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

Council Agenda
September 24, 2026

Thursday, September 24, 2026
9:00 a.m. – 2:00 p.m.

Time	Item	Purpose
9:15 a.m. (5 mins)	**1. Land Acknowledgement**	
9:20 a.m. (3 mins)	**2. Approval of Agenda**	Decision
9:23 a.m. (2 mins)	**3. Call for Conflicts of Interest**	
9:25 a.m. (10 mins)	**4. Registrar & CEO Remarks**	Information & Discussion
	5. Consent Agenda	
9:35 a.m. (5 mins)	5.1 Draft Minutes of June 4, 2026 Council Meeting 5.2 Standing Committee Appointment: Conduct Committee 5.3 Statutory Committee Appointment: Inquiries, Complaints and Reports Committee 5.4 2027 Council Meeting Dates	Decision
9:40 a.m. (30 mins)	**6. Labour Mobility Registrants: Jurisprudence Examination**	Decision
	7. Reports	
10:05 a.m. (40 mins)	7.1 Report of the August 13, 2026 Finance & Risk Committee Meeting • Draft Minutes of the August 13, 2026 Finance & Risk Committee meeting	Decision

	• Unaudited Financial Statements for the Six Months Ended June 30, 2026 • Proposal to amend By-Law No. 2: Fees	
10:45 a.m. (15 mins)	**Break**	
	8. Strategic Items	
11:00 a.m. (60 mins)	8.1 Standards Revisions 8.1.1 Scope of Practice and Medication Practice Standards 8.1.2 Confidentiality and Privacy Practice Standard 8.1.3 Nurse Practitioner Practice Standard	Decisions
12:00 a.m. (60 mins)	**Lunch**	
1:00 p.m. (40 mins)	8.2 Strategic Plan 2021-2026 Reporting	Information & Discussion
1:40 p.m. (15 mins)	**9. Registrar & CEO Remarks**	Information & Discussion
okay1:55 p.m. (5 mins)	**10. Dates of Upcoming Meetings** December 9 & 10, 2026 – Virtual	Information
2:00 p.m.	**11. Conclusion**	

Resources:
Council's Planning Calendar
Council's Governance Principles
Council's Team Norms
Council and Committee Code of Conduct

Information Items:
Draft Minutes of Executive Committee Meeting of August 13, 2026
Draft Minutes of Governance Committee Meeting of August 13, 2026
Draft Minutes of the Patient Relations Committee Meeting of August 13, 2026
Summary of Council Member Annual Declarations

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Council Minutes

June 4, 2026

Present

R. Lastimosa Jr., Chair	M. Hogard	P. Carmichael Pilon
D. Bankole	D. Jha	L. Poonasamy
R. Burke	J. Ko	D. Scott
W. Cheuk	A. Lamsen	M. Sheculski
J. Ding	J. Lane	W. Stryker
G. Grewal	S. Leduc	D. Thompson
T. Hillhouse	H. Anyia	S. Wilson
J. Mathew	G. Fox	M. Sack
T. Holland	S. Douglas	K. Wagg
L. Rietze	N. Melnyk	S. Mumberson
M. Boudreau	S. Viau	K. Neilipovitz

Regrets

C. Baretto	C. Gilchrist	F. Kim
L. Carpenter	L. Given	F. Osime
S. Larmour		

Guests

B. MacKenzie, Hilborn LLP	U. Paracha, Hilborn LLP	M. Krauter, Chair, Nominating Committee

Staff

A. Brennand	S. Mills	T. Terzis
S. Crawford	R. Sussman, recorder	

*Additional staff will be noted in the minutes for their respective agenda item.

Land Acknowledgement

M. Sack shared a Land Acknowledgement.

Agenda

The agenda was circulated. Council was advised of a proposed change in the timing of the agenda, suggesting that item 7.2 would be addressed ahead of item 7.1

Motion 1

Moved by K. Wagg, seconded by S. Mumberson,

That the agenda for the Council meeting of June 4, 2026 be accepted as amended.

CARRIED

Conflicts of interest

R. Lastimosa Jr. asked that Council members review the agenda and declare if they have conflicts of interest for any of the items. L. Rietze, S. Viau, A. Lamsen, and J. Ko declared a conflict for item 6.3.

No further conflicts were declared.

Registrar & CEO Remarks

S. Crawford, Registrar & CEO, shared opening remarks. She noted the upcoming transition to a single classification of nurse practitioner in July and the system partner engagement underway. She highlighted the many engagement opportunities that occurred with external partners including presentations and conferences.

CNO launched a new engagement activity that uses informal, virtual lunch-hour sessions designed to create space for two-way dialogue with nurses. Early sessions were focused on topics like certifying death, Quality Assurance and documentation. CNO also developed a new presentation series for applicants and nursing students. The March session introduced final year nursing students and soon to be applicants to CNO, walked them through the registration process and provided an opportunity to answer questions. Further sessions will be held throughout the year to support new cohorts.

The Aesthetics practice guideline is being updated and will be released shortly. New practice requirements related to aesthetics will be proposed to the Scope of Practice and Medication standards and will come to a future Council meeting for review.

Consent Agenda

R. Lastimosa Jr. introduced the consent agenda. Council received briefing materials on all items included in the consent agenda. It was noted that T. Holland's name was inadvertently left off the attendance list for the March 12, 2026 Council minutes, and would be added.

Motion 2

Moved by W. Cheuk, seconded by A. Lamsen,

That, through approval of the consent agenda, the following be approved:

The minutes of the Council meeting of March 12 ,2026, as amended;

The 2025 Annual Report;

The appointment of Wes Stryker, public member of Council, to the Quality Assurance Committee;

In accordance with Article 55.02 of By-Law No. 1: General, leaving the RN Council member seat in the Southwestern District vacant until June 2027;

The appointment of Doreen Bankole, RN, Todd Hillhouse, public member of Council and Shari Wilson, public member of Council as members of the Finance & Risk Committee for 2026-2027;

The appointment of Jijo Mathew, RN, Kimberly Wagg, RPN and Shari Wilson, public member of Council, as members of the Conduct Committee for 2026-2027; and

The appointment of Nicole Krywionek, RN, to the Inquiries, Complaints & Reports Committee until June 2027.

CARRIED

Strategic Plan 2021-2026 Reporting

Council received a report on the current Strategic Plan. S. Crawford outlined the outcome measures presented on the dashboard. Council inquired about feedback related to the Transition to Practice (TTP) program. B. Knowles, Director, Analytics & Research, advised that an evaluation is underway and will require time to gather sufficient feedback. The evaluation results will be brought to Council. S. Crawford advised that an evaluation and analysis is built into the process prior to any significant changes being implemented.

S. Crawford presented data regarding the project progress dashboard. Council asked about tracking average application lengths. B. Knowles explained that CNO tracks timelines for applications and can distill data by many factors and components of the application process. M. DoCouto, Director, Registration & Customer Service advised that on average, Internationally Educated Nurses (IENs) are registered within 12 months from meeting the education requirement, and labour mobility applicants can be registered within two days. Council noted improvements on timelines for applicants over the course of the Strategic Plan 2021-2026 period.

Organizational Health

E. Horlock, Director People & Communications, provided a presentation on CNO's Organizational Health. She noted the importance of creating a healthy organizational culture, and that the talent management strategy integrates recruitment, development, and engagement. Key indicators show strong organizational health: high retention, low turnover, and strong employee engagement, with strengths in leadership, trust, and culture. Progress is monitored through surveys, governance mechanisms, and external Human Resources expertise provided by the Advisory Committee on Human Resources. CNO demonstrates ongoing commitment to adapting and maintaining a healthy, high-performing workplace.

Council asked about survey trends and tracking. E. Horlock confirmed that survey responses are anonymous and confidential, and the survey is administered by an external party. The survey provides aggregate data which enables CNO to identify trends. Organizational and team plans are created annually to address feedback from staff, and results are reported during team meetings and all staff forums. CNO also conducts exit surveys for employees who are leaving CNO.

Council asked about succession planning. E. Horlock explained that CNO plans to update its current approach with a revised framework this year.

Council inquired about development opportunities. It was noted that CNO offers a variety of learning programs including through online platforms, a formal coaching program (including streams in leadership, general and equity topics), and workshops for all staff, managers and

team leads. CNO's Equity Plan and Indigenous Equity Framework play important roles to promote learning about diversity, equity and inclusion, and Indigenous culture.

Nursing Education Program Approval

R. Lastimosa Jr. advised that this item relates to both approval of the Brock University, Concurrent Bachelor of Nursing /Master of Nursing program, as well as the Annual Nursing Education Program Review.

S. Viau, L. Rietze, J. Ko, and A. Lamsen identified conflicts and left the meeting.

Brock University's Concurrent Bachelor of Nursing (BN)/Master of Nursing (MN) Program

Motion 3

Moved by P. Sullivan, seconded by T. Hillhouse,

> That Council approve Brock University's Concurrent Bachelor of Nursing (BN)/Master of Nursing (MN) Program.

CARRIED

Annual Nursing Education Program Review

Motion 4

Moved by R. Burke, seconded by D. Thompson,

> That Council approve the nursing programs noted in the Annual Review recommendations as listed in Attachment 2 to the decision note.

CARRIED

S. Viau, L. Rietze, J. Ko, and A. Lamsen returned to the meeting.

National Nurse Practitioner (NP) Framework: Neonatal NPs and Exam Registration Requirements

S. Crawford reminded Council that at the March 2026 Council meeting, Council approved a new, national entry-level NP registration exam, as well as by-law amendments to support implementation of a single NP framework coming into effect on July 1, 2026.

To support the transition to a single NP classification, and support neonatal health human resource needs in Ontario, neonatal NP applicants will have terms, conditions, and limitations (TCL) applied to their NP certificate of registration which would limit them to practice within the neonatal patient population or clinical setting that aligns with the scope and competencies of their NP neonatal education and training.

Applicants must meet all other registration requirements including an exam requirement. Council is being asked to consider approving neonatal NP examinations to enable these NP applicants to meet the examination requirement.

Motion 5

Moved by K. Neilipovitz, seconded by D. Jha,

> That Council confirm its continued approval of the Neonatal Nurse Practitioner Core Board Certification Examination (if written in January 1994 or later) administered by the National Certification Corporation (NCC) for registration as an NP for individuals who will have practice TCLs (neonatal practice setting only) effective July 1, 2026. The applicant must have successfully completed this exam within three attempts.

CARRIED

Motion 6

Moved by L. Rietze, seconded by S. Wilson,

> That Council approve the Alberta Neonatal Nurse Practitioner Objective Structured Clinical Examination (NNP-OSCE) administered in partnership with the University of Alberta and the College of Registered Nurses of Alberta (if written between March 1, 2024 and December 31, 2026) for registration as an NP for individuals who will have practice TCLs (neonatal practice setting only) effective July 1, 2026. The applicant must have successfully completed the NNP-OSCE within three attempts.

CARRIED

Proposed Amendments to By-Law No. 2: Fees

R. Lastimosa Jr. reminded Council that in March, the circulation of Fees By-Law amendments for a 60-day consultation period, was approved. These by-law amendments were two-fold, the implementation of a 25% fee credit for labour mobility applicants applying under automatic recognition and the introduction of a new approach to setting fees. A summary of the feedback received from the consultation was included in the briefing note.

At the May meeting of the Finance & Risk Committee, the committee reviewed a preliminary report on the feedback received. The Finance & Risk Committee confirmed that the proposed by-law amendments related to automatic recognition and the new approach to setting fees are in the public interest. Council was reminded that a 2/3 majority is required to amend by-laws.

Motion 7

Moved by M. Sheculski, seconded by G. Grewal,

> That Council approve the proposed amendment to By-Law No. 2: Fees, article 2.02.1.1, related to automatic recognition for labour mobility applicants as it appears in Attachment 1 effective June 24, 2026.

CARRIED

Council asked about the communication plan to inform registrants of the rationale for the fee changes. S. Mills, Chief Operating Officer, advised that robust communication plans are developed to outline these types of changes.

Council discussed legislative, operational and cost considerations and constraints surrounding options to pay fees in instalments or adjust the fee payment deadline.

Council asked about providing information during renewal about how fees are used. S. Mills advised that staff would initiate this work as part of the annual renewal process. Council was reminded that a 2/3 majority is required to amend by-laws.

Motion 8

Moved by D. Scott, seconded by S. Wilson,

> That Council approve all other proposed amendments to By-Law No. 2: Fees, as they appear in Attachment 1 effective June 24, 2026.

CARRIED with one abstention (R. Burke)

Report of the May 14, 2026 Finance & Risk Committee Meeting

V. Adetoye, Director, Business Services & Chief Financial Officer, as well as auditors from Hillborn LLP joined the meeting. Council received the report of the Finance & Risk Committee meeting of May 14, 2026. M. Hogard presented an overview of the report.

Audited Financial Statements for the Year Ended December 31, 2025

Auditors from Hillborn LLP explained the purpose of the audit is to provide an independent opinion on CNO's financial statements and to ensure that the financial statements are free from material misstatement. Their role is to provide an opinion on the fairness of financial statements. It was noted that the audit is a collaborative process conducted in accordance with generally accepted auditing standards, with the common goal of ensuring reliable and accurate financial statements. The accounting standards for not-for-profit organizations as prescribed by CPA Canada remained unchanged for 2025 and therefore no changes were made to the format or presentation of the financial statements.

The auditors confirmed that Hillborn LLP did not provide any services to CNO beyond the annual audit. In their opinion, the financial statements present fairly and CNO's financial position as at December 31, 2025, are free of material misstatements.

Motion 9

Moved by M. Hogard, seconded by D. Thompson,

> That Council approve CNO's audited financial statements for the year ended December 31, 2025.

CARRIED

Unaudited Financial Statements for the Three Months Ended March 31, 2026

Council received the unaudited financial statements for the three months ended March 31, 2026.

Motion 10

Moved by M. Hogard, seconded by W. Stryker,

> That Council approve the unaudited financial statements for the three-month period ended March 31, 2026.

CARRIED

Terms of Reference: Advisory Committee on Human Resources

The Terms of Reference for the Advisory Committee on Human Resources were due for their biennial review.

Motion 11

Moved by M. Hogard, seconded by M. Boudreau,

> That Council approve the proposed revisions to the Advisory Committee on Human Resources Terms of Reference as they appear in Attachment 5 to the report.

CARRIED

Terms of Reference: Finance & Risk Committee

The Terms of Reference for the Finance & Risk Committee were due for their biennial review. Proposed revisions align with the changes in the Advisory Committee on Human Resources Terms of Reference and are editorial in nature.

Motion 12

Moved by M. Hogard, seconded by J. Ko,

> That Council approve the proposed revisions to the Finance & Risk Committee Terms of Reference as they appear in Attachment 6 to the report.

CARRIED

Auditor Appointment

The Finance & Risk Committee is recommending the reappointment of Hilborn as auditors for 2026.

Motion 13

Moved by M. Hogard, seconded by D. Scott,

> That Council approve that Hilborn LLP be reappointed as CNO's auditors for the 2026 fiscal year.

CARRIED

Nominating Committee Report

M. Krauter, Chair of the Nominating Committee presented the Nominating Committee report. She reported that the Nominating Committee advises on competency-based appointments as well as recommending improvements to appointments processes.

Nominating Committee Terms of Reference

Proposed revisions are intended to introduce greater flexibility in the committee's composition, in light of challenges getting Council members to apply to serve on the committee and due to quorum issues experienced because of a mid-year resignation. The proposed revisions include:

- moving from 5 committee members to a range of between 5 and 7 members;
- moving from a requirement of 1 nurse council member and 1 public council member to a minimum of 1 council member on the committee

The committee would still be able to appoint more than one Council member – either a nurse or public member

Motion 14

Moved by T. Holland, seconded by P. Sullivan,

> That, based on the recommendation of the Nominating Committee, Council approve the revised Nominating Committee Terms of Reference as set out in Attachment 2.

CARRIED

M. Krauter declared a conflict for the remaining items in the Nominating Committee Report and left the meeting.

Appointment of Nominating Committee

R. Lastimosa Jr. explained when Council approved the revised Terms of Reference, it enabled the appointment of two non-Council members to the Nominating Committee. With the increased flexibility in the Terms of Reference, the Nominating Committee has recommended two non-Council members.

Motion 15

Moved by R. Burke, seconded by S. Mumberson,

> That, subject to Council approving the proposed revisions to the Nominating Committee Terms of Reference as shown in Attachment 2, the Nominating Committee recommends to Council that two non-Council members (named below) be appointed to serve as members of the Nominating Committee for a two-year term, ending in June 2028.
>
> - Morgan Krauter
> - Marc Spector

CARRIED

Appointment of Nominating Committee Chair

R. Lastimosa Jr. advised the Nominating Committee has presented a recommendation for Morgan Krauter to serve as chair of the Nominating Committee.

Motion 16

Moved by W. Cheuk, seconded by D. Jha,

> That, based on the recommendation of the Nominating Committee, Council appoint Morgan Krauter as the Chair of the Nominating Committee for 2026-2027.

CARRIED

Council Governance Priorities

R. Lastimosa Jr. noted that following the third-party evaluation of Council effectiveness, and in consultation with the Governance Committee, a number of proposed governance

priorities were identified for implementation in 2026-2029. They will be reviewed annually and refined as necessary.

Motion 17

Moved by S. Viau, seconded by D. Thompson,

> That Council approve the governance priorities identified in the briefing note for implementation in 2026-2029.

CARRIED

Council Development Plan

R. Lastimosa Jr. explained the topics proposed for Council development are informed by several factors, including the College Performance Measurement Framework (CPMF) requirement that ongoing education be guided by evaluation results, evolving public expectations and priorities identified by Council members. The topics align with Council's annual plan, with a view to upcoming decisions and governance priorities.

Council suggested it would be beneficial to receive additional governance education throughout the year. S. Crawford advised that staff will look for opportunities regarding this request.

Registrar & CEO Closing Remarks

S. Crawford noted the level of engagement of Council members. She highlighted that a focus moving forward is on preparing for the January launch of the new strategic plan by defining specific actions and success measures, while completing current plan objectives for a smooth transition. Efforts are underway to communicate the plan publicly and engage system partners.

CNO is also enhancing the Nursing Data Dashboard with more detailed, timely, and customizable application data. Additionally, a new policy makes it easier for non-binary and gender non-conforming nurses to update their legal names on the public register, respecting human rights related a person's gender identity and expression.

Next Meeting

R. Lastimosa Jr. identified that the next meeting will be September 23 and 24, 2026. He informed Council that the meeting will be hybrid (virtual and in-person).

Conclusion

At 2:27 p.m., on conclusion of the agenda

Motion 18

Moved by D. Scott, seconded by K. Wagg,

That the June 2026 Council meeting conclude.

CARRIED

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Standing Committee Appointment: Conduct Committee

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

The Nominating Committee recommends standing committee appointments for Council's approval. Council is asked to consider appointing a member to the Conduct Committee.

> **Motion:**
>
> That, based on the recommendation of the Nominating Committee, Council appoint Maria Sheculski, public member of Council, to serve as a member of the Conduct Committee until June 2027.

Background

The Conduct Committee is a standing committee of Council that manages concerns regarding breaches of the Council and Committee Code of Conduct, if a written complaint is received in accordance with Article 16.04 of By-Law No. 1: General.

In June, Council approved the appointment of two nurse members and one public member of Council to the Conduct Committee, leaving one public member vacancy. Since then, Maria Sheculski, public member of Council, has expressed interest in serving on the Conduct Committee.

In July 2026, the Nominating Committee approved a motion by email to recommend Maria Sheculski's appointment to the Conduct Committee.

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Statutory Committee Appointment: Inquiries, Complaints and Reports Committee

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

To support the ongoing effectiveness of CNO's statutory committees, Council is being asked to confirm a statutory committee appointment.

> **Motion:**
> That Council confirm the appointment of Sandra Ross, RN, to the Inquiries, Complaints & Reports Committee until June 2027.

Public protection rationale

Statutory committees play a key role in public safety. To maintain their effectiveness, it is important that committees be fully constituted with highly qualified members to ensure they can carry out their mandates effectively. This includes filling vacancies in a timely manner.

Background

The Executive Committee fills mid-year vacancies, in accordance with Article 31.03 of By-Law No. 1: General.

At its meeting on August 13, 2026, the Executive Committee approved an appointment to address a vacancy on the Inquiries, Complaints and Reports Committee (ICRC) as a result of a nurse Committee member resignation. In accordance with Article 31.05 of By-Law No. 1: General, Council is being asked to confirm this appointment.

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2027 Council Meeting Dates

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

Council is being asked to review and approve the proposed schedule and meeting dates for 2027. Due to scheduling challenges, the September 2027 Council meeting dates are still to be determined and will be brought forward for Council approval at the December 2026 meeting.

Motion:
That Council approve the following meeting dates for 2027:

Dates of Council Meetings:

- Wednesday, March 10 and Thursday, March 11, 2027
- Wednesday, June 2 and Thursday, June 3, 2027
- Wednesday, December 8 and Thursday, December 9, 2027

Public protection rationale

Council performs critical functions that are necessary to meet CNO's public protection purpose. Setting meeting dates in advance allows for advance planning for Council and staff and communication with system partners.

Background

In accordance with Article 7.02 of By-Law No. 1: General, Council meetings take place on dates set by Council. To support planning, proposed dates are selected with consideration to holidays, and other significant dates/events that may impact travel and attendance. Council dates for the coming year are then approved by Council each September.

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Labour Mobility Registrants – Jurisprudence Examination

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

This briefing note seeks Council's support to require labour mobility registrants to complete the Jurisprudence Exam (JE) under Quality Assurance (QA) authority, as permitted by the regulations outlined below.

Motion:

That Council approve using the authority in Ontario Regulation 275/94 under the *Nursing Act, 1991,* specifically subsection 24(2)[1], to require labour mobility registrants to complete the Jurisprudence Examination.

Question for consideration

Does Council approve using the authority in the QA regulations to require labour mobility registrants to complete the JE?

Public protection rationale

Requiring labour mobility registrants to complete the JE ensures that registrants registered in other Canadian provinces and territories, who register to practice nursing in Ontario, have the necessary knowledge of current Ontario laws and CNO practice standards. Limited understanding of Ontario's legislative framework, combined with differences in scope of practice across Canada, may have implications for patient safety.

Background on JE for labour mobility

The JE is one of eight entry-to-practice registration requirements for nursing applicants. CNO has two JEs. All applicants wishing to register in the General, Temporary or Special Assignment class, must successfully complete the Registered Nurse/ Registered Practical Nurse JE. Nurse Practitioner (NP) applicants must successfully complete the Registered Nurse (Extended Class) JE.

[1] From regulation 275/94 under the *Nursing Act, 1991*: 24 (2) Each member to whom this Part applies shall participate in a member assessment in accordance with a program approved by Council.

CNO's JEs are designed with an interactive, user-friendly learning approach. The learning modules have testing questions to assess an applicant's knowledge and understanding of the laws and practice standards that govern the nursing profession in Ontario. The current JE is an online, multiple-choice question, "open book" exam, which means that applicants can assess and use online resources (e.g., laws and CNO's practice standards, web resources) while writing the exam. Applicants have unlimited opportunities to write the exam within a 30-day period and may obtain additional time by paying for another 30-day period.

Beginning January 1, 2026, CNO committed to registering labour mobility applicants within two (2) business days through "automatic recognition" provisions, as set out in legislation. As of September 14, 2026, CNO has registered 1060 registrants through automatic recognition. Automatic recognition legislation does not specify JE as a registration requirement. To support safe, ethical and quality nursing care to Ontarians, CNO is also committed to implementing a mechanism that supports awareness of current Ontario laws as well as CNO practice standards for those who have registered through automatic recognition. By implementing a post-registration requirement for labour mobility registrants to complete JE, CNO will also be applying a consistent approach with all applicants and labour mobility registrants completing JE.

As of January 1, 2026, in the absence of being able to require completion of JE for labour mobility applicants, CNO provided voluntary access to JE to these registrants to promote awareness of the applicable Ontario laws as well as CNO practice standards. While there has been voluntary uptake in completion of the JE, it is in the public interest to ensure that all labour mobility registrants are able to demonstrate knowledge and understanding of the laws, regulations, CNO by-laws, and practice standards that govern the nursing profession in Ontario.

Quality Assurance Regulations

QA regulations[2] under the *Nursing Act, 1991*, enable CNO to require labour mobility registrants to complete the JE exam after registration. This authority is granted under the "member assessment" component of the QA program.

The intent of using the QA regulations in this context is to ensure that all labour mobility registrants, who are registered under the automatic recognition legislation, are supported to ensure they have knowledge of Ontario-specific laws as well as practice standards. The use of the QA regulations for this purpose ensures fairness and provides a clear mechanism and process to require labour mobility registrants to complete JE post registration.

[2] 24 (2) Each member to whom this Part applies shall participate in a member assessment in accordance with a program approved by Council.

Non-compliance and unsatisfactory outcomes

According to CNO data, JE has a high compliance and success rate for applicants who are required to meet this registration requirement before they can be registered with CNO. For labour mobility registrants, completion of JE will be required post-registration under QA authority, if supported by Council. In the event of non-compliance or lack of success among labour mobility registrants, CNO plans to utilize a supportive approach, such as one-to-one coaching to assist registrants in addressing any learning gaps and supporting registrants in meeting the requirement. This leverages and builds on the supportive approach CNO has developed in the QA program and through other CNO processes, such as Meet with Member (one-to-one coaching offered by CNO).

If the labour mobility registrant continues to be non-compliant, CNO is proposing a fee by-law amendment that would require registrants who do not attempt the JE within a specified time limit (e.g. 30 days) after being notified to pay a $400 non-compliance fee. In addition, a proposed article is included which gives the Registrar discretion to extend the timeline to make an attempt where exceptional circumstances justify additional time before any penalty fee is applied. For reference, see the proposed penalty fee by-law in the Finance and Risk Committee report (Agenda item 7.1).

Upon implementation of this mechanism for JE compliance among labour mobility registrants, CNO would track unsatisfactory outcomes and non-compliance, monitor future conduct issues, review uptake of optional support measures and determine if further steps are necessary.

Next steps

Subject to Council's approval of the proposed approach in using the QA regulations to require labour mobility registrants to complete JE, staff will move to implement this approach. Also subject to Council's approval of the proposed approach, Council will be asked to consider circulation of proposed amendments to By-Law No. 2: Fees, for a 60-day period, as outlined in Agenda Item 7.1, Report of the August 13, 2026 Finance and Risk Committee Meeting, to initiate the non-compliance fee.

Report of the August 13, 2026 Finance & Risk Committee Meeting

Contact for questions or more information

Veronica Adetoye, Director, Business Services & Chief Financial Officer

The first meeting of the 2026-2027 Finance & Risk Committee was held on August 13, 2026. See Attachment 1 for the draft minutes.

Unaudited Financial Statements

The unaudited financial statements for the six-month period ended June 30, 2026 (Attachment 2) were reviewed. The financial statements included a variance analysis, and the Management Discussion and Analysis included reports on projects and risk.

The surplus (excess of revenues over expenses) for the period is $3.4M, which is $2.2M higher than the budgeted surplus of $1.2M. This is comprised of:

- $1.1M more revenue than budget; and
- $1.1M expenses less than budget.

Based on a detailed discussion of the statements and the Management Discussion and Analysis, the Finance & Risk Committee recommends:

> **Motion:**
>
> That Council approve the unaudited financial statements for the six-month period ended June 30, 2026.

2027 Budget Development

The Finance & Risk Committee received an outline of the process for developing the 2027 budget. The budget will identify resources needed and expected costs required to fulfill CNO's regulatory mandate, deliver elements of the strategic plan, and support initiatives and projects to be carried out during the year.

The Committee will be presented with a detailed review of the budget in November, prior to presentation to Council in December. Council will participate in a professional

development session on finance and the budget process to support its review of the 2027 budget.

Investment Portfolio Report

The Committee received CNO's annual investment portfolio report as part of their oversight on finance and risk. All investment decisions are made in accordance with CNO's Investment Policy.

Proposed By-law Amendments: Jurisprudence Exam Penalty Fee

The Finance & Risk Committee reviewed a proposal to amend By-Law No. 2: Fees, to implement a penalty fee for labour mobility registrants who do not comply with attempting the Jurisprudence Examination (JE) post-registration.

The Committee discussed the importance of having all nursing applicants, including labour mobility registrants, complete the JE to ensure they have knowledge of Ontario specific laws and CNO practice standards. Agenda item 6.0 details how authority under the Quality Assurance (QA) regulation can be leveraged to require labour mobility registrants to complete the JE post-registration.

The JE has a high compliance and success rate among current nursing applicants, and that is expected to be the norm among labour mobility registrants should they be required to take the exam. As such, the $400 penalty fee proposed is intended to encourage compliance, and any revenue generated is expected to be minimal. The proposed by-law amendments also include a provision that provides the Registrar with the discretion to extend the completion timeline for writing the JE under extraordinary circumstances. This will ensure that a penalty fee for non-compliance is applied fairly.

Attachment 3 outlines the proposed Fees By-law amendments along with the rationale for the changes.

Subject to Council's approval to require labour mobility registrants to take the JE under the authority in the QA regulations, the Finance & Risk Committee is recommending:

> **Motion:**
>
> That Council approve a 60-day circulation period for the proposed amendments to By-Law No. 2: Fees related to implementing a penalty fee, as they appear in Attachment 3.

As is required under the *Health Professions Procedural Code,* the amendments are being recommended for circulation. Final decision will be made by Council in December 2026.

Attachments:

1. Draft minutes of the Finance Committee meeting of August 13, 2026
2. Unaudited Financial Statements for the six-months ended June 30, 2026
3. Proposed amendments to By-Law No.2: Fees, including rationale for the amendments

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

Finance & Risk Committee Minutes

August 13, 2026 at 1:00 p.m.

Present

M. Hogard, Chair
D. Bankole
G. Grewal
T. Hillhouse
R. Lastimosa Jr.
J. Nunes
S. Wlison

Staff

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

Chair

M. Hogard chaired the meeting.

Agenda

The agenda had been circulated and was approved on consent.

Minutes

Minutes of the Finance & Risk Committee meeting of May 14, 2026 had been circulated.

Motion 1

Moved by J. Nunes, seconded by R. Lastimosa Jr.,

> That the minutes of the Finance & Risk Committee meeting of May 14, 2026 be accepted as presented.

CARRIED

Financial Statements

V. Adetoye reviewed the unaudited financial statements for the six months ended June 30, 2026. The statement of financial position depicts a decrease in both assets and liabilities as expected when compared to December 2025.

At the end of the second quarter there was a surplus of $3.4M, which is $2.2M higher than the budgeted surplus of $1.2M. It was noted that revenues are $1.1M higher than

budget due to an increase in the overall registration and application numbers, as well as higher interest income. Expenses for the period are $1.1M lower than budgeted. The main contributors to this variance are employee salaries and expenses due to the timing of filling some positions. It was noted that the favourable expense variance is partially offset by an increase in legal costs, resulting from the need for legal advice on registration-related matters and a higher volume of complex cases.

The Committee reviewed the confidential Management Discussion and Analysis (MD&A). As part of the report, the Committee received information on various initiatives and projects, as well as a risk dashboard that identified potential risks, which are analyzed based on their potential impact and likelihood.

Motion 2

Moved by D. Bankole, seconded by S. Wilson,

> That it be recommended that Council approve the unaudited financial statements for the six months ended June 30, 2026.

CARRIED

Budget Development Plan

The Committee received an overview of CNO's budget development process.

V. Adetoye highlighted CNO's approach to budgeting, noting that CNO reviews its ongoing regulatory mandate as informed by external and internal events, such as potential legislation changes and/or anticipated changes in registration/application volumes. CNO operates in a dynamic environment and has the ability to adapt to changing priorities to ensure we can appropriately respond to arising needs.

It was noted that CNO takes a conservative approach to estimating revenues, based on a trend analysis and the amount of each fee. For 2027, the fees as prescribed in the Fee Table will be used for generating estimates. The new approach to setting fees as detailed in the Fees By-law, and approved by Council in June 2026, allows CNO remain agile to respond to anticipated changes in revenue each year (i.e., changes in expected registration volumes).

The draft budget will undergo significant internal review, prior to presentation to the Committee in November.

Investment Portfolio Report

The Committee received CNO's annual investment portfolio report. This report provides an overview of CNO's investments, specifically focusing on the Guaranteed Investment Certificates (GICs) with CNO banks and are categorized into short and long-term investments. The combined total investments were valued at $36.8M at the end of 2025. V. Adetoye noted that the investments outlined in the report align with the 2025 audited financial statements that were reviewed by the Committee in May and approved by Council in June 2026.

CNO is a not-for-profit organization, and therefore investments are not intended to generate a large return. All investments are made in accordance with CNO's corresponding policy as approved by the Finance & Risk Committee.

Proposed By-law Amendments: Jurisprudence Exam Penalty Fee

The Committee reviewed a proposal to amend By-Law No. 2: Fees, to implement a penalty fee for labour mobility registrants who do not comply with attempting the jurisprudence examination post-registration.

Currently, labour mobility applicants applying under automatic recognition are not required to complete the jurisprudence exam, and in the absence of a requirement, CNO provides voluntary access to the exam to promote understanding of the applicable Ontario laws and CNO practice standards. In September, Council will consider compelling labour mobility registrants to complete the jurisprudence exam post-registration by leveraging Quality Assurance (QA) regulations. If Council approves the approach, by-law amendments are required to introduce a penalty fee for non-compliance.

The Committee discussed the importance of having all nurses, including labour mobility registrants, complete the jurisprudence exam. This ensures that all new registrants have the necessary knowledge required to practice in Ontario and promotes safe nursing practice. They concurred that the $400 penalty fee proposed would encourage compliance to complete the exam within the specified timeframe and also discussed how the QA authority would be leveraged to address non-compliance. Furthermore, a mechanism has been built into the by-laws to account for exceptions, whereby the Registrar has the authority to extend the completion timeline under exceptional circumstances.

The Committee supported the amendments to the Fees By-law presented.

Motion 3

Moved by J. Nunes, seconded by, R. Lastimosa Jr.,

> That Council approve a 60-day circulation period for the proposed amendments to By-Law No. 2: Fees related to implementing a penalty fee, as they appear in Attachment 1.

CARRIED

Self-Monitoring Tool

The self-monitoring tool supports the committee in assessing if it is fulfilling its mandate. The committee reviewed the items from the tool that were relevant to the current meeting and confirmed that it met its terms of reference for the meeting.

Next Meeting

The next meeting will be the afternoon of November 19, 2026.

Conclusion

At 2:00 p.m., on completion of the agenda and consent, the meeting concluded.

_____

Chair

Attachment 2

COLLEGE OF NURSES OF ONTARIO

FINANCIAL STATEMENTS AND NOTES

FOR THE SIX MONTHS ENDED June 30, 2026 (Unaudited)

College of Nurses of Ontario
Statement of Financial Position ($000)
As at June 30

	2026 June	2025 June	2025 December
ASSETS			
Current assets			
Cash	46,101	36,964	93,911
Investments	34,872	44,914	30,949
Other receivables	45	274	546
Prepaid expenses	1,767	1,803	1,976
	82,784	83,955	127,383
Investments	12,479	5,746	5,874
Capital assets			
Furniture and fixtures	1,812	1,812	1,812
Equipment - non computer	534	534	534
Computer equipment	7,074	5,417	5,903
Building	6,836	6,836	6,836
Building improvements	5,780	5,542	5,556
Land	3,225	3,225	3,225
Art	45	45	45
	25,305	23,410	23,910
Less: Accumulated amortization	(14,449)	(12,946)	(13,677)
	10,857	10,463	10,233
Intangible Assets	2,305	2,305	2,305
Less: Accumulated amortization	(2,222)	(2,150)	(2,175)
	83	155	130
	106,202	**100,320**	**143,620**
LIABILITIES			
Current liabilities			
Accounts payable and accrued liabilities	9,950	9,209	19,908
Deferred registration and examination fees	38,819	36,349	69,667
	48,769	45,558	89,574
	48,769	45,558	89,574
NET ASSETS			
Net assets invested in capital assets	10,939	10,619	10,363
Unrestricted net assets	46,494	44,143	43,682
	57,434	54,762	54,045
	106,202	**100,320**	**143,620**

College of Nurses of Ontario
Statement of Operations ($000)
For the Six Months Ending June 30

	2026 Year to Date June			2025 Year to Date June			2026 Budget	
	Budget	Actual	Variance ($) Fav/(Unfav)	Budget	Actual	Variance ($) Fav/(Unfav)	Remaining	Approved
REVENUES								
Registration fees	40,532	41,309	777	38,116	38,459	343	40,642	81,952
Application assessment	4,601	4,762	160	4,833	4,930	97	3,027	7,789
Verification and transcripts	78	75	(2)	61	78	17	82	158
Interest income	1,323	1,506	183	1,296	1,732	436	1,077	2,583
Examination	376	385	9	546	413	(133)	289	674
Other	21	25	3	24	2	(22)	135	159
Total Revenues	**46,932**	**48,062**	**1,130**	**44,875**	**45,614**	**739**	**45,253**	**93,315**
EXPENSES								
Employee salaries and benefits	34,407	34,098	309	30,873	31,093	(220)	35,326	69,424
Employee related expenses	668	389	278	693	350	343	1,355	1,744
Contractors and consultants	1,063	864	199	1,880	1,854	26	1,870	2,734
Legal services	1,858	2,605	(748)	2,025	1,966	59	1,210	3,816
Equipment, operating supplies and other services	3,745	3,651	94	3,287	2,743	544	5,753	9,404
Taxes, utilities and depreciation	960	954	6	1,016	1,007	9	954	1,908
Exam fees	112	114	(2)	70	137	(67)	87	202
Non-staff remuneration and expenses	429	409	21	445	323	122	454	863
Total Base Operating Expenses	**43,242**	**43,085**	**157**	**40,290**	**39,474**	**816**	**47,010**	**90,095**
Project Expenses	2,500	1,588	912	2,100	2,010	90	3,412	5,000
Total Expenses	**45,742**	**44,673**	**1,069**	**42,390**	**41,484**	**906**	**50,422**	**95,095**
Excess of (expenses over revenues) / revenues over expenses	**1,190**	**3,389**	**2,198**	**2,486**	**4,131**	**1,645**	**(5,169)**	**(1,780)**
Opening net assets		**54,045**			**50,631**			
Closing net assets		**57,434**			**54,762**			

College of Nurses of Ontario
Statement of Changes in Net Assets ($000)
For the Six Months Ending June 30

	2026			2025
	Invested in Capital and Intangible Assets	**Unrestricted**	**Total**	**December**
Balance, beginning of year	**10,363**	**43,682**	**54,045**	**50,631**
Excess of (expenses over revenues)/revenues over expenses	(819)	4,208	3,389	3,414
Purchase of capital assets	1,396	(1,396)	-	-
Balance, end of year	**10,939**	**46,494**	**57,434**	**54,045**

College of Nurses of Ontario
Statement of Cash Flows ($000)
For the Six Months Ending June 30

	2026 June	2025 June
Cash flows from operating activities		
Excess of revenue over expense for the year	3,389	4,131
Adjustments to determine net cash provided by/(used in) operating activities		
Amortization of capital assets	772	840
Amortization of intangible assets	47	53
Interest not received during the year capitalized to investments	(659)	(797)
Interest received during the year previously capitalized to investments	733	479
	4,282	**4,706**
Changes in non-cash working capital items		
Decrease in amounts receivable	501	(6)
Decrease in prepaid expenses	209	28
Decrease in accounts payable and accrued liabilities	(9,958)	(8,986)
Decrease in deferred registration fees	(30,848)	(28,633)
	(35,814)	(32,891)
Cash flow from investing activities		
Purchase of investment	(27,317)	(25,716)
Proceeds from disposal of investments	16,716	28,736
Purchase of capital assets	(1,396)	(59)
	(11,997)	2,962
Net increase in cash and cash equivalents	(47,811)	(29,929)
Cash and cash equivalents, beginning of year	93,911	66,894
Cash and cash equivalent, end of year	**46,101**	**36,964**

Attachment 3

Proposed amendments to By-law No.2: Fees

6.03 A registrant who fails to attempt the jurisprudence examination within the specified time by the College, shall pay the Penalty Fee - Jurisprudence Examination as set out in the Fee Table.

6.03.1 Despite article 6.03, the Registrar may extend the time specified by the College if, in the Registrar's opinion, the circumstances are sufficiently extraordinary to warrant an extension and are not based upon the ability of the individual member to pay the fee.

Rationale Chart

Proposed Change	Rationale
6.03 A registrant who fails to attempt the jurisprudence examination within the specified time by the College, shall pay the Penalty Fee - Jurisprudence Examination as set out in the Fee Table.	The proposed fee by-law creates a clear administrative consequence for non-compliance with attempting the JE. It supports timely completion of the JE, promoting knowledge of Ontario-specific laws and practice standards.
6.03.1 Despite article 6.03, the Registrar may extend the time specified by the College if, in the Registrar's opinion, the circumstances are sufficiently extraordinary to warrant an extension and are not based upon the ability of the individual member to pay the fee.	This provision gives the Registrar discretion to extend the completion timeline where extraordinary circumstances justify additional time. It supports fairness by ensuring the penalty fee is not applied where a registrant is unable to comply for reasons outside their control, while maintaining the expectation that labour mobility registrants complete the JE within the required timeframe. Excluding the registrant's ability to pay as a basis for extension helps maintain consistent application of the fee and avoids using the extension process to waive the fee.

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

Standard Revisions: Scope of Practice and Medication Practice Standards

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

The purpose of this decision note is to provide Council with information to support decision-making regarding proposed revisions to the *Scope of Practice* and *Medication* standards.

> **Motion:**
>
> That the amendments to the *Scope of Practice* and *Medication* practice standards, as set out in Attachments 1 and 2 of this decision note, be approved by Council effective March 1, 2027.

Question for consideration

Does Council require additional information or clarification to support decision-making related to the practice standards?

Public protection rationale

Standards revisions are proposed to address current evidence and emerging areas of risk to support safe client care.

Background

As outlined in the *Regulated Health Professions Act, 1991*[1], Council's governance role includes approving standards of nursing practice. Practice standards outline the professional practice expectations for nurses. They inform nurses of their accountabilities and educate the public and system partners on what to expect of nurses.

[1] Subsection 94(3) of Schedule 2 of the *Regulated Health Professions Act, 1991* (i.e. the *Health professions procedural code*) refers to "standards of practice made by the Council".

Overview of changes: *Scope of Practice* and *Medication* standards

CNO is proposing the following revisions to two practice standards related to aesthetic services and to authorizing mechanisms:

- specific expectations in aesthetics services
    - a client-specific order would be required for aesthetic procedures involving a prescription drug or controlled act, not a directive, which is currently permissible and applies to multiple clients who meet specified conditions.
    - an expectation to be onsite when the nurse delegates the performance of a controlled act to an individual who does not otherwise have authority to perform that act
- an expectation to complete a client assessment prior to issuing a client-specific order in all settings[2]
    - while this is consistent with current guidance from CNO, this is not explicit in CNO's standards of practice
    - a client assessment can be in-person or virtual as appropriate
- additional expectations for delegation that apply to all nurses in all practice settings
    - while expectations for delegation are set out in legislation, we have seen in practice that they are open to misinterpretation. The proposed changes support nurses in understanding their legislated accountabilities by being more specific about expectations in the *Scope of Practice* standard

What are aesthetic services?

Aesthetics is a growing and evolving area of practice in nursing. Aesthetic services are cosmetic procedures used to enhance, preserve or alter a client's appearance (for example, Botox injections, dermal filler injections, microneedling) and may include procedures that involve controlled acts. A controlled act, as set out in the *Regulated Health Professions Act, 1991* (RHPA), is a health care service that requires appropriate authority and competence to ensure client safety (for example, administering a substance by injection is a controlled act). Aesthetics services can carry the same risks for clients as medical procedures, including adverse events such as infection, pain, and in serious cases, even death. As more nurses provide aesthetic services involving more complex procedures and controlled acts in non-traditional health care settings, CNO has an accountability to evolve to practice standards to support safe, ethical and quality care.

Drivers for CNO exploring aesthetics included emerging professional conduct data and action other regulators were exploring (these are described in the evidence below). As CNO explored multiple sources of data, it became clear that there were potential gaps

[2] This applies to Nurse Practitioners (NPs) as well as Registered Nurse (RNs) who are authorized to prescribe a drug

in expectations, which led CNO to propose potential changes to standards that are being considered by Council.

What are authorizing mechanisms?

Authorizing mechanisms are a means by which the authority to perform an intervention is obtained, or the decision is made to perform an activity. It is through these authorizing mechanisms that a nurse obtains the authority to perform a controlled act. Controlled acts are defined in the RHPA as acts which may be performed or delegated by authorized regulated health professionals. Health profession-specific legislation, such as the *Nursing Act, 1991*, sets out which controlled acts each health profession is authorized to perform. For example, RN/RPNs are authorized to administer a substance by injection if ordered by a nurse practitioner (NP) or a physician. Controlled acts are considered potentially harmful if performed by someone who does not have the required knowledge, skill, and judgment.

There are two types of authorizing mechanisms:

- **Orders**
  - A client-specific order may authorize a procedure for an individual client that could occur over time - with the specifics for that individual client and their individual needs, such as frequency of a procedure, as part of the client-specific order (for example, an NP ordering a specific antibiotic for a client with an infection – with a stated amount, route and frequency for that antibiotic)
  - A directive is an order for an activity that may be implemented for multiple clients when specific conditions and circumstances are met (for example, if a patient presents to the Emergency Room with a suspected heart attack, a directive could allow a nurse to perform an electrocardiogram, administer aspirin and/or draw blood for a client who meets the defined conditions, without waiting for a client-specific order)
- **Delegation**
  - If an individual does not have legislated authority to perform a controlled act, whether they are regulated or unregulated, a regulated care provider who has authority to perform the controlled act (through their health profession specific act) can temporarily give the ‘delegatee’ authority to perform the controlled act by having it “delegated” to them
  - A nurse who delegates a controlled act is responsible for the decision to delegate and for ensuring all of the requirements for delegation are met (see *Scope of Practice* standard)

Evidence and engagement that informed the proposed changes

The proposed changes are informed by evidence including CNO's professional conduct and practice inquiry data, literature, regulatory body reviews and consultation with system partners. The analysis found inconsistencies across aesthetics practice and potential gaps in expectations.

The analysis of Professional Conduct case file data from 2019-2025 related to aesthetic practice showed the following:

- NPs were disproportionately represented in aesthetic cases compared with other matters
- Concerns disproportionately relate to consent, scope of practice including authorizing mechanisms, fraud and fees

The analysis of CNO practice-related inquiries from 2022-2025 also captured new and emerging scenarios, trends, and issues. Nurses are increasingly asking about aesthetic procedures, and they have questions about their scope of practice, new technology and treatments, and non-traditional practice settings.

While there was limited literature on the regulatory aspects of this practice setting, the available evidence points to the need for strengthened regulatory expectations, to promote safe nursing practice and client safety. Please see the reference list for articles reviewed.

With respect to other regulators, CNO reviewed web content and met with a number of nursing and physician regulators from across Canada, as well as health profession regulators in Ontario. The majority of nursing regulators have set expectations and/or have guidance to support safe client care in aesthetics practice. Many nursing and physician regulators across Canada have expectations for authorizing mechanisms that are similar to the changes to standards CNO is proposing (for example, not allowing directives for aesthetics procedures involving prescription drugs and/or controlled acts).

Also, CNO engaged and received input and general support for the proposed revisions from system partners, including Health Canada with respect to requirements of the *Food and Drug Regulations*, public health units, nursing associations, employers and academic institutions. Key recommendations, which are reflected within the proposed changes to Council, included consistency of language and the integration of additional areas of risk, such as infection prevention and control measures.

Further, CNO engaged members of CNO's Nurse Advisory Group and Nurse Practitioner Advisory Group. They reviewed and provided feedback on draft material and gave input on areas of risk.

To gain insight into the public perspective, CNO engaged the Citizen Advisory Group to provide feedback on the proposed changes related to aesthetic services specifically regarding:

- whether clients should receive an individual assessment and have a treatment plan before receiving aesthetic procedures that involve prescription drugs and/or controlled acts
- whether a nurse should be onsite during an aesthetic procedure involving a controlled act that they delegated (for example, administering a substance by injection)
- other risks or concerns

CNO heard that all respondents felt strongly that clients should be appropriately assessed prior to establishing a treatment plan for aesthetics procedures. Respondents expressed concern that each client may have unique needs that would influence treatments and the care provided. Additionally, most felt that nurses should be onsite supervising unregulated care providers during the procedures due to the potential risk and support needed to manage complications. When asked about the requirement for assessment, one respondent stated “each client is different and should be assessed before any treatment. An assessment could avoid potential issues and highlight areas of concern.”

Summary of changes based on feedback

System partner and survey feedback informed numerous changes to the *Scope of Practice* and *Medication* standards outlined in Attachment 3. In summary the changes include:

- clarifying assessment can be completed in-person or when appropriate, virtually
- replacing the term ‘direct orders’ with ‘client-specific orders’
- clarifying that ‘client-specific orders’ can apply to a single point in time, or for treatment over an extended period
- clarifying that delegation is only applicable to controlled acts that the individual does not have legislated authority to perform or when there are no restrictions to the individual’s registration or through their regulatory college (specifically, RNs and RPNs do not require delegation when performing controlled acts such as injections or procedures below the skin)
- integrating examples of delegation, including to unregulated care providers for injections
- clarifying onsite requirements for delegating to unregulated care providers or non-nurse regulated health care providers when providing aesthetic services

During the consultation period, CNO received questions from nurses and system partners about the proposed changes, responded to media requests and monitored social media. Monitoring activities allowed CNO to assess support for the changes (e.g. over social media) and correct any misinformation about delegation and client-specific orders.

After the consultation ended, a forum of Canadian physicians who work in aesthetic medicine wrote "to express our strong support for the recent efforts to strengthen public protection in aesthetic practice, including the Aesthetic Services guideline and the proposed changes that would require direct orders". They also offered recommendations (some of which are already captured in CNO documents, some of which may inform guidance to support implementing the changes pending Council's decision).

Knowledge translation resources

To support knowledge translation for the revised *Scope of Practice* and *Medication* standards, CNO will use a variety of approaches. CNO will host webinars to introduce the upcoming changes and give nurses, employers and self-employed nurses time to prepare. CNO will also use approaches that support accessible and efficient learning such as creating micro-learning videos and frequently asked questions to support the application of concepts. The *Aesthetic Services* practice guideline, that was published in July 2026 to support nurses working in aesthetic settings, will also be revised to reflect the changes to the standards, if approved.

The revised practice standards will be promoted in all external presentations, conferences, and exhibitor booths. CNO will continue to monitor questions that arise and will develop additional resources to support understanding and use in practice.

Next steps

Subject to Council's approval, CNO will:

1. engage and help nurses and other system partners to understand and implement the changes
2. develop new resources and revise existing resources to support application of the revised standards
3. update CNO's *Aesthetic Services* practice guideline to reflect the changes to the standards
4. Ongoing monitoring related to aesthetic services

Attachments

1. Draft changes to *Scope of Practice* standard
   - Highlighted green font reflects proposed additions; highlighted blue strikethrough reflects proposed deletions
2. Draft changes to *Medication* standard
   - Highlighted green font reflects proposed additions; highlighted blue strikethrough reflects proposed deletions
3. Summary of Public Consultation Survey

Reference List

Role of the Licensed Nurse in the Practice of Aesthetics. (2022). *ASBN Update, 27*(6), 16

Barton, C. (2023). The safeguarding gap. *Journal of Aesthetic Nursing, 12*(8), 345.

Brennan, A. (2023). Towards a specialist practitioner in aesthetic nursing. *Journal of Aesthetic Nursing, 12*(9), 406–409.

Mather, L. (2023). The advantages and challenges associated with the Government's legislation for the aesthetics sector in England. *Journal of Aesthetic Nursing, 12*(9), 403–405.

Administration of Cosmetic/Aesthetic Medications. (2022). *Momentum (Ohio Board of Nursing), 20*(4), 30.

Lee, A. (2022). How national regulation will improve patient outcomes. *Journal of Aesthetic Nursing, 11*(10), 450–454.

Sudetic, J. (2023). Facility Recommendations for Medical Aesthetic Procedures in Canada. *Plastic & Aesthetic Nursing (PAN), 43*(3), 124–130.

Sines, D. (2024). Continuing the journey towards the achievement of public protection, safeguarding and regulatory oversight. *Journal of Aesthetic Nursing, 13*(3):99-102.

Practice Standard

Scope of Practice

ET INFIRMIERS DE L'ONTARIO

Nurses[1] often face decisions about whether they can perform specific activities. This practice standard outlines the legislated scope of nursing practice and other key requirements for nurses when deciding whether to perform an **activity** for safe client care. The term **client** care is used broadly to represent nursing practice across the system with individuals, families, communities or populations and includes paid or volunteer roles.

Scope of practice refers to a range of activities that nurses' have the legislated **authority** to perform. This authority is defined in legislation, namely the *Nursing Act, 1991* and the *Regulated Health Professions Act, 1991* (RHPA). Employer policies and practice setting requirements, as well as the individual nurse's **competence**, also impact nurses' decisions and accountability related to scope of practice. This standard outlines the expectations for all nurses when determining if they have the authority to perform a specific activity, if it is appropriate for them to perform and if they are competent to perform the activity safely.

The *Nursing Act, 1991*, defines the nursing scope of practice as:

The practice of nursing is the promotion of health and the assessment of, the provision of care for and the treatment of health conditions by supportive, preventive, therapeutic, palliative and rehabilitative means to attain or maintain optimal function.[2]

This standard expands on the accountabilities found in the *Code of Conduct* (the Code), the central practice standard for nurses. Nurses are expected to practice in compliance with relevant legislation, the Code and all other CNO practice standards. Contravening legislation or failing to meet the standards of practice could be **professional misconduct**.

[1] In this document, nurse refers to a Registered Nurse (RN), Registered Practical Nurse (RPN), and Nurse Practitioner (NP).

[2] See section 3 of the *Nursing Act, 1991*.

To meet the expectations of this standard, a nurse must consider each of the following key concepts:

Authority

Nurses must know their legislated scope of practice, including controlled acts, and **authorizing mechanisms**.

Context

Nurses must determine if their practice environment or setting supports the performance of an activity and has the available resources to support safe client care.

Competence

Nurses must ensure they have the individual knowledge, skill and judgment to perform an activity.

Each concept includes a set of nursing accountabilities, which are described in this practice standard. To ensure it is appropriate to perform an activity, nurses are expected to demonstrate these accountabilities.

This practice standard integrates information from and replaces the *Decisions about Procedures and Authority* practice standard and two guidelines, *Authorizing Mechanisms*, and the *RN and RPN Practice: The Client, the Nurse, and the Environment*.

Bolded terms are defined in the glossary at the end of the document.

AUTHORITY

Nurses must ensure they have the legal authority prior to performing any activity. This includes ensuring their practice complies with all relevant legislation, they have the appropriate authorizing mechanisms in place and they have assessed the **context** of their practice and their own competence to ensure they can provide safe client care.

Legislation

Nurses are accountable to practice in compliance with the regulations under the RHPA and the *Nursing Act, 1991*. The RHPA applies to all regulated health professions, while the *Nursing Act, 1991* is specific to the nursing profession. These Acts give nurses the legal authority to perform activities, including controlled acts.

Other legislation also may be relevant to a nurse's practice. Nurses are accountable to comply with all legislation that applies to their practice or practice setting.

Controlled acts

Controlled acts are defined in the RHPA[3] as acts which may be performed only by authorized regulated health professionals. The *Nursing Act, 1991*, authorizes nurses to perform specific controlled acts when providing health care services to an individual. Controlled acts are considered potentially harmful if performed by someone who does not have the required knowledge, skill and judgment.

Controlled acts authorized to RNs and RPNs

Registered Nurses (RNs) and Registered Practical Nurses (RPNs) are authorized to perform the following five controlled acts, if ordered by a physician, dentist, chiropodist, midwife or Nurse Practitioner (NP), or if initiated in accordance with conditions set out in the regulation, and as authorized in their practice setting[4]:

1. performing a prescribed procedure below the dermis or a mucous membrane

2. administering a substance by injection or inhalation

3. putting an instrument, hand or finger
   i) beyond the external ear canal
   ii) beyond the point in the nasal passages where they normally narrow
   iii) beyond the larynx
   iv) beyond the opening of the urethra
   v) beyond the labia majora
   vi) beyond the anal verge
   vii) into an artificial opening into the body

4. treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning

5. dispensing a drug

Additionally, RNs and RPNs may dispense or administer by injection or inhalation certain medications[5] if ordered by RNs with prescribing authority, if permitted by the setting and in compliance with all relevant legislation, the standards of practice of the profession and applicable employer policies. See *Medication* practice standard for dispensing requirements.

[3] See subsection 27(2) of *RHPA, 1991.*

[4] Subject to the terms, conditions and limitations imposed of the certificate of registration.

[5] See subsections 18(3) and 20(3) of O. Reg. 275/94.

Controlled acts authorized to RNs with prescribing authority

Registered Nurses who have completed CNO's Council-approved education are authorized to perform the following additional controlled acts,[6] in accordance with conditions set out in the regulation, and as authorized by their practice setting:

1. prescribe a medication, or a drug from within a category of medications, set out in the regulation

2. communicate to a client or a client's representative a diagnosis made by the RN where the purpose of that communication is for prescribing the medication

Additionally, RNs with prescribing authority may dispense or administer by injection or inhalation a medication they are authorized to prescribe without an order from another authorized provider.[7] For more information about RN prescribing, see the *Registered Nurse (RN) Prescribing* practice standard.

Controlled acts authorized to Nurse Practitioners

Nurse Practitioners have an extended scope of practice and are authorized to diagnose, order and interpret diagnostic tests, prescribe medications and order other treatments for clients. Nurse Practitioners are autonomous and are accountable for their own practice and to employer policies. Controlled acts are not the only legislated authority informing a NP's scope of practice and accountabilities. For more information related to NPs' scope of practice and accountabilities, please review the *Nurse Practitioner* practice standard.

Nurse Practitioners are authorized to perform the following eight controlled acts:[8,9]

1. communicating to a client or client's representative a diagnosis made by the NP identifying as the cause of a client's symptoms, a disease or disorder

2. performing a procedure below the dermis or a mucous membrane

continued >

[6] See subsection 5.1(1) of the *Nursing Act, 1991.*
[7] Subject to the terms, conditions and limitations imposed on the certificate of registration.
[8] See subsection 5.1(1) of the *Nursing Act, 1991.*
[9] Subject to the terms, conditions and limitations imposed on the certificate of registration.

3. putting an instrument, hand or finger
   i) beyond the external ear canal
   ii) beyond the point in the nasal passages where they normally narrow
   iii) beyond the larynx
   iv) beyond the opening of the urethra
   v) beyond the labia majora
   vi) beyond the anal verge
   vii) into an artificial opening into the body

4. applying or ordering the application of a specified form of energy

5. setting or casting a fracture of a bone or dislocation of a joint

6. administering a substance by injection or inhalation, in accordance with the regulation or when it has been ordered by another health care professional or physician who is authorized to order the procedure

7. prescribing, dispensing, selling and compounding a drug in accordance with the regulation

8. treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning

Exemptions and exceptions

The RHPA identifies some exemptions that permit nurses, under some conditions, to perform specific controlled acts that do not require an order or **delegation** for the performance of the controlled acts. Some settings or organizations may still require orders for these controlled acts for client safety.
The RHPA[10] also provides some exceptions that allow persons who are not authorized as members of a regulated health profession, for example, unregulated care providers, to perform controlled acts in some situations, including emergency situations. For a list of exemptions and exceptions see Appendix A: Exemptions and exceptions for controlled acts.

[10] See Section 29 of the RHPA.

Authorizing mechanisms

There are two ways RNs and RPNs obtain authority to perform a controlled act:

 orders

 delegation

Orders

An order is an authorizing mechanism for a procedure, treatment, drug or activity. Orders include ~~direct orders~~ client-specific orders and **directives**. An order is required when an activity:

- is a controlled act authorized to nursing, with the exception of those controlled acts that a nurse may **initiate** on their own authority (see Appendix ~~D~~B: RN and RPN initiation of controlled acts)
  - ✓ Nurses can accept orders for controlled acts from the following authorized providers: Physicians, Nurse Practitioners, Dentists, Chiropodists, Midwives and Registered Nurses with prescribing authority[11]
- involves the administration of a prescription medication that does not involve a controlled act (for example, oral or topical)
  - ✓ Nurses can accept an order to administer a prescription medication that does not involve a controlled act from a prescriber who has the authority through their health profession specific legislation
- is delegated and does not fall under a controlled act authorized to nursing
- is a requirement by legislation that applies to a practice setting, such as the *Public Hospitals Act.*

Orders may also be required as part of the client's plan of care or if specified in practice-setting policies.

[11] See subsection 5(1) of the *Nursing Act, 1991* and section 20 of regulation 275/94 under the *Nursing Act, 1991*.

~~Direct orders~~ Client-specific orders

~~A direct order is client-specific regarding an activity. It may be written or verbal (oral).~~ A client-specific order is a written or verbal order for an individual client. Verbal orders must be ~~only be~~ used only in emergency situations or when the ~~prescriber~~ provider ~~is unable to~~ cannot document the order in the moment, such as in the operating room.

Before issuing a client-specific order, NPs must complete an initial client assessment, in-person or virtual[12], and establish a plan of care with follow-up. RNs with prescribing authority must also ensure an initial assessment is complete before issuing a client-specific order.

Directives

A directive is an order for an activity or series of activities that may be implemented for a number of clients when specific conditions are met and specific circumstances exist. A directive is always written by a regulated health professional who has the legislated authority to order the activity and for which they have the ultimate responsibility. For more information, see the *Directives* practice guideline.

Practices requiring a client-specific order

Many practice areas use client-specific orders; however, given the increased risk of harm involved, nurses must use client-specific orders in the following practices.

Controlled substances

Federal legislation requires that NPs issue client-specific orders when prescribing controlled substances[13].

Aesthetic services

When providing **aesthetic services** that involve prescription drugs[14] or treatments involving controlled acts (for example, injections of any substance, whether a prescription drug or otherwise), CNO requires that NPs issue only client-specific orders, and nurses accept only client-specific orders from authorized providers. For more information on aesthetic services see the *Aesthetic Services* practice guideline.

[12] Refer to the *Virtual Care* practice guideline to inform when a virtual assessment is appropriate.

[13] Section 127 of the *Controlled Substances Regulations*.

[14] *The Food and Drug Regulations* specify the sale of prescription drugs (for example, neuromodulators) requires a client-specific order from an authorized prescriber (for example, NP, physician). *Food and Drugs Regulations*, made under the *Food and Drugs Act*.

Nurses and delegation

Delegation occurs when a nurse or other regulated health professional (**delegator**), who is legally authorized and competent to perform a controlled act[15], temporarily grants their authority to perform that controlled act to another individual (**delegatee**). Nurses can delegate controlled acts that they have the authority to perform, as noted in the section on controlled acts (see page 6), and nurses can receive delegation of controlled acts that they are not otherwise authorized to perform, if requirements are met. (See delegation requirements on page 12).

Delegation by nurses

Nurses who are authorized to perform controlled acts can delegate them to certain individuals, including ~~other regulated health professionals or~~ unregulated care providers or other regulated health professionals[16], subject to the restrictions outlined below (see page 12)~~, for example, family members of clients~~. A nurse who delegates a controlled act is responsible for the decision to delegate and for ensuring the delegatee is competent to perform the controlled act. For example, a nurse may delegate performing an injection to an unregulated care provider since the nurse has the authority to perform this controlled act.

Delegation to nurses

Nurses can receive delegation for controlled acts they are not authorized to perform. Nurses who perform controlled acts delegated to them are responsible for the decision to carry out the controlled act and for the performance of the

[15] Controlled acts nurses have access to are in the *Nursing Act, 1991*: sections 4, 4.1, 5.1.

[16] Nurses can delegate to other regulated health professionals who do not have access to the controlled act through their profession specific act.

act. ~~A nurse's responsibility may include delegating activities and accepting delegation of activities according to regulation, which specifies requirements that must be met. See Appendix B: Requirements for delegating controlled acts and Appendix C: Requirements for accepting delegation of controlled acts.~~ For example, an RPN may receive delegation from an NP to communicate a diagnosis to a client, as this is a controlled act not authorized to RPNs.

Delegation requirements

Delegation requirements include those set out in regulation under the *Nursing Act, 1991*, and those set by this standard to support safe delegation. All nurses are accountable to these requirements when delegating the authority to perform a controlled act to an unregulated care provider or another regulated health professional, and when receiving delegation. As delegation is a temporary, client-specific transfer of authority for a controlled act only, the delegating nurse remains responsible for the client's ongoing nursing care, including assessment, care planning and follow-up.

Requirements for delegating controlled acts

Regulation 275/94 under the *Nursing Act, 1991*, requires that the delegating nurse has:

1) the authority under the *Nursing Act, 1991*, to perform the controlled act
2) the knowledge, skill and judgment to perform the controlled act safely and ethically
3) a nurse-client relationship with the client for whom the controlled act will be performed
4) considered whether the delegation of the controlled act is appropriate, bearing in mind the best interests and needs of the client
5) taken reasonable steps to ensure that sufficient safeguards and resources are available to the delegatee so that the controlled act may be performed safely and ethically
6) considered whether delegation of the controlled act should be subject to any conditions to ensure that it is performed safely and ethically and has made the delegation subject to conditions
7) after taking reasonable steps, is satisfied that the delegatee is a person who is permitted to accept the delegation
8) after taking reasonable steps, is satisfied that the delegatee is,
   (a) a member of the CNO who has a nurse-client relationship with the client
   (b) a health care provider who has a professional relationship with the client
   (c) a person in the client's household, or
   (d) a person who routinely provides assistance or treatment for the client
9) ensured the delegatee has the knowledge, skill and judgment to perform the controlled act safely and ethically

10) delegated a controlled act but has reasonable grounds to believe that the delegatee no longer has the ability to perform the controlled act safely and ethically, the nurse must immediately cease to delegate the controlled act to that delegatee

11) documented details of the delegation that must include:

(a) a written record of the particulars of the delegation and is available in the place where the controlled act is to be performed, before it is performed

(b) a written record of the particulars of the delegation, or a copy of the record, is placed in the client record at the time the delegation takes place or within a reasonable period of time afterwards

(c) recording particulars of the delegation (the date of the delegation, the delegatee's name) in the client record either at the time the delegation takes place or within a reasonable period of time afterwards.

This standard requires that a nurse meet all of the following additional requirements for delegation. The nurse must:

1) assess the client

2) ensure the treatment ordered is appropriate with a clear understanding of ongoing management and follow up, including the nurse's accountability to follow up after the delegated act has been performed

3) communicate to the client plans for delegation and obtain their consent for the activity

4) actively assess whether delegation is appropriate or if the nurse (delegator) should be performing the controlled act instead of the potential delegatee based on the client's needs

5) not delegate when the primary reasons for delegating are for monetary gain and/or convenience

6) assess the environment where the controlled act will be performed and ensure it is safe and suitable, including infection prevention and control measures (for more details, see below Principle: Context)

7) if the delegatee is a regulated health professional, ensure through the delegatee's regulatory college that the delegatee is not in the Non-Practising Class or Inactive Class and their registration is not revoked or suspended, or subject to terms, conditions or limitations, that may restrict them from accepting delegation

8) assess the knowledge, skill and judgment of the delegatee, and where possible observe, or validate the delegatee's ability to perform the controlled act, including related to identifying and managing anticipated outcomes and complications or escalating when needed

9) ensure ongoing supervision and assessment of the delegatee and follow-up of the client, to ensure the controlled act is being performed safely and ethically.

Requirements for the nurse accepting delegation of controlled acts

Regulation 275/94 under the *Nursing Act, 1991*, requires that the delegating nurse has:

1) the knowledge, skill and judgment to perform the controlled act safely and ethically

2) a nurse-client relationship with the client for whom the controlled act is to be performed

3) considered whether performing the controlled act is appropriate, bearing in mind the best interests and needs of the client

4) after taking reasonable steps, is satisfied that there are sufficient safeguards and resources available to ensure that the controlled act can be performed safely and ethically

5) no reason to believe that the delegator is not permitted to delegate that controlled act

6) if the delegation is subject to any conditions ensured that the conditions have been met

7) after performing a controlled act that was delegated to them must record the particulars of the delegation in the client record, unless:

   (a) a written record of the particulars of the delegation is available in the place where the controlled act is to be performed

   (b) a written record of the particulars of the delegation, or a copy of the record, is in the client record

   (c) the particulars of the delegation have already been recorded in the client record (the date of the delegation, the delegator's name, if controlled act was delegated to the nurse, the conditions, if any, applicable to the delegation).

Delegation restrictions

Regulations under the *Nursing Act, 1991* contain the following:

The following are delegation restrictions for nurses:

- nurses cannot delegate a controlled act that has been delegated to them. This is referred to as sub-delegation[17]
- nurses in the Temporary Class[18] and the Emergency Class[19] are not permitted to delegate or accept delegation
- nurses in the Special Assignment Class[20] are not permitted to delegate to other health care professionals.

[17] See subsection 37(2) of O. Reg. 275/94.

[18] See subsection 5.1(1), paragraphs 5 and 6 of O. Reg. 275/94.

[19] See subsection 7(5)6 and 7(5)7 of O. Reg. 275/94.

[20] See subsection 6(5)5 of O. Reg. 275/94.

Registered Nurses and RPNs cannot delegate these controlled acts:[21]

- treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning
- dispensing a drug.

Registered Nurses with prescribing authority cannot delegate these controlled acts:[22]

- prescribing a medication
- communicating to a client or a client's representative a diagnosis made by the RN where the purpose of that communication is for prescribing the medication.

Nurse Practitioners cannot delegate these controlled acts:[23]

- prescribing, dispensing, selling or compounding medication
- ordering the application of a form of energy
- setting a fracture or joint dislocation
- treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.

Added delegation requirements for aesthetic services:

Given the risks involved in nursing practice related to aesthetics services, CNO requires that nurses who are delegating controlled acts to unregulated care providers or other non-nurse health providers:

- must be onsite for the entirety of the procedure when they have delegated an aesthetics procedure.

[21] See subsections 35(2) and 35(3) of O. Reg. 275/94.

[22] See section 36(2)-(5) of O. Reg. 275/94.

[23] See section 36(2)-(5) of O. Reg. 275/94 For example, nurses are not allowed to initiate controlled acts under The *Public Hospital's Act, 1990.*

When an authorizing mechanism is not required: Initiation

Initiation[24] occurs when RNs or RPNs are permitted by regulation to independently assess and perform specific controlled acts without an order. Not all nurses will be able to initiate specific controlled acts, as this authority may not apply to certain practice settings because of legislation[25] or facility policies. As with all activities, nurses must ensure they have informed consent. See Appendix ~~D~~B: RN and RPN initiation of controlled acts.

Nursing accountabilities: Authority

Nurses are expected to demonstrate the following nursing accountabilities in relation to authority:

- know and work in compliance with legislation, including
  - ✓ performing controlled acts only in the context of a therapeutic nurse-client relationship
  - ✓ ensuring appropriate authority is in place in the form of ~~direct orders~~ client-specific-orders or directives
  - ✓ following orders that are clear, complete and appropriate
  - ✓ ensuring delegation, in addition to an order, is permitted and in place before performing a controlled act that is not authorized under the *Nursing Act, 1991*
  - ✓ ensuring that the initiation of activities complies with the regulatory and practice-specific legislation and employer policies
- document orders and activities performed or initiated as outlined in the *Documentation* practice standard
- obtain informed consent as outlined in the *Consent* practice guideline

[24] See sections 15 and 15.1 of O. Reg. 275/94 of the *Nursing Act, 1991.*

[25] For example, nurses are not allowed to initiate controlled acts under The *Public Hospital's Act, 1990.*

CONTEXT

A nurse who has the legal authority to perform an activity must also consider if it is appropriate to do so within the context of their practice setting. Context may include the broader environment in which nurses work, the health care setting and the available resources to support the nurse and client.

A quality practice setting is a workplace that supports nursing practice, fosters professional development and promotes the delivery of quality care. This includes where and how care is provided to ensure all safety precautions are taken.

Nurses must ensure their practice complies with all applicable legislation, including practice specific legislation and employer policies. Nurses must recognize that employers can limit but cannot expand their legislated scope of practice. When employer policies conflict, nurses' primary accountability is to meet the CNO standards of practice. Nurses must ensure compliance with practice standards and advocate for policies that support safe client care.

Client safety is a shared responsibility and requires partnership. As partners, both employers and nurses, share accountability for creating environments that support quality practice. Nursing is a profession focused on collaborative relationships that promote the best possible outcomes for clients. Nurses foster interprofessional relationships and routinely collaborate and communicate with the health care team to provide safe client care.

Nursing accountabilities: Context

Nurses are expected to demonstrate the following accountabilities in relation to context:

- ensure practice setting policies permit and support nurses to perform an activity
- assess and advocate for the necessary resources to support the performance of an activity and to manage outcomes
- support the development of a practice environment that enhances collaboration and leads to improved client outcomes
- consider any environmental risks that could impact the ability to safely perform an activity
- consult and advocate to the employer for clear employer policies and procedures
- collaborate and communicate with other health care team members for safe and effective client care and as needed, escalate to an appropriate health care provider
- refrain from any activity that is not appropriate or safe for clients in the practice setting or under workplace policies
- perform activities in practice settings where health services are routinely performed
- comply with all safety requirements, for example, infection, prevention and control, using best available evidence to inform practice

COMPETENCE

A nurse who has the legal authority and has assessed the context of their practice environment also must ensure they have the competence to safely perform an activity. Competence is the knowledge, skill and judgment required to perform an activity safely within a nurse's role and practice setting. Nursing competence also includes leadership, decision-making and critical-thinking skills. Nurses are accountable to continually reflect on their practice and determine their learning needs to ensure they can provide safe client care.

An individual nurse's competence can evolve over time. Being self-reflective and committed to life-long learning is a critical part of providing safe client care. Nurses participate in quality assurance activities throughout their careers. This includes continually self-reflecting, identifying learning needs and developing a learning plan to maintain competence. Nurses also must participate in CNO's Quality Assurance program, which is a legislated requirement in the RHPA.[26]

The requirements needed to achieve the competence to safely perform a particular activity is specific to each nurse and includes education, training and experience. Nurses are expected to communicate with their employer if they require additional learning or professional development to provide safe client care.

[26] See the Health Professions Procedural Code in Schedule 2 of the *Regulated Health Professions Act, 1991.*

Nursing accountabilities: Competence

Nurses are expected to demonstrate the following nursing accountabilities in relation to competence:

- demonstrate the knowledge, skill, and judgment to perform an activity safely and effectively, including
  - ✓ understanding the client's overall condition and needs
  - ✓ understanding the purpose of the intervention
  - ✓ understanding the indications and contraindications
  - ✓ assessing the risks and benefits
  - ✓ demonstrating cognitive and technical competence to perform the activity
  - ✓ managing potential outcomes and modifying actions as appropriate
- determine if the client's condition warrants the performance of the activity
- perform an activity that is based on the best interests of the client and includes the client's wishes
- consult or transfer care to another care provider when necessary for safe client care
- refrain from performing any activity when not competent to perform and, as needed, escalate to an appropriate health care provider
- self-reflect, identify learning needs and continuously seek out and integrate learning to improve their knowledge, skill and judgement in relation to their practice
- participate in CNO's Quality Assurance Program

GLOSSARY

Activity: An intervention, procedure or action taken to promote, manage and support client care.

Aesthetic services: Are the provision of procedures, including those that involve controlled acts, for the purpose of cosmetic treatment to enhance, preserve or alter a client's appearance. Examples of aesthetic services provided by nurses include but are not limited to the administration of neuromodulators, dermal fillers, thread lifts, platelet rich plasma and microneedling.

Authority: When a nurse is legally entitled to perform an activity by the RHPA, the *Nursing Act, 1991* and the regulations under those Acts, is permitted by setting-specific legislation and employer policies and the required authorizing mechanisms are in place.

Authorizing mechanism: A means by which the authority to perform an intervention is obtained or the decision is made to perform an activity.

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

~~**Direct orders**~~ **Client-specific orders:** ~~Client specific orders~~ An order for an individual client that may be written or verbal. A health care professional, such as a physician, NP, dentist, chiropodist, midwife or RN with prescribing authority, can give a ~~direct order~~ client-specific order ~~for~~ to authorize a specific ~~activity~~ procedure, treatment, drug or activity, to be administered at a specific time or which could occur over time.

Competence: The knowledge, skill and judgment required to perform an activity safely and manage outcomes within a nurse's role and practice setting.

Context: The broader environment in which nurses work, the health care setting and the available resources to support the nurse and client.

Delegatee: The individual receiving delegation from a regulated health professional who has the authority and competence to perform an intervention under one of the controlled acts.

Delegation: A formal process through which a regulated health

professional (delegator), who has the authority and competence to perform a procedure under one of the controlled acts, temporarily delegates the performance of that procedure to another individual (delegatee).

Delegator: An authorized regulated health professional who transfers to another individual the authority to perform an intervention under one of the controlled acts.

Directive: An order for an activity or series of activities that may be implemented for a number of clients, when specific conditions are met and specific circumstances exist. A directive is always written by an individual or a group, who are authorized regulated health care provider(s), who have the legislated authority to order the activity and for which they have ultimate responsibility.

Initiate: A process where RNs or RPNs are permitted to independently assess and perform specific controlled acts without an order, in certain settings pursuant to the authority and conditions set out in the regulation.

Professional misconduct: An act or omission that contravenes nurses' legislated obligations and/or the standards of practice and ethics of the profession. Professional misconduct is defined in section 51(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professionals Act, 1991*, and further described in the Professional Misconduct regulation (O.Reg, 799/93) under the *Nursing Act, 1991*.

APPENDIX A: EXEMPTIONS AND EXCEPTIONS FOR CONTROLLED ACTS

The RHPA provides several exemptions and exceptions that allow persons who are regulated health professionals, unregulated care providers and members of the public to perform controlled acts.

These exemptions include:

- ear piercing or body piercing for the purpose of accommodating a piece of jewelry[27]
- electrolysis
- tattooing for cosmetic purposes
- male circumcision as part of a religious tradition or ceremony[28]
- taking a blood sample by a person employed by a laboratory licensed under the *Laboratory and Specimen Collection Centre Licensing Act, 1990*[29]
- diagnostic ultrasound[30]
- acupuncture[31]
- prescribing normal saline for venipuncture[32]

These exceptions[33] include:

- providing first aid or temporary assistance in an emergency
- under the supervision or direction of a member of the profession, a student is learning to become a member of that profession and the performance of the procedure is within the scope of the professional's practice
- treating a person by prayer or spiritual means in accordance with the religion of the person giving the treatment
- treating a member of a person's household and the procedure is within the second[34] or third[35] controlled act authorized to nursing
- assisting a person with their routine activities of living and the procedure is within the second or third controlled act authorized to nursing

continued >

[27] *Regulated Health Professions Act* O. Reg. 107/96, s. 8; S.O. 2006, c. 27, s. 19 (1).
[28] Section 9 of O. Reg. 107/96.
[29] Section 11 of O. Reg. 107/96.
[30] See section 4.1 in O. Reg. 107/96.
[31] Section 8(2), (3), (5)-(6), of O. Reg. 107/96.
[32] Section 13 of O. Reg. 107/96.
[33] See subsection 30(5) in the *Regulated Health Professions Act, 1991.*
[34] Administering a substance by injection or inhalation.
[35] Putting an instrument, hand or finger as listed in subsection 4(3) of the *Nursing Act, 1991.*

Emergency situations

The RHPA allows members of the public and regulated health care providers to perform controlled acts without authorization when providing first aid or temporary assistance in an emergency.[36]
CNO maintains, however, that in situations in which it is anticipated that emergencies will likely occur, such as in a hospital or long-term care facility, nurses should ensure a standardized process to enable nurses to attain and maintain competence in performing emergency procedures that are outside the controlled acts authorized to nursing. This process includes:

- education and ongoing assessment of competence with the involvement of a health professional authorized and competent to perform the procedure
- documentation of the process
- written criteria to select appropriate clients and identify treatment parameters
- necessary authority and/or resources to manage client outcomes

[36] See subsection 29(1) in the R*egulated Health Professions Act, 1991.*

APPENDIX B: REQUIREMENTS FOR DELEGATING CONTROLLED ACTS

As outlined in the regulation under the Nursing Act, 1991, a nurse may delegate when all the following requirements[37] are met:

Requirement 1
The nurse has the authority under the Nursing Act, 1991, to perform the controlled act.

Requirement 2
The nurse has the knowledge, skill and judgment to perform the controlled act safely and ethically.

Requirement 3
The nurse has a nurse-client relationship with the client for whom the controlled act will be performed.

Requirement 4
The nurse has considered whether the delegation of the controlled act is appropriate, bearing in mind the best interests and needs of the client.

Requirement 5
After taking reasonable steps, the nurse is satisfied that sufficient safeguards and resources are available to the delegatee so that the controlled act may be performed safely and ethically.

Requirement 6
The nurse has considered whether delegation of the controlled act should be subject to any conditions to ensure that it is performed safely and ethically and has made the delegation subject to conditions.

Requirement 7
After taking reasonable steps, the nurse is satisfied that the delegatee is a person who is permitted to accept the delegation and is

- a member of CNO who has a nurse-client relationship with the client
- a health care provider who has a professional relationship with the client
- a person in the client's household
- a person who routinely provides assistance or treatment for the client

continued >

[37] See sections 37, 39 and 42 of O. Reg. 275/94 of the Nursing Act, 1991.

Requirement 8

When the delegatee is a nurse or other regulated health professional, the nurse must be satisfied that the delegatee has the knowledge, skill and judgment to perform the controlled act safely and ethically.

When the delegatee is not a regulated health professional, the nurse must be satisfied that the delegatee has the knowledge, skill and judgment to perform the controlled act safely and ethically and that the delegation is appropriate for the client.

Requirement 9

If the nurse has delegated a controlled act but has reasonable grounds to believe that the delegatee no longer has the ability to perform the controlled act safely and ethically, the nurse must immediately cease to delegate the controlled act to that delegatee.

Requirement 10

The delegating nurse shall:

- ensure that a written record of the particulars of the delegation is available in the place where the controlled act is to be performed, before it is performed
- ensure that a written record of the particulars of the delegation, or a copy of the record, is placed in the client record at the time the delegation takes place or within a reasonable period of time afterwards
- record particulars of the delegation in the client record either at the time the delegation takes place or within a reasonable period of time afterwards

Any record of the particulars of a delegation must include:

- the date of the delegation
- the delegator's name, if the controlled act was delegated to the nurse
- the delegatee's name, if the controlled act was delegated by the nurse
- the conditions, if any, applicable to the delegation

APPENDIX C: REQUIREMENTS FOR ACCEPTING DELEGATION OF CONTROLLED ACTS

As outlined in the regulation under the Nursing Act, 1991, a nurse may accept delegation when all the following requirements[38] are met:

Requirement 1
The nurse has the knowledge, skill and judgment to perform the controlled act safely and ethically.

Requirement 2
The nurse has a nurse-client relationship with the client for whom the controlled act is to be performed.

Requirement 3
The nurse has considered whether performing the controlled act is appropriate, bearing in mind the best interests and needs of the client.

Requirement 4
After taking reasonable steps, the nurse is satisfied that there are sufficient safeguards and resources available to ensure that the controlled act can be performed safely and ethically.

Requirement 5
The nurse has no reason to believe that the delegator is not permitted to delegate that controlled act.

Requirement 6
If the delegation is subject to any conditions, the nurse has ensured that the conditions have been met.

Requirement 7
Nurses who perform a controlled act that was delegated to them must record the particulars of the delegation in the client record, unless

- a written record of the particulars of the delegation is available in the place where the controlled act is to be performed
- a written record of the particulars of the delegation, or a copy of the record, is in the client record
- the particulars of the delegation have already been recorded in the client record

Any record of the particulars of a delegation must include:

- the date of the delegation
- the delegator's name, if the controlled act was delegated to the nurse
- the delegatee's name, if the controlled act was delegated by the nurse
- the conditions, if any, applicable to the delegation

[38] See sections 41 and 42 of O. Reg. 275/94 of the Nursing Act, 1991.

APPENDIX ~~D~~B: RN AND RPN INITIATION OF CONTROLLED ACTS

As outlined in the regulation under the *Nursing Act, 1991*, RNs and RPNs may initiate[39] the following:

1. **care of a wound below the dermis or below a mucous membrane:**
   - cleansing
   - soaking
   - irrigating
   - probing
   - debriding
   - packing
   - dressing
2. **venipuncture to**
   - establish peripheral venous access and maintain patency when client requires medical attention and delaying venipuncture is likely to be harmful
   - 0.9% NaCl only
3. **for the purposes of assisting the client with health management activities that require putting an instrument beyond the**
   - point in the nasal passages where they normally narrow
   - larynx
   - opening of the urethra
4. **for the purpose of assessing the client or assisting the client with health management activities that require putting an instrument or finger beyond the**
   - anal verge
   - artificial opening into the client's body
5. **for the purposes of assessing a client or assisting the client with health management activities that require putting an instrument, hand or finger beyond the**
   - labia majora
6. **treating, by means of psychotherapy technique, delivered through a therapeutic relationship, an individual's serious disorder of thought, cognition, mood, emotional regulation, perception or memory that may seriously impair the individual's judgement, insight, behaviour, communication or social functioning.**

Registered Nurses who meet the conditions to initiate any of the above controlled acts may provide an order for an RN or an RPN to perform these specific controlled acts.

[39] See sections 15 and 15.1 of O. Reg. 275/94 of the *Nursing Act, 1991.*

Scope of Practice

Practice Standard

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AUG 2026-44-6-2

PRACTICE STANDARD

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

Medication

Table of Contents

Introduction

The purpose of the *Medication* practice standard is to outline nurses' accountabilities when engaging in medication practices, such as administration, **dispensing**, medication storage, inventory management and disposal.

Three principles outline the expectations related to medication practices that promote public protection:

- authority
- competence
- safety

All medications have potential to cause harm and nurses are accountable to comply with all relevant legislation, applicable employer policies and the standards of practice of the profession, when engaging in medication practices.

This practice standard applies to all nurses. Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs). In addition, NPs are accountable for the expectations outlined in the *Nurse Practitioner* practice standard, and RNs with prescribing authority are accountable for the expectations outlined in the *Registered Nurse (RN) Prescribing* practice standard.

Bolded terms are defined in the glossary.

Authority

Nurses must have the appropriate authority to perform medication practices.

RNs[1] and RPNs require an order for a medication practice when:

- a **controlled act** is involved
  - ✓ Nurses can accept orders for controlled acts from the following authorized providers: Physicians, Nurse Practitioners, Dentists, Chiropodists, Midwives and Registered Nurses with prescribing authority[2]
- administering a prescription medication[3] that does not involve a controlled act (for example, oral or topical)
  - ✓ Nurses can accept an order to administer a prescription medication from an authorized prescriber who has the authority through their health profession specific legislation
- it is required by legislation that applies to a practice setting, such as the *Public Hospitals Act.*

Nurses:

- accept orders that are
  - ✓ clear
  - ✓ complete
  - ✓ appropriate
- must have a therapeutic nurse-client relationship when engaging in all medication practices, including administering by injection or inhalation, or dispensing a medication
- must only dispense or administer by injection or inhalation medication for therapeutic purposes.

When a nurse receives a medication order that is unclear, incomplete or inappropriate, the nurse must not perform the medication practice. Instead, the nurse must follow up with a prescriber in a timely manner.

[1] RNs with prescribing authority may dispense or administer by injection or inhalation a medication that they are authorized to prescribe without an order from another authorized provider.

[2] See subsection 5(1) of the *Nursing Act, 1991* and section 20 of regulation 275/94 under the *Nursing Act, 1991*.

[3] Medications requiring a prescription can be found in the Health Canada Drug Product Database.

Orders for medication can be ~~direct orders~~ **client-specific orders**, which apply to one client, or **directives**, which apply to more than one client. ~~Orders for controlled substances must be direct orders.~~ For more information about orders and authorizing mechanisms, see *Scope of Practice* standard.

Practices requiring a client-specific order

Many practice areas use client-specific orders; however, given the increased risk of harm involved, nurses must use client-specific orders in the following practices.

Controlled substances

Federal legislation requires that NPs issue client-specific orders when prescribing controlled substances[4].

Aesthetic services

When providing aesthetic services that involve prescription drugs or treatments involving controlled acts (for example, injections of any substance, whether a prescription drug or otherwise), CNO requires that NPs issue only client-specific orders, and nurses accept only client-specific orders from authorized prescribers. For more information on aesthetic services see CNO's *Scope of Practice* standard and *Aesthetic Services* practice guideline.

The *Food and Drug Regulations*[5] specify the sale of prescription drugs (for example, neuromodulators) requires a client-specific order from an authorized prescriber.

Competence

Nurses ensure that they have the knowledge, skill and judgment needed to perform medication practices safely.

Nurses:

- seek information from the client about their medication history
- collaborate with the client in making decisions about the plan of care in relation to medication practices
- provide education to the client regarding their medication and strategies for minimizing risk
- ensure their medication practices are **evidence-informed**
- assess the appropriateness of the medication practice by considering the client, the medication and the environment
- know the limits of their own knowledge, skill and judgement and get help as needed
- do not perform medication practices they are not competent to perform.

Safety

Nurses promote safe care and contribute to a culture of safety within their practice environments, when involved in medication practices.[6]

Nurses:

- must administer medication using the route of administration indicated by the prescriber
- must dispense the medication directly to the client or their representative

[4] Section 127 of the *Controlled Substances Regulations*

[5] Food and Drugs Regulations, made under the *Food and Drugs Act*.

[6] See subsection 16(1) of O. Reg. 275/94.

- must document and retain a copy of the information recorded on the container in which the medication was dispensed and include the information in the client's health record (see *Appendix A: Information required on labels for dispensed medicatio*n)
- must be satisfied the medication has not and will not expire before the date on which the client is expected to take the last of the medication
- must have reasonable grounds to believe the medication has been obtained and stored safely and in accordance with any applicable legislation
- must promote and/or implement strategies to minimize the risk of misuse, addiction and **drug diversion**
- must take appropriate action to prevent, resolve or minimize the risk of harm to a client from a **medication error** or **adverse reaction**
- must report medication errors, **near misses** or adverse reactions in a timely manner
- must comply with applicable legislative requirements, employer policies and standards of practice related to the secure and appropriate storage, transportation, documentation and waste of all medication (including controlled substances)
- must not engage in conduct that results, directly or indirectly, in a personal or financial benefit that conflicts with their professional or ethical duty to a client as a result of dispensing a medication
- must collaborate in the development, implementation and evaluation of system approaches that support safe medication practices within the health care team.

Appendix A: Information required on labels for dispensed medication

Labels for dispensed medication must include[7] the following:

i. identification number, if applicable

ii. dispensing nurse's name and title along with the name and title of the prescriber, if the nurse is not the prescriber

iii. name, address and telephone number of the place from which the medication is dispensed

iv. identification of the medication, as to its name, its strength (where applicable) and, if available, its manufacturer

v. quantity of the medication dispensed

vi. date the medication is dispensed

vii. expiry date of the medication, if applicable

viii. name of the client for whom the medication is dispensed

ix. directions for use

The dispensing nurse must retain a copy of the information recorded on the container as part of the client's health record.

[7] See subsection 18(5)6 & 18(5)7 of O. Reg 275/94.

Glossary

Adverse drug reaction: As defined in the Food and Drug Regulations, a noxious and unintended response to a drug, which occurs at doses normally used or tested for the diagnosis, treatment or prevention of a disease or the modification of an organic function.

Adverse reaction: As defined in the Natural Health Products Regulations, a noxious and unintended response to a natural health product that occurs at any dose used or tested for the diagnosis, treatment or prevention of a disease or for modifying an organic function.

Aesthetic services: Are the provision of procedures, including those that involve controlled acts, for the purpose of cosmetic treatment to enhance, preserve or alter a client's appearance. Examples of aesthetic services provided by nurses include, but are not limited to, the administration of neuromodulators, dermal fillers, thread lifts, platelet rich plasma and microneedling.

Client-specific order: An order for an individual client that may be written or verbal. A health care professional, such as a physician, NP, dentist, chiropodist, midwife or RN with prescribing authority, can give a client-specific order to authorize a specific procedure, treatment, drug or activity, to be administered at a specific time or which could occur over time.

Controlled acts: Acts that could cause harm if performed by those who do not have the knowledge, skill and judgment to perform them. These activities are listed in the *Regulated Health Professions Act, 1991.* ~~(CNO, 2014).~~

Directives: An order for an activity or series of activities that may be implemented for a number of clients when specific conditions are met and specific circumstances exist. A directive is always written by a regulated health professional who has the legislated authority to order the activity and for which they have the ultimate responsibility.

Dispensing: To select, prepare and transfer stock medication for one or more prescribed medication doses to a client or the client's representative for administration at a later time.

Drug diversion: When controlled substances are intentionally transferred from legitimate distribution and dispensing channels (National Opioid Use Guideline Group, 2010).

Evidence-informed: Practice that is based on successful strategies that improve client outcomes and are derived from a combination of various sources of evidence, including client perspective, research, national guidelines, policies, consensus statements, expert opinion and quality improvement data ~~(CNO, 2014)~~.

Medication error: Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging and nomenclature; compounding; dispensing; distribution; administration; education; monitoring and use (National Coordinating Council for Medication Error Reporting and Prevention, ~~2014~~ n.d.).

Near miss: An event, situation, or error that took place but was captured before reaching the patient (ISMP, 2009).

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Attachment 3

Public consultation survey

After proposed changes to the Scope of Practice and Medication standards were developed based on the evidence described above, CNO sent consultation surveys to a broad range of external system partners, including nurses, employers, health regulators in Ontario, nursing regulators across Canada, academics (colleges and universities), associations, unions and health care organizations. In addition to the random sample of nurses, CNO purposefully surveyed nurses who identified as working in aesthetic services. The survey was also made public through CNO's website and promoted on social media, allowing anyone, including the public, to provide feedback. Through the survey, CNO obtained diverse nursing and system-level perspectives on the proposed changes.

The survey was disseminated from July 9 to 22, 2026, to a sample of 12,000 nurses [NPs, RNs and RPNs]. In addition to a random sample, the survey was oversampled for NPs, nurses working in home and community settings and those who identified as practicing in 'aesthetics or cosmetics.' As a result, 25% of those sampled identified as practicing in aesthetics, 31% were nurses in community settings,18% were NPs (compared to 2.6% of the nursing population) and 25% of the sample was random. As described above, the survey was also sent to other system partners (27) and CNO promoted the survey link on social media and a link to the survey was posted on the public consultation page from July 9 to 22.

For survey responses to *Scope of Practice* and *Medication* standards*,* 462 completed responses were received. Of respondents, 87% identified as nurses, comprising 43% RNs, 31% RPNs and 25% NPs. Members of the public represented 8% of the sample, while 5% identified as representatives of organizations. Nurses working in aesthetics practice accounted for 44% of respondents.

Scope of Practice and Medication standards themes

Overall, CNO received positive feedback on the proposed changes to the *Scope of Practice* and *Medication* standards. Approximately 80% of the respondents felt the proposed standards were clear and easy to understand. Many system partners, such as associations, regulators, and nursing employers, were in support of the proposed changes.

For example, one respondent noted: "I appreciate the development of these new standards and believe they are an important step in strengthening public protection. Aesthetic nursing has grown rapidly, and there are increasing numbers of nurses entering this area of practice with limited education, mentorship, or clinical oversight. These are invasive procedures with real risks and the potential for serious complications. Clear standards and expectations

may help promote safer practice, improve accountability, and provide greater consistency across the profession for both nurses and the public."

One organization noted: "Explicitly requiring direct orders following an initial client assessment for aesthetic services strengthens public protection. The additional specificity throughout the proposed changes also strengthens enforceability. The delegation requirements preamble is well written in plain language and sets the context for the following requirements."

CNO thematically analyzed, reviewed and integrated qualitative feedback into the proposed revisions, where relevant. Respondents' feedback led to several key revisions, including:

- clarifying the differences between client-specific orders, directives and delegation
- clarifying the proposed onsite requirement

Survey respondents requested examples and guidance on assessment and delegation requirements, as well as additional resources to support implementation in practice.

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

Standard Revision: Confidentiality and Privacy – Personal Health Information Practice Standard

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

The purpose of this decision note is to provide Council with information to support decision-making regarding proposed revisions to the *Confidentiality and Privacy - Personal Health Information* practice standard.

> **Motion:**
>
> That the *Confidentiality and Privacy – Personal Health Information* practice standard, as set out in Attachment 1 of this decision note, be approved by Council effective December 1, 2026.

Questions for consideration

Does Council require additional information or clarification to support decision-making related to the practice standard?

Public protection rationale

Developing modern standards of practice supports CNO's mandate to protect the public by advancing CNO's strategic outcome that "nurses' conduct will exemplify understanding and integration of CNO standards for safe practice".

Background

As outlined in the *Regulated Health Professions Act, 1991*[1] Council's governance role includes approving standards of nursing practice. Practice standards outline the professional practice expectations for nurses. They inform nurses of their accountabilities and educate the public and system partners on what to expect of nurses.

Since 2020, Council has engaged in modernizing practice standards. Informed by evidence, the following objectives are applied to the revision of standards:

[1] Subsection 94(3) of Schedule 2 of the *Regulated Health Professions Act, 1991* (i.e. the *Health professions procedural code*) refers to "standards of practice made by the Council".

- accessible (clear and easy to understand)
- defensible (evidence-informed, measurable)
- relevant (reflect contemporary practice to prevent risk, informed by system partners including nurses)

Confidentiality and Privacy – Personal Health Information

CNO is proposing revisions to the *Confidentiality and Privacy – Personal Health Information (C&P)* practice standard. This standard is highly used by academic partners, employers and nurses. While there have been some updates over the years, *the standard* has not undergone a comprehensive update since 2008.

Summary of changes

The following changes have been integrated based on the evidence review and input from system partners including through the survey:

- **updated format** – to align with other modern standards
- **'Partners in Safety' section added** – to highlight the importance of employer/organizational role as Health Information Custodian (HICs) and policies and procedures that prioritize, support and enable client safety and meeting legislative requirements
- **glossary added** – definitions frequently used and terms identified as previously unclear or vague by system partners (for example, consent directive/lockbox, unauthorized access)
- **removed duplicative content** – mapped to all existing CNO standards, such as CNO's *Code of Conduct* standard, and removed duplicate content (for example removed accountability that was duplicated by section 5.3 in the Code with a reference and hyperlink to the Code so this information continues to be readily available)
- **streamlined multiple accountabilities** – rolled up multiple specific accountabilities into higher level accountabilities (for example, not sharing passwords, not using standard email, using confidentiality warning on fax coversheets, etc.)
- **added expectations related to technology and social media** – identified gaps related to impact of technology and integrated new content, including related to the use of shared electronic information systems, social media and artificial intelligence (AI)
- **added new nursing accountabilities:**
    - Access: (1 new)
        - comply with employer/organizational policies related to access, including use of approved devices and platforms
    - Collection: (3 new)
        - ensure confidentiality during the collection and storage of personal health information (PHI), whether in hard copy or electronic form (for example, a secure electronic medical record system)

        - comply with employer/organizational policies related to collection, including using only approved devices and platforms
        - be able to inform the client on the type of PHI being collected through technology platforms, whether it will be recorded and where it will be stored
    - Use: (5 new)
        - only use a client's PHI for the purpose that it was originally collected, such as to inform and support the client's care plan. This includes information collected from shared systems (for example, Connecting Ontario or Clinical Connect)
        - follow employer/organizational policies for use of PHI, shared systems, approved devices and technologies, secure communication methods and record retention
        - use technologies that meet legislative and employer/organizational policies and procedures use their knowledge, skill and judgment when evaluating risks, appropriateness and accuracy of using AI technologies
        - maintain clients' privacy on social media and never use identifiable client information without the client's informed consent
- **integrated equity expectations** – replace gender specific pronouns (he/she) with gender neutral pronouns (they/them) to be inclusive
- **legislation referenced in text** – based on legal feedback and to enhance ability to find specific sections of legislation

Many sources of internal and external evidence informed the proposed revisions including:

- a regulatory body review
- literature review
- Information and Privacy Commissioner of Ontario (IPC) decisions and orders
- Citizen Advocacy Group's Public Expectations of Health Care Providers Use of Artificial Intelligence report
- professional conduct data
- practice inquiries data
- alignment with CNO practice guidelines
- input from CNO's Employer & Academic Reference Groups
- input from other system partners
- legal input public survey of the proposed changes (please see attachment 2 for information about the survey process as well as quantitative and qualitative findings)

CNO's Nurse Advisory Group (NAG) supported revisions between November 2025 to June 2026 by sharing practice expertise. The group was composed to reflect the diversity of the nursing profession across Ontario, as well as diverse practice settings and roles in the province. NAG provided valuable input on areas of risk and strategies to make standards more accessible and relevant to nursing practice.

Integrating the public's perspective

The standard leans heavily on Ontario privacy legislation and has been set up to align with the legislative requirements in the *Personal Health Information Protection Act, 2004* (PHIPA). At its core, PHIPA is framed to protect the public's interests. It establishes privacy rights for the public and imposes obligations in protecting PHI. PHIPA balances the privacy rights of individuals with the legitimate need to collect, use and disclose PHI to deliver effective and timely health care.

As part of the evidence gathering and analysis process to inform draft revisions to the *Confidentiality and Privacy – Personal Health Information* standard, all IPC decisions and orders from 2005 through 2025 were reviewed. In other words, PHIPA matters that members of the public brought forward to the IPC were reviewed. This included a review of cases that involved nurses and an overall thematic summary.

Another source of information was the Citizen Advisory Group report from November 25, 2024 "Public Expectations of Health Care Providers Use of Artificial Intelligence". Lastly, CNO promoted the survey to members of the public. Please see Attachment 2 for a summary of the public consultation survey.

Knowledge translation resources

Subject to approval, the revised standard will come into effect on December 1, 2026. While the standard has been modernized in format and presentation, most accountabilities remain unchanged. The revisions align with PHIPA, which has not undergone significant changes in recent years. Given these considerations, a two-month implementation period is recommended. This implementation timeline provides partners with sufficient time to prepare for and operationalize the changes following Council's approval.

To support knowledge translation for the revised standard, CNO will be using a variety of approaches. Subject to approval of the standard, this fall, CNO will host a webinar to introduce the upcoming changes and give nurses, employers and academic partners time to prepare. The webinar will be recorded and posted on CNO's website for future access. These sessions will help organizations update their policies, if any changes are needed, ahead of the implementation date.

In response to feedback from NAG and the public survey, CNO will use approaches that support accessible and efficient learning—such as creating micro-learning videos, case scenarios based on frequently asked questions, and updated web resources to support the application of concepts. The revised practice standard will be promoted in an article in *The Standard,* external presentations, conferences and exhibitor booths in the coming year. CNO will continue to monitor any questions that arise and will develop additional resources to support understanding and consistent use in practice.

Next steps

Subject to Council's approval, CNO will:

1. develop new resources and revise existing resources to support application of the revised standard
2. engage and help nurses and other system partners to understand and implement the changes.

Attachment

1. Draft *Confidentiality and Privacy – Personal Health Information* practice standard
2. Summary of Public Consultation Survey

Confidentiality and Privacy — Personal Health Information

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

Contents

The College of Nurses of Ontario's (CNO) practice standards outline accountabilities for nurses and inform the public, including clients and organizations, what to expect of nurses. The standards apply to all nurses regardless of their role, job description or area of practice. Nurses are expected to practice in compliance with relevant legislation, the Code of Conduct, all other standards of practice of the profession and applicable employer and organizational policies. Not complying with legislation or failing to meet the standards of practice may be considered ***professional misconduct****.*

Introduction

A therapeutic nurse-client relationship is essential to the **clients'** health and well-being and is grounded in trust, respect and empathy. One way that nurses can build nurse-client relationships based on trust is by respecting clients' rights around confidentiality and privacy. Nurses have professional and legal obligations to maintain the confidentiality and privacy of client **personal health information**.

This standard outlines nurses' accountabilities for safeguarding clients' personal health information in accordance with privacy legislation. Although this standard focuses on the *Personal Health Information Protection Act, 2004* (PHIPA) requirements, nurses should be aware that other legislation may also apply depending on their role, area of practice or setting. These may include, but are not limited to, the *Freedom of Information and Protection of Privacy Act, 1990*, the *Municipal Freedom of Information and Protection of Privacy Act, 1990*, the *Personal Information Protection and Electronic Documents Act*, the *Privacy Act*, the *Regulated Health Professions Act, 1991* (RHPA), the *Quality of Care Information Protection Act, 2016*, the *Substitute Decisions Act, 1992* and other sector-specific legislation.

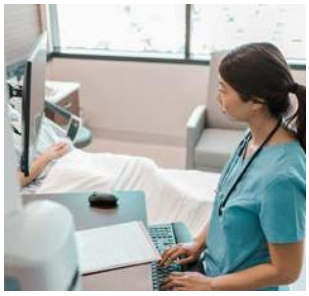
Nurses must ensure there is transparency in how client personal health information is accessed, collected, used and disclosed. As technologies continue to evolve, nurses are required to continue to meet confidentiality and privacy requirements regardless of the format or platform used to manage a client's personal health information. This includes technologies such as email, text or instant messaging, telephone, **artificial intelligence** (AI) tools, video or audio conferencing, fax and internet. See CNO's ***Virtual Care*** practice guideline and *Artificial intelligence in nursing practice* guidance and educational tool for more information.

Bolded terms are defined in the glossary at the end of the document.

To meet the expectations for this practice standard, nurses must consider the following personal health information principles:

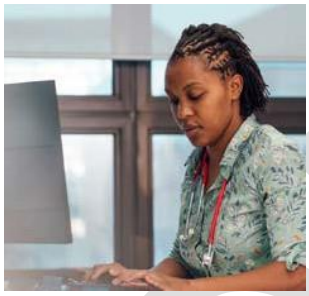
Access

Nurses access the least amount of personal health information required to meet the purpose of the task. When authorized, nurses access information only for the intended purposes to promote safe and quality care.



Collection

Nurses gather, acquire, receive or obtain only as much personal health information as necessary for the specific purpose of the collection.



Use

Nurses view, handle or deal with personal health information only for the intended purposes.

Disclosure

Nurses meet legal and professional accountabilities when making personal health information available or releasing it to another health information custodian or authorized person.

Each principle includes a set of nursing accountabilities, which are described in this standard.

Personal health information

As outlined in PHIPA [s 4(1)], personal health information is any **identifying information** about an **individual** that is in verbal, written or electronic form if the information relates to:

- the physical or mental health of an individual, including family health history
- the provision of health care to an individual (including the identity of the health care provider providing care to the individual)
- a plan that outlines the home and community care services to be provided by a health care provider or Ontario Health Team, funded under section 21 of the *Connecting Care Act, 2019*
- payments, eligibility for health care or eligibility for coverage for health care
- the donation of body parts or substances (for example, blood), or information gained from testing these body parts or substances
- the individual's health number (for example, Ontario Health Insurance Plan (OHIP) number)
- the identity of an individual's **substitute decision-maker**
- the individual's digital health identifier or other identifying information related to the creation of the digital health identifier.

Clients do not have to be named for information to be considered personal health information. Information is "identifying" if a person can be recognized from it, or when it can be combined with other information to identify a person. When a **record** includes any personal health information, the entire record must be managed in accordance with personal health information legislation. This includes when a record contains both personal health information and other **personal information**, which is known as a mixed record.

The *Personal Health Information Protection Act*

PHIPA establishes rules for the management of personal health information, including its access, **collection**, **use** and **disclosure**, and outlines the client's rights regarding their personal health information in Ontario.

PHIPA also describes accountabilities related to **data minimization**. Data minimization refers to the collection, use and disclosure of only the personal information reasonably necessary to meet the purposes of the collection, use or disclosure, as the case may be [PHIPA, s 30(2)].

PHIPA requires that personal health information be kept confidential and secure. PHIPA balances a client's right to **information privacy** with the need of health care providers and organizations providing health care to access and share health information.

PHIPA outlines two key roles:

Health information custodian

A person or organization listed in section 3 of PHIPA that, as a result of their power or duties or work set out in PHIPA, has custody or control of personal health information [**Information and Privacy Commissioner of Ontario** (IPC), September 2015]. This can include individuals providing care. **Health information custodians** (HICs) are responsible for:

a. developing, implementing, maintaining and monitoring practices and policies that ensure the confidentiality and **security** of personal health information

b. ensuring that records are accurate, complete, up-to-date as necessary and retained, transferred and disposed of in a secure manner that follows prescribed requirements

c. ensuring that all **agents** are informed of their duties under PHIPA and that the HIC and its agent(s) comply with the Act.

Agent

Any person who is authorized by a HIC to carry out services or activities involving personal health information on the HIC's behalf and for the HIC's purposes outlined in section 17 of PHIPA (IPC, September 2015). This can include nurses who are employees, volunteers or contracted or credentialed by health care organizations (for example, clinics, laboratories, home and community care providers, hospitals, long-term care facilities, retirement homes and online telehealth platforms). Agents are responsible for complying with PHIPA and:

a. only using or handling the personal health information as the HIC is permitted or required to

b. respecting any conditions or restrictions a HIC may establish with respect to the agent's use or handing of personal health information

c. using or handling the information the agent requires to complete their duties

d. notifying the HIC if personal health information is stolen, lost, used, retained, disclosed or accessed without authority.

Nurses who are HICs

Nurses who are **self-employed**, (see CNO's *Independent Practice* guideline), or those employed in health services in non-health care settings (for example, school nurses) may be considered HICs rather than agents. Nurses acting as HICs are responsible for:

- designating a contact person, if they are not performing this function, to facilitate compliance with PHIPA and to respond to access or correction requests, inquiries and complaints from the public (PHIPA, s 15)
- posting a physical notice within the clinical environment or an electronic notice on their website that generally describes their information practices, how to reach the contact person, the process for accessing records or requesting corrections and the complaint process for clients (PHIPA, s 16)
- developing policies and procedures related to the personal health information in their custody and control
- ensuring information practices comply with PHIPA and its regulations
- ensuring information is accurate, complete and up to date [PHIPA, s 11(1)]
- ensuring information is retained, transferred and disposed of securely
- **reporting** annual statistical reports to the IPC which covers breaches, as well as access and correction requests.

More information related to accountabilities of HICs can be found in the Partners in safety section.

Personal health information belongs to the client

PHIPA recognizes that personal health information belongs to clients and the HIC simply has custody and control (accountability) for the collection, use, disclosure and retention of a client's health record. Capable clients, including a child who is less than 16 years of age, have the right to give, limit, refuse or withdraw their consent to the access, collection, use and disclosure of their

personal health information. If there is a conflict between a capable child and the child's substitute decision-maker (for example, a parent, guardian or a children's aid society), the decision of the child to give, withhold or withdraw consent or provide personal health information prevails [PHIPA, s 23(3)].

Clients have the right to instruct that a part of their personal health information is not shared with other providers. This is a **consent directive**, commonly referred to as a **lockbox** provision. If a client instructs a nurse not to release a part of their personal health information to another practitioner, the nurse must advise the recipient practitioner that some relevant information
is incomplete or has been withheld at the direction of the client [PHIPA, s 38(2)]. The receiving practitioner must obtain the client's consent to access the records subject to the consent directive and should explain to the client the repercussions of not being enabled access to those records (for example, delayed receipt of care). Employer/organizational lockbox policies and procedures should outline the roles and responsibilities of staff to facilitate lockbox requests. A lockbox cannot impede a HIC from recording personal health information about an individual that is required by law or by established standards of professional or institutional practice (IPC, September 2015).

Locked personal health information may be disclosed when the HIC believes, on reasonable grounds, that disclosure is necessary to eliminate or reduce a significant risk of serious bodily harm to an individual or a group [PHIPA, s 40(1)]. Nurses should consider legal requirements regarding disclosure of confidential information, including PHIPA, legislated reporting requirements, employer and/or other relevant organizational policies and resources and CNO standards and resources. For example, the *Child, Youth and Family Services Act* requires professionals to report to a Children's Aid Society instances where they suspect or have reason to believe that a child under 16 requires protection (CYFSA, s 125).

If a client is incapable of consenting to the access, collection, use or disclosure of personal health information by a HIC, a substitute decision-maker may give, withhold or withdraw consent on behalf of the individual. Rules for who may act as a substitute decision-maker are similar to those in the *Health Care Consent Act, 1996*. See CNO's *Consent* guideline for more information, including the hierarchy of substitute decision makers. PHIPA also contains directions for substitute decision-makers when considering decisions relating to consent, appeal routes (for example, the Consent and Capacity Board) for clients found incapable and ways to deal with conflicts between people acting as client representatives.

Clients' right to access their personal health information

Clients have a right to request access to their personal health information (PHIPA s 52). There are specific situations where this access may be refused. Possible grounds in PHIPA for refusing client access to their own personal health information include:

- records that contain **quality of care information** [s 51(1)]
- personal health information required for quality assurance programs [s 51(1)]
- raw data from standardized psychological tests or assessments [s 51(1)]
- when access to the information may present a risk of serious harm to the treatment or recovery of the client, or of serious bodily harm to another person [s 52(1)]
- when access to the information would reveal the identity of a confidential source of information or reveal the identity of a person who was required by law to provide information [s 52(1)].

When an exception applies, the client must be given access to any part of the record that can reasonably be separated from the information they are not permitted to access (IPC, 2015 September).

Clients also have the right to correct their personal health information. This means clients can request changes if they believe the record is inaccurate or incomplete. Requests for corrections can be made verbally or in writing. Ontario's health privacy law allows a HIC to correct the client's health records in response to an informal, oral request; but they can ask the client to submit the request in writing (IPC, n.d.-b). Clients can only request corrections to their information if access has been provided. They may not restrict the access, collection, use or disclosure of their personal health information that is required by law or professional standards.

Client requests to correct personal health information may be refused in the following circumstances:

- the request is frivolous, vexatious or made in bad faith [PHIPA, s 55(6)]
- the HIC did not create the record and does not have sufficient knowledge, expertise or authority to make the correction [PHIPA, s 55(9)]
- the information is a professional opinion or observation made in good faith [PHIPA, s 55(9)].

HICs must respond to access or correction requests as soon as possible, but no later than 30 days after receiving a request. An extension of up to a maximum additional 30 calendar days is permitted if responding within the initial period would unreasonably interfere with the HIC's operations or if necessary consultations make a timely response impractical [PHIPA, s 55(3)].

Clients can file a complaint to an organization's contact person or to the IPC about refusals to access requests or other breaches of PHIPA. The IPC reviews all complaints it receives, and it may contact the complainant and the organization to resolve the issue.

Consent

Consent is a core concept in PHIPA. It is a general rule that a client's consent is required for a person or organization to collect, use or disclose their personal health information, except where PHIPA explicitly allows a collection, use or disclosure without consent. Under PHIPA, regardless of whether it is express or implied, consent must be knowledgeable, voluntary (not obtained through deception or coercion), related to the information in question and given by the client (IPC, September 2015).

A HIC may receive personal health information from the client, their substitute decision-maker or another HIC to help them to provide care to the client. The HIC can assume that it has the client's implied consent to collect, use or disclose the information for the purposes of providing or assisting in providing health care to the client, unless the HIC that receives the information is aware that the client has applied a lockbox to their personal health information [PHIPA, s 20(2)].

Withhold or withdrawal of consent

Clients have the right to withhold or withdraw consent to the access, collection, use or disclosure of their personal health information or personal information. For example, a client may ask a nurse or their HIC to apply a lockbox so their personal health information would not be shared with a specific health care provider. Application of the lockbox does not have a retroactive effect and is only valid from the point it is applied moving forward. The client's express consent would be required if, in the future, there was a need for the nurse or HIC to share their personal health information with a HIC whose access was blocked. Clients may give express consent verbally or in written form, and nurses should document when express consent has been obtained.

Situations where a client's express consent is required

Express consent of the client is required for the access, collection, use and/or disclosure of their personal health information or personal information in certain situations, for example, where the information is being:

- disclosed outside of the health care team (for example, submitting personal health information to a person or an organization that is not a HIC, such as an insurance company on an insurance claim of the client) (PHIPA s 49)
- collected, used or disclosed for fundraising (though contact information can be provided without express consent) (PHIPA, s 32)
- collected, used or disclosed for marketing or marketing research activities (PHIPA, s 33).

Clients may give express consent verbally or in written form, and PHIPA does not require that it be in any specific format. Nurses should document when express consent has been obtained.

Collection, use or disclosure without consent

PHIPA permits HICs to collect, use or disclose a client's personal health information without their consent in certain circumstances. For example, a HIC may:

- rely on the decision of the client's substitute decision-maker, to access, collect, use or disclose the client's information in a situation where the client is injured, incapacitated or ill and they are unable to give consent personally
- disclose a client's personal health information if they have reasonable grounds to believe one or more individual(s) are at a risk of serious bodily harm [PHIPA, s 40(1)].

Access

Under PHIPA, nurses may access a client's personal health information only when it is necessary for providing or assisting in the client's care, or when required to carry out their authorized duties. Although this information may be easily accessible within the care environment, nurses are not permitted to view or use it for any reason outside of their professional duties (Canadian Nurses Protective Society, 2021). **Unauthorized access**, more commonly known as a breach, is the collection, use or disclosure of personal health information without legal authority. "Snooping" is an example of a breach where an individual inappropriately accesses a client's personal health information without the client's consent, when they are not involved in providing care to the client, or for purposes that are not permitted or required (IPC, n.d.-d). If a patient record is accessed without authorization, the employer may take action ranging from remedial steps (for example, mandatory training) to disciplinary action (for example, suspension up to termination).

A report may also be filed with CNO. For more information see *Filing a Report*. Also, after the completion of an investigation, the IPC may issue administrative monetary penalties to both individuals and organizations when there has been a violation of PHIPA. In addition, violations of PHIPA prosecuted as provincial offences may result in court-imposed fines and/or other penalties as permitted by law.

Accountabilities

To uphold the principle of access, nurses must:

- ensure clients or substitute decision-makers know who on the **health care team** can access their information and how that information will be shared among health care

team members, including information collected through technology platforms

- only access the amount and type of client health records necessary:
  - to provide care or for authorized duties (for example, not using "hover to discover")
  - at the times required to provide that care or carry out authorized duties
  - through appropriate means, including on shared electronic health record systems (for example, Connecting Ontario or Clinical Connect)
- inform clients about their right to access or correct personal health information about their care, including processes or steps to obtain that information
- inform other health care providers when they are receiving incomplete health records (for example, when there is a lockbox)
- maintain confidentiality for the duration of the nurse-client relationship and after the relationship ends, including after a client's death
- comply with employer/organizational policies related to access, including use of approved devices and platforms
- ensure personal health information is safeguarded against theft, loss, unauthorized access, use or modification, including when using technology (for example, logging out of electronic health records or ensuring records are not left unattended).

Collection

PHIPA defines collection as the gathering, acquiring, receiving or obtaining of personal health information (PHIPA, s 2).

Collection of a client's personal health information may be completed by one or more members of the client's health care team. The health care team includes everyone involved in providing care to the client, regardless of whether they are employed by the same organization. The Information and Privacy Commissioner of Ontario (August 2015), describes this concept as the "circle of care": the ability of health care practitioners to assume a client's implied consent to collect, use or disclose the client's personal health information with one another when they provide health care to the client. PHIPA does not use the term "circle of care", instead it specifies the specific conditions that must be met to assume a client's implied consent to the collection, use or disclosure of their personal health information [PHIPA, s 20(2)]. It is a HIC's obligation to fulfil these conditions.

It may be reasonable for a HIC to post a physical notice in their office or an electronic notice on their website to inform their clients of how their personal health information is accessed, collected, used and disclosed. Before a HIC uses a notice to inform their clients about their personal health information, the HIC must contemplate how likely it would be for their clients to see the notice; whether the notice would help the client to be knowledgeable of how their personal health information is handled; and understand the actions the client may choose to take to restrict the access, collection, use and disclosure of their personal health information.

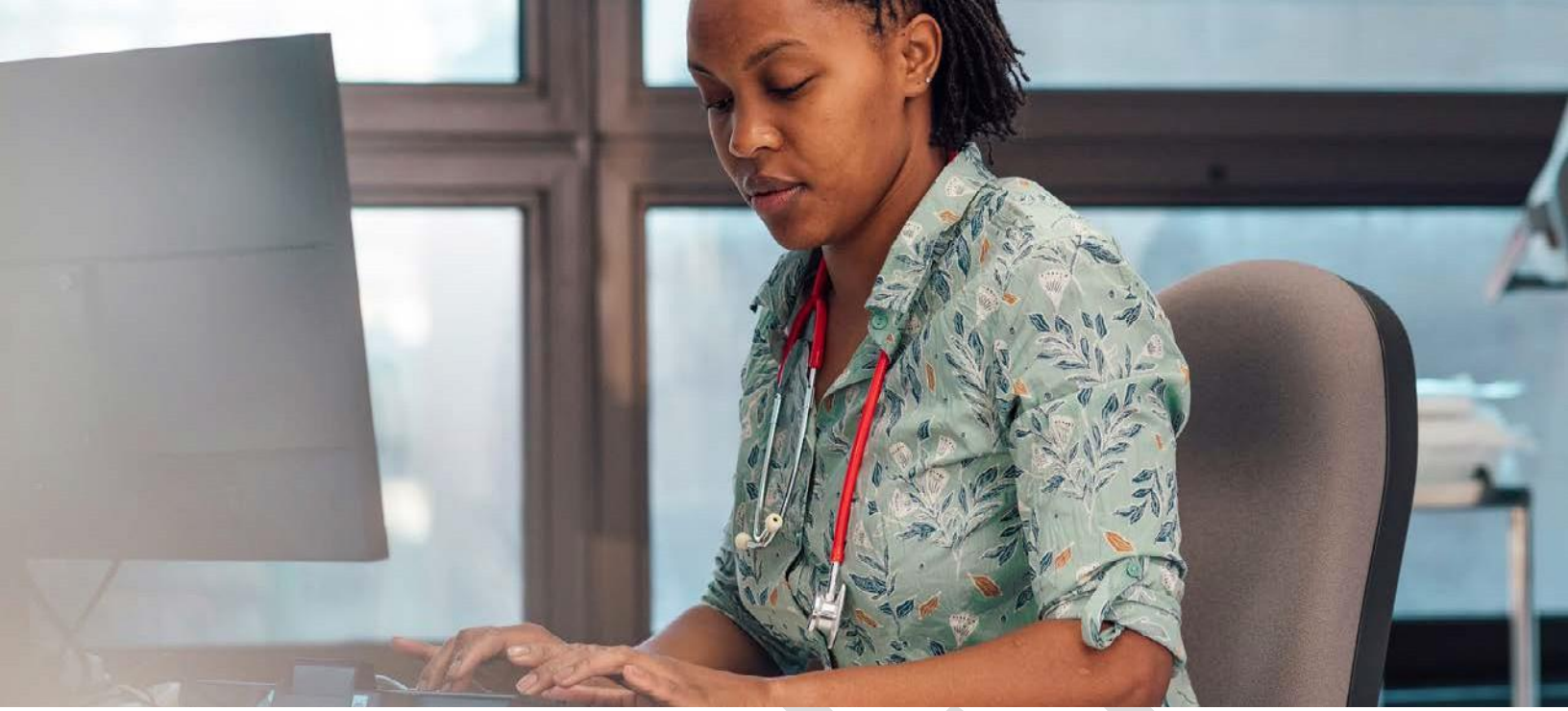
PHIPA lists conditions that permit **indirect collection** of personal health information. Indirect collection is the collection of personal health information from someone other than the client, with or without consent. Some examples of when personal health information can be collected indirectly include when:

- the client cannot provide it (for example, they are unconscious)
- there is a question as to the accuracy of the information provided by the client
- obtaining consent would affect the timeliness of care
- required or permitted by law to collect it indirectly.

Accountabilities

To uphold the principle of collection, nurses must:

- obtain consent to collect personal health information from the client or substitute decision-maker, unless PHIPA allows collection without consent or indirect collection
- collect personal health information directly from the client or substitute decision-maker, unless PHIPA allows indirect collection
- collect only the personal health information that is needed to plan and provide care
- ensure confidentiality during the collection and storage of personal health information, whether in hard copy or electronic form (for example, a secure electronic medical record system)
- comply with employer/organizational policies related to collection, including using only approved devices and platforms
- be able to inform the client on the type of personal health information being collected through technology platforms, whether it will be recorded and where it will be stored
- obtain and document client's **express consent** prior to taking photographs, videos or recordings.



Use

In PHIPA, use means to view, handle or deal with personal health information in the custody or under the control of a HIC (PHIPA, s 2). Sharing a client's personal health information amongst members of the client's health care team within a HIC to facilitate care is one use of information under PHIPA.

Nurses should collaborate with clients and any person or community the client wants involved in their care, as per the *Code of Conduct*. For example, the health care team may include cultural service providers such as Traditional Wellness Practitioners, Nutritional Healers, Medicine Persons and other religious or spiritual care providers.

Accountabilities

To uphold the principle of use, nurses must:

- only use a client's personal health information for the purpose that it was originally collected, such as to inform and support the client's care plan. This includes information collected from shared systems (for example, Connecting Ontario or Clinical Connect)
- ensure the secure transmission, transfer and/or disposal of personal health information in any format (hard copy or electronic form)
- follow employer/organizational policies for use of personal health information, shared systems, approved devices and technologies, secure communication methods and record retention

- inform clients or substitute decision-makers when information may be used for purposes other than client care (for example, quality improvement)
- use technologies that meet legislative and employer/organizational policies and procedures
- maintain clients' privacy on **social media** and never use identifiable client information without the client's **informed consent**
- use their knowledge, skill and judgment when evaluating risks, appropriateness and accuracy of using AI technologies.

Disclosure

Disclosure is defined as making information available or releasing it to another HIC or person. Under PHIPA, "disclose" does *not* include "use." This means that when a HIC has already collected a client's personal health information to provide care, the HIC is allowed to *use* that same information for other permitted purposes — for example, *planning or delivering the programs or services it provides or funds* (PHIPA s 37). In most cases, when staff or agents within the same HIC share a client's personal health information *internally*, this is considered to be a *use*, not a *disclosure*, because the information is staying within the same organization and being used for the HIC's authorized functions.

Disclosure without consent

PHIPA includes situations where a HIC is permitted to disclose personal health information without the consent of the client. For example:

- if the information is reasonably necessary to provide health care and consent cannot be obtained in a timely manner, unless the client has expressly asked that it not be shared
- if contacting a relative, friend or potential substitute decision-maker for an individual who is injured, incapacitated or ill and unable to give consent personally
- if the HIC is a facility providing health care, and the facility is confirming that an individual is a client or resident of the facility, their general health status (for example, critical, poor, fair, stable) and their location in the facility, where the client has been given (at the earliest reasonable opportunity after admission) the option to object to such disclosure and has not done so

- if required to eliminate or reduce a significant risk of serious bodily harm to an individual or group (PHIPA, s 40(1)
- to the Public Guardian and Trustee, a children's aid society and the Children's Lawyer for the purpose of carrying out their statutory functions
- as required for legal proceedings subject to any requirements or restrictions
- if a disclosure is required for a purpose under the *Health Protection and Promotion Act, 1990* (HPPA) or the *Immunization of School Pupils Act* (ISPA) [PHIPA, s 39(2)(a)]
- as required or permitted by law (see examples under "report" in the Glossary).

For more information about disclosure, refer to sections 38-50 in PHIPA, the HPPA, the ISPA or the IPC.

Accountabilities

To uphold the principle of disclosure, nurses must:

- take reasonable steps to provide care interactions in a private setting to maintain confidentiality
- obtain express consent from the client or substitute decision-maker before disclosing client information outside the health care team
- ensure confidentiality during disclosure of personal health information, whether verbally, in hard copy or electronic form
- assess whether disclosure may result in any harm to the client, and consult the health care team when there are concerns about potential harm from sharing information
- advise the client of any duty to report information to another agency or facility
- report information as required by law (for example, *Child, Youth and Family Services Act, 2017*, HPPA, RHPA)
- offer the client the opportunity to report information themselves when appropriate (for example, informing a partner about possible sexually transmitted and blood-borne infections)
- notify the appropriate authority if the client does not report information themselves
- verify that anyone requesting information has the legal authority to access it (for example, police officers who requests with a court order and ensure they only receive the information relevant to the request)

- seek guidance from the designated contact person required under PHIPA or relevant legislation before releasing information
- report any suspected or known confidentiality breaches and follow employer/organizational protocol for stolen, lost or improperly accessed personal health information.

Partners in safety

In Ontario's health care system, employers and organizations that are HICs — as well as nurses who are self-employed HICs — have primary responsibility for protecting the confidentiality and privacy of personal health information. HICs are accountable for the personal health information in their custody or control, and for the actions of their agents (including nurses and third parties) who access, collect, use or disclose that information on their behalf. HICs must provide notice to clients about information practices and ensure that clients are aware of their personal health information privacy rights.

Employers, as HICs, support agents in meeting their legal and professional obligations by establishing privacy-protective work environments, providing clear policies and procedures, delivering education and annual training, and implementing secure administrative, physical and electronic safeguards. These practices enable nurses to comply with legislative requirements and CNO practice standards.

All employers have a duty to the public to align confidentiality and privacy practices with current legislation so that they support client safety and public trust.

HICs are also responsible for safeguarding the confidentiality and privacy of the personal health information of clients if their organization chooses to use technologies such as electronic medical record systems or AI. Having a strong governance and accountability framework established before using an AI system is critical to upholding privacy by design principles and ensuring ongoing compliance with PHIPA (IPC, 2026). Policies, procedures and practices should clearly set out the accountabilities of the HIC, their agents, (which can include nurses) and others who act on their behalf, including third-party service providers or vendors such as electronic service providers or health information network providers (IPC, 2026).

All partners in safety, including HICs, employers and nurses, share the responsibility for creating environments that support quality practice. Nurses should advocate for policies and procedures that protect confidentiality when none exist and can include consulting with the IPC.

Nurses must report any suspected or known privacy breaches and follow employer/organizational procedures. HICs are responsible for notifying individuals (and if legally required, the IPC) when health information is stolen or lost, or if it is used or disclosed without the necessary authority (PHIPA, s 12). HICs are also responsible for submitting a privacy breach annual report, which must include incidents that did not meet the threshold for individual reporting to the IPC.

Glossary

Agent: People who are authorized to act for, or on behalf of, a health information custodian, as per the *Personal Health Information Protection Act, 2004* (PHIPA, s 2). In general, nurses who are employees or volunteers, or contracted or credentialed by a HIC, such as a clinic, laboratory, home and community care providers, hospital or long-term care facility, are considered "agents" of the HIC (Virtual Care, 2026).

Artificial intelligence (AI): Encompasses a broad spectrum of technologies aimed at mimicking cognitive functions associated with human intelligence (Virtual Care, 2026).

Client: An individual, family, group, community or population receiving nursing care, including, but not limited to, "patients" or "residents" (Code of Conduct, 2026).

Collection: In relation to personal health information, means to gather, acquire, receive or obtain the information by any means from any source [PHIPA, s 4(2)].

Consent directive: A directive that withholds or withdraws, in whole or in part, the individual's consent to the collection, use and disclosure of his or her personal health information by means of the electronic health record by a health information custodian for the purposes of providing or assisting in the provision of health care to the individual [PHIPA, s 55.1(1)].

Data minimization: Refers to the collection, use and disclosure of only the personal information reasonably necessary to meet the purposes of the collection, use or disclosure, as the case may be [PHIPA, s 30(2)].

Disclosure: Means to make the information available or to release it to another health information custodian or to another person, in the custody or under the control of a health information custodian or a person. Does not include the use of the information (PHIPA, s 2).

Express consent: Verbal or written approval from an individual to a health information custodian to collect, use or disclose the individual's personal health information for a specific purpose (IPC, n.d.-c).

Health care team: Members of the intraprofessional and/or interprofessional team and/or community supporting client care. This also includes students, new learners and Indigenous and traditional healers (Code of Conduct, 2026).

Health information custodian (HIC): A person or organization listed in the *Personal Health Information Protection Act, 2004* (PHIPA) or its regulations that, as a result of their power or duties or work set out in PHIPA, has custody or control of personal health information (IPC, September 2015) [PHIPA, s. 3(1); O. Reg. 329/04 s. 3(1)]. HICs are responsible for practices and policies that ensure the confidentiality and security of personal health information and complying with PHIPA.

Identifying information: Information that identifies an individual or for which it is reasonably foreseeable that it could be used, either alone or with other information, to identify an individual [PHIPA, s 4(2)].

Indirect collection: the collection of personal health information from someone other than the client, with or without consent.

Individual: In relation to personal health information in the *Personal Health Information Protection Act, 2004*, means the individual, whether living or deceased, with respect to whom the information was or is being collected or created (PHIPA, s 2). The term "individual" is used in place of "client" when referencing the language in the legislation.

Information privacy: The client's right to control how their personal health information is collected, used and disclosed.

Information and Privacy Commissioner of Ontario (IPC): Provides oversight of Ontario's laws that establish rules for the way institutions may collect, use and disclose your personal information (IPC, n.d.-a). Please see www.ipc.on.ca for more information.

Informed consent: As described under the *Health Care Consent Act, 1996,* a person's consent is informed if the person receives information about a treatment that a reasonable person in the same circumstances would require to make a decision and if the person receives responses to their requests for additional information about the treatment.

The information must include the treatment's nature, expected benefits, material risks and side effects; alternative courses of action; and likely consequences of not having the treatment (Code of Conduct, 2026).

Lockbox: Term commonly used to describe the rights of individuals to withhold or withdraw their consent to the collection, use or disclosure of their personal health information for health care purposes (IPC, September 2015).

Personal health information: Identifying information about clients in oral or recorded form as described in the *Personal Health Information Protection Act, 2004*, s 4(1).

Personal information: Any information in oral or recorded form that could be used either on its own, or in combination with other available information, to identify an individual (Government of Ontario, 2024).

Professional misconduct: An act or omission that contravenes nurses' legislated obligations and/or the standards of practice and ethics of the profession. Professional misconduct is defined in section 51(1) of the Health Professions Procedural Code, which is Schedule 2 to the *Regulated Health Professions Act, 1991*, and further described in the Professional Misconduct regulation (O. Reg. 799/93) under the *Nursing Act, 1991*.

Quality of care information: Information defined in the *Quality of Care Information Protection Act, 2016* that:

(a) is collected or prepared for a quality of care committee for the sole or primary purpose of assisting the committee in carrying out its quality of care functions

(b) relates to the discussions and deliberations of a quality of care committee in carrying out its quality of care functions

(c) relates solely or primarily to any activity that a quality of care committee carries on as part of its quality of care functions, including information contained in records that a quality of care committee creates or maintains related to its quality of care functions [Quality of Care Information Protection Act, s 2(2)].

Quality of care information does not include any of the following:

1. Information contained in a patient record.
2. Information contained in a record that is required by law to be created or to be maintained.
3. Information relating to a patient in respect of a critical incident that describes,
    i. facts of what occurred with respect to the incident,
    ii. what the quality of care committee or health facility has identified, if anything, as the cause or causes of the incident,
    iii. the consequences of the critical incident for the patient, as they become known,
    iv. the actions taken and recommended to be taken to address the consequences of the critical incident for the patient, including any health care or treatment that is advisable, or
    v. the systemic steps, if any, that a health facility is taking or has taken in order to avoid or reduce the risk of further similar incidents.

4. Information that consists of facts contained in a record of an incident involving the provision of health care to a patient.
5. Information that a regulation specifies is not quality of care information and that a quality of care committee collects or prepares after the day on which that regulation comes into force [*Quality of Care Information Protection Act*, s 2(3)].

Record: Information in any form or medium, including written, printed, photographic or electronic form or otherwise, but does not include a computer program or other mechanism that can produce a record (PHIPA, s 2).

Report: The legal and organizational requirement to disclose safety issues related to health care professionals' individual practice, or issues impacting practice settings (Code of Conduct, 2026). Examples of legal reporting requirements include:

- Reporting to proper authorities any health care team member whose actions or behaviours toward clients are unsafe or unprofessional according to applicable legislation, including, but not limited to, the *Fixing Long-Term Care Homes Act, 2021*, *Child, Youth and Family Services Act, 2017*, *Public Hospitals Act*, and the *Retirement Homes Act, 2010.*
- Reporting a regulated health professional's sexual abuse of a client to the Registrar of the proper regulatory college according to the *Regulated Health Professions Act, 1991*.
- *Health Protection and Promotion Act* permits a practitioner to disclose personal health information related to reporting of a communicable disease, a disease of public health significance, a virulent disease or a reportable event following the administration of an immunization agent to designated parties (for example, a medical officer of health or a public health unit) without obtaining consent in certain circumstances.

Security: The processes and tools that ensure confidentiality of information.

Self-employed: Nurses who are self-employed own their own economic enterprise or have a financial investment in the enterprise for the purposes of offering nursing services (Independent Practice, 2025).

Social media: Online communication tools (websites and applications) used for interaction, content sharing and collaboration. Types of social media include blogs or microblogs (personal, professional, or anonymous), discussion forums, message boards, social networking sites and content-sharing websites (Code of Conduct, 2026).

Substitute decision-maker: Person, identified by the *Health Care Consent Act, 1996*, who makes a treatment decision for someone who cannot make their own decision. See CNO's *Consent* guideline for more information (Code of Conduct, 2026).

Unauthorized access: The collection, use or disclosure of personal health information without the consent of a client or not permitted by PHIPA or another law (IPC, n.d.-d). Also referred to as a breach.

Use: To view, handle or otherwise deal with personal health information in the custody or under the control of a health information custodian or a person. Does not include the disclosure of information (PHIPA, s 2).

Virtual care: The delivery, management and coordination of health services using electronic information and digital telecommunication technologies to provide client-centred care (Virtual Care, 2026).

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Confidentiality and Privacy — Personal Health Information

Practice Standard

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JULY 2026-38-2

Attachment 2

Summary of Public Consultation Survey

After changes were made based on the evidence described above, a consultation survey was sent out for the draft standard to nurse registrants and a broad range of external system partners including, employers, health regulators in Ontario, nursing regulators across Canada, academics (colleges and universities), nursing associations, nursing unions, health care organizations and government. In addition, CNO made the survey public through CNO's website and promoted it on social media, which means anyone was able to access the survey and provide feedback.

The survey was disseminated to a random selection of 12,000 nurses [Nurse Practitioners (NPs), Registered Nurses (RNs) and Registered Practical Nurses (RPNs)], including 393 nurses whose preferred language is French, in addition to other system partners.

A total of 159 completed responses were received. The survey responses comprised of 87% from nurses [48% RNs, 32% RPNs, 6% NPs and 1% from nurses with dual registration (RN and RPN)], 9% from the "other" category including system partners and 3% from members of the public.

Themes

Through the survey, CNO obtained diverse perspectives at a nursing and system level on the draft standard. Overall, the feedback on the revised standard was positive. Approximately 97% of the respondents felt the standard was clear and easy to understand.

For example, one respondent noted:
"I would also like to acknowledge a number of meaningful improvements in the current draft. The revised structure, organized around access, collection, use and disclosure, really improves the overall clarity and usability of the standard. The inclusion of emerging technologies, such as virtual care and AI, is also appreciated and reflects how practice is evolving. In addition, the broader recognition of legislative context, including references to public health legislation, and the stronger emphasis on organizational accountability through the 'Partners in Safety' section are helpful additions that support a more practical and system-level approach to applying the standard."

In addition to the positive feedback, there was constructive feedback. Qualitative feedback was thematically analyzed, reviewed and integrated into the draft, where relevant. Key revisions included:

- consolidating information related to consent into a dedicated section
- enhancing the clarity of 'disclosure' and 'use' in the context of PHI
- adding additional relevant legislation examples

CNO also received feedback that will help to inform the development of practice support and knowledge translation resources to support the application of the standard.

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Standard Revision: Nurse Practitioner Practice Standard

Decision note – September 2026 Council

Contact for questions or more information

Angie Brennand, Director, Strategy

Purpose and action required

The purpose of this decision note is to provide Council with information to support decision-making regarding a proposed revision to the *Nurse Practitioner* practice standard.

Motion:

That the following paragraph from the *Nurse Practitioner* standard be removed, effective October 1, 2026:

> *Under federal law, NPs are not authorized to prescribe the following controlled substances:*
> - *opium*
> - *coca leaves*

Question for consideration

Does Council require additional information or clarification to support decision-making related to the practice standard?

Public protection rationale

Standards align with legislative requirements to support nurses meeting their accountabilities for client care.

Background

As outlined in the *Regulated Health Professions Act, 1991*[1] Council's governance role includes approving standards of nursing practice. Practice standards outline the professional practice expectations for nurses. They inform nurses of their accountabilities and educate the public and system partners on what to expect of nurses.

[1] Subsection 94(3) of Schedule 2 of the *Regulated Health Professions Act, 1991* (i.e. the *Health Professions Procedural Code*) refers to "standards of practice made by the Council".

The change to the *Nurse Practitioner* practice standard, as described in the motion, is proposed to ensure the standard aligns with federal legislation. On October 1, 2026, the federal government's new *Controlled Substances Regulation* (CSR) will come into effect. The CSR will consolidate several existing regulations currently under the *Controlled Drugs and Substances Act* as well as bring together six class exemptions into a single, modernized regulation. The current regulations have inconsistent expectations for different categories of controlled substances (e.g. related to storage, documentation, reporting losses) and they prohibit NPs from prescribing two drugs: opium and coca leaves. The new CSR does not include these drug prohibitions. In addition, the CSR streamlines expectations across all categories of controlled substances.

Removal of the prescribing prohibition will not impact Nurse Practitioner (NP) practice given that, as described in Health Canada's *Regulatory Impact Analysis Statement* [2] on the CSR, "restrictions on prescribing opium and coca leaves are not needed, since practitioners can only prescribe marketed drugs". Opium and coca leaves are not marketed drugs and practitioners (including physicians) can only access these drugs through Health Canada's Special Access Program (SAP). As per the *Regulatory Impact Analysis Statement,* the SAP "allows practitioners to request access to drugs that have shown promise in clinical trials or have been approved in other countries, but that have not been authorized for sale in Canada. This program provides access to non-marketed drugs for the emergency treatment of patients with serious or life-threatening conditions in instances where conventional therapies have failed, are unsuitable or are unavailable."

Next steps

Subject to Council's approval, CNO will:

1. update the *Nurse Practitioner* practice standard
2. as part of the broader communications plan around CSR:
    - CNO will communicate changes to system partners including NPs
    - revise NP web resources, including the FAQ section to support NPs in understanding and applying the changes to the updated CSR

[2] Health Canada (2025). Regulatory Impact Analysis Statement. Retrieved July 29, 2026 from https://gazette.gc.ca/rp-pr/p2/2025/2025-12-17/html/sor-dors242-eng.html

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Strategic Plan 2021-2026 Reporting

Discussion Note – September 2026 Council

Contact for questions or more information

Silvie Crawford, Registrar & CEO

Purpose

This discussion note supports Council in its governance oversight of the Strategic Plan.

Questions for consideration

Does Council have any questions about our progress on the current Strategic Plan?

Public protection rationale

Implementation of the Strategic Plan supports CNO meeting its commitment to protect the public by promoting safe nursing practice.

Background

Council receives quarterly updates on the *Strategic Plan 2021-2026* to support its governance oversight accountability. This report covers Q2 2026 and highlights new activity since the previous Council update, with one Q3 update noted on page 4.

Most planned deliverables under the *Strategic Plan 2021-2026* are complete and have been rolled into ongoing operations. These achievements set a solid foundation for CNO's new strategic plan, which takes effect in January 2027.

Outcome Measures

The updated outcome dashboard, with data up to the end of June (Q2) 2026 is included with this report. It reports on the outcome measures and pillar performance, which demonstrate CNO's progress towards the outcomes and includes leading measures. Further information related to the description, rationale and timing of each measure can be found in Attachment 3 (Orientation Guide).

Outcome Measures: Progress Updates

Outcome 1: Applicants for registration will experience processes that are evidence-informed, fair, inclusive and effective, contributing to improved public access to safe nursing care

Registration regulation changes related to internationally educated nurse (IEN) education took effect in April 2025 and are now fully operational. As of end of Q2, over

4,000 IEN registrations have been granted since the regulation changes went into effect, and 5,800 IENs have completed the TTP course.

CNO has completed initial work related to evidence of practice requirements, providing a strong foundation from which to move forward. We are now assessing current requirements in the context of public protection, changing health system needs and opportunities for greater national consistency. Continuing this work beyond the current strategic plan will help ensure CNO's requirements remain responsive and aligned with the evolving landscape.

Outcome 2: Nurses' conduct exemplifies understanding and integration of CNO standards of safe practice

The new Quality Assurance (QA) assessment module on the Scope of Practice standard is now operational.

The Standards Utilization Survey will be administered in September 2026, and results will be reported to Council in December. The survey collects data about newly developed or revised standards and guidelines; previously completed in 2021 and 2024, both yielded consistent results with 97% of nurses reporting familiarity with CNO standards.

Outcome 3: CNO will be recognized as a trusted system partner to nurses, employers and the public

Work under outcome 3 is complete and operational.

CNO undertakes regular and proactive engagements with nurses, system partners and the public.

Engagement with system partners is embedded in all relevant CNO processes. This is reflected in Council's briefing notes, Registrar & CEO updates, and CNO's ongoing work in equity engagements.

Our engagement strengthens relationships and builds trust, informs CNO of system needs and perspectives, and ensures system partners understand their obligations in a regulated health environment. This work has increased our understanding of how CNO is perceived by nurses and the public, and we continue to regularly incorporate engagement strategies that promote success.

By the end of Q2 2026, CNO had almost 118,000 followers across all social media channels.

Strategic Plan Pillar Updates

Pillar 1: Build and Operate an Insights Capability

Work under pillar 1 is complete and operational.

CNO successfully implemented dashboards across its teams. Dashboards and reporting tools are actively supporting registration, professional practice and professional conduct processes. These tools are enabling data-driven decision-making and ongoing performance monitoring.

The Enterprise Data Lakehouse Project achieved its core objectives and is fully operationalized. The centralized data environment, enhanced business intelligence capabilities, and data governance practices are now in steady-state use across CNO.

Pillar 2: Operate with Agility

Work under pillar 2 is complete and operational.

Key achievements included implementing a prioritization model, establishing a stage-gate approval process, and creating an organization-wide project management function. A resourcing model was implemented, and decision-making frameworks for corporate projects and operational planning were finalized. Together, these initiatives enabled us to establish a two-speed organizational model, providing CNO with the ability to effectively manage both operational and strategic initiatives.

Pillar 3: Enable Proactivity

Work under pillar 3 is complete and operational.

CNO's approach to proactive regulation focussed on identifying emerging risks early and working with system partners to address them. In 2024–2025 we applied this approach through three pieces of work (described below) that have collectively fulfilled and closed the Proactivity Pillar.

- An AI initiative that drew on consultations with regulators, academics and the Citizen Advisory Group (members of the public) to produce governance/risk practices, and AI guidance for nurses.
- A risk-based update to the Documentation and Therapeutic Nurse–Client Relationship standards, prioritized from internal insights and supported by consultation with a Nurse Advisory Group, employer and academic reference groups, and public consultation.
- An enterprise communications approach for higher-risk matters, including Professional Conduct cases, that aligns public statements with legislation, law-enforcement partners and CNO's public-protection mandate.

Pillar 4: Engage and Mobilize our Key System Partners

Work under pillar 4 is complete and operational.
CNO closed this pillar in Q3. Over the course of CNO's *Strategic Plan 2021-2026* CNO has prioritized engaging more broadly, establishing new relationships, fostering our existing system partner relationships to deepen our understanding of shared priorities related to promoting safe nursing practice.

CNO has met goals related to the major activities in the current strategic plan:

Build internal systems and processes to create the foundation for successful system partner collaboration:

- Engagement trackers established and are now used enterprise-wide
- Centralized external presentation repository
- External presentation intake process established

Capitalize on collaboration opportunities with system partners,

- Establishing net new relationships with system partners
- Collaborating on joint webinars, panel discussions and working groups across the sector
- Leading and collaborating on high-profile projects with system partners:
    - Nursys[1] – Canadian nursing regulatory bodies
    - Labour Mobility – Government partners
    - Single Classification of NP Framework – Other regulators, associations, government partners, public consultations, interest groups

Evolve our culture to support system partner engagement

- Enterprise-wide approach to system partner engagement
- Demonstrating the importance of engagement in the work that CNO does

Work with our system partners to benefit the patient care system.

- Establishing partnerships with members of both Indigenous and Equity Deserving groups working in health care settings
- Deepening relationships with government partners, nursing associations and other regulators
- Making nursing workforce data more available and meaningful to system partners

[1] Nursys in Canada is a secure electronic national database of nurse registration and discipline information from Canadian nursing regulatory bodies. The database provides Canadian nursing regulators with the necessary information to quickly and accurately verify that a nurse is safe to work across national, provincial and territorial jurisdictions.

Pillar 4 was designed to build the foundation and establish the relationships, mechanisms and procedures required for effective external system partner engagement. With foundational structures and practices now in place, the objectives of Pillar 4 have been met and *Pillar 4 is now closed*. The relationships, insights and approaches developed through this pillar will carry forward into the *2027–2031 Strategic Plan.*

Next steps

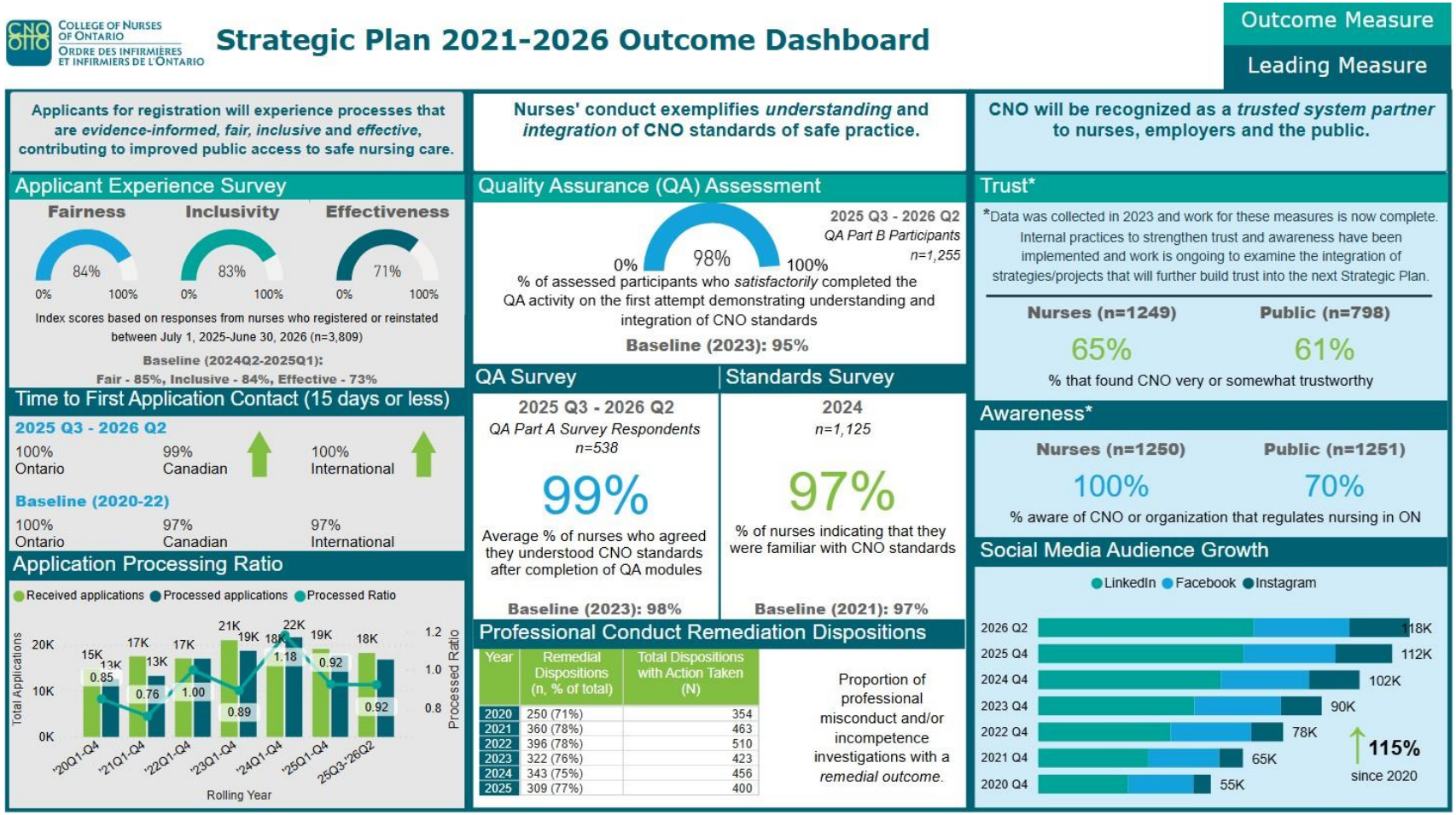
In December 2026, CNO will provide a final report to Council on the current plan (*Strategic Plan 2021-2026*).

CNO's *2027-2031 Strategic Plan* comes into effect in January 2027.

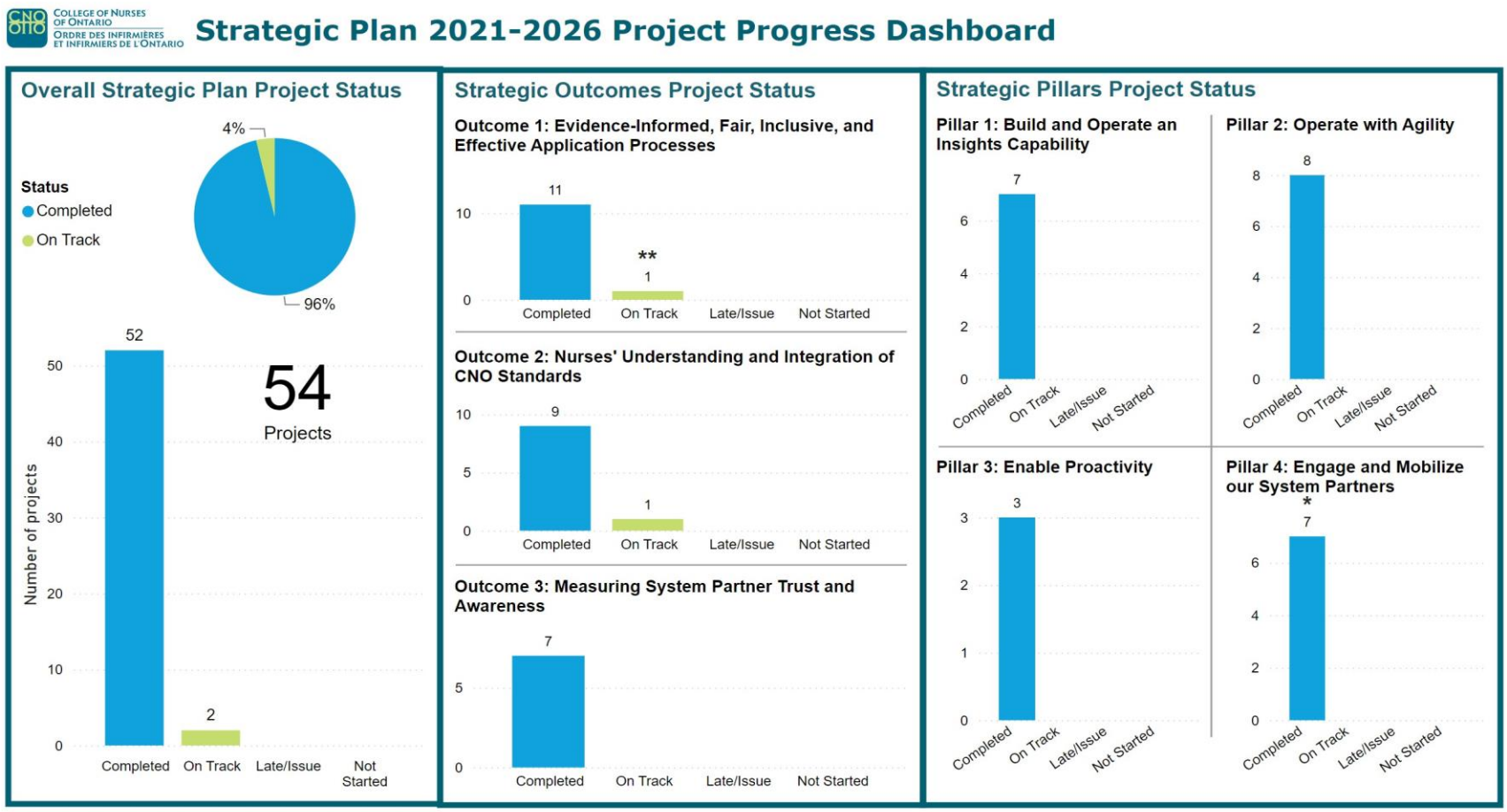
Attachments

1. *Strategic Plan 2021-2026* Outcome Measures Dashboard
2. *Strategic Plan 2021-2026* Project Progress Dashboard
3. Orientation Guide to the Strategic Plan Outcome Measures Dashboard

Attachment 1: Strategic Plan 2021-2026 Outcome Measures Dashboard (up to the end of June 2026)



Attachment 2: Strategic Plan 2021-2026 Project Progress Dashboard *



*Work under Pillar 4 closed in Q3 (see briefing note for more information). All other metrics are up to the end of June 2026.

**Evidence of practice project is in progress – we are assessing current requirements in the context of public protection, changing health system needs and opportunities for greater national consistency. This project will continue after this strategic plan is closed to help ensure CNO's requirements remain responsive to, and aligned with needs.

Attachment 3: Orientation Guide to the Strategic Plan Outcome Measures Dashboard

In September 2023, CNO introduced the Strategic Plan Dashboard for monitoring and presenting the progress of the implementation of the Strategic Plan.

The dashboard contains one outcome measure and multiple leading measures for each of the three Strategic Plan outcomes.

The outcome measures (directly related to the outcome) show whether CNO is achieving the outcomes, while the leading measures (not directly measuring the outcomes but related to them) show whether CNO is on track to do so.

It is important to note that outcomes and leading measures have different baseline years as the result of different measurement periods related to when the measures were established.

Each of the outcomes and related measures are described below:

Outcome 1:
Applicants for registration will experience processes that are evidence-informed, fair, inclusive and effective, contributing to improved public access to safe nursing care.

Outcome Measure: Applicant experience survey results

Description:
Fairness, Inclusivity and Effectiveness index scores are calculated from responses to multiple questions from the Applicant Experience Survey measuring the experience of applicants with CNO's registration process.

Rationale:
The survey results provide a direct measure of all constructs listed in the outcome (fair, inclusive, and effective).

Timing:
The survey launched in June 2024 with nurses who registered or reinstated since April 1, 2024. New survey invitations are sent at the start of every month to nurses who registered or reinstated in the previous month.

The baseline scores were calculated using results from the first 12 months of the survey covering nurses who registered between April 1, 2024 and Mach 31, 2025.

The index scores are calculated using a 12-month rolling average to mitigate seasonal variations in the profile of registrants.

Leading Measure: Time to first application contact

Description: Measures the percentage of applicants contacted within 15 days of submission.

Rationale: This is an operational metric of effectiveness and ensures that applicants are contacted in a timely manner once they apply. All registration applicant types (e.g., Ontario, International, and Canadian) are compared to ensure similarity (fairness). This metric is a requirement for CNO based on the established target set by legislation.

Timing: The measure is derived from operational data from CNO's Customer Relationship Management (CRM) database (PULSE) and is available since the start of the Strategic Plan (2020 Q1). It is reported on a rolling 12-month basis to mitigate seasonal variations in application volumes and is compared to a baseline of applications received from 2020-2022.

Leading Measure: Application processing ratio

Description: Measures the number of applications processed divided by the number of applications received.

Rationale: Greater efficiency in processing applications (more applications processed than received) should result in faster registration for applicants and reflects an effective registration process.

Timing: The measure is derived from operational data from CNO's CRM database (PULSE) and is available since the start of the Strategic Plan (2020 Q1). It is reported on a rolling 12-month basis to mitigate seasonal variations in application volumes.

Outcome 2:
Nurses' conduct exemplifies understanding and integration of CNO standards of safe practice.

Outcome Measure: Quality Assurance (QA) assessment results

Description: Measures the proportion of participants who satisfactorily completed the Code of Conduct QA assessment activity on their first attempt (from Part B of the QA program).

Rationale: The results from Part B provide an objective measure of understanding and integration of standards as participants apply their knowledge to real experiences. An increase in the proportion of participants who are successful would reflect an increase in the understanding and integration of the standards.

Timing: The measure is derived from operational data from CNO's CRM database (PULSE). The baseline data is from 2023 when the Code of Conduct QA Assessment activity was first introduced. The measure is calculated on a rolling 12-month basis to mitigate seasonal variations in the number of nurses completing QA Assessment.

Leading Measure: QA survey results

Description: Measures the perception of QA participants regarding their understanding of CNO standards after completion of QA modules (from Part A of the QA program).

Rationale: This measures self-perceived knowledge of standards as a proxy measure of understanding.

Timing: The survey is sent to nurses upon completion of Part A of the QA program. The baseline was established using data from 2023 when the survey was first administered. The measure is calculated on a rolling 12-month basis to mitigate seasonal variations in the number of nurses completing QA Assessment.

Leading Measure: Standards utilization survey results

Description: Measures familiarity with practice standards.

Rationale: Familiarity with CNO standards is a proxy measure for understanding.

Timing: The baseline score come from a standards modernization membership survey, which was administered in 2021. The survey has only been repeated once in 2024 and CNO plans to update the scores using a similar survey in 2026.

Leading Measure: Professional Conduct remediation dispositions

Description: Measures the proportion of professional conduct (professional misconduct and/or incompetence) investigations with a remedial outcome.

Rationale: An increase in the proportion of remedial outcomes reflects action by the Inquires, Complaints and Reports Committee (ICRC) to address nurses' practice deficiencies and improve understanding and integration of the standards of practice of the profession through directing remedial outcomes, wherever appropriate, potentially reducing referrals to discipline.

Timing: The measure is updated annually using data from the ICRC annual report.

Outcome 3:
CNO will be recognized as a trusted system partner to nurses, employers and the public.

Outcome Measure: Trust index/score survey results

Description: Measures the level of trust in CNO from the perspectives of system partners.

Rationale: This is a direct and representative measure of trust for various system partners.

Timing: The survey data was collected in 2023 and work for these measures is now complete.

Leading Measure: Awareness and perception survey results

Description: Measure of system partners' awareness and perception of CNO as an organization and its regulatory mandate.

Rationale: This measures awareness and perception of CNO in system partners and underpins trust (based on the theoretical model where awareness is first needed to establish trust).

Timing: The survey data was collected in 2023 and work for these measures is now complete.

Leading Measure: Social media audience growth

Description: Measures the number of followers for each of CNO's social media accounts.

Rationale: This measures the growth of CNO's followers and is a proxy measure for awareness, which is a necessary antecedent for trust.

Timing: The baseline audience counts for social media platforms are from the end of Q4 2020. The counts are updated at the end of every quarter.

2026-2027

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Council Planning Calendar

	September 2026	December 2026	March 2027	June 2027
Regular Items	**Minutes:** June Council August Executive Committee (report to Council) August Governance Committee (report to Council)	**Minutes:** September Council November Executive Committee (report to Council) November Governance Committee (report to Council)	**Minutes:** December Council February Executive Committee (report to Council) February Governance Committee (report to Council)	**Minutes:** March Council May Executive Committee (report to Council) May Governance Committee (report to Council)

	▪ CEO Remarks
	▪ Finance & Risk Committee Report
	  ▪ Unaudited statements
		▪ CEO Remarks
		▪ Finance & Risk Committee Report
		  ▪ Unaudited statements
		  ▪ 2027 Budget
			▪ CEO Remarks
			▪ Finance & Risk Committee Report
			  ▪ Unaudited year-end Financial Statements
			▪ Statutory Committee Annual Reports
				▪ CEO Remarks
				▪ 2026 Annual Report
				▪ Finance & Risk Committee Report
				  ▪ 2026 Audited Financial Statements
				  ▪ Unaudited statements
				  ▪ 2027 Auditor Appointment

Strategic Items	▪ Strategic Plan Reporting ▪ Standards of Practice ▪ Labour Mobility Registrants - Jurisprudence Examination	▪ Strategic Plan Reporting – Closing 2021-2026 Strategic Plan ▪ Hearings Initiative Pilot ▪ Organizational Health ▪ Nursing Education Program Approvals (as required)	▪ Nursing Education Program Approvals (as required)	▪ 2027-2031 Strategic Plan Reporting ▪ Nursing Education Program Approvals (as required) ▪ Standard(s) of Practice ▪ Organizational Health

Governance & Council Operations	▪ 2027 Council meeting dates	▪ Governance Priorities and Proposed Workplan for 2027	▪ Appointments: ▪ Appointment of Statutory Committee Members and Chairs ▪ Appointment of Advisory Committee on Human Resources Members and Chair ▪ Executive Committee Election ▪ Council Development Plan	▪ Nominating Committee Report ▪ Appointment of Standing Committee Members ▪ Appointment of Nominating Committee Chair ▪ Council Governance Priorities
Council Development	▪ Ontario Fairness Commissioner ▪ Artificial Intelligence Guidance for Council Members ▪ Primer on Nursing Practice in Aesthetic Services	▪ CNO Finance and Budget ▪ Truth and Reconciliation Calls to Action 23 & 24	▪ New reporting – strategic and regulatory oversight ▪ Workforce Census	▪ Orientation for All Council Members: Governance and Regulation

Governance Principles

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

Accountability

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

Adaptability

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

Competence

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

Diversity

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

Independence

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

Integrity

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

Transparency

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

Approved by Council, September 2016

TEAM NORMS

As members of Council, we are committed to:

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

Adopted by Council
September 2021

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

Executive Committee Minutes

August 13, 2026

Present

R. Lastimosa Jr., Chair
M. Hogard
M. Sack
G. Grewal
D. Thompson

Staff

A. Brennand
S. Crawford
S. Mills
A. Arthur
T. Terzis
R. Sussman, Recorder

Agenda

Members of the Executive Committee (the Committee) received the agenda for the Executive Committee meeting of August 13, 2026.

Motion 1

Moved by D. Thompson, seconded by G. Grewal,

> That the agenda for the Executive Committee meeting of August 13, 2026, be approved as circulated.

CARRIED

Draft Minutes

The Committee received the draft minutes for the Executive Committee meeting of May 14, 2026.

Motion 2

Moved by M. Hogard, seconded by G. Grewal,

> That the minutes for the Executive Committee meeting of May 14, 2026, be approved as circulated.

CARRIED

Appointment to fill Inquiries, Complaints and Reports Committee (ICRC) Vacancy

The Executive Committee received a briefing related to filling a vacancy on ICRC created by the resignation of a committee member.

Motion 3

Moved by G. Grewal, seconded by M. Sack,

> The Executive Committee approves the appointment of Sandra Ross, to the Inquiries, Complaints and Reports Committee, with the term ending June 2027.

CARRIED

September 2026 Draft Council Agenda

The Committee received the draft agenda for the September Council meeting. S. Crawford highlighted the practice standards coming to Council for review and approval. Standards and guidelines are intended to provide valuable information and guidance to both nurses and the public. S. Crawford advised that consultations on the proposed revisions have taken place and that staff will collate the feedback to share with Council.

S. Crawford noted that a decision related to the Jurisprudence Exam for labour mobility registrants, and a related fee bylaw amendment will also come to Council. This item is intended to ensure consistent entry to practice requirements for all applicants.

Motion 4

Moved by M. Hogard, seconded by G. Grewal,

> That the Executive Committee approve the September 2026 Council agenda.

CARRIED

Hearings Initiative Update

The Committee received a briefing note regarding the Hearings Initiative. It was noted that an information session was held for members of the Discipline and Fitness to Practise Committees, and there will be another session held in September.

June Council Debrief and Meeting Effectiveness

Feedback from the post-Council survey identified opportunities to improve the meeting experience for members participating virtually via Zoom. T. Terzis outlined options that had been explored to enhance participation, noting that enhancements to the meeting room technology would involve significant costs. It was proposed that the Chair identify Council members by name when recognizing them to speak and encourage members to introduce themselves before commenting. In addition, CNO staff will capture discussions occurring in the Council chamber by focusing existing cameras on the speakers. The Committee expressed support for the proposed changes.

Dates of Council Meetings for 2027

The Committee received a briefing note outlining the proposed Council meeting dates for 2027, which will be presented to Council for approval.

Motion 5

Moved by G. Grewal, seconded by M. Hogard,

> That the Executive Committee recommend to Council the Council meeting dates for 2027 as shown in the Executive Committee package.

CARRIED

From Your Executive

R. Lastimosa Jr. informed the Committee that this message is shared with Council members between Council meetings. The Committee agreed that the communication could provide an update on the plans for hybrid Council meetings.

Executive Session

The Committee met in a closed session with S. Crawford, CNO's Registrar & CEO.

College of Nurses of Ontario
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THE STANDARD OF CARE.

Governance Committee Minutes

August 13, 2026

Present

R. Lastimosa Jr., Chair	M. Sack	D. Thompson
M. Hogard	G. Grewal	

Staff

A. Brennand	S. Mills	T. Terzis
S. Crawford	A. Arthur	R. Sussman, Recorder

Agenda

Members of the Governance Committee (the Committee) received the agenda for the Governance Committee meeting of August 13, 2026.

Motion 1

Moved by D. Thompson, seconded by M. Hogard,

> That the agenda for the Governance Committee meeting of August 13, 2026, be approved as circulated.

CARRIED

Draft Minutes

The Committee received the draft minutes for the Governance Committee meeting of April 13, 2026.

Motion 2

Moved by M. Sack, seconded by D. Thompson,

> That the minutes for the Governance Committee meeting of April 13, 2026, be approved as circulated.

CARRIED

The Committee received the draft minutes for the Governance Committee meeting of May 14, 2026.

Motion 3

Moved by M. Hogard, seconded by M. Sack,

> That the minutes for the Governance Committee meeting of May 14, 2026, be approved as circulated.

CARRIED

Draft September Council Development

The Committee received a briefing note on the proposed topics for the September Council Development session, including a presentation by the Ontario Fairness Commissioner, guidance on artificial intelligence for Council members, and a primer on aesthetic nursing practice. It was also noted that at the end of the session, Council will be able to provide feedback on Council's effectiveness and future development topics.

The meeting concluded.

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

Patient Relations Committee Minutes

August 13, 2026

Present

R. Lastimosa Jr., Chair	M. Sack	D. Thompson
M. Hogard	G. Grewal	

Staff

A. Brennand	S. Mills	T. Terzis
S. Crawford	A. Arthur	R. Sussman, Recorder

Agenda

The Patient Relations Committee met on August 13, 2026, and noted that there were no agenda items for consideration. The meeting was then concluded.

Council and Committee Code of Conduct Compliance Form: Council Member Responses

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

The Council and Committee Code of Conduct Compliance Form must be completed annually by CNO Council and committee members. For Council members, responses are made available to the public in accordance with the College Performance Management Framework requirements.

Council members were asked to confirm the following statements:

Declaration:

1. I have read and understand the Code
2. I commit to meeting the expectations set out in the Code
3. I confirm that I have reviewed the provisions from the *Regulated Health Professions Act, 1991* related to confidentiality and that I will behave in accordance with those requirements

Conflict of interest:

4. I confirm that I have reviewed Article 6 provisions with respect to conflict of interest and confirm to the best of my abilities that my personal or private interests do not conflict with, or cannot reasonably be seen nor perceived to conflict with my responsibilities to CNO
5. I confirm that I do not hold, and have not held any position prohibited[1] within the three years prior to commencing my term of office under Articles 6.10, 6.11, 6.12, or 6.13 of the Code
6. I confirm that I have not been an employee of, or contractor for, CNO for at least one year preceding the commencement of my term of office under Article 6.23

Conflict of interest positions:

A conflict of interest occurs when a member's personal or private interests conflict with, or can reasonably be seen or perceived to conflict with, the member's responsibilities to CNO.

7. If you serve[2] on any organizations or positions where it is reasonably conceivable that a conflict of interest or bias could arise, or where a reasonable person, knowing of your involvement, might perceive that there could be a conflict of interest or bias, please list the organizations and positions below

Final confirmation and declaration of changes:

8. I confirm that, to the best of my ability, I have identified all positions for which I believe there is a potential for a conflict of interest
9. I am aware of that the Code requires me to advise the Registrar & CEO of any changes to the information provided here in a reasonable amount of time
10. I commit to meeting the expectations in the Council and Committee Code of Conduct

[1] Participation as a member of an expert working group or panel related to best practice is not a prohibited position

[2] Includes but is not limited to: employment, consulting, serving on a board, or volunteering

2026 Council member responses

Full name	Declaration (1, 2, 3)	No conflict of interest (4, 5, 6)	Possible conflict of interest positions (7)	Final confirmation and declaration of changes (8, 9, 10)
Bankole, Doreen	Yes	Yes		Yes
Boudreau, Madison	Yes	Yes	• Nipigon District Memorial Hospital, Director of Quality	Yes
Baretto, Clinton	Yes	Yes	• NPAO, Co-Chair Independent Practice Working Group	Yes
Burke, Randall	Yes	Yes		Yes
Carmichael Pilon, Patti	Yes	Yes	• Blessed Sacrament Church, Member of Finance Committee	Yes
Carpenter, Lynda	Yes	Yes		Yes
Cheuk, Wendy	Yes	Yes	• Michael Garron Hospital, Director of Nursing Practice and Education • RNAO, BPSO working group • Unity Health, Afterhours Manager	Yes
Gilchrist, Carly	Yes	Yes		Yes
Given, Lorne	Yes	Yes		Yes
Grewal, Geeta	Yes	Yes		Yes
Hillhouse, Todd	Yes	Yes		Yes
Hogard, Michael Allan	Yes	Yes	• Riverside Healthcare facilities, Staff Nurse • Ministry of the Solicitor General, Staff Nurse	Yes
Holland, Terry	Yes	Yes		Yes
Jha, Dheeraj	Yes	Yes		Yes
Kim, Fred	Yes	Yes		Yes
Ko, Jeffrey	Yes	Yes	• Niagara College Canada, Professor	Yes
Lamsen, Alexis	Yes	Yes	• Conestoga College, Associate Professor	Yes
Lane, Jeanette	Yes	Yes		Yes
Larmour, Sandra	Yes	Yes		Yes
Lastimosa, Jr., Rodolfo	Yes	Yes		Yes
Mathew, Jijo	Yes	Yes	• We Care4 U Staffing Solution, Director	Yes
Melnyk, Nicole	Yes	Yes	• Carefor, Interim Director, Professional Practice and Clinical Excellence	Yes
Mumberson, Christopher Scott	Yes	Yes		Yes
Neilipovitz, Kristen	Yes	Yes		Yes
Osime, Fidelia	Yes	Yes		Yes
Poonasamy, Lalitha	Yes	Yes		Yes
Rietze, Lori	Yes	Yes	• Canadian Association of Schools of Nursing, Faculty Member, Research Committee Member • Laurentian University, Faculty • Centre for Research in Occupational Safety and Health, Research Fellow	Yes
Scott, Diane	Yes	Yes		Yes
Sheculski, Maria	Yes	Yes		Yes
Stryker, Wes	Yes	Yes		Yes
Thompson, Diane	Yes	Yes		Yes

Full name	Declaration (1, 2, 3)	No conflict of interest (4, 5, 6)	Possible conflict of interest positions (7)	Final confirmation and declaration of changes (8, 9, 10)
Viau, Sophie	Yes	Yes	• La Cité Collège, Contract Teacher RPN program	Yes
Wagg, Kimberly	Yes	Yes		Yes
Wilson, Shari	Yes	Yes		Yes