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

Council Meeting

September 28, 2022

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

NOTICE OF MEETING OF COUNCIL

A meeting of the College of Midwives of Ontario will take place on Wednesday, September 28, 2022 from 1:00 PM to 4:30 PM in the College's Board Room at 21 St. Clair Ave. E., Suite 303, Toronto, Ontario.

This meeting is open to the public. Any individuals wanting to observe the meeting should contact the College at cmo@cmo.on.ca or 416.640.2252 ext. 227 for access details.

L'Ordre des sages-femmes de l'Ontario tiendra une réunion le 28 septembre, de 13 h 00 à 16 h 30, dans la salle de conférence de l'Ordre, située au 21, av. St. Clair E., bureau 303, Toronto, Ontario.

Cette réunion est ouverte au public. Toute personne intéressée peut obtenir les détails pour accéder à la réunion en écrivant à l'Ordre, à cmo@cmo.on.ca, ou en composant le 416-640-2252, poste 227.

Kelly Dobbin,
Registrar & CEO

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

CMO Council Meetings – Guidelines for Observers

- Council meetings are held at the College of Midwives of Ontario in the Board Room (21 St. Clair Ave E, Ste 303)
- Those attending the Council meetings as observers do not participate in the meeting.
- Observers are asked to be quiet during the meeting, and keep side conversations to a minimum.
- Observers are asked to limit comings and goings during the meeting. There are morning and afternoon refreshment breaks and a one-hour break for lunch.
- Please turn off or silence mobile devices while in the Council Board Room.
- If a portion of the meeting is closed to the public, an announcement will be made to move in-camera. If known in advance, in-camera items are noted on the agenda. The agenda is posted to the CMO website one week prior to the scheduled Council meeting.
- The College is a fragrance-free environment. This applies to all staff, CMO members, Council representatives and visitors to the CMO.
- Observers can access the Council package materials approximately one week prior to the scheduled Council Meeting.

If you have any questions after the meeting, please contact the College at cmo@cmo.on.ca or by phone at 416-640-2252, ext 227.

Strategic Framework
2021–2026

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

The 2021-2026 Strategic Framework is a high-level statement of the College's vision, mission, outcomes and key priorities over the next five years. It paves the way forward for the organization, builds a stronger sense of common purpose and direction and a shared understanding of why we exist, what guides our work, and what we want to achieve as an organization.

Our Vision

A leader in regulatory excellence, inspiring trust and confidence

Our Mission

Regulating midwifery in the public interest

Our Strategic Priorities

1. Regulation that enables the midwifery profession to evolve.
2. Effective use of data to identify and act on existing and emerging risks.
3. Building engagement and fostering trust with the public and the profession.

Key Outcomes We Are Expected to Achieve

1. Clients and the public can be confident that midwives possess and maintain knowledge, skills and behaviours relevant to their professional practice and exercise clinical and professional judgment to provide safe and effective care.
2. Clients and the public can be confident that midwives practise the profession with honesty and integrity and regard their responsibility to the client as paramount.
3. Clients and the public can be confident that midwives demonstrate accountability by complying with legislative and regulatory requirements.
4. Clients and the public trust that the College of Midwives of Ontario regulates in the public interest.

Our Guiding Principles

These interrelated principles define how we strive to work as an organization, shape our culture and our relationships with the public, midwives, and partner organizations.

Accountability
We make fair, consistent and defensible decisions, incorporating diverse and inclusive views.

Equity
We identify, remove and prevent systemic inequities.

Transparency
We act openly and honestly to enhance accountability.

Integrity
We act with humility and respect and apply a lens of social justice to our work.

Proportionality
We allocate resources proportionate to the risk posed to our regulatory outcomes.

Innovation
We translate opportunity into tangible benefits for the organization.

COUNCIL AGENDA

Wednesday, September 28, 2022 | 1:00 pm to 4:30 pm
College of Midwives of Ontario
21 St Clair Ave, Suite 303 | Boardroom

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
1.	Call to Order, Land Acknowledgment	C. Ramlogan Salanga	1:00	INFORMATION		
2.	Conflict of Interest	C. Ramlogan Salanga	1:05			
3.	Review and Approval of Proposed Agenda	C. Ramlogan Salanga	1:08	MOTION	3.0 Agenda	5
4.	Consent Agenda - Draft Minutes of June 22, Council Meeting Q1 Reports for: - Inquiries, Complaints and Reports Committee Report - Registration Committee - Quality Assurance Committee - Discipline Committee - Fitness to Practise Committee - Client Relations Committee	C. Ramlogan SaFlanga	1:10	MOTION	4.0 Draft Minutes 4.1 ICRC Committee 4.2 Registration Committee 4.3 QAC Committee 4.4 Discipline Committee 4.5 FTP Committee 4.6 CRC Committee	7
5.	Alternative Dispute Resolution Policy	S. Lewis	1:15	APPROVAL	5.0 Briefing Note 5.1 Proposed ADR Policy (revised) 5.2 ADR Eligibility Policy 5.3 Guide to ADR 5.4 Guide to filing a complaint 5.5 Mediator Policy (revised) 5.6 ADR Facilitator Policy	32
6.	Annual Council Evaluation	S. Goodwin	1:30	INFORMATION /DISCUSSION	-	-
7.	Chair Report	C. Ramlogan Salanga	2:00	APPROVAL	7.0 Chair Report	59

Item	Discussion Topic	Presenter	Time	Action	Materials	Pg
8.	Registrar Report	K. Dobbin	2:15	APPROVAL	8.0 Registrar Report 8.1 Grey Matters 8.2 OFC Risk rating report	61
9.	Executive Committee Report	C. Ramlogan Salanga	2:45	APPROVAL	9.0 Briefing Note 9.1 Q1 SOP 9.2 Assessment of External auditor summary report 9.3 Proposed Interim committee composition 9.4 2024 Exec and Council dates	72
10.	IN CAMERA (Approval of Minutes)	C. Ramlogan Salanga	3:00	MOTION	-	
	BREAK		3:05			
11.	Regulatory Oversight of Birth Centres		3:20			
	Presentation	K. Dobbin		INFORMATION		
	Facility Standards & Clinical Practice Parameters revisions	K. Dobbin		APPROVAL	11.0 Briefing Note 11.1 FS & CPP (revised) 11.2 Section 5.08 General Bylaw	80
12.	Executive Election	K. Dobbin	3:50		12.0 Schedule 1 Process for Election of Officers	108
13.	Approval of 2022-2023 Slate of Council	C. Ramlogan Salanga	4:15	APPROVAL	13.0 2022-2023 Slate of Council	110
14.	Housekeeping	Z. Grant	4:20	INFORMATION		
15.	Adjournment	C. Ramlogan Salanga	4:30	MOTION		
	Next Meetings: December 6-7, 2022 March 21-22, 2023 June 20-21, 2023 October 3-4, 2023 December 5-6, 2023			INFORMATION		

MINUTES OF COUNCIL MEETING

Held on June 22, 2022, |9:30 am to 2:50 pm
Videoconference Zoom

Chair:	Claire Ramlogan-Salanga, RM
Present:	Lilly Martin, RM; Edan Thomas, RM; Claudette Leduc, RM; Isabelle Milot, RM; Marianna Kaminska; Judith Murray; Don Strickland; Karen McKenzie, RM; Alexia Singh, RM; Hardeep Fervaha, RM; Jacqueline Morrison
Regrets:	Pete Aarssen
Staff:	Kelly Dobbin; Johanna Geraci; Nadja Gale;
Observers/Guests:	Deborah Bosner (AOM (Association of Ontario Midwives); Blair Mackenzie (Hilborn); Geoff Clute (Hilborn)
Recorder	Zahra Grant

1. Call to Order, Welcome and Land Acknowledgement

   Claire Ramlogan-Salanga, Chair, called the meeting to order at 9:31 am and welcomed all present.

   Alexia Singh shared a land acknowledgement and reflection.

2. Declaration of Conflict of Interests

   No conflicts were declared.

3. Proposed Agenda

   The proposed agenda of June 22, 2022, was approved as presented.

   Moved: Marianna Kaminska
   Seconded: Karen McKenzie
   CARRIED

4. Consent Agenda

   The consent agenda was approved as presented.

   MOTION: THAT THE CONSENT AGENDA CONSISTING OF:

   Draft Minutes of March 30, 2022 Council Meeting and Annual Reports for:
   - Executive Committee

- Inquiries, Complaints and Reports Committee
- Registration Committee
- Discipline Committee
- Fitness to Practise Committee
- Client Relations Committee
- Quality Assurance Committee

Moved: Alexia Singh
Seconded: Judith Murray
CARRIED

5. Chair Report

Claire Ramlogan-Salanga, Chair provided highlights of the Chair report.

Professional member elections are underway during the month of June and voting will close at 11:59 pm on June 30th. Six candidates are running for three positions, and it was noted that three of the candidates had also attended the information sessions, an indication that the sessions may be contributing to increased engagement. Both information sessions, the general and the one for racialized midwives, were well attended and the College plans to continue to provide the sessions as part of the elections process annually.

Council was provided with updates regarding Assessment of the Auditor and the annual Registrar's review, as well as a summary of the feedback received from the March training day and meeting. Feedback continues to be positive, and Council is engaged and benefitting from the trainings and meetings.

MOTION: That the Chair report to Council be approved as presented

Moved: Hardeep Fervaha
Seconded: Edan Thomas
CARRIED

6. Executive Committee Report

I. Governance Policies

Council was presented with revised Governance Policies which had been reviewed by the Executive Committee and brought to Council for final approval. The revisions include changes to incorporate principles of equity, diversity and inclusion, an update to CRL-4 regarding the approach and process for evaluation of the Registrar-CEO, as well as some general updates to language and a few copy edits. A language glossary was also added to the policies for reference.

Some additional revisions and edits were directed by Council and the policies were approved with revisions.

ACTIONS:
- Add 'ability' to glossary
- Remove 'fellow'
- Remove extra 'prior to' from point #8 of CRL4
- Remove reference 'long-term care'

II. Audited Financial Statements

**Blair MacKenzie and Geoff Clute of Hilborn joined the meeting at 10:04 am.*

Blair MacKenzie of Hilborn Associates joined the meeting to present the audited financial statements of the fiscal year ending March 31, 2022, to Council. Hilborn is a firm that operates independently of the College to perform the audit in accordance with auditing standards. It was presented to Council that in the opinion of the auditor, the financial statements present fairly, in all material respects, the financial position of the College on March 31, 2022, and the results of its operations and cash flows for the year ended in accordance with Canadian accounting standards for not-for-profit organizations. Mr. MacKenzie emphasized that it was a clean unmodified opinion, with no disagreements from the management team to the contrary. It was a collaborative process, with the firm working with management and the Executive committee to accomplish the goal of the audit, which is to determine that there are no material misstatements within the financial statements.

Mr. MacKenzie walked the Council through an in-depth review of the audited financial statements, reviewing how the firm forms the basis for their opinion and the roles and responsibilities of management and the Executive committee in the process. Council members were able to ask questions and get clarification where needed before a motion was made to approve the audited financial statements.

III. Q4 Statement of Operations

Stefano Biscotti, Director of Operations walked the Council through the Q4 Statement of Operations. The statement was previously reviewed and approved by the Executive Committee.

Overall, the College is in a good financial position with a strong asset base.

MOTIONS:

I. That the Executive Committee Report be accepted as presented.

II. That the Audited Financial statements as of March 31, 2022 of the College of Midwives of Ontario be approved as presented.

III. That the revisions to the Governance Policies be approved with revisions discussed.

Moved: Marianna Kaminska

Seconded: Judith Murray
CARRIED

7. Registrar Report

Kelly Dobbin, Registrar introduced the report and provided highlights to Council.

A report regarding the government's proposed bill 106 which relates to registration-related changes and how it may impact the College and our registration requirements, was provided. They Registration Committee is monitoring the proposed changes and working toward developing a policy with respect to language proficiency requirements. Legal counsel will also be consulted, but for now since there has not been any confirmed direction from the Ministry, these issues remain for consideration and preparation.

Council was also reminded of current conversations being had in the sector around governance reform and while any specific bills have yet to be proposed, the potential reforms are something the College aims to be prepared for.

A summary of other highlights from the past quarter was also provided before the Registrar discussed the Operational Plan. Council was provided with the update in response to staffing changes as well as continuing to navigate the Covid-19 pandemic and timing expectations for initiatives of the Strategic Plan. An outline of which initiatives have been completed, are currently underway, what is planned and where timelines have been adjusted was provided to Council.

MOTION: That the Registrar's Report be accepted as presented.

Moved: Donald Strickland
Seconded: Alexia Singh
CARRIED

8. Registration Committee: Assessment & Orientation Program for Internationally Trained Midwives

Isabelle Milot, Chair of Registration provided a summary of the work the committee has undertaken with expert consultation on a program for establishing equivalency that meets the registration requirements of the Registration Regulation for internationally trained midwives. The new orientation and assessment program is being designed so that applicants who otherwise do not meet the non-exemptible education requirements for a certificate of registration may be given a fair opportunity to demonstrate equivalency to the qualifications outlined in the Registration Regulation (i.e., a baccalaureate degree in health sciences (midwifery) from a university in Ontario).

Nadja Gale, Manager of Registration joined to review with Council the phases and modules being proposed for a piloting cycle with a small number of applicants

**Due to some technical difficulties being experienced by staff presenter, Council went IN-CAMERA at 11:53 am to allow issue to be resolved, then Council took a break for lunch.*

After lunch, Nadja Gale continued to go through the various aspects of the proposed program and how it establishes qualifications for safe entry to practise while ensuring fairness, objectivity, impartiality, and transparency in the process.

The issue of how clinical experience would be addressed without the Canadian experience clinical placements and how this may impact midwives entering the profession through this route, as it will require more supervision at the onset of registration and practice. The College is currently having conversations with the Ontario Midwifery Program regarding funding and the needs to support the profession in providing sufficient supervision to internationally educated midwives. Members of the Council emphasized the importance of ensuring that internationally educated midwives in the program get introduced to the community so that they are not disadvantaged compared to midwives who graduated from Ontario midwifery education programs (MEP) and were able to form relationships with midwives and practices throughout their clinical placements.

Piloting of the program will be an opportunity to identify and address any other gaps that may not be currently apparent. Council approved the program for the pilot.

MOTION: That Council approves the pilot of the new College orientation and assessment program for internationally educated midwives for the purpose of determining qualifications that are equivalent to the degree referred to in the Registration Regulation in accordance with section 8. (1)1.iii of O. Reg. 168/11 Registration Regulation, under the Midwifery Act, 1991.

Moved: Alexia Singh
Seconded: Isabelle Milot
CARRIED

9. IN-CAMERA

Council went In Camera as per provisions of section 7(2)1(b) of Schedule 2 of the *RHPA* which state that the Council may exclude the public from any meeting or part of meeting if it satisfied that, financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public.

MOTION: Be it resolved that Council move in-camera at 11:53 AM

Moved: Lilly Martin
Seconded: Hardeep Singh
CARRIED

MOTION: resolved that Council move out of in-camera at 12:24 pm.
Moved: Isabelle
Seconded: Alexia
CARRIED

10. Quality Assurance Committee: Professional Standards

I. Second Birth Attendant Standard

Lilly Martin, Chair of the Quality Assurance Committee introduced the Second Birth Attendant Standard to Council for approval after public consultation and another review by the Quality Assurance Committee. Revisions to the standard are being considered to address the requirement that second birth attendants have certification in NRP (Neonatal Resuscitation Program). The Canadian Paediatric Society (CPS), the Canadian organization responsible for delivering this program, is only available to licensed or regulated health professionals and students of those professions. Midwives from a small number of rural practices cannot meet this standard because they cannot reliably find second birth attendants who are eligible to enroll in NRP. The College has been providing waivers on an annual basis to a small number of midwives for working below the standard.
Waivers are for extenuating circumstances and are not a permanent solution. As a solution, the Quality Assurance Committee is recommending revisions to the Second Birth Attendant Standard by removing the requirement for certification in NRP. Instead, the standard will replace the requirement for *certification* in NRP with the requirement of *competence* in NRP.

The regulatory impact assessment provided in the meeting materials thoroughly covered research and evidence including the findings from the 30-day consultation where most respondents were in favour of the changes. Council approved the Standard with a September 1, 2022, implementation date.

II. Clinical Education & Supervision Standard

The Clinical Education and Supervision Standard was also presented to Council. The standard underwent two separate consultations. The first in fall 2021 after which the committee provided significant redirection and revisions before approving a second 30-day consultation. The second consultation of the standard was received well and was supported by registrants and stakeholders. The committee reviewed and directed a few more revisions based on feedback before approving the document to be brought to Council for approval.

Council had a robust discussion with some minor revisions for clarity and the standard was approved with a September 1, 2022, implementation date.

Actions:
- Point #4 of standard. Add "discussion with client regarding role of student" "client consent obtained when student is involved" or clarity

- #7 give definition of clear guidance by adding in descriptor such as "Clinical expectations" "clinical role"

MOTIONS

I. That the revised Second Birth Attendant standard be approved with implementation date of September 1, 2022.

II. That the Professional Responsibilities When Supervising Students standard with revisions discussed be approved with an implementation date of September 1, 2022.

Moved: Donald Strickland
Seconded: Edan Thomas
CARRIED

11. ADJOURNEMENT

MOTION: THAT THE MEETING BE ADJOURNED AT 2:52 PM.
Moved: Alexia Singh
Seconded: Lilly Martin
CARRIED

INQUIRIES, COMPLAINTS & REPORTS COMMITTEE

Q1 REPORT TO COUNCIL
April 1, 2021 to June 30, 2021

Committee Members

Chair: Susan Lewis
Professional: : Lilly Martin, RM; Claudette Leduc, RM, Edan Thomas, RM
Public: Judith Murray, Marianna Kaminska

Non-Council: Samantha Heiydt, Jillian Evans, Susan Lewis, Christi Johnston, RM, Sarah Kirkland RM, Maureen Silverman RM, Emily Gaudreau, RM

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held	7	–	–	–	7
Number of Committee Meetings Held	0	–	–	–	0
Number of Trainings	0	–	–	–	0

Notes:
Q1: 5 panel meetings were held by videoconference, 2 were email panels

Caseload Work of the ICRC

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Files Carried Over from previous reporting period	21	–	–	–	N/A	1	–	–	–	N/A
New files	12	–	–	–	12	0	–	–	–	0
Closed files	15	–	–	–	15	1	–	–	–	1
Active files at end of reporting period	18	–	–	–	N/A	0	–	–	–	N/A

Notes:
Q1: Twelve new complaint files were a result of receiving seven complaints. Three complaints involved more than one midwife.

Themes of New Matters

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Communication	6	–	–	–	6	0	–	–	–	0
Competence /Patient Care	11	–	–	–	11	0	–	–	–	0
Professional Conduct & Behaviour	3	–	–	–	3	0	–	–	–	0
Record Keeping	4	–	–	–	4	0	–	–	–	0
Sexual abuse /Harassment / Boundary Violations	0	–	–	–	0	0	–	–	–	0
Unauthorized Practice	0	–	–	–	0	0	–	–	–	0
Other: Practice Management	0	–	–	–	0	0	–	–	–	0
Other: Masking concerns re COVID	0	–	–	–	0	0	–	–	–	0

Notes:
Category of themes are based on the current methodology set out by the Ministry for the College Performance Measurement Framework (CPMF) Reporting Tool. These categories may change in the next reporting period to reflect any changes to CPMF reporting requirements and/or categories the College wishes to track.
Some complaints involve more than one theme.

Source of New Matters

	Complaints					Reports				
Source of New Matters	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Client	10	–	–	–	1	0	–	–	–	0
Family Member	1	–	–	–	1	0	–	–	–	0
Health Care Provider	0	–	–	–	0	0	–	–	–	0
Information received by Mandatory / Self Report	0	–	–	–	1	0	–	–	–	0
Information received from another source	0	–	–	–	0	0	–	–	–	0
Additional Concern arising from an existing investigation	0	–	–	–	0	0	–	–	–	0
Another Midwife	1	–	–	–	1	0	–	–	–	0

Outcomes/Completed Cases

Number of Resolved Cases and Outcomes	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
ADR Resolution	5	–	–	–	5	N/A				
Complaints Withdrawn	0	–	–	–	0	N/A				
Frivolous and Vexatious	0	–	–	–	0	N/A				
No Action	7	–	–	–	7	0	–	–	–	0
Advice & Recommendations	3	–	–	–	3	0	–	–	–	0
Specified Continuing Education or Remediation Program (SCERP)	1	–	–	–	1	0	–	–	–	0
Oral Caution	0	–	–	–	0	1	–	–	–	1
SCERP AND Oral Caution	0	–	–	–	0	0	–	–	–	0
Referral to Discipline Committee	0	–	–	–	0	0	–	–	–	0
Referral to Fitness to Practise Committee	0	–	–	–	0	0	–	–	–	0
Acknowledgement & Undertaking	0	–	–	–	0	0	–	–	–	0
Undertaking to Restrict Practise	0	–	–	–	0	0	–	–	–	0
Undertaking to Resign and Never Reapply	0	–	–	–	0	0	–	–	–	0

Note: where decisions contain more than one outcome or multiple issues, both will be captured. Accordingly, the total number of decisions may not equal the total number of outcomes or cases.

Themes of Completed Matters where action was taken by the ICRC

	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Competence /Patient Care	–	–	–	–	0	1	–	–	–	1
• *Management of hypertension*	–	–	–	–	0	1	–	–	–	1
Communication	3	–	–	–	0	0	–	–	–	0
• *Student Supervisor*	1	–	–	–	0	0	–	–	–	0
• *ICD regarding staffing*	1	–	–	–	1	0	–	–	–	0
• *Providing supportive care*	1	–	–	–	1	0	–	–	–	0
Record Keeping	1	–	–	–	1	0	–	–	–	0

Notes:
Matters where the ICRC referred specified allegations to the Discipline Committee or did not take any action are not included. Outcomes in this category are the result of the ICRC issuing advice or recommendations, and/or ordering a SCERP.
Category of main themes are based on the current methodology set out by the Ministry for the College Performance Measurement Framework (CPMF) Reporting Tool. Sub categories represent the concern of the ICRC that required remediation. These categories may change in the next reporting period to reflect any changes to CPMF reporting requirements and/or categories the College wishes to track.
Outcomes of some complaints involve more than one theme. Some complaints may involve more than one midwife.

Timelines

Closed cases	Complaints					Reports				
	Q1	Q2	Q3	Q4	Total	Q1	Q2	Q3	Q4	Total
Number of files closed by ADR <120 days	5	–	–	–	5	–	–	–	–	–
Number of files closed <150 days	3	–	–	–	3	1	–	–	–	1
Number of files closed between 150 days and 210 days	6	–	–	–	6	0	–	–	–	0
Number of files closed >210 days	1	–	–	–	1	0	–	–	–	0
Average: (reported in number of days)	189	–	–	–	189	91	–	–	–	91
Median: (reported in number of days)	206	–	–	–	206	91	–	–	–	91
Average: for ADR cases (reported in number of days)	70	–	–	–	70					

Notes:
Time is calculated from receipt of complaint until the date of the final decision and reasons.

Alternative Dispute Resolution

Stats	Q1	Q2	Q3	Q4	Total
Open files with ADR (Files carried over)	4	–	–	–	N/A
New files referred to ADR	7	–	–	–	7
Closed files with in 60 days	2	–	–	–	2
Closed files with in 120 days	4	–	–	–	4
Files returned to ICRC due to timeframe	N/A	–	–	–	N/A
Files returned to ICRC due to unsuccessful mediation	1	–	–	–	1
Files returned to ICRC - Registrar did not ratify the agreement	N/A	–	–	–	N/A
Open files as at end of reporting period	5	–	–	–	5

Other useful information:	Q1	Q2	Q3	Q4	Total
Total Number of Complaints Received	12	–	–	–	12
Number of complaints that were not ADR eligible	7	–	–	–	7
Number of Complaints that were ADR eligible	5	–	–	–	5
Number of Complaints ELIGIBLE that proceeded to ADR upon consent of all parties	3*	–	–	–	3
Number of Registrants who agreed to participate in ADR	3	–	–	–	3
Number of Complainants who agreed to participate in ADR	3	–	–	–	3

Notes:
**Two responses were outstanding at the end of the reporting period*

.

Appeals

Complaint Matters	Q1	Q2	Q3	Q4	Total
Open HPARB appeals (Appeals carried over)	11	–	–	–	N/A
New HPARB appeals	1	–	–	–	0
Completed HPARB appeals	0	–	–	–	0
Open HPARB appeals (at end of reporting period)	12	–	–	–	12

Notes:
Open files: The eleven open appeals are representative of six complaint matters. Five complaints involve more than one midwife. All appeals are by Complainants.

Respectfully Submitted,

Susan Lewis

REGISTRATION COMMITTEE

Q1 REPORT TO COUNCIL
April 1, 2021 to June 30, 2021

General

Committee Members

Chair	Isabelle Milot, RM
Professional	Karen McKenzie, RM;
Public	Peter Aarssen; Oliver Okafor
Non-Council	Maryam Rahimi-Chatri, RM; Jessican Raison, RM; Jillian Evans; Samantha Heiydt; Nadine Robertson

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Panel Meetings Held*	2	-	-	-	2
Number of Committee Meetings Held*	2	-	-	-	2
Number of Trainings*	0	-	-	-	0

** Of the 4 meetings held to date, 4 occurred by videoconference using Microsoft Teams.*

In Q1, the Registration Committee addressed the following:

APPROVAL OF THE QUALIFYING EXAM

The Registration Committee passed a motion to reinstate the Canadian Midwifery Registration Exam (CMRE) set and administered by the Canadian Midwifery Regulators Council (CMRC) as the qualifying examination for the purpose of s. 8(1)3 of the Registration Regulation made under the *Midwifery Act, 1991*.

NEW ORIENTATION AND ASSESSMENT PROGRAM

The Registration Committee reviewed and discussed the proposed format and structure of the new orientation and assessment program that is being developed by an expert consultant retained by the College for this purpose. In addition, the Registration Committee reviewed and discussed the admission criteria and rationale for enrollment in the new orientation and assessment program. The consultant met with the Registration Committee and answered the Committee's questions. The Registration Committee approved the criteria and agreed to recommend to Council that they approve the implementation of a pilot of the new orientation and assessment program for the

purpose of determining equivalent qualifications under the Registration Regulation, to enable entry to practice for internationally educated midwives.

At its June 2022 meeting, the Council approved the pilot of the new College orientation and assessment program for internationally educated midwives for the purpose of determining qualifications that are equivalent to the degree referred to in the Registration Regulation in accordance with section 8.(1)1.iii of O. Reg. 168/11 under the *Midwifery Act, 1991*.

Committee, panel, membership changes and statistics follow:

Members by Class of Registration	#				%
	Q1 (1088)	Q2 (-)	Q3 (-)	Q4 (-)	Total
General	744	-	-	-	68
General with new registrant conditions	87	-	-	-	8
Supervised practice	9	-	-	-	1
Inactive	248	-	-	-	23
Transitional	0	-	-	-	0

New Members by Class of Registration	#					%
	Q1 (39)	Q2 (-)	Q3 (-)	Q4 (-)	Total (39)	Total
General	2	-	-	-	2	5
General with new registrant conditions	33	-	-	-	33	85
Supervised practice	4	-	-	-	4	10
Inactive	0	-	-	-	0	0
Transitional	0	-	-	-	0	0

	#	%

New Members by Route of Entry	Q1 (39)	Q2 (-)	Q3 (-)	Q4 (-)	Total (39)	Total
Laurentian University graduates	4	-	-	-	4	10
McMaster University graduates	18	-	-	-	18	46
Toronto Metropolitan University graduates	14	-	-	-	14	36
International Midwifery Pre-registration Program (IMPP) graduates	1	-	-	-	1	2.67
Out of province certificate holders (midwife applicants) from other Canadian regulated midwifery jurisdictions	1	-	-	-	1	2.67
Former members	1	-	-	-	1	2.66

Panel Referrals	Q1	Q2	Q3	Q4	Total
Total Number of referrals to a panel of the Registration Committee	3	-	-	-	3

Files Reviewed at Panel by Category	Q1 (3)	Q2 (-)	Q3 (-)	Q4 (-)	Total (3)
Application for registration[1]	0	-	-	-	0
Class change – Inactive to General[2]	3	-	-	-	3
Active practice requirements shortfall[3]	0	-	-	-	0
Re-issuance of a Supervised Practice certificate of registration[4]	0	-	-	-	0
Reinstatement within one year following revocation[5]	0	-	-	-	0
Variation of terms, conditions and limitations[6]	0	-	-	-	0

Panel Outcomes by Category

Panel Outcomes By Application for Registration[1]	Q1 (0)	Q2 (-)	Q3 (-)	Q4 (-)	Total (0)
Application approved – Registrar directed to issue certificate of registration	0	-	-	-	0
Application approved – Registrar directed to issue a certificate of registration if the applicant successfully completes examinations set or approved by the panel	0	-	-	-	0
Application approved - Registrar directed to issue a certificate of registration if the applicant successfully completes additional training specified by the panel	0	-	-	-	0
Application approved – Registrar directed to impose terms, conditions and limitations on certificate	0	-	-	-	0
Application not approved – Registrar directed to refuse to issue certificate	0	-	-	-	0
Panel Outcomes By Class change – Inactive to General[2]	Q1 (2)	Q2 (-)	Q3 (-)	Q4 (-)	Total (2)
Requalification program approved – General certificate to be re-issued	2	-	-	-	2
Requalification program approved – General certificate to be issued with terms, conditions, or limitations	0	-	-	-	0
Requalification program approved with supervision required – Supervised Practice certificate to be issued	0	-	-	-	0
Panel Outcomes By Active Practice Requirements Shortfall[3]	Q1 (0)	Q2 (-)	Q3 (-)	Q4 (-)	Total (0)
Exception granted – extenuating circumstances demonstrated	0	-	-	-	0
Shortfall plan required	0	-	-	-	0
Shortfall plan and undertaking imposing terms, conditions and limitations	0	-	-	-	0

Panel Outcomes By Re-issuance of a Supervised Practice certificate of registration[4]	Q1 (0)	Q2 (-)	Q3 (-)	Q4 (-)	Total (0)
Re-issuance approved – supervised practice extended	0	-	-	-	0
Re-issuance not approved	0	-	-	-	0
Panel Outcomes By Reinstatement within one year following revocation[5]	**Q1 (0)**	**Q2 (-)**	**Q3 (-)**	**Q4 (-)**	**Total (0)**
Requalification program approved – no supervised practice required	0	-	-	-	0
Requalification program approved – supervised practice required	0	-	-	-	0
Panel Outcomes By Variation of terms, conditions and limitations[6]	**Q1 (0)**	**Q2 (-)**	**Q3 (-)**	**Q4 (-)**	**Total (0)**
Application refused	0	-	-	-	0
Registrar directed to remove any term, condition or limitation imposed on the certificate of registration	0	-	-	-	0
Registrar directed to modify terms, conditions or limitations on the certificate of registration	0	-	-	-	0

Timelines: from referral to a panel, to a written decision	Q1 (2)	Q2 (-)	Q3 (-)	Q4 (-)	Total (2)
Files closed within 30 days	0	-	-	-	0
Files closed within 60 days	2	-	-	-	2
Files closed beyond 60 days	0	-	-	-	0
Median: (reported in number of days)	47.5	-	-	-	47.5
Average: (reported in number of days)	47.5	-	-	-	47.5

Registration Decisions appealed to the Health Professions Appeal and Review Board (HPARB)	Q1 (0)	Q2 (-)	Q3 (-)	Q4 (-)
Open HPARB appeals as of quarter end	0	-	-	-

New HPARB appeals	0	-	-	-
Completed HPARB appeals	0	-	-	-
Open HPARB appeals at quarter end	0	-	-	-

Of those appeals completed, the number of registration decision appeals that:	Q1 (n/a)	Q2 (-)	Q3 (-)	Q4 (-)
Confirmed the decision	n/a	-	-	-
Required the College to issue a certificate of registration to the applicant upon successful completion of any examinations or training the Registration Committee may specify	n/a	-	-	-
Required the Committee to issue a certificate of registration to the applicant, with any terms, conditions and limitations the HPARB considers appropriate	n/a	-	-	-
Were referred back for further consideration	n/a	-	-	-

Attrition[7]	#	%
Q1	10	1
Q2	-	-
Q3	-	-
Q4	-	-

Respectfully Submitted,

Isabelle Milot, RM

Notes:

1. *Applications for registration can include first time (initial) applications and applications for re-registration from former members. If the former member resigned within five years prior to the date of re-application, the Registration*

Regulation requires them to complete a requalification program that has been approved by the Registration Committee.

2. *Under the Registration Regulation, members who wish to be re-issued a general certificate of registration and who do not meet one or more of the non-exemptible requirements for a general certificate, with the exception of having to repeat the midwifery education program and the qualifying exam, are required to complete a requalification program that has been approved by a panel of the Registration Committee. Often members will be referred because they do not meet the current clinical experience and active practice requirements for a general certificate.*

3. *It is a condition on every general certificate of registration that the member shall carry on active practice as outlined in the Registration Regulation. Where a member fails to meet these conditions (i.e. has not attended sufficient births in various settings in a specific timeframe), the member is referred to a panel of the Registration Committee to determine if an exception may be granted or if a shortfall plan is required.*

4. *Under the Registration Regulation, a Supervised Practice certificate of registration may only be granted for a period of up to one year. Therefore, if a member has not successfully completed their Plan for Supervised Practice and Evaluation within 12 months of issuance of a supervised practice certificate, the member may request an extension and the certificate may only be re-issued if the Registration Committee approves of it being reissued.*

5. *Where a former member wishes to be reinstated within one year following revocation, under the Registration Regulation, the former member is required to complete a requalification program that has been approved by the Registration Committee.*

6. *Under the Health Professions Procedural Code, Schedule 2 of the Regulated Health Professionals Act, 1991, a member may apply to the Registration Committee for an order directing the Registrar to remove or modify any term, condition or limitation imposed on the member's certificate of registration as a result of a registration proceeding.*

7. *Attrition rate includes the number of midwives who left the profession (e.g. resignation) and former members' certificates that have been suspended/revoked/expired. It does not include inactive members. The rate of attrition is expressed as a percentage.*

QUALITY ASSURANCE COMMITTEE

REPORT TO COUNCIL – Q1
April 1, 2022 to June 30, 2022

Committee Members

Chair: Lilly Martin, RM
Professional: Isabelle Milot, RM
Public: Donald Strickland
Non-Council: Sabrina Blaise, RM; Kristen Wilkinson, RM; Sally Lewis

Activities of the Committee

	Q1
Number of Panel Meetings Held	0
Number of Committee Meetings Held	1
Number of Trainings	0

Committee Meeting – June 3, 2022

Items

Practice Environment Survey

The committee discussed and gave direction to staff regarding options to address results of the Practice Environment survey. This includes the creation of resource toolkit, the development of a guiding document about risk management in the practice environment for practices and the development of additional standards for practice owners that will be included in the Professional Standards for Midwives.

Professional Standards

Second Birth Attendant Standard
The Committee reviewed the Second Birth Attendant Standard post-consultation. Some minor revisions were directed by the committee with the decision to bring to Council for approval with an implementation date of September 1, 2022.

Clinical Supervision Standard
The Committee reviewed the Clinical Supervision Standard post-consultation. Revisions were made by staff to the standard informed by feedback received during the consultation and the title of the standard was changed to Professional Responsibilities When Supervising Students to better reflect the

standard's intent to set out the requirements for midwives who are in a supervisory role during midwifery care. Some minor addition revisions were directed by the committee with the decision to bring to Council for approval with an implementation date of September 1, 2022.

Record Keeping Standard for Midwives
The Committee reviewed the latest revisions to the Record Keeping Standard for Midwives and made the recommendation to submit to Council to approve for a 30-day consultation.

Attachments:

None.

Respectfully Submitted,

Lilly Martin, Chair

DISCIPLINE COMMITTEE

Q1 REPORT TO COUNCIL
April 1, 2021 to June 30, 2021

Committee Members

Chair: Judith Murray
Professional: : Edan Thomas, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM, Karen McKenzie, RM Alexia Singh, RM, Hardeep Fervaha, RM
Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Oliver Okafor
Non-Council: Susan Lewis

Activities of the Committee

	Q1	Q2	Q3	Q4	Total
Number of Prehearing Conferences Held	0	–	–	–	0
Number of Hearing Days	0	–	–	–	0
Number of Meetings	1	–	–	–	1
Number of Trainings	1*	–	–	–	1

*The meeting held on June 21, 2022 consisted of committee training.

Caseload Work

	Q1	Q2	Q3	Q4	Total
Open files (Files carried over from previous report)	1	–	–	–	1
Number of new referrals by the ICRC	0	–	–	–	0
Closed files	1*	–	–	–	1
Open files (Files carried over to next reporting period)	0	–	–	–	0

*A contested hearing was held last fiscal year on January 10, 11, 12 and February 28, 2022. The discipline panel issued their decision on this matter on May 24, 2022.

Types of Hearings	Q1	Q2	Q3	Q4	Total
Number of Uncontested Hearings	0	–	–	–	0
Number of Contested Hearings	0	–	–	–	0

Statistics on Closed Cases

Findings of Professional Misconduct	Q1	Q2	Q3	Q4	Total
Failed to maintain a standard of practice of the profession	0	–	–	–	0
Engaging in conduct relevant to the practice of the profession that would reasonably be regarded by registrants as disgraceful dishonourable, or unprofessional	0	–	–	–	0

Decisions Issued

Midwife "A"
A panel of the Discipline Committee issued their decision on May 24, 2022 and made no findings of professional misconduct against the registrant.
Decision and Reasons

Hearing Data	Q1	Q2	Q3	Q4	Total
Days from date of Notice of Hearing to last hearing date	314	–	–	–	–
Days from last hearing date to release of decision	85				
Total	399				

Respectfully Submitted,
Judith Murray

FITNESS TO PRACTISE COMMITTEE

Q1 REPORT TO COUNCIL
April 1, 2022 to June 30, 2022

Committee Members

Chair: Judith Murray
Professional: : Edan Thomas, RM, Lilly Martin, RM, Claudette Leduc, RM, Isabelle Milot, RM, Karen McKenzie, RM Alexia Singh, RM, Hardeep Fervaha, RM
Public: Judith Murray, Marianna Kaminska, Peter Aarssen, Donald Stickland, Oliver Okafor
Non-Council: Susan Lewis

Activities of the Panel

	Q1	Q2	Q3	Q4	Total
Number of Hearings Held	0	–	–	–	0
Number of Committee Meetings Held	1	–	–	–	1
Number of Trainings	1*	–	–	–	1

*The meeting held on June 21, 2022 consisted of committee training.

Caseload Work of the Panel

	Q1	Q2	Q3	Q4	Total
Referrals from the ICRC	0	–	–	–	0

Respectfully Submitted,

Judith Murray

CLIENT RELATIONS COMMITTEE

Q1 REPORT TO COUNCIL
April 1, 2021 to June 30, 2021

Committee Members

Chair	Pete Aarssen
Professional	Hardeep Fervaha
Public	Oliver Okafor
Non-Council	

Committee Meetings

N/A

Panel Meetings/Hearings

N/A

Trainings

N/A

Items

N/A

Attachments:

N/A

Respectfully Submitted,

Pete Aarssen, Chair

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Alternative Dispute Resolution Process ("ADR")

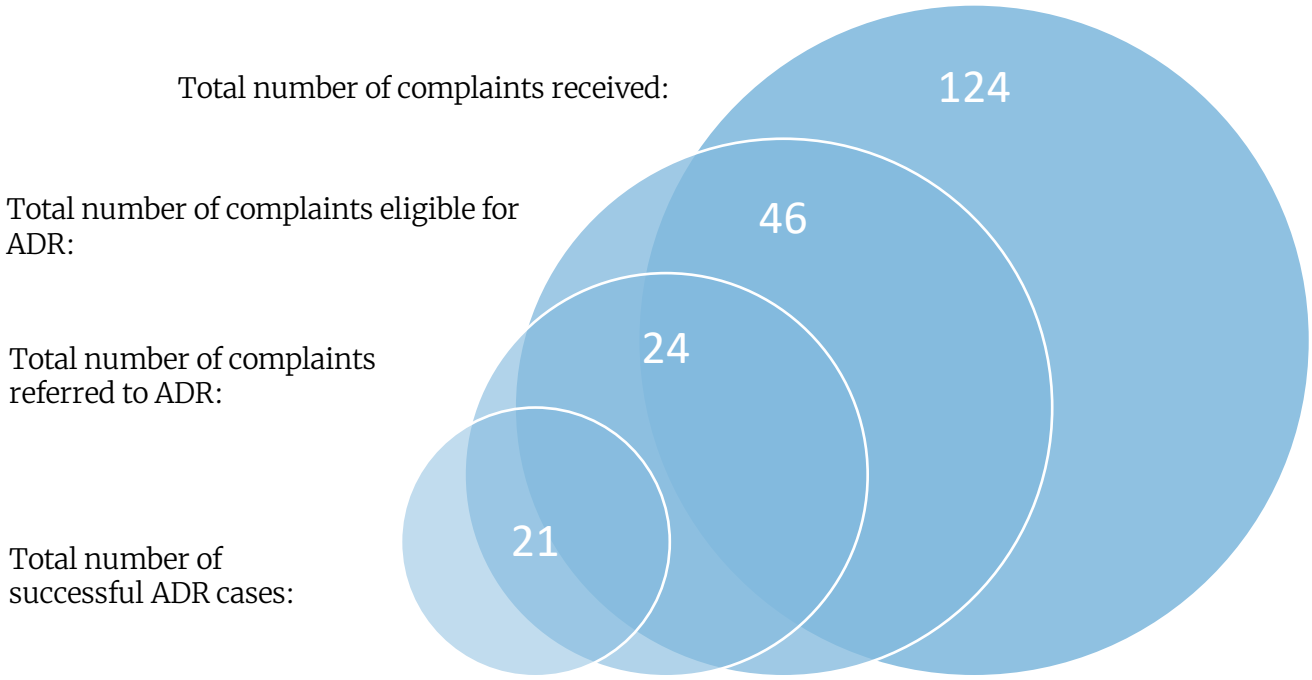
Summary

The ICRC is proposing changes to the way the College has been administering the ADR program.

Background

Effective April 1, 2019, the College implemented its ADR program. In 2022, College staff conducted a review of the program to determine its efficacy and where improvements could be made.

Below is a chart of the data compiled since ADR was implemented:

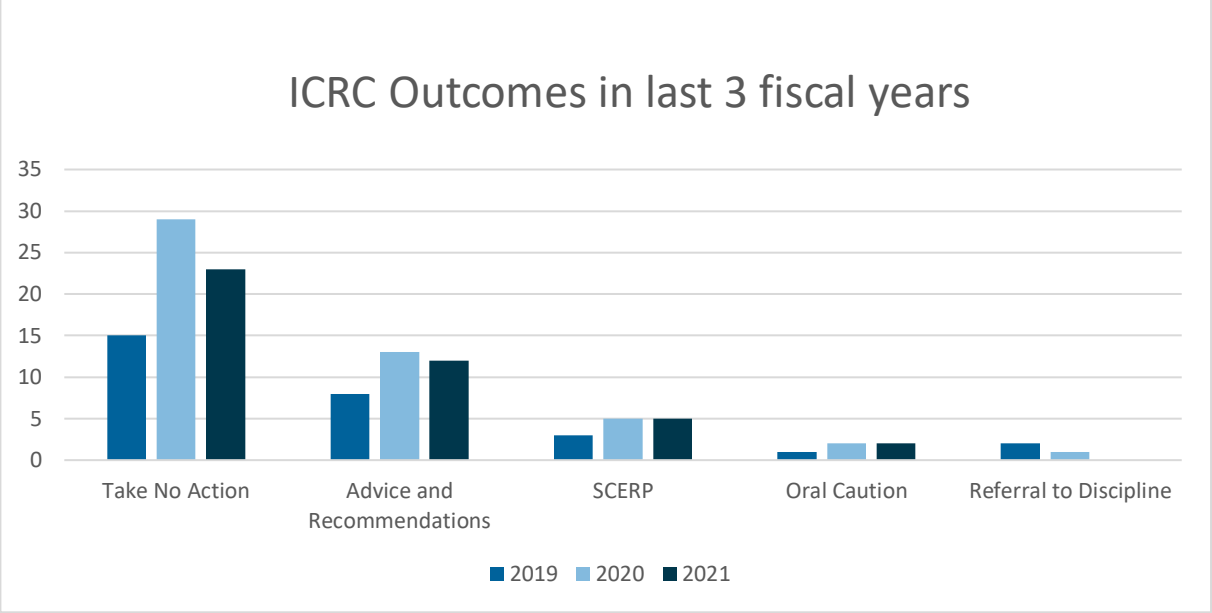


Some of the initial observations made to the ICRC included the following:

- Despite the number of complaints eligible to be processed through ADR, it was noted that midwives usually consented, but complainants did not. Furthermore, the College noted an increase in appeals from complainants of ICRC decisions to HPARB last year, indicating that complainants were not happy with the outcomes at ICRC.
- With the existing eligibility criteria, some complaints that were not identified as medium or high risk complaints were still excluded from ADR (for example, having an

open complaint or investigation or having a prior history in the preceding 3 years for which action was taken automatically deemed a case ineligible).

- The majority of all complaints processed through the ICRC process resulted in a low to medium risk outcome. See chart below:



- Currently, the ICRC considers ADR resolutions as part of a registrant's prior history. However, ADR resolutions do not need to be categorized as prior history since the RHPA states that the ICRC must consider prior decisions regarding the registrant (and through ADR there is no decision made, the complaint is closed on the consent of the parties).
- Currently, information about the ADR process is fragmented between the Guide to ADR and the ADR Eligibility Policy.
- The existing Guide to Filing a Complaint is silent on the ADR process.
- The existing documents require a change from the terminology of "member" to "registrant"

Key Considerations

The below summarizes the main changes brought forward to Council for review and approval:

Streamlining Resources

In 2019, an ADR Eligibility Policy was approved by Council and a Guide to ADR was approved by the ICRC. The College also has a Guide to Complaints whereby the target audience is complainants, and a separate document for midwives entitled the Complaints Process for Midwives.

To streamline and provide complete information to complainants, registrants and the public, the ADR Eligibility Policy was expanded to become the ADR Policy. This ensures

consistent information about the process is provided in one document. Mediators can rely on the new policy to guide their mediation.

Information to supplement the policy is included in guiding documents (and targeted to complainants and midwives as required). The advantage to including information about ADR in the Guide to Filing a Complaint is that it allows complainants to make informed decisions, which is in the public's interest. A section was added to help complainants decide which process is right for them. The Guide to ADR is no longer required as the ADR policy and Guide to Filing a Complaint includes all existing information (and more).

The use of the term "member" has been replaced with "registrant" throughout the documents. Particularly, when dealing with complainants, it is beneficial to avoid any unintended perception that the College represents midwives rather than the public interest. Referring to midwives as registrants helps to avoid a perception of bias.

Expanding ADR Eligibility Criteria

The College conducted an environmental scan to determine what other Colleges are using for criteria (beyond what is required in the RHPA). It was noted that the criteria varied between Colleges.

It was observed that some of our complaints were exempt from the current ADR eligibly in the following circumstances:

- The registrant has a prior discipline history with the College
- The registrant has had a complaint (or complaints) filed with the College in the preceding 3 years regarding their practice for which action was taken but was not referred to the Discipline Committee
- The registrant is currently under investigation for any other issues by the ICRC

The above mentioned criteria meant that, even when a complaint met the other existing eligibility criteria, particularly when the complaint did not involve a practice issue that is considered medium or high risk, and the letter of complaint suggested that ADR may be a better option for the complainant (i.e. when complainants express that they are seeking understanding of an issue and it not apparent that there was a breach of standard or an issue related to communication), many complaints that may have been well-suited for ADR were not referred.

As such, the ICRC determined that the revised eligibility criteria should be as follows:

All the issues of a complaint must meet the criteria for a complaint to be eligible for ADR. ADR will not be used in following circumstances:

1. *If the complaint involves allegations of:*
    - *sexual abuse or incapacity concerns;*
    - *physical, emotional, or financial abuse;*

- *intentional dishonesty or fraud;*
- *intentional acts of harm; or*
- *serious practice or conduct concerns that pose a serious risk of harm to clients*

2. *If the ICRC has:*
    - *referred the matter to the Discipline Committee; or*
    - *released a final decision on the matter*

3. *If due to the circumstances of the complaint or the position of the parties, the Registrar believes that:*
    - *ADR would be ineffective, or*
    - *ADR would not serve the public interest*

The ICRC determined that expanding the criteria for eligibility (or removing some of the barriers) was in the public interest, and that the existing criteria was already embedded in the RHPA (the Code makes it clear that ADR cannot be used if the circumstances of the complaint or the position of the parties leads the Registrar to believe that ADR would not serve the public interest). Additionally, staff always triages complaints at intake to determine risk to public safety. The College is not required to explain to any party why a complaint is not suitable for ADR.

Changing the way Prior History is treated

Currently, the ICRC is provided with, and considers, information related to ADR dispositions as part of prior history. The RHPA states that a panel of the ICRC must consider prior decisions regarding the registrant. Richard Steinecke in the *Complete Guide to the RHPA* states: "The ICRC renders no formal investigation. Rather, the file is closed on the consent of all participants. As a result, the matter does not constitute a "prior history" that must be considered by the ICRC in any future case."

The policy was therefore updated to clarify this:

Resolution agreements are not public and will not be considered as prior history by the ICRC in the assessment of future complaints or reports involving the registrant.

To be clear, the College can consider whether prior history including ADR matters would make it unsuitable for a complaint to be referred to ADR, specifically, under the criteria noted above that it would not serve the public interest.

An additional benefit may be that resolution agreements may be more remedial when there is knowledge that they will not be shared with future panels of the ICRC.

Clarifying that midwives are expected to participate in ADR

We recognize that most midwives obtain legal counsel to assist them with complaints. Language has been included in the policy to set expectations that a midwife will participate in the mediation process but make it clear that they may attend with a representative.

Revisions to the ADR Facilitator Policy

Minor changes were made to this policy, but the changes to make the policy current (and streamline the process where possible) are as follows:

- Recommendations to use the word mediator instead of facilitator so that complainants better understand the process
- No changes recommended to Mediator Qualifications
- Clarify that all efforts are made to achieve resolution within 60 days (not an automatic 120 days).
- Under mediation, recommend that a change be made to set expectations that midwives are expected to attend, but may bring their lawyer with them.

Recommendations

The following recommendations are submitted for consideration:

1. Rescind the current ADR Eligibility Policy and approve the proposed ADR Policy.
2. Approve the revisions to the ADR Facilitator Policy and rename it to the ADR Mediator Policy.

Implementation Date

October 1, 2022. (Given the timing of the Council meeting being near the end of Q2, it allows for consistent tracking by quarter.)

Legislative and Other References

Regulated Health Professions Act, 1991

Attachments

1. PROPOSED ADR Policy (Revised from ADR Eligibility Policy 2022 - FINAL
2. EXISTING ADR Eligibility Policy - 12DEC18
3. EXISTING Guide to ADR - OCT18
4. EXISTING Guide-to-Filing-a-Complaint-March-2020
5. FOR APPROVAL ADR Mediator Policy- Revised 2022
6. EXISTING ADR Facilitator Policy - 22MAY19

Submitted by: ICRC Committee

ALTERNATIVE DISPUTE RESOLUTION POLICY

Purpose

To describe the College's Alternative Dispute Resolution program and outline the criteria that must be met to process a complaint in this manner.

Scope

This policy applies to complaints filed with the College.

Definitions

"Alternative Dispute Resolution (ADR)" [1] – a voluntary process in which an independent mediator assists the complainant and registrant (the parties) in resolving a complaint to create a mutually acceptable resolution.

"Inquiries, Complaints and Reports Committee (ICRC)" – the statutory committee whose mandate is to investigate and render decisions on complaints.

"Mediator" - the person who assists the parties to achieve resolution by acting as the facilitator.

"Registrant" – a midwife registered with the College against whom a complaint is made.

"Resolution Agreement" – a document signed by the registrant and complainant setting out the mutually agreed upon terms as a resolution to the dispute/complaint.

Policy Statement

ADR is an alternative process that allows a registrant and complainant to work together to achieve a resolution that is mutually agreeable. A complaint may be processed by ADR if resolving the issue through ADR is deemed to be in the public interest. In this process, there is no investigation on the facts of the case and the complaint does not proceed via the College's regular ICRC complaints process.

The Program

Once a complaint is deemed suitable for ADR, and both parties agree to participate, the Registrar will formally initiate the process by appointing a mediator. Otherwise, the complaint shall be processed through the regular ICRC complaints process. The registrant and complainant are expected to participate and attend any mediation discussions but either party may bring a representative with them.

The mediator is a neutral third party who is not a member of any College committee or staff and who does not have a conflict of interest with either party. The mediator independently contacts the parties and engages in discussions to achieve resolution. The mediator can propose options or advise when an option may be contrary to the public interest. The mediator will have access to

[1] Section 25.1 of the Code, which is Schedule 2 to the RHPA

clinical or practice advice from the College's practice advisor but details of those communications will remain confidential.

The mediator will only update the College on the status of the process and will not disclose the contents of any discussions to the College. If either party chooses to withdraw from the process, or resolution is not achievable, the mediator will notify the College and return the matter to the College to be processed by the ICRC.

The mediator provides the College with a proposed resolution agreement signed by both parties within 60 days of the referral. If no agreement is reached, the College may agree to extend the ADR process for up to an additional 60 days. If the parties do not achieve resolution within 120 days of the referral of the complaint, the complaint must be processed through the regular ICRC complaints stream.

The Registrar may adopt the proposed resolution or may refer the decision of whether to adopt the proposed resolution to a panel of the ICRC (who may adopt the proposed resolution or continue with its investigation of the complaint) to ensure the agreement is not contrary to the College's public protection mandate. Once the Registrar or ICRC adopts the resolution, the file is closed on the consent of all parties. The complainant cannot file the same complaint again.

If the College becomes aware that a registrant did not comply with any terms of the resolution agreement, the Registrar may take action to address the conduct, which could include commencing an investigation into the concern.[2]

Eligibility

All the issues of a complaint must meet the criteria for a complaint to be eligible for ADR. ADR **will not** be used in following circumstances:

1. If the complaint involves allegations of:
    - sexual abuse[3] or incapacity concerns;
    - physical, emotional, or financial abuse;
    - intentional dishonesty or fraud;
    - intentional acts of harm; or
    - serious practice or conduct concerns that pose a serious risk of harm to clients

2. If the ICRC has:
    - Referred the matter to the Discipline Committee; or
    - Released a final decision on the matter[4]

3. If due to the circumstances of the complaint or the position of the parties, the Registrar believes that:
    - ADR would be ineffective[5] or

[2] An investigation may be commenced pursuant to Section 75(1)(a) of the Code
[3] *Health Professions Procedural Code*, s. 25.1(b).
[4] *Ibid*, s. 25.1(a) and (b).
[5] For example where a complainant may be vulnerable due to age, disability, illness, trauma, emotional state or other personal circumstances.

- ADR would not serve the public interest

Confidentiality

ADR discussions between the parties and with the mediator are confidential and considered "without prejudice." This means that a party cannot use information shared confidentially in the ADR process against the other party in any other forum, including before a College committee. The parties shall not disclose information obtained during the ADR process in any other forum, including to College staff, any ICRC panel, the Health Professions Appeal and Review Board, the Discipline Committee, or in any process of the civil or criminal courts.

The mediator's notes and records, and content of discussions about resolution during the ADR process remain confidential. Details of any communications with the College's Practice Advisor also remain confidential.

Resolution agreements are not public and will not be considered as prior history by the ICRC in the assessment of future complaints or reports involving the registrant.

A copy of the complaint, any documentation related to consent, the resolution agreement, and any information regarding completion of terms in the agreement are kept on file at the College.

References

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, c. 18.

Approved by Council
Approval date December 12, 2018
Implementation Date April 1, 2019
Last reviewed and revised MONTH XX, 2022

ALTERNATIVE DISPUTE RESOLUTION ELIGIBIILITY POLICY

Purpose

The purpose of this policy is to outline the criteria that must be met by a complaint, in order for it to be considered as eligible for ADR.

Scope

This policy applies to complaints filed with the College.

Definitions

ADR – the College's alternative dispute resolution program

Member – a midwife registered with the College

Policy Statement

Upon receipt of a complaint filed with the College or at any point prior to a final decision or referral made by the ICRC, the College will determine if the complaint is eligible for ADR.

ADR cannot be used if:

- The allegations involve sexual abuse[1]
- The allegations concern incapacity
- The complaint has been addressed by the Inquiries, Complaints and Reports Committee ("ICRC") or referred to the Discipline Committee[2]
- The Member has a prior discipline history with the College
- The Member has had a complaint (or complaints) filed with the College in the preceding 3 years regarding their practice for which action was taken but was not referred to the Discipline Committee
- The Member is currently under investigation for any other issues by the ICRC
- The College believes that the public interest requires a formal investigation because the allegations involve:
    - Practice issues that are considered to be medium or high risk to public safety
    - Physical, emotional or financial abuse
    - Intentional dishonesty or fraud
    - High-conflict situations
- Any other circumstance that leads the Registrar to believe that ADR would not be effective or serve the public interest

[1] *Health Professions Procedural Code*, s. 25.1(b).
[2] *Ibid*, s. 25.1(a).

ADR cannot be used to resolve some of the allegations raised in a complaint. If all the allegations in a complaint do not meet the eligibility criteria listed above, the complaint must be addressed by the ICRC.

References

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, c. 18.

Approved by Council
Approval date December 12, 2018
Implementation Date April 1, 2019
Last reviewed and revised

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

Guide on Alternative Dispute Resolution

November 2018

What is Alternative Dispute Resolution?

The *Health Professions Procedural Code* ("HPPC")[1] allows for the use of alternative dispute resolution ("ADR") to address complaints.[2]

ADR is an alternative to the formal complaints process that involves the complainant and member working together with a facilitator to create a resolution to everyone's satisfaction.

ADR provides an opportunity to resolve complaints in a manner that protects the public interest while simultaneously allowing for the complainant and member to actively participate in shaping the resolution.

Which complaints are eligible for ADR?

Many complaints are eligible. However, the HPPC precludes complaints involving alleged sexual abuse or matters that have already been referred to the Discipline Committee.[3]

The College also has an *ADR Eligibility Policy*[4] that further restricts the kinds of matters that can be eligible for ADR.

How will I get the opportunity to participate in ADR?

When the College receives a complaint, College staff will determine its eligibility for ADR according to the *ADR Eligibility Policy*. If the complaint is considered to be eligible, College staff will contact the complainant and member to explore the possibility of using ADR. Both parties must agree to ADR in order for it to be used.

While most complaints are referred to ADR at the beginning of the complaints process, complaints can be dealt with through ADR at any time if they meet the eligibility requirements.

What happens after parties agree to participate in ADR?

A facilitator will meet with the complainant and the member. The facilitator is a neutral person who is not involved with the complaint in any way and is not a College staff member.

Sometimes, an impartial College practice advisor may be involved if information about professional midwifery practice is necessary. This staff person has no involvement with the *Inquiries, Complaints and Reports Committee* ("ICRC").

The facilitator will mediate the discussions in a respectful manner, either with each party separately or with the parties together, depending on the parties' wishes.

Is there a formal investigation?

There is no formal investigation of the facts of the case. The member considers the complainant's perspective and provides an account of their conduct that was considered to be problematic by the complainant. If necessary, the College's practice advisor may provide some information to the facilitator regarding the professional standards of practice to assist the complainant and member in understanding whether the conduct at issue was appropriate.

---

[1] Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18.
[2] *Ibid*, s. 25.1(1).
[3] *Ibid*.
[4] College of Midwives of Ontario ADR Eligibility Policy (December 2018), Available Online at http://www.cmo.on.ca/wp-content/uploads/2019/03/ADR-Eligibility-Policy_12DEC18.pdf .

Do the parties have to pay for ADR?

The College covers the costs of ADR. Any costs that are incurred by the parties outside of the mediation (e.g. meals, travel or accommodate expenses) are carried by the parties.

Where does ADR take place?

ADR typically takes place through telephone (either one-on-one or with both parties by teleconference) and can also occur in-person, if requested by the parties.

What does the resolution look like?

The form of resolution varies according to the circumstances of the case. It can consist of one or more of the following:

- A letter of acknowledgment on part of the member regarding the incident and the impact it has had on the complainant
- An agreement on part of the member to set forth initiatives or changes to improve a particular aspect of care
- An apology by the member
- An agreement by the member to take a remedial or educational course relating to the issue(s) identified in the complaint
- An acknowledgment on part of the complainant that no further action is required, if the complainant learns through the ADR process that the member acted appropriately

Both the complainant and member must sign an agreement outlining the resolution. A copy of the agreement will be provided to both parties. The agreement must be reviewed and ratified by either the Registrar or a panel of the ICRC to ensure the agreement is in accordance with the public interest.[5] A copy of the letter of complaint and any other relevant information will be provided to the Registrar or panel to assist in making the determination.
If a midwife does not comply with any terms of the ratified agreement, this may become grounds for a registrar's investigation under s.75(1)(a) of the HPPC.

It should be noted that once an agreement has been made and ratified by the Registrar or ICRC, it is considered to be a full and final resolution to the matter. Therefore, the complainant cannot file the same complaint again.

Is ADR Confidential?

The HPPC requires that all communications during the ADR process, including the facilitator's notes and records, remain confidential.[6]

Only a copy of the complaint, confidentiality forms, documentation related to consent, the agreement and any information regarding completion of terms in the agreement are kept on file at the College. The agreement is not made public.

The facilitator's notes are not obtained or retained by the College.

Does ADR form part of the member's prior history with the College?

Complaints resolved through ADR are kept on a member's internal record and are considered in the assessment of any future complaints or reports made about the member.

How long does ADR take?

The length of ADR depends on many factors, including the number of issues, the complexity of issues, and the

[5] *Ibid*, s. 25.1(4).

[6] *Ibid*, s. 25.1(2).

availability of all parties. In any event, the HPPC requires that a resolution be reached within 60 days, with a possibility of a time extension to 120 days, if the Registrar or ICRC believes that it is in the public interest to adopt a resolution reached within that time period.

Cases that go through ADR are often completed sooner than those that go through the formal complaints process.

What if ADR is discontinued or is unsuccessful?

ADR may be discontinued or unsuccessful for many reasons, including the following:

- a party can withdraw from the process at any time
- the facilitator or College may end the process in certain circumstances (e.g. if it is evident that either party is abusing the process and/or not acting in good faith)
- the Registrar or ICRC may not ratify the agreement reached

In these cases, the complaint will proceed through the College's formal complaints process.

Any documents created during ADR remain confidential and are not used as part of the formal complaints process. In addition, the facilitator will not be involved in any subsequent investigation.

Who Should I Contact at the College for Information about ADR?

For more information regarding ADR, please contact the Manager of Professional Conduct at 416-640-2252 x. 232.

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

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

Guide to Filing a Complaint

March 2020

conduct@cmo.on.ca
416-450-2252 ext. 224

What is the College of Midwives of Ontario?

The role of the College is to regulate the profession of midwifery in accordance with the *Regulated Health Professions Act*. The primary responsibility of the College is the protection of the public, specifically clients and their infants to whom its members provide care.

The Inquiries, Complaints and Reports Committee (ICRC) investigates and renders decisions on complaints.

Who can make a complaint to the College?

Anyone can make a complaint, including former clients, family members, and other health professionals.

Can I make an anonymous complaint?

Formal complaints cannot be anonymous. If you do not wish to make a formal complaint, you can provide information about your concerns to the College anonymously. In this case, the College will consider the information, and may conduct further investigation, however, you will not be a party to the process or notified of the outcome. If you wish to proceed with a formal complaint, we require your name, and contact details in order to initiate the complaints process.

Will the midwife know I made a complaint?

As a part of the process, the midwife is notified of your complaint within 14 days of receiving your letter of complaint. They will also have an opportunity to provide a written response to the complaint. This response is usually shared with you, and you are provided with an opportunity to provide additional information.

What does the complaints process look like?

The College must receive the complaint in a permanent form, either written or recorded (audio or video). You must include the following information:

- Your full name
- Your mailing and email addresses
- Name(s) of Midwife/Midwives at issue
- Name(s) of Practice(s) at Issue
- Name(s) of Hospital(s) or other health clinics, if applicable
- Date of incident
- An explanation of your concerns
- Other details you wish to include with your complaint

If you need assistance with identifying a midwife, the College can assist. It is helpful for the College if the issues of your complaint are clearly identified.

The College will contact you within two business days of receiving your complaint. Usually College staff will arrange a phone call to explain the complaints process and to confirm the main issues of your complaint.

The College will also mail you a letter that confirms receipt of your complaint (and explains the process) within 14 days.

How is a complaint investigated?

The College will request your midwifery record. The midwife is asked to respond

to your complaint within 30 days (although sometimes extensions are granted).

The ICRC will determine if further investigation is required. This could include obtaining other health records including hospital records, or EMS records, etc. if they are deemed relevant to your complaint. The ICRC may also engage a third-party investigator to conduct an interview with you and/or anyone that they believe can provide further information into the matter. Before the ICRC meets to make a decision on the complaint, the midwife receives a copy of all of the records that have been gathered for the investigation and provided an opportunity to provide a further written submission.
When the investigation is complete, the matter is scheduled to be deliberated by a Panel ICRC. The Panel consists of both members of the College as well as appointed members of the public.

The ICRC Risk Assessment Framework is a tool that aids the Panel in making fair, consistent and transparent decisions, and is posted on the College website.

Will my information be kept confidential?

Health regulatory college investigation procedures are designed to keep information about the complainant confidential. However, it is important to note that your personal information will be released to the midwife that is the subject of the complaint. You should also be aware that if your complaint is appealed to the Board, or if the complaint is referred to the Discipline Committee, the case will be heard in a hearing which is open to the public.

What are the possible outcomes?

The ICRC can decide the following outcomes:

- Take no action as the Panel was of the view that the midwife met the standards of the profession
- Offer advice and recommendations
- Require the midwife to complete a Specified Continuing Education or Remediation Program (SCERP) which can include courses, papers, or chart audits
- Administer an oral caution, where the midwife appears before the panel
- Require the midwife to sign an acknowledgment and undertaking, which is a voluntary agreement between the midwife and the College to place certain restrictions on the member's practise
- Refer specified allegations of professional misconduct and/or incompetence in the complaint to the Discipline Committee
- Refer the matter to the Fitness to Practise Committee, where the matter involves an allegation regarding the physical or mental capacity of the midwife

The Panel has no authority to assess injury or award compensation to the complainant. That is the subject of civil court proceedings.

How long is the process going to take?

The College aims to complete its investigation within 150 days. However, due to the complexity of some cases, and delays in obtaining records, the investigation can take longer. You will receive status updates once the investigation has reached the 150-day and 210-day mark, and then monthly updates after that if still not completed.

How will I find out the outcome?

You and the midwife will both receive a copy of the final decision made by the panel of the ICRC in the mail. The Decision and Reasons document that you receive will advise you of the outcome and explain the reasons why they made the decision that they did.

Are any outcomes public?

A summary of the following dispositions is posted on the College's public register permanently.

- Oral cautions
- All SCERPs
- All Acknowledgments & Undertakings (while in effect only)
- Specified allegations when there is a referral to the Discipline Committee
- Referrals to the Fitness to Practise Committee

No personal client or complainant information is included in this summary.

The purpose of the public register is to provide the public with information about midwives, which may assist them in deciding who to choose for their care.

The public register is found on the College website at this link: https://onlineservice.cmo.on.ca/webs/cmo/register/?t=1.

Can I appeal the decision?

If you are dissatisfied with a decision from the ICRC, an appeal to the Health Professions Appeal and Review Board may be made at:

Health Professions Appeal and Review Board
151 Bloor Street West, 9th Floor Toronto ON M5S 1S4

Tel: 416-327-8512
Toll-Free: 1-866-282-2179
Fax: 416-327-8524
Email: hparb@ontario.ca

Please note, if you decide to make an appeal to the Board, personal health information and other information collected during the health regulatory college's investigation must be disclosed to the board.

If you have any questions regarding your complaint, please contact the Professional Conduct Coordinator at 416.640.2252 ext. 224 or conduct@cmo.on.ca at any time.

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

ALTERNATIVE DISPUTE RESOLUTION MEDIATOR POLICY

Purpose

The purpose of this policy is to describe the qualifications that must be possessed by candidates who wish to serve as alternative dispute resolution ("ADR") mediators, the mediator application process and the responsibilities of mediators once selected.

Scope

This policy applies to all candidates who have applied to become or have been selected to become mediators for complaints being resolved through ADR at the College.

Definitions

Mediator – a neutral, third party that assists in guiding the complainant(s) and registrant of the College to a mutually agreeable and voluntary settlement of a complaint

Policy Statement

Mediator Qualifications

In order to be considered as qualified to become a mediator for a matter that has been referred to ADR, a candidate must:

- Have undertaken at least 40 hours of basic mediation/negotiation training in a course acceptable to the College
- Have completed at least:
    - Two matters utilizing an alternative dispute resolution process as the lead mediator; or
    - Three matters utilizing an alternative dispute resolution process as a co-mediator
- Be in good standing with any regulated profession that they may belong to

Candidates will be selected based on their experience and training in ADR as well as their educational and professional/work backgrounds.

Candidates must exhibit the following characteristics:

- Patience and non-judgment
- Empathy and objectivity
- Trustworthiness
- Strong verbal and active listening skills
- Flexibility and creativity
- Confidence and control of the process
- Ability to recognize and manage power dynamics

Candidate Approval Process

In order to be approved by the College, the candidate must:

- Provide a resume which lists all post-secondary education, as well as any professional degrees, certificates and/or designations
- Provide a copy of any and all supporting documentation, including proof of completion of ADR training and completion of matters using ADR
- A letter of good standing from any professional regulatory body they belong to
- At least two reference letters from relevant sources
- Be interviewed by a College staff member to determine their suitability

Once approved, before engaging the services of the candidate, the mediator must agree to and sign a contractual document that sets out the terms of the agreement.

Selection on a Matter

One the parties agree to ADR, the Registrar will appoint a College approved mediator to facilitate the resolution. If appointed, a mediator must:

- Confirm that they have no conflict of interest in the matter
- Ensure all efforts are made to achieve resolution within 60 days of the referral
- Contact the parties within 5 business days of being appointed
- Abide by relevant College policies and agreements

The Mediation

- The mediator acknowledges that the registrant and complainant are expected to participate and attend any mediation discussions but either party may bring a representative with them.
- The mediator will conduct a mediation in a style acceptable to the parties involved, which may be facilitated by videoconference or telephone meeting
- Efforts should be made to conduct videoconference mediations before in person meetings are considered. However, in the exceptional circumstance where the parties would like to meet in person, the mediator, in consultation with relevant College Staff, will secure an appropriate and private location at a reasonable cost, which will be borne by the College. Any costs for location must be approved by the College first.
- The mediator must ensure that all parties are fully informed about the process
- The mediator must respond to any College requests for updates on the matter and estimated timelines that takes into account the time period within which ADR matters must be resolved, as required by legislation[1]
- The mediator may contact the College's practice advisor, in the event the mediator has any clinical questions relevant to the matter. The mediator can also request that the practice advisor attend the mediation to answer clinical questions.

[1] s. 25.1(6) of the *Health Professions Procedural Code* requires that ADR matters be resolved within 60 days of referral, with the possibility of a time extension to 120 days.

- The mediator must not disclose any content of the ADR discussions with any College staff unless required by law.
- The mediator can cease the ADR process on their own authority or by order of the Registrar, if it is evident that either party is abusing the process and/or not acting in good faith
- The mediator may draft the resolution agreement on a template form provided by the College and must submit a signed resolution agreement to the College with all the required signatures

Compensation

- Mediators will invoice the College according to the terms of their contract. Prior approval for any overage or expenses associated with a matter must be pre-approved by the College to be eligible for payment.

References

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, c.18.

Approved by Executive Committee
Approval date May 22, 2019
Implementation Date May 22, 2019
Last reviewed and revised September 28, 2022

ALTERNATIVE DISPUTE RESOLUTION FACILITATOR POLICY

Purpose

The purpose of this policy is to describe the qualifications that must be possessed by candidates who wish to serve as alternative dispute resolution ("ADR") facilitators, the facilitator application process and the responsibilities of facilitators once selected.

Scope

This policy applies to all candidates who have applied to become or have been selected to become facilitators for complaints being resolved through ADR at the College.

Definitions

Facilitator – a neutral, third party that assists in guiding the complainant(s) and member of the College to a mutually agreeable and voluntary settlement of a complaint

Policy Statement

Facilitator Qualifications

In order to be considered as qualified to become a facilitator for a matter that has been referred to ADR, a candidate must:

- Have undertaken at least 40 hours of basic mediation/negotiation training in a course acceptable to the College
- Have completed at least:
    - Two matters utilizing an alternative dispute resolution process as the lead facilitator; or
    - Three matters utilizing an alternative dispute resolution process as a co-facilitator
- Be in good standing with any regulated profession that they may belong to

Candidates will be selected based on their experience and training in ADR as well as their educational and professional/work backgrounds.

Candidates must exhibit the following characteristics:

- Patience and non-judgment
- Empathy and objectivity
- Trustworthiness
- Strong verbal and active listening skills
- Flexibility and creativity
- Confidence and control of the process
- Ability to recognize and manage power dynamics

Candidate Approval Process

In order to be approved by the College, the candidate must:

- Provide a resume which lists all post-secondary education, as well as any professional degrees, certificates and/or designations
- Provide a copy of any and all supporting documentation, including proof of completion of ADR training and completion of matters using ADR
- A letter of good standing from any professional regulatory body they belong to
- At least two reference letters from relevant sources
- Be interviewed by a College staff member to determine their suitability

Selection on a Matter

If selected, a facilitator must:

- Complete a conflict check before being formally assigned to a matter
- Abide by relevant College policies and agreements
- Make contact with the parties within 7 days of being selected

The Facilitation

- The facilitator may conduct a mediation in person or electronically (e.g. by telephone or videoconference) according to the wishes of the parties involved
- In the event the parties would like to meet in person, the facilitator, in consultation with relevant College Staff, will secure an appropriate and private location at a reasonable cost, which will be borne by the College. Any costs for location must be approved by the College first.
- The facilitator must ensure that all parties are fully informed about the process
- The facilitator must respond to any College requests for updates on the matter and estimated timelines that takes into account the time period within which ADR matters must be resolved, as required by legislation[1]
- The facilitator may contact the College's practice advisor, in the event the facilitator has any clinical questions relevant to the matter. The facilitator can also request that the practice advisor attend the mediation to answer clinical questions.
- The facilitator must not disclose any content of the ADR discussions with any College staff unless required by law.
- The facilitator can cease the ADR process on their own authority or by order of the Registrar, if it is evident that either party is abusing the process and/or not acting in good faith
- The facilitator must draft the resolution agreement on a template form provided by the College and submit it to the College with all the required signatures

Compensation

[1] s. 25.1(6) of the *Health Professions Procedural Code* requires that ADR matters be resolved within 60 days of referral, with the possibility of a time extension to 120 days.

- Facilitators will be provided with compensation at a lump-sum rate by the College, with the possibility of overage with prior written approval from the College.
- Facilitators will be compensated for any travel expenses associated with a matter that have been pre-approved by the College

References

Health Professions Procedural Code, Schedule 2 to the *Regulated Health Professions Act*, S.O. 1991, c.18.

Approved by Executive Committee
Approval date May 22, 2019
Implementation Date May 22, 2019
Last reviewed and revised May 22, 2019

CHAIR REPORT

REPORT TO COUNCIL – September 2022
Prepared by: Claire Ramlogan Salanga RM

1. General Highlights

   The trees are teaching us a lesson as their leaves change colour and fall to the ground, change is good and sometimes we have to let go of precious things to continue our growth. The College continues to work through changes in its organizational structure with an aim to build a modern regulatory body that is efficient and effective. Council will also be experiencing change as we return to an in-person meeting; the first in over two years. The remaining Council and training sessions will remain virtual in order to reduce Council's carbon footprint and continue with social distancing during the winter and early spring seasons. This hybrid format will remain in place for this fiscal year.

2. Governance

   Weekly meetings with the Registrar continue to keep me well-informed of ongoing work at the College. I am happy to report that the Registrar and staff continue to work diligently on strategic priorities.

   Last June, our Council training focused on Discipline and Fitness to Practise Committee Training and a Chairing Panel. We were joined by Luisa Ritacca from Stockwood Barristers who led the Council through a review of the terms of reference for these committees as well as the rules of procedure for conducting Discipline and Fitness to Practise hearings. The second session was moderated by College staff member Zahra Grant who led a conversation with our existing Chairs to discuss their experiences in the role as well as provide tips and insights to members who may be interested in the position.

   Our Council survey was completed after Training and Council days. Overall, Council members enjoyed all sessions, and they reported that all sessions were productive and useful. A few members mentioned their appreciation of the safe environment they feel when attending Council meetings. This curated environment encourages members to express their opinions and contribute to the discussions freely. I am proud of the efforts we have all put forth over the past three years to build this equitable, safe and inclusive Council. Well done everyone.

   Lastly, as I mentioned earlier, change and growth are a good things. However, I am sad to say goodbye to two of our professional Council members, Lilly Martin and Claudette Leduc, as well as public member Pete Aarssen.

   Lilly has been on Council for three terms, which amounts to nine consecutive years. During that time Lilly has been the Chair of the Quality Assurance Committee. She has also served on numerous other committees, including Registration, ICRC, Discipline and Fitness to Practise. Her contributions to the College's Quality Assurance Program have been thoughtful,

constructive and insightful. Council members will miss Lilly's kindness, insightful points of view and commitment to the College's mandate. Thank you for your time and contributions; we wish you the best!

Claudette has come to the end of a three-year term and in that time, she has been a member-at-large of the Executive Committee, and also served on Registration and Discipline and Fitness to Practise Committees. While on the Council, Claudette has voiced her opinions while also making space for others to challenge, agree or disagree. Claudette's inquisitive participation on Council will be missed. Thank you for your time and contributions, Claudette. We look forward to your participation in non-Council committee work.

Pete joined our Council in May of 2020 as a public appointee and brought finance, business, and Board expertise to the College. Pete chaired the Client Relations Committee during this time and sought to expand its role to include public engagement. Thank you, Pete, for your contributions to the College, we wish you well in your retirement!

I would like to welcome two new professional members to Council, Jyothy Nair and Robyn Berman. Jyothy is joining us as midwife practising in Vaughan and Robyn is joining us from Ottawa, where she is Clinical Lead at the Ottawa Birth and Wellness Centre. Welcome to you both, we all look forward to working with you in meeting our mandate and completing our strategic plan.

3. Stakeholder Engagement

1. CMO/AOM Meeting – Aug 18, 2022
2. CMRC AGM & Board Meeting - Sept 12, 2022
3. OMSC – Sept 26, 2022

REGISTRAR-CEO QUARTERLY REPORT

REPORT TO COUNCIL – September 28, 2022
Submitted by: Kelly Dobbin

The Registrar-CEO Quarterly Report assures Council that the College operates effectively and achieves its strategic goals, and that the Registrar performs in accordance with the expected duties outlined in Council's Governance Policies.

The Registrar-CEO is accountable for the College's performance in six main areas:

1. Strategic Leadership and Direction Setting
2. Development and Achievement of Goals
3. Reputation and Relationship Management
4. Financial Accountability and Management
5. People and Organizational Leadership
6. Council Governance and Engagement

1. Strategic Leadership and Direction Setting

Meetings with the Ministry of Health

As reported to you in June 2022, Schedule 6 of Bill 106 *Pandemic and Emergency Preparedness Act, 2022* proposes amendments to the *Regulated Health Professions Act, 1991* to add new requirements to the Health Professions Procedural Code and to add new regulation-making powers. Proposed changes will:

- make Colleges comply with English or French language proficiency requirements that are accepted by Immigration, Refugees and Citizenship Canada (IRCC);
- prohibit Colleges from imposing Canadian experience as a qualification for registration for internationally educated applicants (unless otherwise exempt in regulations);
- make College Councils establish emergency classes of registration, and;
- comply with time limits for certain decisions related to registration of applicants.

The Ministry obtained written feedback from the health regulatory Colleges, and, in addition, we had the opportunity to meet with them separately to discuss the potential unintended consequences that a prohibition on Canadian experience may cause in regard to the assessment of internationally educated midwives (IEMs).

While the Orientation and Assessment program that is being piloted by the College this year does not have a Canadian experience (or clerkship) component, we are aware that an evaluation of the pilot may result in a recommendation to reinstate it. We described the benefits of being able to assess an IEM's competencies through placement in a midwifery practice group setting and discussed the benefits of orienting to the Canadian context in which midwifery is practiced prior to a final assessment of skills, knowledge, and judgment. Furthermore, professional contacts made when practising in the community and hospital settings could lead to improved employment opportunities.

The College has met with the Regulatory Oversight Branch of the Ministry twice since June to further discussions with respect to the proposed changes to the Designated Drugs Regulation and Schedule 2 of the General Regulation under the *Laboratory and Specimen Collection Centre Licensing Act*. Some new challenges have been identified in that the American Hospital Formulary Service (the classification system recommended by the Ministry for midwives to prescribe and administer categories of drugs) is no longer being used by the Health Canada Drug Product Online Database. The Ministry is aware of this problem and is looking into options to address it. The College has also engaged in discussions with the Ontario College of Pharmacists to better understand the potential challenges due to this change.

The College has received an increase in communications from midwives in recent months detailing the challenges that clients face when trying to access laboratory tests that fall under the midwifery scope of practice but that do not appear on the list of the tests that midwives may order. The College has shared these communications with the Ministry to highlight the ongoing frustrations of clients, midwives, and physicians as they try to coordinate access to lab testing that fall within the midwifery scope of practice, such as Non-Invasive Prenatal Testing (NIPT).

2. Development and Achievement of Goals

Office Of the Fairness Commissioner

In April 2021, the Office of the Fairness Commissioner (OFC) launched its new Risk-Informed Compliance Framework (RICF), which came into effect on April 1, 2022. This framework relies both on the regulator's historical performance, and a series of forward-looking risk factors that could impact a regulator's ability to achieve better registration outcomes for applicants.

We are very pleased to report that the College was assessed and placed in a low-risk category for the April 1, 2022 to March 31, 2023 assessment period. As a low-risk regulator, the tools that the OFC may utilize to continue to work with us include annual meetings and sharing of best practices and educational resources. A letter from the OFC outlining the RICF and the analysis used to determine our results is attached.

3. Reputation and Relationship Management

Internationally Educated Midwives

The College continues to develop a new Orientation and Assessment pilot program for internationally educated midwives (IEM) who seek registration in Ontario. As Council is aware, the College previously relied on the International Midwifery Pre-registration Program (IMPP) to provide assessment and bridging for these individuals. When the IMPP suspended its program in August 2021, the College needed to find a way to assess IEM's qualifications to determine equivalency for entry-to-practise in Ontario.

The College has recently partnered with We Know Training (WKT) and is working closely with them to administer the online orientation and assessment components of the program. The content of three modules is currently being shared with WKT, and we expect to launch the program once the online

portal is tested. WKT will also be responsible for delivering the online exams in a secure manner, which involves online proctoring, and is also how the Canadian Midwifery Registration Exam is delivered. The College is communicating and also working on developing further communications to ensure IEMs know what to expect.

Communications with Registrants and the Public

Regular communications with registrants and the public continue to take place via email, social media, and our published newsletter. Our next newsletter will be published in October, following the September Council meeting and will highlight decisions made at the September Council meeting, including the newly elected Executive Committee, and a reminder of the revised standards that came into effect on September 1st. We expect it to be an exciting issue as we also anticipate information sharing new content relevant to College finances, Investigations and Hearings, Registration and the Quality Assurance Committee.

The College conducted one consultation in July and August to seek feedback on proposed changes to the Record Keeping Standard. We received 20 responses to the consultation which will be analyzed and brought forward to the Quality Assurance Committee for consideration.

These communications help us to achieve our strategic priority of building engagement and fostering trust with the public and the profession.

Stakeholder Meetings

Over the summer, the College met with leadership from the Association of Ontario Midwives, the Midwifery Education Programs, and the Ontario Midwifery Strategy Council. Information sharing, maintaining positive relationships, and identification of issues that are of mutual benefit or concern has been the focus of these meetings.

In addition, the College met with the Association of Ontario Doulas, at their request, to discuss concerns regarding "traditional birth attendants", doulas, and former midwives who may be present at births that are not attended by midwives or physicians (typically referred to as "unassisted births" or "free births"). The College is aware of this practice, looks into each report it receives, and will continue to take the necessary steps to address any unauthorized practice of midwifery.

The College continues participate in regular Health Profession Regulators of Ontario (HPRO) and Canadian Midwifery Regulators Council (CMRC) board meetings. In addition, staff and Council Chair actively participate (and in some cases lead) CMRC committees, including the Equity Diversity and Inclusion Committee, the Registration Affairs Committee, the Professional Practice Committee, the Executive Committee, and the Canadian Midwifery Registration Exam Committee. The Registrar also represents the CMRC on the Accreditation Council, the body responsible for the accreditation of Canadian Baccalaureate Midwifery Education Programs.

4. Financial Accountability and Management

Statement of Operations

The Q1 Statement of Operations was approved by the Executive Committee at its last meeting and is presented under the Executive Committee's report to Council for your information.

The College's 2021-2022 Annual Report and approved Financial Statements (approved by Council in June) will be submitted to the Minister of Health, Hon. Sylvia Jones, by September 30th, as per our requirements under s.6 of the *Regulated Health Professions Act*. A copy of the annual report will be provided to Council at the same time.

5. People and Organizational Leadership

Hybrid College Operations

The College is continuing to assess and develop an events-based, hybrid work environment, and is considering how best to move forward regarding the physical operating space. The College continues to work mostly remotely, however, over the summer months and until a plan is solidified, staff have been provided with the flexibility of being able to work from the office. In-person office attendance is not currently required or guaranteed. The College continues to operate efficiently in this hybrid operation which continues to provide services to the public and to registrants and operates without disruption to the College's public protection mandate.

Most meetings continue to be scheduled remotely, however, the College will consider and facilitate in-person appointments and meetings where warranted. Regular mail, registered mail, or non-signature-required parcel envelopes can be delivered to the office through the newly acquired mail slot. Courier packages requiring signatures, cannot be received at the College office unless pre-planned.

Professional Development

A two-day Canadian Network of Agencies for Regulation (CNAR) conference in Charlottetown, PEI has been booked for the Registrar, Council Chair, and for an employee participating in our leadership development program. The opportunity to learn and network in person is most welcome after 2.5 years of online meetings and conferences.

The Registrar and Chair will attend with the Canadian Midwifery Regulators Council (CMRC) which is scheduled to occur in PEI for two days following the conference

Staff Update

The College welcomes Victoria Marshall, Communications and Stakeholder Relations Officer, back from her parental leave. Karen Wilson, who was contracted to assist with the College's communications needs in recent months will complete several ongoing projects which will allow for a smooth transition for Victoria. We thank Karen for her assistance.

6. Council Governance and Engagement

Council Members

We welcome Robyn Berman and Jyothy Nair as newly elected professional members of Council. Council orientations for our two new members are scheduled in September and again through Governance Orientation/Re-orientation Training scheduled for Council and non-Council members on the morning of September 28th[th]. We look forward to working with them.

We thank departing Council members Lilly Martin, Claudette Leduc, and Pete Aarssen for their contributions to the College. We recognize their significant contributions to the College demonstrated by their engagement to Council and various committees over the years. We wish them all the best in their future endeavours.

Executive Elections

Executive officer positions will be elected at the September Council meeting. We thank those who have put their names forward for nomination.

Attachments:

1. *Grey Areas*, Applied Governance, by Natasha Danson, September 2022, No. 270
2. The Office of the Fairness Commissioner, Cumulative Risk Rating for the College of Midwives, 2022.

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

Applied Governance

by Natasha Danson
September 2022 - No. 270

While there is a lot of talk about governance principles and governance reform, there are precious few resources on how governance principles should be applied to a specific regulator. Last spring two experienced regulatory experts, Harry Cayton from the UK and Deanna Williams from Ontario, conducted a review of the governance approach taken at the Ontario College of Social Workers and Social Service Workers. The report includes the application of some recurring governance challenges to the current practices of that particular regulator.

Definition of "Governance"

For a word that is used frequently these days, there is no established definition of "governance". The report offers the following definition of "good governance":

> In this report we consider that good governance is the effective, efficient, transparent and accountable delivery of an organization's objectives thus creating confidence and trust in its members, clients and the public. Good governance is as much about behaviours and their outcomes as structures.

This definition has the advantage of identifying the goals of good governance. However, those with little prior experience with governance discussions may find that definition theoretical.

A more descriptive definition of "governance" that we have used is:

> Governance is an organization's choice as to how it will perform its functions including:
>
> - Setting its missions, goals and strategies
> - Selecting its Board, committee and staff members
> - Ensuring compliance with fiduciary duties and
> - Assigning and enforcing roles within the organization.

That definition, however, does not distinguish between good and bad governance choices.

Election of Professional Board Members

Not surprisingly in light of broader discussions in the regulatory space, the report questions the election of registrants to the Board. However, specific observations were made in addition to the usual arguments about ensuring that Board members have demonstrated the necessary competencies and skills. The report notes that the electoral system is also a major barrier to turnover of registrant Directors. Eleven of the 14 registrant Directors were in a second or later term of office and had served 101 years amongst them.

The report further argued that the election method of selection actually prevents diversity:

> Elected boards are only representative of those who are willing to stand and those who vote for them. They are often likely to be drawn from a narrow socio-economic group and from older members of a profession.

Perhaps even more blunt is the following comment:

> Arguing that elections create diversity, while allowing individuals to be re-elected multiple times, is merely one way of maintaining the influence of those already in position.

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

The report says that the selection process should emphasize obtaining credible candidates rather than candidates that represent the profession.

The report also thought it remarkable that "not one of the current public appointees identified themselves as service users."

Executive Committee

While noting that the use of an Executive Committee was required by the legislation, the report questions its utility. The report suggested that the role of the Executive Committee, beyond making urgent decisions between Board meetings, was unclear; according to the report, the Executive Committee tended to duplicate the work of other committees and of the Board. The report recommended limiting the Executive Committee's role to addressing Board matters if they could not wait until the next Board meeting.

Governance Policies and Procedures

Many regulators are criticized for having inadequate policies and procedures. However, in this case, the report observed that this College had more than 270 pages of governance polices contained in 31 separate documents. Board members indicated that they were unfamiliar with them and that they had to rely on staff to identify them.

The report recommended that a unified policy would "provide a framework within which decisions can be made in line with its statutory responsibilities and in the interests of clients and the public."

The report de-emphasized the significance of rules of order used by Boards, suggesting that a team approach to the conduct of Board meetings was more critical.

Risk Management

The report commended the corporate risk management approach of the College, including the existence of a risk register, and commended that risk management was a significant part of the work of a number of the regulator's committees.

However, the report observed that risk of harm to the public, including clients of registrants, was not as prominent. A number of the recommendations and suggestions related to incorporating risk-based regulation as a major focus of the organization, including the Board.

Roles

There are many descriptions of the roles of various entities within an organization, particularly that of the Board and staff. Perhaps one of the oldest metaphors is that the Board steers and staff row. The report has a helpful description: the Board provides strategy and oversight; staff offer delivery and management. The report indicates that this distinction is also essential for the Board Chair and CEO relationship to succeed. The report suggests that the title "Chair" was more descriptive of the office's role than that of "President".

The report was not supportive of anonymized feedback surveys. Rather, Board members:

> should review their own practice annually in an identifiable and accountable survey and should discuss the results together and be prepared individually to be responsible for what they have said and for what improvements should be made. Anonymity is not transparency.

The report emphasized the need for the Chair to focus on facilitating Board meetings and providing

leadership to the Board. The Chair should not make decisions on their own.

In terms of the CEO, the report challenged the view of some Board members that the CEO was there to "do their bidding". The report indicated that Board members should respect the CEO's ability to decline to respond to inappropriate requests for information.

Code of Conduct

The report only briefly touched on the fiduciary duties of Board members. It commented that, while rules were necessary, personal values and behaviour are more important. Board members, particularly the Chair, need to "politely challenge colleagues who behave inappropriately". The report described an incident of disrespect demonstrated during an observed Board meeting that ought to have been addressed immediately.

The report concluded with:

> Our final recommendation is the simplest of all: treat each other with respect and courtesy and put common sense and the benefit of service users and the public at the centre of your decision-making.

The report can be found at: https://www.ocswssw.org/wp-content/uploads/OCSWSSW-governance-report.pdf.

FAIRNESS COMMISSIONER
COMMISSAIRE À L'ÉQUITÉ

OFFICE OF THE FAIRNESS COMMISSIONER
Suite 300, 180 Dundas St W., Toronto ON M7A 2S6

Dear Regulator:

Re: Cumulative Risk Rating for the College of Midwives of Ontario

As you are aware, in April 2021, the Office of the Fairness Commissioner (OFC) launched its new Risk-Informed Compliance Framework (RICF), which fully comes into effect on April 1, 2022. This framework will rely both on the regulator's historical performance, and a series of forward-looking risk factors that could impact a regulator's ability to achieve better registration outcomes for applicants.

Our office has chosen to implement this initiative in a staged fashion, to include a 12-month transition period to allow regulators to migrate to the new system and to comply with any outstanding OFC recommendations. During this transition period, which began on April 1, 2021, OFC compliance analysts reviewed each regulator's historical performance, the steps taken to implement any outstanding recommendations, and how the regulator has addressed each of our office's forward-looking risk factors. Our office gathered the necessary information through virtual meetings and the administration of a risk-assessment questionnaire.

As the compliance analyst responsible for the College of Midwives of Ontario (College), I then initiated an analysis of both the College's performance, and impact of the forward-looking risk factors, to identify an appropriate cumulative risk rating for the College. In undertaking this work, I also consulted with the Fairness Commissioner and OFC management.

As you, know the OFC has established three cumulative risk categories, which have been categorized as low-risk, moderately low-risk and moderate to high-risk. Following a review of the relevant considerations, which I will outline more fully below, I have determined that the College should be placed in the low-risk category for the April 1, 2022 to March 31, 2023 assessment period. My analysis follows.

Historical Compliance

I will start with my assessment of the College's historical performance. The RICF outlines five indicators that our office takes into account to assess the historical performance of a regulator. These are:

- The nature and extent of material compliance recommendations that the OFC has issued to the regulator in the last compliance cycle.

- The extent to which the regulator has complied with these recommendations and avoided new issues.

- The regulator's observed motivation to work with the OFC on defined compliance objectives.

- The content of decisions issued by the courts or tribunals that discuss the regulator's registration practices.

- The degree to which the regulator's registration processes exhibit the attributes of transparency objectivity, impartiality and fairness, as demonstrated, for example, by the number of OFC recognized "commendable practices" and/or other best practices and innovations that the regulator has instituted over time.

Under this scheme, a regulator can be placed into one of three *compliance* categories: full compliance with the objectives of the legislation, substantial compliance with the objectives of the legislation and performance that falls short of compliance with the objectives of the legislation.

In undertaking this analysis, I would note that the OFC did not issue any compliance recommendations to the College during the last assessment cycle, which took place in 2020 nor has the office written any since that date. Hence, the College is not subject to any outstanding recommendations at this time.

I would also note that the College has shown a willingness to work constructively with our office on defined compliance objectives and has taken a number of innovative steps to enhance the transparency objectivity, impartiality, and fairness of its processes.

Based on my assessment of these considerations, I would place the College in the category of full compliance.

Forward-looking Risk Factors

The OFC has also identified five forward-looking risk factors to help determine a regulator's risk profile. These risk factors identify the existing and potential risks posed to fair registration access for Canadians and internationally trained individuals. The considerations involve:

- Organizational capacity.

- The overall control that a regulator exerts over its assessment and registration processes.

- The regulator's response to emergency situations, such as the Covid-19 pandemic.
- An over-reliance on Canadian experience requirements.
- Public policy considerations.

Once these factors are considered, the OFC will then perform a traditional risk assessment that considers both the probability that a risk will occur and the significance of the consequences.

The final step in the risk assessment process is to determine a cumulative risk category for the regulator. The policy indicates that OFC will do so by aggregating the derived risk profile of a regulator with its historical performance assessment.

I have undertaken this analysis and have concluded that low risk profile best portrays the College's situation for the next 12-months.

As a low-risk regulator, the tools that the OFC may utilize to continue to work with you include annual meetings and sharing of best practices and educational resources.

I want to thank you again for your patience as the OFC transitioned to our new framework and look forward to continuing to support your organization.

Regards,

Maram Khalif, Compliance Analyst at the Office of the Fairness Commissioner

c.c.: Irwin Glasberg, Commissioner
c.c.: Hilary Forgie-Resnick, Director
c.c.: Stephanie Mah, Business and Operation Manager

EXECUTIVE COMMITTEE

REPORT TO COUNCIL September 2022

Committee Members

Chair	Claire Ramlogan-Salanga, RM
Professional	Edan Thomas, RM (VC); Claudette Leduc
Public	Don Strickland (VC); Marianna Kaminska

Committee Meetings

September 7, 2022 | Videoconference

Items

Q1 Statement of Operations

The committee reviewed and approved the Q1 Statement of Operations. Revenue is tracking in line with projections and the College is in good cash flow position with no concerns financially. The statement is attached for reference.

Assessment of the Auditor

The committee completed their report for the Annual Assessment of the External Auditor. A summary of the report is attached for approval. The committee is recommending that Council reappoint Hilborn, LLP as the external financial auditor of the College for 2022 fiscal.

Interim Committee Appointments

The committee did a review of committee composition in consideration there will be a few vacancies open with public Council appointee, Pete Aarssen resigning from the Council and two professional members, Lilly Martin and Claudette Leduc whose terms will end upon the approval of the 2022-2023 slate of Council members. Both Lilly and Claudette have submitted applications to serve as non-Council members and the committee is recommending that they be appointed as non-Council members until December 2022. Pete currently sits on the Registration and the Client Relations Committees, where he also serves as Chair, leaving vacancies in those positions as well.

That Executive committee recommends that the following interim appointment be approved until annual committee term appointments and composition resets at the December Council meeting:

Claudette Leduc be appointed to ICRC as a professional non-Council member.

That Lilly Martin be appointed to ICRC and QAC as a professional non-Council member and remain Chair of QAC.

That Jacqueline Morrison be appointed to Registration and Client Relations Committees.

That Oliver Okafor be appointed as interim Chair of the Client Relations Committee.

The proposed composition is attached.

2024 Meeting Dates
The committee approved 2024 meeting dates for Executive Committee and Council. The approved dates are attached.

The following motions are being brought forward for approval:

I. That the Executive report be approved as presented
II. That the annual assessment of the auditor summary report be accepted as presented and that Hilborn, LLP be appointed as the auditor for the 2022-2023 fiscal year.
III. That the proposed interim committee composition be approved as presented.

Attachments:

1. Q1 Statement of Operations
2. Assessment of External Auditor Report summary
3. Proposed Interim Committee Composition
4. 2024 Executive Committee & Council dates

Respectfully Submitted,

Claire Ramlogan-Salanga

The College of Midwives of Ontario

Q1 Statement of Operations (Fiscal April 1, 2022 - March 31, 2023)

April 1, 2022 - March 31 2023

	F23 Projected Revenue	F23 Projected Revenue to end of Q1	Q1 Revenue F23	Q1 Revenue F22	Percentage Variance Against Budget
REVENUE					
Membership Fees	$ 2,632,432	$ 658,108	$ 651,194	$ 612,855	25%
Administration & Other	$ 78,973	$ 19,743	$ 25,961	$ 13,409	33%
Project Funding - Birth Centres	$ 64,347	$ 16,087	$ 16,146	$ 15,910	25%
TOTAL REVENUE	**$ 2,775,752**	**$ 693,938**	**$ 693,301**	**$ 642,173**	**25%**

	F23 Budget Expenses	F23 Budget to end of Q1	Q1 Spending F23	Q1 Spending F22	Percentage Variance Against Budget
EXPENSES					
Salaries & Benefits	$ 1,631,035	$ 407,759	$ 293,106	$ 337,082	18%
Professional Fees	$ 259,347	$ 64,837	$ 27,323	$ 12,097	11%
Council and Committee	$ 148,208	$ 37,052	$ 28,766	$ 31,525	19%
Office & General	$ 141,097	$ 35,274	$ 11,238	$ 17,397	8%
Information Technology, Security & Data	$ 159,323	$ 39,831	$ 29,594	$ 22,985	19%
Rent & Utilities	$ 202,602	$ 50,651	$ 46,990	$ 46,887	23%
Conferences, Meeting Attendance & Membership Fees	$ 83,400	$ 20,850	$ 63,310	$ 54,605	76%
Panel & Programs	$ 283,040	$ 70,760	$ 2,450	$ 4,352	1%
Birth Centre Assessment & Support	$ 64,347	$ 16,087	$ 16,600	$ 15,071	26%
Capital Expenditures	$ 44,344	$ 11,086	$ 10,766	$ 10,875	24%
TOTAL EXPENDITURES	**$ 3,016,743**	**$ 754,186**	**$ 530,142**	**$ 552,876**	**18%**
PROJECTED GAIN / (LOSS)	**$ (240,991)**	**$ (60,248)**	**$ 163,159**	**$ 89,297**	

ADDITIONAL NOTES

1 An accrual was set aside at the end of the previous fiscal to bring outstanding Professional Conduct matters to their conclusion. Tracking of the spending in this area against the accrual recorded is as follows:

Total Accrual	$ 109,513
Accrual Budget to end of Q1	$ 27,378
Accrual Spending to end of Q1	$ 38,197

ANNUAL ASSESSMENT REPORT TO COUNCIL

Reporting year:	April 1 2021 – March 31 2022
Summary observations:	Overall, the Executive committee felt well informed by Hilborn during all stages of the audit process. This was the third year in which the audit was virtual. EC members remained engaged in the online audit process, if not more so than in the traditional in-person format. The ability to share screens and view the audit platform more easily has improved the EC's understanding of the process. Areas where there were questions, Hilborn's staff provided rational for their approaches and decision-making process. Council and the EC were able to meet with both Blair (manager) and Geoff (lead auditor) to ask questions and ensure that a quality audit had occurred. Auditing processes were fully explained, and questions were candidly answered. The auditor again appears to have had a very professional and positive working relationship with the new Director of Operations. Both the Engagement letter and the Final Opinion letter gave a detailed explanation of the audit process, with the rendering of a clean Opinion on the financial statements of the College. Executive is confident the External Audit Tool remains useful and have no suggestions for improvement currently. We look forward to working with Hilborn again next year and recommend an annual assessment for fiscal 2022.
Recommendations made to the auditor:	None currently.

Recommended audit structure for the following year (FOR APPROVAL BY COUNCIL):	☐ Comprehensive Assessment X Annual Assessment
Any recommended changes to the assessment process for future:	None

Proposed Interim Committee Composition September 2022

Slate of Council Members	ICRC	QAC	Discipline/FTP	Registration	Client Relations
Elected/Appointed					
Council Members **Professional Members** 1. Claire Ramlogan-Salanga 2. Edan Thomas 3. Isabelle Milot 4. Karen McKenzie 5. Alexia Singh 6. Hardeep Fervaha 7. Robyn Berman 8. Jyothy Nair **Public Members** 9. Marianna Kaminska 10. Judith Murray 11. Donald Strickland 12. Oliver Okafor 13. Jacqueline Morrison 14. Vacant 15. Vacant **Non-Council Members** **Professional** 1. Christi Johnston, RM 2. Maryam Rahimi-Chatri 3. Sabrina Blaise 4. Sarah Kirkland 5. Kristen Wilkenson 6. Jessica Raison 7. Maureen Silverman 8. Emily Gaudreau 9. Claudette Leduc 10. Lilly Martin **Public** 1. Samantha Heiydt 2. Jill Evans 3. Sally Lewis 4. Nadine Robertson	**Chair:** Sally (NC) Edan Judith Marianna **Non- Council** Christi Sarah Emily Maureen Lilly Claudette Samantha Jill	**Chair:** Lilly (NC) Isabelle Alexia Don **Non- Council** Sabrina Kristen Sally	**Chair:** **Judith** Edan Karen Isabelle Alexia Hardeep Marianna Don Oliver **Non-Council** Sally	**Chair:** Isabelle Karen Oliver Jacqueline **Non-Council** Maryam Jessica Samantha Jill Nadine	**Chair:** Oliver Hardeep Jacqueline

Approved 2024 Executive Committee and Council Dates

Executive Committee Dates

February 28, 2024
May 15, 2024
September 11, 2024
November 13, 2024

Council Dates

March 26-27, 2024
June 25-26, 2024
October 1-2, 2024
December 10-11, 2024

IN CAMERA

The IN CAMERA session of the of Council meeting excludes the attendance of public observers pursuant to the Health Professions Procedural Code of the Regulated Health Professions Act, 1991, section 7(2)(b).

FOR APPROVAL

BRIEFING NOTE FOR COUNCIL

Subject: Facility Standards & Clinical Practice Parameters

Background

The Facility Standards & Clinical Practice Parameters for Midwife-Led Birth Centres sets out the minimum standards for all midwife-led birth centres and serves as the basis for College assessments conducted on behalf of the Ministry of Health.

In 2020 and 2021, assessments of the Ottawa Birth and Wellness Centre and the Toronto Birth Centre were conducted. Some of the feedback of the assessments from the assessors was to consider aligning the eligibility criteria for the Quality Advisor with the eligibility criteria for Council members in the General Bylaws.

Key Considerations

In the College Bylaws, where it lists the eligibility criteria for Council members, it includes a condition which disqualifies members from taking on these roles if a Specified Continuing Education Remedial Program (SCERP) or caution was issued to the member in the preceding three years. The rationale for including this criterion in the College bylaws was related to reputation management of the College Council as the order of a SCERP or caution by the ICRC was considered serious. The current criteria for the Quality Advisor of birth centres does not account for the three-year window, with disqualification applicable if the issuance occurred at any point in time in the registrant's history.

Understanding that the order of SCERPS and/or cautions are meant as a remedial, non- punitive order, the criteria for the Quality Advisor is proposed to be revised to align with all similar criteria for that of a Council member.

The tracked changes (section 4.1.1 on page 10 only) are attached.

Recommendations

The following motion is being brought forward for approval:

That the revisions to the Facility Standards & Clinical Practice Parameters be approved as presented.

Legislative and Other References

N/A

Attachments

1. Revised Facility Standards & Clinical Practice Guidelines
2. Excerpt of General Bylaw Section 5.08 Eligibility for Election

Submitted by:

Zahra Grant, Council Coordinator

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

Facility Standards & Clinical Practice Parameters for Midwife-Led Birth Centres

Effective January 1, 2019

Table of Contents

Preface

The core services provided in a birth centre are midwife-led and consistent with the *Midwifery Act, 1991,* the Regulations made under the *Act*, and Ontario midwifery standards of practice. The licensed facility in which core services are provided is consistent with the *Independent Health Facilities Act* and the Regulations made under the *Act*.

The Facility Standards & Clinical Practice Parameters for Midwife-Led Birth Centres set minimum standards for all midwife-led birth centres and serves as the basis for College assessments conducted on behalf of the Ministry of Health and Long-Term Care.

The Facility Standards and Clinical Practice Parameters for Midwife-Led Birth Centres do not replace clinical judgment. Rather, the minimum standards are intended to enable appointed health care providers (HCP) and staff to provide safe, quality care within the licensed facility. All appointed HCPs working in a midwife-led birth centre will follow the approved protocols, policies and procedures.

The Facility Standards and Clinical Practice Parameters for Midwife-Led Birth Centres are subject to periodic review. Amendments in the form of replacement pages may be issued from time to time. Such pages will be posted to the College's website. The College will perform a comprehensive review, in consultation with the Ministry and all licensed midwife-led birth centres, every 5 years.

Volume 1:
Facility Standards

1 Organization and Administration

1.1 Governance

1.1.1 General

The Midwife-Led Birth Centre (MLBC) is a not-for-profit corporation with a governing Board of Directors (Board) and is separate from other health, hospital, or medical services.

The MLBC Board meets the following governance requirements:

a) the Board reviews and approves the vision, mission and values of the organization with input from staff and key stakeholders;
b) the Board reviews the vision, mission and values occurs at least every five years, or earlier if there is a significant change in the environment, scope of services or mandate of the organization;
c) the Board has a written code of conduct and/or policies that addresses confidentiality, diversity and inclusion, anti- discrimination, ethical conduct, and conflict of interest;
d) the Board has written policies and procedures that outline the Board's role, responsibilities and structure;
e) governance policies and procedures are reviewed and approved by the Board at minimum every five years and updated as needed;
f) the Board develops and approves the organization's strategic goals or ends and reviews them annually;
g) the strategic plan outlines multi-year strategic directions and goals or ends;
h) the executive director's role and responsibilities are detailed in writing;
i) the Board uses an objective and transparent recruitment and hiring process for senior management positions;
j) a contingency plan for temporary absences of the executive director is in writing;
k) the Board reviews, at least annually, the organization's progress in achieving operational objectives; and
l) minutes of the Board's meeting are documented in accordance with legal requirements.

1.1.2 Accountability

The MLBC Board has a formal accountability relationship with the Ministry of Health and Long- Term Care pursuant to the Terms of Funding. In turn, the MLBC Executive Director is accountable to the MLBC Board.

1.2 Administration

The MLBC adheres to the following minimum administrative standards:

a) there is a written organizational structure;
b) there is a human resources management plan in place;
c) there is evidence of adherence to generally accepted accounting principles, in the form of an auditor's opinion contained within the organization's financial statements and/or organizational response to a management letter;

d) there are written agreements for contracted and/or purchased services obtained from individuals or other facilities; and
e) there is a process for informing the community of the services provided in the MLBC.

1.3 Client Services

1.3.1 General

Core services are consistent with the *Midwifery Act, 1991*, the Regulations made under the *Act*, and Ontario midwifery standards of practice. All health care providers (HCPs) delivering core services within the MLBC are subject to the regulation of their respective authority for the care they provide to their clients. However, all HCPs providing care at a MLBC are also required to follow the approved protocols, policies and procedures of the MLBC.

1.3.2 Language

An effective plan is in place to provide services in both official languages, in accordance with the *French Language Services Act,* in those areas designated as being bilingual and for those public service agencies designated under the Act. This includes all written information and signs.

1.3.3 Accessibility

The MLBC operates in accordance with the requirements of the *Accessibility for Ontarians with Disability Act.* An effective plan is in place to provide translation services and sign language interpretation. Information is made available in plain language, both in print and online.

1.3.4 Orientation

The MLBC provides opportunity for orientation to the facility and services for all clients. The orientation information may be accessed in-person or through written material and examples of items to include are:

a) eligibility for admission;
b) services offered;
c) services not available;
d) geographic location.

1.3.5 Core Services

Core services include the provision of care to clients during labour and the immediate postpartum period and to their newborn babies. Core services are the birth services covered within the funding agreement between the Ministry of Health and Long-Term Care (MOHLTC) and the MLBC.

The following are examples of interventions and services that are not available at a MLBC:

a) pharmaceutical augmentation or induction of labour;
b) epidural, regional and/or general anesthesia;
c) forceps or vacuum extractions;
d) caesarean section; and
e) narcotic analgesia.

2 Staffing a Birth Centre

2.1 General

The MLBC complies with all relevant workplace health and safety and employment standards and laws, including but not limited to:

a) Ministry of Labour's *Employment Standards Act*;
b) Ministry of Labour's *Occupational Health and Safety Act*;
c) Integrated Accessibility Standards under the *Accessibility for Ontarians with Disabilities Act 2005*.

2.2 Executive Director and Staff

The Executive Director ensures access to core services 24 hours a day, 7 days a week, and 365 days a year.

There is staff to:

a) deliver safe care to clients;
b) provide security and safety for clients, visitors, HCPs and staff;
c) administer operations;
d) clean and maintain the facility;
e) provide orientation and continuing education for staff and HCPs; and
f) allow for one staff member or HCP who is certified in Basic Cardiac Life Support (BCLS) to be on site when any client or visitor accessing core services are present.

2.3 Staff Orientation, Continuing Education and Evaluation

There is an orientation process for new staff and HCPs that provides the training appropriate to the position and allows staff and HCPs to be able to:

a) deliver safe care to clients;
b) provide security and safety for clients, visitors, HCPs and staff; and
c) maintain a safe and clean facility.

There is a continuing education program for all staff and HCPs to improve skills necessary to provide safe services within the facility.

All staff and HCPs directly involved in core services should be certified in BCLS.

All staff receives evaluation of their performance at least annually.

3. Health Care Providers

3.1 Qualifications of health care providers delivering core services

There is an effective process in place to ensure all HCPs are qualified to provide core services on their own authority. At a minimum:

a) midwives providing core services are to be registered with the College of Midwives of Ontario and eligible to provide core services;
b) Aboriginal Midwives working under the exemption referenced in s. 8 of *the Midwifery Act, 1991* and s. 35 of the *Regulated Health Professions Act,1991* meet the requirements set out by their community authority;
c) physicians providing core services are to be registered with the College of Physicians and Surgeons of Ontario and are eligible to provide core services;
d) HCPs maintain and provide evidence acceptable to the Board of the knowledge and skills required to provide core services; and
e) HCPs have professional liability insurance coverage to a level acceptable to the Board.

3.2 Credentialing and Maintenance of Appointment

3.2.1 Credentialing

The MLBC Board of Directors credentials and appoints all HCPs delivering core services on their own authority.

Where the HCP is a member of a regulatory college under the *Regulated Health Professions Act, 1991,* the process includes:

a) obtaining relevant information, including registration and professional conduct information, from the appropriate health regulatory college(s) for initial and re- appointments;
b) requiring each HCP to consent to the release of professional conduct information to the MLBC in the form of a Letter of Professional Conduct or equivalent; and
c) monitoring and reporting restriction, suspension and revocation of appointments in accordance with the Schedule 2 of the *Regulated Health Professions Act, 1991* (Health Professions Procedural Code) mandatory reporting requirements.

Where the HCP is an Aboriginal Midwife, this process includes:

d) obtaining relevant information, including confirmation of current endorsement, from the community authority or council for initial or re-appointments;
e) requiring each Aboriginal Midwife to consent to the release of relevant information from the community authority to the MLBC in the form of a Letter(s) of Professional Conduct or equivalent; and
f) monitoring and reporting restriction, suspension and revocation of appointment in accordance with the community authority's usual practice.

3.2.2 Maintenance of Appointment

A review of the credentials of all appointed HCPs providing core services is conducted at least annually and will include a check that:

a) midwives providing core services are registered with the College of Midwives of Ontario and eligible to provide core services;

b) Aboriginal Midwives working under the exemption referenced in the *Midwifery Act, 1991* and s. 35 of the *Regulated Health Professions Act,1991*, meet the requirements set out by their community authority;
c) physicians providing core services are registered with the College of Physicians and Surgeons of Ontario and are eligible to provide core services;
d) HCPs have professional liability insurance coverage to a level acceptable to the Board; and
e) HCPs have met the Board's facility-based continuing education and training requirements for HCPs providing core services at the MLBC.

4 Quality Management

4.1 Quality Advisor

4.1.1 General

The Quality Advisor acts in accordance with O. Regulation 57/92, s.1 under the *Independent Health Facilities Act* (IHFA). The Quality Advisor or their designate is a midwife, registered with the College of Midwives of Ontario, and:

a) holds the appropriate certificate of registration;
b) is not in default of payment of any fees prescribed by College bylaw;
c) is not the subject of any disciplinary or incapacity proceeding, in any jurisdiction;
d) has not been the subject of any professional misconduct, incompetence or incapacity finding, in any jurisdiction;
e) has not had a certificate of registration revoked or suspended, in any jurisdiction, for any reason other than non-payment of fees;
f) does not have a notation on the Public Register of a finding of professional negligence or malpractice made against the member;
g) does not have a notation on the Public Register of a criminal charge or a charge under the Health Insurance Act or the Controlled Drugs and Substances Act;
h) does not have a notation on the Public Register of a criminal finding of guilt or a finding of guilt under the Health Insurance Act or the Controlled Drugs and Substances Act;
i) does not have a notation on the Public Register of a charge made by a court in relation to any provincial or federal offence;
j) does not have a notation on the Public Register of a finding of guilt made by a court in relation to any provincial or federal offence;
k) is not subject to any revocations, suspension or restriction of privileges with a hospital, birth centre or health facility in Ontario reported to the College under section 85.5 of the Code;
l) is not subject to a term, condition, limitation or undertaking imposed by or provided to either the Discipline Committee or the Fitness to Practice Committee;
m) does not have a notation on the Public Register of an undertaking provided to the College in relation to a matter involving the Inquiries, Complaint and Reports Committee;
n) is not currently subject to an interim order made by a panel of the Inquiries, Complaints and Reports Committee;
o) does not have a notation on the Public Register of having been ordered to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned in the preceding three (3) years;
p) does not have a notation on the Public Register of being ordered to complete a specified continuing education or remediation program required by a panel of the Inquiries, Complaints and Reports Committee in the preceding three (3) years;
q) is not in any default of returning any required information or form required under the Regulations or the by-laws to the College; and
r) is not in default of any order issued by any panel or committee of the College.

The Quality Advisor or designate:

s) is present at the MLBC to effectively observe the delivery of core services;
t) is available on call when not present in the facility;
u) ensures core services are provided in accordance with Ontario midwifery standards of practice;

v) chairs the Quality Advisory Committee; and
w) leads the Quality Management Program.

4.1.2 Responsibilities to the Board of Directors

The Quality Advisor is responsible for advising the Board on the professional aspects of the MLBC, including:

a) recommendations and actions taken to improve the quality of care in the facility;
b) recommendations for appointment and re-appointment of HCPs;
c) recommendations for restriction, suspension or revocation of appointments;
d) recommendations from the QAC regarding policies, procedures and protocols; and
e) recommendations resulting from Ministry of Health or College of Midwives of Ontario assessments.

4.2 Quality Advisory Committee

4.2.1 General

The MLBC has a Quality Advisory Committee (QAC) in accordance with O. Reg. 57/92, s. 1-3. under the *Independent Health Facilities Act* (IHFA).

The QAC has a mechanism in place to seek input from stakeholders, including clients, appointed health care providers, other relevant health professionals, relevant community organizations, and MLBC staff.

The QAC meets at least annually and maintains a set agenda and minutes of meetings.

4.3 Quality Management Program

4.3.1 General

The MLBC has a Quality Management Program that evaluates the quality of care provided in the facility and informs quality improvement initiatives. The MLBC determines the methods most suitable to their needs for collecting the information and data to evaluate the quality of care.

At a minimum, the QMP systematically evaluates the following:

a) clinical outcomes of client and newborn care;
b) all adverse clinical events;
c) facility safety and incident reports;
d) quality of care provided by appointed health care providers;
e) quality of services provided by staff;
f) infection prevention and control practices, lapses and breaches;
g) client and community feedback;
h) health care provider feedback;
i) staff feedback;
j) compliance with IHFA
k) compliance with PHIPA
l) compliance with CMO CPP & FS
m) compliance with and effectiveness of MLBC policies, procedures and protocols;
n) impact of non-core services on the core services of the MLBC;
o) records management; and

p) clinical equipment and supplies.

4.3.2 Data Collection

All data collection, including that relating to the quality management program, is collected in accordance with:

- *Independent Health Facilities Act, R.S.O. 1990, c.1.3 O. Reg. 57/92:*
- *Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A*
- College of Midwives of Ontario standards

5. Policies and Procedures

5.1 General

The MLBC has written policies and procedures that are available to all HCPs and staff. The policies and procedures inform and provide sufficient guidance to ensure:

a) the goals of the MLBC are achieved;
b) roles and responsibilities are defined;
c) clients are provided with safe care;
d) there is appropriate guidance for emergencies;
e) sufficient and appropriate equipment, supplies and medications are available;
f) the facility is adequately maintained;
g) infection controls standards are upheld;
h) the quality management program fulfills its objectives; and
i) the staff have documented in writing that they have reviewed these annually.

The policies and procedures are updated as needed and reviewed at least every 5 years.

6 Health Records

6.1 General

Heath records are to be created and maintained in accordance with:

- *Independent Health Facilities Act, R.S.O. 1990, c.1.3 0. Reg. 57/92:*
- *Personal Health Information Protection Act, 2004, S.O. 2004, c. 3, Sched. A*
- College of Midwives of Ontario standards

7 Physical Facility

7.1 General

The physical facility of the MLBC has adequate space to provide a safe, comfortable and satisfactory experience for clients and their chosen family members and support people, HCPs and staff.

It is open to accommodate clients labouring and giving birth 24 hours a day, 7 days a week, 365 days a year.

7.2 Physical Facility and Equipment

7.2.1 Construction

The MLBC complies with the following:

a) Canadian Standards Association (CSA) standard for health care facilities;
b) Ontario Building Code;
c) Accessibility for Ontarians with Disabilities Act (AODA); and
d) Canadian Centre for Occupational Health and Safety (CCOHS), including Workplace Hazardous Materials Information System (WHMIS).

The MLBC meets all relevant construction, fire, safety, health codes, zoning regulations and legislation.

7.2.2 Facility Design and Furnishing

With respect to all services provided, the MLBC demonstrates the following:

a) the physical facility adequately ensures privacy for every client;
b) layout facilitates the provision of safe care;
c) heating, cooling and ventilation systems ensure comfort and safety;
d) the security of clients, visitors, HCPs and staff;
e) the facility is barrier free and accessible to emergency stretchers; and
f) furnishings and facility structures are in compliance with current Provincial Infectious Diseases Advisory Committee (PIDAC) standards

7.2.3 Facility Inspections

The facility maintains a record of inspections by the Public Health Department, Fire Department, building inspectors and others concerned with public safety as required by municipal, provincial and federal standards.

8 Medications, Equipment and Supplies Management

8.1 General

The MLBC provides equipment, supplies and medications necessary for safe delivery of core services. All HCPs and clinical staff are oriented to use all medications, equipment and supplies.

8.1.1 Medication Inventory and Storage

A drug inventory and storage system are in place. Periodic inspection is conducted to ensure restocking takes place and all expired drugs are replaced and safely discarded.

8.1.2 Medical Gases

Medical gases that are within the midwifery scope to administer are available to all clients delivering in the MLBC. The MLBC has appropriate equipment and physical facility standards to ensure their safe administration, ventilation, storage, and removal.

8.2 Birth Equipment and Supplies

The MLBC has effective procedures to ensure that equipment and supplies are appropriately stocked, not expired, stored and maintained, and are readily accessible for the provision of services.

Equipment used in providing core services is regularly assessed for accuracy and reliability in accordance with manufacturer's specifications.

8.3 Non-Obstetrical Emergency Equipment

Suitable equipment for non-obstetrical emergencies is available at the birth centre for all visitors, clients and staff and includes:

a) portable emergency resuscitation equipment;
b) defibrillator; and
c) epinephrine for anaphylaxis.

9 Infection Prevention and Control Practices

9.1 General

The MLBC is held to the following standards established by the Provincial Infectious Diseases Advisory Committee (PIDAC) to ensure appropriate infection prevention and control in the facility and in the reprocessing of equipment (where applicable):

a) Infection Prevention and Control for Clinical Office Practice; and
b) Best Practices in Cleaning, Disinfection and Sterilization of Medical Equipment/Devices

With respect to the cleaning and maintenance of birthing pools or tubs, the MLBC is held to manufacturer's guidelines and the following standard:

c) Best Practices in Perinatology (Section D. Environmental Cleaning in Perinatal Care)

9.2 Biomedical Waste

9.2.1 General

All HCPs and staff, including those providing cleaning services, are competent to handle and dispose of biomedical waste in accordance with *Routine Practices and Additional Precautions In All Health Care Settings* (PIDAC, 2011).

9.2.2 Disposal of Biomedical Waste and Placentas

All biomedical waste, including placentas are disposed of in accordance with *C-4: The Management Of Biomedical Waste In Ontario*. Clients wishing to keep their placenta after giving birth are accommodated and provided guidance on safe transport, burial and/or disposal.

Volume 2:
Clinical Practice Parameters

10 Planned Place of Birth

10.1 Eligibility for Admission

The MLBC establishes and publishes eligibility for admission criteria that is consistent with the *Midwifery Act*, the regulations made under the Act, and Ontario midwifery standards of practice.

The obligation to ensure that the client is fully informed of the risks, benefits and alternatives to giving birth in the MLBC rest with the primary health care provider.

The MLBC establishes the following minimum criteria for determining eligibility for admission:

a) the client is under the care of an appointed MLBC health care provider;
b) the client is in good health;
c) the client is experiencing an uncomplicated pregnancy;
d) the client and the HCP have a reasonable expectation of having an uncomplicated labour and birth;
e) the fetus is expected to be healthy at birth;
f) there are no impediments to instituting common emergency procedures if necessary;
g) there are no difficulties foreseen in transporting the client/newborn with the usual emergency transport system; and
h) the result of consultations, when required, is confirmation of healthy pregnancy or labour progress.

11 Transfer from the Birth Centre

11.1 General

The MLBC liaises with local hospitals and emergency services to develop procedures for seamless and safe transfers of clients and newborns.

The HCP determines the need for transport to a hospital, the appropriate method of transport, and the intended receiving hospital.

11.2 Transport

The MLBC has the following:

a) An agreement with the receiving hospital when an appointed HCP does not have admitting privileges at that hospital.
b) A protocol for initiating emergency services that includes, at a minimum,
    i. the designated person responsible for calling 911;
    ii. the designated person responsible for contacting the receiving health facility;
    iii. communication with involved family members; and
    iv. documentation to be used to facilitate and record the transfer.

11.3 Refusal of Client/Newborn Transport

If the client refuses the transfer for themselves or the newborn, the attending HCP documents the refusal.

12 Laboratory and Diagnostic Samples

12.1 General

The MLBC provides all equipment and supplies to allow HCPs to collect, store and transport samples for laboratory testing relevant to core services.

13 Research Activities

13.1 General

Research is conducted,

a) in accordance with written research policies and procedures approved by the MLBC Board of Directors;
b) by researchers trained to conduct such research;
c) in a manner that protects the client's health, choice, comfort, safety, and right to privacy;
d) in a manner that protects the MLBC and clients from unsafe practices;
e) after approval by an external Ethics Review Board; and
f) after approval IHF Director approval.

13.2 Data collection

Data collection relating adheres to the *Personal Health Information Privacy Act, 2004, S.O. 2004, c. 3, Sched. A.*

14 Education

14.1 Clinical Placements

The MLBC provides access to students in clinical placements from programs acceptable to the Board.

At a minimum, the MLBC provides:

a) opportunities for midwifery clinical educational placements; and
b) opportunities for inter-professional clinical educational placements.

a) the number of Council members whose term of office has expired or will expire on the day of the first Council meeting after the election, and

b) the number of Council members whose seat has become vacant and not been filled before June.

5.08 – Eligibility for Election

A Member is eligible for election to the Council if, on the deadline for the receipt of nominations and up to and including the final date for voting in the election,

a) the Member holds a certificate of registration other than a certificate in the Transitional class;

b) the Member is not in default of payment of any fees prescribed by College by-law;

c) the Member is not the subject of any disciplinary or incapacity proceeding, in any jurisdiction;

d) the Member has not been the subject of any professional misconduct or incompetence finding, in any jurisdiction;

e) the Member's certificate of registration has not been revoked or suspended, in any jurisdiction for any reason other than non-payment of fees;

f) the Member does not have a notation on the register of a finding of professional negligence or malpractice made against the member;

g) the Member does not have a notation on the register of a criminal charge or a charge under the *Health Insurance Act* or the *Controlled Drugs and Substances Act*;

h) the Member does not have a notation on the register of a criminal finding of guilt or a finding of guilt under the *Health Insurance Act* or the *Controlled Drugs and Substances Act*;

i) the Member does not have a notation on the register of a charge in relation to any provincial or federal offence;

j) the Member does not have a notation on the register of a finding of guilt made by a court in relation to any provincial or federal offence;

k) the Member is not subject to any revocations, suspensions or restriction of privileges with a hospital, birth centre or health facility in Ontario reported to the College under section 85.5 of the Code;

l) the Member's certificate of registration is not subject to a term, condition, or limitation imposed by either the Discipline Committee or the Fitness to Practice Committee;

m) the Member does not have a notation on the register of an undertaking provided to the College in relation to a matter involving the Member's conduct or capacity;

n) the Member is not currently the subject of an interim order made by a panel of the Inquiries, Complaints and Reports Committee;

o) the Member does not have a notation on the register of having been ordered to appear before a panel of the Inquiries, Complaints and Reports Committee to be cautioned in the preceding three (3) years;

p) the Member does not have a notation on the register of having been ordered to complete a specified continuing education or remediation program required by a panel of the Inquiries, Complaints and Reports Committee in the preceding three (3) years;

q) the Member has not been a director, board member, officer or employee of a Professional Association in the preceding 12 months;

r) the Member has not been director, owner, or board member of an educational institution relating to midwifery in the preceding 12 months;

s) the Member has not been disqualified from Council within the preceding three (3) years;

t) the Member is not a member of a council of any other college regulated under the RHPA;

u) the Member is not and has not been an employee of the College during the previous two (2) years;

v) the Member has been nominated in accordance with the by-laws;

w) the Member has completed and returned the conflict of interest questionnaire and the Member does not have a conflict of interest to serve as a member of Council;

x) the Member is not in any default of returning any information or form required under the Regulations or the by-laws to the College;

y) the Member principally practises or principally resides in Ontario; and

z) the Member has successfully completed the College's training program relating to the duties, obligations and expectations of Council and Committee members prior to the date of nomination.

5.09 – Eligibility to Vote

A Member is eligible to vote in an election for members of Council if, on the day the election opens, the Member,

a) holds a certificate of registration other than a certificate in the Transitional class;

b) principally practices or principally resides in Ontario;

c) is not in default of any fees or other amounts owed the College; and

d) is not in default of returning any information or form required under the Regulations or by-laws to the College.

SCHEDULE 1

Process for Election of Officers

The elections will be supervised by the Registrar. The Registrar may be assisted by scrutineers.

A member of Council is eligible for election to the Executive Committee if, on the date of the election, the member has served, wherever possible, at least twelve (12) months on Council.

The term of office of a member of the Executive Committee shall commence on the day of the first meeting of the Executive Committee after the election and shall continue for approximately one (1) year, until the term of office of the subsequently elected Executive Committee commences or until they resign or are removed from their office or from Council, or until such other time designated by Council, whichever occurs first.

At least forty-five (45) days before the date of the election, the Registrar shall notify every member of Council of the date of the election and of the procedure, criteria and deadline for Council members to submit, in writing, their candidacy for a position as a member of the Executive Committee and any personal statement that the member wishes to be circulated to the Council in support of their candidacy.

Before the first regular meeting of the newly elected Council each year or any other Council meeting designated for the purpose by Council resolution, the Registrar shall send an invitation to all Council members requesting any person wishing to stand for election to the offices of the Chair, Vice-Chair (Professional), Vice-Chair (Public) and Executive Committee member(s) to indicate so, in writing, to the Registrar.

A Council member's written intent must be returned to the Registrar no later than 11:59 p.m. on the day one week before the meeting of Council when the election of officers shall take place. The Registrar may, at any time, inform a Council member about any other Council member's written intent that has been submitted before the deadline. At least five (5) days prior to the meeting of Council when the election of officers shall take place, the Registrar shall circulate to the Council a list of the eligible candidates for election to the offices of the Chair, Vice-Chair (Professional), Vice-Chair (Public) and Executive Committee members.

A Council member may withdraw as a candidate at any time before the election.

At the meeting of Council when the election of officers shall take place, the Registrar shall present the names of eligible candidates who have indicated their interest for the position of Chair.

Where there is only one nominee for a position, that person shall be elected by acclamation. In the event that there is more than one candidate for the office, the voting will be conducted by ballot, with the result being tabulated and then recorded

and reported by the Registrar. Before the vote, candidates shall be given the opportunity to speak briefly (order to be determined by lot). The election of a candidate shall be confirmed by a majority vote of those present and voting. Where no candidate receives a majority vote, the candidate receiving the fewest votes shall be disqualified and Council shall, by ballot, vote on the remaining candidates until one candidate receives a majority vote.

Where no candidate is nominated for a position or, in the case of Executive Committee members at large, where there are insufficient nominations for the number of positions available, nominations from the floor will be permitted.

In the event of a tie, a second ballot will take place. If the second ballot also results in a tie, the winning candidate will be determined by lot.

The results of each election will be tabulated and reported by the Registrar, with the number of votes accorded to each candidate to remain confidential.

Once the Chair is elected, the Vice-Chair (Professional), shall be nominated and elected in a similar manner. Once the Vice-Chair (Professional) has been elected, the Vice-Chair (Public) shall be nominated and elected. The remaining Executive Committee positions shall be filled in a similar manner.

Once the election is completed, the Registrar shall call for a motion to destroy the ballots.

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

2022-2023 Slate of Council Members

Elected Professional Members

- Claire Ramlogan-Salanga, RM
- Edan Thomas, RM
- Isabelle Milot, RM
- Karen McKenzie, RM
- Alexia Singh, RM
- Hardeep Fervaha, RM
- Robyn Berman, RM
- Joythy Nair, RM

Appointed Public Members

- Marianna Kaminska
- Judith Murray
- Donald Strickland
- Oliver Okafor
- Jacqueline Morrison

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Claire Ramlogan-Salanga

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Claire Ramlogan-Salanga	CRS	Sept 25/20
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Marianna Kaminska

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Marianna Kaminska	Marianna K.	Oct 2, 2020
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Claudette Leduc

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Claudette Leduc — Sep 23 20

Name (please print) — Signature — Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

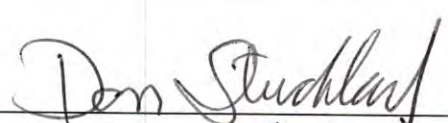
To the best of my knowledge, I,

Don Strickland

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Don Strickland		09/22/2020
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Edan Thomas _____

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

[X] DO NOT have an actual or perceived conflict of interest.

[ ] DO have a conflict of interest (please explain)

_____

_____

_____

_____

_____

Edan Thomas  September 23 2020

Name (please print) Signature Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Isabelle Milot

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

I. Milot — Name (please print)

Signature

Sept 23-20 — Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Judith Murray

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Judith Murray — Judith Murray — 26-11-20

Name (please print) — Signature — Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

KAREN McKENZIE

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

[X] **DO NOT** have an actual or perceived conflict of interest.

[ ] **DO** have a conflict of interest (please explain)

KAREN McKENZIE	K McKenzie	2020-09-29
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Lilly Martin

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☒ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Lilly Martin | [signature] | 29 Sept 20

Name (please print) | Signature | Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Pete Aarssen

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

- [x] **DO NOT** have an actual or perceived conflict of interest.
- [ ] **DO** have a conflict of interest (please explain)

Pete Aarssen		September 23, 2020
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages in accordance with the Ministry's College Performance Measurement Framework.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

Dr. Oliver Okafor

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☒ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

Dr. OLIVER OKAFOR — Name (please print)

Signature

June 21, 2021 — Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages, as required in accordance to Ministry direction.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

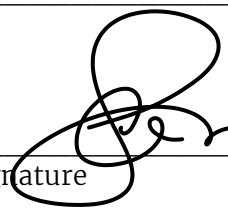
To the best of my knowledge, I,

ALEXIA SINGH

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☒ DO NOT have an actual or perceived conflict of interest.

☐ DO have a conflict of interest (please explain)

Alexia Singh |  | July 8/2021

Name (please print) | Signature | Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages, as required in accordance to Ministry direction.

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

_Hardeep Fervaha_____

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

✓DO NOT have an actual or perceived conflict of interest.

DO have a conflict of interest (please explain)

_____

_____

_____

_____

_____

Hardeep Fervaha

September 20, 2021

_____ Name (please print)

Signature Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages, as required in accordance to Ministry direction.9

Disclosure of Conflict of Interest

I undertake to comply with the conflict of interest provisions in the By-laws and to inform Council or a Committee of Council of any conflict of interest that may arise during the course of the coming year involving the undersigned.

To the best of my knowledge, I,

JACQUELINE MORRISON

a member of Council or a Committee of the Council of the College of Midwives of Ontario, currently

☑ **DO NOT** have an actual or perceived conflict of interest.

☐ **DO** have a conflict of interest (please explain)

_____

_____

_____

_____

_____

JACQUELINE MORRISON		FEBRUARY 8th, 2022
Name (please print)	Signature	Date

*Please note your signed conflict of interest form may be appended to publicly available Council packages, as required in accordance to Ministry direction.