Ontario College of Pharmacists
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Agenda

ONTARIO COLLEGE OF PHARMACISTS

BOARD MEETING AGENDA

MONDAY, MARCH 22, 2021
9:00 A.M. – 5:00 P.M.
TUESDAY, MARCH 23, 2021 (if needed)
9:00 A.M – 12:00 P.M.

VISUAL - http://ontcollege.adobeconnect.com/boardofdirectors

1. Land Acknowledgement

2. Noting Members Present

3. Declaration of Conflict

4. Approval of Agenda

5. Chair's Opening Remarks
5.1 150 Year OCP Anniversary
5.2 Briefing Note - Chair's Report for March 2021……..... Appendix 5.1

6. Approval of Minutes of Previous Meeting
6.1 Minutes of December 2020 Board Meeting ..... Appendix 6.1
6.2 Minutes of January 2021 Board Meeting ..... Appendix 6.2

7. Matters Arising from Previous Meetings

8. For Information
8.1 Strategic Priorities Presentation
8.2 Registrar's Report for March 2021 ……..... Appendix 8.2
8.3 College Performance Measurement Framework ..... Appendix 8.3
8.4 Outcomes Focused Regulation Presentation

9. For Decision
9.1 Briefing Note – Finance and Audit Committee – Approval of Audited Financial Statements
…….....…. Appendix 9.1
9.2 Briefing Note – Executive Committee – Appointment of the Screening Committee
……. Appendix 9.2
9.3 Briefing Note – Governance Committee – Board Policies ……..…… Appendix 9.3
9.4 Briefing Note – Practice Policy Review Process and Briefing Note ..…….. Appendix 9.4
9.4a Virtual Care Policy …….. Appendix 9.4a
9.4b Cross-Jurisdictional Services Policy …… Appendix 9.4b
9.4c Long Term Care Policy …….. Appendix 9.4c

10. Adjournment

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BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Billy Cheung, Board Chair

TOPIC: Chair's Report to March 2021 Board

ISSUE: As set out in the Governance Manual, the Chair is required to submit a report of activities at each Board meeting.

PUBLIC INTEREST RATIONALE: This report is circulated and posted publicly and speaks to the transparency of the Board and its activities.

BACKGROUND: I respectfully submit a report on my activities since the December 2020 Meeting. In addition to regular meetings and phone calls with the CEO & Registrar and the Vice Chair, listed below are the meetings, conferences or presentations I attended on behalf of the College during the reporting period.

Posting of the Executive Committee Minutes
On January 29, 2021 the Executive Committee met to discuss the new College Performance Measurement Framework (CPMF) expectation that the College post either 1) a report on discussions and decisions along with other meeting information or 2) the minutes of Executive Committee Meetings. The Committee was in agreement that going forward the minutes of the Executive Committee Meetings will be posted on the website.

December Board Meeting Evaluation
Attached to my report is a summary of the December Board Meeting Evaluation, the results of which will assist us in understanding and recognizing what is working well and identifying areas for improvement as we strive to advance the College's mandate to serve and protect the public interest.

College and Other Stakeholder Meetings:
January 11, 2021 – Emergency Board Meeting
January 28, 2021 – Finance & Audit Committee Meeting
January 29, 2021 – Executive Committee Meeting
January 29, 2021 – Virtual Coffee with the CEO & Registrar and Board Directors
February 1, 2021 – Executive Committee Meeting
February 3, 2021 – Governance Committee Meeting
February 10 & 17 – Governance Committee Catch Ups
February 12, 2021 – Discipline Hearing
February 24, 2021 – Discipline Hearing
March 3, 2021 – Finance & Audit Committee Meeting
March 3 & 10 – Governance Committee Catch Ups
Regular Bi-weekly meetings with CEO & Registrar

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BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Billy Cheung, Board Chair

TOPIC: December 2020 Board Meeting Evaluation

ISSUE: As set out in the Governance Manual, after each Board meeting, the Board circulates an evaluation of the effectiveness of the meeting and provides suggestions for improvement.

BACKGROUND:
At the conclusion of the December 2020 Board meeting, the Board Directors were polled for feedback on the meetings and proceedings. 19 Board Directors responded to the survey and a summary of the input is being provided to the Board for information.

1. **In accordance with Governance philosophy the Board and staff work collaboratively, each in distinct roles, to carry out self-regulation of the pharmacy profession in the interest of the public and in the context of our mission statement and legislated mandate. How would you evaluate the meeting overall?**

Answer Options	Always	Frequently	Often	Occasionally	Never	Response Count
1. In accordance with the governance philosophy, topics were related to the interest of the public and the purpose of OCP	14	4	1	0	0	19
2. Members were well prepared to participate effectively in discussion and decision making	12	5	2	0	0	19
3. In accordance with the governance philosophy, The Board worked interdependently with staff	14	4	1	0	0	19
4. There was effective use of time	8	4	5	2	0	19
5. There was an appropriate level of discussion of issues	9	8	1	1	0	19
6. The discussion was focused, clear, concise, and on topic	7	7	4	1	0	19
7. The technological tools used to facilitate the meeting supported the Board's discussion and decision making process	10	6	1	2	0	19
7A. Audio tools are effective	13	3	1	2	0	19
7b. Speaking order (raising hand) and voting tools are effective	10	6	1	2	0	19
7c. Video tools are effective	11	4	2	1	1	19

2. **Did the meeting further the public interest?**

   YES = 18
   NO = 1

3. **Identify the issue for which you felt the discussion and decision-making process worked best, and why.**

   - elections - very smoothly run including opportunity to vote privately

- No Issues
- The challenging task of voting for senior positions on Executive worked very well
- The election process worked well, and was able to proceed in a time effective and clear manner
- Elections discussion and voting.
- Emergency Assignment Certificates. The discussion was always referenced to its benefit to the public interest.
- I felt that all the issues had good discussion and a clear understanding of it was given by either staff or Billy.
- the voting process for executive positions as well as the policy approvals
- I am not certain

4. Identify the issue(s) for which you have felt the discussion and decision-making process was not effective, and why. Note any areas where the distinction between governance and operations was unclear.

- None noted
- No Issue
- There were a few occasions where the questions and discussion steered away from the specific focus of the briefing note and decision to be made.
- The Chair acknowledged at the meeting's beginning, that it was going to be a long day, and that videoconferencing was tiring. Therefore, frequent breaks would be provided, and a long lunch. However, between 9am-12:15pm there was only one 15 minute break. After lunch, there was but one 5 minute break despite hours of meeting time. This situation can be, and should be, easily addressed next meeting.
- It was quite challenging to keep our attention focused on every topic as the meeting dragged on. There were a number of agenda topics that were hardly touched which denied some of us to ask our questions. I think compressing this meeting to a day resulted to an overload of information. I will respectfully suggest that we allocate a 2-day or at least 1.5 days for a meeting with this heavy agenda. For example, the Indigenous talk, election, training by Richard and discussion of the Registrar's performance appraisal may take a half day. The remaining agenda items can be for another full day. That will offer opportunities for all the items to be covered in more fulsome manner and enable directors to ask their questions.
- The issues were relevant, and generally reviewed well prior to voting, however, the pervasive distraction that contributed to ineffectiveness throughout the entire meeting was the Adobe Connect virtual platform. In spite of being an advanced user of most virtual conferencing platforms, Adobe Connect created unnecessary distractions, interfered with the ability to present slides, follow discussions, see video feeds, distracting "zoom ins" of other cameras, necessitated frequent change of web cams due errors and restarts (>7 times during the day). The issue of significant concern was that when Adobe Connect was encountering errors, did not register the raised hand function either. It was such a welcome change to switch to Zoom for the In Camera session.
- Time used on Indigenous issues is not about operations.
- Ran out of time for discussion or review of the CEO's report.
- Registrar's Report: Time management during the meeting was not sufficient to allow for this important agenda item.
- I didn’t find this statement to be true
- N/A
- I am not certain

5. **Using the Code of Conduct and Procedures for Board and Committee Members as your guide, in general, how satisfied are you with the Board Directors' ability to demonstrate the principles of accountability, respect, integrity and openness?**

Answer Choices	Responses
Completely Satisfied	11
Mostly Satisfied	7
Neither Satisfied Nor Dissatisfied	0
Mostly Dissatisfied	1
Completely Dissatisfied	0
Total Responses	19

6. **Suggestions or comments on the agenda, format or brevity of the virtual meetings?**

- None
- None right now
- Actual breaks built into the Agenda, or a staff/Board Director who assists the Chair is assigned the task to find frequent and appropriate break times. The HPRO Governance training, over the course of 3 hours, included two 15 minute breaks. The Agenda should be flexible enough to ensure that Directors have the opportunity to fully discuss policy issues, but also have time to recover
- Please refer to #4 comment
- 1) Consider change to Zoom (Professional version) or Microsoft Teams. With many choices now available, the virtual platform should enable more effective meetings, rather than be a significant impediment to communication. We should not need to reduce our technology (using lower resolution webcams, for example, not be able to use the audio function), in order to use the product. 2) If we are to continue full day meetings, suggest move topics requiring less discussion (ex. approval of previous minutes, housekeeping issues) to the end of the meeting, to ensure we are addressing the complex or more challenging issues when we are most effective, earlier in the day.
- None
- Its all good to me
- It seems we didnt gauged the time required as well as we could. The end of the meeting was rushed.
- I well understand that we have to hold our meetings virtually at this time, however, I personally find them very long, when having to be "on" all day. This latest meeting was exceptionally long, with the added meeting at 4 p.m. If there is a future way to break up the meeting into perhaps two different dates, that might be favourable for many. Thanks for any consideration given.
- Virtual meetings are difficult, especially when they last all day. I suggest more frequent but shorter meetings.

7. **Suggestions for improvement and General Comments**

- So far so good
- The meeting ran way over time in many sections and Board members could have been better managed to stay on topic however the discussion still felt relevant at all times and I think everyone appreciated the ability to make their comments and be heard.

- Overall, the meeting went very well. Suggestion: where there are important regulatory amendments that the Board is asked to consider or approve, only those pages within the regulation that deal with the amendment should be included, along with surrounding provisions that may needed to understand the context. Please avoid including the entire regulation in the Appendices
- Billy did a great job chairing. It went over in time but we should have had 2 days scheduled like we normally do in September
- It would have been preferable to get a heads-up on the way the Registrar's performance appraisal would be carried out. I only noted that this was going to be a separate meeting requiring a different link because of another director's clarifying email. Two other directors had to use only the phone in a near-state of frenzy.
- As above. Overall, technology issues aside, the members of the Board prevailed and functioned well. The College staff worked well with the Board, and was helpful and informative. The preparation (HPRO) and materials were useful. I believe increased communication between all persons present at the meeting could be facilitated by a more user friendly platform, as it seems many of the public members also had difficulty participating.
- Perhaps the CAO's comments etc should come first rather than last.
- None
- Improved time management for specific items and ensuring discussion remains "on topic". This was the Chair's first meeting and he had to deal with several new members who (rightly) needed more in-depth clarification. I have every confidence this will improve.
- I am so very tired of watching my fellow directors struggle with their video and audio throughout the meeting. We want our public directors to be able to participate fully and I found we continued to lose them on video or audio throughout. Can we please explore using some other platform?
- the above comment should have been inserted here. Please see above. Thank you.
- One person, a member of the Executive Committee, seemed to speak on every item, frequently several times. I think he needs to be counselled about his conduct.

Respectfully submitted,

Billy Cheung, Board Chair

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MINUTES OF MEETING

OF BOARD OF DIRECTORS

DECEMBER 7, 2020

Page

MONDAY, DECEMBER 7, 2020 – 9:00 A.M.

HELD VIA VIDEOCONFERENCE

Elected Members

Mr. Douglas Brown, Port Perry
Mr. Billy Cheung, Markham
Ms. Sarah Ingram, North York
Mr. James Morrison, Burlington
Mr. Goran Petrovic, Kitchener
Ms. Tracey Phillips, Westport
Ms. Ruth-Anne Plaxton, Owen Sound
Mr. Mark Scanlon, Peterborough
Mr. Siva Sivapalan, Burlington
Ms. Laura Weyland, Toronto

Dr. Lisa Dolovich, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto
Dr. David Edwards, Hallman Director, School of Pharmacy, University of Waterloo

Members Appointed by the Lieutenant-Governor-in-Council

Mr. Stephen Adams, London
Mr. David Breukelman, Burlington
Ms. Christine Henderson, Toronto
Ms. Tammy Cotie**,** Brockville
Ms. Elnora Magboo, Brampton
Mr. Rick Phillips, London
Mr. Gene Szabo, Kanata
Ms. Devinder Walia, Etobicoke
Mr. Rick Webster, Minesing

Staff present

Ms. Nancy Lum-Wilson, CEO/Registrar
Ms. Angela Bates, Director, Conduct
Ms. Connie Campbell, Director, Corporate Services
Ms. Susan James, Director, Quality
Ms. Sarah MacDougall, Board & Committee Liaison

Invited Guests

Mr. Troy Hill
Ms. Deanna Williams
Mr. Richard Steinecke
Ms. Valerie Davis
Mr. Régis Valliancourt
Ms. Nadia Facca
Mr. Mike Hannalah
Mr. Kyro Maseh
Ms. Laura Weyland
Ms. Karen Riley
Ms. Leigh Smith
Ms. Connie Beck

Ms. Laura Weyland, 2019-2020 Board Chair welcomed Directors and leadership to the meeting. Attendees were reminded of the of the virtual meeting program features and informed that, as in previous meetings, votes will be registered and recorded using the voting features within the program.

1. Land Acknowledgement

Ms. Weyland invited guest speaker Troy Hill, a member of the Kanien'kéha:ke (Mohawk) community and educator on the Six Nations of the Grand River Territory to perform the land acknowledgment and thanksgiving address to open the meeting.

2. Noting Members Present

Member attendance was noted.

3. Declaration of Conflict

There were no conflicts declared.

4. Approval of Agenda

A motion to approve the Agenda was moved and seconded. **The motion CARRIED.**

5. Chair's Opening Remarks

Ms. Weyland welcomed the returning and new members of the Board for the coming year and indicated that the Chair's report was circulated for information.

Ms. Weyland welcomed newly appointed public member, Rick Phillips as well as Sara Ingram, Doug Brown and Ruth-Anne Plaxton who were elected to the Board in November 2020.

Ms. Weyland thanked and acknowledged the contribution of Dave Edwards a member of the Board for 10 years as he is stepping down from his role as Hallman Director of the University of Waterloo as of January 2021 and will be replaced by Andrea Edington.

6. Approval of Minutes of Previous Meeting

6.1 Minutes of September 2020 Board Meeting
6.2 Minutes of November 2020 Board Meeting

It was moved and seconded that the Minutes of the September and November 2020 Board meetings be approved. The motion CARRIED.

7. Matters Arising from Previous Meetings

There were no matters arising.

8. Briefing Note - Registrar's Report on Election of Board Directors

Ms. Lum-Wilson provided a summary of the election results.

9. Briefing Notes – Governance

9.1 Briefing Note – Election of Executive Committee

Mr. Cheung informed the Board that a list of candidates for election to the Executive Committee had been circulated to the Board and those interested had provided materials for the Board's consideration.

Election of Board Chair

Ms. Weyland noted that there was one candidate, Mr. Billy Cheung seeking the position of Board Chair. After confirming that Mr. Cheung wished to let his name stand, Ms. Weyland asked for further nominations from the floor. No further nominations were received.

Mr. Cheung was declared Chair of the Board for the 2020-2021 term. He addressed the Board.

Past Chair's Award

Mr. Cheung informed the Board that Ms. Weyland was in receipt of the plaque, sent on behalf of the Canadian Foundation of Pharmacy, as well as her gift from the College as a token of her efforts and dedication during her two-plus year term as Chair. Ms. Weyland addressed the Board.

Election of Vice Chair

Mr. Cheung noted that there were two candidates seeking the position of Vice-Chair, Mr. David Breukelman and Mr. Mark Scanlon. After confirming that both candidates wished to let their names stand, Mr. Cheung asked for further nominations from the floor. No further nominations were received. Each candidate addressed the Board and an election was held.

Mr. Breukelman was elected Vice-Chair of the Board for the 2020-2021 term.

Election of Executive Committee

Mr. Cheung noted that as Mr. Breukelman is a Public Director and was elected Vice-Chair, the Board would elect two Elected Directors at large to the Executive Committee. The Board noted that Mr. James Morrison, Mr. Mark Scanlon and Mr. Siva Sivapalan had submitted their intention to be elected to the Executive Committee. Mr. Cheung then asked for nominations from the floor.

No further nominations were received. Each candidate addressed the Board and an election was held. Mr. James Morrison and Mr. Siva Sivapalan were elected to the Executive Committee for the 2020-2021 term.

Mr. Cheung next noted that the Board would elect one additional Public Director to the Executive Committee and informed the Board that Ms. Christine Henderson and Mr. Gene Szabo had expressed an interest prior to the meeting. Mr. Szabo indicated that he would withdraw his candidacy and Mr. Cheung asked if there were nominations from the floor.

No further nominations were received. Ms. Christine Henderson was declared acclaimed to the Executive Committee for the 2020-2021 term.

9.2 Briefing Note – Committee Slate for Consideration

The Board was presented with the proposed Committee Slate for the 2020-2021 term as prepared by the Governance Committee. Mr. Cheung informed the Board that the committees were constituted according to legislation and the College's bylaws. The appointments were a combination of returning members and candidates vetted by the screening committee. The Governance Committee also took into account a wide range of perspectives, disciplines and specialties as well as diversity of geographic location, gender and age.

The Board discussed the committee appointments and composition and identified the following action items.

- Ensure there are processes developed to create a clear line of communication between the Board and Committees.

- Given the shortened timeline of the Board year, it will be communicated to the members of the Discipline Committee that they may not have an opportunity to sit on many panels this year.

Following discussion, **the motion was called to a vote.**

The motion: That the Board resolve that the attached slate of candidates be approved to serve on the College Committees for a term that expires at the first regular meeting of the Board following the next regular election. The motion was moved and seconded. The motion CARRIED.

10. For Decision

10.1 Briefing Note – Governance Committee – Board Policies

Mr. Cheung presented the briefing note and the first of a series of policies drafted to replace the College's Governance Manual. Mr. Cheung welcomed Ms. Deanna Williams of Dundee Consulting as the consultant whom the College has engaged to draft the policies. The Board discussed the elements of the policies and identified the following as an issue the Governance Committee could consider for future evolution of the policies:

- Consider developing processes to minimize or remove bias from candidate selection for the Board, Committees and Panels.

Following discussion, **the motion was called to a vote**.

The motion: That the Board approve the policies contained in Section 1 Board Governance Framework and Section 2: Roles and Accountabilities. The motion was moved and seconded. The motion CARRIED.

Conflict of Interest Presentation
Mr. Cheung introduced Mr. Richard Steinecke who made a presentation to the Board on Conflict of Interest.

Mr. Cheung then asked Mr. Breukelman to chair the meeting on his behalf while he presented the agenda items coming forward on behalf of the Finance and Audit Committee.

10.2 Briefing Note – Finance and Audit Committee-Appointment of Auditors

Mr. Cheung informed the Board that Tinkham and Associates have served as the College's auditors since 2017 and that the Committee continues to be satisfied with the Firm. The Board briefly discussed the option of going to tender in the coming years and determined that the Finance and Audit Committee will continue to oversee this contract and will report on its decision at a future meeting.

Following discussion, **the motion was called to a vote.**

The motion: That Tinkham LLP Chartered Professional Accountants be appointed as Auditor for 2020.The motion was moved and seconded. The motion CARRIED.

10.3 Briefing Note – Finance and Audit Committee - 2021 Operating Budget

Mr. Cheung advised that the Finance and Audit Committee was bringing forward the 2021 Operating Budget for approval. The Director of Corporate Services, Ms. Connie Campbell, presented a high-level overview of the budget to the Board. The Board briefly discussed the reserves on hand and the plans to replenish them, as well as, the efforts to increase the Discipline cost recovery amounts. The Board was informed that the Executive Committee would meet in January to review the compensation considerations for the coming year.

Following discussion, **the motion was called to a vote.**

The motion: That the Board of Directors approve the attached 2021 Operating and Capital Budget. The motion was moved and seconded. The motion CARRIED.

10.4 Briefing Note – Registrar - Emergency Assignment Certificates

Ms. Susan James presented the briefing note for the Board to consider and approve the jurisdictions for both pharmacists and pharmacy technicians that would be acceptable, should the regulations to allow for Emergency Assignment Registration Certificates be approved by Cabinet.

Following discussion, **the motion was called to a vote.**

The motion: That the Board approve resolutions, to come into effect upon filing of regulations that enable pharmacist and pharmacy technician emergency assignment registration certificates.

The Board (Council) approves Canada and the United States of America as jurisdictions in which a pharmacist could currently be practicing.

The Board (Council) approves Canada and the United States of America as jurisdictions in which a pharmacist could have practiced within three years prior to the day on which the applicant met all other requirements for the issuance of a certificate of registration as a pharmacist (emergency assignment).

The Board (Council) approves the provinces of Canada (except Quebec) as the jurisdictions in which a pharmacy technician could currently be practicing.

The Board (Council) approves the provinces of Canada (except Quebec) as the jurisdictions in which a pharmacy technician could have practiced within three years prior to the day on which the applicant met all other requirements for the issuance of a certificate of registration as a pharmacy technician (emergency assignment).

The motion was moved and seconded. The motion CARRIED.

10.5 Briefing Note - Community Practice Environment Accountability Principles

Ms. Lum-Wilson presented on the principles developed by the Community Practice Environment Advisory Group (CPEAG), which was made up of a diverse group of stakeholders. The Board offered their gratitude and congratulations to the Advisory Group on the creation of the principles, which will support the delivery of safe and high quality patient care. It was discussed that the roll out is not intended to be prescriptive but collaborative and that future policies can be considered during implementation as needed.

Following discussion, **the motion was called to a vote.**

That the Board endorse the proposed *Guiding Principles of Shared Accountability in Community Pharmacy.* The motion was moved and seconded. The motion CARRIED.

11. For Information

11.1. Briefing Note – Registrar's Report to the Board

Mr. Cheung invited Ms. Nancy Lum-Wilson to provide a brief overview of the report. Highlights of the report included the Q3 scorecard and a preview of the 2021 scorecard as well as the College's Risk Register for 2020 and the prospective 2021 Risk Register.

Following questions, **the briefing note was received for information.**

12. Other Matters

12.1. Outcomes Focused Regulation Presentation

Mr. Cheung explained that the outcome focused regulation presentation would have to be deferred until the March Board meeting due to timing.

13. Unfinished Business

Mr. Cheung thanked the Directors for attending the open portion of the meeting and informed the Board that a meeting evaluation would be circulated.

14. Registrar's Annual Performance Appraisal – In Camera

As this issue pertained to a personnel matter, and accordingly met the requirements for having an in-camera session under Section 7 of the Health Professions Procedural Code, the discussion was held *in-camera*. Ms. Valerie Davis, President, Lysistrata Incorporated, facilitated a presentation of the Registrar's Performance Appraisal results for 2020. Board Directors from 2019-2020 as well as 2020-2021 were invited to attend.

It was moved and seconded that the Board move in camera at 4:15 p.m., in order to discuss the Registrar's annual performance appraisal. The motion CARRIED.

Staff and observers did not attend this portion of the meeting.

15. Motion of Adjournment

There being no further business**, at 5:17 p.m., a motion to adjourn the meeting was moved and seconded. The motion CARRIED.**

Sarah MacDougall
Board & Committee Liaison

Billy B. Cheung
Board Chair

Ontario College of Pharmacists

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MINUTES OF MEETING

OF THE BOARD OF DIRECTORS

JANUARY 11, 2021

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MONDAY, JANUARY 11, 2021 – 1:00 P.M.

HELD VIA VIDEOCONFERECE

Elected Members
Mr. Douglas Brown, Port Perry
Mr. Billy Cheung, Markham
Ms. Sarah Ingram, North York
Mr. James Morrison, Burlington
Mr. Goran Petrovic, Kitchener
Ms. Tracey Phillips, Westport
Ms. Ruth-Anne Plaxton, Owen Sound
Mr. Mark Scanlon, Peterborough
Mr. Siva Sivapalan, Burlington

Dr. Lisa Dolovich, Dean, Leslie Dan Faculty of Pharmacy, University of Toronto
Dr. Andrea Edington, Hallman Director, School of Pharmacy, University of Waterloo

Members Appointed by the Lieutenant-Governor-in-Council
Mr. Stephen Adams, London
Mr. David Breukelman, Burlington
Ms. Christine Henderson, Toronto
Ms. Tammy Cotie**,** Brockville
Ms. Elnora Magboo, Brampton
Mr. Rick Phillips, London
Mr. Gene Szabo, Kanata - **Regrets**
Ms. Devinder Walia, Etobicoke
Mr. Rick Webster, Minesing

Staff present
Ms. Nancy Lum-Wilson, CEO/Registrar
Ms. Angela Bates, Director, Conduct
Ms. Connie Campbell, Director, Corporate Services
Ms. Susan James, Director, Quality
Ms. Sarah MacDougall, Board & Committee Liaison

Chair's Opening Remarks

Mr. Cheung welcomed everyone to the special meeting to discuss the feedback from the public consultation regarding the proposed changes to the regulations to allow for emergency assignment registration certificates. Directors were informed of the virtual meeting platform features and informed that votes will be registered and recorded using the voting features within the program.

Mr. Cheung welcomed the new Hallman Director of the School of Pharmacy at the University of Waterloo, Andrea Edington.

1. Noting Members Present

Member attendance was noted for those in attendance and via roll call for those participating via teleconference.

2. Declaration of Conflict

There were no other conflicts declared.

3. Approval of Agenda

A motion to approve the Agenda was moved and seconded. The motion CARRIED.

4. For Decision

4.1 Briefing Note – Emergency Assignment Registration

Mr. Cheung invited Susan James, Director of Quality to present the briefing note.

Ms. James reviewed the key points in the briefing note regarding the feedback received during the 10 day consultation on the proposed changes to the regulations to enable the new class of emergency registration certificates.

Ms. James reminded the Board that the proposed regulatory changes were to address not only the current public health emergency, which is prolonged, but also any future emergency situations that may result in an immediate and short term need for surge capacity in the workforce, and therefore the amendments were drafted to address variable situations and as such, the consultation feedback was considered in this context.

Ms. James noted that the consultation, although abridged, resulted in a sound number of responses, primarily in support of the proposal for emergency assignment registration certificates and no concerns requiring changes to the regulations approved by the Board in November. It was reiterated that candidates under the emergency assignment registration class would be subject to supervision (to be reinforced in updated College guidelines) and as will all registrants, these professionals would be required to work within their personal scope of practice.

The Board discussed the recommendation of the Ontario Fairness Commissioner regarding evaluation and was assured that the College embraces that approach and will consider how best to track the candidates and assess the outcomes of the approach from both a patient safety and workforce capacity perspective.

Following discussion, **the motion was called to a vote.**

The motion: It is recommended that the Board approve the proposed amendments to *General Regulation 202/94* under *the Pharmacy Act* for submission to the Ministry of Health.

The motion was moved and seconded. The motion CARRIED.

5.0 Motion of Adjournment

There being no further business**, at 1:55 p.m., a motion to adjourn the meeting was moved and seconded. The motion CARRIED.**

Sarah MacDougall
Board & Committee Liaison

Billy B. Cheung
Board Chair

BOARD BRIEFING NOTE

MEETING DATE: MARCH 2021

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Nancy Lum-Wilson, CEO and Registrar

TOPIC: Registrar's Report March 2021

ISSUE: As set out in the Governance Manual, the College's Board of Directors holds the Registrar accountable for the operational performance of the organization. The Registrar is expected to report on these activities at every Board meeting.

BACKGROUND: I respectfully submit a report on the activities that have taken place since the December 2020 Board Meeting. In addition to various internal meetings with staff and regular meetings and phone calls with the Chair and Vice Chair, summarized below are the matters that I dealt with on behalf of the College during the reporting period.

PUBLIC INTEREST RATIONALE: The Registrar is responsible for reviewing the effectiveness of the College in achieving its public interest mandate and the implementation of the College's strategic plan and directional policies.

Strategic Priorities Progress Update

A key part of the Registrar's performance is to regularly provide an update to the Board on the College's Operational Plan. I am pleased to present the Q4 2020 scorecard (See Attachment 1) for your review which provides a snapshot of the performance of the College against the established objectives for the year. The scorecard information is further supported by the Definitions document (Attachment 2) and a Summary / Improvement Strategies with explanations of variances against the plan (Attachment 3).

In addition to providing the Q4 Board of Directors performance scorecard, we are pleased to present a 2021 performance scorecard that sets out the key performance measures along with the milestones and targets for each (see Attachment 4). Note that the Performance categories used over the past few years - Governance, Regulatory, Reputation and Operations, have been replaced with the domains set out in the recently released College Performance Measurement Framework (CPMF).

As the Board is aware, the College is revitalizing its orientation program. As part of the orientation program this year, all members attended a regulatory focused Health Professional Regulators of Ontario (HPRO) governance training session led by Richard Steineke. The Board Chair and I have also planned two additional components for which we will seeking your feedback to determine whether they will remain as components of the orientation:

- A presentation to the Board today highlighting the process used to arrive at the Strategic Plan, how the Plan supports the legislated objects and how the annual operational plan supports the strategic priorities; and
- An orientation day on May 10th that will bring in governance experts from the McMaster Directors College program to lead a discussion on the Board's role in oversight, strategy and risk as it relates to a regulatory body with a legislated mandate.

COVID-19 Pandemic Update

Provincial Vaccine Distribution Strategy

The provincial government has updated its strategy for the distribution of the COVID-19 vaccines across the province and has reiterated the role of pharmacy as local public health units are given the responsibility to manage and implement vaccination efforts, including scheduling appointments for the public and for pharmacy professionals, in their local communities. While the College has and will continue to engage with provincial health officials as the vaccination rollout plan moves forward, pharmacies are being directed to work with their local public health units directly to ensure they have accurate information for their specific region.

In addition to the information the College provided the Public Health Units (PHUs) following administration of the Vaccine Administration Preparation Readiness and Supplemental Surveys, the College has continued to respond to requests from the PHUs for information regarding the role/scope and regulatory expectations for pharmacy professionals and pharmacies in relation to vaccine administration. Most recently we have assisted in their effort to communicate information to pharmacy professionals about the process for receiving the vaccine, in accordance with the Ministry's Phase 2 prioritization of healthcare workers.

On March 10th, the government announced the expansion of delivery options for administration of the COVID-19 vaccine, including the addition of primary care settings and pharmacies. Starting March 12th, over 325 pharmacies, in three public health regions (Toronto, Kingston, Frontenac, Lennox and Addington and Windsor-Essex) started to administer the Astra-Zeneca vaccine to eligible adults aged 60-64, as part of a delivery pilot program. As vaccine supply increases, more pharmacies from other regions will be included in this effort.

Emergency Registration Certificates

The College continues to work with the provincial government as it moves toward approval of the regulatory changes submitted to the Minister early in January to allow for temporary emergency assignment registration certificates for pharmacists and pharmacy technicians during provincial emergencies that place pressure on pharmacy workforce capacity. In anticipation of approval of the regulation changes, the College has developed an implementation plan that considers how best to support those in the profession who want to apply for the emergency assignment registration certificates once approved. Details will be communicated to all registrants at that time.

Pharmacy Examining Board of Canada (PEBC) Update

Although the pandemic has presented the Pharmacy Examining Board of Canada, its stakeholders and candidates with multiple challenges, the PEBC Board and staff have remained committed, and worked tirelessly to administer the entry to practice exams safely while maintaining exam integrity. In January, PEBC provided the regulators with a full report (Attachment 5) of the status of exam administrations for 2021, along with plans to explore a virtual performance exam, which would reduce the risk of future disruptions of the in-person performance based exams.

In late February, the College was pleased to be informed of the provincial government's decision to amend provincial regulations in response to the COVID-19 pandemic, that permit PEBC to administer its in-person, performance examinations under the current provincial reopening framework for the upcoming Pharmacist Qualifying Examination Part II (OSCE). This allowed the PEBC to administer the February 28, 2021 exam in Ontario for all of the registered candidates, an important step in eliminating a backlog of pharmacy graduates from 2020 who were not able to complete this requirement for registration with the College.

Ministry/Government Activities

College Performance Measurement Framework

In September 2020, the Ontario Ministry of Health formally announced the launch of a College Performance Measurement Framework (CPMF) for all Ontario health professional regulators. The Ministry intent of the CPMF is to strengthen accountability and oversight of Ontario's health regulatory colleges in meeting their fiduciary duties and serving the public interest through a quality improvement approach. As previously reported, the College was among a small group of regulators involved in supporting the Ministry's drafting of this tool, with a recognition that it will continue to evolve as more experience is gained. The first CPMF report is due to the Ministry by March 31, 2021, and I am pleased to share the report with the Board prior to its submission to the Ministry. Most recently, the Ministry has requested the continued involvement of the College as it begins work to refine the metrics for year 2. Please refer to the briefing note provided in the Board meeting materials.

Federal/Provincial Initiatives

On December 8, 2021 OCP participated in a Ministry led meeting - MAiD (Medical Assistance in Dying): Bill C-7 Implementation and Electronic Medical Certificate of Death: Proposed Expansion to Palliative Care Settings. The purpose of the meeting was to review the regulatory amendments and consider implementation challenges as well as areas in Bill C-7 that require further clarity and how the MOH can assist in the implementation of the changes of the Bill. Since that meeting, the federal government has approved amendments to the original Bill, which now require Senate approval.

The Ontario Opioid Drug Observatory (OODO) Semi-Annual Steering Committee Meeting was held January 18, 2021. Project updates were provided on the status of the funded projects; new projects underway and other opioid-related Ontario Drug Policy and Research Network (ODPRN) projects. Additionally the Steering Committee discussed ongoing funding for New Canadian Institutes of Health Research (CIHR) Proposals.

Health Canada

A meeting with Heath Canada representatives from the Compliance and Risk Management Division, Inspection and Licensing, and Policy and Regulatory Strategies Directorate was held on January 28, 2021. The purpose of the meeting was to discuss the current oversight of Drug Preparation Premises (DPP). Representatives from HC signaled a continued commitment to work with pharmacy regulators to establish a long term regulatory model for commercial compounding practices. A new framework from Health Canada would enable the College to review the existing model for DPPs, which was intended as a temporary response to address a regulatory gap identified in 2013 in relation to the chemotherapy under-dosing incident in Ontario.

Regulatory Organizations

Advisory Group for Regulatory Excellency (AGRE)

On December 8th, AGRE met to review its financial report. There was also discussion around Identifying possible Regulatory Risks for Colleges in Ontario governed by the Regulated Health Professions Act. There was acknowledgement that it would be prudent for regulators to consider diversity and inclusion in all regulatory activities. Particularly associated with the Black, Indigenous and People of Colour (BIPOC) community.

Health Professional Regulators of Ontario (HPRO)

The HPRO Board of Directors meeting was held on December 16, 2020. Discussions on implementation of the College Performance Measurement Framework (CPMF) took place and a speaker on Diversity

and Inclusion presented to the Board. An update was also provided on meetings held with the Office of the Fairness Commissioner as well as HPRO re-initiating its commitment to forming a Cultural Safety and Humility Working Group and selecting a Chair if a volunteer is forthcoming.

HPRO Anti-BIPOC Racism Working Group:
The College is now a member of HPRO's Anti-BIPOC Racism Working Group which is exploring a number of strategies that can be adopted by the province's health regulators to prevent and reduce the impact of racism and discrimination faced by Ontario's Black and Indigenous populations and the province's diverse communities in accessing health services. The group has engaged diversity and inclusion expert, Dr. Javeed Sukhera, as part of this initiative. The strategies brought forward from this group will complement the development of an internal Diversity and Inclusion Strategy underway at the College, our continued efforts to understand how best to collect data on the diversity and experiences of our registrants and those enrolled in academic programs across the province and our Indigenous Cultural Competency initiative.

Covid-19 Information Exchange Sessions with Pharmacy Stakeholders
Beginning January 11th, the College has been hosting bi-weekly Covid-19 Information Exchange Sessions with Pharmacy Stakeholders. These meetings were originally organized to allow pharmacy stakeholders to share information about distribution issues through one member of the Premier's Distribution Task Force, back to that Task Force (TF) table. As the meetings progressed, the participating Distribution TF members identified that they serve as a valuable forum for information sharing not only from the Distribution TF but also with other Ministry representatives working on the vaccination effort and have requested that the forum continues to meet. The College has also invited each of the PHUs to identify a pharmacy lead to attend these meetings to promote further channels for information sharing.

Pharmacy Stakeholders

Pharmacy Associations
College staff have continued to meet regularly with the Ontario Pharmacists Association (OPA), Neighborhood Pharmacy Association of Canada (NPAC) and Ontario Branch of the Canadian Society of Hospital Pharmacy (CSHP-OB) to share information and coordinate our efforts regarding pharmacy related issues associated with the COVID-19 pandemic. In addition staff have participated in stakeholder meetings hosted by the Canadian Pharmacists Association, with a similar goal to remain informed and to coordinate the efforts of pharmacy stakeholders with regard to the pandemic.

National Association of Pharmacy Regulatory Authorities (NAPRA)

NAPRA's Cross-Jurisdictional Framework meeting took place December 8, 2020. The discussions focused on the development and revision of draft principles to guide the development of a framework to govern cross-jurisdictional practices within Canada.

The NAPRA Board of Directors meeting was held on January 27, 2021. The Board discussed further work on compounding competencies, the NDS Modernization Task Force and restoring the culture of professionalism in pharmacy practice. The NAPRA Board was briefed on status and proposed next steps.

NAPRA has also continued to host regular COVID update meetings to allow a platform for the pharmacy regulators to be informed of nationally focussed efforts related to the pandemic, including regular updates from the Public Health Association of Canada and Health Canada.

Miscellaneous Items

AIMS update

The College is moving forward with its AIMS data strategy that will provide registrants with actionable insights to support quality improvement initiatives and improve patient safety. As part of this strategy, an expert group with experience in medication safety, clinical pharmacy and pharmacy operations, academia and data analysts will apply robust data analysis techniques to provide key findings and recommendations to the profession. Additionally, as part of the College's commitment to finding fiscal efficiencies, the College and Pharmapod engaged in productive discussions during the yearly contract review cycle that resulted in some changes to the contract. Both parties share the common goal of improving engagement with the AIMS platform and agreed that this is a shared responsibility. As such, performance targets have been established as a part of the contract. A robust engagement plan is being finalized, and will focus on supporting pharmacy professionals with uptake of AIMS in their practice.

Provider Experience Indicators

Following the Board's endorsement of the *Guiding Principles for Shared Accountability in Community Pharmacy* in December, the College recruited seven Part A community pharmacists and three community pharmacy technicians to be members of the Provider Experience Indicator Working group. An open call for interested pharmacy professionals was circulated and 49 pharmacists and 20 pharmacy technicians submitted their interest in participating. Members were selected based on pre-established criteria to ensure balanced representation based on practice location, years of experience, and type of the pharmacy ownership. Members represent a of range experiences, with years of practice ranging from 5 years to 35 years, across most regions of Ontario.

Between March and September, working group members will develop an initial set of indicators that can be measured through the annual renewal process, starting in 2022. Ontario Health - Quality representatives will continue their involvement in the Quality Indicators for Pharmacy initiative by providing their expertise in indicator development and measurement with the working group. Regular updates will be provided through the College's website, as part of our commitment to transparency.

Community Practice Environment Implementation Advisory Group

The Community Practice Environment Advisory Group completed the first phase of their work developing principles for shared accountability for community pharmacy. On February 17th, the advisory group members met to confirm their commitment to implementing the principles within their organizations as well promoting the adoption of the principles across community pharmacy stakeholders. The College is developing an implementation plan for regulator-specific commitments, and organizational members are doing the same. These plans will be shared and discussed at an upcoming meeting.

The advisory group is preparing a joint statement on our commitment to the principles, and will promote their adoption across community pharmacy.

Non-Hazardous Sterile Compounding - weighting standards

The College is moving forward with weighting of the operational assessment tools that will align with an outcomes based approach. Non-Hazardous sterile compounding was identified as a high risk area and is the first assessment tool being weighted. An external consultant was engaged in the process to ensure that the weightings are valid, defensible and in the best interest of the profession and the public. The process involved surveying registrants engaged in this practice and then focus groups were held to validate and clarify results. The external consultant will be completing a psychometric analysis and providing models on how to incorporate the weighting into the assessment to achieve a risk-based outcome. Further updates will be provided as this work progresses and additional weighting exercises are completed.

New eLearning for Public Appointees
On January 25th the Ministry of Health Announced that a new mandatory eLearning Training program will be made available to Public Appointees of the College. Appointees will receive a link to the training from the Public Appointments Secretariat (PAS) in the coming weeks/months, if they have not already received it, and will need to repeat the training every 5 years. More information can be found in Attachment 6.

OCP Annual Report
The 2020 annual report, which will highlight key accomplishments and activities aligned with the Strategic Framework and Board-defined priorities, will be posted to Boardvantage and then published online following the March 22 Board meeting and approval of the audited financial statements.

Digital Health

Clinical Viewers
College staff have been working with Ontario Health-Digital Services to create a communication plan to invite pharmacies to sign up for access to the provincial clinical viewer in their Local Health Integration Network (LHIN). The Connecting Ontario Clinical Viewer is the designated clinical viewer for authorized providers in LHINs 5 to 14, and Clinical Connect is the designated clinical viewer for authorized providers in LHINs 1 to 4. A “Fact Sheet” is in the final drafting stages and we expect to begin supporting Ontario Health’s messaging to encourage pharmacies to onboard in the coming weeks.

PrescribeIT
College staff participate in bimonthly meetings with PrescribeIT enabling us to stay informed of their work and to ensure that the pharmacy standards of practice are considered throughout the development/deployment of the service. As of February 24, 2021, there are a total of 1,577 pharmacies and 2,941 prescribers in Ontario utilizing the service.

Quarterly Scorecard - OCP Board of Directors - Q4 2020

No.	Strategic Plan Alignment SP1	SP2	SP3	2019 Actual	Key Performance Indicators and Milestones	2020 Q1	Q2	Q3	Q4	YTD	Annual Target	Pandemic Impact
					Governance and Strategic Measures							
1		✓	✓	n/a	**2020/2021 Board elected under new governance framework*				7-Dec	n/a	8/10/20	11/10/20
2		✓	✓	n/a	**2020/2021 Committees operating under new governance framework*				7-Dec	n/a	12/1/20	2/1/21
3	✓	✓	✓	n/a	**Proactive Risk Register Developed for 2021*				7-Dec	n/a	12/30/20	
					Regulatory Measures							
4		✓		26%	% of Complaints disposed of within 150 days	cumulative measure (YTD)				23%	32%	
5		✓		103/396	Number of complaints disposed within 150 days / total number disposed	cumulative measure (YTD)				117 /505	172 / 536	
6		✓		37%	% of Registrar's Inquiries disposed of within 365 days	cumulative measure (YTD)				33%	42%	46%
7		✓		38 / 102	Number of Registrar's Inquires disposed within 365 days / total number disposed	cumulative measure (YTD)				55 / 165	56 / 134	62 / 134
8		✓		87%	% HPARB complaint decisions confirmed (decisions confirmed/HPARB decisions)	cumulative measure (YTD)				88% (22/25)	75%	
9		✓		84%	% of decisions for uncontested hearings issued within 60 days (total # decisions/total # hearings)	cumulative measure (YTD)				80% (24/30)	72%	
10	✓			46%	% of Community pharmacies active on AIMS platform	cumulative measure (YTD)				44%	60%	monitor
11	✓	✓		n/a	**AIMS in hospital - Implementation plan developed*		HOLD	move to 2021		n/a	12/30/20	2021
12	✓			n/a	**College resources in place to enable registrant uptake of expanded scope.*				31-Dec	n/a	9/1/20	
13	✓			n/a	**Evaluate the New Practice Assessment Model*		HOLD	move to 2021		n/a	12/30/20	2021
					Stakeholder, Transparency and Reputational Measures							
14	✓	✓	✓	n/a	**Review and refine public register to conform to new transparency framework*				27-Oct	n/a	9/30/20	11/30/20
15		✓		n/a	**Implement the Indigenous Cultural Competency Initiative*				7-Dec	n/a	12/4/20	
					Financial and Operational Performance Measures							
16			✓	60%	% Engagement drivers, organizational culture (subset)	Conducted in July				71%	70%	see #22
17	✓	✓	✓	0.81%	% variance of operating annual budget to year end actuals	Annual Report January 2021				-3.3%	within 5%	see #23
18			✓	n/a	**Implement a Talent Management Strategy to support succession planning*			move to 2021		n/a	6/30/20	10/9/20
19		✓	✓	n/a	**Discipline Costs Recovery - Investigation costs incorporated*		22-Jun			n/a	7/10/20	
					Pandemic Measures							
20		✓	✓	n/a	**Accelerated Board and Committee Remuneration & Expenses Model/Policy/Framework*	n/a	15-May			n/a	n/a	6/1/20
21		✓		n/a	**Implement computer based testing for Jurisprudence exam*	n/a		8-Oct		n/a	6/1/21	11/30/20
22			✓	n/a	Measure employee engagement during pandemic - supplement to indicator #16	Conducted in July				85%	n/a	70%
23	✓	✓	✓	n/a	% variance of actual to revised financial forecast - supplement to indicator #17	Annual Report January 2021				-1.8%	n/a	monitor
24		✓		n/a	% of Conduct Intakes related to pandemic	7% (52/744)	30% (137/454	8% (28/352)	7% (27/377)	13%	n/a	monitor
25	✓			n/a	% of Practice Inquiries related to pandemic	21% (207/987)	39% (286/733)	7% (43/615)	7% (42/595)	20%	n/a	monitor
26		✓		n/a	Total # of notifications or pharmacy operational changes related to pandemic	620	569	26	15	1,231	n/a	monitor
27	✓			n/a	Number of Practice guidance documents revised or developed due to pandemic	5	15	3	1	24	n/a	monitor
28	✓	✓		n/a	**Discipline Committee direction, training and capacity in virtual proceedings completed*		6-May			n/a	n/a	5/6/20

SP Ref. (Strategic Alignment)

SP1: Enhance system and patient outcomes through collaboration & optimization of current scope of practice

SP2: Strengthen trust and confidence in the College's role as a patients-first regulator

SP3: Enhance capacity to address emerging opportunities & advance quality & safe pharmacy practice & regulatory excellence

Legend	*Indicator Performance to Target*	**Milestone Performance to Target*
n/a = not applicable	On Target within 10%	On Track (proceeding per plan)
** Indicates a project milestone*	Approaching Target >10% - 25%	Potential Risk
Completed milestone	Beyond Target >25%	Risk/Roadblock

19-Feb-21

Revised: Sept 9, 2020

Scorecard Measure	Indicator or Milestone Definition	Performance
#1 2020/2021 Board elected under new governance framework	Part of the Governance Reform project, elections of members under the new governance framework is complete.	On Track Potential Risk Risk/Roadblock
#2 2020/2021 Committees operating under new governance framework	Part of the Governance Reform project, all committees are oriented and operating under the new governance framework.	On Track Potential Risk Risk/Roadblock
#3 Proactive Risk Register Developed for 2021	As part of governance reform, the current process of staff presenting a retrospective risk report to the Board annually will be replaced with a proactive Risk Register with prioritized risks, along with impacts, mitigation strategies and success measures presented for Board consideration at the start of each year.	On Track Potential Risk Risk/Roadblock
#4 % Complaints disposed within 150 days	The % of complaints compliant with the statutory requirement to dispose of complaints (including s. 75.1c Investigator appointments + complaints where Investigator is not required) within 150 days. The 150 days begins the date the complaint is "filed" and ends on the date the complaint is disposed of (decision mailed).	% performance is: 29% or more 24% – 28% 23% or less
#5 Number of complaints disposed within 150 days/total number disposed	This indicator illustrates the volume of complaints represented in indicator #4 above, including those that exceed 150 days.	
#6 % Registrar's Inquiries disposed within 365 days	The % of the Registrar's Inquiries (75.1a) disposed of within 365 days. The 365 days begins the date the Inquiry is "filed" and ends on the date the Inquiry is disposed of (decision mailed).	% performance is: 39% or more 32% – 38% 31% or less
#7 Number of Registrar's Inquiries disposed within 365 days/total number disposed	This indicator illustrates the volumes of Registrar's Inquires represented in indicator #6 above, including those that exceed 365 days.	
#8 % HPARB complaint decisions confirmed (# decisions confirmed/# HPARB decisions)	The % of HPARB (Health Professions Appeal and Review Board) complaint decision requests confirmed.	% performance is: 67% or more 56% – 66% 55% or less
#9 % Decisions for uncontested hearings issued within 60 days (total # of uncontested decisions issued)	The % of "Decisions" for uncontested hearings that are issued within 60 days. The period of measurement for this indicator begins from the last day of the hearing to the date the hearing "Decision" was released to the parties. The total number of uncontested decisions issued for the quarter is shown in brackets.	% performance is: 65% or more 54% – 64% 53% or less

Revised: Sept 9, 2020

Scorecard Measure	Indicator or Milestone Definition	Performance
#10 % of Community pharmacies active on AIMS platform	This indicator measures the % of community pharmacies who are actively recording incidents and near misses on the AIMS (Assurance & Improvement in Medication Safety) platform out of the pharmacies who have agreed to participate.	% performance is: 54% or more 45% - 53% 44% or less
#11 AIMS in hospital – Implementation plan developed	Part of the AIMS in hospitals project, this milestone marks the completion of the implementation plan.	On Track Potential Risk Risk/Roadblock
#12 College resources in place to enable registrant uptake of expanded scope	Part of the Expanded Scope of Practice project, this milestone marks the readiness of resources needed to support the registrants' implementation of expanded scope.	On Track Potential Risk Risk/Roadblock
#13 Evaluate the New Practice Assessment Model	This milestone evaluates the new practice assessment model to recommended improvements identified in the 2019 evaluation report.	On Track Potential Risk Risk/Roadblock
#14 Review and refine public register to conform to new transparency framework	This milestone confirms completion of a comprehensive review and recommendation for proposed information, display and functionality amendments to the Public Register in keeping with the Transparency Framework and AGRE transparency principles.	On Track Potential Risk Risk/Roadblock
#15 Implement the Indigenous Cultural Competency Initiative	This milestone marks the completion of the first phase of the Indigenous Cultural Competency initiative including the development of recommendations to define the organization's Commitment to Act and ongoing implementation of education experiences for Board, staff and registrants.	On Track Potential Risk Risk/Roadblock
#16 % Engagement drivers, organizational culture (subset)	A pulse employee engagement survey will conducted by an external 3rd party in June. The indicator that will be focused on is Organizational Culture. Results from this survey will be available in July 2020. The target is set at the industry benchmark.	% performance is: 63% or more 52% - 62% 51% or less
#17 % Variance of operating annual budget to year end actuals	This is a measure of the variance of actual operating expenses against budget. Achieving operating outcomes with additional efficiencies would exceed performance.	% performance is: 5.5% or less 5.6% - 6.3% 6.4% or more
#18 Implement a Talent Management Strategy to support succession planning	The focus will be to ensure that we have the right talent in the right place at the right time. This will therefore focus on performance improvement, succession planning, and individual development.	On Track Potential Risk Risk/Roadblock
#19 Discipline Costs Recovery – Investigation costs incorporated	Part of the Discipline Cost Recovery Model project, this milestone reflects the incorporation of investigation costs into bills of cost for recovery collection orders.	On Track Potential Risk Risk/Roadblock

#20 Accelerated Board and Committee Remuneration & Expenses Model/Policy/Framework	Part of the governance reform project, this millstone reflects the accelerated full implementation of the remuneration framework from Sept 2020 to March 2020.	On Track Potential Risk Risk/Roadblock
#21 Implement computer based testing for Jurisprudence exam	This milestone marks the implementation of PC based remote testing to adhere to social distancing guidelines	On Track Potential Risk Risk/Roadblock
#22 Measure employee engagement during pandemic – supplement to indicator #16	This will measure how we are continuing to engage employees through the pandemic. We are aiming for a 70% score.	
#23 % variance of actual to revised financial forecast – supplement to indicator #17	This is a measure of the variance of actual operating expenses against a revised financial forecast.	
#24 % of Conduct Intakes related to pandemic	This indicator measures the impact of the pandemic on the volume of intakes received.	
#25 % of Practice Inquiries related to pandemic	This indicator measures the impact of the pandemic on the volume of inquiries received by Pharmacy Practice.	
#26 Total # of notifications of pharmacy operational changes related to pandemic	This indicator shows the total number of notifications to the College of pandemic related changes to pharmacy operations (changes are closures & changes in business hours).	
#27 Number of Practice guidance documents revised or developed due to pandemic	This indicator shows the number of practice guidance documents that were developed or required revisions to support practice during to the pandemic (includes Policies, Guidelines, and Fact Sheets, Practice Tools, Position Statements, Resources and Guidance documents).	
#28 Discipline Committee direction, training and capacity in virtual proceedings completed	This milestone marks the readiness for DC proceedings moving to a virtual platform.	On Track Potential Risk Risk/Roadblock

Scorecard Measure	Q4 2020 BOD Summary / Improvement Strategies
#1 *2020/2021 Board elected under new governance framework	This milestone was completed December 7th.
#2 *2020/2021 Committees operating under new governance framework	This milestone was completed December 7th.
#3 *Proactive Risk Register Developed for 2021	This milestone was completed December 7th.
#4 % Complaints disposed within 150 days	Target of 32% not met due to clearance of 2016-18 investigations backlog, and ongoing reduction of ICRC decisions backlog. Record number of complaints decisions issued by ICRC increased the denominator thereby reducing the overall percentage meeting the target.
#5 Number of complaints disposed within 150 days / total number disposed	Larger denominator due to backlog clearance, with record number of complaints decisions issued in 2020. .
#6 % Registrar's Inquiries disposed within 365 days	Target of 42% not met due to clearance of 2016-18 investigations backlog, ongoing processing of 2019 cases, and ongoing reduction of ICRC decisions backlog. Record number of RI decisions issued by ICRC increased the denominator, thereby reducing the overall percentage meeting the target.
#7 Number of Registrar's Inquiries disposed within 365 days / total number disposed	Larger denominator due to backlog clearance, with record number of RI decisions issued in 2020.
#8 % Health Professions Appeal and Review Board (HPARB) complaint decisions confirmed (# decisions confirmed/ # HPARB decisions)	Target met.
#9 % Decisions for uncontested hearings issued within 60 days (total # of uncontested decisions issued)	Target met.

#10 % of community pharmacies active on AIMS platform	Recording rates remain low compared to last year. Given the pandemic and added pressure on the profession, this may persist until the environment stabilizes. In December the AIMS software contract was renegotiated embedding performance targets linked to the number of active pharmacies and average number of incidents reported per pharmacy. To support attainment of the targets, both parties commited to collaborate on implementation of a robust engagement plan.
#11 *AIMS in hospital - Implementation plan developed	An alternative solution for interoperability is not proceeding. Development of an implementation plan within the current enviroment of pandemic limitations has resulted in a shift in timing to 2021.
#12 *College resources in place to enable registrant uptake of expanded scope.	This milestone was completed December 31st.
#13 *Evaluate the New Practice Assessment Model	Due to the pandemic and interruption of on-site assessments, the inter-rater reliability project that forms the core of this evaluation has been suspended. The target date has been moved to 2022.
#14 *Review and refine public register to conform to new transparency framework	This milestone was completed October 27th.
#15 *Implement the Indigenous Cultural Competency Initiative	This milestone was completed December 7th.
#16 % Engagement drivers, organizational culture (subset)	Reported in Q3.Target met.
#17 % variance of operating annual budget to year-end actuals	Target met.
#18 *Implement a Talent Management Strategy to support succession planning	Moved to 2021.
#19 Discipline Costs Recovery - Investigation costs incorporated	This milestone was completed June 22nd.

#20 *Accelerated Board and Committee Remuneration & Expenses Model/Policy/Framework	This milestone was completed May 15th.
#21 *Implement computer based testing for Jurisprudence exam	This milestone was completed October 8th.
#22 Measure employee engagement during pandemic – supplement to indicator #16	Reported in Q3. Target met.
#23 % variance of actual to revised financial forecast – supplement to indicator #17	Target met/exceeded.
#24 % of Conduct Intakes related to pandemic	Q4 % of Conduct Intake inquiries were similar to Q3 levels; an anticpated increase due to the second wave of the pandemic did not materialize.
#25 % of Practice Inquiries related to pandemic	Q4 % of inquiries were similar to Q3 levels (7% of inquiries related to the pandemic). We anticipate Q1 of 2021 will see a sharp increase.
#26 Total # of notifications of pharmacy operational changes related to pandemic	Q4 and Q3 have significantly decreased over the first two quarters of 2020. We anticipate this trend will continue to diminish in 2021.
#27 Number of Practice guidance documents revised or developed due to pandemic	One (1) guidance document was created Q4 in comparison to three (3) that were revised in Q3.
#28 Discipline Committee direction, training and capacity in virtual proceedings completed	This milestone was completed May 6th.

2021 Quarterly Scorecard - OCP Board of Directors - Q1

No.	Strategic Alignment SP1	SP2	SP3	2020 Actual	Key Performance Indicators and Milestones	2021 YTD (year-to-date) YTD Q1	YTD Q2	YTD Q3	YTD Q4	2021 Target
					Domain 1: Governance					
1		✓	✓	n/a	***Implement new board orientation program centered on approved Board Policies**					09/30/21
					Domain 2: Resources					
2		✓		-3%	**% variance of operating annual budget to year end actuals**	Annual Report January 2022				+/- 5%
3		✓		n/a	**% Engagement drivers, Work Life Balance (subset)**	Scheduled for the fall				Benchmark
					Domain 3: System Partner					
4		✓		n/a	***Implement diversity & Indigenous cultural competency awareness strategies**					12/01/21
5	✓			n/a	***Community Practice Environmental Initiative implementation plan developed**					06/30/21
					Domain 4: Information Management					
6		✓		n/a	***Implementation of updated privacy & information management protocols with training**					08/06/21
					Domain 5: Regulatory Policies					
7	✓			n/a	***Development of Practice Support Tools for Minor Ailments**					12/31/21
8		✓	✓	n/a	***New regulation re COVID vaccine for BOD approval**	01/22/21				01/31/21
					Domain 6: Suitability To Practice					
9		✓		371	**90th percentile working days to dispose Complaints**					≤ 352 days
10		✓		18%	**% of High and Moderate risk Complaints disposed of within 150 days**					≥ 25%
11		✓		744	**90th percentile working days to dispose Registrar's Inquiries**					≤ 707 days
12		✓		33%	**% of High and Moderate risk Registrar's Inquiries disposed of within 365 days**					≥ 36%
13		✓		88%	**% HPARB complaint Decisions confirmed (Decisions confirmed/Decisions submitted)**					≥ 88%
14		✓		497	**90th percentile working days to dispose uncontested hearings**					≤ 497 days
15		✓		80%	**% of Decisions for uncontested hearings issued within 60 days (within 60/total hearings)**					≥ 80%
16		✓		n/a	**90th percentile working days to dispose contested hearings**					≤ 674 days
17	✓			47%	**% of Community pharmacies entering events on AIMS platform**					≥ 80%
18	✓			45%	**% of Pharmacist practice assessments completed**					100% (861)
19	✓			47%	**% of Pharmacy Technician practice assessments completed (pending Regulation)**					100% (300)
					Domain 7: Measurement, Reporting & Improvement					
20	✓	✓	✓	n/a	***Integrated risk management program phase 1: BOD orientation and reporting**					12/31/2021

LEGEND			
Strategic Alignment	**Indicator Range**	**Milestone Range**	**Symbols**
SP1: Enhance system and patient outcomes through collaboration & optimization of current scope of practice	Meets or Exceeds target	On Track (proceeding per plan)	n/a Not Avail.
SP2: Strengthen trust and confidence in the College's role as a patients-first regulator	Approaching Target ≤ 25%	Potential Risk	* Milestone
SP3: Enhance capacity to address emerging opportunities & advance quality & safe pharmacy practice & regulatory excellence	Beyond Target > 25%	Risk/Roadblock	Completed

Approved by: OCP Executive Team

Approved on: Mar 11, 2021

Last updated: 3/12/2021

2021 Indicator Definition – OCP Board of Director Scorecard

Approved by: OCP Executive Team Approved on: Mar 11, 2012 Last revised: Mar 11, 2021

Scorecard Measure	Indicator or Milestone Definition	Target Justification	Performance
#1 Implement new board orientation program centered on approved Board Policies	This measures progress against governance reform with the specific 2021 goal of implementation of the new Board Orientation Program that supports effective onboarding of new Board members and re-orientation of existing Board members.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock
#2 % Variance of operating annual budget to year end actuals	Indicator measures the variance of actual operating expenses against the annual budget. Achieving operating outcomes with additional efficiencies would exceed performance.	Target set based on acceptable variance of spend compared to budget.	% Variation is: +/- 5% +/- 5.6% – 6.3% +/- 6.4% or more
#3 % Engagement drivers, Work Life Balance (subset)	Indicator measures the % of staff engagement relating to the Work Life Balance section of the employee survey. This survey will be conducted in the fall with results available at year end.	McLean & Company industry benchmark latest standard.	% Engagement is:
#4 Implement diversity & Indigenous cultural competency awareness strategies amongst Board, staff & registrants	This milestone measures the implementation of the diversity and indigenous cultural competency awareness strategies for Board members, staff and registrants. Other major milestones include data collection, analysis and solution development.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock
#5 Community Practice Environmental Initiative implementation plan developed	This milestone measures the completion of the College's plan to implement guiding principles of a shared accountability model with community pharmacy organizations in consultation with the Community Practice Environment Advisory Group.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock
#6 Implementation of updated privacy & information management protocols with training	This milestone measures the implementation of the updated privacy and management protocols and the completion of the associated mandatory staff training.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock

2021 Indicator Definition – OCP Board of Director Scorecard

Approved by: OCP Executive Team Approved on: Mar 11, 2012 Last revised: Mar 11, 2021

Scorecard Measure	Indicator or Milestone Definition	Target Justification	Performance
#7 Development of Practice Support Tools for Minor Ailments	This milestone measures the development of strategies that will support registrants with the expanded scope for minor ailment prescribing.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock
#8 New regulation re: COVID vaccine for Board approval	This milestone measured the approval of the regulatory authority for vaccine administration by all pharmacy professionals.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock
#9 90th percentile working days to dispose complaints	Indicator measures the maximum amount of time (in working days) in which 9 out of 10 complaints are disposed, with only 1 out of the 10 taking longer.	New CPMF reporting indicator. Target set at 5% improvement to 2020.	Number of days is: ≤ 352 353 – 440 ≥ 441
#10 % High and Moderate risk complaints disposed of within 150 days.	Indicator measures the % of high and moderate risk complaints meeting the statutory requirement to dispose of all complaints within 150 days from date of filing to date the ICRC decision is sent. This change in focus from all complaints to high and moderate risk complaints is consistent with the ministry's CPMF mandate and risk-based regulation. *(Note: Indicator revised since Dec 7th, 2020 board meeting)*	Shifted focus to high and moderate risk complaints as per College's goal towards risk-based regulation. Target will be set based on 2019 performance data (as 2020 performance was affected by other factors, e.g., clearance of backlogs).	% Complaints is: ≥ 25% 19% – 24% ≤ 18%
#11 90th percentile working days to dispose Registrar's inquiries	Indicator measures the maximum amount of time (in working days) in which 9 out of 10 Registrar's inquiries are disposed, with only 1 out of the 10 taking longer.	New CPMF reporting indicator. Target set at 5% improvement to 2020.	Number of days is: ≤ 707 708 – 883 ≥ 884

2021 Indicator Definition – OCP Board of Director Scorecard

Approved by: OCP Executive Team Approved on: Mar 11, 2012 Last revised: Mar 11, 2021

Scorecard Measure	Indicator or Milestone Definition	Target Justification	Performance
#12 % high and moderate risk Registrar's inquiries (RI's) disposed within 365 days.	Indicator measures the % of high and moderate risk RI's (s. 75(1) (a) investigations) to dispose of all RI's within 365 days from date of filing to date the ICRC decision is sent. This change in focus from all RI's to high and moderate risk RI's is consistent with the ministry's CPMF mandate and risk-based regulation. *(Note: Indicator revised since Dec 7th, 2020 board meeting)*	Shifted focus to high and moderate risk RI's as per College's goal towards risk-based regulation. Target will be set based on 2019 performance data (as 2020 performance was affected by other factors, e.g., clearance of backlogs).	% Registrar's inquires is: ≥ 36% 27% – 35% ≤ 26%
#13 % HPARB complaint decisions confirmed	Indicator measures the % of HPARB (Health Professions Appeal and Review Board) reviews of ICRC complaints investigations and decisions, requested by either party, that are confirmed by HPARB.	Monitoring indicator. Target set to 2020 performance.	% Complaints is: ≥ 88% 66% – 87% ≤ 65%
#14 90th percentile working days to dispose uncontested Hearings	Indicator measures the maximum amount of time (in working days) in which 9 out of 10 uncontested Hearings are disposed, with only 1 out of the 10 taking longer.	New CPMF reporting indicator. Target set to 2020 baseline. Monitor. No reductions expected in 2021 due to steadily increasing referrals and staffing, resource and panel constraints.	Number of days is : ≤ 497 498 – 621 ≥ 622
#15 % Decisions for uncontested hearings issued within 60 days	Indicator measures % of written "decisions" for uncontested hearings that are issued within 60 days of the hearing, beginning from the last day of the hearing to the day the written "decision" is released to the registrant and complainant. Total number of uncontested written "decisions" issued for the quarter is shown in brackets.	Monitoring indicator. Target set to 2020 performance.	% Decisions is: ≥ 80% 60% – 79% ≤ 59%
#16 90th percentile working days to dispose contested Hearings	Indicator measures the maximum amount of time (in working days) in which 9 out of 10 contested Hearings are disposed (the day a written decision is released), with only 1 out of the 10 taking longer.	New CPMF reporting indicator. Target set to 2019 baseline. Monitor. No reductions expected in 2021 due to steadily increasing referrals and staffing, resource and panel constraints.	Number of days is: ≤ 674 675 – 843 ≥ 844

2021 Indicator Definition – OCP Board of Director Scorecard

Approved by: OCP Executive Team Approved on: Mar 11, 2012 Last revised: Mar 11, 2021

Scorecard Measure	Indicator or Milestone Definition	Target Justification	Performance
#17 % of Community pharmacies active on AIMS platform	Indicator measures the % of community pharmacies actively recording events (incidents & near misses) on the AIMS (Assurance & Improvement in Medication Safety) platform out of the total accredited pharmacies.	Target set to the terms in the contractual agreement with vendor.	% of pharmacies is: ≥ 80% 60% – 79% ≤ 59%
#18 % of Pharmacist practice assessments completed	Indicator measures the % of the 861 planned initial community and hospital pharmacist practice assessments completed. Note the introduction of a new assessment model (separation of practice and operational assessments) in 2018 resulted in smaller specialized teams and correspondingly fewer assessments compared to prior years. Performance flag applies to number of completed assessments at year end.	Target set to 2021 planned assessments based on resource capacity and assessment complexity.	% of assessments is: 100% (861) ≥ 75% (646 – 860) < 75% (645 or less)
#19 % of Pharmacy technician practice assessments completed (pending Regulation)	Indicator measures the % of the 300 planned initial community and hospital pharmacy technician (voluntary) practice assessments completed. Performance flag applies to number of completed assessments at year end.	Target set to 2021 planned assessments based on resource capacity and assessment complexity.	% of assessments is: 100% (300) ≥ 75% (225 – 299) < 75% (224 or less)
#20 Integrated risk management program phase 1: Board of Director (BOD) orientation and reporting	This milestone measures the implementation of a structured review and reporting process for prospective risks and the education of the Board on their role on risk oversight.	Milestone set based on approved project schedule.	Milestone is: On Track Potential Risk Risk/Roadblock

LEGEND	
Indicator Range	**Milestone Range**
Meets or Exceeds target	On Track (proceeding per plan)
Approaching Target ≤ 25%	Potential Risk
Beyond Target > 25%	Risk/Roadblock

The Pharmacy Examining Board of Canada

Le Bureau des examinateurs en pharmacie du Canada

717 Church Street, Toronto, Ontario, Canada M4W 2M4 • Telephone (416) 979-2431, Fax 599-9244 • www.pebc.ca

TO: NAPRA and Provincial Regulatory Authorities

FROM: John A. Pugsley, Registrar-Treasurer

DATE: **January 25, 2021**

RE: PEBC Update on the Administration of PEBC Examinations and Plans for 2021

Delivery of PEBC Computer-Based Examinations Via Prometric Remote Proctoring and at Prometric Test Centres

Taking into consideration the ongoing COVID-19 pandemic and the potential need for social distancing, the PEBC Board of Directors in May 2020 approved the use of remote proctoring (RP) as an additional examination delivery modality for the 2020 administrations of the Pharmacist Evaluating Examination, Pharmacist Qualifying Examination - Part I (MCQ) and Pharmacy Technician Qualifying Examination- Part I (MCQ). For 2020, candidates had a choice to take PEBC's computer-based examinations on-site at Prometric test centres or via their *ProProctor* remote proctoring platform.

Testing Modalities and Candidate Performance

As part of the Board's consideration for remote proctoring, an important aspect was to ensure the validity and reliability of the exam results through RP as compared to taking the exam at a test centre. PEBC's Lead Psychometrician reviewed key measures of performance to determine whether there was any difference between the testing modalities. Based on the detailed analysis of the three administrations, the validity and reliability of the exam results are maintained, regardless of the testing modality.

Candidate Satisfaction with Remote Proctoring

Based on feedback surveys, candidates indicated they were overall satisfied with PEBC's offering of the remote proctoring option. Although there were candidates who had internet connectivity issues, many also commented that their exam went smoothly.

Prometric has recently made changes to their RP platform. These changes will enhance the stability of the platform and minimize the potential for candidate disconnections. PEBC continues to work with candidates to ensure they are well prepared for the testing experience through website information, informational videos, trouble shooting tips and a live RP demo exam.

At the October PEBC Mid-Year Board Meeting, the Board of Directors approved the continued use of remote proctoring for PEBC's computer-based, multiple choice examinations until February 2022.

PEBC Computer-Based Examinations for 2021

Pharmacist Evaluating Examination:

The Winter 2021 Pharmacist Evaluating Examination was held on January 13th. Approximately 1050 candidates took the examination of which approximately two-thirds took the exam via remote proctoring nationally and internationally. Candidates who were unable to take advantage of remote proctoring in their own homes took their examination at Prometric test centres. Prometric test centres adhered to pandemic protocols including the wearing of masks by all staff and candidates, sanitizing of test stations before and after each use, and screening of candidates prior to entry into the centre as per public health guidelines.

The Summer Pharmacist Evaluating Examination will be held on June 16, 2021.

Pharmacy Technician Qualifying Examination – Part I (MCQ)

The Winter Pharmacy Technician Qualifying Examination-Part I (MCQ) will be administered on April 8, 2021 and the Summer Pharmacy Technician Qualifying Examination-Part I (MCQ) will be administered on September 13, 2021 via computer-based testing through remote proctoring and Prometric test centres.

Pharmacist Qualifying Examination – Part I (MCQ)

The Spring Pharmacist Qualifying Examination – Part I (MCQ) will be administered on May 25-27, 2021 and the Fall Pharmacist Qualifying Examination – Part I (MCQ) will be administered on November 8-12, 2021 via computer-based testing through remote proctoring and Prometric Test Centres.

Performance-based Examinations

PEBC will continue to follow national and provincial public health agency guidelines and in consultation with public health experts to ensure that the procedures in place will allow for the safe administration of our performance examinations.

Based on current public health guidelines, the following principles will be followed for a safe administration during 2021:

- minimizing gatherings of large groups in a single space
- COVID-19 screening of candidates and personnel
- utilizing personal protection measures, including the wearing of ASTM Level II masks by all candidates and personnel
- conducting enhanced sanitization of common areas and materials as required
- maintaining physical distancing throughout the exam **(max. 3 participants per station**)

Since September 2020, PEBC has been able to successfully administer the OSCE and OSPE across the country to a total of 1700 candidates with no reported COVID cases.

OSCE/OSPE Capacity Issues:

In 2017, the Board approved a policy which allowed PEBC to set limits to the number of candidates it would test in the OSCE annually at 3000. It was stipulated that when the number of applications exceed the number of spaces, PEBC would prioritize first-time test takers over repeat test takers.

The pandemic brought to light the need to enhance the policy to better manage the exceeding capacity demands for the OSCE spaces. The limit of 3000 annually does not reflect the capacity constraints at each individual administration which could vary based on the ability to recruit enough exam centres and tracks.

PEBC has decided that it would be appropriate to broaden the policy to indicate that when the number of applications exceed the number of spaces available for a given administration, regardless of the numbers, it will reserve the right to prioritize allocations to first-time test-takers over repeat test takers, followed by the date of receipt of a completed application.

At the Mid-Year Board Meeting in October 2020, the Board of Directors approved a motion that PEBC prioritize space allocations for a given administration to first-time test takers over repeat test takers in the OSCE and OSPE.

Winter 2021 Pharmacist Qualifying Examination – Part II (OSCE) (Contingency Administration)

In anticipation of challenges with the November OSCE, last summer, PEBC had proactively secured a date for a supplementary OSCE to be held in late February 2021. PEBC is currently in the process of preparing for this administration to eliminate the backlog. PEBC has been collaborating with its partners at the exam centres, and as required some of the Deans of the universities, some professional associations, provincial regulatory authorities and specific student groups to engage with provincial governments and public health offices to permit a successful administration.

Candidates impacted by the cancellation of some of the examination centres for the November 2020 OSCE as well as applicants for the November 2020 OSCE who were unable to be accommodated in November are eligible to take the OSCE on February 28th. Currently PEBC plans to test approximately 540 candidates at a total of seven centres in Quebec, Ontario, Manitoba, Alberta and British Columbia. PEBC will not be running an OSCE in Toronto in view of the past challenges it faced last November.

To help ensure the administration of our OSCE in Ontario during the Covid-19 pandemic, PEBC has written to the Minister of Health in Ontario, Chief Medical Officer for Ontario Public Health, and the Ontario Ministry of College and Universities to seek classification of our exams as essential postgraduate health-related assessments and therefore subject to the same public health restrictions/exemptions as post-secondary institutions, regardless of where the examinations are administered. PEBC received endorsements from: the Ontario Pharmacists Association, the Leslie Dan Faculty of Pharmacy - University of Toronto, the University of Waterloo School of Pharmacy, as well as the University of Toronto Pharmacy Class of 2020 and the University of Waterloo Pharmacy Class of 2020 and the Canadian Society of Hospital Pharmacists – Ontario Branch.

Pharmacy Technician Qualifying Examination – Part II (OSPE)

The Winter Pharmacy Technician Qualifying Examination-Part II (OSPE) will be administered on April 10, 2021 at multiple sites across Canada. PEBC has received approximately 620 applicants for this examination administration. The Summer Pharmacy Technician Qualifying Examination-Part II (OSPE) will be held on September 19, 2021.

Pharmacist Qualifying Examination – Part II (OSCE)

The Spring Pharmacist Qualifying Examination – Part II (OSCE) will be administered on May 30, 2021. Typically, the May OSCE is administered to approximately 1300 candidates; however, in past years, PEBC has administered the OSCE to a larger number of candidates. PEBC will be looking to maximize capacity to the greatest extent possible; however, it will have a better understanding of the capacity requirements for the May OSCE after the application deadline passes and after the completion of the supplementary administration at the end of February.

The Fall Pharmacist Qualifying Examination – Part II (OSCE) will be administered on November 6, 2021.

Virtual Performance Examinations

PEBC recognizes there continue to be concerns that the current state of the pandemic and public health regulations could prevent some OSCE/OSPE administrations from partially or completely proceeding. With that in mind, PEBC has committed to exploring a virtual performance exam to mitigate the risk of extended or future disruptions to the administration of its performance exams.

An integral part of PEBC's decision to accept a virtual delivery model is the assurance of the validity, reliability and generalizability of the assessment results. Furthermore, PEBC will need to assess the implications of a virtual offering, including security of exam content, technology requirements for all participants as well as cost implications.

To assist PEBC in making this determination on the use of virtual performance exams, PEBC is currently establishing two committees to assist with the process. The first, a **Steering Committee**, is a broader, strategic committee whose focus will be on the 'should' question of a virtual offering, while the second, **Implementation Committee**, will be an operational committee focused on how to administer the performance exams virtually and determine how a future 'scale-up' could occur. The Steering Committee will oversee the Implementation Committee and will update and advise PEBC's Committee on Examinations on the best course of action. The Terms of Reference for each of these committees have been approved by the Executive Committee along with a preliminary budget.

The purpose of the Steering Committee is to:

- determine the necessity for a virtual Pharmacist Qualifying Examination-Part II and a virtual Pharmacy Technician Qualifying Examination-Part II Performance Examination as a temporary measure or permanent delivery model.

- oversee the development, research, and implementation of a pilot for a virtual Pharmacist Qualifying Examination-Part II Performance Examination and a Pharmacy Technician Qualifying Examination-Part II Performance Examination in 2021.

- advise the Committee on Examinations on the appropriateness of a full-scale implementation of a fully virtual or dual modality (live and virtual) administration of PEBC's performance examinations.

The purpose of the Implementation Committee is to conduct virtual performance exam pilots to support the Steering Committee's deliberations and recommendations to PEBC's Committee on Examinations. The Committee will:

- Develop and implement a plan to pilot a virtual Pharmacist Qualifying Examination - Part II Performance Examination
- Develop and implement a plan to pilot a virtual Pharmacy Technician Qualifying Examination - Part II Performance Examination

The pandemic has introduced many challenges to PEBC, its stakeholders and to candidates. PEBC is committed to doing everything possible to administer its exams successfully, placing the safety and wellness of candidates, exam personnel and PEBC staff at the forefront, while maintaining the integrity of its exam processes. Despite the ongoing uncertainty with the pandemic, PEBC continues to prepare for the administration of the upcoming exams while also anticipating potential obstacles so that we are prepared to deal with them effectively, resulting in positive outcomes.

Ministry of Health
Ministry of Long-Term Care

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Ontario

January 25, 2021

Memorandum To: Provincial Agencies and Health and Long-Term Care Entities

From: Peter Kaftarian
Assistant Deputy Minister and Chief Administrative Officer

Subject: New eLearning for Public Appointees

I am pleased to inform you that that the government has launched a new eLearning program for all public appointees which will be administered by the Public Appointments Secretariat (PAS).

This program will take approximately two to three hours to complete and will work across different digital platforms and devices. It will provide appointees with foundational knowledge on the agency sector, their roles and responsibilities as public appointees including their fiduciary duties and acting in an ethical way.

To ensure that the eLearning meets the needs of users, appointees will be surveyed to assess its impact and identify needs for future updates.

PAS will send emails to appointees with instructions on how to access the training between now and April 2021. Appointees will be able to easily access the eLearning through their PAS user accounts and will be asked to complete the eLearning within 30 days of receiving the initial link.

All current and future public appointees will be expected to complete this new eLearning regardless if they have received similar training when they were first appointed years ago. Appointees will also be required to do this eLearning once every five years.

Please note that in keeping with the practices of public appointee training that PAS has offered in the past and since there is an element of public service in all appointments, appointees will not be entitled to receive remuneration to complete this mandatory training.

Please feel free to provide the public appointees on your Board / Council a heads up that they should expect to receive a link to this eLearning in the coming weeks / months.

…/2

If you have any questions, please contact Christy Hackney, Manager, Corporate Management Branch at Christy.Hackney@ontario.ca or (416) 704-9537.

Sincerely,

Peter Kaftarian

c: Ministry Program Area Contacts
John Amodeo, Director, Corporate Management Branch
Christy Hackney, Manager, Corporate Management Branch

Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	FOR INFORMATION	X

INITIATED BY: Nancy Lum-Wilson, CEO and Registrar

TOPIC: College Performance Measurement Framework

ISSUE: The Ministry of Health released the inaugural College Performance Measurement Framework (CPMF) intended to apply a standardized and transparent approach to reporting on the performance of Ontario's health regulatory colleges and support system-wide quality improvement. All colleges are required to submit to the Ministry and publish online a report using the framework by March 31, 2021. The College has completed its first CPMF report and it is presented to the Board for information (see appendices).

PUBLIC INTEREST RATIONALE:

The objective of the CPMF aligns with the College's Board-defined vision, mission and values, and strategic priorities and will become an important reporting mechanism to demonstrate the College's performance against standards and regulatory best practices as it relates to the fulfilment of its public mandate and legislated objects.

BACKGROUND:

- The Ministry has developed the CPMF as a standardized approach to measuring and reporting on health regulatory college performance.
- While the tool is heavily process focused, the inaugural report is a first attempt by the Ministry to provide baseline information on the structures and processes each college currently has in place along with activities that are being undertaken to demonstrate continuous improvement in performance.
- All 26 provincial health regulatory colleges are required to complete and submit the CPMF reporting tool to the Ministry by March 31, 2021.
- The framework and corresponding reporting tool were developed over the course of two years with input from colleges. OCP was among a group of colleges that played an active role in the development of the CPMF in collaboration with the Ministry. All health regulatory colleges subsequently had an opportunity to provide additional feedback on a draft reporting tool which the Ministry considered in its release of the final reporting tool and corresponding resources in December 2020.
- Accompanying the release of the CPMF reporting tool is a technical specifications document intended to support a consistent understanding and interpretation of the standards (see appendices).
- The Ministry is planning to post a summary report on its website that will capture CPMF responses at a system level.
- Once the CPMF reports are submitted, the Ministry will use the information contained in the submissions to further evaluate and refine the reporting tool. The Ministry has recently requested the continued involvement of the College in this work.

ANALYSIS:

- The CPMF consists of seven domains: Governance, Resources, System Partners, Information Management, Regulatory Policies, Suitability to Practice, and Measurement, Reporting and Improvement.

- Within each domain, specific components such as standards, measures, evidence and planned improvement activities set out expectations and requirements for the colleges to include/respond to in their reports at an operational level.
- Overall, the College meets all of the standards expressed in the CPMF, with opportunities for ongoing improvement articulated throughout the report.
- The framework reinforces the College's approach to fulfilling its mandate of serving and protecting the public through the collection, analysis and transparent reporting of data – with the goal of using that data to continually improve performance as an accountable health regulator that has adopted principles of right-touch regulation focused on outcomes.
- The College has modified its Board Scorecard to mirror the CPMF reporting domains in order to further demonstrate and reinforce continued alignment with the Ministry's expectations and the College's commitment to transparency, public accountability and performance improvement.
- The CPMF does not, and is not intended to, replace the requirement for colleges to publish and submit annual reports to the Minister. At this time, the College will continue to publish an annual report, which includes audited financial statements, information on performance against the College's mandate as well as its vision, mission, values and strategic priorities, and summary of discipline findings for the previous year (as stipulated in legislation).

NEXT STEPS:

The College will submit the CPMF to the Ministry by March 31, 2021 and will post the CPMF and corresponding documents to its website under About the College/Performance and Accountability.

Technical Specifications for Quantitative College Performance Measurement Framework Measures

December 2020

Table of Contents: Context Measure

INTRODUCTION

This document serves as a companion document to the College Performance Measurement Framework (CPMF) Reporting Tool. It is designed to provide Ontario's health regulatory Colleges (Colleges) with recommended methodology for calculating the quantitative measures that form part of the CPMF. However, recognizing that at this point in time, the data may not be readily available for each College to calculate the quantitative measures in the recommended manner (e.g., due to differences in definitions), where this is the case a College can report the information in a manner that is conducive to their data infrastructure and availability.

If a College is reporting the information in a manner that is different than the recommended methodology as set out below, for transparency purposes a College is being asked to provide the following information in the CPMF Reporting Tool:

- Indicate that is using its own methodology.
- Provide a brief rationale for why it is using its own methodology.

Where a College chooses to report a context measure using methodology other than outlined in the following Technical Specifications document, the ministry asks the College to provide the methodology to the ministry so that it can understand how the College calculated the information provided.

Table 1: The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.

Suitability to Practice Domain > Standard 12: The complaints process is accessible and supportive.

Measure 12.1, Evidence b	**The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.**
Description	Indicates whether the College provides an individualized response to 90% of inquiries from the public within 5 days and provides timelines for follow up where necessary.
Calculation Methods	Numerator/Denominator
Numerator	Number of responses provided to the initial public inquiry (including expected timeline for follow-up) within 5 days. (See definition for public below).
Denominator	All inquiries from the public related to the College's complaints process received within the reporting period.
Exclusions	• Inquiries from anyone other than the "public" as defined below. • Inquires not related to the complaints process. • Calls to file a complaint or Inquiries about a complaint that has been filed with the College.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Public:** Any individual, including media and researchers, who contacts the College. **Inquiry:** Within the context of this Evidence, an inquiry is defined as the time when an individual, who is from the public, seeks information from the College. **Response:** The College sends an individualized response to the inquiry and provides either a resolution or timelines for follow up where necessary.

Measure 12.1, Evidence b	The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.
	Method of Receipt: This refers to the form and manner in which the inquiry is received by the College. It may take the form of a phone call, email, social media or physical correspondence (e.g., letter).

Table 2: Context Measure – the type and distribution of QA/QI activities or assessments used in CY 2020[1]

Suitability to Practice Domain > Standard 11: The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Context Measure #1	Type and distribution of QA/QI activities and assessments used in CY2020
Description	The type of QA and QI activities and assessments that the College uses to assess a registrant's ongoing competence and support registrants in maintaining competence, and the distribution of the activities and assessments used (e.g., CPD portfolio review/audit, practice site visit/inspection, patient chart audit/chart-simulated recall, examination, multi-source feedback/360-degree reviews, clinical simulation or objective structured clinical examination, direct observation in practice, etc.).
Calculation Method	This Measure captures two separate calculations: 1. Distribution of QA/QI activities or assessments i. Report the distinct types of activities or assessments used by the College. ii. Calculate the number activities or assessments undertaken across each type of activity or assessment. Note: - Where the number in a given type of QA/QI activity or assessment is between 1 and 5, report in CPMF Reporting Tool as "NR" - Where no registrant underwent a particular type of QA/QI activity or assessment, report in CPMF Reporting Tool as "0".
Exclusions	• Remedial activities required of registrants outside of the College's QA program (e.g., remediation ordered by a Panel of the ICRC). • QA activities undertaken by inactive or non-practising registrants.

[1] *Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested contextual information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.*

Context Measure #1	Type and distribution of QA/QI activities and assessments used in CY2020
	• All QA activities or assessments undertaken by active registrants of a College outside of the of the QA Program.
Inclusion	• All QA activities or assessments undertaken by active registrants of a College as part of the QA Program. • All QI activities or assessment undertaken by active registrants of a College.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**QA activity and assessment:** the different types of QA activities and assessments that registrants undergo/undertake to improve their practice and/or a College uses to assess the ongoing competence of registrant's practice, including any activity and assessment that assesses (either through self-assessment or College assessment) knowledge, skills and judgment or expectations for a registrant's practice and where non-compliance may lead to a QA Committee referral (e.g., article review, peer circles, CPD portfolio review/audit, practice site visit/inspection, patient chart audit/chart-simulated recall, examination, multi-source feedback/360-degree reviews, clinical simulation or objective structured clinical examination, direct observation in practice, etc.). **QI activity and assessment:** the different types of quality improvement activities and assessments that use a preventative/proactive approach and are more focused on individual practice and self-assessments to identify opportunities for self-directed learning and improvement in an individual's practice. These activities occur outside of the legislated QA Program and include activities, such as, for example a Quality Improvement Survey, Practice Profile, Self-Guided Chart Review; Data-Driven Quality Improvement; and a Practice Improvement Plan. **Inactive or non-practicing registrants:** includes any registrants who have a certificate of registration that does not permit them to provide direct patient care or to engage in the practice of the profession. It is noted that Colleges may use different terms to identify classes of certificates of registration and the use of "inactive or non-practicing" is intended to represent all such certificate classes used by the various Colleges.

Table 3: Context Measure – the total number of registrants who participated in QA Program in CY 2020

Suitability to Practice Domain > Standard 11: The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Context Measure #2	Total number of registrants who participated in the QA Program in CY 2020
Description	The total number of registrants that participated in an activity or assessment as part of the Quality Assurance Program.
Calculation Method	The total number of registrants that underwent at least one activity or assessment as part of the QA Program within the reporting period.
Exclusions	• All inactive or non-practicing registrants who underwent QA activities or assessment. • All QI activities or assessment undertaken by active registrants of a College. • All QA activities or assessments undertaken by active registrants of a College outside of the of the QA Program.
Inclusion	• Registrants who initiated a QA activity or assessment within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**QA activity and assessment:** the different types of QA activities and assessments that registrants undergo/undertake to improve their practice and/or a College uses to assess the ongoing competence of registrant's practice, including any activity and assessment that assesses (either through self-assessment or College assessment) knowledge, skills and judgment or expectations for a registrant's practice and where non-compliance may lead to a QA Committee referral (e.g., article review, peer circles, CPD portfolio review/audit, practice site visit/inspection, patient chart audit/chart-simulated recall, examination, multi-source

Context Measure #2	Total number of registrants who participated in the QA Program in CY 2020
	feedback/360-degree reviews, clinical simulation or objective structured clinical examination, direct observation in practice, etc.). QI activity and assessment: the different types of quality improvement activities and assessments that use a preventative/proactive approach and are more focused on individual practice and self-assessments to identify opportunities for self-directed learning and improvement in an individual's practice. These activities occur outside of the legislated QA Program and include activities, such as, for example a Quality Improvement Survey, Practice Profile, Self-Guided Chart Review; Data-Driven Quality Improvement; and a Practice Improvement Plan. Inactive or non-practicing registrants: includes any registrants who have a certificate of registration that does not permit them to provide direct patient care or to engage in the practice of the profession. It is noted that Colleges may use different terms to identify classes of certificates of registration and the use of "inactive or non-practicing" is intended to represent all such certificate classes used by the various Colleges.

Table 4: Context Measure – the rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation

Suitability to Practice Domain > Standard 11: The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Context Measure #3	Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation.
Description	The proportion of registrants that undertook a QA activity or assessment as part of the QA Program and were directed by the QA Committee to undertake remediation.
Calculation Method	Numerator/Denominator – Where the number of registrants referred to the QA Committee is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no referrals have been made to the QA Committee as part of the QA Program, report in CPMF Reporting Tool as "0".
Numerator	Number of registrants who undertook an activity or assessment as part of the QA Program and were required to undertake remediation at the direction of the QA Committee.
Denominator	Total number of registrants who undertook an activity or assessment as part of the QA Program.
Exclusions	• All inactive or non-practicing registrants who undertook QA activities or assessment. • Remediation ordered by any other Committee of the College.
Inclusion	• All active registrants who undertook a QA activity or assessment as part of the QA Program.

Context Measure #3	Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Inactive or non-practicing registrants:** includes any registrants who have a certificate of registration that does not permit them to provide direct patient care or to engage in the practice of the profession. It is noted that Colleges may use different terms to identify classes of certificates of registration and the use of "inactive or non-practicing" is intended to represent all certificate classes used by the various Colleges. **Remediation activity or assessment:** The different methods that a QA Committee can require a registrant to undertake in order to provide additional support to registrants where the QA committee determines a registrant does not demonstrate the required knowledge, skills or judgment including, specified continuing education or remediation programs (e.g., course work or education programs, etc.).

Table 5: Context Measure – the rate of registrants who were directed to undertake remediation by the QA Committee that demonstrated required knowledge, skills, and judgment following remediation

Suitability to Practice Domain > Standard 11: The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Context Measure #4(i)	Rate of registrants who demonstrated required knowledge, skills, and judgment following remediation.
Description	The proportion of registrants that, following remediation directed by the QA Committee, subsequently demonstrate the required knowledge, skills and judgment the remediation was intended to address.
Calculation Method	Numerator/Denominator – Where the number of registrants that, following remediation directed by the QA Committee, subsequently demonstrate the required knowledge, skills and judgment the remediation is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no registrants demonstrated the required knowledge, skill and judgment following remediation, report in CPMF Reporting Tool as "0".
Numerator	Total number of registrants that were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undergo a remediation activity and who subsequently demonstrated the required knowledge, skills and judgment following the remediation activity.
Denominator	Total number of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undergo a remediation activity as part of the QA Program (see Context Measure #3 numerator – these numbers should align)

Context Measure #4(i)	Rate of registrants who demonstrated required knowledge, skills, and judgment following remediation.
Exclusions	• All inactive or non-practicing registrants who underwent QA activities or assessment. • Any remediation activity that the College cannot verify whether upon completion the registrant demonstrated the required knowledge, skills or judgment or where the College cannot/does not have an auditing process. • Any registrant who has not completed remediation or has not been reassessed by the College within the reporting period (remediation is ongoing, registrant refusal to undertake).
Inclusion	• All registrants who completed required remediation activity within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	Remediation activity or assessment: The different methods that a QA Committee can require a registrant to undertake in order to provide additional support to registrants where the QA committee determines a registrant does not demonstrate the required knowledge, skills or judgment including, specified continuing education or remediation programs (e.g., course work or education programs, etc.). Inactive or non-practicing registrants: includes any registrants who have a certificate of registration that does not permit them to provide direct patient care or to engage in the practice of the profession. It is noted that Colleges may use different terms to identify classes of certificates of registration and the use of "inactive or non-practicing" is intended to represent all such certificate classes used by the various Colleges.

Table 6: Context Measure – the rate of registrants who were directed to undertake remediation by the QA Committee that are still undertaking remediation

Suitability to Practice Domain > Standard 11: The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Context Measure #4(ii)	Rate of registrants still undertaking remediation (i.e. remediation in progress)
Description	The proportion of registrants that were required by the QA Committee to undergo remediation as part of the QA Program that have not yet completed the remediation during the reporting period.
Calculation Method	Numerator/Denominator – Where the number of registrants still undertaking remediation is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no registrants are still undertaking remediation, report in CPMF Reporting Tool as "0".
Numerator	Total number of registrants who were required by the QA Committee to undergo a remediation activity as part of the QA Program that have not completed the remediation within the reporting period.
Denominator	Total number of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undergo a remediation activity as part of the QA Program (see Context Measure #3 numerator – these numbers should align).
Exclusions	• All inactive or non-practicing registrants required to undertake remediation. • Registrants required to undertake remediation who cease being a registrant for any reason or those that move to the inactive class.
Inclusion	• Registrants who initiated, but have not completed, remediation within the reporting period.

Context Measure #4(ii)	Rate of registrants still undertaking remediation (i.e. remediation in progress)
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Remediation activity or assessment:** The different methods that a QA Committee can require a registrant to undertake/undergo in order to provide additional support to registrants where the QA committee determines a registrant does not demonstrate the required knowledge, skills or judgment including, specified continuing education or remediation programs (e.g., course work or education programs, etc.). **Inactive or non-practicing registrants:** includes any registrants who have a certificate of registration that does not permit them to provide direct patient care or to engage in the practice of the profession. It is noted that Colleges may use different terms to identify classes of certificates of registration and the use of "inactive or non-practicing" is intended to represent all such certificate classes used by the various Colleges.

Table 7: Context Measure – the distribution of formal complaints and Registrar's Investigations by theme in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #5	Distribution of formal complaints and Registrar's Investigations by theme in CY 2020
Description	The distribution of complaints by theme as determined by the College, and the distribution of Registrar's reports by theme as determined by the College.
Calculation Method	1. Report the total number of formal complaints filed against registrants, and the number of complaints received across each of the following themes. 2. Report the total number of Registrar initiated investigations against registrants, and the number of complaints received across each of the following themes. 3. Report the percentage of the total formal complaints and Registrar initiated investigations represented for each theme [e.g., if there are 200 formal complaints and 20 with advertising as a theme then you would report (20/200) X 100 =10%]. Note: – Where the number in a given theme is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – When reporting % in the CPMF Reporting Tool use the reported numbers as the total when calculating the % (i.e. exclude the values where the College reports NR). Where no complaints have been received for a theme, report in CPMF Reporting Tool as "0". – Where there are multiple themes for a single complaint or Register's Investigation, each theme related to the complaint or Registrar's Investigation should be included in the count.

Context Measure #5	Distribution of formal complaints and Registrar's Investigations by theme in CY 2020
	– Where one of the allegations within a complaint could be categorized under multiple themes, Colleges are asked to report the theme they deem most appropriate.
Theme:	Examples:
Advertising:	Concerns that an advertisement related to a registrant's practice is in violation of a College's requirements, which depending on the profession, could include allegations that it is false or misleading, claims service superiority, contains patient testimonials, discriminatory, among other allegations.
Billing and Fees:	Concerns regarding a fee, billing or account submitted by or on behalf of the registrant, which could include allegations that a payment is misleading, unfair, reasonable, inaccurate, or unclear, failure to disclose to a patient the fee for a service before the service is provided, failure to provide itemized accounting for services and/or products on request, or where charges do not align with the regulator's guidance on billing arrangements, block fees, and/or payment plans.
Communication:	Concerns regarding a registrant's communication with a patient, a patient's relatives and/or a patient's decision-makers which could include a casual or uncaring attitude, disrespect, insensitivity, or communication of a non-therapeutic or culturally inappropriate matter.
Competence / Patient Care:	Complaints that a registrant provided care that did not meet standards and expectations of the profession which could include allegations that a registrant harmed a patient by providing a service, or performed or delegated a controlled act without the knowledge, skills and judgment to perform it, allegations regarding treatment decisions or outcomes, assessment, examinations, referrals, or failure to obtain consent.
Fraud:	Allegations that a registrant intentionally falsified a record, signed or issued a document containing a statement that the registrant knows or ought to know contains a false or misleading statement, or knowingly sought a payment from a person for a service that has been paid in full by another payer.

Context Measure #5	Distribution of formal complaints and Registrar's Investigations by theme in CY 2020
Professional Conduct & Behaviour:	Concerns against a registrant of unbecoming, disgraceful, dishonorable or unprofessional conduct, including allegations of patient abuse, failure to maintain the standards of practice of the profession, practising the profession while in a conflict of interest or breach of confidentiality.
Record Keeping:	Concerns regarding a registrant's financial and patient records, including retention of records and complying with the necessary privacy legislation. Allegations could include that the registrant failed to maintain records, include insufficient information, that the records are not understandable (legible, in English or French, etc.), organized (e.g., dated, etc.) or accurate (contain required information such as fees charged, date of services, up to date, permanent, etc.).
Sexual Abuse / Harassment / Boundary Violations:	Allegations against a registrant that could include engaging in sexual intercourse or other forms of physical relations with a patient, entering into an intimate or romantic relationship with a patient, remarks of a sexual nature towards a patient, sharing intimate details of the registrant's personal life, giving or receiving extravagant gifts from the patient, influencing a patient to change their will or other testamentary instrument, or initiating non-clinical touch with a patient.
Unauthorized Practice:	Concerns that a registrant has contravened, by act or omission, a term, condition or limitation on their certificate of registration, practised the profession while under suspension, or practised outside of the profession's scope of practice.
Other:	Concerns that do not fall into any of the above themes above.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. • Complaints that are withdrawn by the Registrar at the request of a complainant.
Inclusion	• Complaints that are formally submitted to the College. • Matters where the ICRC approved the appointment of an investigator after reviewing a report. • Complaints resolved through Alternative Dispute Resolution.
Reporting period	January 1, 2020 to December 31, 2020

Context Measure #5	Distribution of formal complaints and Registrar's Investigations by theme in CY 2020
Data source	Local data collection by the College
Definition	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Table 8: Context Measure – the total number of formal complaints that were brought forward to the ICRC during the reporting period in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #6	Total number of formal complaints that were brought forward to the ICRC in CY 2020
Description	The total number of formal complaints the College receives that were brought forward to a Panel of the ICRC during the reporting period.
Calculation Method	The total number of formal complaints that were brought forward for review by a Panel of the ICRC within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • All health-related inquiries. • Matters where the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • Formal complaints that are withdrawn by the Registrar at the request of a complainant.
Inclusion	• All complaints that a Panel of the ICRC determines are frivolous and vexatious in nature. • Formal Complaints to the College. • Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA. • Formal complaints that meet eligibility criteria for use of the ADR process.
Reporting period	January 1, 2020 to December 31, 2020

Context Measure #6	Total number of formal complaints that were brought forward to the ICRC in CY 2020
Data source	Local data collection by the College
Definitions	**Alternative Dispute Resolution (ADR):** means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute. **Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Table 9: Context Measure – the total number of ICRC matters brought forward as a result of a Registrar's Investigation in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #7	Total number of ICRC matters brought forward as a result of a Registrar's Investigation in CY 2020
Description	The total number of ICRC matters that come to a Panel of the ICRC for review as a result of a Registrar's investigation during the reporting period.
Calculation Method	All Registrars Investigations that are brought to a Panel of the ICRC for review.
Exclusions	• Formal complaints to the College. • Reports or concerns that the Registrar does not bring to the ICRC for review.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.

Table 10: Context Measure – the total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in reporting period in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #8	Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020
Description	The total number of ICRC matters where an investigator was appointed by a Panel of the ICRC and/or Registrar during the reporting period.
Calculation Method	All requests or notifications for appointment of an investigator brought forward to a Panel of the ICRC that were approved within the calendar year.
Exclusions	• All formal complaints that a Panel of the ICRC determines are frivolous and vexatious in nature. • Formal complaints withdrawn by the Registrar at the request of a complainant. • All requests for appointment under s.75(1)(c) under the RHPA.
Inclusion	• All requests for appointment under s.75(1)(a), s. 75(1)(b) and s.75(2) under the RHPA. • ICRC appointment of an investigator based on Registrar's belief that a registrant has committed an act of professional misconduct or is incompetent. • Registrar appointment of an investigator based on Registrar's belief that the conduct of the registrant would expose or would likely expose his or her patients to harm or injury.

Context Measure #8	Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020
	• Registrar appointment of an investigator upon request by a Panel of the ICRC after receiving information about a registrant from the Quality Assurance Committee.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 11: Context Measure – of the formal complaints that were disposed of in CY 2020 the rate that proceeded to Alternative Dispute Resolution (ADR)

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(i)	Rate of formal complaints that proceeded to Alternative Dispute Resolution (ADR) in CY 2020
Description	The proportion of all formal complaints filed with the College that are eligible and that use the ADR process to try and resolve the complaint.
Calculation Method	Numerator/Denominator – Where the number of formal complaints that proceeded to ADR is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no formal complaints proceeded to ADR, report in CPMF Reporting Tool as "0".
Numerator	Total number of formal complaints filed within the reporting period where both parties agree, and the Registrar approves, the use of the ADR process.
Denominator	The total number of formal complaints filed against registrants within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Formal complaints that are withdrawn by the Registrar at the request of a complainant. • All complaints that a Panel of the ICRC determines are frivolous and vexatious in nature. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.

Context Measure #9(i)	Rate of formal complaints that proceeded to Alternative Dispute Resolution (ADR) in CY 2020
Inclusion	• Formal complaints to the College. • Formal complaints that meet eligibility criteria for use of the ADR process. • Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Alternative Dispute Resolution (ADR):** means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute. **Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Table 12: Context Measure – of the formal complaints that were disposed of in CY 2020 the rate that were resolved through Alternative Dispute Resolution (ADR)

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(ii)	Rate of formal complaints that were resolved through ADR in CY 2020
Description	The proportion of all formal complaints filed with the College that are resolved through the ADR process.
Calculation Method	Numerator/Denominator – Where the number of formal complaints that were resolved through ADR is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no formal complaints were resolved through ADR, report in CPMF Reporting Tool as "0".
Numerator	Total number of formal complaints filed within the reporting period resolved through the ADR process.
Denominator	Total number of formal complaints filed against registrants within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Formal Complaints that are withdrawn by the Registrar at the request of a complainant. • All complaints that a Panel of the ICRC determines are frivolous and vexatious in nature. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.

Context Measure #9(ii)	Rate of formal complaints that were resolved through ADR in CY 2020
Inclusion	• Formal complaints to the College. • Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Alternative Dispute Resolution (ADR):** means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute. **Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Table 13: Context Measure – total number of formal complaints that were disposed of by the ICRC in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure # 9(iii)	Total number of formal complaints that were disposed by the ICRC in CY 2020
Description	The total number of formal complaints a Panel of the ICRC disposed of through a decision by the ICRC Panel.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Formal complaints that are withdrawn by the Registrar at the request of a complainant. • All concerns that a Panel of the ICRC determines are frivolous and vexatious in nature. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.
Inclusion	• Formal complaints to the College. • Formal complaints resolved through Alternative Dispute Resolution. • All complaints where a decision was provided to the registrant and complainant (if any) by the College within the reporting period. • Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and

Context Measure # 9(iii)	Total number of formal complaints that were disposed by the ICRC in CY 2020
	other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Disposal:** The day upon which a decision was provided to the registrant and complainant by the College (i.e., the date the reasons are released and sent to the registrant and complainant). **Alternative Dispute Resolution (ADR):** means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.

Table 14: Context Measure –the rate of formal complaints that proceeded to ICRC and are still pending in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(iv)	Rate of formal complaints that proceeded to ICRC and are still pending in CY 2020
Description	The total number of formal complaints that have been submitted to a Panel of the ICRC where the complaint has not been disposed of through a decision by an ICRC Panel.
Calculation Method	Numerator/Denominator
Numerator	Total number of formal complaints brought forward to a Panel of the ICRC for disposition within the reporting period where an ICRC Panel has not provided a decision to the registrant and complainant within the reporting period.
Denominator	Total number of formal complaints that were brought forward to a Panel of the ICRC in CY 2020. (this should align with the number from CM 6)
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Formal complaints that are withdrawn by the Registrar at the request of a complainant. • All complaints where a decision was provided to the registrant and complainant (if any) by the College within the reporting period. • All formal complaints submitted to a Panel of the ICRC for reasons other than a disposition (e.g. undertaking, investigation advice, request to summons a witness) • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.

Context Measure #9(iv)	Rate of formal complaints that proceeded to ICRC and are still pending in CY 2020
	• Formal complaints resolved through Alternative Dispute Resolution (ADR)
Inclusion	• Formal complaints to the College. • Complaints where an appointment of an investigator has been made under s.75(1)(c)
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Disposal:** The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant). **Alternative Dispute Resolution (ADR):** means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.

Table 15: Context Measure – of the formal complaints that were disposed of in CY 2020 the rate that were withdrawn by the Registrar at the request of a complainant

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(v)	Rate of formal complaints withdrawn by the Registrar at the request of a complainant in CY 2020
Description	The total number of formal complaints received that are withdrawn by the Registrar at the request of a complainant.
Calculation Method	Numerator/Denominator – Where the number of formal complaints withdrawn by the Registrar at the request of a complainant is between 1 and 5, report in CPMF Reporting Tool as "NR" for both the number reported and %. – Where no formal complaints were withdrawn by the Registrar at the request of a complainant, report in CPMF Reporting Tool as "0".
Numerator	Total number of formal complaints within the reporting period that are withdrawn by the Registrar at the request of a complainant.
Denominator	Total number of formal complaints filed against registrants within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • All concerns that a Panel of the ICRC determines are frivolous and vexatious in nature. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.

Context Measure #9(v)	Rate of formal complaints withdrawn by the Registrar at the request of a complainant in CY 2020
Inclusion	• Formal complaints to the College. • Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest.

Table 16: Context Measure – of the formal complaints that were disposed of in CY 2020 the rate that are disposed of by the ICRC as frivolous and vexatious

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(vi)	Rate of formal complaints that are disposed of by the ICRC as frivolous and vexatious in CY2020
Description	The total number of formal complaints received that a Panel of the ICRC determines are frivolous or vexatious, and where a Panel of the ICRC takes no action with respect to the complaint.
Calculation Method	Numerator/Denominator
Numerator	Total number of formal complaints within the reporting period that a Panel of the ICRC disposes of as frivolous or vexatious.
Denominator	Total number of formal complaints filed against registrants within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report. • All health-related inquiries.
Inclusion	• Formal complaints to the College. • Complaints where an appointment of an investigator has been made under s.75(1)(c) under the RHPA
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College

Context Measure #9(vi)	Rate of formal complaints that are disposed of by the ICRC as frivolous and vexatious in CY2020
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 17: Context Measure – of the formal complaints and Registrar's Investigations that were disposed of in CY 2020 the rate that are disposed of by the ICRC as a referral to the Discipline Committee

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #9(vii)	Rate of formal complaints and Registrar's Investigations that are disposed of by the ICRC as a referral to the Discipline Committee in CY 2020
Description	The total number of formal complaints received that a Panel of the ICRC disposes of through a referral of specified allegations to the Discipline Committee.
Calculation Method	Numerator/Denominator
Numerator	Total number of formal complaints within the reporting period that a Panel of the ICRC disposes of through a referral of specified allegations to the Discipline Committee.
Denominator	Total number of formal complaints filed against registrants within the reporting period.
Exclusions	• Complaint inquiries and other interactions with the College that do not result in a formal complaint. • Formal complaints that are withdrawn by the Registrar at the request of a complainant. • All concerns that a Panel of the ICRC determines are frivolous and vexatious in nature. • All health-related inquiries.
Inclusion	• Formal complaints to the College. • Formal complaints resolved through Alternative Dispute Resolution. • All complaints where a decision was provided to the registrant and complainant (if any) by the College within the reporting period.

Context Measure #9(vii)	Rate of formal complaints and Registrar's Investigations that are disposed of by the ICRC as a referral to the Discipline Committee in CY 2020
	• Complaints where an appointment of an investigator has been made under s.75(1)(c) of the RHPA • Complaints where an appointment of an investigator has been made under s.75(1)(a), s. 75(1)(b) and s.75(2) under the RHPA.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Disposal:** The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant). **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 18: Context Measure – the distribution of ICRC decisions by theme in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #10	Distribution of ICRC decisions by theme in CY 2020
Description	The total number of each type of ICRC decision for each of the 10 high-level themes
Calculation Method	1. Report the total number of ICRC decisions, and the number of ICRC decisions across each of the following themes. Note: – Where the number in a given theme is between 1 and 5, report in CPMF Reporting Tool as "NR" – Where no complaints have been received for a theme, report in CPMF Reporting Tool as "0". – In reporting on the number of each type of ICRC decision (as defined below in definitions section) across all themes, the College will already have identified the main themes applicable to the complaint or Registrar's Investigation at the intake stage of the incoming matter. As such, when a decision is made by a Panel of the ICRC about a formal complaint or report those themes identified at intake would continue to be attributed to the matter at the hearing stage. – Where there are multiple themes for a single complaint or report, each theme related to the complaint or report should be included in the count. – Where one of the allegations within a complaint could be categorized under multiple themes, Colleges are asked to report the theme they deem most appropriate.

Context Measure #10	Distribution of ICRC decisions by theme in CY 2020
Theme:	Examples:
Advertising:	Concerns that an advertisement related to a registrant's practice is in violation of a College's requirements, which depending on the profession could include allegations that it is false or misleading, claims service superiority, contains patient testimonials, discriminatory.
Billing and Fees:	Concerns regarding a fee, billing or account submitted by or on behalf of the registrant, which could include allegations that a payment is misleading, unfair, unreasonable, inaccurate, or unclear, failure to disclose to a patient the fee for a service before the service is provided, failure to provide itemized accounting for services and/or products on request, or where a charge do not align with regulator's guidance on billing arrangements, block fees, payment plans.
Communication:	Concerns regarding a registrant's communication with a patient, a patient's relatives and/or a patient's decision makers which could include a casual or uncaring attitude, disrespect, insensitivity, or communication of a non-therapeutic or culturally inappropriate matter.
Competence / Patient Care:	Concerns that a registrant provided care that did not meet standards and expectations of the profession which could include allegations that a registrant harmed a patient by providing a service, or performed or delegated a controlled act without the knowledge, skills and judgment to perform it, allegations regarding treatment decisions or outcomes, assessment, examinations, referrals, or failure to obtain consent.
Fraud:	Allegations that a registrant intentionally falsified a record, signed or issued a document containing a statement that the registrant knows or ought to know contains a false or misleading statement, or knowingly sought a payment from a person for a service that has been paid in full by another payer.
Professional Conduct & Behaviour:	Concerns against a registrant of unbecoming, disgraceful, dishonorable or unprofessional conduct, including allegations of patient abuse, failure to maintain the standards of practice of the profession, practising the profession while in a conflict of interest or a breach of confidentiality.

Context Measure #10	Distribution of ICRC decisions by theme in CY 2020
Record Keeping:	Complaints regarding a registrant's financial and patient records, including retention of records and complying with the necessary privacy legislation. Allegations could include that the registrant failed to maintain records, include sufficient information, that the records are not understandable (legible, in English or French, etc.), organized (e.g., dated, etc.) or accurate (contain required information such as fees charged, date of services, up to date, permanent, etc.).
Sexual Abuse / Harassment / Boundary Violations:	Allegations against a registrant that could include engaging in sexual intercourse or other forms of physical relations with a patient, entering into an intimate or romantic relationship with a patient, remarks of a sexual nature towards a patient, sharing intimate details of the registrant's personal life, giving or receiving extravagant gifts from the patient, influencing a patient to change their will or other testamentary instrument, or initiating non-clinical touch with a patient.
Unauthorized Practice:	Complaints that a registrant has contravened, by act or omission, a term, condition or limitation on their certificate of registration, practised the profession while under suspension, or practised outside of the profession's scope of practice.
Other:	Complaints that do not fall into any of the above themes above.
Exclusions	• All complaints that a Panel of the ICRC determines are frivolous and vexatious in nature. • Complaints withdrawn by the Registrar at the request of a complainant. • Complaints that are still under review at end of reporting period.
Inclusion	• All complaints where a decision was provided to the registrant and complainant by the College within the reporting period. • Matters where a Panel of the ICRC or Registrar approved the appointment of an investigator after reviewing a report.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College

Context Measure #10	Distribution of ICRC decisions by theme in CY 2020
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **ICRC Decision:** Includes where a Panel of the ICRC does one or more of the following with respect to a registrant: 1. Takes no action, 2. Proves advice or recommendations, 3. Issues an oral Caution, 4. Orders a specified continuing education or remediation program, 5. Agrees to an undertaking, 6. Refers specified allegations to the Discipline Committee, 7. Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws. **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 19: Context Measure – the 90th percentile disposal of a formal complaint in working days in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #11(i)	90th percentile disposal of a formal complaint in working days in CY 2020
Description	The time that a College requires to dispose of 9 out of 10 complaints.
Calculation Method	Disposal of complaints: 1. Calculate the length of time in disposing of each complaint within the reporting period. 2. Apply inclusions and exclusion criteria. 3. Sort the total number of disposals from shortest to longest. 4. The 90th percentile is the number of working days where 9 out of 10 complaints have been disposed of.
Exclusions	• All concerns that a Panel of the ICRC determines are frivolous and vexatious in nature. • Complaints withdrawn by the Registrar at the request of a complainant. • All health-related inquiries. • All matters brought to a Panel of the ICRC as a result of a Registrar's Investigation.
Inclusion	• All complaints where a decision was provided by the ICRC to the registrant and complainant (if any) within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College

Context Measure #11(i)	90th percentile disposal of a formal complaint in working days in CY 2020
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Time of Receipt:** • Complaint: Day the College receives a complaint regarding a registrant that contains the information required by the College to initiate an investigation (e.g., in writing or in another acceptable form, etc.). **Disposal:** • Complaint: The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant). **ICRC Decision:** Includes where a Panel of the ICRC does one or more of the following with respect to a registrant: 1. Takes no action, 2. Provides advice or recommendations, 3. Issues an oral Caution, 4. Orders a specified continuing education or remediation program (SCERP), 5. Agrees to an undertaking,

Context Measure #11(i)	90th percentile disposal of a formal complaint in working days in CY 2020
	6. Refers specified allegations to the Discipline Committee, 7. Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws. **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 20: Context Measure – the 90th percentile disposal of a Registrar's Investigation in working days in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #11(ii)	90th percentile disposal of a Registrar's Investigation in working days in CY 2020
Description	The time that a College requires to dispose of 9 out of 10 Registrar's investigations.
Calculation Method	Disposal of Registrar's investigations: 1. Calculate the length of time in disposing of each Registrar's investigation within the reporting period. 2. Apply inclusions and exclusion criteria. 3. Sort the total number of disposals from shortest to longest. 4. The 90th percentile is the number of working days where 9 out of 10 Registrar's investigations have been disposed of.
Exclusions	• All concerns that a Panel of the ICRC determines are frivolous and vexatious in nature. • Complaints withdrawn by the Registrar at the request of a complainant. • All health-related inquiries. • All formal complaints.
Inclusion	• All Registrar's investigations where a decision was provided by the ICRC to the registrant and complainant (if any) within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and

Context Measure #11(ii)	90th percentile disposal of a Registrar's Investigation in working days in CY 2020
	other interactions with the College that do not result in a formally submitted complaint. **Registrar's investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days. **Formal Complaints withdrawn by Registrar at the request of a complainant:** Any formal complaint withdrawn by the Registrar prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. **Time of Receipt:** • Registrar's investigation: The day the Registrar determines that information received about a registrant will result in a referral to a panel of the ICRC for approval of the appointment of an investigator. **Disposal:** • Registrar's investigation: The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant). **ICRC Decision:** Includes where a Panel of the ICRC does one or more of the following with respect to a registrant: 1. Takes no action, 2. Provides advice or recommendations, 3. Issues an oral Caution, 4. Orders a specified continuing education or remediation program (SCERP), 5. Agrees to an undertaking, 6. Refers specified allegations to the Discipline Committee,

Context Measure #11(ii)	90th percentile disposal of a Registrar's Investigation in working days in CY 2020
	7. Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws. **Frivolous and vexatious:** ICRC can decide to take no action where the Panel considers a complaint to be frivolous, vexatious, made in bad faith, moot or otherwise an abuse of process.

Table 21: Context Measure – the 90th percentile disposal of an uncontested discipline hearing in working days in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #12(i)	90th percentile disposal of an uncontested discipline hearing in working days in CY 2020
Description	The time that a College requires to dispose of 9 out of 10 uncontested discipline hearings
Calculation Method	1. Calculate the length of time of each uncontested discipline hearing disposed of within the reporting period. 2. Apply inclusions and exclusion criteria. 3. Sort the total number of uncontested discipline hearing disposals from shortest to longest. 4. The 90th percentile is the number of working days where 9 out of 10 uncontested discipline hearings have been disposed of.
Exclusions	• Appeals to the Health Professions Appeal and Review Board or Divisional Court.
Inclusion	• All uncontested discipline hearings where a decision was provided to the registrant and complainant (if any) by the College within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Time of Receipt:** Day a Panel of the ICRC refers a matter to Discipline Committee. **Disposal:** Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).

Context Measure #12(i)	90th percentile disposal of an uncontested discipline hearing in working days in CY 2020
	Uncontested Discipline Hearing: In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the Respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent. **Contested Discipline Hearing:** In a contested hearing, the College and Registrant disagree on some or all of the allegations, penalty and/or costs.

Table 22: Context Measure – the 90th percentile disposal of a contested discipline hearing in working days in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #12(ii)	90th percentile disposal of a contested discipline hearing in working days in CY 2020
Description	The time that a College requires to dispose of 9 out of 10 contested discipline hearings.
Calculation Method	1. Calculate the length of time of each contested discipline hearing disposed of within the reporting period. 2. Apply inclusions and exclusion criteria. 3. Sort the total number of contested discipline hearing disposals from shortest to longest. 4. The 90th percentile is the number of working days where 9 out of 10 contested discipline hearings have been disposed of.
Exclusions	• Appeals to the Health Professions Appeal and Review Board or Divisional Court.
Inclusion	• All contested discipline hearings where a decision was provided to the registrant and complainant (if any) by the College within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College
Definitions	**Time of Receipt:** Day a Panel of the ICRC refers a matter to Discipline Committee. **Disposal:** Day where all relevant decisions were provided to the registrant and complainant by the College (i.e., the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).

Context Measure #12(ii)	90th percentile disposal of a contested discipline hearing in working days in CY 2020
	Uncontested Discipline Hearing: In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the Respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent. **Contested Discipline Hearing:** In a contested hearing, the College and Registrant disagree on some or all of the allegations, penalty and/or costs.

Table 23: Context Measure – the distribution of discipline findings by theme in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #13	Distribution of discipline finding by type in CY 2020
Description	The total number of each type of finding made by a Panel of the Discipline Committee for each of the 13 high level findings for both formal complaints and Registrar's Investigation (as identified under Findings section).
Calculation Method	1. Report the total number of findings made by a Panel of the Discipline Committee across each of the following findings for all formal complaints and Registrar's investigations. **Note:** - Where the number under a given finding is between 1 and 5, report in CPMF Reporting Tool as "NR" - Where no findings have been received for a theme, report in CPMF Reporting Tool as "0". - Where there are multiple findings for a discipline decision, each finding related to the discipline decision should be included in the count. - Where one of the findings within a decision could be categorized under multiple categories, Colleges are asked to report the finding they deem most appropriate.
Findings:	**Description of Findings**
Sexual abuse:	Matters that deal with a registrant engaging in sexual intercourse or other forms of physical relations with a patient, entering into an intimate or romantic relationship with a patient, remarks of a sexual nature towards a patient, sharing intimate details of the registrant's personal life, giving or receiving extravagant gifts from the patient, influencing a patient to change their will or other testamentary instrument, or initiating non-clinical touch with a patient.

Context Measure #13	Distribution of discipline finding by type in CY 2020
Incompetence:	Matters where a registrant provided care that did not meet standards and expectations of the profession which could include allegations that a registrant harmed a patient by providing a service, or performed or delegated a controlled act without the knowledge, skills and judgment to perform it, allegations regarding treatment decisions or outcomes, assessment, examinations, referrals, or failure to obtain consent.
Fail to maintain standard:	Matters where a registrant's practice did not meet reasonable expectations placed on the registrant by his or her College and by the profession to ensure that care is provided in a responsible, safe and ethical manner.
Improper use of a controlled act:	Matters that deal with circumstances where a registrant engaged in a controlled act for purposes other than its intended purpose. This can include for example, prescribing, dispensing or selling a drug for an improper purpose.
Conduct unbecoming:	Matters that deal with the conduct on the part of a registrant that occur outside of the practice of the profession that is contrary to the public interest, or which harms his/her standing of the profession in the eyes of the public.
Dishonorable, disgraceful, unprofessional:	Matters that deal with conduct by a registrant in the course of practising the profession that has not been foreseen by specific definitions of professional misconduct articulated by the College but would be considered by the majority of registrants to be disgraceful, dishonourable or unprofessional conduct. Such behaviour goes beyond legitimate professional discretion, or errors in judgment, and constitutes misconduct as defined by the profession – as opposed to the public.
Offence conviction:	Matters where the registrant has been found guilty of an offence that is relevant to the registrant's suitability to practise.
Contravene certificate restrictions:	Matters where a registrant has contravened, by act or omission, a term, condition or limitation on their certificate of registration, or practised the profession while under suspension.

Context Measure #13	Distribution of discipline finding by type in CY 2020
Finding in another jurisdiction:	Matters where the governing body of another health profession in Ontario, or the governing body of a health profession in a jurisdiction other than Ontario, has found that the registrant committed an act of professional misconduct that would, in the opinion of a discipline panel, be an act of professional misconduct as defined in the RHPA or an act of professional misconduct as defined in the profession specific regulation.
Breach of orders and undertakings:	Matters where a registrant has contravened, by act or omission, a restriction placed on his or her practice through an order by a Panel of a committee of the College or undertaking that the registrant entered into with the College.
Falsifying records:	Matters regarding a registrant's financial and patient records, where the registrant was found to have intentionally falsified a record.
False or misleading document:	Matters where a registrant signed or issued a document containing a statement that the registrant knows or ought to know contains a false or misleading statement, or knowingly sought a payment from a person for a service that has been paid in full by another payer.
Contravene relevant Acts:	Matters where a registrant contravenes any provision of relevant Canadian legislation if the purpose of the law is to protect or promote public health (broadly defined), or if the contravention is relevant to the registrant's suitability to practise.
Exclusions	• All formal complaints or Registrar investigations that were not referred to a Panel of the Discipline Committee within the reporting period.
Inclusion	• All decisions issued by a Panel of the Discipline Committee within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College

Context Measure #13	Distribution of discipline finding by type in CY 2020
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.

Table 24: Context Measure – the distribution of discipline orders by type in CY 2020

Suitability to Practice Domain > Standard 13: All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public

Context Measure #14	Distribution of discipline orders by type in CY 2020
Description	The total number of each type of order made by a Panel of the Discipline Committee for each of type of order (as identified below under Orders section).
Calculation Method	1. Report the total number of orders made by a Panel of the Discipline Committee for each type of order for all formal complaints and Registrar's investigations. Note: - Where the number under a given order is between 1 and 5, report in CPMF Reporting Tool as "NR" - Where no orders have been received for a theme, report in CPMF Reporting Tool as "0".
Orders:	**Description of Orders**
Revocation	Occurs where a Panel of the discipline or fitness to practice committee makes an order to "revoke" a certificate of registration which terminates the registrant's registration with the College and therefore his/her ability to practice the profession.
Suspension	A suspension of a registrant's certificate of registration occurs for a set period of time during which the registrant is not permitted to: • Hold himself/herself out as a person qualified to practice the profession in Ontario, including using restricted titles (e.g. doctor, nurse), • Practice the profession in Ontario, or • Perform controlled acts restricted to the profession under the *Regulated Health Professions Act, 1991*.

Context Measure #14	Distribution of discipline orders by type in CY 2020
Terms, Conditions and Limitations on a Certificate of Registration **Reprimand and an Undertaking** **Reprimand**	Terms, Conditions and Limitations on a certificate of registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a College's website. An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee. A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the Panel has with his or her practice
Exclusions	• All formal complaints or Registrar investigations that were not referred to a Panel of the Discipline Committee within the reporting period. • Allegations referred to discipline that were withdrawn before a hearing is complete.
Inclusion	• All decisions issued by a Panel of the Discipline Committee within the reporting period.
Reporting period	January 1, 2020 to December 31, 2020
Data source	Local data collection by the College

Context Measure #14	Distribution of discipline orders by type in CY 2020
Definitions	**Formal Complaint:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquiries and other interactions with the College that do not result in a formally submitted complaint. **Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.

For questions and/or comments, or to request permission to use, adapt or reproduce the information in the CPMF please contact:

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Health Workforce Regulatory Oversight Branch
Strategic Policy, Planning & French Language Services Division
Ministry of Health
438 University Avenue, 10th floor
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Ministry of Health
Ministry of Long-Term Care

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Ontario

MEMORANDUM TO: Registrars and CEOs of Ontario's Health Regulatory Colleges

FROM: Sean Court
Assistant Deputy Minister

DATE: Tuesday December 1st, 2020

RE: **Formal launch of the College Performance Measurement Framework**

In follow up to my memo on September 1, 2020 regarding the 'soft launch' of the College Performance Measurement Framework (CPMF), I am pleased to inform you that today the Ministry of Health (ministry) is formally launching the CPMF.

I would like to thank you all for your comments and feedback that have helped inform the final drafts of the Reporting Tool and the Technical Specifications Document. Your feedback was used to provide further clarification to many of the Measures and Context Measures.

The CPMF that you have helped to develop will, for the first time in Ontario, further strengthen the accountability and oversight of Ontario's health regulatory Colleges by providing information that is transparent, consistent and aligned across all Colleges on their performance in serving the public's interest.

This work places a focus on areas of improvement (e.g., better support for changing public expectations, patient needs, and delivery of care models); makes it easier for patients, their families and employers to navigate the regulatory system; and through highlighting best practices reduces variation in the efficiency and effectiveness with which colleges carry out their functions.

The ministry is also aware that data and responses provided from the year 2020 are likely to be impacted by COVID-19, and that while the majority of the information requested in this reporting cycle should not be impacted, there may be instances where the requested data or information may be a significant outlier from previous years.

…/2

Ministry staff will work with you to ensure that this context is clearly communicated in the Colleges' Reporting Tools that will be posted on Colleges' websites to help the public better understand the information provided.

The ministry will not review and assess the degree to which a College has implemented the CPMF Standards for the purpose of publicly reporting on how well each College is performing during this first reporting cycle. However, during this baseline reporting cycle the ministry will:

- Provide each College with performance feedback and potentially identify opportunities for improvement, and
- Draft and post a Summary Report on the ministry website that will capture the Colleges' CPMF results at a system level (as opposed to the performance of each individual College).

Prior to beginning the second CPMF reporting cycle in October 2021, the ministry, together with the Colleges, the public and experts will evaluate and refine the CPMF based on the results of the reports and feedback received during the first reporting iteration. It is envisioned that for the second reporting cycle Colleges will be only asked to report back on improvements identified during baseline reporting, any changes in comparison to baseline reporting and any changes resulting from the refined Standards, Measures and Evidence.

I would like to thank all of you again for your advice and support to date.

The ministry looks forward to continuing this very important work with you over the coming year.

Sincerely,

_____

Sean Court
Assistant Deputy Minister

c. Helen Angus, Deputy Minister, Ministry of Health (MOH)
Allison Henry, Director, Health Workforce Regulatory Oversight Branch, MOH

Ontario College of Pharmacists

Putting patients first since 1871

Ontario College of Pharmacists (OCP)

College Performance Measurement Framework (CPMF) Reporting Tool

March 31, 2021

INTRODUCTION

THE COLLEGE PERFORMANCE MEASUREMENT FRAMEWORK (CPMF)

A CPMF has been developed by the Ontario Ministry of Health in close collaboration with Ontario's health regulatory Colleges (Colleges), subject matter experts and the public with the aim of answering the question "how well are Colleges executing their mandate which is to act in the public interest?". This information will:

1. strengthen accountability and oversight of Ontario's health regulatory Colleges; and
2. help Colleges improve their performance.

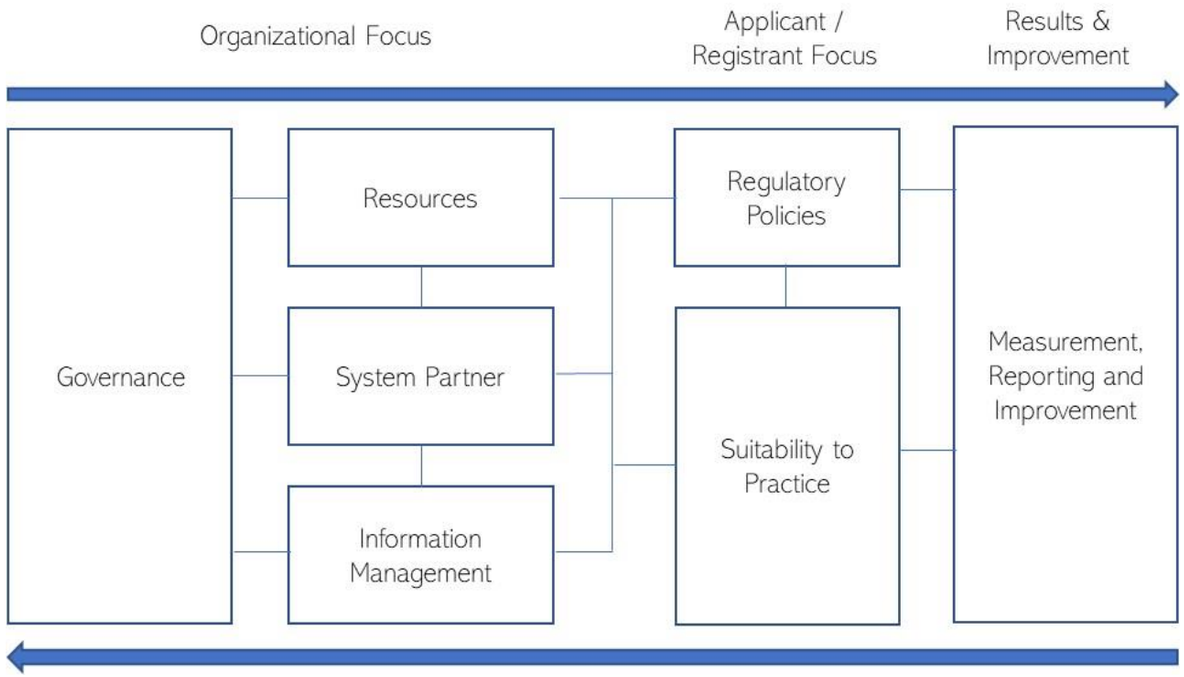
a) Components of the CPMF:

1	**Measurement domains**	→	Critical attributes of an excellent health regulator in Ontario that should be measured for the purpose of the CPMF.
2	**Standards**	→	Best practices of regulatory excellence a College is expected to achieve and against which a College will be measured.
3	**Measures**	→	Further specifications of the standard that will guide the evidence a College should provide and the assessment of a College in achieving the standard.
4	**Evidence**	→	Decisions, activities, processes, or the quantifiable results that are being used to demonstrate and assess a College's achievement of a standard.
5	**Context measures**	→	Statistical data Colleges report that will provide helpful context about a College's performance related to a standard.
6	**Planned improvement actions**	→	Initiatives a College commits to implement over the next reporting period to improve its performance on one or more standards, where appropriate.

b) Measurement domains:

The proposed CPMF has seven measurement domains. These domains were identified as the most critical attributes that contribute to a College effectively serving and protecting the public interest (Figure 1). The measurement domains relate to Ontario's health regulatory Colleges' key statutory functions and key organizational aspects, identified through discussions with the Colleges and experts, that enable a College to carry out its functions well.

Figure 1: CPMF Model for measuring regulatory excellence



The seven domains are interdependent and together lead to the outcomes that a College is expected to achieve as an excellent regulator. Table 1 describes what is being measured by each domain.

Table 1: Overview of what the Framework is measuring

	Domain	Areas of focus
1	**Governance**	• The efforts a College undertakes to ensure that Council and Statutory Committees have the required knowledge and skills to warrant good governance. • Integrity in Council decision making. • The efforts a College undertakes in disclosing decisions made or is planning to make and actions taken, that are communicated in ways that are accessible to, timely and useful for relevant audiences.
2	**Resources**	• The College's ability to have the financial and human resources to meet its statutory objects and regulatory mandate, now and in the future.
3	**System Partner**	• The extent to which a College is working with other Colleges and system partners, where appropriate, to help execute its mandate in a more effective, efficient and/or coordinated manner and to ensure it is responsive to changing public expectation.
4	**Information Management**	• The efforts a College undertakes to ensure that the confidential information it deals with is retained securely and used appropriately in the course of administering its regulatory activities and legislative duties and objects.
5	**Regulatory Policies**	• The College's policies, standards of practice, and practice guidelines are based on the best available evidence, reflect current best practices, are aligned with changing publications and where appropriate aligned with other Colleges.
6	**Suitability to Practice**	• The efforts a College undertakes to ensure that only those individuals who are qualified, skilled and competent are registered, and only those registrants who remain competent, safe and ethical continue to practice the profession.
7	**Measurement, Reporting and Improvement**	• The College continuously assesses risks, and measures, evaluates, and improves its performance. • The College is transparent about its performance and improvement activities.

c) Standards, Measures, Evidence, and Improvement:

The CPMF is primarily organized around five components: **domains**, **standards**, **measures**, **evidence** and **improvement**, as noted on page 3. The following example demonstrates the type of information provided under each component and how the information is presented within the Reporting Tool.

Example:

Domain 1: Governance			
Standard →	**Measure** →	**Evidence** →	**Improvement**
1. Council and Statutory Committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.	1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria. By-laws will be updated to reflect the screening criteria as a component of the election process to determine professional registrant eligibility to run for a Council position.
		b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	• The College is planning a project to develop required competencies for Council and Committees and will develop screening criteria.
		c. Prior to attending their first meeting, public appointments to Council undertake a rigorous orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	Nil
	2. Council and Statutory Committees regularly assess their effectiveness and address identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	Nil
		b. The framework includes a third-party assessment of Council effectiveness at minimum every three years.	Nil

THE CPMF REPORTING TOOL

For the first time in Ontario, the CPMF Reporting Tool (along with the companion Technical Specifications for Quantitative CPMF Measures document) will provide comprehensive and consistent information to the public, the Ministry of Health ('ministry') and other stakeholders by each of Ontario's health regulatory Colleges (Colleges). In providing this information each College will:

1. meet with the ministry to discuss the system partner domain;
2. complete the self-assessment;
3. post the Council approved completed CPMF Report on its website; and
4. submit the CPMF Report to the ministry.

The ministry will not assess whether a College meets or does not meet the Standards. The purpose of the first iteration of the CPMF is to provide the public, the ministry and other stakeholders with baseline information respecting a College's activities and processes regarding best practices of regulatory excellence and, where relevant, the College's performance improvement commitments. Furthermore, the reported results will help to lay a foundation upon which expectations and benchmarks for regulatory excellence can be refined and improved. Finally, the results of the first iteration may stimulate discussions about regulatory excellence and performance improvement among Council members and senior staff within a College, as well as between Colleges, the public, the ministry, registrants and other stakeholders.

The information reported through the completed CPMF Reporting Tools will be used by the ministry to strengthen its oversight role of Ontario's 26 health regulatory Colleges and may help to identify areas of concern that warrant closer attention and potential follow-up.

Furthermore, the ministry will develop a Summary Report highlighting key findings regarding the best practices Colleges already have in place, areas for improvement and the various commitments Colleges have made to improve their performance in serving and protecting the public. The focus of the Summary Report will be on the performance of the regulatory system (as opposed to the performance of each individual College), what initiatives health regulatory Colleges are undertaking to improve regulatory excellence and areas where opportunities exist for colleges to learn from each other. The ministry's Summary Report will be posted publicly.

As this will be the first time that Colleges will report on their performance against the proposed CPMF standards, it is recognized that the initial results will require comprehensive responses to obtain the required baseline information. It is envisioned that subsequent reporting iterations will be less intensive and ask Colleges only to report on:

- Improvements a College committed to undertake in the previous CPMF Report;
- Changes in comparison to baseline reporting; and
- Changes resulting from refined standards, measures and evidence.[1]

[1] Informed by the results from the first reporting iteration, the standards, measures and evidence will be evaluated and where appropriate further refined before the next reporting iteration.

Completing the CPMF Reporting Tool

Colleges will be asked to provide information in the right-hand column of each table indicating the degree to which they fulfill the "required Evidence" set out in column two.

Furthermore,

- where a College fulfills the "required evidence" it will have to:
  - provide link(s) to relevant background materials, policies and processes ***OR*** provide a concise overview of this information.
- where a College responds that it "partially" meets required evidence, the following information is required:
  - clarification of which component of the evidence the College meets and the component that the College does not meet;
  - for the component the College meets, provide link(s) to relevant background material, policies and processes ***OR*** provide a concise overview of this information; and
  - for the component the College does not meet, whether it is currently engaged in, or planning to implement the missing component over the next reporting period.
- where a College does not fulfill the required evidence, it will have to:
  - indicate whether it is currently engaged in or planning to implement the standard over the next reporting period.

Furthermore, there may be instances where a College responds that it meets required evidence but, in the spirit of continuous improvement, plans to improve its activities or processes related to the respective Measure. A College is encouraged to highlight these planned improvement activities.

While the CPMF Reporting Tool seeks to clarify the information requested, it is not intended to direct College activities and processes or restrict the manner in which a College fulfills its fiduciary duties. Where a term or concept is not explicitly defined in the proposed CPMF Reporting Tool the ministry relies on individual Colleges, as subject matter experts, to determine how a term should be appropriately interpreted given the uniqueness of the profession each College oversees.

The areas outlined in red in the example below are what Colleges will be asked to complete.

Example:

DOMAIN 1: GOVERNANCE

Standard 1

Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.

Measure	Required evidence	College response
1. Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. Meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes ☐ Partially ☐ No ☐ • The competency/suitability criteria are public: Yes ☐ No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* • Duration of orientation training: • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): • Insert a link to website if training topics are public ***OR*** list orientation training topics: *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional):*

PART 1: MEASUREMENT DOMAINS

The following tables outline the information that Colleges are being asked to report on for each of the Standards. Colleges are asked to provide **evidence** of decisions, activities, processes, and verifiable results that demonstrate the achievement of relevant standards and encourages Colleges to not only to identify whether they are working on, or are planning to implement, the missing component if the response is "No", but also to provide information on improvement plans or improvement activities underway if the response is "Yes" or "Partially".

DOMAIN 1: GOVERNANCE

Standard 1

Council and statutory committee members have the knowledge, skills, and commitment needed to effectively execute their fiduciary role and responsibilities pertaining to the mandate of the College.

Measure	Required evidence	College response
1.1 Where possible, Council and Statutory Committee members demonstrate that they have the knowledge, skills, and commitment prior to becoming a member of Council or a Statutory Committee.	a. Professional members are eligible to stand for election to Council only after: i. meeting pre-defined competency / suitability criteria, and ii. attending an orientation training about the College's mandate and expectations pertaining to the member's role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • The competency/suitability criteria are public: Yes X No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* See below • Duration of orientation training: See below • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): See below • Insert a link to website if training topics are public ***OR*** list orientation training topics: See below **Competency Based Requirements** • The Ontario College of Pharmacists ("the College") introduced a Governance Renewal initiative in 2018. In 2020, it implemented several components including competency-based selection for the

		Board of Directors (formerly called Council) and Statutory Committees, greater separation of Board and Statutory Committees, governance best practices regarding equal representation of public and elected members along with a smaller Board size, and the greater involvement of members of the public on Statutory Committees.
		• Applying the By-Law making power set out in the *Health Professions Procedural Code* under the *Regulated Health Professions Act (RHPA), 1991* to set the qualification of registrants seeking election to the Board of Directors, the College has enshrined in the By-Law the competencies required of individuals seeking election to the Board, including the clear articulation of the College's public interest mandate. The competencies include a requirement for experience serving various patient populations as well as specific knowledge, skills and experience in Board governance and oversight.
		  ○ College By-Laws
		• Individuals seeking election must complete a comprehensive application and provide references that can attest to their competence. The application questionnaire sets out the public interest focus of the College and seeks responses that illustrate applicants' understanding of the role and responsibilities/duties of a Board member.
		  ○ Board of Directors Application Form
		• A robust screening process assesses if the applicants are qualified to run for election. Applications are first screened by external consultants with experience in recruitment and governance and a report is produced for consideration by the College's Screening Committee which is comprised of Board Directors and Lay Committee Appointees with regulatory governance experience. Individuals who are not deemed qualified are notified of the fact and reasons, along with suggestions for how they might develop their skills if they choose to run in the future.
		  ○ Board of Directors Profile
		• Noting that this is the first year applying the criteria, the College recognizes that there will still be gaps in competencies. However, competencies will improve with each cycle. In addition, the College believes that it is important to work with the government in ensuring that the appointment of public members also consider any competency gaps that may be identified such that the Board, as a whole, is best positioned to function at a high level.
		
		Training and Orientation
		• Information about roles and responsibilities of Board Directors is posted on the website and circulated broadly across communication channels prior to the start of the election process. In addition to general information about the College and the function of the Board, the Board Director Profile further articulates the responsibilities and commitments of Board Directors, details about what it means to be a Board Director and expectations about serving in the public interest.

		• Once Board Directors are elected and prior to engaging in Board business, they participate in formal orientation and training which further outlines roles, responsibilities and expectations of all Board Directors elected or appointed to a health regulatory college Board. ○ New Board Orientation Agenda ○ HPRO (Health Profession Regulators of Ontario) Governance Training for RHPA Colleges (Nov 2020)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes X No ☐
		Additional comments for clarification (optional): • Following the implementation of the governance renewal, the College now refers to Council as the Board of Directors; the roles of President and Vice President are also now referred to as Chair and Vice Chair respectively; and Non Council Committee Members are now referred to as Professional Committee Appointees (pharmacy professionals) or Lay Committee Appointees (members of the public). • The College is in the process of reviewing its governance activities as it gains more experience within this new Governance Framework and is examining the training and orientation programs for the Board. Comprehensive Board and Committee policies are in development for consideration by the Board. ○ December 2020 Board Materials with Index of Board Policies • The College believes the current competency based assessment is more robust than a general requirement to attend an orientation session and, therefore, considers this standard as being met.
	b. Statutory Committee candidates have: i. met pre-defined competency / suitability criteria, and ii. attended an orientation training about the mandate of the Committee and expectations pertaining to a member's role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• The competency / suitability criteria are public: Yes X No ☐ *If yes, please insert link to where they can be found, if not please list criteria:* • *Professional Committee Appointee Application Guide* • *Professional Committee Appointee Application* • *Lay Committee Appointee Application Information (webpage)* • *Lay Committee Appointee Application* • *Behaviour Key Competencies for Committee Appointees* • Duration of each Statutory Committee orientation training:

		See below • Format of each orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): See below • Insert link to website if training topics are public ***OR*** list orientation training topics for Statutory Committee: See below **Competency Based Requirements** • As part of a broader governance renewal initiative, in 2018 the College implemented competency screening for Committee candidates prior to being considered eligible for appointment. Members of the profession (Professional Committee Appointees, PCAs) as well as members of the public (Lay Committee Appointees, LCAs) seeking appointment to a Committee must complete a comprehensive application that speaks to their competence/suitability. The application questionnaire clearly sets out the public interest focus of the College and seeks responses that illustrate the applicant's understanding of the role and responsibility of a College Committee Appointee. • A robust screening process is followed to assess if the applicants are qualified to serve on a Committee. Applications are first screened by the College's Human Resources Department and a summary is produced for consideration by a College Screening Committee comprised of Board Directors and Lay Committee Appointees with regulatory governance experience. **Training and Orientation** • Prior to applying to become a Committee Appointee, information and resources are provided along with expectations outlined in the application process which explains roles and responsibilities of members of each Committee. • Once appointed to a Committee, members participate in a Committee-specific orientation session prior to or at the same time as their first Committee meeting. This applies to Professional and Lay Committee Appointees as well as Board Directors appointed to serve on Committees as required in statute.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional):

		• The College is in the process of reviewing its governance activities as it gains more experience within its new Governance Framework and may further examine training and orientation programs for the Board along with the development of specific Board and Committee policies to support the new framework where required.
	c. Prior to attending their first meeting, public appointments to Council (Board) undertake an orientation training course about the College's mandate and expectations pertaining to the appointee's role and responsibilities.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Duration of orientation training: • In addition to the one-hour orientation by the CEO & Registrar and Board Chair, all Board members, including public members, participate in a six-hour HPRO Governance Training for RHPA Colleges session presented with each new Board orientation. As the Ministry has now instituted a governance training course for public members of the Board, there will be an expectation that all public members maintain currency of this training. • Format of orientation training (e.g. in-person, online, with facilitator, testing knowledge at the end): • Orientation has historically been in-person with College staff, Board members and a facilitator, unless virtual formats are adopted for specific reasons (such as the pandemic and associated public health measures implemented restricting in-person meetings). In future, the format will be revisited. • Insert link to website if training topics are public ***OR*** list orientation training topics: • Prior to the first meeting of the Board, all new Board Directors attend an orientation meeting. In addition, at the first meeting of Board or before, the College provides training on governance in a regulatory environment (CLEAR (Council on Licensure, Enforcement and Regulation) 2018, HPRO 2020). ○ New Board Orientation Agenda *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*
		Additional comments for clarification (optional): • In 2021, the College has expanded its orientation program to include an in-depth review of strategic and operational plans, financial health and the College's risk register as well as current issues facing

		the College and/or profession to enable incoming Board Directors to feel confident and prepared to contribute in a meaningful way as they assume their roles.
1.2 Council regularly assesses its effectiveness and addresses identified opportunities for improvement through ongoing education.	a. Council has developed and implemented a framework to regularly evaluate the effectiveness of: i. Council meetings; ii. Council	The College fulfills this requirement: Yes X Partially ☐ No ☐

		• Year when Framework was developed ***OR*** last updated:
		  • The current Governance Manual which includes information on the evaluation framework used at the College was last updated was 2016 (see below).
		• Insert a link to Framework ***OR*** link to Council (Board) meeting materials where (updated) Framework is found and was approved:
		  • Governance Manual
		• Evaluation and assessment results are discussed at public Council (Board) meeting: Yes X No ☐
		If yes, insert link to last Council (Board) meeting where the most recent evaluation results have been presented and discussed:
		  • Board Meeting Materials from December 2020 (contains Board Meeting, Board Overall and Individual Director Evaluations)

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • As part of the College's governance reform initiative, the Governance Manual currently in place will be replaced by a series of standalone policies, the first of which were passed by the Board in December 2020. Additional policies are under development and will be completed in 2021.
	b. The framework includes a third-party assessment of Council effectiveness at a minimum every three years.	The College fulfills this requirement: Yes ☐ Partially ☐ No X
		• A third party has been engaged by the College for evaluation of Council (Board) effectiveness: Yes ☐ No X *If yes, how often over the last five years?* • Year of last third-party evaluation:

		n/a *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes X No ☐*
		Additional comments for clarification (optional) • The College engaged an external consultant starting in June 2019 to review the current Governance Manual and draft updated Board policies incorporating best practices to help complement the new By-Laws and support the Governance Framework.
	c. Ongoing training provided to Council has been informed by: i. the outcome of relevant evaluation(s), and/or ii. the needs identified by Council members.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a link to documents outlining how outcome evaluations and/or needs identified by members have informed Council (Board) training: • Board Meeting Agenda September 2020 • Insert a link to Council (Board) meeting materials where this information is found ***OR*** • Describe briefly how this has been done for the training provided over the last year. • The feedback from the June 2020 Board meeting evaluation prompted the Board Chair to circulate *Schedule C – Rules of Order of the Board* prior to the meeting and address the renewed adherence to the established rules regarding Board Directors speaking during the debate on a motion. • Training is also provided in the form of general education on specific regulatory topics of interest and relevance to the Board. These topics have included presentations on the College's Data Strategy, Right-Touch Regulation, Outcomes-Focused Regulation, Conduct Cost Recovery, Governance Reform, Indigenous Cultural Competency, Conflict of Interest and Transparency.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional):

		• Starting In 2021 the Governance Committee will use a skills and practice environment inventory to determine the gaps for recruitment and to identify opportunities for additional training and development.
Standard 2 **Council decisions are made in the public interest.**		
Measure	**Required evidence**	**College response**
2.1 All decisions related to a Council's strategic objectives, regulatory processes, and activities are impartial, evidence-informed, and advance the public interest.	a. The College Council has a Code of Conduct and 'Conflict of Interest' policy that is accessible to the public.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Year when Council Code of Conduct and 'Conflict of Interest' Policy was implemented ***OR*** last evaluated/updated: • Code of Conduct: 2020 • Conflict of Interest: 2016 (currently under review) • Insert a link to Council Code of Conduct and 'Conflict of Interest' Policy ***OR*** Council meeting materials where the policy is found and was discussed and approved: • Code of Conduct - (page 76 - 77) • Conflict of Interest - (page 45 – 46)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • In addition to conflict of interest expectations articulated in the Governance Manual and College By-Laws, further education regarding expectations as it relates to conflict of interest is included with annual Board orientation and is addressed by the Chair at every Board meeting and at every Statutory Committee meeting. • The College plans to develop a standalone conflict of interest policy as part of the ongoing review of governance of the College.
	b. The College enforces cooling off periods[2].	The College fulfills this requirement: Yes X No ☐

		• Cooling off period is enforced through: Conflict of interest policy ☐ By-law X Competency/Suitability criteria ☐ Other <*please specify*>
		
		• The year that the cooling off period policy was developed ***OR*** last evaluated/updated: 2020
		
		• How does the college define the cooling off period?
		  • Insert a link to policy /document specifying the cooling off period, including circumstances where it is enforced; ***OR***
		  • insert a link to Council meeting where cooling off period has been discussed and decided upon; ***OR***
		  • where not publicly available, please describe briefly cooling off policy:
		
		  • Cooling Off Period – College By-laws (see page 7)

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)

[2] Cooling off period refers to the time required before an individual can be elected to Council where an individual holds a position that could create an actual or perceived conflict of interest with respect to his or her role and responsibility at the college.

	c. The College has a conflict of interest questionnaire that all Council members must complete annually. Additionally: i. the completed questionnaires are included as an appendix to each Council meeting package; ii. questionnaires include definitions of conflict of interest; iii. questionnaires include questions based on areas of risk for conflict of	The College fulfills this requirement: Yes ☐ Partially X No ☐ • The year when conflict of interest the questionnaire was implemented ***OR*** last evaluated/updated: 2016 • Member(s) update his or her questionnaire at each Council meeting based on Council agenda items: Always ☐ Often ☐ Sometimes ☐ Never X • Insert a link to most recent Council meeting materials that includes the questionnaire: See below (under Additional Comments)

	interest identified by Council that are specific to the profession and/or College; and iv. at the beginning of each Council meeting, members must declare any updates to their responses and any conflict of interest specific to the meeting agenda.	*If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes X No ☐* *Additional comments for clarification (optional)* • A focus on Board Director expectations regarding conflict of interest is a part of the orientation session at each new Board year and includes information on regulatory requirements and various scenarios to support Board Directors' understanding of these expectations • Expectations regarding conflict of interest are currently expressed in By-Laws and in the Governance Manual; however, a Board Policy is currently in development and is expected to be completed in 2021. • The current attestations required of the Board of Directors is part of the Governance Manual and all Board Directors are required to confirm their attestation annually and declare any conflicts of interest, real or perceived, at each meeting. – See appendix 1 of the Governance Manual • At every Board and Committee Meeting the Chair will ask Board Directors and Committee Appointees to declare any conflicts and they are recorded and managed accordingly. • The College plans to review the annual attestation as part of the ongoing review of governance of the College.
	d. Meeting materials for Council enable the public to clearly identify the public interest rationale (See Appendix A) and the evidence supporting a decision related to the College's strategic direction or regulatory processes and actions (e.g. the minutes include a link to a publicly available briefing note).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Describe how the College makes public interest rationale for Council decisions accessible for the public: • Matters that come before the Board for approval or decision are accompanied by a supporting briefing note which includes a section that defines the public interest rationale for the item coming forward to the Board. • The content of each briefing note reinforces the connection of the matter to the College's mandate and Board's role. This includes providing the necessary context and background to support the Board's decision-making and understanding and any key considerations that must be included in order to demonstrate the item as a matter of public interest. Briefing notes are supplemented by verbal updates, and occasionally visual presentations, which are used to further emphasize the content of the matter before the Board as well as the public interest rationale. • Insert a link to meeting materials that include an example of how the College references a public interest rationale: • Meeting Materials – September 2020 Board Meeting

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)
Standard 3 **The College acts to foster public trust through transparency about decisions made and actions taken.**		
Measure	**Required evidence**	**College response**
.1 Council decisions are transparent.	a. Council minutes (once approved) are clearly posted on the College's website. Attached to the minutes is a status update on implementation of Council decisions to date (e.g. indicate whether decisions have been implemented, and if not, the status of the implementation).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert link to webpage where Council minutes are posted: • Minutes are found on the Board meeting materials/reports section of the website https://www.ocpinfo.com/about/council-committees/council-meetings-reports/
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • In addition to posting materials on our website before and after each Board meeting, the College promotes the meetings via our registrant and public/stakeholder communication channels including social media posts and e-newsletters. This also includes tweeting highlights and decisions made by the Board in real-time at each meeting. • Summary Board Reports are also posted online as a further method to communicate Board decisions and areas of focus from each meeting prior to meeting minutes being posted following their approval.
	b. The following information about Executive Committee meetings is clearly posted on the College's website (alternatively the College can post the approved minutes if it includes the following information). i. the meeting date;	The College fulfills this requirement: Yes ☐ Partially ☐ No X
		• Insert a link to webpage where Executive Committee minutes / meeting information are posted: • Executive Committee minutes are not currently posted online.

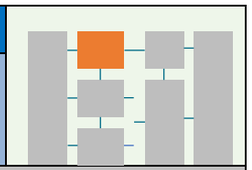
	ii. the rationale for the meeting; iii. a report on discussions and decisions when Executive Committee acts as Council or discusses/deliberates on matters or materials that will be brought forward to or affect Council; and iv. if decisions will be ratified by Council.	*If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes X No ☐* *Additional comments for clarification (optional)* • Meeting minutes of the Executive Committee, which does not approve items on behalf of the Board except on matters related to governance and staff compensation or if the Board should not be fully constituted, are not currently posted on the website. While the Executive Committee does preview the material to come to the Board, they do not alter or amend recommendations put forward to the Board by other Statutory Committees or staff. • The College is currently exploring options, including the posting of summaries with action/decision items (if any) from each Executive Committee meeting.
	c. Colleges that have a strategic plan and/or strategic objectives post them clearly on the College's website (where a College does not have a strategic plan, the activities or programs it plans to undertake).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to the College's latest strategic plan and/or strategic objectives: • Strategic Framework 2019-2021 (extended to 2022) *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)* • In addition to posting the Strategic Framework and related priorities online, the College routinely includes the framework in every Board meeting package, at every Board and Statutory Committee orientation meeting, in regular College publications including the annual report and *Pharmacy Connection* magazine, and via social media when communicating about the role of the College and its strategic and operational priorities and mandate.
3.2 Information provided by the College is accessible and timely.	a. Notice of Council meeting and relevant materials are posted at least one week in advance.	The College fulfills this requirement: Yes X Partially ☐ No ☐ *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐*

		Additional comments for clarification (optional) • Board Meeting information including agendas ○ https://www.ocpinfo.com/about/council-committees/council-meetings-reports/ • In addition to posting the Board meeting materials online, the College promotes the meeting through its various registrant/stakeholder and public communication channels including social media and e-newsletters.
	b. Notice of Discipline Hearings are posted at least one week in advance and materials are posted (e.g. allegations referred)	The College fulfills this requirement: Yes X Partially ☐ No ☐
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • Notice of Discipline Hearings are posted at least a week in advance with required information posted online via the website and public register. Please see the following link for more details about the Discipline Hearing process and about information posted to our Find a Pharmacy/Professional Tool (public register). • Discipline process – information for the public and registrants • *Information about what is posted on our public register*

DOMAIN 2: RESOURCES

Standard 4

The College is a responsible steward of its (financial and human) resources.



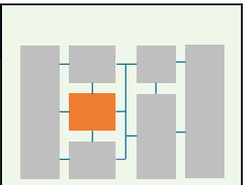
Measure	Required evidence	College response

4.1 The College demonstrates responsible stewardship of its financial and human resources in achieving its statutory objectives and regulatory mandate.	a. The College's strategic plan (or, where a College does not have a strategic plan, the activities or programs it plans to undertake) has been costed and resources have been allocated accordingly.
	
	Further clarification:
	A College's strategic plan and budget should be designed to complement and support each other. To that end, budget allocation should depend on the activities or programs a College undertakes or identifies to achieve its goals. To do this, a College should have estimated the costs of each activity or program and the budget should be allocated accordingly.
		The College fulfills this requirement: Yes X Partially ☐ No ☐
		
		• Insert a link to Council meeting materials that include approved budget ***OR*** link to most recent approved budget:
		  • 2019 Operating Budget
		  • 2019 Budget Presentation
		  • 2021 Operating Budget
		  • 2021 Operation Plan Priorities
		  • Deferral of Strategic Planning
		  • 2019-2022/2023 Strategic Framework
		
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		
		Additional comments for clarification (optional)
		
		• A new Strategic Framework was developed in 2018 by the Board to set the strategic priorities of the College for 2019-2021 (extended to 2022 and possibly 2023, further to the pandemic situation).
		• Each year, following reaffirmation of the strategic priorities defined in the Framework, the operational plan priorities for the following year are presented to the Board. These planned priorities outline the College's annual commitment towards the Strategic Framework, which form the foundation for the development of a budget, which is then followed by budget approval.

	b. The College: i. has a "financial reserve policy" that sets out the level of reserves the College needs to build and maintain in order to meet its legislative requirements in case there are	The College fulfills this requirement: Yes X Partially ☐ No ☐ If applicable: • Insert a link to "financial reserve policy" ***OR*** Council meeting materials where financial reserve policy has been discussed and approved:

	unexpected expenses and/or a reduction in revenue and furthermore, sets out the criteria for using the reserves; ii. possesses the level of reserve set out in its "financial reserve policy".	• The College maintains reserve funds in order to cover variable and/or unforeseen costs and expenses in accordance with the Finance and Audit Committee Policy – Reserve Funds ○ Link to the Reserve Funds Policy • The College has internally restricted net assets to be used for specific purposes in accordance with the Finance and Audit Committee Policy. These reserve funds are reviewed during the audit and included as part of the notes to the audited financial statements. ○ Link to the 2019 audited financial statement – Notes to Financial Statements, page 9 • Insert most recent date when "financial reserve policy" has been developed ***OR*** reviewed/updated: • Last reviewed in 2018, next review in 2021 • Has the financial reserve policy been validated by a financial auditor? Yes X No ☐
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)
	c. Council is accountable for the success and sustainability of the organization it governs. This includes ensuring that the organization has the workforce it needs to be successful now and, in the future (e.g. processes and procedures for succession planning, as well as current staffing levels to support College operations).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a date and link to Council meeting materials where the College's Human Resource plan, as it relates to the Operational and Financial plan, was discussed. • 2019 Budget Presentation, pages 23 & 24 • 2020 Budget • 2021 Budget
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The new Strategic Framework created in 2018, and the subsequent annual operational plans, sets the expectation for significant new key regulatory initiatives. Accordingly, salary budgets reflect the addition of new staff in key regulatory program areas. To ensure that staff costs were effectively managed and to make greater use of the resources available, a focused effort to assess work processes

		and seek efficiency improvement remains a priority. Wherever practical, positions are filled on a temporary contract basis to provide the greatest flexibility moving forward as efficiencies are realized. New staffing was required in 2020 and again in 2021 to address a growing Conduct caseload and increased assessment/inspection activity, which are outlined in briefing notes and appendices presented to the Board found in the links noted above.

DOMAIN 3: SYSTEM PARTNER	
Standard 5 **The College actively engages with other health regulatory Colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.**	
Standard 6 **The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public expectations.**	
Standard 7 **The College responds in a timely and effective manner to changing public expectations.**	

	College response
Measure / Required evidence: **N/A**	***Colleges are requested to provide a narrative that highlights their organization's best practices for each of the following three standards. An exhaustive list of interactions with every system partner the College engages is not required.*** ***Colleges may wish to provide Information that includes their key activities and outcomes for each best practice discussed with the ministry, or examples of system partnership that, while not specifically discussed, a College may wish to highlight as a result of that dialogue. For the initial reporting cycle, information may be from the recent past, the reporting period, or is related to an ongoing activity (e.g., planned outcomes).***

The three standards under this domain are not assessed based on measures and evidence like other domains, as there is no 'best practice' regarding the execution of these three standards. Instead, Colleges will report on key activities, outcomes, and next steps that have emerged through a dialogue with the Ministry of Health. Beyond discussing what Colleges have done, the dialogue might also identify other potential areas for alignment with other Colleges and system partners. In preparation for their meetings with the ministry, Colleges have been asked to submit the following information: • Colleges should consider the questions pertaining to each standard and identify examples of initiatives and projects undertaken during the reporting period that demonstrate the three standards, and the dates on which these initiatives were undertaken.	**Standard 5: The College actively engages with other health regulatory colleges and system partners to align oversight of the practice of the profession and support execution of its mandate.** Recognizing that a College determines entry to practice for the profession it governs, and that it sets ongoing standards of practice within a health system where the profession it regulates has multiple layers of oversight (e.g. by employers, different legislation, etc.), Standard 5 captures how the College works with other health regulatory colleges and other system partners to support and strengthen alignment of practice expectations, discipline processes, and quality improvement across all parts of the health system where the profession practices. In particular, a College is asked to report on: • *How it has engaged other health regulatory Colleges and other system partners to strengthen the execution of its oversight mandate and aligned practice expectations? Please provide details of initiatives undertaken, how engagement has shaped the outcome of the policy/program and identify the specific changes implemented at the College (e.g. joint standards of practice, common expectations in workplace settings, communications, policies, guidance, website etc.).* In 2020, the College was invested in a number of high priority activities aimed at promoting and supporting safe and effective pharmacy practice in which engagement with health system partners and alignment of practice expectations within the profession and with other professions was critical. The following are specific examples that demonstrate achievement of this standard through a systems-based and public-informed approach. Additional details and outcomes associated with system partner engagement are further elaborated in Standards 6 and 7: **Supporting Responsive, Safe and Quality Pharmacy Care During the COVID-19 Pandemic** • Upon the declaration of the provincial state of emergency in response to the COVID-19 pandemic, the College shifted its focus to support the profession's response to the pandemic in line with its legislated role as a regulator by helping to align and reinforce practice expectations of pharmacy professionals during a period of significant upheaval in how health professionals typically operated and practiced. a. The shift to virtual care particularly among physicians in order to maintain important access to primary care for both COVID and non-COVID patients necessitated effective communication between prescriber and pharmacy. Through engagement with partners such as the College of Physicians and Surgeons of Ontario (CPSO), College of Nurses of Ontario (CNO) and professional associations such as the Ontario Pharmacists Association (OPA) and Ontario Medical Association (OMA), changes to processes regarding acceptance of email prescriptions and better alignment of expectations across both professions were implemented in order for patients to continue to have timely access to their medications while maintaining an appropriate standard of safety, quality and protection of personal health information. b. It was important that patients prescribed pain medications had timely access to their medications. With the amendments to federal controlled substances regulations, the College developed the necessary resources in collaboration with partners including other regulators such as CPSO and CNO and professional associations to support the implementation of these temporary amendments within practice in Ontario. c. As an essential service to their communities, pharmacies and pharmacy professionals had to respond quickly and effectively to adapt to changes to how healthcare was to be delivered. The College produced and communicated timely and well-informed guidance from multiple system sources including the Public Health Ontario, Public Health Agency of Canada, OPA, Canadian Pharmacists Association (CPhA) to support evolving prescribing practices, regulatory changes and infection control and prevention measures to ensure that the College and its stakeholders/partners were providing appropriate support to the profession. The College has also worked with the 34 Public Health Units to provide the necessary information to assist them in capacity planning, such that there will be as many access points as possible to support the mass vaccination efforts in the province. **Reinforcing Pharmacy's Role in the Provincial Response to the Opioid Crisis** • The prolonged worldwide opioid crisis has had a significant impact on the lives of Ontarians. Early engagement with health system partners, including hospitals and regulators of professions who can prescribe controlled substances such as CPSO and CNO, as well as with pharmacy stakeholders including professional

	associations, established that pharmacy professionals have a critical role in preventing the loss and diversion of controlled substances. The College routinely engages and collaborates with these and other partners to align professional expectations and support the development of effective working relationships between medical, dental, and pharmacy professionals. • Since convening a Task Force of pharmacy professionals and a physician to develop an Opioid Strategy, the College has continued to engage patients, pharmacy professionals, hospitals, community pharmacies and government agencies that have supported the development of solutions to identified areas of risk. • After the approval of the Opioid Strategy in 2017, the College has continued to work with various federal and provincial stakeholders, including the Office of Controlled Substances, Health Canada, the Ontario Drug Policy Research Network (ODPRN), CPSO and the Centre for Addiction and Mental Health (CAMH) to respond to the opioid crisis. This includes the establishment of a data sharing agreement with federal partners to further understand the loss or theft of controlled substances, providing research guidance to understand practice changes during the opioid crisis and working with experts in the field to share best practices with registrants. **Enhancing Medication Safety in Pharmacy** • All healthcare professionals that either prescribe, dispense or administer medications have a role in the prevention of medication incidents. As medication experts, pharmacy professionals play an instrumental role in helping to provide the right care to the right patient at the right time, and that includes helping to prevent medication errors and near misses within or involving pharmacies. • Recognizing the growing awareness of medication safety in pharmacy and the impact errors can have on people's lives in Ontario, across the country and around the globe, the College focused on the development and spread of a medication safety program first launched in late 2018 which became known as the Assurance and Improvement in Medication Safety (AIMS) Program. The program included a standardized requirement of all pharmacy professionals and pharmacies in Ontario regarding continuous quality assurance in medication safety practice including mandatory anonymous reporting of medication incidents. • The College has worked alongside patients, registrants, pharmacy operators, including chain operators and associations to improve pharmacy professional engagement with the program and the various tools designed to promote and support continuous quality improvement and patient safety. **Establishing System Focused Quality Indicators for Pharmacy** • In 2018, the College undertook a significant initiative in partnership with Ontario Health (Quality) to establish Quality indicators for Pharmacy that are aligned with Ontario health system indicators. The goal of this work is to shift the pharmacy sector, through a continuous quality improvement approach, to focus on impact of pharmacy care on patient and system outcomes, providing the public and stakeholders with a clearer picture of the overall quality of pharmacy care in Ontario. • The work aligns with the College's right-touch and outcomes focused approach to regulating. using data to inform decision making • Partners from across the health system were engaged, and included academia, the Ministry of Health, physicians, pharmacists, associations, data and analytics experts, and patients. **Strengthening the Practice Environment in Community Pharmacy** • Pharmacies in Ontario are required to operate according to the Standards of Operation and pharmacy professionals are required to practice according to the Standards of Practice of their professions (pharmacists and pharmacy technicians). As pharmacies have evolved to play a greater role in our health system and as the scope of practice of pharmacists has evolved along with the introduction of pharmacy technicians as a regulated profession in the province, feedback from registrants and patients over the years has identified an opportunity to examine the community pharmacy practice environment in order to identify potential barriers to meeting operational and practice standards consistently. This included better understanding expectations of patients, pharmacy professionals, corporate owners/operators and professional associations as it related to a shared accountability for the provision of safe, high quality care.

- In collaboration with an Advisory Group comprising of pharmacy associations, corporate owners/operators/employers, pharmacy professionals and patient advisors, the College led the development of guiding principles of shared accountability for community pharmacy. The College also facilitated focus groups with patients and registrants to further enhance the needed insights that would guide the development of accountability principles.
- Further to the work that the College started in 2018 on the development of system-based quality indicators for pharmacy with Ontario Health (Quality) that was launched in 2019, this work forms the basis for the development of Provider Experience Indicators per the Quadruple Aim healthcare improvement framework.

Expanding the Scope of Practice of Pharmacists to Enable Prescribing for Minor Ailments

- In 2019 the Minister of Health requested that the College develop regulations to expand the scope of practice of Ontario pharmacists, including enabling pharmacists to prescribe medications for certain minor ailments. Regulations needed to be developed that not only considered the expectations of pharmacists to engage in the expanded scope of practice safely but to do so in collaboration with other members of a patient's healthcare team.
- With these key principles in mind, the College facilitated an extensive open consultation and stakeholder engagement strategy that included a multi-disciplinary steering group throughout 2019 and 2020 to help inform and shape the minor ailments regulation that would not only serve patients but align with the existing structures and relationships within the Ontario health system. These insights have further supported the work in preparing for implementation of the approved regulations including the development of relevant resources and guidance materials to reinforce patient- and system-informed practice expectations.

Standard 6: The College maintains cooperative and collaborative relationships to ensure it is responsive to changing public/societal expectations.

The intent of standard 6 is to demonstrate that a College has formed the necessary relationships with system partners to ensure that it receives and contributes information about relevant changes to public expectations. This could include both relationships where the College is "pushed" information by system partners, or where the College proactively seeks information in a timely manner.

- *Please provide some examples of partners the College regularly interacts with including patients/public and how the College leverages those relationships to ensure it can respond to changing public/societal expectations.*
- *In addition to the partners it regularly interacts with, the College is asked to include information about how it identifies relevant system partners, maintains relationships so that the College is able access relevant information from partners in a timely manner, and leverages the information obtained to respond (specific examples of when and how a College responded is requested in standard 7).*

ENGAGEMENT AND COLLABORATION WITH PATIENTS/THE PUBLIC

The College's approach to patient and public engagement is aligned with the principles of the International Association of Public Participation (IAP2) Framework, with a focus on consulting, involving and collaborating with patients/public. This is an approach we have embedded in our activities over the past several years as the public/patients are considered equal partners alongside

Standard 7: The College responds in a timely and effective manner to changing public expectations.

Standard 7 highlights successful achievements of when a College leveraged the system partner relationships outlined in Standard 6 to implement changes to College policies, programs, standards etc., demonstrating how the College responded to changing public expectations in a timely manner.

- *How has the College responded to changing public expectations over the reporting period and how has this shaped the outcome of a College policy/program? How did the College engage the public/patients to inform changes to the relevant policy/program? (e.g. Instances where the College has taken the lead in strengthening interprofessional collaboration to improve patient experience, examples of how the College has signaled professional obligations and/or learning opportunities with respect to the treatment of opioid addictions, etc.).*
- *The College is asked to provide an example(s) of key successes and achievements from the reporting year.*

The College's systems-based approach to regulatory oversight includes close collaboration with system partners and the public which has directly influenced our ability to respond to and integrate public and system-informed practice expectations, best demonstrated using the areas of focus articulated in CPMF Standard 5.

	pharmacy professionals and health system stakeholders to guide and advise on policy matters that will directly impact the quality and safety of patient care, with an increased focus on regulatory and practice priorities that impact patient outcomes. These activities are over and above how the College seeks feedback on and responds to input received through open consultations.
	
	Targeted engagement for greater qualitative insights
	• The College uses focus groups conducted by an independent third party to discuss specific topics and seek input from patients/public to help enhance the College's understanding of public opinions and expectations which help inform decisions, direction, strategies and approaches used by the regulator.
	• This past year, the College facilitated eight focus groups with members of the public principally on two topics: patient experiences in community pharmacies and insights on potential changes to the public register.
	  ○ As part of the Community Practice Environment Initiative, insights into patient experiences in community pharmacies in Ontario were considered and shared with a multi-disciplinary advisory group comprised of pharmacy professionals, associations, owner/operators, and patients and used in the identification of accountability principles currently in development. These principles will address common issues raised by patients such as ways to educate and improve public understanding of the role of pharmacy professionals and the safe, quality care they should expect as patients when visiting a pharmacy.
	  ○ Insights from the public regarding changes to the public register helped the College understand views and opinions regarding information, functionality and design of the public register, user preferences, expectations of information related to pharmacy assessments and how information regarding concerns involving pharmacy professionals is displayed.
	  ○ The insights also have been used to identify recommendations for implementation in 2021 that further advance the College's commitment to transparency including adding additional information to register related to pharmacy operational assessment outcomes and the reason/type of assessment performed.
	  ○ These focus groups, most recently conducted by Leger on our behalf, have ensured a diverse mix of perspectives in these discussions as representation was sought from participants who
		Supporting Responsive, Safe and Quality Pharmacy Care During the COVID-19 Pandemic
		• Throughout 2020, the College routinely engaged stakeholders to respond to COVID-19 related practice matters, from reinforcement of registrant and public facing messaging to help clarify what patients should expect in pharmacies during the pandemic to reminders to professionals about infection prevention and control (IPAC) protocols. Examples include:
		• Amended regulations to enable timely access to care
		  ○ The Board approved the proposed provincial regulation amendments needed to enable implementation of the Health Canada Section 56 Exemption under the Controlled Drugs and Substances Act (CDSA) permitting pharmacists to transfer, refill, renew and adapt controlled substances prescriptions, which were then promptly approved by the provincial government.
		  ○ The College acted quickly to develop the necessary guidance to support the implementation of these temporary amendments and coordinated communication with organizations such as the CPSO and CNO as their registrants were also impacted by the Section 56 Exemption. The College also engaged broader system partners including NAPRA (National Association of Pharmacy Regulatory Authorities) which supported alignment, where appropriate, between and across jurisdictions and supported information sharing from agencies such as Health Canada and the Public Health Agency of Canada.
		  ○ The College leveraged its relationship with the Office of Controlled Substances (OCS) at Health Canada and was able to capitalize on that relationship to ensure the regulatory changes addressed unique challenges to Ontario regulations. For example, the College was able to provide the OCS with feedback on utilization of the exemption to help inform their decision to extend regulatory amendments, by drawing on our relationships with other partners including the Ontario Drug Policy Research Network (ODPRN) and by accessing Agency for Healthcare Research and Quality (ARHQ) data.
		• Developed, informed and updated practice guidance and policies
		  ○ The College developed and updated practice policy and guidance resources related to the emerging and unique issues associated with providing patient care during the COVID-19 pandemic. Select

	reflected Ontario's diverse population and patient needs including those from racialized communities. • The College is part of a collaborative of other provincial health regulators that sponsors a Citizen Advisory Group (CAG), patients/members of the public from throughout the province who come together quarterly to discuss various topics of interest to sponsor regulators and their respective public-protection mandates. ○ Specific topics explored by the College included expanded scope of practice, supporting the College in identifying regulatory amendments to enable prescribing for minor ailments by Ontario pharmacists that considers the input of patients and the public who would potentially access these services, including what they would expect from their pharmacists engaging in such activities. ***Direct involvement in advisory capacities*** • The College has adopted an engagement strategy that includes formal involvement of patients, patient advocates and those with lived experience as members of advisory groups, working groups and task forces on specific initiatives, programs and strategies. Examples from the reporting period include the Community Practice Environment Advisory Group, Quality Indicators Expert Panel, and Minor Ailments Advisory Group. ○ Each of these groups integrated patients as equal members who worked alongside pharmacy and other healthcare professionals, health system stakeholders, pharmacy operators and academic representatives to advise on and contribute to the objectives of each of the initiatives undertaken by each group. ○ Patient representatives helped shape the development of regulations enabling prescribing for minor ailments by pharmacists, contributed to the establishment of accountability principles for community pharmacy and provided advice on the selection of specific quality indicators that will be used to measure and report on pharmacy quality across the province. ○ Examples from outside of reporting period but which are important recent examples to emphasize include the involvement of patient advisors on a Medication Safety Task Force that resulted in the introduction of Canada's largest medication safety program of its kind for community pharmacies, our Opioid Strategy and our Cannabis Strategy, each designed to provide guidance and	policies were updated as were several practice fact sheets such as those related to central fill and the validation of prescriptions for controlled substances, to provide further clarity for registrants. • Addressed barriers to effective continuity of care ○ As challenges in practice were identified, the College worked to remove regulatory barriers where appropriate by adapting practice policies and providing guidance to registrants so that they were able to provide the necessary pharmacy services to support their patients. ○ For example, as physicians began working from home without access to the usual forms of communication with pharmacies, College staff promptly collaborated with various stakeholders including associations and other regulators to develop a practical solution by enabling and permitting the use of unconventional communication methods between prescribers and pharmacies to ensure continuity of care for patients while maintaining the protection of personal health information. • Monitored and responded to inquiries and emerging priorities ○ College staff established daily meetings and frequent stakeholder discussions to track issues related to COVID-19 in order to support prompt and effective communication to registrants. Staff also tracked and categorized inquiries from the public and registrants in order to identify where there was the greatest need for clarity and to pinpoint issues that might require specific resources or messaging. ○ Some examples included reinforcing the ability of pharmacy professionals to apply their professional judgement when providing care in an emergency situation or when dispensing medications while considering the risk of drug shortages during the pandemic as well as reminders on the consistent use of masks and other personal protective equipment by professionals in pharmacies. • Maximized its communication channels ○ The College quickly amended its communication tools to focus on timely COVID-19-related information and practice communication. A dedicated and prominent webpage is updated frequently and includes information on the latest updates and resources for pharmacy professionals developed by the College as well as updates and links to resources from other organizations. Public

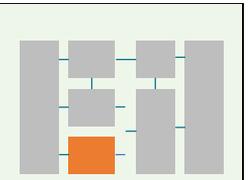
	resources for pharmacy professionals to provide optimal and safe health care. • This year, the College moved forward with a series of governance renewal best practices which will, among other things, result in an equal number of members of the public and elected professional members on the Board of Directors (formerly referred to as Council), in addition to two academic appointments which will provide an effective balance of public and professional perspectives as the Board executes its fiduciary responsibilities. ○ The governance renewal includes the involvement of Professional Committee Appointees (PCAs) and Lay Committee Appointees (LCAs), which the College recruits from the community at large, to further support the adoption of governance best practices and ensure an equal representation of the public in our work. • Starting in late 2019, the College's Patient Relations Committee discussed topics related to the College's patient relations program and its commitment to enhancing the Indigenous Cultural Competency of pharmacy professionals and staff and Board of the regulator in response to the growing awareness of the health disparities faced by Ontario's Indigenous communities and the opportunities for governing bodies and healthcare professionals to engage in reconciliation. This work included engaging directly with members of the Indigenous community. ***Informal engagement through interactions with the public*** • The College regularly analyzes trends in inquiries from the public received through the College's Pharmacy Practice team which helps to identify education and communication opportunities on emerging issues for both registrants and the public, which are then pushed out through various communication channels. For example, inquiries from registrants regarding the safe dispensing and management of narcotics have led to the opportunity to reinforce the use of narcotics practice tools and other resources in publications such as Pharmacy Connection and our website. • The College routinely uses complaints-related information to educate and instruct registrants on best practices, obligations and expectations on specific practice matters that are encountered by registrants as an opportunity to improve and prevent similar incidents from occurring. For example, a complaint received by the College regarding an interaction between a patient and a registrant which left the patient feeling that their personal identity was disrespected led to the publication of an article under	information on the website was also posted frequently, which reinforced messages from public health as well as information to help the public understand expected experiences as their pharmacies adopted public health measures. **Reinforcing Pharmacy's Role in the Provincial Response to the Opioid Crisis** • In December 2019, the College published the Framework for Improving the Safety and Security of Controlled Substances in Hospital High Risk Areas. These recommendations were developed after the College initiated a partnered table that included representatives from Accreditation Canada/Health Standards Organization, Ministry of Health, Ontario Health (Quality), the OHA, the Institute for Safe Medication Practices Canada (ISMP), the Canadian Anesthesiologists Society, the Canadian Society of Hospital Pharmacists (CSHP) Ontario Branch and a number of academic, community and rural hospitals as well as a patient representative. In doing so the College leveraged many existing and well-established system relationships with these organizations to engage them effectively on this new initiative. ○ The work of implementing and evaluating the framework is still ongoing, which includes engaging the partnered table as well as key health system stakeholders that can contribute to the prevention of drug diversion in hospitals. This work continued into early 2020 but was put on hold as a result of the COVID-19 pandemic and its impact on hospital and pharmacy operations. **Enhancing Medication Safety in Pharmacy** • In late 2019, the College publicly released aggregate data reported through the incident recording platform along with a report from an independent response team made up of pharmacy, academic and medication safety experts. ○ For the first time in Ontario, the number and type of medication incidents reported by pharmacies and the causal factors associated with them was now available. The data bulletin also included analysis of a subset of the data with tips on how to prevent medication from being dispensed to the incorrect patient. • Through feedback from registrants, pharmacy owners and pharmacy chains, the College implemented various activities, such as utilizing existing

	our Practice Insights series in *Pharmacy Connection* reminding registrants of their individual and collective responsibility to respect patient choices, individuality and diversity, a principle under our Code of Ethics. **ENGAGEMENT AND COLLABORATION WITH SYSTEM PARTNERS** The College has adopted a systems-based approach to its regulatory programs and initiatives based heavily on collaboration and participation amongst and between various partners – from regulatory and government agencies, associations, hospitals and organizations focused on healthcare quality and safety, and the profession as a whole – in recognition of the role pharmacy, and its regulator, plays within an integrated healthcare system. The examples below demonstrate its approach and how the College is able to leverage these system partner relationships to respond to public and broader system expectations over the past year. ***Targeted engagement and involvement in identified regulatory priorities and programs*** • As part of the College's COVID-19 pandemic response, which included providing practice supports, guidance and relevant information to registrants in line with our regulatory role, the College collaborated with the College of Physicians and Surgeons of Ontario (CPSO), the College of Nurses of Ontario (CNO), the Ontario Pharmacists Association (OPA) and other stakeholders regarding regulatory amendments to Section 56 of the Controlled Drugs and Substances Act and cooperatively problem-solved in the identification and communication of appropriate solutions regarding email prescriptions as physicians turned to more virtual methods of patient care. The College continues to routinely engage these stakeholders to respond to COVID-19 related practice matters, from reinforcement of registrant and public facing messaging to help clarify what patients should expect in pharmacies during the pandemic to reminders to professionals about infection prevention and control (IPAC) protocols based on public input shared with the College, to support pharmacy professionals in their delivery of safe pharmacy services to their patients and communities. • Since the development and publication of the Quality Indicators in Community Pharmacy in collaboration with Ontario Health Quality (OHQ) and with the direct input of a multi-disciplinary expert panel including patients in 2019, the College has continued to work with data experts and health system stakeholders, including OHQ and the Ministry of Health to	communication tools to highlight key requirements of the AIMS Program and reinforcing key messages during operational and practice assessments. • In addition, the College developed and implemented quality improvement tools (such as the Pharmacy Safety Self-Assessment) in 2020 in collaboration and with input from registrants and medication safety partners to help pharmacies track their efforts to enhance patient safety over time. These efforts have led to 99% of pharmacies in Ontario having activated the AIMS platform at the end of 2020. Throughout the year, the College has also collected feedback on the usability of the platform and will be incorporating changes to the incident-recording platform that will enhance data collection. • As part of a public reporting framework, the College supports transparency and sharing of data for the purposes of improving quality and patient safety. The College published updated aggregate provincial AIMS data in the fall of 2020 on the College website. This data provides insight into the type of medication incidents and near misses being recorded in community pharmacies as more and more pharmacies use the system to report on incidents and learn from them to prevent them from recurring. **Strengthening the Practice Environment in Community Pharmacy** • Throughout the latter half of 2020, the Community Practice Environment Advisory Group members incorporated all the feedback from patients/the public, registrants as well as their own practice insights and identified seven principles that would enable a community practice environment that supports professionalism and safe, high-quality patient care. • The College Board unanimously endorsed the principles and supported implementation across all pharmacies, commencing in 2021. Work is now underway to implement the principles with each of the stakeholders on the Advisory Group sharing responsibility for supporting their adoption within community pharmacies throughout Ontario. The work also forms the basis for the development of the Provider Experience Indicators per the Quadruple Aim framework that underpins the Quality Indicators for Pharmacy initiative that was launched in 2019. • In addition, the insights gleaned through the engagement activities with professionals and patients has shaped other strategies and activities planned for 2021, including greater public/patient education regarding what they should expect from pharmacies and regulated pharmacy professionals and the role of the College.

	release the quality indicators data set in November 2020. This work now includes the development of indicators related to patient experience. • In July 2020, the College commenced the Community Practice Environment Initiative aimed at enhancing the safety and accountability within community pharmacies and to respond to the insights expressed by pharmacy professionals and patients received through focus groups, surveys and consultations. In addition to the members of the Community Practice Environment Advisory Group, registrants and patients were engaged to solicit feedback on the development of accountability principles that will serve as a foundation for collaborative work going forward. • During the development of the amendment to the *Pharmacy Act, 1991 O.Reg 202/94*, which, if approved, will authorize pharmacists to prescribe certain minor ailments in addition to other scope of practice changes, the College engaged other health regulatory colleges such as CPSO, CNO, the College of Optometrists of Ontario and the College of Midwives of Ontario starting from June 2019 until present. The College has also engaged pharmacist associations such as OPA, Neighbourhood Pharmacy Association of Canada, and the Canadian Society of Hospital Pharmacists (Ontario Branch) to receive their input, feedback and considerations during the drafting of the regulations. OCP also connected with other health professional associations including the OMA, the Ontario College of Family Physicians, and the Nurse Practitioner Association of Ontario to hear their recommendations, feedback and considerations given their current experience as prescribers in the Ontario health care system in order to further broaden understanding of public/patient and system expectations and perspectives. ***Informal engagement to maintain responsiveness to emerging issues, public expectations and priorities*** • The College has been collaborating with Ontario Health, Digital services to facilitate pharmacies' access to clinical viewers. Access to these records will enable pharmacists and technicians to better serve their patients. The College also engages on a regular basis with PrescribeIT to ensure that the e-prescribing service aligns with the standards of the profession and patient expectations of pharmacy practice. • The College regularly engages with Ontario Health (Cancer Care Ontario) to discuss practice issues, share information and ensure alignment with standards of practice and expectations of pharmacy practice and frequently	**Expanding the Scope of Practice of Pharmacists to Enable Prescribing for Minor Ailments** • Feedback from the open consultation as well as from stakeholder engagement activities that started at the beginning of regulatory drafting was incorporated into the final regulatory submission to the Minister of Health in June 2020. • As a result of these engagement activities, the College strengthened and will continue to leverage many new and existing connections and relationships as the College prepares for the implementation of minor ailments prescribing, once the regulatory amendments are approved by the provincial government. • In addition, the College has carefully reviewed and considered all of the feedback through the consultation and engagement exercises and notes that the proposed regulatory changes to expand scope of practice for pharmacists will meet the Minister's objectives to optimize the education and training of pharmacists, streamline care pathways, increase access to minor and routine care in the community and support improved patient and system outcomes, while also supporting interprofessional collaboration. • Various health system stakeholders including public health agencies, Ontario Health Quality, the OMA, AFHTO and OCFP identified existing clinical resources that prescribers currently use, which will be critical for pharmacists to refer to. By linking to these references, all prescribers would refer to the same resources, supporting consistent prescribing practices for minor ailments. • During the review of the regulation that refers to prescriber notification when a pharmacist administers a drug in Schedule 1 or 2 by injection or inhalation, the College consulted CNO, CPSO, OMA and OCFP in early 2020. These consultations changed the College's approach to prescriber notification so that pharmacists are expected to notify prescribers of drug administration within a reasonable time, at every administration, unless the prescriber advises the pharmacist in advance that notification is unnecessary. • From late 2019 until present, the College has been working with CNO, College of Optometrists of Ontario, College of Midwives of Ontario and College of Chiropodists of Ontario who received similar guidance from the Ministry as they were also drafting regulations that would authorize their registrants to prescribe a select list of drugs.

	engages the Ontario Hospital Association (OHA) to discuss and collaborate on issues related to hospital pharmacy practice to ensure a safe medication management system. • The College engages regularly with HPRO (Health Profession Regulators of Ontario) where health regulatory colleges collectively identify opportunities to respond to changing public expectations, including opportunities related to implementing governance best practice and reform within existing legislative frameworks to strengthen public confidence in the role of regulators. • Frequent formal and informal discussions and information sharing between the College and provincial and national pharmacy associations have enabled effective collaboration and information sharing so that regulatory perspectives and the input and experiences of pharmacy professionals who interact with patients every day on emerging practice matters and concerns can be shared openly with a view to supporting effective communication and ultimately quality pharmacy practice. Examples include the College's role as a member of the Quality Steering Committee of the Association of Family Health Teams of Ontario (AFHTO) which works to support the implementation and growth of primary care teams by promoting best practices, and the College's partnership with Ontario Health (North) and Ontario Health (Quality) to develop a systems approach to enable collaboration between primary care and community pharmacy to improve care for patients with depression.	○ The colleges collaborated to identify appropriate resources for registrants to help them understand the American Hospital Formulary Service (AHFS) classifications and how to interpret the regulation, since the reference to AHFS classifications in regulations was new to most professions. The colleges developed and shared resources to support consistency around how to use the AHFS classifications and ensure the regulation would be interpreted consistently. • The College is working on an implementation plan that addresses the recommendations and concerns noted through the consultation activities. The plan includes the development of mandatory education as an orientation to the regulatory requirements and expectations for minor ailment prescribing and a communication plan to inform the public and other stakeholders of what pharmacists are authorized to do and what they should expect from their pharmacies and professionals as minor ailment prescribing is enabled in the province. These messages were further refined as a direct result of the stakeholder and public engagement sessions held throughout late 2019 and into 2020.

DOMAIN 4: INFORMATION MANAGEMENT



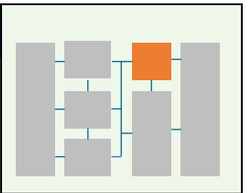
Standard 8

Information collected by the College is protected from unauthorized disclosure.

Measure	Required evidence	College response
8.1 The College demonstrates how it protects against unauthorized disclosure of information.	a. The College has and uses policies and processes to govern the collection, use, disclosure, and protection of information that is of a personal (both health and non- health) or sensitive nature that it holds	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to policies and processes ***OR*** provide brief description of the respective policies and processes. • **Governance** Information governance principles are in place for physical records, unstructured electronic information (email, documents, web pages), and structured information (databases). The Information and Data Management function provides policies, standards, processes, and tools for the governance of College data and information assets with: • Information Management Policy • Records Management Policy • Data Management Policy • Email Management Policy • The College's Privacy Code outlines the how the College manages the collection, use, disclosure, and protection of personal information and personal health information at the College. • The protection of information is supplemented by the Records Retention Schedule that governs the life cycle of a record, or series of records, from creation or receipt to disposition or permanent preservation. • **Security/Protection** Various reports and tools are used to ensure the security of data and information at the College. These include: • Testing such as regular simulated cyber-attack penetration testing and cyber security updates • Education such as information security training required by all OCP staff • Incoming content security such as connection filtering and anti-malware • Outgoing content security such as email encryption • Monitoring of staff accounts for malware, phishing and virus attacks • Access controls such as different levels of access for staff and contractors

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The College is actively working on modernizing information management and privacy activities. A new Privacy and Information Access Policy and Manual has been developed and will be published once all staff have been trained by the end of August 2021. • An update to the Information Management policies and standards will complement the Privacy and Information Access Policy to ensure that all staff are aware of their responsibilities when handling College information/data. The Records Retention Schedule will also be updated by end of year 2021 to inform taxonomy design for a new document management system. • Development of a cyber-attack response protocol will be completed in 2021 for implementation by 2022.

DOMAIN 5: REGULATORY POLICIES



Standard 9

Policies, standards of practice, and practice guidelines are based in the best available evidence, reflect current best practices, are aligned with changing public expectations, and where appropriate aligned with other Colleges.

Measure	Required evidence	College response
9.1 All policies, standards of practice, and practice guidelines are up to date and relevant to the current practice environment (e.g. where appropriate, reflective of changing population health needs, public/societal expectations, models of care, clinical evidence, advances in technology).	a. The College has processes in place for evaluating its policies, standards of practice, and practice guidelines to determine whether they are appropriate, or require revisions, or if new direction or guidance is required based on the current practice environment.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to document(s) that outline how the College evaluates its policies, standards of practice, and practice guidelines to ensure they are up to date and relevant to the current practice environment ***OR*** describe in a few words the College's evaluation process (e.g. what triggers an evaluation, what steps are being taken, which stakeholders are being engaged in the evaluation and how). • The College takes a multi-pronged approach to evaluating its policies, standards of practice and practice guidelines. • **The Policy Review Process:** ○ As of January 2020, the College implemented the policy review process which supports the goal of having each policy and practice guideline reviewed every three to five years per industry standards. Through this process, these documents undergo robust review including jurisdictional and environmental scans and literature reviews to ensure the policy response is appropriate and effective based on the current practice environment. • **External Stakeholder Engagement/Proactive Monitoring:** ○ In addition to the policy review process, College staff proactively monitor the practice environment via a number of different mechanisms including our practice and operational assessment process, complaints and intakes trends, practice queries from professionals and the public received by our practice consultants and collaboration with external stakeholders. ○ This practice highlights gaps and the potential need for the creation of new documents, revisions of old documents or pivoting to a new direction to respond to the current practice environment and emerging areas of focus or risk outside of the scheduled policy review process. It also ensures that these documents reflect current legislation and regulation. ○ To align with pharmacy regulators across Canada, the College adapts and/or adopts standards from the National Association of Pharmacy Regulatory Authorities (NAPRA). The

		College also works alongside other provincial pharmacy regulatory authorities (PRAs) to develop and update national standards based on updates to practice and the changing landscape of pharmacy. The College periodically reviews the standards to ensure that they are relevant and responds with either creating our own standards to address the new climate or works with stakeholders to revise the document to meet the current practice environment. • **Examples of College Policies, Standards of Practice and Practice Guidelines Under Review in 2020:** ○ Administering a Substance by Injection or Inhalation ○ Initiating, Adapting and Renewing Prescriptions ○ Operating Internet Sites ○ Prescriptions – Out of Country • **Examples of College Policies, Standards of Practice and Practice Guidelines Revised in 2020:** ○ Preventing Sexual Abuse and Harassment ○ Protecting the Cold Chain • **COVID-19 Related Revisions** ○ Administering a Substance by Injection or Inhalation ○ Centralized Prescription Processing ○ Faxed Transmission of Prescriptions ○ Initiating, Adapting and Renewing Prescriptions
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	b. Provide information on when policies, standards, and practice guidelines have been newly developed or updated, and demonstrate how the College took into account the following components: i. evidence and data, ii. the risk posed to patients / the public,	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• For two recent new policies or amendments, either insert a link to document(s) that demonstrate how those components were taken into account in developing or amending the respective policy, standard or practice guideline (including with whom it engaged and how) ***OR*** describe it in a few words. • The College takes into account components i-vi as part of the policy review process, There are two ways policies, standards and practice guidelines are considered for review: ○ Through the policy review process of being reviewed once every three to five years.

	iii. the current practice environment, iv. alignment with other health regulatory Colleges (where appropriate, for example where practice matters overlap) v. expectations of the public, and vi. stakeholder views and feedback.	○ Triggered through external engagement and proactive monitoring of current practice environment • As such, we have provided an example of each. It is important to note that since this process started in January 2020, not all the policies have undergone a review through this process and prescribed timeline. The College is working towards ensuring that every policy meets this timeline of review. 1. **Protecting the Cold Chain:** a. In the first step of the policy review process, "Research and Review," College staff explored current data and evidence around the subject matter through an intensive jurisdictional scan and an academic literature review. The policy, which is currently under review, will be updated to reflect key updates in the National Vaccine Storage and Handling Guidelines for Immunization Providers and the Vaccine Storage and Handling Protocol, 2018. This step also included engaging practice advisors (people who are in pharmacies daily, routinely completing assessments) and reviewing internally gathered data (such as pharmacy operational and practice assessments and complaints) for the profession. The evidence found during this step fed into the drafting and revision part of the review. b. In addition to the jurisdictional scan and the academic literature review, the "Research and Review" step involved reviewing any complaints or patient experiences that have been documented related to the policy. During this step, College staff reviewed any legal issues or cases that had arisen around the Cold Chain. Since there were no outstanding concerns, this policy did not need to have a working group created to discuss the risks/concerns in detail. c. The College worked with health regulators who oversee professions that store vaccines (e.g. College of Nurses of Ontario, College of Physicians and Surgeons of Ontario) through consultation and informal discussions. d. If a policy is undergoing extensive changes and/or is deemed as a contentious/collaborative matter that would benefit from receiving feedback from the public, stakeholders or other professions, it will be posted on the College's website for public consultation. The Protecting the Cold Chain policy was a minor update and therefore did not go out for consultation. However, the College worked with external stakeholders, such as the Ontario Pharmacists Association and Canadian Society of Hospital Pharmacists, to review the drafted policy from the perspective of the practicing pharmacy professional as well as the community and hospital operations perspective. The feedback was considered, and when appropriate, worked into the revised policy. 2. **COVID-19 – Centralized Prescription Processing** a. As part of the policy monitoring process, the College became aware that the current Centralized Prescription Processing policy (Central Fill) was causing barriers to practice as

		the practice environment changed to respond to COVID-19. The addendum demonstrates the College's examination of these components and the resulting update of the policy to address the change in the practice environment. b. The Central Fill policy review started with discussions with stakeholders to better understand the barriers and potential solutions. This lead to understanding the risk posed to patients/the public if the policy did not change. After a risk was determined, the College examined the language of other jurisdictions to understand the options available to us. c. As a result of this work, the College found that streamlining the Central Fill process to limit the physical contact between patients and pharmacy professionals would help in the continuity of care as well as in the fight against COVID-19. The language in the addendum addresses areas of concern, such as the integrity of the drug product as well as cross-provincial delivery. This was published on our website on April 15, 2020. As COVID-19 responses change and require different approaches, the College continues to monitor to ensure that this approach is suitable.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 10

The College has processes and procedures in place to assess the competency, safety, and ethics of the people it registers.

Measure	Required evidence	College response
10.1 Applicants meet all College requirements before they are able to practice.	a. Processes are in place to ensure that only those who meet the registration requirements receive a certificate to practice (e.g., how it operationalizes the registration of members, including the review and validation of submitted documentation to detect fraudulent documents, confirmation of information from supervisors, etc.)[3].	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link that outlines the policies or processes in place to ensure the documentation provided by candidates meets registration requirements ***OR*** describe in a few words the processes and checks that are carried out: • Insert a link ***OR*** provide an overview of the process undertaken to review how a college operationalizes its registration processes to ensure documentation provided by candidates meets registration requirements (e.g., communication with other regulators in other jurisdictions to secure records of good conduct, confirmation of information from supervisors, educators, etc.): • To register as a pharmacist or pharmacy technician, an applicant must meet the registration requirements that are specified in the *General Regulation under the Pharmacy Act, 1991*. Some of these requirements are specific to the certificate of registration for which the applicant is applying (i.e., pharmacist vs. pharmacy technician). **Third Party Pharmacy Organizations That Support the College's Registration Requirements** • The College collaborates with a number of third-party Canadian pharmacy organizations to set and uphold the registration requirements. Since these organizations are referred to throughout sections 9a and 9b, their role in the College's registration requirements and our relationships with them are briefly described below: ○ The Canadian Council for Accreditation of Pharmacy Programs (CCAPP) is responsible for developing and maintaining accreditation standards for educational programs for pharmacy professionals and for reviewing the Canadian programs based on these standards. The College has a memorandum of understanding with CCAPP. ○ The National Association of Pharmacy Regulatory Authorities (NAPRA) provides a forum for pharmacy regulatory authorities across Canada to address common issues and share knowledge and experiences relevant to pharmacy regulation. NAPRA created and maintains the National Model Licensing Program that includes entry-to-practice competencies upon which the CCAPP accreditation standards, the College's practice-based assessments and the Pharmacy Examining Board of Canada's (PEBC) examinations are

based, as well as the language proficiency requirements for licensure. In addition, NAPRA, along with the provincial pharmacy regulatory authorities, developed the Pharmacists' Gateway Canada, as the starting point for international pharmacy graduates and Accreditation Council for Pharmacy Education (ACPE)-accredited program graduates to begin the initial credentialing process.

- The Pharmacy Examining Board of Canada (PEBC) is the authorized professional credentialing organization for immigration purposes (federally), and is responsible for assessing the qualifications and competence of pharmacy professionals. The College has a memorandum of understanding with PEBC.

Registration Requirements and Document Authentication Processes

- For each of the eight registration requirements, the required standard(s) is briefly described below to promote understanding of what the applicant must meet for their application to be considered. The College's processes for document authentication are then described for each registration requirement.

1. **Education** – Graduation from an educational institution that is:
   - accredited by the Canadian Council for Accreditation of Pharmacy Programs (CCAPP)
   - accredited by the Accreditation Council for Pharmacy Education (ACPE) which is the American counterpart to CCAPP, or
   - recognized by the Pharmacy Examining Board of Canada (PEBC)'s evaluation process to become eligible to take the PEBC's Qualifying Exam and successful completion of:
     - Parts I and II of the relevant PEBC Qualifying Exam on the first attempt, or
     - College Board approved bridging education for international graduates:
       - Pharmacist applicants - International Pharmacy Graduate (IPG) Program or University of Toronto, PharmD for Pharmacists Program
       - Pharmacy technician applicants - University of Toronto, School of Continuing Studies Canadian Health Care System, Culture and Context for Internationally Educated Healthcare Professionals course in addition to any other course(s) or program as identified by the Registration Committee

   a. ***Document Authentication:*** **CCAPP**
   The College receives graduation lists directly from the CCAPP-accredited programs for pharmacists and pharmacy technicians in Ontario. For graduates of a CCAPP-accredited program outside of Ontario, the College requires an official letter directly from the education institution confirming the applicant's graduation.

   b. ***Document Authentication:*** **NAPRA**
   Through NAPRA, the College has agreed on national standards for registration including documentation and the authentication process. The Pharmacists' Gateway Canada is the

starting point for international pharmacy graduates and ACPE-accredited program graduates to begin the initial credentialing process.

c. ***Document Authentication:*** **PEBC**
PEBC Identification Authentication and Document Evaluation Process:
Proof of identification and graduation from a recognized pharmacy education program for international graduates are confirmed by the PEBC and scanned into the Pharmacists' Gateway Canada for pharmacist applicants or stored by the PEBC for pharmacy technician applicants. International pharmacist applicants must also successfully complete the PEBC Pharmacist Evaluating Exam that tests applicants' background knowledge base in the pharmaceutical sciences and preparation for the practice of pharmacy. Documents submitted to the PEBC are also reviewed by College staff upon application. The College accepts the documentation process that PEBC follows to verify the identification and education credential requirements and any determination that PEBC has made using an alternative verification approach. Information about identification requirements and alternatives for required documentation is provided.

2. **Jurisprudence Examination** – Successful completion of an exam based on an examination blueprint that has been approved by the Registration Committee to assess a candidate's knowledge of federal and provincial legislation affecting pharmacy practice in Ontario.
   a. ***Document Authentication:*** The College manages applications for this computer-based exam and informs candidates of their result.
   b. ***Identification Authentication:*** Candidates must submit proof of identification when they apply to register with the College and must present proof of their identification at the testing centre or to the remote proctor on the day of the exam. Information about acceptable identification for this exam is provided.

3. **Practice-based assessment** – Successful completion of the Practice Assessment of Competence at Entry (PACE) for pharmacist applicants or Structured Practical Training (SPT) for pharmacy technician applicants. These practice based assessments are administered by the College.
   a. ***Document Authentication:*** The College manages applications to undergo these practice-based assessments, and informs candidates of their outcome.
   b. ***Identification Authentication:*** PACE candidates must provide valid, government-issued photo identification to their assessor.

4. **Pharmacy Examining Board of Canada (PEBC) Qualifying Examination** – Successful completion of the national certification exam for pharmacists or for pharmacy technicians. These exams are based on the NAPRA Professional Competencies for Canadian Pharmacists at Entry to Practice or

		the Professional Competencies for Canadian Pharmacy Technicians at Entry to Practice, respectively. a. ***Document Authentication:*** A pass result list with the successful candidates on each exam is electronically transmitted directly to the College from the PEBC. An individual candidate's pass result is also posted in their Pharmacists' Gateway Canada profile if applicable and available. b. ***PEBC Identification Authentication:*** Candidates must submit proof of identification with their application for each part of the relevant Qualifying Exam and must present proof of their identification at the testing centres (or to the remote proctor) on the day(s) of the exams. Information about the identification requirements and alternatives for required documentation for pharmacist candidates and pharmacy technician candidates is provided. **5.** **Language proficiency** – International applicants must meet the minimum acceptable test scores for one of the objective, high stakes tests as set by NAPRA for pharmacists or pharmacy technicians, provide acceptable non-objective evidence of language proficiency, or request that a panel of the Registration Committee consider other evidence of the applicant's language proficiency. Graduates of a CCAPP- or ACPE-accredited education program are considered to have met this requirement. a. ***Document Authentication:*** Language proficiency test score reports must be provided directly to the College (or the Pharmacists' Gateway, if applicable) from the testing institution, or are confirmed online with the testing institution by College staff. The language testing centres evaluate proof of identification for all test takers. Letters or transcripts submitted as non-objective evidence must be sent directly to the College from the applicant's pharmacy school, employer, secondary school or school board, and/or undergraduate university. **6.** **Good character** – Police background check with no positive findings and a self-declaration of good character. a. ***Document Authentication:*** The police background check must be provided through an OCP-contracted background and identity services provider (accessed directly by staff), or obtained at the applicant's local police station and submitted as a notarized copy or original of the documentation. The declaration of good character is completed within the College's online application. **7.** **Canadian citizenship or legal status in Canada** – Must be legally entitled to live in Canada and to work in a pharmacy in Ontario.

		a. ***Document Authentication:*** The applicant must provide a notarized copy or original documentation of their identity and citizenship or status in Canada. Documentation is reviewed by College staff for authenticity, and retained in the applicant's file. **8.** Personal professional liability insurance – Must have required coverage as prescribed in OCP By-Laws. a. ***Document Authentication:*** The applicant must complete a declaration confirming that they have obtained and will maintain personal professional liability insurance as specified in the College's By-Laws while registered with the College. College staff may review evidence of personal professional liability insurance as needed. • **Mobility within Canada** - Applicants who are currently licensed as a pharmacist or pharmacy technician in another Canadian province are considered to have met, and do not need to provide documentation of the education, practice-based assessment (i.e., PACE or SPT) and PEBC Qualifying Exam requirements in accordance with the labour mobility provisions of the Agreement on Internal Trade (AIT). These applicants must provide evidence of meeting the other registration requirements as described above. a. ***Document Authentication:*** A current letter of standing as validation of current licensure must be provided directly to the College from the pharmacy regulator of any Canadian province or territory where the applicant holds an active license. College staff may verify the applicant's registration information using the public register of the other province(s). b. The College's expectations for document authentication are provided for candidates on the Supporting Documentation for Registration page.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)

[3] *This measure is intended to demonstrate how a College ensures an applicant meets every registration requirement set out in its registration regulation prior to engaging in the full scope of practice allowed under any certificate of registration, including whether an applicant is eligible to be granted an exemption from a particular requirement.*

	b. The College periodically reviews its criteria and processes for determining	The College fulfills this requirement: Yes X Partially ☐ No ☐

	whether an applicant meets its registration requirements, against best practices (e.g. how a College determines language proficiency).	• Insert a link that outlines the policies or processes in place for identifying best practices to assess whether an applicant meets registration requirements (e.g. how to assess English proficiency, suitability to practice etc.), link to Council meeting materials where these have been discussed and decided upon ***OR*** describe in a few words the process and checks that are carried out. • Provide the date when the criteria to assess registration requirements was last reviewed and updated. **Review of Registration Criteria and Processes** • The primary purpose of the College's registration resolutions and the registration policies is to set the criteria for assessment of applications. The Registration Resolutions are updated as required (last updated December 2019). The Registration Policies are reviewed every year (last reviewed November 2019). The resolutions and policies are based on best practices in professional regulation and assessment. • The College is involved with a number of professional regulatory organizations including the Canadian Network of Agencies for Regulation (CNAR), the Council on Licensure, Enforcement & Regulation (CLEAR), and Ontario Regulators for Access Consortium (ORAC). By attending and presenting at conferences organized by these organizations, College staff keep abreast of best practices and developments in registration and assessment for entry to practice. Staff in the College's Registrant Competence department also attend educational events hosted by companies such as Touchstone Institute and Steinecke Maciura LeBlanc to learn about best practices in assessment and registration. • Changes in best practices in registration criteria or processes are monitored by College staff and may trigger an evaluation. In general, the steps outlined below are followed: 1. Conduct preliminary background research and an environmental scan. 2. Contract with an external consultant to gather data and/or provide expert knowledge. 3. Review research findings and expert recommendations to determine the changes required. 4. If further development is required, pilot test the proposed changes. 5. Launch the changes. 6. Evaluate the impact of the changes • The Registration Committee and/or Board is informed and approves decisions as necessary, at key milestones. • This data-informed process was followed for these changes to the College's registration criteria or processes: ○ 2015 – Non-objective evidence of language proficiency policy updated ○ 2016 – Assessment tool for Relevance to Suitability to Practice, Operate a Pharmacy or be Registered as a Member introduced for use by panels of the Registration Committee (Reference: September 2015 Council minutes, item 19.1) ○ 2018 – Practice Assessment of Competence at Entry (PACE) for pharmacist applicants

launched (Reference: June 2019 Council minutes, item 10.2)
- 2018 – Structured Practical Training (SPT) activities for pharmacy technician applicants updated
- 2018 – Registration and Quality Assurance regulation changes submitted to Government (Reference: December 2017 Council minutes, item 9.1)
- 2019 – Guidelines for testing accommodations updated (Reference: March 2019 Registration Committee minutes)
- 2019 – Police background check requirement introduced for all applicants
- 2019 – Competency based blueprint for a new Jurisprudence, Ethics and Professionalism assessment approved by Committee
- 2019 – Academic misconduct added to Declaration of Good Character
- 2020 - TOEFL iBT Special Home Edition test accepted due to COVID-19 pandemic
- 2020 – Computer-based format for Jurisprudence Exam launched due to COVID-19 pandemic

Third Party Pharmacy Organizations Review that support the College's Registration Criteria and Processes

- According to the College's memorandum of understanding with the,
  - **Canadian Council for Accreditation of Pharmacy Programs (CCAPP),** CCAPP is responsible for developing and maintaining up-to-date accreditation standards for educational programs for pharmacy professionals using a valid, reliable and defensible process, and for reviewing the Canadian programs based on these standards. CCAPP's Board of Directors is composed of representatives appointed by the Association of Faculties of Pharmacy of Canada, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, the National Association of Pharmacy Regulatory Authorities, The Pharmacy Examining Board of Canada and the Canadian Pharmacy Technician Educators Association. College staff are invited as observers to the CCAPP site visits;
  - **National Association of Pharmacy Regulatory Authorities (NAPRA)** works with pharmacy practitioners, educators and other stakeholders to ensure their programs and processes are current and follow best practices;
  - **Pharmacy Examining Board of Canada (PEBC)**, PEBC is responsible for assessing the qualifications and competence of applicants through a valid, reliable and defensible evaluation and certification process, and for maintaining up-to-date examinations for pharmacy professionals. The PEBC is governed by a national Board of Directors comprised of representatives of the provincial pharmacy regulatory authorities (including the College), the Association of Faculties of Pharmacy of Canada, the Canadian Pharmacists Association, the Canadian Society of Hospital Pharmacists, the Canadian Association of Pharmacy Technicians, and the Canadian Pharmacy Technician Educators Association. PEBC staff participate in the same conferences and educational events as College staff to

		learn about and share best practices in qualification assessments. • Some examples of changes by these third party pharmacy organizations include: ○ 2015 – PEBC Pharmacist Qualifying Exam blueprint updated ○ 2016 – PEBC Pharmacy Technician Qualifying Exam blueprint updated ○ 2018 – CCAPP Accreditation Standards for Canadian First Professional Degree in Pharmacy Program and Accreditation Standards for Canadian Pharmacy Technician Programs updated
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The College will be initiating a standard operating procedures review in 2021.
10.2 Registrants continuously demonstrate they are competent and practice safely and ethically.	a. Checks are carried out to ensure that currency[4] and other ongoing requirements are continually met (e.g., good character, etc.).	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a link to the regulation and/or internal policy document outlining how checks are carried out and what the currency and other requirements include, link to Council meeting materials where documents are found and have been discussed and decided upon ***OR*** provide a brief overview: • Upon annual renewal, pharmacists are required to complete self-declarations regarding, a. Practice requirement (for pharmacists providing patient care) b. Good standing c. Code of Ethics d. Personal professional liability insurance e. Injection authority f. Completion of any required training (for 2020 annual renewal cannabis training was required) • Upon annual renewal, pharmacy technicians are required to complete self-declarations regarding a. Good standing b. Code of Ethics c. Personal professional liability insurance • Once the revised Registration/QA regulations are approved by government, both pharmacists and pharmacy technicians will be required to (1) make an annual declaration of competence

		and (2) identify a designated place of practice where patient care is provided in preparation for a practice assessment when selected.
		
		• List the experts / stakeholders who were consulted on currency:
		
		  • Currency requirements were last reviewed in 2016. The College's Board reviewed proposed Registration/QA regulations in September 2016 (pg.14) and finalized regulations in December 2017 after public consultation. A jurisdictional scan regarding the requirements of other regulators was provided to the Board. The Registration Committee and Quality Assurance Committee were informed of the proposed regulation changes.
		  • Experts/stakeholders consulted included other Ontario regulators, pharmacy regulators across Canada, and academics with expertise in continuing competency and assessment.
		
		• Identify the date when currency requirements were last reviewed and updated:
		
		  • Policy change approval occurred in 2016, followed by development and consultation on regulation throughout 2017. **(The regulation was submitted to government in February 2018; awaiting approval)**
		
		• Describe how the College monitors that registrants meet currency requirements (e.g. self-declaration, audits, random audit etc.) and how frequently this is done.
		
		  • Pharmacists complete a self-declaration indicating that practice hours have been met every year upon annual renewal (pharmacy technicians are not required to self-declare currency as this portion of the regulations have yet to be approved by government.) In addition, pharmacists that engage in patient care are subject to a practice assessment which assesses competency. The goal is to assess all pharmacists providing patient care over six years once supporting legislation (see comment on regulation above) is in place. Ultimately, with the collection of more data, risk-based criteria will be incorporated into the model to determine the frequency of assessments.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The College is initiating a standard operating procedures review in 2021 which will include documentation of the process for currency and other requirements through annual renewal.

[4] *A 'currency requirement' is a requirement for recent experience that demonstrates that a member's skills or related work experience is up-to-date. In the context of this measure, only those currency requirements assessed as part of registration processes are included (e.g. during renewal of a certificate of registration, or at any other time).*

10.3 Registration practices are transparent, objective, impartial, and fair.	a. The College addressed all recommendations, actions for improvement and next steps from its most recent Audit by the Office of the Fairness Commissioner (OFC).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to the most recent assessment report by the OFC ***OR*** provide summary of outcome assessment report: • Fair Registration Practices Reports for pharmacists and pharmacy technicians: • https://www.ocpinfo.com/wp-content/uploads/2020/02/2019_Pharmacists_Fair_Registration_Practices_Report.pdf • https://www.ocpinfo.com/wp-content/uploads/2020/02/2019_Pharmacy_Technician_Fair_Registration_Practices_Report.pdf • Where an action plan was issued, is it: Completed ☐ In Progress ☐ Not Started ☐ No Action Plan Issued X *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Measure	Required evidence	College response
11.1 The College supports registrants in applying the (new/revised) standards of	a. Provide examples of how the College assists registrants in implementing	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Provide a brief description of a recent example of how the College has assisted its registrants in

practice and practice guidelines applicable to their practice.	required changes to standards of practice or practice guidelines (beyond communicating the existence of new standard, FAQs, or supporting documents).	the uptake of a new or amended standard: • Name of Standard • Duration of period that support was provided • Activities undertaken to support registrants • % of registrants reached/participated by each activity • Evaluation conducted on effectiveness of support provided **Opioid Strategy for Pharmacy** • In 2017, the College published an Opioid Strategy for Pharmacy. The Strategy, developed by a multi-disciplinary Opioid Task Force, addresses relevant areas of practice, and considers the health and social factors that are related to problematic opioid use. • As part of the Strategy, an Opioid Policy was developed in 2018 outlining the College's expectations for pharmacy professionals regarding opioids. To support the application of the policy in practice, the College created an Opioid Practice Tool as a hub for relevant resources. External resources on best opioid prescribing and dispensing practices were promoted. • The College collaborated with the University of Waterloo School of Pharmacy to develop, Pharmacy5in5 which is an interactive, online and app-based teaching tool that houses self-assessment quizzes and other educational resources. Specific modules addressing guidance for Naloxone, Assessing Opioid Prescriptions and Managing Narcotic Inventory were developed. • Through pharmacy and practice assessments that take place at the pharmacy, College Operations Advisors and Practice Advisors are able to provide education regarding security of narcotics and controlled drugs as well as focus on appropriate pharmacist assessment, decision making, documentation and patient communication in relation to dispensing these drugs. • Guidance on the dispensing of naloxone was developed. Additionally, practice consultants provide support and resources to pharmacy professionals who contact the College with specific questions. • Quality indicators and interactive tools have been published which identify regional and provincial trends that can help registrants and teams focus their efforts when developing continuous quality improvement initiatives in their own practice as it relates to safe and effective opioid dispensing. • Does the College always provide this level of support: Yes X No ☐ *If not, please provide a brief explanation:* *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (optional)*

11.2 The College effectively administers the assessment component(s) of its QA Program in a manner that is aligned with right touch regulation[5].	a. The College has processes and policies in place outlining: i. how areas of practice that are evaluated in QA assessments are identified in order to ensure the most impact on the quality of a registrant's practice; ii. details of how the College uses a right touch, evidence informed approach to determine which registrants will undergo an assessment activity (and which type if multiple assessment activities); and iii. criteria that will inform the remediation activities a registrant must undergo based on the QA assessment, where necessary.	The College fulfills this requirement: Yes Partially X No ☐ • List the College's priority areas of focus for QA assessment and briefly describe how they have been identified ***OR*** link to website where this information can be found: • General information about the College's QA program is available in the *Winter 2020 Pharmacy Connection* magazine. ○ https://pharmacyconnection.ca/quality-assurance-supporting-safe-and-quality-care-winter-2020/ • General information about practice assessments could be found in the QA program section of the College's website. ○ https://www.ocpinfo.com/practice-education/qa-program/practice-assessments/ • Is the process taken above for identifying priority areas codified in a policy: Yes ☐ No X *If yes, please insert link to policy* • The College's practice historically has been to have QA program policies approved by the QA Committee; however, this process has not been codified in policy. With the development of new governance and operational policies underway there is an opportunity to formalize these activities through policy. • Insert a link to document(s) outlining details of right touch approach and evidence used (e.g. data, literature, expert panel) to inform assessment approach ***OR*** describe right touch approach and evidence used: • Several sources of evidence were used to inform the assessment approach. ○ An extensive scoping review, conducted by Dr. Zubin Austin, an academic researcher in competence assessment, provides the basis for the multi-modal QA process that the College has adopted. ○ A QA Re-design Advisory Group, with representatives from the QA Committee, pharmacists, pharmacy technicians and the public, was established to guide the creation of a new QA program. ○ In addition, a number of panels (with pharmacists from various practice settings, pharmacy technicians from various practice settings, and academic representatives) were established to provide input in the development of assessment tools and processes. ○ Finally, an assessment consultant/ psychometrician was contracted to evaluate the

		assessment tools and processes for practice assessments (the first portion of the QA re-design which is nearing completion).
		
		• Throughout the re-design, changes were approved by the QA Committee and the Board.
		  ○ Literature review / Environmental scan
		  ○ Logic model for OCP's QA Program
		  ○ Review of policy options for the College's QA Program - *An Authentic, Practice-Based Assessment as a Catalyst for Continuous Professional Development* (published article) https://www.mdpi.com/2226-4787/8/1/15
		  ○ Evaluation of practice assessment by assessment consultant
		
		• Provide the year the right touch approach was implemented ***OR*** when it was evaluated/updated (if applicable):
		If evaluated/updated, did the college engage the following stakeholders in the evaluation:
		  – *Public* *Yes* Ξ *No* □
		  – *Employers* *Yes* Ξ *No* □
		  – *Registrants* *Yes* Ξ *No* □
		  – *other stakeholders* *Yes* Ξ *No* □
		
		• The College's approach to regulation has evolved over the past several years in order to adapt to emerging best practices and in 2011 began to implement a number of practices aligned with a right-touch approach to regulation which was first signaled to registrants through a series of engagement activities called Navigating the Grey in 2011 and Moving the Mountain in 2015.
		• This approach, among other things, informed the development of a redesigned QA program which considers the core principles of right-touch regulation such as proportionality and risk-informed interventions and the growing use of data in decision making. The QA program for pharmacists and pharmacy technicians was subsequently evaluated and re-designed starting in 2014.
		• As the College has continued to consider such practices in its regulatory activities, it has remained focused on implementing a balanced and flexible approach to regulatory oversight, with outcomes at the centre of everything it does. Grounded in core practices of right-touch and risk-based regulation, the College is further evolving its overall oversight approach through the adoption of outcomes-focused regulation principles which further considers the use of data to define the most appropriate regulatory actions and interventions to take in order to reduce risk and influence better regulatory, patient and system outcomes through continuous quality improvement. Implementation of the systems-based Quality Improvement indicators for Pharmacy and the Assurance and Improvement in Medication Safety (AIMS) Program are examples of the evolution of the College's outcomes focused approach to regulating

		• Insert link to document that outlines criteria to inform remediation activities ***OR*** list criteria: • The following practice assessment criteria serve as a self-evaluation for pharmacists and pharmacy technicians. In addition, the results of a practice assessment using these criteria form the basis for remediation activities. ○ Practice Assessment Criteria – Community Pharmacists ○ Practice Assessment Criteria – Hospital and other Healthcare Facility Pharmacists ○ Practice Assessment Criteria – Community and Hospital Pharmacy Technicians
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The College's QA program redesign, intended to align with right-touch regulatory principles and practices, includes the following: ○ Focusing QA activities on those providing patient care (OCP's two-part public register enables easy identification of pharmacists providing patient care; a similar two-part register will be available for pharmacy technicians once the proposed regulations are approved); ○ Increasing registrants' interactions with various QA activities, ranging from self-assessment to practice assessment (and assessing every registrant approximately every 6 years); ○ Transitioning assessments to the place of practice to ensure that registrants not only know what to do and how to do it, but that they actually are engaging in the appropriate activities; ○ Providing remediation up-front when gaps are identified so that only those that are unable to improve practice are referred to the Quality Assurance Committee; ○ Increasing frequency of assessments based on risk (For example, those not meeting standards could potentially undergo a reassessment by a QA practice advisor, and a reassessment by the QA peer assessor; ○ Adding a post-remedial assessment which takes place approximately one year after remediation; and ○ Using a CQI model for practice assessments so that practice is improved for all registrants, even those already meeting standards. • The College has invested significant effort into determining appropriate remediation for those with identified gaps, including the establishment of a professional development and remediation business unit in 2017. A consistent classification scheme was developed and is now used across

		College programs in order to gather data on gaps and in order to classify appropriate remediation resources. The remediation resource catalogue is used by adjudicatory committees. • The College is interested in measuring outcomes. Pharmacy quality indicators have been developed and will be used to gather data to provide a broader understanding of competency gaps and impact on patient outcomes which will be influenced through broad quality improvement activities.

5 "Right touch" regulation is an approach to regulatory oversight that applies the minimal amount of regulatory force required to achieve a desired outcome. (Professional Standards Authority. Right Touch Regulation. https://www.professionalstandards.org.uk/publications/right-touch-regulation).

11.3 The College effectively remediates and monitors registrants who demonstrate unsatisfactory knowledge, skills, and judgment.	a. The College tracks the results of remediation activities a registrant is directed to undertake as part of its QA Program and assesses whether the registrant subsequently demonstrates the required knowledge, skill and judgement while practicing.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to the College's process for monitoring whether registrant's complete remediation activities ***OR*** describe the process: • As outlined in the practice assessment process diagram (link below), the primary method for ensuring that registrants complete remediation is a follow-up practice assessment. Follow-up assessments are scheduled for those registrants that are determined unsuccessful in an initial practice assessment (conducted by the College's practice advisor) and after coaching is provided by a pharmacist assigned by the College. If the registrant is still unsuccessful (does not demonstrate the competencies assessed), a QA assessment is required and the case is referred to the QA Committee. • When the QA Committee orders specified remediation, the registrant is required to submit a self-declaration indicating completion of the remediation or evidence of successful completion of the remediation if there is an assessment component. In addition, a post-remedial assessment is required one year later. ○ General information about OCP's QA program (College's Pharmacy Connect newsletter, Winter 2020) • Insert a link to the College's process for determining whether a registrant has demonstrated the knowledge, skills and judgement following remediation ***OR*** describe the process: • Registrants that are required to complete specified remediation by the QA Committee are

		required to undergo a post-remedial assessment approximately one year later to determine if they have adopted the required knowledge, skills and judgement to continue practicing in an active role as a pharmacist. ○ QAC Policy – Post-Remedial Assessment
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed) • The *Pharmacy Act* regulations do not yet incorporate pharmacy technicians. This regulation has been submitted to government and is awaiting approval. The pharmacy technicians that have engaged in QA activities, which were initiated in 2019, have done so voluntarily.

Standard 12

The complaints process is accessible and supportive.

Measure	Required evidence	College response
12.1 The College enables and supports anyone who raises a concern about a registrant.	a. The different stages of the complaints process and all relevant supports available to complainants are clearly communicated and set out on the College's website and are communicated directly to complainants who are engaged in the complaints process, including what a complainant can expect at each stage and the supports available to them (e.g. funding for sexual abuse therapy).	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to the College's website that describes in an accessible manner for the public the College's complaints process including, options to resolve a complaint and the potential outcomes associated with the respective options and supports available to the complainant: • The College's complaints process is prescribed in the *Health Professions Procedural Code ("the Code")* under the *Regulated Health Professions Act (RHPA) 1991.* • Once the College receives a formal complaint, the complaint will be investigated by staff, including follow-up discussions to clarify the complainant's concerns. In some cases resolution of the complaint may be appropriate. Investigated complaints are reviewed by the Inquiries, Complaints and Reports Committee (ICRC), and may result in a number of actions, including advice or recommendations, direction to complete remediation, a caution in person, or a referral of specified allegations to the College's Discipline Committee. Complainants and registrants are kept apprised of the progress of the complaint. • Link to Complaints Information: https://www.ocpinfo.com/protecting-the-public/complaints-reports/ • Link to File a Complaint: https://www.ocpinfo.com/protecting-the-public/complaints-reports/file-a-complaint

		• Video: How to File a Complaint: https://www.youtube.com/watch?v=B0wxBG-6R9E • Complaints Process: https://www.ocpinfo.com/protecting-the-public/complaints-reports/file-a-complaint/complaints-process/ • Complaints Process Infographic: https://www.ocpinfo.com/wp-content/uploads/2019/05/Complaints_Process_Infographic.pdf • FAQs: https://www.ocpinfo.com/protecting-the-public/complaints-reports/file-a-complaint/faq-complaint/ • Does the College evaluate whether the information provided is clear and useful: Yes X No ☐ • A review of website content and other communication (e.g. templates) is conducted regularly and feedback received from members of the public and complainants is considered when making any revisions. • Feedback is collected during introductory phone calls with complainants for the purpose of verifying the accuracy of the information, obtaining additional information, explaining the process and timelines and obtaining feedback about whether the call was helpful. • Feedback is also received as part of a report provided by an independent third-party consultant as it relates to the experience of complainants who have made allegations of sexual abuse. The College has contracted with the consultant as a way to provide additional supports to victims of alleged sexual abuse and to provide non-legal guidance to complainants to help orient them through the college's complaints and discipline processes. The consultant provides a report to the College on an annual basis that includes high-level recommendations on how the College can improve its complaints processes for vulnerable complainants. • Does the College have policies and procedures in place to ensure that all relevant information is received during intake and at each stage of the complaints process: Yes X No ☐ • The intake and complaints processes are well documented and procedures are in place for gathering information and evidence and obtaining responses during the investigation. • Every investigation has a documented investigation plan which sets out the requirements with respect to: ○ Which information is required to be gathered in light of the allegations ○ Who will be interviewed ○ Records required and from whom and where

		○ Additional information required to corroborate or refute the allegations ○ Whether a site attendance is required or whether the information be obtained from another source ○ If an analysis is required, what constitutes a representative sample and a reasonable time-frame ○ Whether there is sufficient information for the ICRC to make a decision ○ Whether special powers under s. 76 of the *Code* will be required to conduct an adequate investigation (e.g., issuing a summons) ○ Whether legal input is required (e.g., a prosecutorial assessment) ○ Estimated timelines for completion of investigation and listing for ICRC
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional) • The College intends to implement a survey to solicit further feedback on information provided to the complainants and their interactions with staff during the investigation of their complaint.
	b. The College responds to 90% of inquiries from the public within 5 business days, with follow-up timelines as necessary.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• The College responds to 97% of inquiries from the public within five business days (see companion document: technical specifications for quantitative CPMF measures)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
	c. Examples of the activities the College has undertaken in supporting the public during the complaints process.	• List all the support available for public during complaints process: Below is a list of supports available for the public during the complaints process including: • Facilitation of requests for accommodation to access the complaints process; for example, if someone is unable to write or type, staff will assist a complainant in recording their concerns in alternative means; large font correspondence; and any other accommodations required for the complainant to meaningfully participate in the process

		• Provision of additional information and supports for those reporting sexual abuse
		• Provision of translation services as required/requested
		• For every complaint filed, staff assigned to the complaint conduct an introductory call with the complainant within five days of receipt of the complaint for the purposes of:
		  ○ Introducing themselves to the complainant as the person who will be conducting the investigation and with whom the complainant will be interacting throughout the course of the investigation;
		  ○ Explaining the various steps in the complaints process and their associated timelines;
		  ○ Clarifying the complainant's concerns and confirming the scope of the complaint;
		  ○ Explaining the reasons why certain registrants have been named in the complaint; and
		  ○ For suitable cases, exploring with the complainant if they are open to a resolution other than the formal complaints process.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
12.2 All parties to a complaint and discipline process are kept up to date on the progress of their case, and complainants are supported to participate effectively in the process.	a. Provide details about how the College ensures that all parties are regularly updated on the progress of their complaint or discipline case and are supported to participate in the process.	The College fulfills this requirement: Yes X Partially ☐ No ☐

		• Insert a link to document(s) outlining how all parties will be kept up to date and support available at the various stages of the process ***OR*** provide a brief description:
		
		  • The College provides regular correspondence with the complainant throughout the various stages of the investigation including notification that the investigation is complete and the approximate number of weeks when the matter will be reviewed by ICRC.
		  • If the complaint process exceed the statutory timeline, in accordance with *s. 28 of the Code*, regular correspondence is sent to update the complainant and registrant at regular intervals
		  • Legal staff and prosecutors act as a point of contact for registrants and complainants in the discipline process.
		  • Complainants in sexual abuse cases can access additional confidential support through an independent support person retained by the College for this purpose as they move through the investigation and discipline process.
		  • Registrants are provided with Notices of Hearing and Allegations following a referral of allegations or incapacity information to the Discipline Committee or Fitness to Practise Committee.
		  • Registrants are provided with disclosure in advance of hearings.

		• Registrants participate in pre-hearing conferences and, if needed, case management conferences as well as their contested and uncontested Discipline and Fitness to Practise Committee hearings.
		• The College considers and supports accommodation requests from parties and witnesses to participate in hearings (e.g., interpreters; ability for vulnerable witnesses to testify behind screens, other supports).
		• Registrants and complainants receive written decisions and reasons following hearings, including (for registrants), information about appeal rights.
		• Additional information is also made available through the following resources:
		  ○ Upcoming discipline hearing dates and a summary of the allegations are posted to OCP website:
		  ○ https://www.ocpinfo.com/protecting-the-public/discipline-process/upcoming-discipline-hearings/
		  ○ Public website includes a section describing the discipline process:
		  ○ https://www.ocpinfo.com/protecting-the-public/discipline-process/
		  ○ The Discipline Committee's Rules of Procedure and related forms are available on the OCP website
		  ○ https://www.ocpinfo.com/library/other/download/Rules%20of%20Procedure.pdf

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (optional)
Standard 13 **All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.**		
Measure	**Required evidence**	**College response**
13.1 The College addresses complaints in a right touch manner.	a. The College has accessible, up-to-date, documented guidance setting out the framework for assessing risk and acting on complaints, including the prioritization of investigations, complaints, and reports (e.g. risk matrix, decision matrix/tree, triage protocol).	The College fulfills this requirement: Yes ☐ Partially X No ☐
		• Insert a link to guidance document ***OR*** describe briefly the framework and how it is being applied: • Risk is initially assessed based on the likelihood of patient and public harm including consideration of the need for an Interim Order under the *Code*. As additional information is obtained during the course of conducting an investigation, the risk level is adjusted and prioritization may change in accordance with the most recent risk assessment.

		• Risk is assessed as high, medium, or low depending on the category(ies) of concern(s), the seriousness of the concerns, and whether there is a prior history of similar or other concerning conduct on the part of the registrant.
		• Provide the year when it was implemented ***OR*** evaluated/updated (if applicable):
		  • The College has always assessed risk once the complaint is first received for all concerns to determine priority, urgency, and how quickly a site attendance might be required. In 2017, the Conduct Division adopted a qualitative risk framework for conducting a risk assessment of new complaints and reports, and tracking began. This risk assessment carries into the investigation stage. In 2020, the process was updated to document any changes to the risk assignment of the complaint or report as more information becomes available.
		  • A new tool is under development to incorporate all components of the risk assessment framework and promote consistent application among all those who use it, to be implemented in 2021-22.

		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes X No ☐ • The College intends to publish the new risk assessment tool once finalized, in 2021-22.
		Additional comments for clarification (optional)

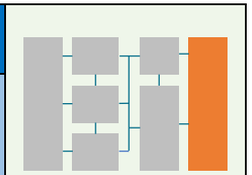
Standard 14 **The College complaints process is coordinated and integrated.**		
Measure	**Required evidence**	**College response**

14.1 The College demonstrates that it shares concerns about a registrant with other relevant regulators and external system partners (e.g. law enforcement, government, etc.).	a. The College's policy outlining consistent criteria for disclosure and examples of the general circumstances and type of information that has been shared between the College and other relevant system partners, within the legal framework, about concerns with individuals and any results.	The College fulfills this requirement: Yes Partially R No ☐
		• Insert a link to policy OR describe briefly the policy:
		  • The College has a policy regarding responding to information requests from police: https://www.ocpinfo.com/extra/CPMF/Police-Request-for-Member-Information.pdf
		  • Although the College does not currently have a written policy for sharing information with other relevant regulators and external system partners such as the Ministry, law enforcement or Health Canada, the College reviews information obtained during the course of an

		investigation and determines if there is evidence of concerning conduct on the part of another regulated health professional which should be reported to the health professional's regulator or elsewhere to protect the public interest. • If concerning conduct is identified and the pharmacy professional is also licensed with another regulator, the College discloses that information to the health professional's other regulator in accordance with that specific exception under *Section 36 (1) of the Regulated Health Professions Act, 1991* (RHPA). • Occasionally, other regulators may request information from the OCP. The College intends to develop a policy and procedure addressing the criteria and process for sharing information under Section 36 of the RHPA within the next two years. • The College has conducted joint investigations in collaboration with other health regulatory colleges when the alleged misconduct under investigation overlaps with the conduct of another regulated health professional, there is a shared practice site and/or it is a multidisciplinary setting where there may be a financial connection. • Provide an overview of whom the College has shared information over the past year and purpose of sharing that information (i.e. general sectors of system partner, such as 'hospital', or 'long-term care home'). • ***Whom:*** *College of Physicians and Surgeons of Nova Scotia, Florida Department of Health and Minnesota Board of Medical Practice* **Purpose:** The Inquiries, Complaints & Reports Committee (ICRC) directed that the College disclose information to these organizations with respect to a physician licensed in all of these jurisdictions, and who was involved in a specific prescription scheme. The ICRC also directed that information be provided to the Mississippi State Board of Medical Licensure about a different physician also involved in the scheme. • ***Whom:*** *Police and Ontario Drug Benefit (ODB) Plan:* **Purpose:** The ICRC directed that information regarding a pharmacist's misconduct be brought to the attention of law enforcement and ODB. • ***Whom:*** *College of Nurses (CNO) of Ontario:* **Purpose:** The ICRC directed information to be shared with the CNO regarding a nurse. • ***Whom:*** *Royal College of Dental Surgeons (RCDSO) of Ontario:* **Purpose:** ICRC directed that information regarding a dentist's possible misconduct be brought to the attention of the RCDSO.

		• ***Whom:*** *College of Physicians and Surgeons (CPSO) of Ontario:* **Purpose:** The ICRC directed that information regarding a physician's prescribing be brought to the attention of the CPSO.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed) • The College is developing a policy to identify matters which contain information that, in the interest of public protection and patient safety, should be disclosed to other parties.

DOMAIN 7: MEASUREMENT, REPORTING, AND IMPROVEMENT



Standard 15

The College monitors, reports on, and improves its performance.

Measure	Required evidence	College response

15.1 Council uses Key Performance Indicators (KPIs) in tracking and reviewing the College's performance and regularly reviews internal and external risks that could impact the College's performance.	a. Outline the College's KPI's, including a clear rationale for why each is important.	The College fulfills this requirement: Yes X Partially ☐ No ☐
		• Insert a link to document that list College's KPIs with an explanation for why these KPIs have been selected (including what the results the respective KPIs tells, and how it relates to the College meeting its strategic objectives and is therefore relevant to track), link to Council meeting materials where this information is included ***OR*** list KPIs and rationale for selection:
		  • In 2018, the College instituted a balanced scorecard approach using the performance categories suggested by the Council on Licensure, Enforcement and Regulation (CLEAR), an internationally recognized organization of regulatory organizations. Key performance indicators (KPIs) are selected annually by the executive team based on the public interest, commitment and duty as a health professional regulator, the College's Strategic Framework and the annual operating plan that sets out new initiatives to advance these priorities. On the scorecard, each KPI is aligned to at least one of the three strategic priorities (SP1, SP2 and SP3) on the 2019-2021 (2022) Strategic Framework.
		  ○ 2020 KPI selection rationale
		  ○ 2019 Meeting material with draft scorecard (page 322 Section 12.2d, Appendix 12.2)
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed)

	b. Council uses performance and risk information to regularly assess the College's progress against stated strategic objectives and regulatory outcomes.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to last year's Council meetings materials where Council discussed the College's progress against stated strategic objectives, regulatory outcomes and risks that may impact the College's ability to meet its objectives and the corresponding meeting minutes:

		• At each quarterly Board meeting, the CEO & Registrar presents on the College's progress towards meeting the College's strategic and regulatory priorities and outcomes followed by an interactive discussion. ○ Section 6.3 Registrar Report - March 2020 BOD Meeting Material (page 310) ○ 2020 Q2 Registrar Report – September 2020 BOD Meeting (page 49) ○ 2020 Q2 BOD Strategic Performance Scorecard ○ 2020 Q2 Board of Director Strategic Performance Descriptive Summary. • Since 2015, an annual risk report is presented at the March Board meeting detailing the College's efforts in risks mitigation from the year prior. A prospective risk register was prepared for the Board's consideration in December 2020. ○ 2019 Risk Management Report ○ 2021 Prospective Risk Register, 2020 Risk Register and Risk Management Plan • The College's performance and risk information are reviewed quarterly with the Board. Financial, regulatory and organizational performance are presented by Committee Chairs and the CEO & Registrar respectively. The Board assesses the information brought forward and votes on next steps. ○ Financial Risk: 2020 Operating and Capital Budget (December 2019 BOD Meeting, Section 11.2, page 293) ○ Strategic Objective: Scope of Practice Minor Ailments (March 2020 BOD Meeting, Section 5.2, page 96) • During the COVID-19 pandemic, the College reviewed its performance and strategic commitments as a health professional regulator in the context of the pandemic. As a result, pandemic-related indicators were introduced along with a reforecast of the 2020 budget. • 2020 Q1 BOD Strategic Performance Scorecard with NEW Pandemic Measures • The Board discussion on the College's performance and risk reporting has not been outlined in detail in the Board minutes.
		If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐
		Additional comments for clarification (if needed) • In 2021, the College will, 1. Build capacity to orient the Board of Directors on their role in regularly assessing the College's progress against strategic and regulatory priorities and outcomes.

		2. Document performance and risk discussion in Board meeting minutes. 3. Review and restructure the College's scorecard and risk presentation at Board meetings.
15.2 Council directs action in response to College performance on its KPIs and risk reviews.	a. Where relevant, demonstrate how performance and risk review findings have translated into improvement activities.	The College fulfills this requirement: Yes ☐ Partially X No ☐ • Insert a link to Council meeting materials where relevant changes were discussed and decided upon: • The Board works through the CEO & Registrar to operationalize the College's Strategic Framework and *"as a result, the Board does not involve itself in operational matters but rather holds the Registrar accountable for operational performance outcomes"* - OCP Board of Directors Governance Manual (Updated April 2016) • The College continuously evaluates and makes improvements. The College has produced an annual retrospective risk management report since 2015 which summaries risks encountered throughout the year and the mitigation activities that were put into place. In 2019, a multi-year Data Strategy was launched to strengthen the College's use of data insight and trends for more comprehensive and timely decision making and evolution of an outcomes-focused approach to regulation. ◦ 2019 Risk Management Report ◦ 2019 Data Strategy • As an example of how the identification of risk contributed to policy decision from the Board, in response to the COVID-19 pandemic, the Board held a special meeting to consider the issue of mandatory masking in pharmacies. ◦ Regulatory: Approach to Masking in Pharmacies (July 2020 Special BOD Meeting, Section 4.1, page 2) *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes* X *No* ☐ • In 2021, the College will, 1. Review and evaluate the Board role and responsibility for oversight of the College's performance and risk management. 2. Embed topics of risk identification, risk priority and risk tolerance in 2021 Board meetings. 3. Operationalize the College's risk management program including the 2021 prospective risk register.

		Additional comments for clarification (if needed)
15.3 The College regularly reports publicly on its performance.	a. Performance results related to a College's strategic objectives and regulatory activities are made public on the College's website.	The College fulfills this requirement: Yes X Partially ☐ No ☐ • Insert a link to College's dashboard or relevant section of the College's website: • Every year an annual report is produced to showcase the College's strategic, regulatory and financial outcomes and to demonstrate to the Minister, stakeholders and the public its performance related to its public protection mandate and legislated objects. The report provides a summary of the College's accomplishments and its alignment to the multi-year Strategic Framework. The report is shared publicly through our website, our Board meetings and on our social media platforms and through direct communication with stakeholders. ○ OCP annual reports • The College regularly reports on its performance publicly via the website and in the quarterly Board meetings. Each quarter, the CEO & Registrar presents the quarterly performance results and updates on key initiatives the College had committed to throughout the year. This CEO & Registrar report is available in the Board meeting materials. ○ BOD meeting materials *If the response is "partially" or "no", is the College planning to improve its performance over the next reporting period? Yes ☐ No ☐* *Additional comments for clarification (if needed)*

PART 2: CONTEXT MEASURES

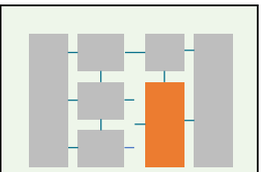
The following tables require Colleges to provide **statistical data** that will provide helpful context about a College's performance related to the standards. The context measures are non-directional, which means no conclusions can be drawn from the results in terms of whether they are 'good' or 'bad' without having a more in-depth understanding of what specifically drives those results.

In order to facilitate consistency in reporting, a recommended methodology to calculate the information is provided in the companion document "Technical Specifications for Quantitative College Performance Measurement Framework Measures." However, recognizing that at this point in time, the data may not be readily available for each College to calculate the context measure in the recommended manner (e.g. due to differences in definitions), a College can report the information in a manner that is conducive to its data infrastructure and availability.

In those instances where a College does not have the data or the ability to calculate the context measure at this point in time it should state: 'Nil' and indicate any plans to collect the data in the future.

Where deemed appropriate, Colleges are encouraged to provide additional information to ensure the context measure is properly contextualized to its unique situation. Finally, where a College chooses to report a context measure using methodology other than outlined in the following Technical Document, the College is asked to provide the methodology in order to understand how the College calculated the information provided.

Domain 6: Suitability to Practice



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 1. Type and distribution of QA/QI activities and assessments used in CY 2020*

Type of QA/QI activity or assessment	#
Self Assessments completed selected for 2020 A. Pharmacists: 3061 B. Pharmacy Technicians: 998	4059[1]
Knowledge Assessment (currently only used for pharmacists moving from Part B to A)	5
Practice Assessment[2] – routine practice assessment, B to A A. Pharmacists: 545 B. Pharmacy Technicians: 261	806[1]
Practice Assessment – Coaching[2] A. Pharmacists: 36 B. Pharmacy Technicians: 14	50
Practice Re-assessment[2] A. Pharmacists: 14 B. Pharmacy Technicians: 2	16
Practice Assessment – QA assessments[2] A. Pharmacists: NR B. Pharmacy Technicians: NR	NR

What does this information tell us? *Quality assurance (QA) and Quality Improvement (QI) are critical components in ensuring that professionals provide care that is safe, effective, patient centred and ethical. In addition, health care professionals face a number of ongoing changes that might impact how they practice (e.g. changing roles and responsibilities, changing public expectations, legislative changes).*

The information provided here illustrates the diversity of QA activities the College undertook in assessing the competency of its registrants and the QA and QI activities its registrants undertook to maintain competency in CY 2020. The diversity of QA/QI activities and assessments is reflective of a College's risk-based approach in executing its QA program, whereby the frequency of assessment and activities to maintain competency are informed by the risk of a registrant not acting competently. Details of how the College determined the appropriateness of its assessment component of its QA program are described or referenced by the College in Measure 13(a) of Standard 11.

* *Registrants may be undergoing multiple QA activities over the course of the reporting period. While future iterations of the CPMF may evolve to capture the different permutations of pathways registrants may undergo as part of a College's QA Program, the requested statistical information recognizes the current limitations in data availability today and is therefore limited to type and distribution of QA/QI activities or assessments used in the reporting period.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

Additional comments for clarification (if needed)

1. The *Pharmacy Act* regulations do not yet incorporate pharmacy technicians. The regulation has been submitted to government and is awaiting approval. Those pharmacy technicians who have engaged in QA activities have done so voluntarily.
2. OCP's Practice Assessment model involves three steps prior to referral to the QA Committee: (1) routine practice assessment; (2) coaching and re-assessment and (3) QA assessment. Note that remediation in the form of coaching is provided up-front. If the registrant is successful upon re-assessment, referral to the QA Committee does not occur.

Domain 6: Suitability to Practice

Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
	#	%	
CM 2. Total number of registrants who participated in the QA Program CY 2020 A. Pharmacists: 3519 B. Pharmacy Technicians: 1219[1]	3519/ 15847 1219 / 5194	22.21% 23.47%	***What does this information tell us?*** *If a registrant's knowledge, skills and judgement to practice safely, effectively and ethically have been assessed or reassessed and found to be unsatisfactory or a registrant is non-compliant with a College's QA Program, the College may refer him or her to the College's QA Committee.*

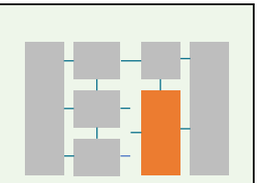
CM 3. Rate of registrants who were referred to the QA Committee as part of the QA Program in CY 2020 where the QA Committee directed the registrant to undertake remediation. * Pharmacists: NR Pharmacy Technicians: NR	NR	NR	*The information provided here shows how many registrants who underwent an activity or assessment in CY 2020 as part of the QA program where the QA Committee deemed that their practice is unsatisfactory and as a result have been directed to participate in specified continuing education or remediation program.*

Additional comments for clarification (optional)

1. The *Pharmacy Act* regulations do not yet incorporate pharmacy technicians. The regulation has been submitted to government and is awaiting approval. Those pharmacy technicians who have engaged in QA activities have done so voluntarily.
2. OCP's Practice Assessment model involves three steps prior to referral to the QA Committee: (1) routine practice assessment; (2) coaching and re-assessment and (3) QA assessment. Note that remediation in the form of coaching is provided up-front. If the registrant is successful upon re-assessment, referral to the QA Committee does not occur.
3. Because the technical specification document indicates the numerator as the number of registrants who undertook an activity or assessment as part of the QA program and were required to undertake remediation at the direction of the QA Committee, only those who had a routine practice assessment in 2020 were counted for this item (i.e. one registrant). Altogether, four registrants were undergoing remediation in 2020. Three registrants had the remediation ordered by the QA Committee in 2019 and one registrant had remediation ordered by the QA Committee in 2020.

** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*

Domain 6: Suitability to Practice



Standard 11

The College ensures the continued competence of all active registrants through its Quality Assurance processes. This includes an assessment of their competency, professionalism, ethical practice, and quality of care.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)			
CM 4. Outcome of remedial activities in CY 2020*:	#	%	***What does this information tell us?*** *This information provides insight into the outcome of the College's remedial activities directed by the QA Committee and may help a College evaluate the effectiveness of its "QA remediation activities". Without additional context no conclusions can be drawn on how successful the*
I. Registrants who demonstrated required knowledge, skills, and judgment following remediation**	NR	NR	

II. Registrants still undertaking remediation (i.e. remediation in progress)	NR	NR	*QA remediation activities are, as many factors may influence the practice and behaviour registrants (continue to) display.*

Additional comments for clarification (if needed)

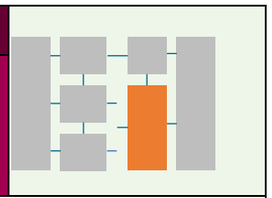
1. Based on the technical specification document, the denominator for CM4 should align with the numerator in CM3. As such, only the registrant that underwent a practice assessment in 2020 and had remediation ordered by the QA Committee in 2020 is reflected.
2. Note that in addition to the 3-step OCP Practice Assessment model described above, a post-remedial practice assessment is required approximately one year after remediation is completed. Thus, registrants who have been through the process are expected to demonstrate the required knowledge, skills and judgement following remediation, but it would not occur in the same calendar year. One registrant was undertaking remediation (still in progress).

** NR = Non-reportable: results are not shown due to < 5 cases (for both # and %)*
*** This measure may include registrants who were directed to undertake remediation in the previous year and completed reassessment in CY2020.*

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: ☐ Recommended X College methodology

If College methodology, please specify rationale for reporting according to College methodology: OCP themes differ from CPMF themes. Please refer to the attachment for data and OCP theme definitions.

Context Measure (CM)

CM 5. Distribution of formal complaints* and Registrar's Investigations by theme in CY 2020	Formal Complaints received‡		Registrar Investigations initiated‡	
Themes:	#	%	#	%
I. Advertising				
II. Billing and Fees				
III. Communication				
IV. Competence / Patient Care	***See the OCP themes attachment for reported data***			
V. Fraud				
VI. Professional Conduct & Behaviour				
VII. Record keeping				
VIII. Sexual Abuse / Harassment / Boundary Violations				
IX. Unauthorized Practice				
X. Other <*please specify*>				
Total number of formal complaints and Registrar's Investigations**		**100%**		**100%**

What does this information tell us? *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent themes identified in formal complaints received and Registrar's Investigations undertaken by a College.*

* ***Formal Complaint****: A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.*
Registrar's Investigation*: Where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.*

ǂ **NR** = *Non-reportable: results are not shown due to < 5 cases (for both # and %)* *** The requested statistical information (number and distribution by theme) recognizes that formal complaints and registrar's investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations.*	

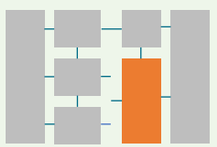
Additional comments for clarification (if needed)

- The College's formal complaint and Registrar investigation themes differ from the recommended themes expressed in the CPMF. The College will further examine the value of the CPMF themes in 2021 to determine their applicability to the College's themes, and/or determine whether changes are needed to improve the current reporting framework.

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology: We have used CPMF recommended methodology with explanations noted below in the comments box

Context Measure (CM)			
CM 6. Total number of formal complaints that were brought forward to the ICRC in CY 2020	452		
CM 7. Total number of ICRC matters brought forward as a result of a Registrars Investigation in CY 2020	156		
CM 8. Total number of requests or notifications for appointment of an investigator through a Registrar's Investigation brought forward to the ICRC that were approved in CY 2020	93		
CM 9. Of the formal complaints* received in CY 2020**:	#	%	
I. Formal complaints that proceeded to Alternative Dispute Resolution (ADR)ǂ	0	0%	
II. Formal complaints that were resolved through ADR	0	0%	
III. Formal complaints that were disposed** of by ICRC	331		
IV. Formal complaints that proceeded to ICRC and are still pending	121	27%	
V. Formal complaints withdrawn by Registrar at the request of a complainant Δ	84	17%	***What does this information tell us?*** *The information helps the public better understand how formal complaints filed with the College and Registrar's Investigations are disposed of or*

VI. Formal complaints that are disposed of by the ICRC as frivolous and vexatious	0	0%	*resolved. Furthermore, it provides transparency on key sources of concern that are being brought forward to the College's committee that investigates concerns about its registrants.*
VII. Formal complaints and Registrars Investigations that are disposed of by the ICRC as a referral to the Discipline Committee	64	11%	
*** **Disposal:** The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).* ** **Formal Complaints:** A statement received by a College in writing or in another acceptable form that contains the information required by the College to initiate an investigation. This excludes complaint inquires and other interactions with the College that do not result in a formally submitted complaint.* ǂ **ADR**: Means mediation, conciliation, negotiation, or any other means of facilitating the resolution of issues in dispute.*			
Δ The Registrar may withdraw a formal complaint prior to any action being taken by a Panel of the ICRC, at the request of the complainant, where the Registrar believed that the withdrawal was in the public interest. # May relate to Registrars Investigations that were brought to ICRC in the previous year.* ** The total number of formal complaints received may not equal the numbers from 9(i) to (vi) as complaints that proceed to ADR and are not resolved will be reviewed at ICRC, and complaints that the ICRC disposes of as frivolous and vexatious and a referral to the Discipline Committee will also be counted in total number of complaints disposed of by ICRC.* ϕ **Registrar's Investigation:** Under s.75(1)(a) of the RHPA, where a Registrar believes, on reasonable and probable grounds, that a registrant has committed an act of professional misconduct or is incompetent he/she can appoint an investigator upon ICRC approval of the appointment. In situations where the Registrar determines that the registrant exposes, or is likely to expose, his/her patient to harm or injury, the Registrar can appoint an investigator immediately without ICRC approval and must inform the ICRC of the appointment within five days.* **NR** = Non-reportable: results are not shown due to < 5 cases (for both # and %)*			

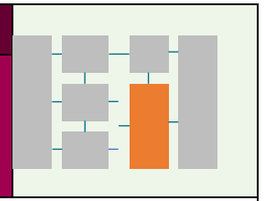
Additional comments for clarification (if needed)

- For CM 6 and CM 7, the College considered "brought forward" to be files where the ICRC reviewed the file and rendered an outcome (though the files may not be finally disposed with a decision issued yet).
- For CM 9 III & IV, in terms of "formal complaints received in CY 2020", the College considered this to mean "formal complaints received by the ICRC in CY 2020" (in other words, formal complaints reviewed by the ICRC with an outcome rendered). The College's ICRC reviewed many files in 2020 that were opened before 2020.
- For CM 9 VII, the College included Registrar's Investigations in this number as stated in the chart above, but noted that the rest of CM 9 relates only to formal complaints (the technical specifications document only refers to formal complaints as well). In alignment with CM 9 III & IV, the College considered CM 9 VIII to mean "formal complaints and Registrar's Investigations received by the ICRC in CY 2020" (both formal complaints and Registrar's Investigations reviewed by the ICRC with an outcome of a referral to discipline).
- For the rest of CM 9, the denominator was 485 which represents all formal complaints received in CY 2020.

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: ☐ Recommended X College methodology

If College methodology, please specify rationale for reporting according to College methodology: OCP themes differ from CPMF themes. Please refer to the attachment for OCP ICRC Decision data.

Context Measure (CM)							
CM 10. Total number of ICRC decisions in 2020	684						
Distribution of ICRC decisions by theme in 2020*	# of ICRC Decisions‡						
Nature of issue	Take no action	Proves advice or recommendations	Issues an oral caution	Orders a specified continuing education or remediation program	Agrees to undertaking	Refers specified allegations to the Discipline Committee	Takes any other action it considers appropriate that is not inconsistent with its governing legislation, regulations or by-laws.
I. Advertising							
II. Billing and Fees							
III. Communication							
IV. Competence / Patient Care	***Please see attached table for reported data.***						
V. Fraud							
VI. Professional Conduct & Behaviour							
VII. Record keeping							
VIII. Sexual Abuse / Harassment / Boundary Violations							
IX. Unauthorized Practice							
X. Other *<please specify>*							

** Number of decisions are corrected for formal complaints ICRC deemed frivolous and vexatious AND decisions can be regarding formal complaints and registrar's investigations brought forward prior to 2020.*

*‡ **NR** = Non-reportable: results are not shown due to < 5 cases.*

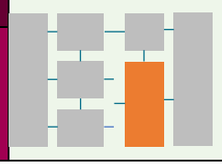
++ The requested statistical information (number and distribution by theme) recognizes that formal complaints and Registrar's Investigations may include allegations that fall under multiple themes identified above, therefore when added together the numbers set out per theme may not equal the total number of formal complaints or registrar's investigations, or findings.

What does this information tell us? *This information will help increase transparency on the type of decisions rendered by ICRC for different themes of formal complaints and Registrar's Investigation and the actions taken to protect the public. In addition, the information may assist in further informing the public regarding what the consequences for a registrant can be associated with a particular theme of complaint or Registrar investigation and could facilitate a dialogue with the public about the appropriateness of an outcome related to a particular formal complaint.*

Additional comments for clarification (if needed)

- The College's themes differ from CPMF themes. The College is exploring capturing additional data to be able to report on CPMF themes, as expressed, for 2021.
- Additional ICRC decision categories were added in the attached document to account for decisions where a SCERP was accompanied with advice/recommendations or with an oral caution so these would not be over-counted.

DOMAIN 6: SUITABILITY TO PRACTICE



Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.

Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology: We have used CPMF recommended methodology with explanations noted below in the comments box

Context Measure (CM)		
CM 11. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 formal complaints or Registrar's investigations are being disposed by the College.* *The information enhances transparency about the timeliness with which a College disposes of formal complaints or Registrar's investigations. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the disposal of a formal complaint filed with, or Registrar's investigation undertaken by, the College.*
I. A formal complaint in working days in CY 2020	371	
II. A Registrar's investigation in working days in CY 2020	744	

* ***Disposal Complaint:*** *The day where a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

* ***Disposal Registrar's Investigation:*** *The day upon which a decision was provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant).*

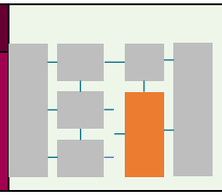
Additional comments for clarification (if needed)

- CM 11 I and II exclude statutory Ontario holidays and weekend days.

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology: We have used CPMF recommended methodology with explanations noted below in the comments box

Context Measure (CM)		
CM 12. 90th Percentile disposal* of:	Days	***What does this information tell us?*** *This information illustrates the maximum length of time in which 9 out of 10 uncontested discipline hearings and 9 out of 10 contested discipline hearings are being disposed. ** *The information enhances transparency about the timeliness with which a discipline hearing undertaken by a College is concluded. As such, the information provides the public, ministry and other stakeholders with information regarding the approximate timelines they can expect for the resolution of a discipline proceeding undertaken by the College.*
I. An uncontested^ discipline hearing in working days in CY 2020	497	
II. A contested# discipline hearing in working days in CY 2020	NR	

* ***Disposal:*** *Day where all relevant decisions were provided to the registrant and complainant by the College (i.e. the date the reasons are released and sent to the registrant and complainant, including both liability and penalty decisions, where relevant).*

^ ***Uncontested Discipline Hearing:*** *In an uncontested hearing, the College reads a statement of facts into the record which is either agreed to or uncontested by the Respondent. Subsequently, the College and the respondent may make a joint submission on penalty and costs or the College may make submissions which are uncontested by the Respondent.*

\# ***Contested Discipline Hearing:*** *In a contested hearing, the College and registrant disagree on some or all of the allegations, penalty and/or costs.*

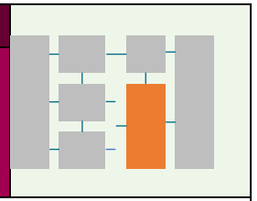
Additional comments for clarification (if needed)

- Please note, one contested hearing was completed in CY 2020; therefore, a 90th percentile cannot be calculated. This was, in part, due to the COVID-19 pandemic and the resulting temporary cancellation and rescheduling of some contested hearing days. Contested hearings have since resumed.
- CM 12 I. excludes statutory Ontario holidays and weekend days.

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology:

Context Measure (CM)

CM 13. Distribution of Discipline finding by type*

Type		#
I.	Sexual abuse	0
II.	Incompetence	0
III.	Fail to maintain Standard	29
IV.	Improper use of a controlled act	NR
V.	Conduct unbecoming	NR
VI.	Dishonorable, disgraceful, unprofessional	38
VII.	Offence conviction	6
VIII.	Contravene certificate restrictions	8
IX.	Findings in another jurisdiction	0
X.	Breach of orders and/or undertaking	7
XI.	Falsifying records	16
XII.	False or misleading document	31
XIII.	Contravene relevant Acts	36

What does this information tell us? *This information facilitates transparency to the public, registrants and the ministry regarding the most prevalent discipline findings where a formal complaint or Registrar's Investigation is referred to the Discipline Committee by the ICRC.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the number of findings may not equal the total number of discipline cases.*

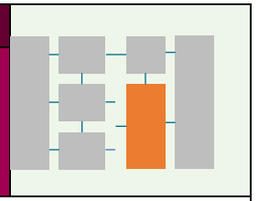
***NR** = Non-reportable: results are not shown due to < 5 cases.*

Additional comments for clarification (if needed)

DOMAIN 6: SUITABILITY TO PRACTICE

Standard 13

All complaints, reports, and investigations are prioritized based on public risk, and conducted in a timely manner with necessary actions to protect the public.



Statistical data collected in accordance with recommended methodology or College own methodology: X Recommended ☐ College methodology

If College methodology, please specify rationale for reporting according to College methodology: We have used CPMF recommended methodology with explanations noted below in the comments box

Context Measure (CM)

CM 14. Distribution of Discipline orders by type*

Type		#
I.	Revocation+	NR
II.	Suspension$	22
III.	Terms, Conditions and Limitations on a Certificate of Registration**	22
IV.	Reprimand^ and an Undertaking#	5
V.	Reprimand^	24

What does this information tell us? *This information will help strengthen transparency on the type of actions taken to protect the public through decisions rendered by the Discipline Committee. It is important to note that no conclusions can be drawn on the appropriateness of the discipline decisions without knowing intimate details of each case including the rationale behind the decision.*

* *The requested statistical information recognizes that an individual discipline case may include multiple findings identified above, therefore when added together the numbers set out for findings and orders may not be equal and may not equal the total number of discipline cases.*

\+ *Revocation of a registrant's certificate of registration occurs where the Discipline or Fitness to Practise Committee of a health regulatory college makes an order to "revoke" the certificate which terminates the registrant's registration with the College and therefore his/her ability to practise the profession.*

$ *A suspension of a registrant's certificate of registration occurs for a set period of time during which the registrant is not permitted to:*

- *Hold himself/herself out as a person qualified to practise the profession in Ontario, including using restricted titles (e.g. doctor, nurse),*
- *Practise the profession in Ontario, or*
- *Perform controlled acts restricted to the profession under the Regulated Health Professions Act, 1991.*

*** Terms, Conditions and Limitations on a Certificate of Registration are restrictions placed on a registrant's practice and are part of the Public Register posted on a health regulatory college's website.*

^ *A reprimand is where a registrant is required to attend publicly before a discipline panel of the College to hear the concerns that the panel has with his or her practice*

\# *An undertaking is a written promise from a registrant that he/she will carry out certain activities or meet specified conditions requested by the College committee.*

***NR** = Non-reportable: results are not shown due to < 5 cases*

Additional comments for clarification (if needed)

- There were two reprimands that were delivered in writing as opposed to attending in person or phone/video. The written reprimands are included in the totals above.

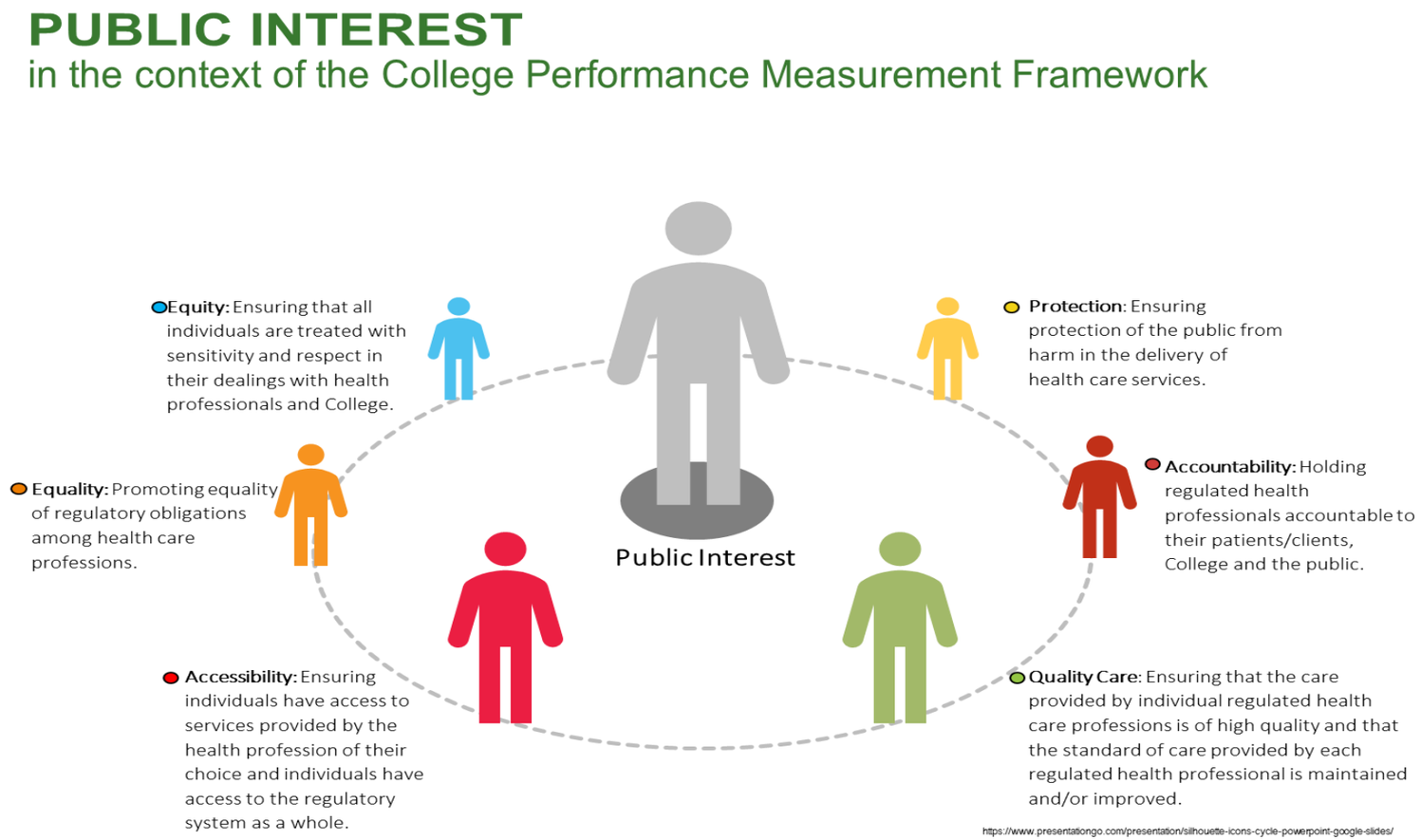
For questions and/or comments, or to request permission to use, adapt or reproduce the information in the CPMF please contact:

Regulatory Oversight and Performance Unit
Health Workforce Regulatory Oversight Branch
Strategic Policy, Planning & French Language Services Division
Ministry of Health
438 University Avenue, 10th floor
Toronto, ON M5G 2K8

E-mail: RegulatoryProjects@Ontario.ca

Appendix A: Public Interest

When contemplating public interest for the purposes of the CPMF, Colleges may wish to consider the following (please note that the ministry does not intend for this to define public interest with respect to College operations):



Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: **Finance and Audit Committee**

TOPIC: Audited Financial Statements

ISSUE: Approval of 2020 Audited Financial Statements

PUBLIC INTEREST RATIONALE: The Finance and Audit Committee (FAC) engages external auditors to assess and test the College's internally produced financial statements, significant accounting policies, management judgements and estimates and the internal control environment to obtain reasonable assurance about whether the financial statements are free from material misstatement.

BACKGROUND: The audit was conducted by a team of auditors from Tinkham LLP Chartered Professional Accountants. Prepared as a result of the audit, the Audited Financial Statements (refer to Appendix C) comprise the College's statement of financial position as of December 31, 2020 including the statement of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements including a summary of significant accounting policies.

In conjunction with the audit, the FAC reviewed and amended the *Reserve Funds* policy to reflect changes within the current operating environment, including a gradual shift to internal prosecution of discipline referrals, and the introduction of annual fee increases equivalent to the Consumer Price Index (CPI). The statements reflect the values set out in the revised *Reserve Funds* policy. (Refer to Appendix A.)

ANALYSIS: The Finance and Audit Committee reviewed the Auditor's Report and internal controls and met with the auditors in in-camera sessions both before and after the audit, and is satisfied that the financial reporting risks outlined in the audit planning letter are being appropriately addressed.

The opinion of the auditor is that the financial statements present fairly, in all material respects, the financial position of the College as of December 31, 2020 and its results of operations and its cash flows for the year then ended in accordance with Canadian Accounting Standards for not-for-profit organizations.

As budget comparisons are not part of the audited statement presentation, we have provided a summary of the financial performance for 2020 compared with budget and mid-year projections, for your information. (Refer to Appendix B.) While we predicted a deficit of $806,698 at mid-year, we ended the year at nearly break-even after capital as set out in the budget.

RECOMMENDATION: **That the Board of Directors approve the attached Audited Financial Statements for the operations of the Ontario College of Pharmacists for 2020 as prepared by management and audited by Tinkham LLP Chartered Professional Accountants.**

Appendix A

Finance and Audit Committee Policy: Reserve Funds

Policy Statement:

The College shall establish and maintain reserve funds in order to cover variable and/or unforeseen costs and expenses.

Policy Date: February 2014; Reviewed 2018; Revised 2021

Procedure:

1. The College shall establish and maintain the following reserve funds: Investigations and Hearings Reserve Fund, Contingency Reserve Fund, and any other reserve funds as deemed appropriate by the Board of Directors.

2. All transfers to and from the reserve funds shall be approved by the Board of Directors upon the recommendation of the Finance and Audit Committee, unless otherwise specified.

3. The details of the funds are as follows:

   i. Investigations and Hearings Reserve Fund

   a) The Investigations and Hearings Reserve Fund is designated to cover costs that exceed annual budget provisions for activities relating to external legal costs for the conduct of inquiries, investigations, discipline hearings, fitness to practice hearings, and appeals.

   b) The amount to be maintained in this fund is to be calculated each year for inclusion in the audited finance statements.

   c) In any fiscal year in which the costs of the activities set out in paragraph 3(a) exceed budget and the College runs an operating deficit for that year, funds may be transferred from this fund to cover the cost overrun.

   ii. Contingency Reserve Fund

   a) The Contingency Reserve Fund is designated to provide for extraordinary expenses that exceed or fall outside of the provisions of the College's operating budget and are not otherwise covered by the Investigations and Hearings Reserve Fund or to fund the College's obligations in extreme circumstances as determined and approved by the Board of Directors including in the event that the College ceases to exist as a statutory corporate body.

   b) The amount to be maintained in this fund is not less than four (4) months operating expenses or such greater amount as may be determined by the Board of Directors.

   c) In the event of dissolution of the Board of Directors, these funds are to be used only upon approval of a person or entity legally authorized to oversee the financial affairs of the College.

4. Maximum Aggregate Value of Reserve Funds: The Finance and Audit Committee will review the reserve funds annually to consider whether to recommend to the Board of Directors means for reducing or augmenting revenues through the annual budget process.

Appendix B

Budget Comparison

Ontario College of Pharmacists
Statement of Operations
Year Ended December 31, 2020

	Budget	Projected	Actual
REVENUE:			
Pharmacist Fees	12,454,130	12,137,574	12,163,503
Pharmacy Technician Fees	2,548,990	2,514,507	2,530,400
Community Pharmacy Fees	5,881,951	5,637,353	5,771,745
DPP Inspection Fees	50,000	18,750	21,875
Certificate of Authorization - HPC	132,375	145,375	156,250
Hospital Pharmacy Fees	1,040,197	1,029,406	1,037,679
Registration Fees	743,056	540,471	502,661
Discipline Cost Recoveries	320,000	250,000	336,000
Investment and Other Revenue	260,000	210,000	190,539
	23,430,699	22,483,436	22,710,651
EXPENDITURES:			
Board & Committee	780,636	670,051	593,476
Personnel	15,983,316	16,130,834	15,903,307
Regulatory Programs	3,879,800	3,919,412	3,701,266
Operations	2,087,664	1,787,126	1,794,461
	22,731,416	22,507,423	21,992,509
EXCESS OF REVENUE OVER EXPENSES BEFORE CAPITAL	699,283	(23,987)	718,142
Deduct: Capital	(676,445)	(782,711)	(735,369)
EXCESS OF REVENUE OVER EXPENSES AFTER CAPITAL	22,838	(806,698)	(17,227)

Appendix C

ONTARIO COLLEGE OF PHARMACISTS

Financial Statements

December 31, 2020

TINKHAM LLP | CHARTERED PROFESSIONAL ACCOUNTANTS

D C Tinkham FCPA FCA CMC LPA
P J Brocklesby CPA CA LPA
M Y Tkachenko CPA CA
M W G Rooke CPA CA LPA
A C Callas CPA CA LPA
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Toronto Ontario M8X 1B1
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TINKHAMCPA.COM

INDEPENDENT AUDITOR'S REPORT

To the Board of Directors of
Ontario College of Pharmacists

Opinion

We have audited the financial statements of the Ontario College of Pharmacists (the "College"), which comprise the statement of financial position as at December 31, 2020, and the statements of operations, changes in net assets, and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at December 31, 2020, and its results of operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

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

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

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

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

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

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

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

TORONTO, Ontario
March 22, 2021

Licensed Public Accountants

ONTARIO COLLEGE OF PHARMACISTS
Statement of Financial Position

As at December 31	2020	2019
Assets		
Current		
Cash	**$ 415,312**	$ 982,629
Investments (note 4)	**10,000,000**	9,100,000
Accounts receivable (note 3)	**384,877**	416,384
Prepaid expenses	**309,054**	306,258
	11,109,243	10,805,271
Property and equipment (note 5)	**4,426,758**	4,135,099
	$ 15,536,001	$ 14,940,370
Liabilities		
Current		
Accounts payable and accrued liabilities	**$ 1,733,785**	$ 1,693,464
Deferred revenue	**5,149,147**	4,863,588
	6,882,932	6,557,052
Net assets		
Internally restricted (note 6)	**8,650,000**	8,350,000
Unrestricted	**3,069**	33,318
	8,653,069	8,383,318
	$ 15,536,001	$ 14,940,370

Commitments (note 7)

Approved on behalf of the Board of Directors

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See accompanying notes to the financial statements.

ONTARIO COLLEGE OF PHARMACISTS
Statement of Operations

Year ended December 31	2020	2019
Revenues		
Registrant fees - Pharmacists	**$ 12,163,503**	$ 10,927,420
- Pharmacy technicians	**2,530,400**	2,211,758
Community pharmacy fees	**5,949,870**	5,487,893
Hospital pharmacy fees	**1,037,679**	954,894
Registration fees	**502,661**	782,700
Discipline cost recoveries	**336,000**	183,694
Investment income	**190,539**	330,836
	22,710,652	20,879,195
Expenses		
Board and committee expenses (schedule I)	**593,477**	775,889
Personnel (schedule II)	**15,903,307**	14,773,637
Regulatory programs (schedule III)	**3,701,266**	4,403,070
Operations (schedule IV)	**1,794,460**	1,879,035
	21,992,510	21,831,631
Excess of revenues over expenses (expenses over revenues) from operations for the year before amortization	**718,142**	(952,436)
Amortization	**448,391**	333,021
Excess of revenues over expenses (expenses over revenues) for the year	**$ 269,751**	$ (1,285,457)

See accompanying notes to the financial statements.

ONTARIO COLLEGE OF PHARMACISTS
Statement of Changes in Net Assets

Year ended December 31	Internally Restricted (note 6)	Unrestricted	2020 Total	2019 Total
Balance, beginning of year	**$ 8,350,000**	**$ 33,318**	**$ 8,383,318**	$ 9,668,775
Excess of revenues over expenses (expenses over revenues) for the year	**-**	**269,751**	**269,751**	(1,285,457)
	8,350,000	**303,069**	**8,653,069**	8,383,318
Inter-fund transfers representing:				
Fee stabilization fund:				
Inter-fund transfer	**(350,000)**	**-**	**(350,000)**	(300,000)
Investigations and hearings reserve fund:				
Inter-fund transfer	**(1,000,000)**	**-**	**(1,000,000)**	300,000
Contingency reserve fund:				
Transfer from unrestricted net assets	**300,000**	**(300,000)**	**-**	-
Inter-fund transfer	**1,350,000**	**-**	**1,350,000**	-
Balance, end of year	**$ 8,650,000**	**$ 3,069**	**$ 8,653,069**	$ 8,383,318

See accompanying notes to the financial statements.

ONTARIO COLLEGE OF PHARMACISTS
Statement of Cash Flows

Year ended December 31	2020	2019
Cash flows provided from (used in) operating activities		
Excess of revenues over expenses (expenses over revenues) for the year	**$ 269,751**	$ (1,285,457)
Item not requiring a cash outlay		
Amortization	**374,007**	333,021
Loss on disposal of capital assets	**74,384**	-
	718,142	(952,436)
Changes in non-cash working capital balances:		
Accounts receivable	**31,507**	(54,621)
Prepaid expenses	**(2,796)**	(18,938)
Accounts payable and accrued liabilities	**40,321**	167,947
Deferred revenue	**285,559**	863,954
	1,072,733	5,906
Cash provided from (used in) investing activities		
Redemption (purchase) of investments (net)	**(900,000)**	643,177
Purchase of equipment	**(562,209)**	(246,550)
Building renovations	**(177,841)**	(43,066)
	(1,640,050)	353,561
Change in cash during the year	**(567,317)**	359,467
Cash, beginning of year	**982,629**	623,162
Cash, end of year	**$ 415,312**	$ 982,629

See accompanying notes to the financial statements.

1 Organization

The Ontario College of Pharmacists (the "College") regulates pharmacy to ensure that the public receives quality services and care. The vision of the College is to lead the advancement of pharmacy to optimize health and wellness through patient centered care.

The College is the registering and regulating body for pharmacy in Ontario. All persons within Ontario who wish to dispense prescriptions and sell products defined as drugs to the public must first have met the professional qualifications set by the College, and be registered as a pharmacist or pharmacy technician. Likewise, all pharmacies must meet certain standards for operations and be accredited by the College. In addition to setting initial standards, the College ensures ongoing adherence to the professional and operational standards.

The College is a not-for-profit organization, incorporated as a non-share corporation in 1871 under the laws of Ontario and, as such, is exempt from income taxes.

2 Significant accounting policies

These financial statements have been prepared by management in accordance with Canadian accounting standards for not-for-profit organizations.

a) Financial instruments

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

b) Property and equipment

Property and equipment are recorded at cost. Amortization is provided over the estimated useful lives of the assets at the following annual rates:

Buildings	4% declining balance
Furniture and equipment	15% declining balance
Computer equipment	straight line over 3 years
Computer software	straight line over 2 years

The above rates are reviewed annually to ensure they are appropriate. Any changes are adjusted for on a prospective basis. If there is an indication that the assets may be impaired, an impairment test is performed that compares carrying amount to net recoverable amount. There were no impairment indicators in 2020.

c) Revenue recognition

i) Fees

The College's principal source of revenue is registrant and pharmacy fees which are recognized as revenue in the period to which these fees relate. Registrant and pharmacy fees received in the current year, applicable to a subsequent year are recorded as deferred revenue on the statement of financial position and will be accounted for in income in the year to which they pertain.

ii) Investment income

Investment income consists of interest and is recognized as earned.

iii) Discipline cost recoveries

Discipline cost recoveries are recognized in the year in which the files have been settled and costs have been awarded.

iv) Other revenues

All other revenues being registration and other fees, rental income and other miscellaneous income are recognized as revenue when services are provided or as earned.

2 Significant accounting policies continued

d) Management estimates

The preparation of the College's financial statements in conformity with Canadian accounting standards for not-for-profit organizations requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities, disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the year.

Key areas where management has made difficult, complex or subjective judgments, often as a result of matters that are uncertain, include, among others, accounts receivable valuation, useful lives for amortization of property and equipment and other assets and liabilities valuation. Actual results could differ from these and other estimates, the impact of which would be recorded in future periods. Estimates and underlying assumptions are reviewed on an ongoing basis.

3 Accounts receivable

As at December 31	**2020**	2019
Accounts receivable and cost recoveries from registrants	**$ 593,091**	$ 441,499
Allowance for impaired receivables	**(346,978)**	(284,478)
Net	**246,113**	157,021
Accrued interest receivable	**81,693**	149,650
HST receivable	**43,884**	98,371
Other receivables	**13,187**	11,342
	$ 384,877	$ 416,384

4 Investments

As at December 31	**2020**	2019
Guaranteed investment certificates, cashable without penalty		
1.22%, maturing April 30, 2021	**$ 10,000,000**	$ -
2.20%, matured March 9, 2020	**-**	3,100,000
2.20%, matured April 27, 2020	**-**	6,000,000
	$ 10,000,000	$ 9,100,000

5 Property and equipment

As at December 31	**2020**		2019	
	Cost	**Accumulated amortization**	Cost	Accumulated amortization
Land	**$ 363,134**	**$ -**	$ 363,134	$ -
Buildings	**6,732,424**	**3,332,649**	6,554,584	3,194,696
Furniture and equipment	**943,705**	**421,639**	1,452,712	1,180,400
Computer hardware	**539,339**	**425,613**	420,611	308,804
Computer software	**478,257**	**450,200**	422,483	394,525
	$ 9,056,859	**$ 4,630,101**	$ 9,213,524	$ 5,078,425
Net book value		**$ 4,426,758**		$ 4,135,099

6 Net assets - internally restricted

The Board of Directors of the College has internally restricted net assets to be used for specific purposes. These funds are not available for unrestricted purposes without approval of the Board.

As at December 31	**2020**	2019
Investigations and hearing reserve fund	**$ 1,500,000**	$ 2,500,000
Contingency reserve fund	**7,150,000**	5,500,000
Fee stabilization fund	**-**	350,000
	$ 8,650,000	$ 8,350,000

a) Investigations and hearings reserve fund

The Investigations and Hearings Reserve Fund is designated to cover external legal costs for the conduct of inquiries, discipline hearings, fitness to practice hearings and appeals which exceed annual budget provisions for those activities.

b) Contingency reserve fund

The Contingency Reserve Fund is designated to provide for extraordinary expenses that exceed or fall outside of the provisions of the College's operating budget and to fund the College's obligations in extreme circumstances as determined and approved by the Board of Directors.

c) Fee stabilization fund

The Fee Stabilization Fund, previously in place to minimize the impact of infrequent fee increases, is deemed redundant given the recent by-law amendment that provides for increases to all fees equivalent to the consumer price index annually.

7 Commitments

a) The College entered an agreement with Pharmapod Canada Limited in December 2020 for a term of five years to provide a medication incident reporting system. The annual future payments, contingent on attaining annual performance targets, are estimated to be $1,300,000.

b) The College has indemnified its past, present and future directors, officers and volunteers against expenses (including legal expenses), judgments and any amount actually or reasonably incurred by them in connection with any action, suit or proceeding, subject to certain restrictions, in which they are sued as a result of their involvement with the College, if they acted honestly and in good faith with a best interest of the College. The College has purchased directors' and officers' liability insurance to mitigate the cost of any potential future suits and actions, but there is no guarantee that the coverage will be sufficient should any action arise.

In the normal course of operations, the College has entered into agreements that include indemnities in favour of third parties, either express or implied, such as in service contracts, lease agreements and purchase contracts. In these agreements, the College agrees to indemnify the counterparties in certain circumstances against losses or liabilities arising from the acts or omissions of the College. The terms of these indemnities are not explicitly defined and the maximum amount of any potential liability cannot be reasonably estimated.

8 Credit facility

The College has a credit facility available in the amount of $1,500,000 bearing interest at bank prime rate, subject to certain terms and conditions. At December 31, 2020, the facility had not been drawn upon.

9 Financial instruments

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the College's risk exposure at the statement of financial position date.

General objectives, policies and processes

The Board of Directors has overall responsibility for the determination of the College's risk management objectives and policies.

Credit risk

Credit risk is the risk that one party to a financial instrument will cause a financial loss for the other party by failing to discharge an obligation. The College is exposed to credit risk through its cash balances with banks, accounts receivable and cost recoveries and investments.

Accounts receivable from registrants are generally unsecured. This risk is mitigated by the College's requirement for registrants to pay their fees in order to renew their annual license to practice. The College also has collection policies in place.

Credit risk associated with cash and investments is minimized by ensuring that these assets are invested in financial obligations of a major Canadian financial institution.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due. The College meets its liquidity requirements and mitigates this risk by monitoring cash activities and expected outflows and holding assets that can be readily converted into cash, so as to meet all cash outflow obligations as they fall due.

Market risk

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

The College is not exposed to currency or equity risk.

Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in market interest rates. The exposure of the College to interest rate risk arises from its interest bearing investments and cash. The primary objective of the College with respect to its fixed income investments ensures the security of principal amounts invested, provides for a high degree of liquidity, and achieves a satisfactory investment return giving consideration to risk.

Changes in risk

There have been no significant changes in risk exposures from the prior year.

ONTARIO COLLEGE OF PHARMACISTS
Schedule I
Board and Committee Expenses

Year ended December 31	2020	2019
Board of directors	**$ 46,070**	$ 98,458
Committees		
Accreditation	**9,721**	6,054
Discipline	**330,032**	374,697
Drug preparation premises (DPP)	**1,201**	2,286
Executive	**9,401**	8,762
Finance and audit	**1,032**	758
Fitness to practice	**4,586**	15,830
Governance and screening committees	**23,469**	94,239
Inquiries, complaints and reports (ICRC)	**86,930**	105,039
Patient relations	**26,051**	31,474
Quality assurance	**17,984**	19,905
Registration	**37,000**	18,387
	$ 593,477	$ 775,889

Schedule II
Personnel

Year ended December 31	2020	2019
Salaries	**$ 13,195,349**	$ 12,118,673
Benefits	**2,436,877**	2,285,791
Personnel costs - other	**271,081**	369,173
	$ 15,903,307	$ 14,773,637

ONTARIO COLLEGE OF PHARMACISTS
Schedule III
Regulatory Programs

Year ended December 31	2020	2019
Association fees - NAPRA	**$ 132,769**	$ 132,769
Communication initiatives	**99,313**	147,086
Consulting - regulatory	**769**	911
Donations, contributions and grants - partnership	**-**	3,000
DPP inspection	**490**	1,184
Election expenses	**6,597**	4,993
Examinations, certificates and registrations	**147,238**	148,257
Government relations	**-**	1,150
Health inquiry / investigation & intake	**20,539**	55,916
Legal - conduct external	**1,440,861**	1,590,867
Legal - regulatory	**65,607**	99,115
Practice assessment of competence at entry	**61,673**	62,032
Practice input initiatives	**1,531,992**	1,959,705
Professional development / remediation	**4,517**	10,716
Professional health program	**85,558**	109,400
Quality assurance - program administration	**103,343**	75,969
	$ 3,701,266	$ 4,403,070

Schedule IV
Operations

Year ended December 31	2020	2019
Association fees - general	**$ 13,474**	$ 14,875
Audit	**26,400**	25,375
Bank / credit card charges	**552,891**	502,996
Consulting - operations	**107,641**	64,327
Courier and delivery	**4,933**	4,973
Donations and contributions - others	**250**	-
Information system maintenance	**382,999**	328,701
Insurance - errors and omissions	**6,301**	5,978
Legal - operations	**5,161**	1,365
Niagara Apothecary:		
Expenses	**17,736**	51,322
Sales, grants and donations	**-**	(18,174)
Office services equipment leasing and maintenance	**25,184**	28,816
Postage	**17,384**	24,547
Property:		
Expenses	**427,366**	440,904
Rental income	**(182,499)**	(169,462)
Publications - annual report and Pharmacy Connection	**38,276**	41,572
Subscriptions	**18,212**	13,428
Supplies and stationery	**21,202**	23,736
Telecommunications	**194,489**	185,755
Travel	**117,060**	308,001
	$ 1,794,460	$ 1,879,035

Ontario College of Pharmacists
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BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Executive Committee

TOPIC: 2021 Screening Committee

ISSUE: Appointment of the Screening Committee to screen for competence of individuals seeking to run for election to the Board and appointment to Committees for the 2021 - 2022 Board year.

PUBLIC INTEREST RATIONALE: Governance best practice supports competency-based selection and appointment of Board and Committee participants. Ensuring there are robust and transparent governance practices setting out the process for screening candidates, including external unbiased individuals versed in governance principles, provides protection against perceived bias..

BACKGROUND: In March 2020, the Board appointed the first Screening Committee to enable the process of screening applicants for competency prior to running for election to the Board. As per the bylaws, the committee is constituted with a mix of Board Members – both Public and Elected and two independent members in order to ensure there is unbiased and neutral perspectives at the table.

The composition of the Screening Committees set out in By-Law No. 6a below.

Composition of the Screening Committee

The Screening Committee shall be composed of:
- Chair of the Governance Committee;
- Two (2) additional Directors, one or more of whom shall be a Public Director; and
- Two (2) or more Lay Committee Appointees.

ANALYSIS: To provide some continuity during these formative years with the new governance structure, the Lay Committee Appointees and Public Director Appointee appointed in 2020 are recommended for reappointment. To minimize the potential for conflict of interest elected Directors whose terms are expiring, and eligible to run for election in 2020 are not recommended for appointment. Likewise, aside from the cross-appointment of the Board Vice-Chair serving as Chair of the Governance Committee as provided in by-law section 9.23, appointees to the Governance Committee are not recommended.

RECOMMENDATION:

That the Board approve the appointments of the Screening Committee as follows.

Screening Committee

a. Proposed Composition:
   - Vice-Chair of the Board – David Breukelman
   - One Public Director – Gene Szabo
   - One Elected Director –Tracey Phillips

David Collie	CPMF Working Group Member, President and CEO, The Electrical Safety Authority, Public Member, NAPRA, ICD Designation
Megan Sloan	Project Coordinator, Planning & Performance at Children's Hospital of Eastern Ontario (CHEO), 2016-2017 Council President, College of Nurses of Ontario

NEXT STEPS:

Key Dates	Schedule
March 2021	• Board Skills Inventory circulated to current Board Directors to facilitate the creation of the 2021 Director Profile.
April 1, 2021 – April 16, 2021 **2.5 weeks**	• April 1: The College will send an email to all eligible voters inviting them to submit an Application via the OCP website if they wish to run for a seat on the Board. • April 16: Applications will close. • College Staff will review applications to confirm eligibility of the candidates. • April 27: External governance consultants will receive a listing of eligible candidates and assess the applications for competence.
April 27, 2021 – May 14, 2021 **3 weeks**	• External governance consultants will prepare a short-list of candidates for consideration by the Screening Committee.
May 18, 2021 – July 2, 2021 **7 weeks**	• The Screening Committee will determine if additional information is required and the manner in which that information can be acquired. Once satisfied, they will finalize the list of approved candidates and notify the candidates of the results of the assessment.
July 13 – August 4, 2021 **22 days**	Voting for the Board of Directors will take place electronically. • July 13, 2021: Voting will commence. • August 4, 2021: Voting will close at 5:00 p.m.
June – July 2021	• The recruitment of the LCAs and PCAs will be conducted following the procedures used in previous years with human resources staff doing the initial review ~~screening~~ and ranking the applications for the screening committee's consideration. • Once the candidates have been screened the Governance Committee will consult with the past-Chairs of the relevant committees and develop a slate of committee appointments for the Board's consideration at the September 2021 Board Meeting.

Ontario College of Pharmacists
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BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Governance Committee

TOPIC: Approval of Board Policies

ISSUE: Replacing the College's current Governance Manual with a series of standalone policies.

PUBLIC INTEREST RATIONALE: Governance best practice calls for clearly articulated systems, policies and processes that ensure the overall effectiveness, direction and accountability of a regulatory entity. Equally important is an understanding of expectations for how individuals behave towards one another as they fulfill the governance roles and how individually and collectively, Directors are able to build and maintain the relationships that will enable the effective delivery of a the College's Objects while also inspiring the confidence and trust of the public, government and registrants. Clear and transparent policies are an important element of good governance.

BACKGROUND:

- In December 2018 the College's Council, now known as the Board, approved the decision to review the governance structure to consider implementing elements of governance best practice.
- Council was presented with the reform elements and decisions over the course of 12 months to enable the drafting of new Bylaws reflective of the changes.
- The new bylaws were presented in December of 2019 and then following public consultation, were ratified by the Board in March of 2020.
- The new bylaws enabled the constitution of the Governance Committee as a standing committee.
- An initial objective of the Committee is to consider the policy framework that will support the Board and committees to replace the current Governance Manual in effect since 2014.
- The College contracted a regulatory governance expert to draft a series of standalone governance policies and related documents for consideration by the new board.
- In December 2020, the Board approved the policies in section 1 and 2.

ANALYSIS: The current governance manual is comprehensive but lengthy and not easily amended. Creating standalone policies enables the board to refer to, consider and amend individual governance topics/concepts, or add or delete polices as issues come to the fore. The creation and approval of policies requires careful consideration. Accordingly, an overall policy framework has been drafted to guide the policy development.

Policies in Section 3, *Policies and Processes Supporting Good Governance* are presented here for the Board's consideration and approval. In addition, an amendment to policy 1.7, Screening, Selection and Appointment is presented for consideration.

RECOMMENDATION:
That the Board approve the following policies:

- 1.7 Screening, Selection and Appointment of Committee Appointees
- 3.1 Orientation of the Board Directors and Committee Appointees
- 3.2 Evaluation of Board Meetings and Processes
- 3.3 Evaluation of Directors and the Board
- 3.4 Evaluation of the Board Chair
- 3.5 Performance Reviews of Committees
- 3.6 CEO & Registrar Performance Evaluation and Compensation
- 3.7 Conduct of Directors and Committee Appointees and the Sanctions Process
- 3.8 Confidentiality and Privacy
- 3.9 Conflict of Interest
- 3.10 Annual Attestations
- 3.11 Supporting Positive Relationships
- 3.12 Board Meeting Rules of Procedure
- 3.13 Respecting Meeting Agendas and Minutes
- 3.14 Use of In Camera Sessions
- 3.15 Board and Committee Communication

NEXT STEPS: Policies in Section 4, *The Board fulfilling its Governance role respecting Oversight and Risk* and Section 5, *Board Education, Training and Development* will be brought forward to the June Board meeting with the intention of having all board policies in place in time for the 2021/2022 Board Year orientation.

Policy 1.7 Screening, Selection and Appointment of Committee Appointees

Purpose:

This policy sets out the processes to be followed for recruitment, screening, selection and appointment of members of all statutory, and standing committees, with the exception of the Executive Committee and the Screening Committee.

Application:

This policy applies to:

- **The Screening and Governance Committees** who oversee the recruitment, screening and selection of appropriate candidates to serve as Committee members, and prepare the slate(s) for ratification by the Board.
- **The Board** who is responsible for receiving and ratifying the proposed slate for Committee membership, as put forth by the Governance committee.

Policy:

All Statutory Committee and standing Committee appointments, with the exception of the Executive Committee and the Screening Committee, shall be made by the Board in accordance with Article 13 of the by-law at the first regular meeting of the Board after each annual election. The term for all committee appointments shall be one year and expire at the first regular meeting of the Board after the next election.

At the first regular meeting of the Board after the election, the Governance Committee will present the Board with a slate for all committees, except for the Executive Committee and the Screening Committee, pursuant to the following process:

Current committee appointees may be considered for reappointment. Additionally, the College will seek applications for individuals interested in serving on committees as appointees. Applications will be initially assessed by the Human Resources staff against the prescribed competencies and shortlisted for the Screening Committee's consideration.

The list of qualified candidates, new and returning, will be provided to the Governance Committee who will compile a proposed committee slate that ensures diversity of the perspectives, experience, ethnicity, age, gender, and geography along with continuity and refresh for every committee. If available, the outgoing Committee Chairs will be consulted on the draft slate prior to presentation to the Board.

Details respecting this policy above are set out in the College's By-laws.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.1 Orientation of Board Directors and Committee Appointees

Purpose:

To articulate the expectations for Board Directors and Committee Appointees regarding timely orientation to the College, Board and Committees.

Application:

This policy applies to:

- **All Board Directors**
- **All Committee Appointees**
- **The CEO & Registrar and the Board Chair -** who are responsible for coordinating and delivering orientation sessions for new Board Directors, and
- **The Committee Chairs and the respective committees' lead staff persons -** who are responsible for coordinating and delivering orientation to the new and returning appointees

Policy:

- All new Board Directors and Committees are expected to undergo orientation
- Orientation to the Board will ideally be held *before* a new Director's first Board meeting; subsequent sessions may be held after that first meeting if deemed necessary
- An orientation session for all new Committee chairs will be held, after their election/selection or appointment as Chair, ideally before he/she chair their first meeting
- An orientation for all new Committee Appointees will be held ideally at the first meeting of the year, with a focus on the specific committee and its mandate as well as general orientation to the College.
- The CEO & Registrar and the Board Chair are responsible for coordinating and delivering all Board orientation sessions
- Committee Orientation is the responsibility of the Committee Chair and the committee's lead staff resource person(s)

The following key elements will be included in the orientation for **Board Directors**:

- Introduction to the Ontario College of Pharmacists, its legislative mandate and its obligations respecting regulation of Pharmacy practice in Ontario
- Overview of the legislative and regulatory frameworks for Pharmacy professionals and pharmacies in Ontario
- Review of the College's current Strategic directions and Goals
- Review of the College's current Operations Plan
- Review of the Board Policies
- Review of the College's financial position and its capacity to implement the strategic and operational plans
- Review of the College's Risk Register
- Introduction to principles of good regulatory governance
- Code of Conduct and attestation
- Confidentiality and Privacy and attestation
- Clarification of respective roles and responsibilities
- Expected engagement in evaluating Board performance through monitoring and evaluation processes (individual, collective, and Chair performance)

The following key elements will be included in the orientation for **Committee Appointees:**

- Introduction to the College, and brief overview of its legislative mandate and obligations respecting regulation of Pharmacy practice in Ontario
- An overview of how the Board's current strategic priorities, goals, and Board philosophies (presented, if possible, by the current Board chair or Vice-Chair) relating to the work of the specific committee
- Review of the Committee Terms of Reference, and proposed work plan for the coming year
- Clarification of respective roles and responsibilities- Committee appointee, Chair, Staff
- Code of Conduct and attestation
- Confidentiality and Privacy and attestation
- Review of good governance principles, as these relate to the specific committee and its work
- Expected engagement in evaluating the Committee's performance through approved processes (meeting, individual, collective and Chair performance)
- In addition to general orientation that will be provided annually to all committees and appointees, targeted orientation or training conducted by external expert(s) will be required of all committee appointees who are appointed to the statutory committees, including the ICRC, Discipline and Fitness to Practice committees of the College

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.2 Board Meeting Effectiveness Assessment Policy

Purpose:

The purpose of this policy is to provide the Board with an opportunity to examine how its meetings are operating and to make suggestions for improvement. It is not an assessment of any individual Director but rather is designed primarily to provide constructive input for the improvement of the Board "as a whole or as a unit".

Application:

This policy applies to:

- **All Board Directors** - who will be expected to evaluate the meeting process semi-annually or more frequently at the direction of the Board Chair.
- **The Board Chair** - who is responsible for receiving, analyzing and reporting back to the Board the results of the evaluation, including identified areas for improvement.

Policy:

Evaluating the Board meetings and processes on a regular basis is an international best governance practice and aligns with this College's commitment to continuous quality improvement in regulatory governance. The process will be periodically reviewed and amended as required to reflect changes in processes and ongoing relevance.

The Board will annually evaluate the effectiveness and efficiency of the Board as a whole, the Board Chair, and Committees.

Accountability

The Board Chair (or other specific designate) has responsibility for the ongoing monitoring and enforcement of this policy. The Board Chair will report on compliance with this policy to the Board at least once per year.

Procedure

- The Board Chair (or designate) will ask each Director to complete a board meeting effectiveness questionnaire.
- The Board Chair (or designate), will summarize the input of the Directors on a confidential basis and prepare a summary for the Board.
- The Chair and CEO & Registrar will receive a copy of the summarized results and it will be circulated to the Board in the materials for the next meeting in the Chair's report. Time will be set aside at that meeting for a full and comprehensive discussion of Board and Board meeting effectiveness, and for the establishment of improvement goals for the Board in the upcoming year.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

MEETING EVALUATION FORM:

***Please note all scores and comments will be anonymized before they are shared**

Materials	Yes	No
1. Were you able to access all of the materials in sufficient time for you to prepare for the meeting?		
2. Were relevant materials provided?		
3. Were the materials sufficient to assist you in deliberations and decision-making with respect to issues arising at the meeting?		
If your answer is No, please provide explanatory comments:		

Meeting Management	Yes	No
4. In your opinion, was the Board prepared and did they actively participate in the dialogue?		
Comments:		
5. Was the Board respectful and considerate of each other and of staff in encouraging and considering diverse viewpoints?		
Comments:		
6. Was the Chair effective in allowing all views to be heard while bringing the matter to a decision?		
Comments:		
7. Were decisions that the Board made consistent with the College's mandate to put public interest first?		
Comments:		
8. In your opinion, did Board discussions stray unnecessarily into operational matters?		
Comments:		

Overall satisfaction with the meeting	Yes	No
9. Did the Board accomplish its goals at the meeting today?		
Comments:		
10. Were the Board's decisions and discussions today appropriately focused on the Board's role of strategic direction and oversight?		
Comments:		

Meeting Process Evaluation	Agree	Disagree
11. Today's meeting started on time.		
12. The agenda was clear and realistic for the allotted meeting time.		
13. I had a clear understanding of the objectives for today's meeting.		
14. Agenda topics were appropriate (i.e. aligned with the College's legislative and regulatory responsibilities)		
15. Adequate background information was provided for each agenda item.		
16. The time spent on each item was appropriate.		
17. I felt supported and valued as a member of this Board.		
18. I felt comfortable and encouraged to discuss and share my opinions openly.		
19. Disagreements were handled openly, honestly, directly and respectfully.		
20. The Chair kept discussions on track.		
21. The Chair was prepared for the meeting.		
22. My peer participants appeared to be prepared for the meeting.		
23. Follow up action item responsibilities were clear to all meeting participants before the meeting was adjourned		
24. Overall, we accomplished our objectives for this meeting.		
25. The technology used for the meeting was effective		

If you answered "Disagree" in any of statements 10-23 please explain:

Please share any other comments that you believe would be useful feedback:

Name: _____

Policy 3.3 Evaluation of Directors and the Board

Purpose:

The purpose of this policy is to ensure the Board engages in regular evaluation processes as part of its commitment to demonstrate accountability and a desire to improve both individual and collective performance and effectiveness.

Application:

This policy applies to:

- **All Board Directors –** who will annually assess their own performance and the collective performance of the Board
- **The Executive Committee –** which will work with the CEO & Registrar to set out a list of ideal Board skills
- **The CEO & Registrar –** who will work with the Executive Committee to set out a list of ideal Board skills
- **The Governance Committee –** which determines the process of evaluation, receives results and reports overall anonymized results, and any recommendations, back to the Board
- **The Board Chair and Board Vice-Chair –** who will meet with individual Board Directors to discuss opportunities for Board and self-improvement of governance skills

Policy:

The Board wishes to improve the quality and depth of its collective skills as well as to improve the performance of the Board as a collective whole. Feedback and data will be gathered in three separate and distinct forms on a regular basis

1. On an annual basis, an objective, self-administered skills assessment will be performed in order to allow the Board to understand its own strengths, gaps and opportunities for improvement;
2. On a regular basis (but at least semi-annually) as determined by the Board Chair, the individual directors will provide anonymized feedback on their own performance in Board meetings; and
3. On a regular basis (but at least semi-annually) as determined by the Board Chair, the individual directors will provide anonymized feedback on the collective Board's performance in Board meetings.

Board Skills Assessment:

The annual evaluation process, which requires participation of all Board Directors, consists of five distinct parts to assess:

Part One – The Executive Committee, in consultation with the CEO & Registrar of the College, sets out a list of forward-looking, ideal skill standards for the Board of Directors as a whole to meet. This is a collaborative effort involving the Board Chair, the CEO & Registrar and should be based upon the forward-looking vision and plans for the College as determined by the Board. These will become the target for skills, performance and makeup of the Board as a whole. These ideal skills are NOT meant to be the standard to which each Director will be held. The skills analysis is designed solely to illustrate strengths and gaps in the Board's overall pool of talent;

Part Two – The Executive Committee will direct the Governance Committee to update the College's Director Skills Assessment Tool to align the tool with the current targets identified in Part One;

Part Three – The Governance Committee will oversee a Board Qualification review using the College's Director Skills Assessment Tool;

Part Four - Board Qualifications and Performance will be reviewed by the Governance Committee, the Board Chair and the CEO & Registrar, then with the entire Board ; and

Part Five - The Board Chair and Board Vice-Chair may meet to discuss opportunities for Board development and may also elect to meet with any number of Directors to discuss opportunities for Board Director development.

Procedure

- All Board Directors will participate annually in completing the Board assessment process which is mandatory and confidential.
- The Governance Committee may determine that analytics and/or reporting should be performed by an external third party. If an external third party is required, they will establish the assessment process in accordance with best practice and in consultation with the Executive Committee and the Governance Committee.
- Each Board Director will complete their individual assessment as well as the overall, anonymized Board assessment annually.
- The Governance Committee shall produce a report that sets out aggregate findings, identified trends or concerns and the overall averaged score for the Board's collective performance in each category.
- The Chair of the Governance Committee shall present the report to the Board Chair and then to the Board for consideration.
- The Governance Committee may consider and recommend training or development based on the feedback for the Board as a whole or for any individual Director of the Board.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Individual Director Performance at Board Meetings – Self Assessment:

Director Performance Self Evaluation Questions

Self Assessment following the Board Meeting	Yes (check here)	No (please comment)
1. As a Director, I exercised my Duty of Care		
2. As a Director, I exercised my Duty of Loyalty		
3. As a Director, I reflected the College's mandate to serve the public interest		
4. As a Director, I understood the College's strategic plan, goals and directions		
5. As a Director, I demonstrated a good understanding of my role and responsibilities		
6. As a Director, I have avoided and declared professional and personal conflicts of interest		
7. As a Director, I understood and respected the roles of the Chair, the CEO & Registrar, the Committees and staff		
8. As a Director, I demonstrated my understanding of the role of the Board in oversight		
9. As a Director, I demonstrated an appropriate level of financial literacy		
10. As a Director, I contributed effectively to the overall performance of the Board		
11. As a Director, I communicated ideas and concepts effectively		
12. As a Director, I was able to think independently and was able to express a view contrary to the wider group's view		
13. As a Director, I listened and respected those with differing opinions		
14. As a Director, I supported all actions and decisions, once they have been made		
15. As a Director, I have contributed effectively to the overall performance of the Board		
16. As a Director, I exhibited sound, balanced judgment for the benefit of all stakeholders		

Individual Director Assessment of Overall Board Performance at Board Meetings:

Overall Board Performance Evaluation Questions

Self-Assessment following the Board Meeting	Yes (check here)	No (please comment)
1. All Directors of the Board exercised their Duty of Care		
2. All Directors of the Board exercised their Duty of Loyalty		
3. All Directors of the Board appeared to understand and reflect the College's mandate to serve the public interest		
4. Through it's discussion and decisions, the Board actively supported the College's Mission, Vision, and Strategic Plan and, in conjunction with the CEO & Registrar, reviewed the ongoing progress made towards implementation		
5. All Directors of the Board demonstrated a good understanding of their role and responsibilities		
6. All Directors of the Board understood and respected the roles of the Chair, the CEO & Registrar, the Committees and staff		
7. Through regular reporting from the Board Chair and the CEO & Registrar, the Board monitored the performance of the CEO & Registrar		
8. The Board was granted transparent access to and input into the College's financial reporting		
9. All Directors of the Board demonstrated an appropriate level of financial literacy		
10. The Board approved and or was updated on operating risks, the annual operating and capital budgets to ensure that the College has necessary resources to effectively fulfil its mandate, and to give effect to the policy and strategic directions that the Board has approved		
11. All Directors of the Board communicated ideas and concepts effectively		
12. The Board, was appraised of and given the opportunity to question the respective performance and terms of reference for committees, task forces or working groups; approved the members which had been selected or appointed, and monitored overall activities through, at minimum, annual reports from each committee		

13. All Directors of the Board appeared to think independently and were able to express a view contrary to the wider group's view		
14. All Directors of the Board listened and respected those with differing opinions		
15. All Directors of the Board appeared to support all actions and decisions, once they have been made		
16. All Directors of the Board contributed effectively to the overall performance of the Board		
17. The Board continued to support and engage in evaluation processes to fulfil Ministry expectations		

Policy 3.4 Evaluation of the Board Chair

Purpose:

The purpose of this policy is to set out the process for evaluation of and feedback to the Board Chair.

Application:

This policy applies to:

- **The Board Chair -** who will annually complete a self-assessment
- **Individual Board Directors -** who will each confidentially assess the performance of the Board Chair in each of the same categories used by the Chair in their self-assessment. Board Directors are reminded to be conscious of their own biases with respect to diversity and inclusion, including gender identity, when assessing others in their respective roles and ensure neutrality in their assessments
- **The Governance Committee Chair** - who receives summarized results and discusses these and any identified opportunities for skills development, with the Board Chair.
- **The CEO and Registrar -** who is responsible for ensuring the results are summarized and the assessments are retained

Policy:

The process of evaluation of the Board Chair by other Board Directors is structured with a focus on quality improvement, to provide feedback to those in the role to strengthen their skill set and empower them to seek support where needed. The Board Chair will complete a self-assessment and receive feedback that includes comparison between their self-assessed score and average score attributed to them by the other Board Directors in each of the corresponding categories.

Procedure:

- Every second meeting Board Directors will be asked to complete an online assessment of the Board Chair's performance and Directors will be offered the opportunity to provide optional feedback on the alternate meetings.
- The Chair of the Governance Committee will receive and review completed assessments, summarize results and meet with the Board Chair to discuss the overall results and any identified opportunities for further skills development.
- Where there is considerable concern(s) expressed respecting the Board Chair's performance, the Chair of the Governance Committee may meet with one or more individual Board Directors to discuss their concerns.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Board Chair Evaluation

Ratings / Scoring		
4	Outstanding/Above Average	Consistently performs beyond expectations; does more than is expected of a Chair; frequently contributes more than average.
3	Fully Satisfactory	Consistently demonstrates the performance expected of a Chair; a solid performer.
2	Adequate	Demonstrates the expected competency but may be inconsistent or has minor weaknesses that could be improved with attention.
1	Could improve	Would benefit by modifying aspects of behaviours to meet the expectations.
X	N/A	Cannot assess the individual on this question; lack of exposure to, or knowledge of, demonstrated behaviours or traits. [1]

Chair Assessment	**Score**
1. I/the Chair conduct(s) the meeting in a way that moves the business of the Board forward while ensuring the integrity and effectiveness of the Board's governance role and processes.	
2. I/the Chair allow(s) adequate time for discussion.	
3. I/the Chair ensure(s) all sides of an issue are heard.	
4. I/the Chair ensure(s) the Board has the necessary information or advice to make decisions.	
5. I/the Chair regularly draw(s) reference to the College's public interest mandate and ensures that the Board operates in accordance with its obligations to meet it	
6. I/the Chair invest(s) time in building relationships with the CEO & Registrar and the Board Directors.	
7. I/the Chair understand(s) the Chair's role as the spokesperson for the Board.	
8. I/the Chair represent(s) the Board with the CEO & Registrar, as required and help(s) to build appropriate relationships with key stakeholders.	
9. I/the Chair promote(s) a positive Board culture.	
10. I/the Chair am/is well prepared for meetings.	
11. I/the Chair am/is effective at demonstrating the core values of compassion, respect, honesty and teamwork.	
12. I/the Chair am/is committed to the mission, vision and strategic plan of the OCP	
13. I/the Chair recognize(s) the ultimate authority of the board and does not attempt to usurp that authority.	
14. I/the Chair facilitate(s) oversight of the CEO & Registrar by the Board as a whole.	
15. I/the Chair ensure(s) the integrity of Board processes.	
16. I/the Chair behave(s) consistently with the bylaws and Board policies and procedures and the Code of Conduct.	
17. I/the Chair communicate(s) effectively and clearly	
18. Overall, I/the Chair has carried out my/their role effectively and in accordance with the Board approved role description.	

[1] All Directors who have been on the Board for more than two or more meetings will complete the assessment.

Policy 3.5 Performance Reviews of Committees

Purpose:

The purpose of this policy is to set out the process for semi-annual evaluation of Board Committees and the performance of Committee members.

Application:

This policy applies to:

- **All Committee Appointees (including Board Directors appointed to Committees)** - who will participate the reviews. All committee appointees are reminded to be conscious of their own biases with respect to diversity and inclusion, including gender identity, when assessing others in their respective roles and ensure neutrality in their assessments
- **All Committee Chairs** - who will participate in and receive results of the reviews
- **Past Committee Chairs** - as per Policy 1.7, will provide the Governance Committee with advice regarding the development of the subsequent year's Committee slate for recommendation by the Governance Committee and consideration by the Board
- **The Governance Committee** - who will receive reports relating to the performance of Appointees to be considered when the annual Committee slate is populated
- **The Board** - who will receive Committee reports at least annually

Policy:

Semi-Annually or at the direction of the Board Chair:

- All Committee appointees will complete:
    - An objective and reflective assessment of the Committee Appointee's:
        - Perspectives on self-performance;
        - Perspectives on the performance of the Committee as a whole; and
        - An expression of interest in reappointment
- The Committee Chairs will complete, at the direction of the Board Chair:
    - An annual Self-Assessment of their performance as Committee Chair
    - Committee Appointee Performance Assessments, in conjunction with Committee staff support, with a view to assess competence, availability and suitability for reappointment
- The Committee Chair and the Chair of the Governance Committee will receive summarized results from the assessments.
- The Committee Chair may seek individual meetings with one or more Committee Appointees if specific concerns arise from the members' assessments.
- The Committee Chair will include anonymized information from the feedback in their annual report to the Board.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Committee Evaluation

**to be completed by each Committee, at least semi-annually, or more frequently if so directed by the Chair*

Name:
Committee:
Date:

Question	Yes	If No or please indicate that you would identify this as an area for growth
1. As a Committee Member, I understand the College's public interest mandate and how the Committee serve fits within that mandate and the Terms of Reference for the Committee.		
2. As a Committee Member, I understand and respect the framework of legislation, regulations, bylaws and policies which guide the College's and this Committee's activities.		
3. As a Committee Member, I understand the duties expected of me regarding my role on the Committee.		
4. As a Committee Member, I feel that I am fully prepared and able to perform my duties with regards to my role on the Committee.		
5. As a Committee Member, I feel that I have a clear understanding of the objectives for the meetings I attend and that agenda topics are aligned with the Committee's Terms of Reference.		
6. As a Committee Member, I maintain committee discussions at a level consistent with my role(s) on the committee and where applicable, without confusing it with my role on the Board (if any).		
7. As a Committee Member, I feel supported and valued as a member of this Committee.		
8. As a Committee Member, I demonstrate leadership and professionalism in my interactions with staff and with other committee appointees.		
9. As a Committee Member, I felt encouraged to discuss and share my opinions openly.		
10. As a Committee Member, I feel that my fellow Committee members come prepared for the meetings.		
11. As a Committee Member, I feel that disagreements are handled openly, honestly and directly.		
12. As a Committee Member, I feel that the Committee Chair keeps the meeting on track.		
13. As a Committee Member, I feel that follow-up action item responsibilities are clear to all meeting participants.		

14. As a Committee Member, I feel that the Committee meets its objectives for its meetings.		
15. As a Committee Member, I remain interested in reappointment to this Committee.		

Additional Comments:

Policy 3.6 CEO & Registrar Performance Evaluation and Compensation

Purpose:

This policy sets out the responsibilities of the various parties respecting the processes related to overseeing and evaluating the CEO & Registrar's performance and compensation.

Application:

- This policy applies to the **Chair and Vice-Chair of the Board,** who are responsible for overseeing the performance and the annual performance evaluation of the CEO & Registrar, and delivering the results, and
- All **Board Directors** who will, at least annually, participate in the evaluation process, and
- The **Executive Committee** who, in accordance with the current by-laws, are responsible for reviewing the compensation of the CEO & Registrar.

CEO & Registrar Performance Evaluation Process:

- The CEO & Registrar will draft annual performance goals, for consideration of the Board Chair and Board Vice-Chair.
- The input from the Board Directors and meets with the CEO & Registrar throughout the year to review performance against targets, provide feedback as necessary and report any issues or concerns to the Board Chair.
- At the determination of the Board Chair, an external consultant may be contracted to coordinate and conduct the annual performance evaluation of the CEO & Registrar, at the conclusion of each Board year. The review process is determined in consultation with the Board's Chair, Vice-Chair and the CEO & Registrar, and will include a survey of all Board Directors. Any assessment tools recommended by the consultant must be validated by the Board Chair.
- The annual performance evaluation will align with the regulated mandate of the College and review will focus on:
    - Performance against established goals;
    - Assessment of leadership competencies; and
    - Interviews with key stakeholders to explore in depth, the perceptions of the CEO & Registrar's strengths and/or identified areas for development.
- The External Consultant synthesizes feedback for discussion with the Board Chair and the Board Vice-Chair, and attends an in-camera session at the year-end Board meeting, to discuss results and future professional development plans with the Board.
- The Board Chair and Board Vice-Chair meet with the Registrar & CEO to deliver and discuss the performance appraisal, and may if they so choose, work with an External Consultant and/or the CEO & Registrar to set goals for development over the upcoming Board year.

CEO & Registrar Compensation:

The role of a regulatory leader differs from that of leaders in other sectors, particularly in the added accountability to ensure that the College meets its legislative and regulatory requirements to effectively regulate in the public interest; and that the College's activities and processes are consistently focused on its mandate to focus on public safety and protection.

Informant interviews conducted with recognized international leaders in professional and occupational regulation, commonly cited the following as best practices respecting compensation in a regulatory body[1]:

I. There is a formal, and transparent process for determining compensation, overseen by the Executive Committee that is delegated its authority on behalf of the Board.
II. There is clarity provided to the Board regarding oversight of the CEO & Registrar by the Board Chair, including confirmation of regular meetings conducted to discuss progress.
III. Compensation is fair and aligned with the respective role and responsibilities of the CEO & Registrar, and also with fair market practices that have been confirmed by external experts through a market review conducted at minimum than every 5 years. Interim adjustments will be substantiated through other information publicly available and accepted by all parties.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

[1] *Reference: from informant interviews conducted with Harry Cayton (former Chief Executive, Professional Standards Authority-PSA (UK); Marc Seale, Former Chief Executive, Health and Care Professions Council- HCPC (UK); and Ginny Hanrahan, Chief Executive-CORU (Ireland), in 2018 and 2020.*

Policy 3.7 Conduct of Directors and Committee Appointees and Sanctions Process

Purpose:

To ensure a shared understanding of the expectations of Board Directors and Committee Appointees and articulate the process for sanctions in the event of a finding of a breach of the Code of Conduct.

Application:

This policy applies to:

- **All Board Directors and Committee Appointees** – who are expected to read, understand the provisions set out within the Board's approved Code of Conduct and sign undertakings[1] of acknowledgement and agreement to adhere to these provisions
- **The Governance Committee and/or Executive Committee** – who will consider the concerns and/or possible breaches of the Code of Conduct and initiate investigations
- **The Board Chair and CEO & Registrar** – who will together oversee the investigation and sanction process
- **The Board** – who will receive a report regarding the outcome of investigations and if necessary, vote on the outcomes of the investigations and proposed sanctions

In all cases where an individual is the subject of the concern or complaint the individual will not participate in the discovery/investigation and shall recuse themselves from all discussions on the matter apart from participating in the resolution (where the individual shall be provided an opportunity to respond to the concern or complaint) or investigation.

Policy:

The College's Code of Conduct sets out the expectation that Board Directors, and Committee Appointees will put the interests of the College and the Public above their own or other interests. All Board Directors and Committee Appointees are expected to exhibit conduct that is ethical, businesslike, and lawful, in a manner that is consistent with the nature of the responsibilities of the Board and the confidence bestowed on it by the public and the registrants. The Board, each individual member of the Board, individual Committee Appointees and any or all of these groups as a whole, are accountable for their individual and overall conduct.

The processes to be followed may slightly differ, depending on whether the conduct of concern relates to a Board Director or a Committee Appointee, as set out below.

Concerns with Board Directors

When a matter or a concern arises regarding the conduct of a Board Director, or an alleged breach by a Board Director of the Code of Conduct, the following process will be followed to assure fairness and to protect the reputation and liability of the College and its Board.

- All concerns related to the conduct of a Board Director should be brought to the attention of either the Board Chair, the Registrar or the Board Vice-Chair who shall bring the concern or complaint to the Governance Committee. The individual who is the subject of the concern or complaint will be notified by the Chair of the Governance Committee (as per bylaw 5.19.3(a)).
- All concerns must be documented, specifically the questionable conduct, in sufficient detail to enable it to be understood. The documentation should identify the element(s) of the Code or

[1] See policy 3.10

Policy that is/are of concern and include, where relevant, supporting evidence. The documentation will include a synopsis of the resolution.

- After review of all material, if it is determined that further action is required, the Governance Chair, in conjunction with the Board Chair will meet with the individual and either:
  I. recommend that the individual participate in coaching and/or further training or development, or
  II. inform the Director that the concern is significant to warrant next steps; and outline the process to be followed for investigating a concern or complaint of a serious nature, as set out in the College's bylaws (section 5.19.3 c-i).

All decisions taken are to be recorded and kept in the individual's file.

Procedural and other Safeguards

When considering whether to impose a sanction, and which sanction to impose, the Board shall be mindful of the general principle of proportionality in determining whether the sanction should be more remedial or punitive in nature.

Concerns with Committee Appointees

When a matter or a concern arises regarding the conduct of a non-Board of Director Committee Appointees or an alleged breach by a Committee Appointee of the Code of Conduct, the following process will be followed to assure fairness and to protect the reputation and liability of the College and its Board and Committees.

- All concerns related to the conduct of a Committee Appointee should be brought to the attention of either the Committee Chair(s), the Board Chair, the Board Vice-Chair or the CEO & Registrar who shall bring the concern to the Chair of the Governance Committee. The subject of the concern or complaint is notified by the Chair of the Governance Committee. If the Committee Appointee serves on other Committees, the Governance Chair will determine if the conduct impacts other appointments and confer with the Chair accordingly.
- All concerns must be documented, specifically the questionable conduct, in sufficient detail to enable it to be understood. The documentation should identify the element(s) of the Code or Policy that is/are of concern and include, where relevant, supporting evidence. The documentation will include a synopsis of the resolution.
- After review of all material, if it is determined that further action is required, the Governance Chair, in conjunction with the Committee Chair will meet with the individual and either:
  i. provide opportunities for coaching and/or further training or development if recommended; or
  ii. inform the Appointee that a significant concern exists and the next steps.
- Where probable grounds for a serious breach of the Code of Conduct exist, the Board Chair and Governance Committee Chair will ask the appointee to resign.
- Should the appointee oppose the decision, the Governance Committee Chair will ask the CEO & Registrar and Board Chair to bring the concern forward to the Board to determine if the appointee should be disqualified from sitting on the committee.
- Before the Board decides whether to disqualify the appointee, the individual shall be afforded an opportunity to address the Board.
- The Board's decision will be considered final.

All decisions taken are to be recorded and kept in the individual's file.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.8 Confidentiality and Privacy

Purpose:

This policy sets out the obligations of all Board and Committee Appointees to preserve the confidentiality and privacy of information that comes to them in the roles within the College.

Application:

This policy applies to:

- **All Board Directors and Committees**

Policy:

As a professional regulatory body, the College is a custodian of considerable personal and other information, some of which may come to the attention of Board Directors and Committee Appointees during the course of their association with the College, and which must, for the most part, be kept confidential. In accordance with s. 36(1) of the Regulated Health Professions Act, the statutory duty of confidentiality does not end when a Board Director or Committee Appointee's role within the College ends, but it continues.

In s. 36 (1) of the RHPA, there are a number of included exceptions listed, where information that would otherwise be considered confidential can be disclosed under prescribed circumstances. In addition, the Ontario government more recently set out new expectations that, unless there is a compelling reason to keep something private- ie. where confidentiality is required under law- the Colleges should be placing such information into the public domain.

Member privacy is important to the College, and OCP is committed to protecting and safeguarding the personal information provided by its registrants. Accordingly, the College has developed a Privacy Policy,

Confidentiality:

Every person involved in the governance and administration of the College are subject to stringent duties of confidentiality. As noted, the main provision, found in subsection 36(1) of the *RHPA*, operates on the basis that all information obtained by individuals governing or administering the College is presumptively confidential, except in prescribed circumstances. Breach of this provision can lead to prosecution, and the imposition of fines of up to $50,000.00 (subsection 40 (2) and (3) of the *RHPA*). Despite this extensive duty of confidentiality, the College also has a competing obligation to be transparent about its activities and to make public certain information about its registrants and its processes.

Each year Board Directors and Committee Appointees are requested to confirm their understanding confidentiality and privacy obligations through signed acknowledgements annually (see 3.10)

Privacy

Personal information collected and handled by the College is subject to the provisions of the College's Privacy Code, which sets out the College's policies and procedures for ensuring the safeguarding of personal information, in accordance with the following ten principles: Accountability; Identifying Purposes; Consent; Limiting Collection; Limiting Use, Disclosure or Retention; Accuracy; Safeguards; Openness; Individual Access; and Challenging Compliance.

The Privacy Code is administered by the College's Director of Finance and Administration, who also serves as the College's Privacy Officer.

Breaches related to confidentiality are dealt with under the provisions of Policy 3.7, Code of Conduct for Board Directors and Committee Appointees and the corresponding sanctions processes.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXX

Policy 3.9 Conflicts of Interest

Purpose:

The purpose of the this policy is to articulate the expectations on Board members and Committee appointees ("Fiduciaries") to avoid, and where that is not possible, to disclose, and where necessary, to declare any appearance of, or actual conflicts of interest.[1]

Application:

This policy applies to:

- **All Board Directors and Committee appointees**

Policy Summary:

Whether a situation constitutes a conflict of interest depends upon all of the circumstances. The following principles provide guidance on how to avoid and address conflicts of interest.

1. *Don't benefit self, spouse or children* – Fiduciaries should not use their positions to directly or indirectly benefit themselves, their spouse or children. Preventing disadvantages to themselves, their spouse or children is a form of "benefit". In some circumstances this expectation applies to others like close friends, colleagues and employers.

2. *Don't disclose College information* - Fiduciaries should not disclose or use any information obtained through their involvement with the College without authorization. Authorization would typically come from a College leader or entity (e.g., CEO & Registrar, Board) applying the *RHPA* criteria. However, in some circumstances the *RHPA* itself would authorize direct disclosure (e.g., a discipline panel issuing reasons for decision).

3. *Don't accept gifts* - Fiduciaries should not accept gifts from anyone who (1) interacts with (2) does business with or (3) wants to do business with the College. Fiduciaries may be able to accept gifts of nominal value ($30.00 or less) that are given as an expression of courtesy or hospitality (e.g., refreshments at a meeting). When in doubt, the Fiduciary should report the gift to the CEO & Registrar.

4. *Be cautious before engaging in outside activity* - Fiduciaries should not engage in activities (including business, employment or volunteer) outside their College roles if doing so would influence or conflict with their role and duties for the College. For example, Fiduciaries should not have a leadership role in a professional advocacy association. Where an outside activity is unavoidable (e.g., employment in a pharmacy role for professional members), a Fiduciary should be particularly alert to disclosing the role when engaging in a College activity that might create a conflict.

5. *Don't give preferential treatment* - Fiduciaries should not give preferential treatment to anyone and take steps to avoid creating the appearance that such treatment is being given. For example, special treatment can include inappropriately providing private access to advocacy groups to discuss upcoming College decisions.

[1] When developing this document the College considered the principles followed by the Ontario Office of the Integrity Commissioner in Ontario Regulation 381/07. The Code of Conduct for Fiduciaries of the College is also relevant here. Some provisions in the *Regulated Health Professions Act*, or *RHPA,* also have some application to Fiduciaries of the College.

6. *Be cautious before participating in decisions* - Fiduciaries should disclose if they or someone closely connected to them could benefit from, or be disadvantaged by, a decision. Similarly caution should be exercised if the participation includes consideration of the interests of the profession or an advocacy group over the public interest. Also, if a Fiduciary has a strongly held personal belief that cannot be set aside, they should not participate. Inappropriate participation could include providing information, expressing opinions or voting.

7. *Declare financial interests* - Fiduciaries should disclose financial interests which may cause the appearance of or an actual conflicts of interest.

8. *Don't seek preferential treatment* - Fiduciaries must not seek preferential treatment from the College. This duty is particularly acute where the Fiduciary is a professional member acting in their role as a regulated person (e.g., responding to a complaint).

9. *Don't switch sides* – Fiduciaries acting on behalf of the College must not assist or advise those dealing with the College (e.g., in a regulatory proceeding, negotiation, or other transaction).

10. *Apply these principles after leaving* - Former Fiduciaries have a continuing obligation to respect these principles. Some obligations, such as not disclosing or using confidential information without authorization, are permanent. Other obligations, such as participating in a leadership in a professional association or lobbying the Ontario government on College-related issues, would apply for a reasonable period of time (e.g., at least twelve months).

11. *There are additional restrictions* – The above principles are not exhaustive. Fiduciaries should be alert to unusual circumstances that create an apparent or actual conflict of interest (e.g., running for public office relevant to the activities of the College).

Procedure:

Where a Fiduciary believes there is any potential for a conflict of interest in their role, they should:

- Consult, as needed, with the appropriate person which, depending on the circumstances, could include the Board Chair and/or the Chair of the Governance Committee and/or the Chair of the committee upon which they serve and/or the CEO & Registrar and/or legal counsel[2].
- If there remains any doubt about whether the Fiduciary may have a conflict, disclose the information to the Board or the Committee and the Board or Committee may collectively decide. Where there is uncertainty, it is usually best to treat the potential conflict of interest as a conflict of interest.
- Accept the Board's or the Committee's determination as to whether there is an appearance of a conflict.
- Where there appears to be a conflict of interest, leave the room (virtual or in person) and not take part in any discussion of, or vote on, the matter.
- Where there appears to be a conflict of interest, not attempt in any way to influence the discussion of, or vote on, the matter.

All declarations of conflicts of interest (or determination that there is no conflict of interest after discussion) should be recorded in the minutes of the meeting.

[2] As a general principle, the proper channel of communication between Fiduciaries and College legal counsel is through the CEO & Registrar's office. This is to ensure that appropriate legal counsel is contacted and to avoid placing the College's legal counsel in a conflict of interest. Directors would typically approach the CEO & Registrar for such advice through the Chair or the Chair of the Governance Committee.

Where a Fiduciary has information suggesting that another Fiduciary has an appearance of a conflict of interest, they must disclose the concern to the appropriate person (i.e., the Board Chair and/or the Chair of the Governance Committee and/or the Chair of the committee upon which they serve and/or the CEO & Registrar and/or legal counsel).

Fiduciaries are requested to confirm their understanding of their duty to avoid and address conflicts of interest through signed acknowledgements annually. They are also requested to provide a list of the organizations with which they are affiliated each year and to update any changes to that list immediately. (see 3.10)

Best practice, according to Harry Cayton, is that 'All Boards should keep and publish a register of interests and any new interests should be declared, and recorded at the start of each meeting. The importance of identifying and reporting conflicts of interest extends to committees and disciplinary panels. Failure to declare any personal or professional or financial knowledge or relationship may result in a failure of probity or even in disciplinary proceedings a miscarriage of justice. (See for example An Inquiry into the performance of the College of Dental Surgeons of British Columbia and the Health Professions Act, PSA 2018)

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.10 Annual Attestations

Purpose:

This policy sets out the expectation that all Board Directors and Committee Appointees will annually read and sign an annual attestation, acknowledging that they have read and understood the provisions of each undertaking and confirming their individual agreement to abide by such provisions.

Application:

This policy applies to:

- **All Board Directors and Committee Appointees**
- **The Chair of Governance, Chair of the Board, Committee Chairs** - who are responsible for dealing with any alleged failures to sign or adhere to the provisions of the respective undertakings

Policy:

All Board Directors and Committee Appointees are annually required to sign undertakings, acknowledging through their signatures, that they have read, understood and agree to comply with the provisions contained within each respective undertaking. A current example of these undertakings is attached to this policy and should be reviewed for its currency annually by the Governance Committee.

Board Directors and Committee Appointees will annually be required to sign Undertakings that they have read, understood and will abide by the following policies as approved by the Board:

- The Code of Conduct for Board and Committee Appointees (as per the Bylaws)
- Confidentiality and Privacy (Policy 3.8)
- Conflicts of Interest (Policy 3.9)
- Policies relating to Roles and Accountabilities (Policy 2.2)
- Policy on Supporting Positive Relationships (Policy 3.11)

Board Directors and Committee Appointees will be provided with a statement defining their Duty of Loyalty and their Duty of Care as they relate to carrying out College business.

Sanctions

Alleged breaches of undertakings will be investigated in accordance with the same process set out under 3.7, where a sanction may be deemed by the Board to be necessary or appropriate.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXX

Policy 3.11 Supporting Positive Relationships

Purpose:

This policy articulates expectations that all Board, Committee and Staff Members are treated with, and treat each other, with dignity and respect in a manner which fosters a productive working environment for all. This policy further addresses the need for Board Directors, Committee Appointees and Staff to exercise caution in their relationships and interactions as a means to minimize a potential for risk.

Application:

This policy applies to:

- **All Board Directors and Committee Appointees, and all members of College staff-** to whom the provisions of this policy directly relate; and to
- **The Chair of the Board and the CEO & Registrar**- who play an important role in resolving any identified matters of concern in a sensitive and expedient manner.

Policy:

The College is committed to maintaining a positive culture and a work environment where all staff members treat each other, and are treated in return, with dignity and respect. Maintaining such a culture, generally established through the leadership of the CEO & Registrar and the Board and Committee Chairs, is only possible with the collective support of individual members of the Board, Committees and Staff.

The expectation that all members of the Board, Committees and College staff will treat each other, and in return, be treated with dignity and respect at all times, is applicable to all persons, who do work on behalf of the College- whether as employed staff, hired external experts or consultants, elected or appointed Directors of the Board, or appointed members of College committees.

No circumstance should arise that creates a regulatory or organizational risk, such as where inappropriate conduct constitutes, or is perceived to constitute, an appearance of bias, a conflict of interest, personal harassment, sexual harassment, or an abuse of authority. To understand, as its happening, that an interaction is, or was unwanted by the other party, requires considerable insight and personal reflection on the part of all individuals.

In circumstances, however well-intentioned, that arise and create discomfort for a staff member, the Board or the Committee Appointee will be identified and the matter resolved through the Board Chair, Chair of the Governance Committee and/or the CEO & Registrar with sensitivity and expediency (see policy 3.7).

Maintaining Positive and Appropriate Relationships amongst Board and Committee Members

Relationships amongst Board and Committee members can have a direct impact on the collective performance and overall effectiveness of the Board, and the Committees. Boards and Committees are most productive where the members work well together, and in a manner that fosters a culture of collegiality, respect and inclusivity.

All members of the Board and all Committee appointees should feel welcomed and valued by their colleagues, and incented to engage in Board/committee discussions and activities. It requires considerable insight and personal reflection on the part of each individual to be able to determine, as an interaction is unfolding, how a discussion is going, and whether the interaction is being received as intended.

Relationships between members of the Board and Committees are built and maintained over time, but are also impacted by the observations of others regarding an individual's demonstrated levels of commitment; preparation; engagement in discussion/debate; participation in Board or committee meetings or other activities; and their treatment of others.

It is expected that all Board Directors and Committee Appointees commit to demonstrating good and appropriate conduct and behaviour in their interactions with each other. The following behaviours or actions can negatively impact the maintenance of positive and appropriate relationships amongst members of the Board, or the Committees and should be avoided:

- making inquiries of a personal nature to a person about another person
- touching physically in any way that may make another person feel uncomfortable
- making comments of a personal nature about any other person
- discussing matters of a personal nature regarding their personal life or circumstances that go beyond boundaries of a business relationship or the limits of an established relationship
- making suggestive remarks or gestures to a fellow Board Director or Committee Appointee
- sharing offensive pictures or jokes, whether considered to be wanted or unwanted, with colleagues
- publicly challenging the integrity of a fellow Board Director or Committee Appointee
- publicly and verbally attacking a fellow Board Director or Committee appointee in regard to their expressed position or views
- engaging, publicly or privately, in name calling, ridiculing, berating, isolating
- engaging, publicly or privately, in offensive comments that demonstrate intolerance or discrimination, including but not limited to insensitivity to race, national or ethnic origin, colour, religion, age, sex, sexual orientation, gender identity or expression, creed, or disability[1].

Maintaining Positive and Appropriate Relationships between Board and Staff Members

The greatest risk relates to a perceived abuse or imbalance of power that can exist between a Director of the Board and College staff, in respect to their ongoing roles within the organization. Accordingly, separate provisions are set out relating to Board and staff relationships, and those relating to members of the Board and the committees.

All Directors of the Board must be aware that they are perceived by staff as individuals who, by virtue of their roles, could have a significant impact on their employment or advancement at the College. As such, Board Directors must exercise caution to ensure their interactions with staff are not perceived by the staff person to be personal in nature and that these do not make the staff person feel uncomfortable or threatened in any way. Staff must similarly exercise good judgement in maintaining positive relationships with Board Directors that remain appropriate to respective roles and authority.

Interactions between Board Directors and staff should be limited to interactions directly related to the individuals' governance or staff roles. It is appropriate for the Board Chair and Board Directors to directly contact the CEO & Registrar.

[1] This diversity language comes from the Canadian Human Rights Act.https://laws-lois.justice.gc.ca/eng/acts/h-6/page-1.html#h-256819

Similarly, it is appropriate for the Chair of a committee to directly contact the staff resource person who is assigned to that committee. It is generally not necessary or appropriate for individual Board or Committee Appointees to directly contact other individual staff members, unless such contact is suggested by the CEO & Registrar.

Following are some examples of interactions which do occur but where **caution should be exercised** on all parts, to decrease the risk that the interactions between Board Directors, Committee Appointees and staff may be perceived as unwelcome or inappropriate:[2]

- sending unsolicited communication to an individual's personal email or calling their personal phone
- offering to meet the staff person, or if staff, a Board Director or Committee Appointee, after business hours or outside the College, even for legitimate business reasons, without the prior knowledge and/or consent of the CEO & Registrar
- making comments of a personal nature about any staff, Board person(s) or Committee Appointees
- discussing matters of a personal nature regarding their personal life or circumstances that go beyond boundaries or normal business situations
- making inquiries of a personal nature to a person about another person
- touching physically in any way that may make a person feel uncomfortable
- giving or exchanging gifts
- entering into any financial arrangement or dealings, such as borrowing or lending money, soliciting charitable donations, or soliciting/offering free or discounted services or advice
- making requests of staff to do something that is not within the staff person's normal job responsibilities
- making requests of staff for special service or treatment

Procedure

- In the event that a concern related to this policy arises, the matter is to be brought to the immediate attention of either the Governance Chair, Board Chair, Committee Chair and/or the CEO & Registrar.
- If the matter concerns the conduct of a Board Director or a Committee Appointee, the Board Chair will manage the issue in accordance with the Board's approved policy on conduct (3.7) and/or the Workplace Harassment Policy and any related sanctions.
- If the matter concerns the conduct of a staff person, the CEO & Registrar will manage the issue in accordance with the associated policies for staff of the College.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

[2] Adapted, with permission from *RCDSO Policy on Interaction of Councillors and Committee Appointees with Staff (approved 2011) and the CVO Governance Manual, 2020*

Policy 3.12 Board Meeting Rules of Procedure

Purpose:

Best practices require boards to spend the bulk of their meeting time planning and providing appropriate strategic oversight in alignment with their governance role.

Effective board meetings require Board Directors to know the duties and responsibilities for their position and to fulfill them to the best of their ability. Board directors are also responsible for ensuring that others are following their responsibilities and for taking responsible action when someone isn't performing as they should.

Application:

This policy applies to:

- **The Board Chair and all Board Directors**
- **Any observers or invited guests in attendance at Board meetings**

Policy:

- The Board will adhere to the established rules of order.
- The CEO & Registrar attends all Board meetings as the Board's primary resource person. Other staff will also attend, per the CEO & Registrar's discretion.
- All Board Directors will participate in meetings. Every Board Director has rights equal to every other Board Director and is encouraged to voice an opinion.
- The Board must uphold the will of the majority but shall hear the voice of the minority.
- The Board will consider only one topic or motion at a time.
- At all meetings, Board Directors and guests are expected to limit the use of cellular telephones, pagers and access to personal email to regularly scheduled breaks. Barring major emergencies, it is inappropriate for the Board meeting to be disrupted by personal matters.
- The minutes of a Board meeting are public, once they have been approved by the Board at its next meeting. The minutes of any 'in camera' session of the Board will be recorded in a confidential manner and are not public.

Procedure:

When developing the Board meeting agenda (see Policy 3.13) the Board Chair and CEO & Registrar will determine the items to be placed on the agenda. Items that require discussion or decision will come forward with a briefing note. Items that do not require discussion can come forward as part of the consent agenda.

Use of the Consent Agenda:

The Board uses a 'consent agenda' to increase efficiency and help the Board make more productive use of their meeting time. The consent agenda is part of the meeting agenda and as such, all supporting materials are also included in the Board meeting package.

The Board collectively agrees on the items that may be routinely addressed through the consent agenda, which could include:

- Minutes of previous meeting
- CEO & Registrar Reports

- Program or Committee Reports
- Staff, Volunteer, or Committee Appointments
- Correspondence requiring no action, but provided for information only
- Perfunctory items - formal approval of items that had much past discussion

The Board Chair leads the following process for approval of the Consent Agenda:

1. At the beginning of the meeting, when seeking approval of the agenda, the Board Chair asks whether any of the Consent Agenda items should be moved to the regular discussion items.
2. When the Consent Agenda is before the Board, and before asking for a motion to approve the consent agenda in its entirety, the Board Chair asks if there are any identified corrections that need to be made on any of the items and whether there are any questions for clarification respecting any of the items included - either of which may give rise to a request by a Board Director to move an item out of the consent agenda.
3. If a Director asks that an item be moved, it must be moved. Any reason is sufficient to move an item. A Director may wish to move an item to discuss it more fully, to further query the item, or to vote against it.
4. Once the item has been moved, the Chair may decide to take up the matter immediately or move it to a matter for discussion.

The Rules of Order at Board Meetings:

Are set out in Schedule C, of the OCP by-laws.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.13 Meeting Agendas and Minutes

Purpose:

To set out the processes for the setting of meeting agendas and minutes of meetings.

Application:

This policy applies to **all meetings of the Board and all College Committees**

Policy:

Agendas

The agendas for all Board meetings are prepared by the Board Chair and the CEO & Registrar for dissemination to the Board of Directors no less than seven days in advance of the next scheduled board meeting.

Committees may propose items for the Board meeting agenda by submitting them to the Board Chair and the CEO & Registrar no less than ten days in advance of the next scheduled board meeting.

Individual Board Directors may propose agenda items to the Board Chair for consideration no less than ten days in advance of the next board meeting, or by submitting a notice of motion at a Board meeting for discussion at a subsequent board meeting, or by obtaining a two thirds vote of the Board to consider the motion on the same day it is submitted.

The agendas for all Committee meetings are likewise prepared by the Committee Chair in consultation with the committee's primary staff resource person. Committee Appointees may propose items for discussion at the meeting by submitting these to the committee chair who will determine whether they will be included in the next committee meeting.

The Board has developed an agenda screening process tool[1] to assist the Board in determining, through answers to specific questions, items that warrant the Board's attention and those which do not. A copy of this screening process tool is included below:

Question #1: Does the proposed agenda item directly relate to College's role and functions as set out below?

- Compliance with its legislated mandate or fulfilling legislated responsibilities
- Advancing the strategic goals of the College in alignment with its legislated mandate
- Policy setting – a matter requiring review, revision or creation of new policy to enable the strategy and set the direction and operating parameters for the College
- Monitoring and overseeing the performance of the College against defined goals (as delivered by the "Operational plan" and measured by key performance indicators)
- The College's leadership role in maintaining relationships with stakeholders (the public, government, pharmacists, medical professionals, etc.)
- College governance and Board performance and development
- The Board's relationship with the Registrar (its sole employee) and their ability to manage the organization

If not, the item should not occupy time on the Board's agenda.

[1] *Adapted from the Council of Healthcare Regulatory Excellence (CHRE), UK*

If the answer to the above is 'yes', proceed to question #2.

Question #2: Whose issue is it?

- The Board's (oversight, strategy and policy)
- The Registrar's (operational, staff-related)

If it is an issue to be addressed by the Registrar it should not appear on the Board's agenda.
If it is a Board issue, proceed to question #3.

Question #3: Has the Board already addressed this issue, either in its established policies or in recent meetings?

Yes_____ No_____

The Board may proceed to question 4, whether the answer to this question is yes, or no.
NOTE: if the answer is yes- and depending on how recently the issue has been addressed- the rules of order may require 2/3 of the Board to agree to revisit the issue.

Question #4: Is the Board satisfied that the issue is adequately addressed by what it has already said?

Yes_____ No_____
If yes, then the matter requires no further discussion by the Board.
If no, then the item should go forward as a proposed agenda item for review by the Board.

Minutes

Board and Committee meeting minutes serve as the College's official record of decisions and action items that occur in the course of a meeting. As a general approach, and in alignment with identified best governance practices, the minutes of Board and committee meetings will reflect only the essence/general themes of discussion; the various positions on a matter that was considered by the Board/committee; and a record of any motion(s) made respecting that matter, and the final results of the vote taken on the matter.

Briefing Notes

Matters come to the Board for its consideration and decision in the form of Briefing Notes which are generally prepared by staff. In alignment with best practices, the Briefing Notes provide the Board with sufficient background information, supporting evidence or other documentation and the expected public interest rationale associated with an issue; all of which serve to inform the Board's decision-making processes.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.14 Use of In-Camera Sessions

Purpose:

This policy sets out the Board's approved processes respecting the use of in-camera sessions.

Application:

This policy applies to: **all Board meetings**

Policy:

The Board embraces principles of transparency, where possible, in all its proceedings, and consistently aims to uphold and defer to this principle. Decisions to exclude the public from public meetings can adversely impact public trust and confidence in the Board even where the rationale or justification for such actions are clearly articulated.

Under s.7 of *the Health Professions Procedural Code ('the Code"),* the Board may exclude the public from any meeting or part of a meeting if it is satisfied that,

(a) matters involving public security may be discussed;
(b) financial, personal or other information that may be disclosed at the meeting is of such a nature that the desirability of avoiding public disclosure of such information in the interest of any person affected or in the public interest outweighs the desirability of adhering to the principle that meetings be open to the public;
(c) a person involved in a criminal proceeding, civil suit or another proceeding may be prejudiced;
(d) personnel matters or property acquisitions will be discussed;
(e) instructions will be given to or opinions received from the solicitors for the college; or
(f) the Board will deliberate whether to exclude the public from a meeting or whether to make an order under subsection 11.08 (ii).

College policy sets out the expectations that the Board Chair, in consultation with the CEO & Registrar, and/or legal counsel if necessary, will carefully consider whether a matter meets the above criteria and where it does, will clearly and publicly announce that the Board will be going into an 'in camera' session to discuss a matter addressed in s. 7 of the Code.

Where the need to go in-camera is anticipated in advance of the meeting, it is Board policy that in-camera sessions will be scheduled, wherever possible, either at the beginning or the end of the meeting to accommodate public guests or observers.

Procedure

- In-camera sessions are not a standing item of an agenda but are determined either as the agenda is formulated by the Board Chair and CEO & Registrar before a meeting or during a meeting when a specific matter arises. If upon receipt of the agenda and in reviewing the Board meeting package, a Board Director believes an agenda item might be best dealt with in-camera, they are expected to contact the Board Chair to discuss this opportunity prior to the Board meeting.
- An agenda item raised for consideration for an in-camera session must be accompanied with sound reasons for the proposition. The Board Chair in consultation with the CEO & Registrar, and/or legal counsel if necessary, will determine the merits of such requests, balancing the subject matter and the public's relevant interests and rights.

- A vote to move in-camera requires a simple majority and a mover and seconder both to go in camera and come out.
- The Board of Directors and, at the discretion of the Board Chair, the CEO & Registrar and the staff they designate will remain in the board meeting. Guests or observers present will be asked to leave the meeting for the duration of the in-camera session. However, the Board may also agree that others may remain in the in-camera session for the Board's deliberations.
- The CEO & Registrar does not attend in-camera sessions, where the CEO & Registrar's performance, contract or compensation are the subject(s) of discussion, unless invited by the Chair to attend to address the Board.
- When coming out of an in-camera session the decision reached or a summary of the decision reached, is provided to the Board meeting minute taker and those present for the official record. The reason for the in-camera session will also be recorded in the official minutes. When staff are excluded the Chair may be required to appoint a minute taker and see that the minutes are retained for reference.
- Members of the public reserve the right to complain to the College regarding any real or perceived misuse of in-camera privilege. Complaints of this nature are to be sent to the Director of Corporate Services in keeping with her function as the College's Privacy Officer.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Policy 3.15 Board and Committee Communication

Purpose:

To establish set out ways in which communication links between the Board and its Committees, task forces, or working groups, will be established and maintained.

Application:

This policy applies to:

- **The Board of Directors**
- **The Chairs of the Committees**

Policy:

In alignment with identified best regulatory governance practices, the College's Board of Directors has approved moving to a governance model that will eventually result in independence of Committees from the Board of Directors. It is important to ensure:

- that the Board has the information regarding the work of established committees, task force(s) or working group(s) that is needed to fulfil its monitoring and oversight role, and
- that the committees, task force(s) or working group(s) are appropriately briefed on the Board's current priorities or philosophies which will guide their work.

Accordingly, means must be in place to ensure these are imparted to at least the Chairs of the respective committees, task forces or working groups before they begin work in a new Board year. It is of the same importance that the Board is kept apprised, through regular reporting or other means, of the progress being made by respective committees, task forces or working groups, in order to fulfil its monitoring and oversight role.

The Board establishes and maintains Communication Links with committees in the following ways:

- The Board Chair, or the Vice-Chair on their behalf, will attend the first orientation session or meeting of a respective committee whose membership is independent from the Board, to share the Board's priorities for the coming year.
- The Board Chair will encourage all Directors who have not yet attended a public Discipline hearing to do so, to gain clarity and understanding regarding the role of the Discipline committee, its panels, and its processes.
- The Chair of a respective committee, whose membership is independent from the Board, will be encouraged to attend Board meeting(s) as an observer.
- At minimum, the respective Chairs will submit an annual reporting of their committee's work and activities to the Board, for information and action, if required.
- Committee Chairs and/or members can be invited, at the Board's discretion, to attend 'Board-away' events, such as education or training programs; planning; team building events; and social events to strengthen linkages and relationships.

Amendment: The Board may amend this policy.
Approval Date: XXX
Last Review: XXX
Last Revision: XXX
Next Review Date: XXXX

Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE
MEETING DATE: March 2021

FOR DECISION	FOR INFORMATION	X

INITIATED BY: **Susan James, Director of Quality**

TOPIC: Policy Review Process Update

ISSUE: Overview of an updated approach to the College's policy development and review process

PUBLIC INTEREST RATIONALE: Setting policies and standards are core College regulatory functions that specify expectations for registrants and are used in conjunction with professional judgement to provide safe, quality care. Registrants are expected to uphold policies and standards in addition to legislative requirements, which all serve as a benchmark against which the conduct of the individual pharmacist is evaluated.

BACKGROUND:

In an effort to reduce regulatory burden, the government has taken an outcomes-based approach to regulation, as articulated in Ontario's Regulatory Policy. The College first applied this approach to regulation drafting in March 2015 when the Board approved changes to the *Drug and Pharmacies Regulation Act, 1990*, and the associated regulations to include oversight of hospital pharmacies. In alignment with the government's direction, the following principles underpinned the changes:

- Regulations will be performance-based.
- Regulations will focus on high-risk practices, those that impact patient safety.
- The approach to drafting regulations will be high level rather than specific. Standards, policies and guidelines will be utilized to address issues wherever possible.
- The regulations will support practice evolution and change.

Consistent with right-touch regulation principles, the College has a range of regulatory tools such as standards, policies, guidelines, fact sheets, that provide a nimble mechanism to define expectations and provide guidance to the registrants where needed (see Appendix 1 for definitions of these tools). In alignment with the government's regulatory principles, the College committed to strengthening the process for updating and reviewing these regulatory tools, including application of a transparent and open consultation process.

As part of this commitment, the College directed additional resources to the policy team to define and implement a structured policy review process while also meeting other College policy priorities. In 2019, the policy review process was established and includes six key steps based on best practices:

1. Research and Review
2. Analysis and drafting
3. Consulation/engagement
4. Review of feedback and re-drafting
5. Final policy implementation
6. Monitoring adherence and measuring outcomes

In 2020, the College developed a plan to apply the review process to all existing and new policies. Policies were prioritized for review in 2020 based on need to incorporate new regulatory

references and need to address emerging practices. As part of this process, two main types of policy changes were distinguished:

1. Policies requiring updates that align with current expectations (non-material changes)
2. Policies requiring revision and/or new content that impacts current expectations or policy direction (material changes)

The review process was completed on the following policies which required non-material updates to align with new regulations were made. As such, the policies were posted on the College website to facilitate expedient access to registrants.

- Administering a Substance by Injection or Inhalation
  - Updated content based on approved regulatory changes for scope of practice.
- Performing a Procedure on Tissues Below the Dermis
  - De-coupled from above guideline and updated based on approved regulatory changes for scope of practice.
- Initiating, Adapting and Renewing Prescriptions
  - Updated content based on approved regulatory changes for scope of practice.

Additionally, the following policies were reviewed and it was determined that more significant revision was required. Therefore, these policies are being presented to the Board, with separate briefing notes, for approval of the next steps in the process.

- Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities
- Virtual Care Policy
- Cross Jurisdictional Services Policy

It has been the tradition that where a material change in expectation of the profession is proposed in a practice policy or standards, Board approval is required. However given the Board's new governance model and work underway to establish Board Policies, further discussion and direction on an approval process is warranted.

NEXT STEPS:

The College will continue to apply the review process to existing and emerging policies. As part of the implementation plan, the following policies have been identified as priority for 2021:

- Centralized Prescription Processing (Central Fill)
- Designated Manager – Professional Supervision of Pharmacy Personnel
- Documentation Guidelines
- Extending the Beyond-Use Dates for Sterile Preparations
- Fees for Professional Pharmacy Services

As part of the review process, the College will identify which policies require material changes, public consultation and/or Board approval. In addition to these policies and as outlined in the review process, the College will continue to monitor the practice environment and will trigger the review cycle should any policy or standards need to be developed to address changing or emerging practices.

Appendix 1: Definitions for regulatory tools

It is important to note that the College may refer to documents from other organizations that may use terminology that does not align with these definitions. To ensure consistency, the College has grouped the documents according to its own definitions even if this does not align with the titling of other organizations.

Standard: Standards outline the minimum mandatory expectations that must be met by the profession. Examples of Standards are:

> **Standards of Operation:** Standards of Operation set expectations around the operation of accredited pharmacies in Ontario.
>
> **Standards of Practice:** Standards of Practice set expectations around the performance that all registrants must meet. Regardless of a registrant's role or practice environment they must perform to the level specified in the Standards of Practice.

Guideline: Guidelines outline more detail around the expectations of a Standard and relevant legislation and how to apply the Standard and/or legislation to support optimal practice. Guidelines are meant as references to be used alongside, not in place of, the Standards and/or legislation. Operational guidelines outline optimal operations of a pharmacy.

Policy: Policies serve as a benchmark against which the conduct of the individual registrant is evaluated. Operational policies outline the College's expectations relating to specific topics within pharmacy operations.

> **The College develops policies through a rigorous process. More information about the College's policy process, including what triggers policy development or review, can be found on the College's Policy Process infographic.**

Guidance: Guidance provides information that articulates or supports the College's expectations in practice for topics/areas that are developing or emerging and will likely be changing in the future. They are based on the circumstances and context at the time they are published.

Position Statement: Position statements outline the College's regulatory or policy stance on emerging issues around a specific area of practice. Position statements can change as they are based on the circumstances and context at the time they are published.

Fact Sheet: A fact sheet summarizes relevant legislation, policies and guidelines in one place.

Framework: A conceptual structure intended to support or guide the building of an approach or an objective. It can set out the conditions required to achieve the desired performance or outcome, and often ensures the inclusion of guiding principles in its approach.

Ontario College of Pharmacists
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BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Susan James, Director of Quality

TOPIC: Draft Virtual Care Policy

ISSUE: Approval to post for consultation a new draft policy that sets out expectations for pharmacy professionals providing virtual care.

PUBLIC INTEREST RATIONALE: Setting standards for pharmacy practice is a core regulatory function of the College. The College publishes practice policies that provide registrants with direction regarding their practice, while reaffirming the values, principles and duties of the pharmacy profession. In addition to providing guidance to the profession, policies serve as a benchmark against which the conduct of the individual pharmacist is evaluated.

BACKGROUND: The provision of healthcare to patients has evolved to include virtual approaches across the health system. These approaches have become prominent and vital to enable the continuity of care for patients during the current pandemic. Several health profession regulators in Ontario have responded to this shift in practice and set standards and/or provided guidance through policy, specific to the provision of professional health services using telephone and/or web-based remote access solutions.

Providing care to patients virtually requires that healthcare professionals consider certain factors such as maintaining a patient's right to privacy, the appropriateness of using a virtual approach to care, and ensuring the same quality as in –person care is provided. The benefit to the patient must outweigh any risks to providing care virtually.

Virtual care in pharmacy practice is an emerging area that is being facilitated by the growth of technological practice supports. As an emerging practice area, the College has drafted a new policy to outline the practice expectations for registrants providing care to patients using virtual approaches (see Appendix A).

ANALYSIS: A comprehensive review of pharmacy regulatory authorities across Canada and of health professional regulators in Ontario, alongside a review of privacy legislation and guidance from external organizations, has informed the development of this new policy.

In response to a sudden transition to virtual care during the early stages of the COVID-19 pandemic, the majority of health profession regulators in Ontario provided guidance to registrants in order to maintain continuity of care. Pharmacy regulatory authorities across Canada also responded to the effects of the pandemic on pharmacy practice by providing advice and guidance for the delivery of virtual care. In Ontario, OPA has provided pharmacists with profession specific information on what to consider when providing virtual care during the pandemic (see Appendix B).

Telemedicine and Telenursing are existing practices that have emerged in the last decade, and the regulatory authorities for physicians and nurses in Ontario had previously established policies and standards to regulate this practice in the public interest. Common definitions of virtual care

include all interactions that occur between a provider and a patient that are not in-person, and typically include telephone interactions. In pharmacy practice, telephone interactions are part of common practice and have not been included in the virtual care policy in order to avoid undue practice expectaions on existing and accepted practice models.

It is expected that virtual care will become an established practice approach across the health system post-pandemic. This draft Virtual Care policy allows the College to set expectations in an emerging practice area that is expected to become standard practice in the years ahead.
Key components of the draft policy include: assessing the appropriateness of using a virtual approach to care provision, obtaining consent, documenting consent and the patient interaction, and protecting a patient's privacy and maintaining confidentiality during the virtual visit.

The College's current Operating Internet Sites policy and the Internet Pharmacies fact sheet were reviewed and assessed for integration with the draft Virtual Care policy. These resources provide guidance to pharmcies operating an online retail presence and relate to the operation of a pharmacy rather than to professional practice requirements, and were therefore not included in this draft policy. The content in these resources will be updated later this year.

As set out in the College's policy review process, stakeholder consultation is an important step in the process in order to allow for feedback and consideration of additional perspectives which may impact the final policy direction.

RECOMMENDATION:
That the Board approve posting of the draft Virtual Care policy for a 60-day public consultation.

NEXT STEPS: Subject to Board approval, the policy will be posted on the College's consultation page and shared through standard communication channels throughout the consultation period. A consultation report, including a summary of feedback and any recommended changes to the draft policy, will be presented to the Board for consideration at the June Board meeting, with the intent to approve the policy.

Appendix A: Draft Virtual Care Policy

Virtual Care Policy

PURPOSE:

This policy articulates the College's expectations regarding the provision of virtual care to patients.

For the provision of virtual care to patients located in another jurisdiction, the College expects registrants to comply with this policy as well as the Cross-Jurisdictional Pharmacy Services policy.

DEFINITIONS:

Virtual Care: a professional interaction between a registrant and a patient that occurs remotely using an enabling technology, such as videoconferencing, text messaging, web-based and mobile applications, that facilitate registrant-patient interaction. In pharmacy, virtual care pertains to clinical activities beyond the regular interactions that occur with patients using a telephone.

Informed Consent: a consent to treatment is informed if, before giving it, the person received the information about the nature, expected benefit, potential risks or side effects, other options and consequences of not having the treatment (or any information that a reasonable person in the same circumstances would require in order to make a decision about the treatment) and the person received responses to their request for additional information (*Health Care Consent Act, 2004*, s.11(2)).

Personal health information (PHI): any information relating to a person's health that identifies the person, including, for example, information about their physical or mental health, family health history, information relating to payments or eligibility for health care, and health card numbers, as well as any identifying information about a patient's substitute decision maker. (For the legislative criteria, see *Personal Health Information Protection Act, 2004, s.4)*

POLICY:

Registrants providing virtual care to patients must meet or exceed all applicable standards, guidance, and legislative requirements for in-person care. Each patient must receive the same standard of care whether they are receiving that care in person or through a virtual visit.

Registrants must practice within the limits of their knowledge, and the decision to provide virtual care must be made in the best interest of their patient.

Providing Virtual Care Services

Registrants must determine whether virtual care is a suitable method of care delivery for the patient interaction and whether providing care virtually will enable them to meet all legal and professional obligations before deciding to provide virtual care to their patients.

A registrant-patient relationship is established when virtual care services are provided, in the same way that a registrant-patient relationship is established when providing pharmacy services in-person.

Documentation requirements remain the same regardless of whether pharmacy services are provided to a patient in-person or through a virtual visit.

Assess Appropriateness of Virtual Care Delivery

Registrants must assess whether virtual care is appropriate for the patient. When making this assessment, registrants are advised to consider the patient's existing health status, specific-healthcare needs and specific circumstances. The benefits to the patient must outweigh any risks to the patient when determining whether to provide virtual care.

Obtain Informed Consent

Before providing virtual care to a patient, a pharmacist must obtain informed consent from the patient or substitute decision-maker.

- Patients or their substitute decision-maker must be informed of the ways in which their right to privacy will be protected and how the confidentiality of their personal health information will be maintained.
- Prior to engaging in virtual care registrants must ensure that this informed consent is received explicitly from the patient or substitute decision-maker, either orally or in writing.
- Registrants must document that they have received consent to deliver virtual care and the mechanism used to provide virtual care in the patient's record.

Maintain Privacy and Confidentiality

Maintaining privacy is a legal and ethical expectation. Registrants providing virtual care must safeguard their patients' right to privacy by ensuring that any technology used has privacy and security settings in accordance with the *Personal Health Information Protection Act, 2004*, and that any processes used to safeguard personal health information (PHI) include a mechanism for notification of theft or loss as required by law. At a minimum, the technology used must have controls to ensure only the intended patient has access to the virtual visit. Whenever personal health information is transmitted and/or stored, secure encryption must be used.

Registrants must confirm the patient's identity before providing virtual care, regardless of whether the patient is new to the pharmacy or if a preexisting registrant-patient relationship exists.

Registrants must provide virtual care in a private environment that ensures patient information is not overheard or seen by others. Communicating this to patients, as well as confirming that they are also in a private environment, is advised.

Ensure Safe and Appropriate Environment

Registrants must ensure that the physical setting in which care is being delivered is appropriate and safe. If observing the administration of a medication, registrants must have a plan in place to manage adverse events and/or emergencies.

Registrants providing virtual care must ensure that the method used is functioning properly and maintains adequate connectivity to support the virtual visit. Due to the instability of some network connections, registrants are advised to have a contingency plan in place to ensure that patients are able to access the pharmacy services they need if an internet connection cannot be maintained.

LEGISLATIVE REFERENCES:
Healthcare Consent Act, 2004, s.11(2)
Personal Health Information Protection Act, 2004, s.4

ADDITIONAL REFERENCES:
Virtual Care Guide - Ontario Pharmacists Association
Article - Protecting Patient Privacy (p.34) – Pharmacy Connection Winter 2018
Article - Reporting Privacy Breaches (p.22) – Pharmacy Connection Fall 2016
Article - Releasing Personal Health Information (p.32) – Pharmacy Connection Summer 2013

IMPLEMENTATION
Published:
Version #: 1.00
College Contact: Practice Department

Revision History

Version #	Date	Action
1		New policy developed

Appendix B: Jurisdictional Insights

Pharmacy Regulatory Authorities across Canada:

- No regulator currently has a standard or policy for the provision of virtual care beyond the current pandemic.
- Guidance has been provided by some pharmacy regulatory authorities to pharmacy professionals that has focused on the provision of virtual care to patients during the pandemic specifically.
    - Alberta College of Pharmacy: detailed guidance is provided and intended to be applicable for the duration of the COVID-19 pandemic. They note that this guidance is not intended to normalize the practice of using virtual care
    - Saskatchewan College of Pharmacy Professionals: information focused on the use of a specific virtual care platform that has been recommended by the College for use.
    - Nova Scotia College of Pharmacists: practice advisory which summarizes applicable legislation and guides the profession on College expectations for practice during the pandemic.
    - New Brunswick College of Pharmacists: detailed guidance is provided and applicable in times of emergency.

Health Profession Regulators in Ontario:

- A few health profession regulators in Ontario (noted below) have set expectations for the provision of virtual care by their registrants through guidelines and policies, while the majority of others have provided information specific to the provision of virtual care during this pandemic.
- All have similar professional expectations related to the protection of privacy and maintainence of confidentiality, documentation requirements, and assessing the appropriateness of using a virtual approach to care provision.

Regulators with set expectations in existing policies and guidelines are:

- College of Physicians and Surgeons of Ontario: Telemedicine policy is currently under review and is anticipated to be updated later this year to capture broader considerations for virtual care as compared to the current focus on telemedicine.
- College of Nurses of Ontario: Telepractice practice guideline provides detailed information on how to practice remotely.
- College of Registered Psychotherapists of Ontario: provides significant guidance on the provision of virtual care through standards, guidelines and advice to regitrants. Related professional standards include: 3.4. Electronic Practice, Section 2. Competence, 3.1. Confidentiality, and 3.2. Informed Consent.

Ontario resources:

- Ontario Health has provided a clinical guidance document. It focuses on how to implement virtual care into daily practice, and it has more concrete information including examples of administrative, technical, and physical safeguards to protect digital personal health information.
- Ontario Pharamcists Association has provided profession specific information to support pharmacy professionals providing virtual care to patients, and answers the most commonly asked questions such as when should pharmacists use virtual care, what platforms are available and virtual care consultation tips.

Ontario College of Pharmacists
Putting patients first since 1871

BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Susan James, Director of Quality

TOPIC: Draft Cross-Jurisdictional Pharmacy Services Policy

ISSUE: Approval to post for consultation a new draft policy that sets out expectations for the provision of pharmacy services to patients in jurisdictions outside of Ontario.

PUBLIC INTEREST RATIONALE: Setting standards for pharmacy practice is a core regulatory function of the College. The College publishes policies that provide registrants with direction regarding their practice, while reaffirming the values, principles and duties of the pharmacy profession. In addition to providing guidance to the profession, policies serve as a benchmark against which the conduct of the individual pharmacist is evaluated.

BACKGROUND: Existing policies and resources are regularly reviewed as part of the College's policy review process to ensure they are up-to-date and provide registrants with a clear set of expectations that guide the practice of pharmacy in Ontario.

The current 'Prescriptions - Out of Country' policy was originally established in 2003 and stipulates that pharmacists must not facilitate the co-signing or re-writing of prescriptions by physicians for out-of-country patients if no physician/patient relationship exists. Since then, changes have been made to Canada's *Food and Drug Regulations* legislation which further clarify the criteria for being considered an authorized practitioner and these changes are reflected in the revised policy.

Additionally, the current 'Out of Province Prescriptions' fact sheet addresses cross-jurisdictional practice matters by providing registrants with information on the application of Ontario's *Drug and Pharmacies Regulation Act, 1990*. The content of this fact sheet was included in this policy review.

Patients access healthcare services across Canadian jurisdictions. In order to facilitate access to pharmacy services across Canadian jurisdictions, NAPRA established a working group last year that has developed a framework to govern pharmacy practice of this nature. While further work continues on the development of this framework, the principles that guide it have informed the expectations set out in the draft policy.

In order to simplify and consolidate all of the expectations related to practice out of Ontario or across jurisdictions, a new Cross Jurisdictional policy is proposed (see Appendix A).

ANALYSIS: The policy review process identified opportunities to clarify existing requirements and update legislative references in the policy. There is also an opportunity to ensure that the College's policy expectations support access to pharmacy services to patients across Canadian jurisdictions, in alignment with NAPRA's draft pan-Canadian cross-jurisdictional framework.

Updates made in the draft policy are summarized below:

1. Facilitating pan-Canadian access to pharmacy services

a. The physical location of the patient influences which legislative and regulatory frameworks are applicable to pharmacy practice. Pharmacy professionals must practice in accordance with the limits of their certificate of registration as well as the legal and regulatory requirements of the jurisdiction where the patient is physically located.

2. Legislative updates
    a. Canada's *Food and Drug Regulations (FDR)* definitions of 'practitioner', 'pharmacist', and 'pharmacy technician' were updated in 2013 to require that the professional must be entitled to practice their profession under applicable provincial laws, and be practising their profession in that province. Therefore a prescription is only valid if the prescriber has an established therapeutic relationship with the patient, and the prescriber is registered and actively practising their profession in a Canadian jurisdiction.

    b. Ontario's *Drugs and Pharmacies Regulation Act, 1990 (DPRA)* places limits on the conditions for dispensing a medication according to a prescription. Section 158 indicates that the pharmacist is to use their professional judgement to determine whether a patient who has presented a prescription from a prescriber outside of Ontario requires the drug to be dispensed by the pharmacy in Ontario.

As set out in the College's policy review process, stakeholder consultation is an important step in the process in order to allow for feedback and consideration of additional perspectives which may impact the final policy direction.

RECOMMENDATION:
That the Board approve posting of the draft Cross-Jurisdictional Pharmacy Services policy for a 60-day public consultation.

NEXT STEPS: Subject to Board approval, the policy will be posted on the College's consultation page and shared through standard communication channels throughout the consultation period. A consultation report, including a summary of feedback and any recommended changes to the draft policy, will be presented to the Board for consideration at the June Board meeting, with the intent to approve the policy.

Cross-Jurisdictional Pharmacy Services Policy

PURPOSE:

This policy articulates the College's expectations for the provision of pharmacy services to patients located in other Canadian jurisdictions, as well as to patients located outside of Canada.

For the provision of virtual care to patients located in another jurisdiction, the College expects registrants to comply with this policy as well as the Virtual Care policy.

DEFINITIONS:

Prescriber: a person who is entitled under the laws of a province to treat patients with a prescription drug, and is practising their profession in that province. (See 'practitioner' in *Food and Drug Regulations,* CRC, c870, C.01.001)

Informed Consent: a consent to treatment is informed if, before giving it, the person received the information about the nature, expected benefit, potential risks or side effects, other options and consequences of not having the treatment (or any information that a reasonable person in the same circumstances would require in order to make a decision about the treatment) and the person received responses to their request for additional information (*Health Care Consent Act, 2004*, s.11(2)).

POLICY:

Registrants providing pharmacy services to patients that are physically located outside of Ontario must meet or exceed all applicable standards, guidance, and legislative requirements that apply when providing care to patients in Ontario.

Providing Pharmacy Services across Canadian Jurisdictions

Registrants providing pharmacy services to patients that are physically located in another Canadian jurisdiction must be aware of, and comply with, the law, regulations, standards and policies, and any other practice requirements applicable in the jurisdiction where the patient is located.

- Registrants are advised that the pharmacy regulatory authority in the jurisdiction where the patient is physically located may require that they be registered in that jurisdiction prior to providing pharmacy services to patients in that jurisdiction.

Obtain Informed Consent

Registrants providing pharmacy services to patients located in another Canadian jurisdiction must obtain explicit informed consent from the patient or their substitute decision maker before delivering cross-jurisdictional pharmacy services.

- Patients or their substitute decision maker must be informed that the Ontario College of Pharmacists may share information with the pharmacy regulator in the patient's jurisdiction for the purposes of regulating the practice of pharmacy.

Out-of-Province Prescriptions

Registrants must only dispense a medication according to a prescription authorized by a practitioner who:

a) is entitled under the laws of another Canadian jurisdiction to treat patients with a prescription medication; and,
b) is practising their profession in that same Canadian jurisdiction.

(*Food and Drug Regulations,* CRC, c870, C.01.001)

Registrants can dispense a medication according to a prescription authorized by a prescriber if in their professional judgement the patient requires the medication be dispensed by the pharmacy in Ontario.

- Registrants must consider the patient's ability to access the medication in their home jurisdiction when deciding to dispense a medication according to a valid prescription.
- Registrants can accept a written, verbal or faxed prescription, including refills, if any. There are no restrictions on accepting new narcotic, controlled drug, benzodiazepine and other target substances prescription orders, provided registrants use professional judgement and practice due diligence in verifying the prescription's authenticity.

(*Drugs and Pharmacy Regulation Act, 1990*, s.1; s.158)

Providing Pharmacy Services to Patients in Ontario

To support access to pharmacy services, pharmacy professionals who are not licensed to practice in Ontario may provide care to patients that are physically located in Ontario if the following conditions are met:

a) they hold a certificate of registration from another Canadian jurisdiction; and,
b) they comply with the laws, regulations, standards and policies, and any other professional practice requirements as stipulated by the Ontario College of Pharmacists.

Providing Pharmacy Services to Patients Not in Canada

Registrants must not provide pharmacy services to patients that are physically located outside of Canada and who do not have an established therapeutic relationship with the pharmacy professional.

Registrants are permitted to provide care to patients where there is an existing therapeutic relationship and the patient is temporarily located outside of Canada.

Out-of-Country Prescriptions

Registrants must not dispense a medication that has been authorized by a prescriber who does not hold a valid certificate of registration in a Canadian jurisdiction.

- As per Canada's *Food and Drug Regulations*, an authorized practitioner (i.e. prescriber) must hold a valid certificate of registration to practice their profession in a Canadian jurisdiction and

maintain an active practice in the Canadian jurisdiction where they are registered. (CRC, c870, C.01.001)

- In situations where a registrant suspects that a prescriber does not maintain an active practice in the Canadian jurisdiction that issued their certificate of registration, it is the registrant's professional responsibility to inquire with the prescriber before dispensing the medication.

Registrants must not facilitate the co-signing or rewriting of prescriptions authorized by prescribers not licensed in Canada.

- Registrants are reminded that prescribers must have an established therapeutic relationship with the patient for whom the prescription is for. (e.g. CPSO's Prescribing Drugs policy).
- It is the professional responsibility of registrants to follow-up with the prescriber if there is any uncertainty about the validity of the prescription or whether the prescribing practitioner has an established therapeutic relationship with the patient.

Registrants dispensing medications according to a prescription authorized by a prescriber for patients physically located outside of Canada must use their professional judgement to determine whether the patient requires the medication be dispensed by the pharmacy in Ontario.

- Registrants must consider the patient's ability to access the medication in their home jurisdiction when deciding to dispense a medication according to a valid prescription.

(*Drugs and Pharmacy Regulation Act*, *1990*, s.1; s.158)

LEGISLATIVE REFERENCES:
Healthcare Consent Act, 2004, s.11(2)
Drug and Pharmacies Regulation Act, 1990, s.1; s.158
Food and Drugs Act, 1985, Food and Drug Regulations, CRC, c870, C.01.001

ADDITIONAL REFERENCES:
Pan-Canadian Cross-Jurisdictional Principles and Framework (once approved)
Fact Sheet - Prescription Transfers - Out-of-Province transfers of prescriptions
Position Statement - Authenticity of Prescriptions using Unique Identifiers for Prescribers

IMPLEMENTATION
Published:
Version #: 2.00
College Contact: Practice Department

Revision History

Version #	Date	Action
1	2003; 2013	Out-of-Country prescriptions policy; Out-of-Province Prescriptions fact sheet
2		Policies combined and updated into Cross-Jurisdictional Pharmacy Services policy

BOARD BRIEFING NOTE
MEETING DATE: MARCH 2021

FOR DECISION	X	FOR INFORMATION

INITIATED BY: Susan James, Director, Quality

TOPIC: *Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities*

ISSUE: Approval to retire the *Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities* due to redundancy.

PUBLIC INTEREST RATIONALE: Setting standards for pharmacy practice is a core regulatory function of the College. The College publishes practice policies that provide registrants with direction regarding their practice, while reaffirming the values, principles and duties of the pharmacy profession. In addition to providing guidance to the profession, policies serve as a benchmark against which the conduct of the individual pharmacist is evaluated.

BACKGROUND: *The Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities* *("LTC* Standards") were approved by Council in January 2007 to address the identified need for guidance to pharmacists working within the long-term care (LTC) sector. At the time, these standards were intended to be applied in conjunction with the College's Standards of Practice, the Standards of Practice for Pharmacy Managers, the Code of Ethics and the Documentation Guidelines.Subsequently, each of these complementary documents have been updated. In April 2009, the *NAPRA Model Standards of Practice for Canadian Pharmacists* ("Standards of Practice") were adopted and in September 2018, the *Standards of Operation for Pharmacies* ("Standards of Operation") were approved.

In addition to the changes, in July 2010, *Ontario Regulation 79/10* ("Regulation") was made under the Long-Term Care Homes Act, 2007 (LTCHA) replacing the *Nursing Homes Act*, *Homes for the Aged and Rest Homes Act* and *Charitable Institutions Act*, and the regulations under each those Acts.

The LTCHA, designed to help ensure that residents of long-term care homes receive safe, consistent, resident-centered care, also set out requirements relating to medication management systems in these facilities.

ANALYSIS: In recommending whether it is appropriate to retire the LTC Standards, the Standards of Practice, Standards of Operation, and the College's existing standards and guidelines were reviewed to determine if the expectations and guidance addressed in the LTC Standards were still necessary or addressed elsewhere (Appendix 1). Based on this review, it was determined that the College's Standards, policies, and guidelines sufficiently cover the expectations outlined in the LTC Standard and therefore retiring the LTC Standards would not present a gap in the College's expectations of pharmacy professionals when providing medication management services in LTC homes.

In addition to comparing the LTC Standards with the standards, policies/guidelines, and Regulation, the College conducted a cross-jurisdictional scan to understand the approach taken by Canadian pharmacy regulators to provide LTC guidance. It was found that there was no uniform approach in outlining expectations for providing pharmacy services to LTC facilities.

Over time, the LTC Standards have become redundant due to the introduction of more recent and applicable standards, policies and regulations. Additionally, the long term care practice envioronment is currently under review and changes impacting existing practice models are anticipated. The College will continue to monitor this environment and consider the need for new standards or policies in order to clarify expectations of pharmacy professionals if new practice models are introduced.

RECOMMENDATION:

That the Board retire the *Standards for Pharmacists Providing Services to Licensed Long-Term Care Facilities,* effective immediately.

NEXT STEPS: If the Board approves the recommendation to retire the Standards, this decision, along with the rationale, will be communicated to the profession through regular communication channels, and the website will be updated to indicate that the Standards are no longer in effect.

Appendix 1: Comparison of *Long-Term Care Standards* with the *Standards of Practice for Pharmacists, Standards of Operation for Pharmacists, and Policies/Guidelines.*

Standard 1: As a member of the interdisciplinary team, which is responsible for providing quality health care for long-term residents, the pharmacist interacts with other health care professionals to develop and implement patient-centred care and optimize therapeutic outcomes.	**Complementary information in *Standards of Practice for Pharmacists*, *Standards of Operations for Pharmacists*, *and Policies/Guidelines***	**Comments**
Clinical Services		
1.1 The pharmacist communicates using effective and appropriate skills / tools to the relevant long-term care facility staff member (s), resident and/or agent of the resident.	**Standards of Practice** 1.60 communication of relevant patient-care information to the patient and patient's health care providers consistent with applicable laws, regulations and policies.	
1.2 The pharmacist utilizes various documentation tools as evidence of such communication.	**Documentation Guidelines** Documentation will include pertinent discussions with the patient and prescriber/health care provider, including notes related to patient education, contact information and any communication which occurred or was attempted, information regarding drug use that is deemed important to patient care, or other patient information pertinent to the situation. **Standards of Practice** Pharmacists regardless of the role they are fulfilling: 1.56. keep clear, accurate and legible records that are consistent with applicable legislation, regulations, policies and standards (1.9) 57. make records in a timely manner, either concomitant with performing of a task or as soon as possible afterwards 58. document their activities and the information necessary to support the rationale and quality of these activities (1.9) 59. adhere to current laws, regulations and policies relating to documentation and applicable to pharmacy practice (3.1)	
1.3 The pharmacist participates in clinical activities relevant to the provision of drug therapy for the purpose of optimizing patient care. Activities may include but are not limited to, a comprehensive medication review and drug utilization reviews.	**Standards of Practice** Pharmacists, when providing patient care as part of the care provided during medication therapy management services: 1.27. rectify medication-therapy problems that pose risks to the patient or can affect the efficacy of the medication by (1.7): • educating the patient, and • making changes in therapy in accordance with authorities granted to	

	pharmacists by laws / regulations / policies / guidelines, or • contacting a prescriber to recommend changes in therapy 28. provide best-possible medication histories to patients or their authorized health care professionals*: • only under conditions specified by applicable laws / regulations / policies / guidelines, and • when patients are at risk for problems with their medications (e.g. demographic risk, complexity of medication regimes, hospitalization or change in physicians) 29. identify and reconcile changes in patient's medication-therapy*: • to patients requesting this service, and • to patients who are at risk for medication-therapy problems related to transitions in health care services (e.g. hospitalization or discharge from hospital)	
1.4 The pharmacist participates in educating members of the interdisciplinary team, residents and/or agents on drug therapy or medication use.	**Standards of Practice** Pharmacists, when providing patient care: 1.9. fulfill their responsibilities to the inter-professional team in accordance with collaborative practice agreements (or similar formal agreements that define team responsibilities) 11. provide information on services available to support patients in maintaining their health and wellness 17. educate patients to whom they dispense medication or medication therapies to enable the patients to receive the intended benefit of the medication or therapies Pharmacists, when managing a pharmacy: 12. organize and support staffing and workflow changes necessary to enable pharmacists to participate in collaborative care initiatives 13. establish and maintain professional relationships with other health care professionals to support collaborative care initiatives 14. provide a work environment that supports collaborative care practices	
1.5 Continuous Quality Management 1.5.1 The pharmacist promotes safe medication practice and participates in the development, implementation and evaluation of these practices.	**Standards of Practice** Pharmacists, when managing a pharmacy: 3.7. develop policies and standard operating procedures that ensure a safe and effective system of medication supply is maintained at all times 8. develop policies and standard operating procedures that support staff's ability to continuously improve the safety and quality of patient care provided 9. develop and implement practice change models based on measurement and improvement in the quality of care and services provided by pharmacists	

1.5.2 The pharmacist participates in the review of medication related incidents and provides recommendations to prevent recurrence.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 3. 10. manage errors, incidents and unsafe practices (2.6) 11. promptly disclose alleged or actual errors, incidents and unsafe practices to those affected and in accordance with legal and professional requirements (2.6) 12. record and report alleged and actual errors, incidents and unsafe practices in accordance with legal and professional requirements (2.6) Pharmacists, when managing a pharmacy: 15. review errors and incidents to determine patterns and causal factors that contribute to patient risk (2.6) 16. develop and implement policies and procedures that minimize errors, incidents and unsafe practices, including supporting staff in their obligation to report adverse events and close-calls (2.6)	
Standard 2:		
Prescription Record Management		
2.1 Prescription Authorization 2.1.1 Signed Quarterly Review/Three Month Review The pharmacist ensures that a system is in place to obtain signed Quarterly Reviews/Three Month Reviews.	**Standards of Practice:** Pharmacists apply their medication and medication use expertise while performing their daily activities. 11. assess the appropriateness of providing a refill of a medication requested by a patient by collecting and interpreting relevant patient information to ensure	
2.1.2 Transcribed Verbal Orders The pharmacist ensures that a system is in place to verify that verbal orders received and transcribed by the nurse have been signed by the prescriber.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 8. adhere to current laws, regulations and policies applicable to pharmacy practice (3.1)	

2.1.3 New Order Permanent filling record The pharmacist verifies and signs the permanent filling record. 2.1.4 Refill Order Permanent filling record 2.1.4.1 The pharmacist signs either each individual permanent filling record or the multi-prescription permanent filling record. The pharmacist is required at a minimum to sign on each page in the case where a multi-prescription permanent filling record is used or per patient if there is more than one patient per page. 2.1.4.2 The pharmacist signs for prescriptions that he/she has personally checked.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 1.56. keep clear, accurate and legible records that are consistent with applicable legislation, regulations, policies and standards (1.9) 57. make records in a timely manner, either concomitant with performing of a task or as soon as possible afterwards 58. document their activities and the information necessary to support the rationale and quality of these activities (1.9) 59. adhere to current laws, regulations and policies relating to documentation and applicable to pharmacy practice (3.1)	NAPRA standards mandate pharmacists adhere to current laws, regulations and policies relating to documentation and applicable to pharmacy practice. Refer to OCP-Documentation for more details.
2.1.5 Quantity determination, reductions & documentation (facility specific policy) The pharmacist follows a facility specific prescription quantity protocol to determine prescription quantity where the prescriber has not specified unless precluded by specific legislation. (Controlled Drug and Substances Act)	**Standards of Practice** Pharmacists, when providing patient care as part of the care provided when dispensing medications or medication therapies : 1.18. ensure required procedures are followed for controlled substances Pharmacists, when responsible for medication distribution / supply: 36. ensure that prescriptions received are complete, authentic and meet all legal and professional requirements (6.1) 37. ensure that products selected are correct and consistent with applicable policies (6.1) 38. ensure that quantities dispensed are correct (6.1) 41. ensure that a final check of prescribed products is performed 44. ensure required procedures are followed for controlled substances Pharmacists regardless of the role they are fulfilling: 56. keep clear, accurate and legible records that are consistent with applicable legislation, regulations, policies and standards (1.9)	

2.2 Record Keeping 2.2.1 Retrievable filing of Quarterly Review/Three Month Review The pharmacist ensures that signed Quarterly Review / Three Month Review are readily retrievable. 2.2.2 Retrievable filing of New Order permanent filling record The pharmacist ensures original prescription orders are cross-referenced to the permanent filling records, and are readily retrievable. 2.2.3 Retrievable filing of Refill Order permanent filling record The pharmacist ensures that the permanent filling record is filed in a manner that is readily retrievable.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 56. keep clear, accurate and legible records that are consistent with applicable legislation, regulations, policies and standards (1.9) **Standards of Operation** - The information technology deployed at the pharmacy meets the minimum standards for national technical, functional and administrative requirements outlined in national standards for pharmacy practice management systems. - Pharmacy professionals are able to access references and resources as required to support the delivery of patient care. - The personal health information of patients and those who receive pharmacy services is protected through the implementation of both administrative and technical safeguards. - The pharmacy has an established schedule for the retention, retrieval and destruction of information. - The pharmacy has technology necessary for the storage and retrieval of all documents associated with the practice of pharmacy at that location.	NAPRA standards mandate pharmacists adhere to current laws, regulations and policies relating to documentation and applicable to pharmacy practice. Refer to OCP-Record Retention, Disclosure, and Disposal for more details
2.3 Invoicing and Receipts Legislation dictates that pharmacists must provide receipts to all patients including those in long-term care facilities at the time of dispensing. 2.3.1The pharmacist provides receipts to residents of long-term care facilities in a manner that is mutually acceptable to the resident or agent, the pharmacist as well as the facility. 2.3.2 The pharmacist invoices residents of long-term care facilities in a manner acceptable to residents or their agents.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 56. keep clear, accurate and legible records that are consistent with applicable legislation, regulations, policies and standards (1.9) 57. make records in a timely manner, either concomitant with performing of a task or as soon as possible afterwards 58. document their activities and the information necessary to support the rationale and quality of these activities (1.9) 59. adhere to current laws, regulations and policies relating to documentation and applicable to pharmacy practice (3.1)	
2.4 Emergency Medication Supply 2.4.1 The pharmacist is involved in the establishment of policies and procedures for the emergency medication supply.	**Standards of Operation** The Pharmacy has implemented a safe medication management system and quality improvement program to support patient safety. **Designated Manager – Medication Procurement and Inventory Management Policy**	

	3. Good inventory control supports procurement and utilizes appropriate systems to track shipments and inventory, and to forecast needs to ensure that patients continue to have reasonable access to pharmaceutical products for their health and well-being; and	
2.4.2 The pharmacist provides medications to fill a long-term care emergency medication supply upon the issuance of a prescription by a facility physician.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 1.8 adhere to current laws, regulations and policies applicable to pharmacy practice (3.1)	
2.4.3 Where an emergency medication supply is provided to a long-term care facility, the pharmacist (or designate) periodically verifies the contents to ensure products are within their expiry date and are properly accounted for.	**Standards of Practice** Pharmacists, when managing a pharmacy: 1. 51. ensure that inventory is managed to remove outdated stock and to ensure the quality and timeliness of medication supply (6.1, 7.3)	
Standard 3:		
Drug Destruction If participating in drug destruction in a long-term care facility, the pharmacist acts in accordance with environmental requirements and ethical principles. 3.1 When a pharmacist is witness to the destruction of drugs at the long-term care facility it must be in compliance with the appropriate legislation, in accordance with the Standards of Practice and the disposal must be in an environmentally appropriate manner.	**Standards of Operation** There is a program for the safe return and disposal of prescription drugs according to national and provincial guidelines.	
Standard 4:		
4.1 The Consultant Pharmacist 4.1.1 The long-term care pharmacy provider identifies at least one pharmacist who acts as a liaison between the providing pharmacy and the long-term care facility.	**Standards of Practice** 1. Expertise in medications and medication use Pharmacists, when providing patient care: 60. document their decisions / actions, supporting patient and related information, and their interpretation of this information, including their:… - communication of relevant patient-care information to the patient and patient's health care providers consistent with applicable laws, regulations and policies. 3. Safety and Quality Pharmacists, when providing patient care:	

	21. pass on information to health care professionals providing care to patients as required (1.6): • only in accordance with applicable laws, regulations and policies, and • to support safe and effective therapy, and • while maintaining patient confidentiality	
4.1.2 The pharmacist(s) identified in section 4.1.1 maintains current knowledge in the provision of long-term care services and best practice in that setting.	**Standards of Practice** Pharmacists regardless of the role they are fulfilling: 1.1. fulfill the provincially mandated requirements for maintenance of competence (e.g. CE, practice assessment, learning portfolio) (3.5) 2. adhere to current laws, regulations and policies applicable to pharmacy practice (3.1) 4. recognize and practice within the limits of their competence 5. use evidence from relevant sources to inform their activities (4.2, 4.3) 6. critically evaluate medication and related information (4.4) 7. present medication and related information in a manner appropriate to the audience (4.5) 8. adhere to current laws, regulations and policies applicable to pharmacy practice (3.1)	
4.1.3 The pharmacy manager shall ensure the availability of the relevant personnel during the College Inspection Process.	**Standards of Practice** Pharmacists, when managing a pharmacy: 1. 53. ensure that the pharmacy meets requirements for accreditation or permits to operate 54. complete activities / submissions required for continued accreditation of the pharmacy	
4.1.4 The consultant pharmacist has access to resources that include but are not limited to: o Journals related to the provision of long-term care services o References relevant to long-term care practice o Current Long Term Care legislation o Copy of Pharmacy Services section of the Ministry of Health and Long-Term Care Program Manual	**Standards of Operation** Pharmacy professionals have access to the information systems and technological support that enables them to meet the standards of practice of the profession.	

4.2 Facility specific Policies & Procedures Manual / Resource Manual 4.2.1 The pharmacy manager ensures that a minimum of resources shall be readily available at the place of practice including drug dosing references as follows: o Drug dosing references which include geriatric dosing o Facility specific quantity protocol policy	**Standards of Operation** Pharmacy professionals have access to the information systems and technological support that enables them to meet the standards of practice of the profession.	