenues) / revenues over expenses** | **(2,961,168)** | **4,209,384** | **7,170,552** | **(1,507,224)** | **5,853,860** | **7,361,084** | **(11,461,246)** | **(7,251,862)** |
| **Opening net assets** | | **47,173,416** | | | **42,737,975** | | | |
| **Closing net assets** | | **51,382,800** | | | **48,591,835** | | | |

**College of Nurses of Ontario**
**Statement of Changes in Net Assets ($)**
**Nine Months Ended September 30**

| | 2022 | | | 2021 |
|---|---|---|---|---|
| | **Invested in Capital and Intangible Assets** | **Unrestricted** | **Total** | **December** |
| **Balance, beginning of period** | **11,876,603** | **35,296,813** | **47,173,416** | **42,737,975** |
| Excess of (expenses over revenues)/revenues over expenses | (1,312,442) | 5,521,826 | 4,209,384 | 4,435,441 |
| Purchase of capital assets | 2,505,969 | (2,505,969) | - | - |
| **Balance, end of period** | **13,070,130** | **38,312,670** | **51,382,800** | **47,173,416** |

**College of Nurses of Ontario**
**Statement of Cash Flows ($)**
**Nine Months Ended September 30**

| | 2022 September | 2021 September |
|---|---|---|
| **Cash flows from operating activities** | | |
| Excess of revenue over expense for the period | 4,209,381 | 5,853,861 |
| Adjustments to determine net cash provided by/(used in) operating activities | | |
| Amortization of capital assets | 1,236,338 | 1,148,139 |
| Amortization of intangible assets | 76,104 | 84,417 |
| Interest not received during the year capitalized to investments | (287,084) | (281,311) |
| Interest received during the year previously capitalized to investments | 276,447 | 589,590 |
| | **5,511,186** | **7,394,696** |
| **Changes in non-cash working capital items** | | |
| Decrease in amounts receivable | 101,996 | 484,890 |
| Decrease (increase) in prepaid expenses | 582,788 | 82,045 |
| (Decrease) in accounts payable and accrued liabilities | (9,458,412) | (6,168,296) |
| (Decrease) in deferred registration fees | (27,741,808) | (31,553,252) |
| | (31,004,250) | (29,759,917) |
| **Cash flow from investing activities** | | |
| Purchase of investment | (27,299,900) | (5,991,595) |
| Proceeds from disposal of investments | 16,991,596 | 26,028,662 |
| Purchase of capital assets | (2,412,673) | (2,879,560) |
| Purchase of intangible assets | (93,296) | (117,494) |
| | (12,814,273) | 17,040,012 |
| Net (decrease) in cash and cash equivalents | (43,818,523) | (12,719,905) |
| Cash and cash equivalents, beginning of year | 64,142,000 | 46,194,137 |
| **Cash and cash equivalent, end of quarter** | **20,323,477** | **33,474,232** |

# College of Nurses of Ontario

# 2023 Draft Operating & Capital Budgets

# Section 1 – Introduction

The Operating and Capital budgets identify the resources needed and the expected costs to:

- meet CNO's regulatory mandate;
- progress on the goals set in Strategic Plan 2021-2024;
- invest in operational enhancements; and
- retain and attract resources needed to achieve these results.

Management has estimated the resources (staffing, supplies, and equipment) needed to achieve the planned outcomes for operational and project activities.

Support functions, such as Analytics & Planning, Strategy, Communications, Regulatory Policy & Research, Information Technology, Finance, Hearings, People & Culture, and Facilities, identify resource requirements based on planned involvement in activities and projects which support CNO regulatory functions.

### 2022 Financial Results Impacting on 2023

A number of financial results in 2022 will impact the financial position at the beginning of 2023, the budget required for 2023, and the results expected for the end of 2023.

The 2022 forecasted operating surplus of $3.402M is $10.654M more than the budgeted deficit of $7.252M, primarily due to higher than anticipated revenue and lower base and project operating expenditures, partially offset by higher than budgeted capital expenditures.

- Revenues are forecasted to be $61.161M which is $2.429M (4.1%) higher than budgeted, mostly due to higher registration revenue and higher interest income.
- Forecasted base operating expenses of $55.115M are $6.144M (10.0%) below budget, primarily due to delays in filling planned and unplanned vacancies, lower than budgeted stipends, and lower operational costs as a result of the pandemic, delays to building re-opening and continued teleworking. These savings were partially offset by higher agency and contractor costs to cover some vacant positions.
- Forecasted project operating expenses of $2.643M are $2.081M (44.0%) lower than budgeted. A number of projects were deferred or delayed in 2022, including some work relating to the strategic plan as resources remained focussed on supporting the healthcare system in its pandemic response.
- Forecasted capital expenditures are $1.7M over budget due to work on Space Redesign being delayed from 2021 to 2022. The information about the delay was not available when the 2022 budget was approved. Overall, the project came in under budget and a capital budget variance for 2022 was approved based on no impact on CNO's annual plan and the forecast offsetting savings in operating expenses.

At year-end 2022, the accumulated operating surplus (unrestricted net assets) is forecast to be $37.508M or 7.8 months of the 2022 expense forecast. This year-end accumulated surplus is above the range of three to six months of operating expenses. However, on January 1, 2023 the same accumulated surplus will be 6.1 months of proposed 2023 operating expenses budget.

**2022 Changes / Initiatives with Significant Impact on the 2023 Budget**

The following changes in 2022 are expected to have an impact on the 2023 budget and future years.

Strategic Plan 2021-2024

- Progress on Strategic Plan implementation has been affected by a number of factors. An assessment on progress will be conducted in early 2023.
- Despite the impact on some components of the implementation, considerable progress has been made on a number of items that contribute to components of the Strategic Plan, including:
    - modernization of the standards of practice;
    - modernizing assessment of applications for registration;
    - Quality Assurance program enhancements including the retirement of the old Quality Assurance platform, introduction of new supporting technology, and a pilot of a new approach to Quality Assurance;
    - completion of work on data governance, one of the first steps towards an improved insights capability;
    - the completion of the first two milestones in the Enterprise Lakehouse, a data repository that will contribute significantly to insights capability; and
    - the introduction of key elements of the agility pillar such as the stage-gate process for projects.
- Over the summer of 2022, CNO created roadmaps for each of the three Outcomes, the four Pillars, and an integrated road map that reflected the interdependences of the roadmaps. Each roadmap identified a sequence of milestones and activities over the life of the Strategic Plan. Related work was undertaken to draft performance measures for each of the Outcomes.
- At the September Council meeting, CNO staff reviewed the Outcome roadmaps and draft measures. Council provided feedback on the content that will be incorporated into a Council presentation at the December meeting.

Applications and Registrations

- CNO continues to receive a large volume of applications from internationally educated nurses (IEN) and Canadian applicants. If the current pace continues, CNO will have received over 21,000 applications by the end of the year, an increase of about 5% from 2021.
- The pace of inbound applications is matched by applications completed in 2022. By the end of September, more applications had been completed already in 2022 than in all of 2021. By the end of the year, it is expected that about 21,000 applications will have been completed, an increase of over 35% from 2021.
- This pace is expected to accelerate in 2023. Recent changes to regulations proposed by CNO related to the Temporary Class and Reinstatement will increase the number of individuals eligible to register to practice in Ontario. Changes introduced in Bill 106 will add to this and create specific target timelines for registration activities adding to demands on CNO's registration function.

Investigations

- In 2022, incoming matters have increased by 9% over 2021. The majority of outsourced investigations were completed. Intake and investigations process improvements and additional investigators increased ICRC case reviews and dispositions and reduced case accumulation by 30%.

Nursys in Canada

- CNO and other Canadian regulators have committed to implementing a national database for sharing nurse registration and discipline information across jurisdictions. Nursys in Canada is a collaborative project between CNO, the British Columbia College of Nurses and Midwives (BCCNM), and the National Council of State Boards of Nursing (NCSBN) to implement a separate Canadian instance of the Nursys system used by regulators in the United States.
- In 2022, the first milestone of the Nursys in Canada pilot was implemented, namely an instance of the Nursys application was installed in the Canada cloud infrastructure and BCCNM and CNO begun submitting registration and discipline data.
- In 2023, the Canadian database with Ontario and British Columbia will support simultaneous searches with the corresponding US system. The plan is that by later in the year, the Canadian operation will be ready to onboard other Canadian regulators.

Information Technology

- In 2022, CNO continued investments in systems and cloud infrastructure with the aim of advancing our technology footprint to better serve the business and strengthen and maintain our cyber security posture. System enhancements to support operational and organizational effectiveness included:
    - Implementation of an Enterprise Data Lakehouse to drive structured analytics and reporting for internal and external stakeholders.
    - Continued improvement to CNO's main information system in line with the Strategic Plan and other regulatory and operational improvements identified by the organization.

Space Redesign

- With no pandemic-related restrictions or work stoppages, a large portion of the Space Redesign construction and finishing work has been completed in 2022 and the project is drawing to a close. Supply chain interruptions and delayed construction materials have hindered the tail end of the project, hence the delay in finishing the project in its entirety. It is anticipated that the project will be fully completed in 2022 and there will be a significant reduction in 2023 capital expenditures from previous years.

**2023 Budget Summary**

The 2023 budget estimates an 8.5% increase in revenue and a 12.1% increase in expenses over the 2022 budget. The net impact is an annual operating deficit of $10.265M (see Schedule 2).

Revenues:
The increase in revenue is the result of an increase in application and registration income and interest income offset by a decrease in examination revenues.

- There has been a significant movement in interest rates. It is expected that the high interest rate environment will continue in the medium term and will continue to impact interest revenues in 2023.

Expenses – Base Operations:
Base operating expenses have increased by 15.9% over the 2022 budget to $70.978M. The following are the main contributing factors for the increase:

- additional resources, recognizing an increased volume of work in registrations, investigations, technology, and other functions;
- compensation changes, reflecting CNO compensation principles as approved by Council, the need to attract and retain skilled staff, and external factors in the employment market; and
- a slight increase in operational costs to support the day-day operations, hosting virtual meetings, skills development and conference attendance.

Base capital costs cover replacement of IT assets such as personal computers as they reach end of life. The budget contains base capital costs of $0.872M as noted in Schedule 6.

Expenses – 2023 Projects

As part of implementing the agility pillar of the Strategic Plan, CNO has implemented a strong, principle-based project development, approval, and management approach that includes a stage-gate methodology and a structured view of all projects known as portfolio management.

While some projects are well-defined and will continue into 2023, other projects are at the early stages of development and accurate estimates of expenditures are not yet available. The introduction of a stage-gate methodology and portfolio management supports agility by allowing projects to be well-defined before they are moved to execution and supports CNO re-assessing which projects it will move forward or slow down when unplanned items arise.

A 2023 draft project budget envelope of $3.0M is proposed for 2023. These amounts represent a significant reduction from the project work initially proposed for 2023 and from the 2022 budget. The 2022 results demonstrate that even with budget available to execute project work, the reliance on subject matter knowledge from teams across CNO will limit the amount of work that can be completed, even with a full staff complement.

Ultimately, all projects are consistent with the direction established in the Strategic Plan. Some projects link directly to progressing on the roadmaps for the four Pillars and three Outcomes. Other projects are enablers and support the Strategic Plan through maintaining or enhancing organization capabilities or operations. The budget, as prepared, reflects planned project expenditures in the following areas:

- Strategic Plan – including resources for projects related to insights capability, registration modernization, agility, and the strategic outcomes.

- Regulatory and operational enhancements – items such as Quality Assurance Transformation, Nursys in Canada, Standards Modernization, governance implementation, and website re-design.
- Infrastructure investments – includes planning for required upgrades to CNO's main information system and implantation of a new financial management system.

It is important to note that external factors can impact on the actual projects executed in a given year. For example, the 2023 budget was developed with an assumption regarding the timelines for the implementation of Bill 106. While an assessment is still underway, the organization may need to focus more resources on registration modernization than currently planned.

**Surpluses, Deficits and Accumulated Surplus Relationship**

The forecast annual operating surplus for 2022 is $3.402M, $10.654M higher than the budgeted deficit of $7.252M.

The expected accumulated unrestricted net assets at the end of 2022 of $37.508M is higher than the budget by $11.013M. The increase in the net assets is made up of:

- the impact of higher capital expenditures net of write offs in 2022 (-$1.680M);
- the higher surplus in 2022 (+$10.654M); and
- the higher opening net assets (+$2.039M).

The draft budget for 2023 estimates an annual operating deficit of $10.265M. When the accumulated unrestricted net assets expected for the end of 2022 ($37.508M) is combined with the annual operating deficit in 2023 ($10.265M) and the impact of capital investments in 2023 ($0.853M), the result is expected to be an accumulated operating surplus of $28.096M at the end of 2023. This amount will represent 4.56 months of budgeted operating expenses, within the approved range of three to six months of the expense budget.

At the end of 2024, the projected unrestricted net assets fall to slightly below the lower limit of the guideline at around 2.29 month's operating coverage. The projection for the years 2025 and 2026 shows unrestricted net assets falling significantly below the lower limit of the guideline at negative 0.17 and negative 2.82 months of operating coverage, respectively.

It is likely that increases to fees will be needed in 2024 in order to maintain the overall financial health of the organization and the operational flexibility required to deal with unforeseen events. This would represent five years since the Annual Fee was increased and even longer since other fees, such as the various application fees, have changed.

## Section 2 – Summary of Revenue and Expenses

Schedule 2, the Summary of Revenue and Expenses, identifies:

- total revenues $63.713M,
- less total base expenses $70.978M,
- less total project expenses $3.0M, and
- **net operating deficit $10.265M.**

**Total revenues are budgeted to increase by $4.982M or 8.5% to $63.713M.**

The increase in revenue is primarily due to:

- an increase in registration numbers (+$3.303M)
- a marginal increase in Canadian and IEN application assessment (+$0.421M), and
- an increase in interest income (+1.266).

**Total operating expenses are budgeted to increase by $7.995M (12.1%), to $73.978M.**

This is made up of base operating increase of $9.719M (15.9%) and a decrease in project operating expenses of $1.724M (-36.5%).

The major contributors to the base operating cost increase are:

- salaries and benefits costs resulting from the addition of permanent and temporary FTEs, inflation and market adjustment and progression (+$7.857M); and
- higher costs for services, equipment, and operating supplies (+$1.333M).

These increases are partially offset by:

- decrease in contractor and consulting costs (-$0.122M), and
- decrease in legal and exam costs (-$0.241M).

The proposed project operating expenses budget for 2023 ($3.0M) is a decrease (-$1.724M) from 2022. With Space Redesign completed, the proposed 2023 budget represents a more normal year for project expenditures.

Schedule 2

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Summary of Revenue and Expenses ($000)**

| | 2020 Actual | 2021 Actual | 2022 Approved budget | 2022 Forecast | 2023 Draft Budget | 2023 Budget Over / (Under) 2022 Budget | | 2024 Proj'n | 2025 Proj'n | 2026 Proj'n |
|---|---|---|---|---|---|---|---|---|---|---|
| **REVENUES** | | | | | | | | | | |
| Registration Fees | 50,356 | 51,877 | 52,072 | 53,439 | **55,375** | 3,303 | 6.3% | 56,659 | 57,979 | 59,361 |
| Application Assessment | 4,789 | 5,589 | 5,300 | 5,491 | **5,721** | 421 | 7.9% | 5,898 | 6,080 | 6,268 |
| Interest Income | 1,143 | 704 | 495 | 1,211 | **1,761** | 1,266 | 255.7% | 1,628 | 1,319 | 1,019 |
| Exam Revenue | 1,898 | 2,898 | 612 | 688 | **358** | (254) | (41.5)% | - | - | - |
| Other Revenue | 162 | 452 | 253 | 332 | **498** | 245 | 97.2% | 449 | 471 | 422 |
| **Total Revenue** | 58,349 | 61,520 | 58,731 | 61,161 | **63,713** | 4,982 | 8.5% | 64,635 | 65,849 | 67,069 |
| **EXPENSES** | | | | | | | | | | |
| Employee salaries and expenses | 33,613 | 37,350 | 45,450 | 40,759 | **54,166** | 8,717 | 19.2% | 57,395 | 60,666 | 64,108 |
| Non-staff remuneration and expenses | 409 | 492 | 631 | 577 | **709** | 77 | 12.3% | 732 | 762 | 792 |
| Contractors and consultants | 3,920 | 4,653 | 4,236 | 4,603 | **4,114** | (122) | (2.9)% | 3,975 | 4,134 | 4,299 |
| Legal services | 2,656 | 3,287 | 3,413 | 2,534 | **3,242** | (171) | (5.0)% | 3,354 | 3,488 | 3,628 |
| Equipment, operating supplies and other services | 4,098 | 4,746 | 5,291 | 4,638 | **6,624** | 1,333 | 25.2% | 6,884 | 7,160 | 7,446 |
| Exam fees | 1,491 | 2,473 | 190 | 212 | **120** | (70) | (36.7)% | 125 | 130 | 135 |
| Taxes, utilities and depreciation | 1,374 | 1,986 | 2,048 | 1,791 | **2,003** | (45) | (2.2)% | 2,120 | 2,129 | 2,075 |
| **Total Base Operating Expenses** | 47,561 | 54,988 | 61,259 | 55,115 | **70,978** | 9,719 | 15.9% | 74,585 | 78,469 | 82,484 |
| Project expenses | 2,249 | 2,096 | 4,724 | 2,643 | **3,000** | (1,724) | (36.5)% | 3,120 | 3,245 | 3,375 |
| **Total Expenses** | 49,810 | 57,084 | 65,983 | 57,759 | **73,978** | 7,995 | 12.1% | 77,705 | 81,714 | 85,858 |
| **Surplus/(Deficit) of Revenue over Expenses** | 8,539 | 4,435 | (7,252) | 3,402 | **(10,265)** | (3,013) | 41.6% | (13,071) | (15,865) | (18,789) |
| **Opening Unrestricted Net Assets** | 26,240 | 35,294 | 33,258 | 35,297 | **37,508** | | | 28,096 | 14,857 | (1,178) |
| Net Capital Assets | 516 | (4,754) | 489 | (1,191) | **853** | | | (168) | (170) | (237) |
| Defined benefit costs - remeasurements and other items | - | 321 | - | - | **-** | | | - | - | - |
| **Closing Unrestricted Net Assets** | **35,294** | **35,297** | **26,495** | **37,508** | **28,096** | | | **14,857** | **(1,178)** | **(20,204)** |
| Accumulated Surplus (# of months) | 8.50 | 7.42 | 4.82 | 7.79 | **4.56** | | | 2.29 | -0.17 | -2.82 |

## Section 3 – Registration Numbers and Revenue Summary

Schedules 3a to 3d show registration revenue analysis for the period from 2020 (2016 for 3d) through 2026. All of the information is broken down by Registered Nurse (RN) and Registered Practical Nurse (RPN) categories.

- 3a Registration Numbers – estimate of annual registrants in all registration classes;
- 3b Registration Revenue Transaction Count – forecast of the number of registration transactions of different types;
- 3c Registration Revenue and Fees – the fees and expected revenue based on the number of fee transactions shown in Schedule 3b; and
- 3d Registration Statistics (graph) – tracking registration counts over time.

The 2023 budget for registration revenue identifies an increase of 6.3% over the 2022 budget. This is primarily the result of the net increase of 5.8% in registration numbers.

Schedules 3a and 3b provide a breakdown of the number of nurses and transactions (respectively) by fee type within each registration category. This breakdown allows CNO to track exact sources of revenue and reconcile the total revenue by its components (e.g., the number of payments multiplied by the fee will result in the total revenue from that fee source).

Schedule 3c identifies the registration revenue. This schedule is also separated by registration category and fee type. The fees by-law identifies the following fees (excl. HST) for 2023:

- Initial Registration $320 (includes annual fee)
- Annual Registration Renewal $270
- General/Extended Class Late Fee $100
- Non-practising Class Renewal/Initial $ 50
- Non-practising Class Late Fee $ 25
- Reinstatement $320 (includes annual fee)
- Reinstatement Penalty $500 (per year worked or used title)

The revenue in Schedule 3c does not include application fees. Application fees are in the "Application Assessment" revenue line in Schedule 2.

Schedule 3a

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Registration Numbers**

| Fee Type | 2020 Actual | 2021 Actual | 2022 Approved Budget | 2022 Forecast | 2023 Draft Budget | 2024 Proj'n | 2025 Proj'n | 2026 Proj'n |
|---|---|---|---|---|---|---|---|---|
| RN Renewals On time | 106,660 | 108,267 | 109,215 | 113,706 | **114,371** | 116,000 | 117,629 | 119,258 |
| RN Renewals Non-Practising On time | 8,620 | 8,645 | 10,131 | 9,614 | **10,564** | 10,160 | 10,779 | 11,397 |
| RN Renewals Non-Practising Late | 2,208 | 2,190 | 500 | 1,460 | **144** | 1,160 | 1,176 | 1,193 |
| RN Renewals Late | 5,141 | 5,542 | 5,000 | 2,357 | **5,000** | 5,000 | 5,000 | 5,000 |
| | **122,629** | **124,644** | **124,846** | **127,137** | **130,079** | **132,320** | **134,584** | **136,848** |
| RN Reinstatements | 284 | 323 | 165 | 351 | **376** | 387 | 399 | 411 |
| NP Initials - Extended Class | 293 | 426 | 350 | 395 | **407** | 420 | 433 | 446 |
| RN Initials - General Class | 5,103 | 5,415 | 5,600 | 7,800 | **8,042** | 8,291 | 8,548 | 8,813 |
| RN Initials - Temporary Class | 1,007 | 1,426 | 900 | 1,154 | **1,190** | 1,227 | 1,265 | 1,304 |
| **Total RN Registrations** | **129,316** | **132,234** | **131,861** | **136,837** | **140,094** | **142,645** | **145,229** | **147,822** |
| RPN Renewals - On time | 51,140 | 52,283 | 54,950 | 55,640 | **56,662** | 58,899 | 61,341 | 63,994 |
| RPN Renewals Non-Practising On time | 2,641 | 2,786 | 3,945 | 3,190 | **3,736** | 4,004 | 4,272 | 4,540 |
| RPN Renewals Non-Practising Late | 827 | 876 | 200 | 682 | **500** | 500 | 500 | 500 |
| RPN Renewals Late | 3,789 | 3,576 | 3,000 | 1,982 | **3,000** | 3,000 | 3,000 | 3,000 |
| | 58,397 | 59,521 | 62,095 | 61,494 | **63,898** | 66,403 | 69,113 | 72,034 |
| RPN Reinstatements | 153 | 197 | 140 | 255 | **262** | 270 | 278 | 286 |
| RPN Initials - General Class | 3,615 | 4,633 | 4,820 | 5,726 | **5,904** | 6,087 | 6,276 | 6,471 |
| RPN Initials - Temporary Class | 591 | 1,037 | 600 | 927 | **956** | 986 | 1,017 | 1,049 |
| **Total RPN Registrations** | **62,756** | **65,388** | **67,655** | **68,402** | **71,020** | **73,746** | **76,684** | **79,840** |
| **Total Registrations** | **192,072** | **197,622** | **199,516** | **205,239** | **211,114** | **216,391** | **221,913** | **227,662** |
| **2023 Budget Over/(Under) 2022 (%)** | | | | | **5.8%** | | | |

Schedule 3b

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Registration Revenue Transaction Count**

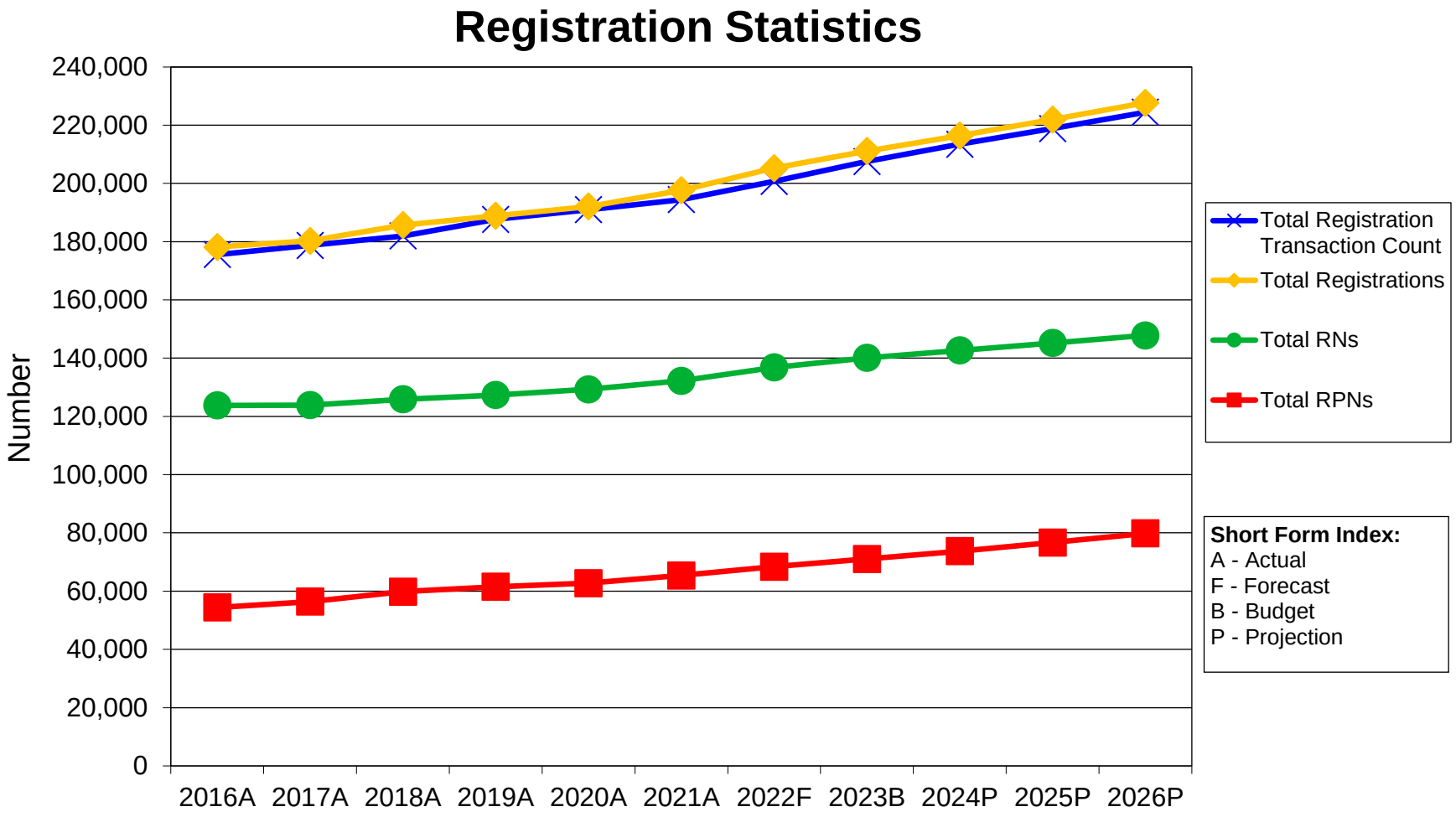
| Fee Type | 2020 Actual | 2021 Actual | 2022 Approved Budget | 2022 Forecast | 2023 Draft Budget | 2024 Proj'n | 2025 Proj'n | 2026 Proj'n |
|---|---|---|---|---|---|---|---|---|
| RN Renewals On time | 106,660 | 108,267 | 109,215 | 113,706 | **114,371** | 116,000 | 117,629 | 119,258 |
| RN Renewals Non-Practising On time | 8,620 | 8,647 | 10,131 | 9,614 | **10,564** | 10,184 | 10,804 | 11,423 |
| RN Renewals Non-Practising Late | 2,208 | 2,190 | 500 | 1,460 | **144** | 1,160 | 1,176 | 1,193 |
| RN Renewals Late | 5,141 | 5,542 | 5,000 | 2,357 | **5,000** | 5,000 | 5,000 | 5,000 |
| | 122,629 | 124,646 | 124,846 | 127,137 | **130,079** | 132,344 | 134,609 | 136,874 |
| RN Reinstatements | 84 | 101 | 60 | 106 | **109** | 112 | 116 | 120 |
| RN Reinstatements from NonPrac to Gen/Ext | 196 | 215 | 100 | 249 | **257** | 265 | 273 | 281 |
| RN Lifting Administrative Suspension | 407 | 260 | 250 | 249 | **257** | 265 | 273 | 281 |
| RN Reinstatement Additional Fee | 4 | 7 | 5 | 10 | **10** | 10 | 10 | 10 |
| NP Initials - Extended Class | 293 | 426 | 350 | 395 | **407** | 420 | 433 | 446 |
| NP Specialty Registration | 298 | 434 | 350 | 399 | **412** | 426 | 440 | 454 |
| RN Initials - General | 5,105 | 5,417 | 5,600 | 7,801 | **8,042** | 8,291 | 8,548 | 8,813 |
| RN Initials -Temporary | 1,007 | 1,426 | 900 | 1,154 | **1,190** | 1,227 | 1,265 | 1,304 |
| RN Temporary to General | 923 | 1,232 | 850 | 937 | **966** | 996 | 1,027 | 1,059 |
| **Total RN Registration Transactions** | **130,946** | **134,164** | **133,311** | **138,437** | **141,729** | **144,356** | **146,994** | **149,642** |
| RPN Renewals - On time | 51,140 | 52,283 | 54,950 | 55,640 | **56,662** | 58,899 | 61,341 | 63,994 |
| RPN Renewals Non-Practising On time | 2,641 | 2,786 | 3,945 | 3,190 | **3,736** | 4,004 | 4,272 | 4,540 |
| RPN Renewals Non-Practising Late | 827 | 876 | 200 | 682 | **500** | 500 | 500 | 500 |
| RPN Renewals Late | 3,789 | 3,576 | 3,000 | 1,982 | **3,000** | 3,000 | 3,000 | 3,000 |
| | 58,397 | 59,521 | 62,095 | 61,494 | **63,898** | 66,403 | 69,113 | 72,034 |
| RPN Reinstatements | 79 | 60 | 55 | 88 | **90** | 93 | 96 | 99 |
| RPN Reinstatements from NonPrac to GEN | 65 | 133 | 80 | 157 | **162** | 167 | 172 | 177 |
| RPN Lifting Administrative Suspension | 295 | 235 | 200 | 252 | **250** | 258 | 266 | 274 |
| RPN Reinstatement Additional Fee | 9 | 4 | 5 | - | **10** | 10 | 10 | 10 |
| RPN Initials - General | 3,615 | 4,633 | 4,820 | 5,726 | **5,904** | 6,087 | 6,276 | 6,471 |
| RPN Initials - Temporary | 591 | 1,037 | 600 | 927 | **956** | 986 | 1,017 | 1,049 |
| RPN Temporary to General | 426 | 877 | 500 | 427 | **440** | 454 | 468 | 483 |
| **Total RPN Registration Transactions** | **63,477** | **66,500** | **68,355** | **69,071** | **71,710** | **74,458** | **77,418** | **80,597** |
| **Total Registration Transactions** | **194,423** | **200,664** | **201,666** | **207,508** | **213,439** | **218,814** | **224,412** | **230,239** |
| **2023 Budget Over/(Under) 2022 (%)** | | | | | **5.8%** | | | |

Schedule 3c

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Registration Revenue ($000) and Fees ($)**

| Fee Type | 2020 Actual | 2021 Actual | 2022 Approved Budget | 2022 Forecast | 2023 Fee | 2023 Draft Budget | 2024 Fee | 2024 Proj'n | 2025 Fee | 2025 Proj'n | 2026 Fee | 2026 Proj'n |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RN Renewals On time | 28,798 | 29,232 | 29,488 | 30,701 | 270 | **30,880** | 270 | 31,320 | 270 | 31,760 | 270 | 32,200 |
| RN Renewals Non-Practising On time | 431 | 433 | 506 | 481 | 50 | **528** | 50 | 509 | 50 | 539 | 50 | 570 |
| RN Renewals Non-Practising Late | 166 | 164 | 38 | 110 | 75 | **11** | 75 | 87 | 75 | 88 | 75 | 89 |
| RN Renewals Late | 1,902 | 2,051 | 1,850 | 872 | 370 | **1,850** | 370 | 1,850 | 370 | 1,850 | 370 | 1,850 |
| | 31,297 | 31,880 | 31,881 | 32,163 | | **33,269** | | 33,766 | | 34,237 | | 34,709 |
| RN Reinstatements | 28 | 32 | 19 | 34 | 320 | **35** | 320 | 36 | 320 | 37 | 320 | 38 |
| RN Reinstatements from NonPrac to Gen/Ext | 53 | 58 | 27 | 67 | 270 | **69** | 270 | 72 | 270 | 74 | 270 | 76 |
| RN Lifting Administrative Suspension | 20 | 13 | 13 | 12 | 50 | **13** | 50 | 13 | 50 | 14 | 50 | 14 |
| RN Reinstatement Additional Fee | 2 | 4 | 3 | 5 | 500 | **5** | 500 | 5 | 500 | 5 | 500 | 5 |
| NP Initials - Extended Class | 15 | 21 | 18 | 20 | 50 | **20** | 50 | 21 | 50 | 22 | 50 | 22 |
| NP Specialty | 15 | 22 | 18 | 20 | 50 | **21** | 50 | 21 | 50 | 22 | 50 | 23 |
| RN Initials - General | 1,697 | 1,753 | 1,792 | 2,496 | 320 | **2,573** | 320 | 2,653 | 320 | 2,735 | 320 | 2,820 |
| RN Initials -Temporary | 322 | 456 | 288 | 369 | 320 | **381** | 320 | 393 | 320 | 405 | 320 | 417 |
| RN Temporary to General | 46 | 62 | 43 | 47 | 50 | **48** | 50 | 50 | 50 | 51 | 50 | 53 |
| **Total RN Registration** | **33,495** | **34,300** | **34,100** | **35,234** | | **36,435** | | **37,030** | | **37,602** | | **38,177** |
| RPN Renewals - On time | 13,808 | 14,116 | 14,837 | 15,023 | 270 | **15,299** | 270 | 15,903 | 270 | 16,562 | 270 | 17,278 |
| RPN Renewals Non-Practising On time | 132 | 139 | 197 | 160 | 50 | **186** | 50 | 200 | 50 | 214 | 50 | 227 |
| RPN Renewals Non-Practising Late | 62 | 66 | 15 | 51 | 75 | **38** | 75 | 38 | 75 | 38 | 75 | 38 |
| RPN Renewals Late | 1,402 | 1,323 | 1,110 | 733 | 370 | **1,110** | 370 | 1,110 | 370 | 1,110 | 370 | 1,110 |
| | 15,403 | 15,645 | 16,159 | 15,967 | | **16,633** | | 17,250 | | 17,923 | | 18,653 |
| RPN Reinstatements | 24 | 19 | 18 | 28 | 320 | **29** | 320 | 30 | 320 | 31 | 320 | 32 |
| RPN Reinstatements from NonPrac to GEN | 18 | 36 | 22 | 42 | 270 | **44** | 270 | 45 | 270 | 46 | 270 | 48 |
| RPN Lifting Administrative Suspension | 15 | 12 | 10 | 13 | 50 | **13** | 50 | 13 | 50 | 13 | 50 | 14 |
| RPN Reinstatement Additional Fee | 5 | 2 | 3 | 5 | 500 | **5** | 500 | 5 | 500 | 5 | 500 | 5 |
| RPN Initials - General | 1,185 | 1,488 | 1,542 | 1,832 | 320 | **1,889** | 320 | 1,948 | 320 | 2,008 | 320 | 2,071 |
| RPN Initials - Temporary | 189 | 332 | 192 | 297 | 320 | **306** | 320 | 316 | 320 | 325 | 320 | 336 |
| RPN Temporary to General | 21 | 44 | 25 | 21 | 50 | **22** | 50 | 23 | 50 | 23 | 50 | 24 |
| **Total RPN Registration** | **16,860** | **17,577** | **17,970** | **18,205** | | **18,940** | | **19,629** | | **20,376** | | **21,182** |
| **Total Registration Revenue** | **50,355** | **51,877** | **52,070** | **53,439** | | **55,375** | | **56,659** | | **57,977** | | **59,359** |
| **2023 Budget Over/(Under) 2022 (%)** | | | | | | **6.3%** | | | | | | |

Schedule 3d


Registration Statistics
240,000
220,000
200,000
180,000
160,000
140,000
120,000
100,000
80,000
60,000
40,000
20,000
0
Number
2016A
2017A
2018A
2019A
2020A
2021A
2022F
2023B
2024P
2025P
2026P
Total Registration Transaction Count
Total Registrations
Total RNs
Total RPNs
Short Form Index:
A - Actual
F - Forecast
B - Budget
P - Projection

## Section 4 – Expense Category Analysis and Project Summary

The presentation of the 2023 budget is based on CNO-wide operating budget that includes base operations and project activities. Some projects may also contain capital costs. All capital expenditures are listed in detail in Section 6.

Staff salaries and benefits have been budgeted using standard rates arrived at by averaging the actual salaries and benefits of all staff at each level. Utilizing standard rates facilitates explanation of variances arising from labour resources and removes the impact of events (e.g., actual negotiated salary) that are outside the control of an individual manager from that manager's reported results. Additionally, the use of standard rates prevents the disclosure of the actual salaries of individual employees while improving visibility of labour costs across the organization.

Schedule 4 provides an explanation by expense category of the changes in budgeted base operating costs for the entire organization. Actual base expenses for 2020 and 2021, the budget and forecast for 2022, and the draft budget for the year 2023 have been included for comparison purposes.

Schedule 4

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Base & Projects Operating Budget Summary ($000)**

| Expense Category | 2020 Actual | 2021 Actual | 2022 Approved Budget | 2022 Forecast | 2023 Draft Budget | 2023 Budget Over /(Under) 2022 Budget | | Comments |
|---|---|---|---|---|---|---|---|---|
| Salary & Employee Expenses | 33,613 | 37,350 | 45,450 | 40,759 | **54,166** | 8,717 | 19.2% | The 2023 budget includes costs for the net addition of 39 new permanent positions and progression and compensation changes for existing staff. 7 of the position were added in 2022 in response to rapdily rising workloads. These new positions are required to:<br>- manage increased volume and complexity of the work<br>- support the achievement of CNO'S madate and strategic objectives |
| Contractors & Consultants | 3,920 | 4,653 | 4,236 | 4,603 | **4,114** | (122) | (2.9)% | The 2023 base budget includes lower costs for outsourced investigations and lower agency charges. |
| Other Services | 1,635 | 1,692 | 1,854 | 1,647 | **1,941** | 87 | 4.7% | The 2023 budget is slightly higher due to marginally higher credit card fees based on volume of activity and slightly higher payroll processing charges with the growth in staff counts. |
| Legal Services | 2,656 | 3,287 | 3,413 | 2,534 | **3,242** | (171) | (5.0)% | The 2023 budget is lower compared to 2022 due to changes in the number of medical reports and lower costs for investigations and prosecutions legal advice. |
| Equipment, Operating Supplies & Telecom Services | 2,462 | 3,054 | 3,436 | 2,991 | **4,683** | 1,246 | 36.3% | The 2023 budget is higher due to increasing costs of cloud services as CNO shifts away from a reliance on purchased hardware and adds new technology to support programs such as Quality Assurance. |
| Examination Fees | 1,491 | 2,473 | 190 | 212 | **120** | (70) | (36.7)% | RPN exam revenue is eliminated effective 2022 as applicants will pay fees directly to the vendor |
| Depreciation Expenses | 1,141 | 1,755 | 1,750 | 1,562 | **1,726** | (24) | (1.4)% | Depreciation is based on the expected capital additions. |
| Non-Staff Remuneration & Expenses | 409 | 492 | 631 | 577 | **709** | 77 | 12.3% | The 2023 budget increase reflects one in-person meeting for each committee and Council as well as increased adhoc ICRC meetings |
| Taxes & Utilities | 233 | 230 | 298 | 229 | **277** | (21) | (7.1)% | The 2023 budget reflects a decrease in hydro and gas utilization and lower than |
| **Base Total** | **47,561** | **54,988** | **61,259** | **55,115** | **70,978** | **9,719** | **15.9%** | |
| **Projects Costs** | **2,249** | **2,096** | **4,724** | **2,643** | **3,000** | **(1,724)** | **(36.5)%** | The 2023 budget includes project envelope of $3M which is lower than the 2022 budget due to:<br>- Space Redesign projected completed in 2022<br>- recognition that availability of internal subject matter experts limits the amount of project work that can be accomplished<br>In 2023, the project budget envelope covers Strategic Plan implementation and projects related to organizational effectiveness. |
| **Total** | **49,810** | **57,084** | **65,983** | **57,759** | **73,978** | **7,995** | **12.1%** | |

## Section 5 – Compensation and Staffing

In determining the annual provision for compensation, the following were considered:

- the compensation principles approved by Council (attached); and
- CNO's fiscal situation, both in the coming year and the projected years.

The compensation principles provide direction that factor in a number of key considerations when looking at compensation changes. This year, these considerations included:

- the rate of inflation since the last time salaries were adjusted;
- the results of a market compensation survey and the reality of a hyper-competitive job market;
- the need to attract and retain the resources required to progress on the Strategic Plan and maintain effective regulatory and supporting functions; and
- input from Council regarding the equitable treatment of staff.

The Sub-Committee on Compensation reviewed the changes to the compensation components incorporated into the 2023 budget. In its report, the Sub-Committee advised the Finance Committee that it believes that these changes are congruent with the Compensation Principles approved by Council (see next page) and with best practices in human resources.

CNO's 2023 proposed compensation budget is $52.226M excluding agency staffing. This is 71% of the overall budget. Employee benefits are 28.5% of the compensation budget. The 2023 compensation budget is $7.850M (17.7%) higher than the 2022 budget. This increase is due to:

- additional staff ($3.850M);
- compensation and benefit cost adjustments ($3.150M); and
- progression of staff within existing salary ranges ($0.850M).

The labour budget increases are primarily due to the net addition of 30.96 full time equivalents (FTE). This is made up of changes in temporary and permanent staff FTEs. In addition to supporting progress on the Strategic Plan, the added resources are required to address increased volume of activities, operational improvements, and privacy and information security.

Overall, the proposed budget adds 39 permanent staff by the end of 2023, bringing the total to 395. Of the 39, 7 positions were added during 2022 in response to increasing workloads and CNO's efforts to respond to the needs of the healthcare system.

## Compensation Principles[1]

### Purpose:

To support an organizational culture of performance excellence by enabling CNO to hire and retain engaged and motivated staffing resources who achieve CNO's mandate.

### Definitions:

**Compensation:**

For the purpose of these principles, compensation is defined to include the following components:

- Annual salary/hourly rates of pay;
- Rewards and recognition to include merit payments, ad hoc performance recognition, growth and learning opportunities;
- Benefits to include insured coverages (such as health and dental) and non-insured plans (such as time away allotments); and
- Retirement savings arrangements to include registered pension plans and Group RRSPs.

**CNO's Employment Market:**

CNO's primary employment market is defined to be: other regulatory organizations. CNO's general employment market is defined to include: the primary employment market and non-profit organizations; Ontario Public Service; municipal governments; post secondary institutions (colleges and Universities); health care; and, on a targeted basis, private sector organizations with which CNO competes for resources.

### Principles:

As foundational assumptions to all Compensation Principles, CNO is committed to ensuring:

- its decisions and activities comply with all relevant legislation; and
- information about individual staff compensation is confidential.

**Externally Competitive**

Achieve and maintain competitive positioning relative to other employers within CNO's general employment market, as defined, on a total compensation basis. CNO's desired competitive position shall not be less than the market median and may be allowed to lead on a total compensation basis within its general employment market.

**Internal Equity**

Develop and consistently apply fair and transparent practices and policies to administer CNO's compensation programs for all applicants and employees.

**Individual Equity**

Ensure compensation-related practices and decisions are ethically, consistently, objectively and equally applied to all employees, with the result that employees perceive and experience fair treatment.

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[1] Approved by Council, June 2011
Revised, December 2013, December 2015, March 2020

Schedule 5

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Permanent and Temporary Staff FTE**

| Team | 2020 FTE | 2021 FTE | 2022 FTE | 2023 FTE |
|---|---|---|---|---|
| Quality | 156.5 | 167.5 | 183.2 | **191.1** |
| Administration | 124.3 | 130.0 | 141.6 | **164.8** |
| Executive Office and Strategy | 26.7 | 28.7 | 29.7 | **29.9** |
| **Total** | **307.5** | **326.2** | **354.5** | **385.7** |

**Labour Budget 2023 ($000)**

| | 2020 FTE Budget | 2021 FTE Budget | 2022 Approved Budget | 2023 Draft Budget | 2023 over 2022 | Comment |
|---|---|---|---|---|---|---|
| Permanent | 35,279 | 38,084 | 43,739 | **51,590** | 7,851 | 30.96 new FTE. |
| Temporary | 1,082 | 351 | 630 | **636** | 6 | Backfilling for permanent resources assigned to projects and leaves. |
| **Total** | **36,361** | **38,435** | **44,369** | **52,226** | **7,857** | |

## Section 6 – Capital Budget

Schedule 6, the draft capital budget, identifies proposed building changes, new or replacement furniture, equipment, and software purchases for the 2023 budget year along with projected estimates through 2026. The listing of capital expenditures is grouped by fixed asset category.

According to CNO's accounting policy, an item is capitalized when it has a useful life of more than one (1) year **and** its value is greater than $500. For example, a personal computer (PC) purchased for $2,000 would be capitalized because it has a useful life of more than 1 year **and** the value is greater than $500. On the other hand, a computer hard drive purchased for $400 is not capitalized even though the estimated useful life is greater than 1 year because the cost is less than $500.

The 2023 capital budget and 2024-2026 projections concentrate on two areas: building and technology infrastructure.

- Building
    - Capital expenditures for furniture and building improvement of $0.15M
    - 2024 to 2026 projections include investments of $0.8M for building improvement and $0.2M for furniture

- Technology
    - The 2023 budget has a provision of $0.722M for hardware refresh and software; and
    - 2024 to 2026 projections include investments of $0.8M for hardware and $0.2M for software.

Schedule 6

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**2023 Capital Budget and 2024-2026 Projections ($000)**

**2023**

| Fixed Asset Category | Description | 2023 |
|---|---|---|
| **Building Improvement** | Building improvement | 100 |
| **Furniture & Fixture** | Furniture | 50 |
| **Hardware** | Personal computers/Servers | 602 |
| **Software** | Servers | 120 |
| | **Total Capital for 2023** | **872** |

**2024**

| Fixed Asset Category | Description | 2024 |
|---|---|---|
| **Building Improvement** | Building improvement | 800 |
| **Furniture & Fixture** | Furniture | 200 |
| **Hardware** | Personal computers/Servers | 800 |
| **Software** | Software | 200 |
| | **Total Capital for 2024** | **2,000** |

**2025**

| Fixed Asset Category | Description | 2025 |
|---|---|---|
| **Building Improvement** | Building improvement | 800 |
| **Furniture & Fixture** | Furniture | 200 |
| **Hardware** | Personal computers/Servers | 800 |
| **Software** | Software | 200 |
| | **Total Capital for 2025** | **2,000** |

**2026**

| Fixed Asset Category | Description | 2026 |
|---|---|---|
| **Building Improvement** | Building improvement | 800 |
| **Furniture & Fixture** | Furniture | 200 |
| **Hardware** | Personal computers/Servers | 800 |
| **Software** | Software | 200 |
| | **Total Capital for 2026** | **2,000** |

## Section 7 – Projection Assumptions for 2024-2026

CNO is considered a leader in delivering on its regulatory mandate. To maintain its leadership position, CNO is required to focus on operational enhancements and progress on its strategic plan. This requires continuous improvement of base operations and investments through projects that contribute to the future well-being of the organization. Several projects and initiatives have been planned that will reach their operational/implementational phase in these years, including realization of many components of Strategic Plan 2021-2024.

Maintaining and improving on operating results across regulatory and support functions, while investing in realizing the Strategic Plan will continue to be a priority. CNO will be prepared to respond to increases in volumes, adding resources where needed. Costs associated with responding to significant volume increases have not been included in the plan.

The projections do not have provisions for the impact of any legislation changes that might emerge between 2024 and 2026.

The projections contain $3.1M, $3.2M, and $3.4M for project expenditures in 2024, 2025, and 2026, respectively.

The projections do not reflect any revenue changes as a result of fee increases.

**Year 2024**

**Revenues:**

- Registration numbers are expected to increase slightly;
- Application income is expected to increase slightly; and
- Interest revenue is expected to decrease with slightly lower amounts invested and lower rates.

**Expenses:**

- General inflation of 4.0%;
- Nurses' Health Program will continue operations;
- Continued implementation of the Strategic Plan 2021-2024 initiatives; and
- Further enhancements to the information and financial systems will be made.

**Accumulated Surplus:**

CNO will incur an annual operating deficit of $13.071M that will result in a net unrestricted asset of $14.857M or 2.29 months of operating costs coverage at the end of the year. This falls below the Finance Committee guideline of a minimum of three months.

**Year 2025**

**Revenues:**

- Overall, growth in registration numbers is expected to remain consistent with historical trends;
- Application income is expected to increase with the Ontario Government's Nursing Transformation initiatives in Ontario colleges boosting nursing applicants; and
- Interest revenue is expected to decrease with slightly lower amounts invested and lower rates.

**Expenses:**

- General inflation of 4.0%;
- Many components of the Strategic Plan 2021-2024 will have been fully operationalized.

**Accumulated Surplus:**
CNO will incur an annual operating deficit of $15.865M that will result in a net unrestricted deficit of $1.178M or -0.17 months operating coverage. This falls below the Finance Committee guideline of a minimum of three months.

**Year 2026**

**Revenues:**

- Overall, growth in registration numbers is expected to remain consistent with historical trends;
- Application income is expected to increase slightly; and
- Interest revenue is expected to decrease with slightly lower amounts invested and lower rates.

**Expenses:**

- General inflation of 4.0%;
- Normal level of investments in operational improvements and new initiatives; and
- Execution of elements of a new strategic plan will commence.

**Accumulated Surplus:**
CNO will incur an annual operating deficit of $18.789M that will result in a net unrestricted deficit of $20.204M or -2.824 month's operating costs. This falls below the Finance Committee guideline of a minimum of three months.

## Section 8 – Financial Position

Schedule 8 identifies the assets, liabilities and net assets (surplus) that CNO has or is projected to have as a result of this budget. It covers 2020 to 2026.

**Assets** are current or long term:

- **Current assets** are cash or assets that can readily be changed to cash in a short period of time.
- **Long term assets** are assets that cannot be turned into cash or expensed within one year, such as long-term investments and fixed assets (building, equipment etc.).

The values of fixed assets on the balance sheet are net of accumulated depreciation. Depreciation is an accounting representation of the reduction in useful life of assets over time through wear or technological change.

**Liabilities** are current or long term.

- **Current liabilities** are the debts owed by CNO for services, supplies, or asset purchases for which a commitment (by contract or receipt) has been made by CNO to pay within one year.
- **Long term liabilities** are the debts owed by CNO for services, supplies, or asset purchases for which a commitment (by contract) has been made by CNO to pay over a period of time greater than one year (e.g., a mortgage). CNO has no long-term debt.

**Net Assets** are the residual of all assets less all liabilities. The result represents the net worth or net book value of CNO, according to the financial records.

- **Invested in Capital Assets** represents the accumulated value of the cost of long-term assets purchased over time (net of accumulated depreciation/amortization) less any long-term debt associated with those assets. CNO's planned capital surplus of $12.214M at the end of 2023 represents funds available to purchase additional capital assets. This surplus is considered to be restricted for the purposes of capital asset replacements.
- **Unrestricted Net Assets** represents the accumulated annual operating surpluses, net of accumulated annual operating deficits and net of the accumulated amount **Invested in Capital Assets**, generated each year since the inception of CNO. An accumulated operating surplus of $28.096M is the result of the 2023 draft budget. These funds are considered to be unrestricted in their use.

Schedule 8

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Statements of Financial Position as at December 31 ($000)**

| | 2020 Actual | 2021 Actual | 2022 Approved Budget | 2022 Forecast | 2023 Draft Budget | 2024 Proj'n | 2025 Proj'n | 2026 Proj'n |
|---|---|---|---|---|---|---|---|---|
| **ASSETS** | | | | | | | | |
| Current Assets: | | | | | | | | |
| Cash | 46,194 | 64,142 | 54,006 | 44,026 | **45,942** | 44,324 | 33,253 | 22,071 |
| Investments | 31,748 | 11,269 | 18,156 | 26,295 | **20,881** | 14,042 | 16,766 | 20,355 |
| Sundry receivables | 499 | 219 | 20 | 20 | **20** | 20 | 20 | 20 |
| Prepaid expenses | 891 | 1,227 | 900 | 900 | **900** | 900 | 900 | 900 |
| | 79,332 | 76,857 | 73,081 | 71,241 | **67,743** | 59,287 | 50,939 | 43,345 |
| Investments | 14,279 | 14,508 | 8,768 | 24,990 | **19,791** | 16,318 | 10,000 | - |
| Capital Assets | 6,915 | 11,675 | 12,889 | 12,850 | **11,960** | 12,026 | 12,128 | 12,324 |
| Intangible Assets | 208 | 201 | 220 | 217 | **255** | 357 | 425 | 465 |
| | 21,402 | 26,385 | 21,877 | 38,057 | **32,005** | 28,700 | 22,553 | 12,789 |
| **Total Assets** | **100,734** | **103,242** | **94,958** | **109,298** | **99,749** | **87,987** | **73,492** | **56,135** |
| **LIABILITIES** | | | | | | | | |
| Current Liabilities: | | | | | | | | |
| Accounts Payable & Accrued Liabilities | 13,821 | 15,557 | 11,030 | 13,000 | **13,260** | 13,525 | 13,796 | 14,072 |
| Deferred Membership Fees | 44,175 | 40,511 | 44,325 | 45,723 | **46,179** | 47,223 | 48,322 | 49,478 |
| | 57,996 | 56,069 | 55,355 | 58,723 | **59,439** | 60,748 | 62,118 | 63,550 |
| **NET ASSETS** | | | | | | | | |
| Invested in Capital Assets | 7,123 | 11,877 | 13,109 | 13,068 | **12,214** | 12,382 | 12,553 | 12,789 |
| Unrestricted | 35,615 | 35,297 | 26,495 | 37,508 | **28,096** | 14,857 | (1,178) | (20,204) |
| | 42,738 | 47,173 | 39,603 | 50,575 | **40,310** | 27,239 | 11,374 | (7,415) |
| **Total Liabilities and Net Assets** | **100,734** | **103,242** | **94,958** | **109,298** | **99,749** | **87,987** | **73,492** | **56,135** |

# Section 9 – Cash Flow

Schedule 9 identifies the activities that generate cash and the use of cash through a year. Annual operating surpluses generate cash while the purchases of capital assets use cash. The schedule covers a period from 2020 to 2026 inclusive.

Schedule 9

**College of Nurses of Ontario**
**Draft Operating and Capital Budget for the Year 2023**
**Statements of Cash Flows ($000)**

| | 2020 Actual | 2021 Actual | 2022 Forecast | 2023 Budget | 2024 Proj'n | 2025 Proj'n | 2026 Proj'n |
|---|---|---|---|---|---|---|---|
| **Cash flows from operating activities** | | | | | | | |
| Excess of expenses over revenues for the period | 8,539 | 4,435 | 3,402 | (10,265) | (13,071) | (15,865) | (18,789) |
| Adjustments to determine net cash provided by (used in) operating activities | | | | | | | |
| Amortization of capital assets | 1,007 | 1,257 | 1,458 | 1,643 | 1,734 | 1,698 | 1,604 |
| Amortization of intangible assets | 134 | 124 | 104 | 83 | 98 | 131 | 160 |
| Loss on disposal of asset | - | 374 | - | - | - | - | - |
| (Increase) decrease net pension expenses over funding | (476) | - | - | - | - | - | - |
| Interest not received during the year capitalized to investments | (557) | (273) | (476) | (682) | (569) | (448) | (355) |
| Interest capitalized on investments | 658 | 719 | 277 | 271 | 215 | 1,042 | 766 |
| | 9,305 | 6,637 | 4,764 | (8,951) | (11,592) | (13,441) | (16,614) |
| **Change in non-cash working capital** | | | | | | | |
| Decrease (increase) in sundry receivables | (477) | 280 | 199 | - | - | - | - |
| (Increase) decrease in prepaid expenses | 135 | (336) | 327 | - | - | - | - |
| Increase (decrease) in accounts payables and accrued liabilities | 464 | 1,737 | (2,557) | 260 | 265 | 271 | 276 |
| Increase (decrease) in deferred membership fees | 900 | (3,664) | 5,212 | 455 | 1,044 | 1,099 | 1,156 |
| | 10,327 | 4,653 | 7,945 | (8,235) | (10,283) | (12,072) | (15,182) |
| **Cash flows from investing activities** | | | | | | | |
| Purchase of investments | (33,289) | (11,225) | (36,300) | (15,000) | (10,000) | (10,000) | (10,000) |
| Proceeds from disposal of investments | 20,534 | 31,029 | 10,992 | 26,024 | 20,665 | 13,000 | 16,000 |
| Purchase of capital assets | (625) | (6,392) | (2,633) | (752) | (1,800) | (1,800) | (1,800) |
| Purchase of intangible assets | - | (117) | (120) | (120) | (200) | (200) | (200) |
| | (13,380) | 13,294 | (28,061) | 10,151 | 8,665 | 1,000 | 4,000 |
| **Net (decrease) increase in cash during year** | (3,053) | 17,948 | (20,116) | 1,916 | (1,618) | (11,072) | (11,182) |
| **Cash, beginning of the period** | 49,247 | 46,194 | 64,142 | 44,026 | 45,942 | 44,324 | 33,253 |
| **Cash, end of the period** | 46,194 | 64,142 | 44,026 | 45,942 | 44,324 | 33,253 | 22,071 |

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**Agenda Item 7.2**

# Discussion Note – December 2022 Council

# By-Law amendments to support effective statutory committee functioning

## Contact for Questions or More Information

Kevin McCarthy, Director, Strategy

## Background

The Executive has discussed a proposal to amend the by-laws related to statutory committees to provide all these committees with the flexibility needed to increase their membership when workloads increase by removing membership maximums set out in by-law. Currently, the Discipline and Fitness to Practise committees have this flexibility but the Inquiries, Complaints and Reports (ICRC), Quality Assurance and Registration committees do not.

In reviewing the by-laws, two clean-up provisions were identified where the specifics regarding ICRC needed to be revised:

- Updating the minimum number of public members on ICRC to reflect the current number of public Council members available to serve on this committee and
- Removing the quorum provision for ICRC.

In March 2020, Council approved in principle the merging of the membership of the Discipline and Fitness to Practise committees. Following that decision, by-law amendments were brought to Council in September 2020[1] for approval. Those by-laws combined the membership of those committees and removed the maximum number of members.

The proposal is to take a similar approach to changes to by-laws related to the ICRC, Quality Assurance and Registration committee's. This discussion note will support Council's input into the proposal. Final draft by-laws will come to Council for approval in March 2023.

CNO has consulted with legal counsel on the draft proposed revisions (see attached table).

[1] The by-law amendments were scheduled to come to Council in June but a change in government led to public member vacancies and Council was not constituted. Executive cannot approve a by-law change, so the decision was made by Council in September.

## Why are changes being proposed now?

ICRC has experienced an increase in both volume and complexity of matters, resulting in a corresponding increase in the workloads of ICRC members. Members have been called in to serve on additional ad hoc panels and agendas have been lengthy.

As of October 2021, additional ICRC meetings were scheduled each month for panels to deliver cautions. The data below reflects the increasing workload and number of ICRC panel meetings.

| | 2020 | 2021 | 2022 (up to Q3) |
|---|---|---|---|
| **ICRC Meetings** | 63 | 80 | 78 |
| **ICRC Dispositions** | 1758 | 2195 | 1796 |

An option being considered to address the workload is the establishment of an additional ICRC panel. Given the current Council structure and the committee commitments of Council members, the only way to have sufficient members for an additional panel is to increase the number of appointed nurse committee members. The current maximums set out in by-law for the ICRC have become a barrier to effective committee functioning.

## Removing the maximum number of members

Similar to the revisions made to Discipline and Fitness to Practise in September 2020, staff are recommending removing the maximum membership for ICRC, Quality Assurance and Registration committees in by-law, allowing for flexibility to address future workload changes. Those changes are show in Attachment 1.

## Updating the minimum number of public members on ICRC

The current by-law sets the minimum number of public members on ICRC at six. This does not reflect the current reality. There are five public members on ICRC. All other public members serve on Discipline and are not able to also serve on ICRC.

Updating the minimum number of public members in by-law will not change the number of public members serving on ICRC. Nor will it prevent adding more public members to ICRC, should more public members be appointed in the future. It will align the by-law with the current reality.

## Removing ICRC quorum provisions

The by-law related to ICRC sets 3 members as the quorum for a meeting of the full committee and a panel of the committee. It is recommended that these provisions be removed for two reasons:

- The overall quorum provisions for all committees set in by-law is a majority of members. The specific quorum of three members for ICRC is not aligned. ICRC currently has 19 members and a majority would be 10. Rules of order also identify a majority as a quorum.

- The quorum for a panel of ICRC is set out in ss 25(3) of the *Health Professions Procedural Code.* Legal counsel has identified it as unnecessary for CNO to include panel quorum provisions in by-law when they are addressed in legislation.

Removal of Article 18.02 is congruent with Council's decision in June of 2022 to remove quorum provisions from the by-laws for the Nominating Committee.

## What impact will these changes have?

Attachment 1 shows all of the proposed changes to the by-laws.

If the by-law amendments are approved in March:

- All the articles setting out statutory committee membership composition will be aligned, with only minimum membership set out in by-law. This will provide all statutory committees with the agility to adapt committee membership to meet changing workload demands
- If it is determined an additional ICRC panel is required for the coming year, Council will be able to appoint committee members to meet the need
- There will be no change to the public membership of ICRC – it will be aligned with the by-law
- A quorum of ICRC will be a majority of members.

No changes are currently being contemplated to the membership structure of the Quality Assurance or Registration committees.

## Next Steps

Pending Council's input, the attached by-laws will be brought forward for Council decision in March 2023.

If an additional ICRC panel is required, additional non-Council members will be recommended to Council for appointment in March 2023.

## Attachment:

1. Table of by-law amendments

## Attachment 1 – Proposed by-law amendments and rationale

| Current by-law | Proposed revision | Rationale |
|---|---|---|
| For all articles below it is proposed that the maximums be deleted for all categories of membership. This will give all statutory committees the flexibility to adjust membership to meet changing workloads. Rationale is provided in Column 3 for other changes.<br><br>All changes below have been reviewed by legal counsel. | | |
| **17. Registration Committee**<br><br>**17.01** The Registration Committee shall be composed of<br><br>i) not fewer than one or more than three elected councillors each of whom was elected as an RN;<br><br>ii) not fewer than one or more than two elected councillors each of whom was elected as an RPN;<br><br>iii) not fewer than three or more than five public councillors;<br><br>iv) not fewer than one or more than three RNs who are appointed committee members; and<br><br>v) not fewer than one or more than two RPNs who are appointed committee members. | **17. Registration Committee**<br><br>**17.01** The Registration Committee shall be composed of<br><br>i) not fewer than one ~~or more than three~~ elected councillor**(**s**)** each of whom was elected as an RN;<br><br>ii) not fewer than one ~~or more than two~~ elected councillor**(**s**)** each of whom was elected as an RPN;<br><br>iii) not fewer than three ~~or more than five~~ public councillors;<br><br>iv) not fewer than one ~~or more than three~~ RNs who are appointed committee members; and<br><br>v) not fewer than one ~~or more than two~~ RPNs who are appointed committee members. | Legal counsel confirmed **(**s**)** is consistent with other articles in CNO's by-laws. This editorial change is made throughout the proposed revision. |
| **18. Inquiries, Complaints and Reports Committee**<br><br>**18.01** The Inquiries, Complaints and Reports Committee shall include all of the | **18. Inquiries, Complaints and Reports Committee**<br><br>18.01 The Inquiries, Complaints and Reports Committee shall include all of the | |

| Current by-law | Proposed revision | Rationale |
|---|---|---|
| members of the Executive Committee and shall be composed of<br><br>i) not fewer than six or more than ten public councillors;<br><br>ii) not fewer than three or more than four elected councillors each of whom was elected as an RN;<br><br>iii) not fewer than one or more than two elected councillors each of whom was elected as an RPN;<br><br>iv) not fewer than three or more than six RNs who are appointed committee members; and<br><br>v) not fewer than two or more than three RPNs who are appointed committee members. | members of the Executive Committee and shall be composed of<br><br>~~i) not fewer than six or more than ten public councillors;~~<br><br>i) not fewer than three ~~or more than four~~ elected councillors each of whom was elected as an RN;<br><br>ii) not fewer than one ~~or more than two~~ elected councillor**(**s**)** each of whom was elected as an RPN;<br><br>iii) not fewer than ~~six~~ **five** ~~or more than ten~~ public councillors;<br><br>iv) not fewer than three ~~or more than six~~ RNs who are appointed committee members; and<br><br>v) not fewer than two ~~or more than three~~ RPNs who are appointed committee members. | Moved to iii below<br>i) to iii) are renumbered to align the order of Council membership with the other articles setting out statutory committee membership<br><br>Updated to reflect the current structure given availability of public members to serve on ICRC. There will be no change to public members on ICRC if this amendment is approved. |
| **18.02** Unless otherwise provided by the Code, three committee members constitute a quorum of the Inquiries, Complaints and Reports Committee or a quorum of a panel of that committee. | ~~**18.02** Unless otherwise provided by the Code, three committee members constitute a quorum of the Inquiries, Complaints and Reports Committee or a quorum of a panel of that committee.~~ | **Unnecessary:**<br>Article 5 establishes quorum for committees<br><br>ss 25(3) of the *Health Professions Procedural Code* establishes 3 members as a quorum for an ICRC panel.<br><br>**Inconsistent with:** |

| Current by-law | Proposed revision | Rationale |
|---|---|---|
| | | Article 5 which establishes “a majority of members” as a quorum for a committee. There are currently 18 members on ICRC. A quorum under Article 5 would be 10 members and under this by-law it would be three.<br><br>Legal counsel has identified it as inappropriate to include a panel quorum in by-law when one exists in legislation. |
| **21. Quality Assurance Committee**<br><br>**21.01** The Quality Assurance Committee shall be composed of<br><br>i) not fewer than two or more than three elected councillors each of whom was elected as an RN;<br><br>ii) not fewer than one and more than two elected councillors each of whom was elected as an RPN;<br><br>iii) not fewer than three and more than five public councillors;<br><br>iv) not fewer than one or more than three RNs who are appointed committee members; and<br><br>v) not fewer than one or more than two RPNs who are appointed committee members. | **21. Quality Assurance Committee**<br><br>**21.01** The Quality Assurance Committee shall be composed of<br><br>i) not fewer than two ~~or more than three~~ elected councillors each of whom was elected as an RN;<br><br>ii) not fewer than one ~~and more than two~~ elected councillor**(**s**)** each of whom was elected as an RPN;<br><br>iii) not fewer than three ~~and more than five~~ public councillors;<br><br>iv) not fewer than one ~~or more than three~~ RNs who are appointed committee members; and<br><br>v) not fewer than one ~~or more than two~~ RPNs who are appointed committee members. | |

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**Agenda Item 4.4**

# Decision Note – December 2022 Council

# Dates of Council meetings

## Contacts for Questions or More Information

Silvie Crawford, Executive Director and CEO

## Decision for consideration re. recommendation of the Executive Committee

That Council approve the following meeting dates for 2023:

- Wednesday and Thursday, September 27 and 28, 2023
- Wednesday and Thursday, December 6 and 7, 2023

## Background

In accordance with Article 7.02 of By-*Law No. 1: General*, Council meetings take place on dates set by Council. To support efficiency, the Executive recommends the dates of meetings to Council.

In September, Council approved the following dates:

- Wednesday and Thursday March 8 and 9, 2023 and
- Wednesday and Thursday, June 7 and 8, 2023.

Decision regarding the dates for September and December 2023 had been deferred pending clarification of external stakeholder activities. The recommended dates do not pose any conflicts with events that would require senior staff or Council participation.

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For Information

# Information Note – December 2022 Council

# Revised Entry Level Competencies for Nurse Practitioners

## Contacts for More Information:

Anne Marie Shin, Director, Professional Practice
Katie Dilworth, Manager, Education Program

## Current Status:

CNO uses the national Entry Level Competencies for Nurse Practitioners (2018) in a number of CNO processes (Program Approval, Quality Assurance, Entry to Practice Requirements, Practice Standards and Professional conduct matters). These competencies were developed by the Canadian Council of Registered Nurse Regulators (CCRNR) in 2015.

## Background:

- Entry level competencies establish the foundation for nursing practice. The NP competencies encompass and build on the registered nurse competencies and serve as the criteria against which entry-level NPs are measured upon initial registration with CNO and entry-to-practice in Ontario. The competencies also guide the assessment of members' continuing competence for maintaining registration with CNO.

- In 2020, the CCRNR Board agreed "to implement the recommendations endorsed by CCRNR regarding a framework for Nurse Practitioner Regulation in Canada.

- A key priority was to update the 2018 NP entry-level competencies to drive NP entry-level education, reflect evolving NP practice, and ensure inter-jurisdictional consistency. Consistency between jurisdictions supports the workforce mobility requirements of the Canadian Free Trade Agreement.

- The Education Subcommittee was established in January 2021 to revise the ELCs. The subcommittee comprised four Steering Committee members, an NP educator, a competency consultant, and the project manager. CNO was represented on this subcommittee.

- Revisions to the national NP competencies were informed by an environmental scan, literature reviews, focus groups, subject matter expert interviews and stakeholder consultation.

- The regulatory body in each jurisdiction validated the entry level competencies and confirmed they are consistent with provincial/territorial legislation.

- The competencies will be incorporated into various College processes (e.g., evaluation of NP curricula as part of program approval, applicant assessments).

**Next Steps:**

- Communication has occurred with our academic partners regarding CCRNRs endorsement of the NP ELCs.

- The revised competencies will be shared with the academic community and other stakeholders after December Council. A transition period will be needed to update curricula and we will be consulting with Stakeholders to determine the time required in the system. The competency document shared will have a clear identification on the document stating that the implementation date of the competencies is yet to be determined.

- In early 2023, multiple workshops and various communication strategies will be used to collaborate with our academic partners regarding implementation of the revised NP ELCs.

**Attachments:**

1. Backgrounder detailing the changes since the 2018 NP ELCs.
2. Final Draft NP Entry Level Competencies approved by CCRNR November 7th, 2022

**Attachment 2:**

**NP ELC Competencies Revision Summary:**

The objective of this attachment is to provide an overall summary of the key changes that were made to the NP ELC competencies since 2018.

The major changes are listed below:

| Assessment | Actions Implemented | Proposed NP ELC Competencies |
|---|---|---|
| The structure of the 2018 NP competencies did not reflect the evolving role and practice of the NP. | The ELCs were organized into roles-based framework and three-tiered structure (Figure 1) that includes a role statement, competencies, and associated performance indicators. The competency framework is in keeping with industry standards for competencies. | The revised ELC competency framework includes 5 roles with 29 competencies and 159 performance indicators.<br>• Clinician<br>• Leader<br>• Advocate<br>• Educator<br>• Scholar<br>See Figure 2 for diagram of roles-based competency framework and how they build on the RN competencies. |
| Evolving healthcare system and environment not reflected in the 2018 NP competencies. | New competencies added that reflect changes in the healthcare system. | <u>Clinician Role</u><br>• Addition of counselling competencies within the to address growing mental health needs of the population.<br>• Addition of virtual care and self-employment expectations.<br><u>Leader Role</u><br>• Enhanced role statement to reflect autonomous role on the NP within the healthcare system. |

| Assessment | Actions Implemented | Proposed NP ELC Competencies |
|---|---|---|
| | | • Introduces health promotion and disease prevention expectations.<br>• Incorporates quality improvement competencies with enhanced safety expectations.<br><u>Advocate Role</u><br>• Competency specific to care of Indigenous Peoples.<br>• Competencies related to equity, diversity and inclusion across all groups that experience racism.<br><u>Educator Role</u><br>• Competencies go beyond person-specific education to include education of groups, communities, and populations.<br><u>Scholar Role</u><br>• Changed role title from researcher to scholar to reflect broader scope.<br>• Competencies focus on participation and leadership in scholarly activities.<br>• Competencies include knowledge translation expectations. |
| Some of the 2018 NP competencies duplicate RN competencies and were not reflective of the NPs autonomous and independent practice. | Comprehensive review of all consultation finding inputs (focus groups, regulatory body input, national NP organizations, jurisdiction specific stakeholders, subject matter experts, NP ELC competency validation survey) | Competencies are sequenced in their most appropriate role and redundancies removed. Action verbs reflect autonomous NP practice. |

| Assessment | Actions Implemented | Proposed NP ELC Competencies |
|---|---|---|
| The preamble (introduction and background) for the NP ELC document was not reflective of the new revisions. | Content was revised to align with the format of the RN ELC preamble and address areas including:<br>• Overarching principles<br>• Structure<br>• Purpose<br>• Expectations | New content reflects the revisions in the competencies, provides better direction for the purpose and expectations of the document, and promotes consistency among jurisdictions. |

**Figure 1: Nurse Practitioner ELC Three-Tiered Structure**

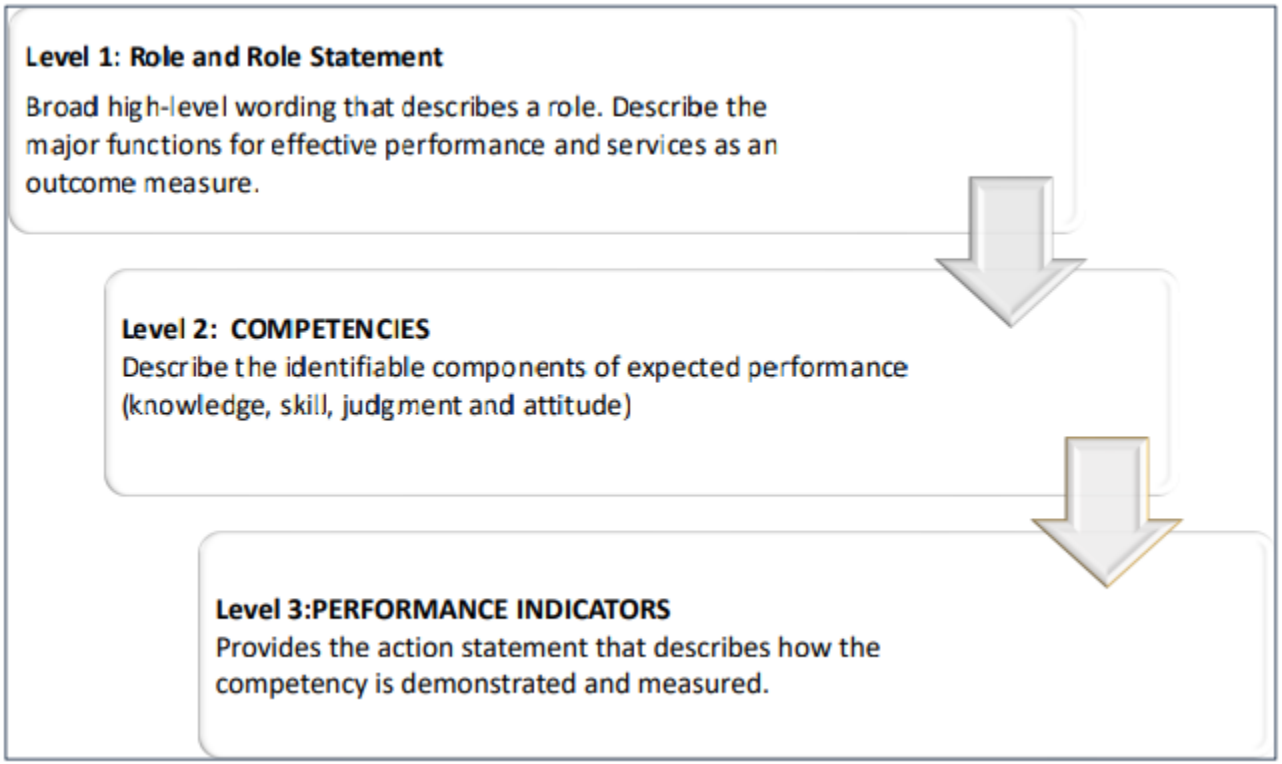
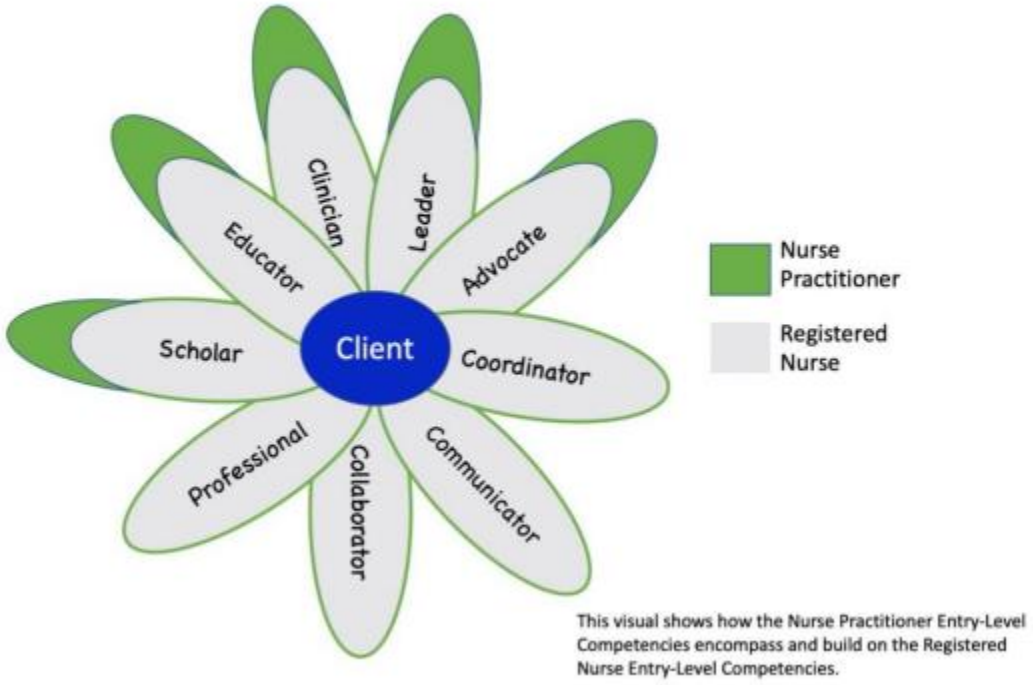


**Figure 2: Nurse Practitioner Role-based Competency Framework**




# Nurse Practitioner

# Entry-Level Competencies

## *FINAL DRAFT*

## Endorsed by the CCRNR Board on

## November 7, 2022

## For Review, Approval, and Implementation by CCRNR Member Organizations

**Ontario implementation date to be determined.**
**These ELCs are not in effect.**

# Entry-Level Competencies

## for Nurse Practitioners

**Table of Contents** **Page**

**Introduction**

The Entry-Level Competencies (ELCs) for Nurse Practitioners reflect the foundational knowledge, skills, and judgement required of Nurse Practitioners to provide safe, competent, ethical, and compassionate care. While Nurse Practitioners' roles and responsibilities may vary by context and client population, this document outlines the competencies that all Nurse Practitioners must possess to be competent when they begin practice.

**Profile of the Entry-Level Nurse Practitioner**

Nurse Practitioners are Registered Nurses with additional experience and nursing education at the Masters level, which enables them to autonomously diagnose and manage care across the life span in all practice settings. As advanced practice nurses, they use their in-depth knowledge and experience to analyze, synthesize and apply evidence to make decisions. They apply theory and knowledge from nursing and other disciplines to provide a comprehensive range of essential services grounded in professional, ethical, and legal standards within a holistic model of care. Nurse Practitioners work across all domains of practice. They provide leadership and collaborate within and across communities, organizations, and populations to improve health and system outcomes. In some settings, Nurse Practitioners assume the role as the most responsible provider.

**Background**

The Canadian Council of Registered Nurse Regulators (CCRNR) first published ELCs for Nurse Practitioners in Canada in 2016. In 2020, CCRNR initiated a process to update the ELCs, which are revised periodically to reflect evolving population needs, health system, and Nurse Practitioner practice. The current revisions were informed by an environmental scan, literature reviews, and stakeholder consultation, and also reflect inter-jurisdictional consistency to support workforce mobility requirements of the Canadian Free Trade Agreement.

**Purpose of the Entry-Level Competencies for Nurse Practitioners**

Nurse Practitioner ELCs reflect the knowledge, skills, and judgement required of Nurse Practitioners to practice safely and ethically. They are used by regulatory bodies for a number of purposes, including but not limited to:

- Academic program approval/recognition
- Assessment of internationally educated applicants
- Assessment of applicants for the purpose of re-entry into the profession
- Practice advice/guidance to clinicians
- Reference for professional conduct matters
- Public and employer awareness of the practice expectations of Nurse Practitioners

**ELCs and Entry-Level Nurse Practitioner Practice**

Nurse Practitioner practice is dynamic and evolving. The Nurse Practitioner ELCs encompass and build on the competencies of a Registered Nurse and establish the foundation for Nurse Practitioner practice. While the ELCs

define entry-level Nurse Practitioner practice, all Nurse Practitioners are ultimately accountable for meeting them throughout their careers.

A nurse practitioner is considered "entry-level" on initial registration or licensure. Their practice draws on a theoretical and experiential knowledge base shaped by their RN practice and their NP education program.

**Principles and Assumptions for Entry-Level Nurse Practitioner Practice**

The following overarching principles and assumptions inform how the ELCs influence the education and practice of entry-level Nurse Practitioners. The entry-level Nurse Practitioner:

- has a strong foundation in nursing theory, and knowledge of health and sciences, humanities, research, and ethics from formal graduate level programs
- practices autonomously within legislation, practice standards, ethics, and scope of practice in their jurisdiction
- works within their scope of practice, and seeks guidance when they encounter situations beyond their individual competence
- is prepared to practice safely, competently, compassionately, and ethically:
    - with all people across the lifespan,
    - with all clients - individuals, families, groups, communities, and populations,
    - in all practice settings, and
    - across all domains of practice
- uses evidence and applies critical thinking throughout all aspects of practice

**Structure**

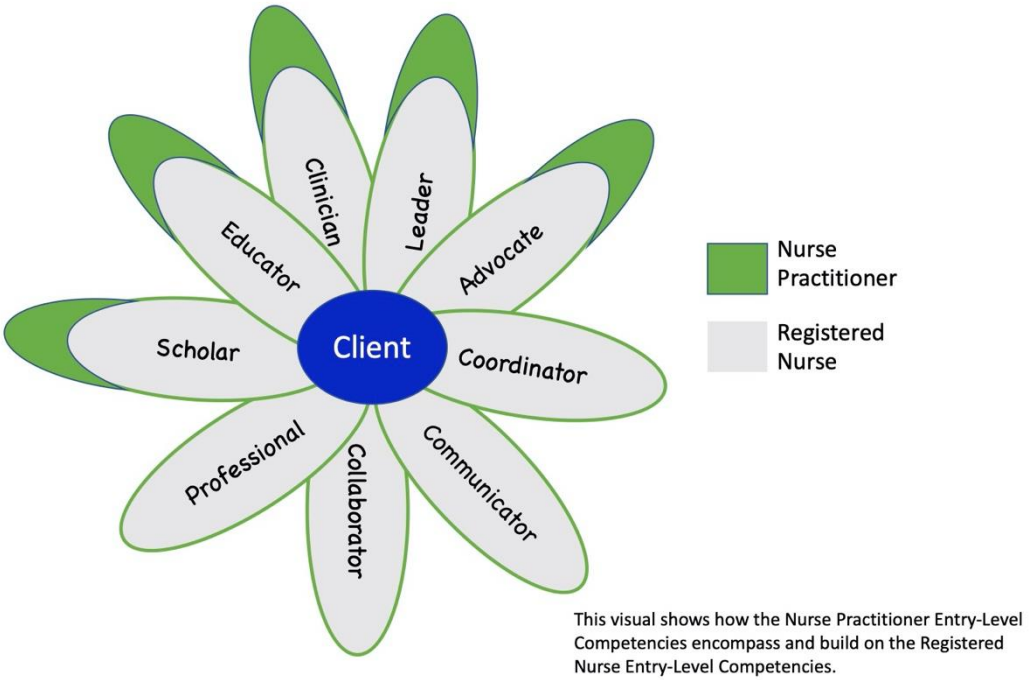
The revised ELCs were developed using a role-based framework that represents the multiple roles Nurse Practitioners assume when providing services in any practice setting. They are an interconnected set of competencies and indicators. For the sake of clarity and to avoid unnecessary repetition, key concepts are mentioned once and assumed to apply to all roles. While each role is presented separately, it is important to note that Nurse Practitioners may use aspects of more than one role at the same time.

The document is organized thematically in a role-based format, similar to the Registered Nurse Entry-level Competencies. The Nurse Practitioner Entry-Level Competencies encompass and build on the Registered Nurse Entry-Level Competencies, focusing on distinct entry-level competencies for Nurse Practitioners. The competencies are accompanied by performance indicators.

There are a total of 29 competencies grouped thematically under five roles:

1. Clinician
2. Leader
3. Advocate
4. Educator
5. Scholar

**Nurse Practitioner Role-based Competency Framework**




This visual shows how the Nurse Practitioner Entry-Level Competencies encompass and build on the Registered Nurse Entry-Level Competencies.

## 1.0 CLINICIAN

Nurse Practitioners deliver safe, competent, compassionate, and ethical care across the lifespan with diverse populations and in a range of practice settings. Nurse Practitioners ground their care in evidence-informed practice and use critical inquiry in their advanced diagnostic and clinical reasoning.

# Assessment

**1.1 Establish the reasons for the client[1] encounter to determine the nature of the services required by the client**

a. Perform initial observational assessment of the client's condition
b. Ask pertinent questions to establish the presenting issues
c. Evaluate information relevant to the client's presenting concerns
d. Prioritize routine, urgent, emergent, and life-threatening situations

**1.2 Obtain informed consent according to legislation and regulatory requirements**

a. Co-create with client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities
b. Support client to make informed decisions, discussing risks, benefits, alternatives, and consequences
c. Obtain informed consent for the collection, use, and disclosure of personal and health information

**1.3 Use critical inquiry to analyze and synthesize information from multiple sources to identify client needs and inform assessment and diagnosis**

a. Establish a shared understanding of client's culture, strengths, and limitations
b. Integrate information specific to the client's biopsychosocial, behavioural, cultural, ethnic, and spiritual circumstances; current developmental life stage; gender expression; and social determinants of health, considering epidemiology and population-level characteristics
c. Integrate findings from past and current health history and investigations
d. Apply current, credible and reliable research, literature, and standards to inform decision-making
e. Collect pharmacological history, including over-the-counter products, and complementary and alternative medicine, natural health products, and traditional medicine
f. Support client's wishes and directions related to advance care planning, and palliative and end-of-life care

**1.4 Conduct an assessment that is relevant to the client's presentation to inform diagnostic decisions**

a. Determine the need for conducting a focused or comprehensive assessment
b. Conduct an assessment using valid and reliable techniques and tools
c. Conduct assessment with sensitivity to client's culture, lived experiences, gender identity, sexuality, and personal expression
d. Conduct a mental-health assessment, applying knowledge of emotional, psychological, and social measures of well-being
e. Conduct a review of systems to identify pertinent presenting findings

[1] Key terms are highlighted in blue text and described at the end of the document.

f. Order and perform screening and diagnostic investigations including point-of-care tests, applying principles of resource stewardship

## Diagnosis

**1.5 Integrate critical inquiry and diagnostic reasoning to formulate differential diagnoses and final diagnoses**

a. Interpret the results of investigations
b. Generate differential diagnoses based on data analysis
c. Create a shared understanding of assessment findings, diagnoses, anticipated outcomes, and prognosis
d. Determine the leading diagnosis based on clinical and diagnostic reasoning

## Management

**1.6 Use clinical reasoning to create a shared management plan based on diagnoses and the client's preferences and goals**

a. Examine, and explore with the client, options for managing the diagnoses
b. Consider availability, cost, determinants of health, clinical efficacy, and potential client adherence to determine feasibility and sustainability of the management plan
c. Determine and prioritize interventions integrating client goals and preferences, resources, and clinical urgency
d. Provide and seek consultation from other professionals and organizations to support client management
e. Use technology to deliver health care services after considering the appropriateness of virtual care services, environmental factors, the nature of the service, the security of the system, alternative approaches, and contingency plans
f. Use electronic health records and tracking systems to accurately collect and document client information and delivery of health services

**1.7 Prescribe and counsel clients on pharmacological and non-pharmacological interventions, across the life span**

a. Follow legislative, regulatory, and organization requirements, when prescribing pharmacological and non-pharmacological interventions
b. Select evidence-informed pharmacological interventions based on diagnoses, concurrent client therapies, and available medication history, using drug-information systems
c. Utilize prescription monitoring and reporting programs according to jurisdictional and legislative requirements
d. Complete medication reconciliation to make clinical decisions based on an analysis of the client's current pharmacological and non-pharmacological therapy
e. Analyze polypharmacy to identify unnecessary and unsafe prescribing, and deprescribe where possible
f. Recommend or order non-pharmacological interventions and complimentary, alternative, and natural health products based on client preference, history, and cultural practice
g. Incorporate principles of pharmacological stewardship
h. Establish a monitoring plan for pharmacological and non-pharmacological interventions
i. Counsel client on pharmacological and non-pharmacological interventions, including indication, benefits, cost, potential adverse effects, interactions, contraindications, precautions, reasons to adhere to the prescribed regimen, required monitoring, and follow up

**1.8 Perform invasive and non-invasive interventions as indicated by the management plan**

a. Co-create with the client an understanding of procedures, including indications, potential risks and benefits, adverse effects, anticipated aftercare, and follow-up care
b. Perform procedures using evidence-informed techniques
c. Monitor and evaluate clinical findings, aftercare, and follow-up
d. Initiate interventions to stabilize the client in urgent, emergent, and life-threatening situations

**1.9 Evaluate effectiveness of the management plan to identify required modifications and/or terminations of treatment**

a. Develop a systematic and timely process for monitoring client progress, and follow-up on results and interventions
b. Evaluate responses to the management plan in collaboration with the client, and revise management plan as needed
c. Discuss and implement follow-up to facilitate continuity of care in collaboration with the client
d. Facilitate implementation of the management plan with the client, family, other health professionals, and community partners
e. Facilitate referral to another practitioner or service if the client would benefit from the consultation or if the client-care needs are beyond the NP's individual competence or scope of practice

## Counselling

**1.10 Co-create a therapeutic counselling relationship that is conducive to optimal health outcomes**

a. Co-create with client a shared understanding of scope of services, expectations, client's strengths and limitations, and priorities
b. Identify barriers that interfere with client's goals
c. Utilize developmentally, socio-demographically, and culturally relevant communication techniques and tools
d. Evaluate effectiveness of counselling relationship and refer to appropriate professionals, when needed

**1.11 Provide counselling interventions as indicated by the management plan**

a. Integrate theories of cognitive and emotional development across the lifespan
b. Identify impact of potential and real biases on the creation of safe spaces
c. Integrate therapeutic use of self to facilitate an optimal experience and outcome for the client
d. Anticipate and respond to the expression of intense emotions in a manner that facilitates a safe and effective resolution
e. Consider the impact of client's personal and contextual factors
f. Provide trauma- and violence-informed care
g. Identify root causes of trauma, including intergenerational trauma, with the client and refer to appropriate professionals
h. Manage transference and countertransference in therapeutic relationships

**1.12 Apply harm-reduction strategies and evidence-informed practice to support clients with substance use disorder, while adhering to federal and provincial/territorial legislation and regulation**

a. Identify potential risks and signs of substance use disorder
b. Co-create a harm-reduction management plan, considering treatment and intervention options
c. Apply evidence-informed and safe prescribing practices when initiating and managing pharmacological and non-pharmacological interventions

d. Adhere to legislation, regulation, and organizational policy related to the safe storage and handling of controlled drugs and substances
e. Provide education on the safe storage and handling of controlled drugs and substances

## Transition of Care, Discharge Planning, Documentation

**1.13 Lead admission, transition of care, and discharge planning that ensures continuity and safety of client care**

a. Collaborate with client to facilitate access to required resources, drug therapy, diagnostic tests, procedures, and follow-up to support the continuum of care
b. Facilitate transfer of information to support continuity of care
c. Facilitate client's access to community services and other system resources
d. Monitor and modify the management plan based on the client's transition needs

**1.14 Conduct record keeping activities, according to legislation and jurisdictional regulatory requirements**

a. Document all client encounters and rationale for actions to facilitate continuity of care
b. Collect, disclose, use, and destroy health information according to privacy and confidentiality legislation, regulations, and jurisdictional regulatory standards
c. Apply relevant security measures to records and documentation

**1.15 Provide safe, ethical, and competent services as a self-employed practitioner**

a. Engage in ethical practices that adhere to jurisdictional and federal legislation, regulations, guidelines, and ethical standards for nursing
b. Employ accurate, honest, and ethical billing and advertising practices
c. Act as a health information custodian to ensure client information is secure and remains confidential
d. Identify and manage potential and real conflicts of interest, always acting in the client's best interest

**1.16 Employ evidence-informed virtual care strategies**

a. Articulate the risks and benefits of virtual care to confirm the client's informed consent to participate in a virtual care visit
b. Maintain client's privacy during virtual encounters, and when transferring data and providing medical documents electronically
c. Determine when the client's health concern can be managed virtually without delaying or fragmenting care
d. Understand the limitations of virtual care when determining the need for in-person assessment and management
e. Adapt history-taking and assessment techniques to effectively complete the virtual client assessment
f. Use effective communication approaches in the virtual care environment
g. Integrate health care technologies and communication platforms to deliver virtual care
h. Adhere to requirements for communication and documentation for virtual client encounters

## 2.0 Leader

Nurse Practitioners demonstrate collaborative leadership within the health care system locally, regionally, nationally, and globally. They are leaders in the development, implementation, and delivery of continuity-based, person-centred care. Nurse Practitioners serve as role models and mentors, demonstrating leadership to advance continuous improvement of client outcomes and health systems. They contribute to implementing and maintaining a high-quality health care system through innovation and policy development. They strive for a culture of excellence and facilitate the development of effective teams and communication within complex health systems.

**2.1 Demonstrate leadership that contributes to high quality health care system**

a. Build partnerships with inter- and intra-professional and intersectoral teams, individuals, communities, and organizations to achieve common goals and shared vision
b. Demonstrate situational awareness when conducting a critical analysis of individual, team, and organizational functioning
c. Engage in, and encourage others in demonstrating transparent communications to support a culture of trust
d. Use principles of team dynamics and conflict resolution to support effective collaboration
e. Support, direct, educate, and mentor colleagues, students, and others to build capacity, competence, and confidence
f. Share expertise within and across teams
g. Demonstrate environmental, financial, and resource stewardship to promote a sustainable health system

**2.2 Contribute to a culture of improvement, safety, and excellence**

a. Engage in environmental scanning to identify future needs of the client and/or health care system
b. Participate in, and lead, quality and risk management initiatives to identify system issues and improve delivery of services
c. Use established benchmarking and best practices to establish goals to facilitate system changes
d. Develop, modify, and implement quality management tools and strategies to collect and track quality improvement data
e. Recommend changes to enhance outcomes based on continuous quality improvement principles
f. Communicate quality improvement outcome data and recommendations to advance knowledge, change practice, and enhance effectiveness of services
g. Anticipate and respond to unfamiliar, complex, and unpredictable situations
h. Advocate for policies for safe and healthy practice environments

**2.3 Design, implement, and evaluate health promotion and disease prevention programs**

a. Engage in environmental scanning to anticipate global, public, and population health trends
b. Propose health promotion and disease prevention programs based on trends, data, literature, identified client needs, and research
c. Apply informatics when using data, information, and knowledge to engage in health surveillance activities
d. Lead implementation of evidence-informed strategies for health promotion, and primary, secondary, and tertiary disease prevention programs
e. Promote awareness of social determinants of health and important health issues
f. Facilitate use of relevant public health resources
g. Develop and implement disaster- and pandemic-planning protocols and policies
h. Evaluate program and strategies and recommend modifications based on evidence-informed rationale

## 3.0 Advocate

Nurse Practitioners influence and improve the health and well-being of their clients, communities, and the broader populations they serve. They address issues related to health inequity, culture, diversity, and inclusion to improve health outcomes and lead advocacy efforts to change policies and legislation.

**3.1 Practice self-awareness to minimize personal bias based on social position and power**

a. Demonstrate cultural humility and examine own assumptions, beliefs, and privileges and challenge biases, stereotypes, and prejudice
b. Address the effects of the unequal distribution of power and resources on the delivery of services
c. Demonstrate respect, open, and effective dialogue, and mutual decision-making
d. Evaluate and seek feedback on own behaviour

**3.2 Contribute to a practice environment that is diverse, equitable, inclusive, and culturally safe**

a. Recognize that everyone has their own unique experiences of discrimination and oppression
b. Demonstrate awareness of, and sensitivity to, client's culture, lived experiences, gender identity, sexuality, and personal expression
c. Address situations when observing others behaving in a racist or discriminatory manner
d. Integrate the client's understanding of health, well-being, and healing into the plan of care
e. Involve the persons or communities that are important to the client
f. Collaborate with local partners and communities, including interpreters and leaders
g. Engage in critical dialogue with other stakeholders to create positive change

**3.3 Provide culturally safe, anti-racist care for Indigenous Peoples**

a. Identify the historical and ongoing effects of colonialism and settlement on the health care experiences of Indigenous Peoples
b. Acknowledge, analyze, and understand the ongoing negative and disproportionate effects of systemic and historical oppression on Indigenous Peoples
c. Recognize that Indigenous languages, histories, heritage, cultural and healing practices, and ways of knowing, may differ between Indigenous communities
d. Demonstrate cultural humility and examine own values, assumptions, beliefs, and privileges that may impact the therapeutic relationship with Indigenous Peoples
e. Utilize the principles of self-determination and support the Indigenous client in making decisions that affect how they want to live their life
f. Acknowledge the Indigenous person's cultural identity, seek to understand their lived experience, and provide time and space needed for discussing needs and goals
g. Identify, integrate, and facilitate the involvement of cultural resources, families, and others such as, community elders, traditional knowledge keepers, cultural navigators, and interpreters, when needed and/or requested
h. Evaluate and seek feedback on own behaviour towards Indigenous Peoples

**3.4 Promote equitable care and service delivery**

a. Navigate systemic barriers to enable access to resources
b. Challenge biases and social structures related to systemic oppression
c. Respond to the social, structural, political, and ecological determinants of health, well-being, and opportunities

d. Address situations and systems of inequity and oppression within own sphere of influence
e. Address impact of unequal distribution of power and resources on the delivery of services

**3.5 Advocate for access to resources and for system changes that demonstrates cultural safety and humility**

a. Support the development of resources and education that address anti-racism and oppression
b. Advocate for environments and policies that support equitable access to care
c. Raise awareness of limitations and bias in information and systems
d. Raise clients' awareness of their right to access quality care

**3.6 Support the development of policies and legislation to improve health**

a. Understand the interdependence of policy and practice
b. Recommend evidenced-informed strategies that influence policy changes
c. Evaluate the impact of policies and legislation on health and health equity
d. Communicate information from multiple sources in a logical and comprehensive, yet concise manner
e. Contribute to the development of policies and legislation

## 4.0 Educator

Nurse Practitioners develop and provide education to a wide range of individuals, groups, communities, and organizations to enhance knowledge and influence nursing practice, health outcomes, and system change.

**4.1 Develop and provide education to build capacity and enhance knowledge and skills**

a. Apply teaching and learning theories to develop, modify, deliver, implement, and evaluate education materials and programs
b. Design evidence-informed educational material and program content
c. Integrate technology to enhance learning experiences and information delivery
d. Mentor others to develop skills to deliver education

**4.2 Evaluate the learning and delivery methods to improve outcomes**

a. Develop and use evaluation instruments to evaluate knowledge acquisition
b. Analyze and synthesize evaluation data to inform modifications to the education content and delivery approach
c. Coach others in evaluating and improving education materials and outcomes

## 5.0 Scholar

Nurse Practitioners seek out, participate in, and demonstrate leadership in research activities to evaluate, explore, and advance knowledge, and support knowledge translation in all domains of nursing.

**5.1 Contribute to research initiatives to promote evidence-informed practice**

a. Seek out collaborative research relationships and partners
b. Understand the connection between research and advanced practice
c. Identify knowledge gaps to determine research priorities
d. Adhere to ethical principles, including the First Nations principles of ownership, control, access, and possession
e. Conduct research using valid and reliable methodologies
f. Analyze research findings to draw valid and reliable conclusions

**5.2 Promote knowledge translation of research findings to improve health care and system outcomes**

a. Discuss the practical benefits and possible applications of research with teams and partners
b. Recommend where research findings can be integrated into practice
c. Share research findings with clients, groups, communities, and organizations
d. Apply research findings to develop standards, guidelines, practices, and policies that improve client care and strengthen health care systems
e. Exhibit leadership in implementing new practice approaches based on research findings
f. Model how research evidence is used to support practice and system changes

| Description of Key Terms | |
|---|---|
| **Anti-racism (Anti-racist)** | The practice of actively identifying, challenging, preventing, eliminating, and changing the values, structures, policies, programs, practices, and behaviours that perpetuate racism. It is more than just being "not racist" but involves taking action to create conditions of greater inclusion, equality, and justice. (Turpel-Lafond, 2020) |
| **Bias** | A way of thinking or operating based explicitly or implicitly on a stereotype or fixed image of a group of people. (Turpel-Lafond, 2020) |
| **Client** | The person, patient or resident who benefits from nursing care. A client may be an individual, a family, group, community or population. (Nurses Association of New Brunswick, 2016) |
| **Co-create** | Engaging in an intentional relationship for the purpose of creating something together. It goes beyond collaboration and client-focused care as it requires the dynamics of the relationship to build something. It means that clients and nurses are equal partners and share power in the relationship. (Hemberg & Bergdahl, 2019) |
| **Colonialism** | Colonialism occurs when groups of people come to a place or country, steal the land and resources from Indigenous peoples, and develop a set of laws and public processes that are designed to violate the human rights of the Indigenous peoples, violently suppress their governance, legal, social, and cultural structures, and force them to conform with the colonial state. (Turpel-Lafond, 2020) |
| **Complementary and alternative medicine** | The terms "complementary medicine" and "alternative medicine" refer to a broad set of health care practices that are not part of that country's own traditional or conventional medicine and are not fully integrated into the dominant health care system. (World Health Organisation 2019)<br><br>Terminology related to care practices and approaches continue to evolve; 'integrative and functional medicine' is emerging as a more inclusive term to replace 'complementary and alternative medicine'. While functional medicine focuses on creating individualized therapies tailored to treat underlying causes of illness, integrative medicine seeks to understand the individual as a whole and applies many forms of therapy to improve wellness. (Allessi, 2019). As 'integrative and functional medicine' is not yet common nomenclature, the more traditional terminology 'complementary and alternative medicine' has been used. |
| **Contextual factors** | There are three layers of contextual factors<br>• Micro contextual factors involve the client's immediate environment – their own health status, family, friends, and their physical environment.<br>• Meso contextual factors involve the policies and processes embedded in the organization and health system that affect the client.<br>• Macro contextual factors involve the larger socioeconomic and political context around the client – social and cultural values and beliefs, laws, and public policies. (ACOTRO, ACOTUP, & CAOT, 2021) |

| Description of Key Terms | |
|---|---|
| **Cultural humility*** | A life-long process of self-reflection and self-critique. It is foundational to achieving a culturally safe environment. While western models of medicine typically begin with an examination of the patient, cultural humility begins with an in-depth examination of the provider's assumptions, beliefs and privilege embedded in their own understanding and practice, as well as the goals of the patient-provider relationship. Undertaking cultural humility allows for Indigenous voices to be front and centre and promotes patient/provider relationships based on respect, open and effective dialogue, and mutual decision-making. This practice ensures Indigenous peoples are partners in the choices that impact them, and ensures they are party and present in their course of care. (Turpel-Lafond, 2020) |
| **Culturally safe** | Culturally 'safe' is a refinement to the concept of 'cultural safety'. A competent NP does everything they can to provide culturally safe care. But they remain aware that they are in a position of power in relation to clients and some clients may never feel fully safe. The NP allows those who receive the service to determine what they consider to be safe. The NP supports them in drawing strength from their identity, culture, and community. Because cultural safety is unlikely to be fully achievable, we work toward it. (ACOTRO, ACOTUP, & CAOT, 2021)<br><br>A culturally safe environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual's identity, who they are, or what they need. Culturally unsafe environments diminish, demean, or disempower the cultural identity and well-being of an individual. (Turpel-Lafond, 2020) |
| **First Nations principles of ownership, control, access, and possession** | The First Nations principles of ownership, control, access, and possession – more commonly known as OCAP® – assert that First Nations have control over data collection processes, and that they own and control how this information can be used. https://fnigc.ca/about-fnigc/ |
| **Gender identity** | A person's internal and deeply felt sense of being man or woman, both, neither, or somewhere along the gender spectrum. A person's gender identity may or may not align with the gender typically associated with the sex they were assigned at birth. Gender identity is not necessarily visible and is not related to sexual orientation (Government of Canada, 2019) |
| **Health inequity** | The presence of systematic disparities in health (or in the major social determinants of health) among groups with different social advantage/disadvantage. (Turpel-Lafond, 2020) |
| **Indigenous peoples** | The first inhabitants of a geographic area. In Canada, Indigenous peoples include those who may identify as First Nations (status and non-status), Métis and/or Inuit (Turpel-Lafond, 2020) |
| **Intergenerational trauma** | Historic and contemporary trauma that has compounded over time and been passed from one generation to the next. The negative cumulative effects can impact individuals, families, communities, and entire populations, resulting in a legacy of physical, psychological, and economic disparities that persist across generations. For Indigenous peoples, the historical trauma includes trauma created as a result of the imposition of assimilative policies and laws aimed at attempted cultural genocide and continues to be built upon by contemporary forms of colonialism and discrimination. (Turpel-Lafond, 2020) |

| Description of Key Terms | |
|---|---|
| **Intersectoral teams** | Intersectoral collaboration is the joint action taken by health and other government sectors, as well as representatives from private, voluntary, and non-profit groups, to improve the health of populations. Intersectoral action takes different forms such as cooperative initiatives, alliances, coalitions or partnerships. https://cbpp-pcpe.phac-aspc.gc.ca |
| **Knowledge translation** | A dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically-sound application of knowledge to improve the health of clients and provides more effective health services and products and strengthen the health care system. (Canadian Institutes of Health Research, 2016) |
| **Point-of-care tests** | Point-of-care testing (POCT) refers to diagnostic tests performed at or near the patient's location by health care professional or other qualified personnel. It can include tests conducted by the patient themselves at home or a community setting. (Cowling & Dolcine, 2017) |
| **Trauma- and violence-Informed care*** | Trauma- and violence-informed care (TVIC) expands on trauma informed care to account for the intersecting impacts of systemic and interpersonal violence and structural inequities on a person's life, emphasizing both historical and ongoing violence and their traumatic impacts. It shifts the focus to a person's experiences of past and current violence, so problems are seen as residing in both their psychological state, and social circumstances. (EQUIP Health Care, n.d.) |
| **Virtual care** | Virtual care refers to any interaction between client and/or members of their circle of care, occurring remotely, using any form of communication or information technology, with the aim of facilitating or maximizing the quality and effectiveness of client care. Virtual care technologies are those forms of technology that allows 'virtual' interactions with health care professionals to occur in real time, from virtually any location. Services provided using virtual care technologies range from simple to complex. Examples of simple technologies may include telephone, text, messenger, or email, etc. Examples of complex technologies may include, but are not limited to, live, two-way audio/video conferencing or virtual visits, teleradiology, telerobotics, remote control surgical instrumentation. (CMA, 2020) |
| **Ways of knowing** | Indicates the vast variety of knowledge that exists across diverse Indigenous communities and signals that learning goes beyond human interaction and relationships to include learning from other elements of creation such as the plant and animal nations, and to "objects" that many people consider to be inanimate. (Queens University Office of Indigenous Initiatives, 2020) |

*Updates the description / definition in 2018 RN entry-level competencies

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