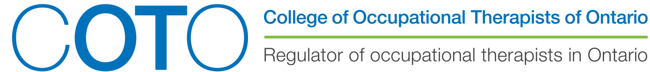


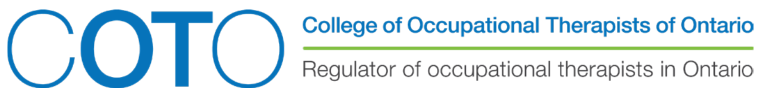
Declaration of Conflict of Interest

All Directors have a duty to act solely in the best interest of the College, consistent with the mandate of the College to act in the public interest, and to maintain the trust and confidence of the public in the integrity of the decision-making processes of the Board. To this end, they must avoid or resolve conflicts of interests while performing their duties for the College and to recuse themselves from any consideration of the matter at issue.

A conflict of interest exists where a reasonable member of the public would conclude that a Director's personal, professional or financial interest, relationship or affiliation may affect their judgment or the discharge of their duties to the College. A conflict of interest may be real or perceived, actual or potential, direct or indirect.

For the Board Meeting of October 30, 2025, all Board Directors in attendance indicated they were in compliance with the College's Conflict of Interest Policy and no declarations were made.

AGENDA ITEM 5.1



BOARD MEETING AGENDA

DATE: Thursday, October 30, 2025 **TIME:** 9:00 a.m. to 3:00 p.m. (Lunch 12:00 to 1:00 p.m.)

College of Occupational Therapists of Ontario
Boardroom
#900 - 20 Bay Street
Toronto ON M5J 2N8

	Agenda Item	Objective	Attach	Time (min)
1.0	**Call to Order**			
2.0	**Public Protection Mandate**			
3.0	**Territorial Acknowledgement***			
4.0	**Declaration of Conflict of Interest**			
5.0	**Approval of Agenda**			
	5.1 Agenda for October 30, 2025	Decision	✓	
	THAT *the agenda be approved as presented.*			
6.0	**Consent Agenda**			
	1. Registrar's Written Report of October 30, 2025 2. Draft Board Minutes of July 9, 2025 3. Draft Board Minutes of June 19, 2025 4. Executive Minutes of September 11, 2025 5. Executive Minutes of July 9, 2025 6. Executive Minutes of June 5, 2025 7. Finance & Audit Minutes of May 22, 2025 8. Finance & Audit Minutes of August 19, 2025	Decision	✓	5
	THAT *the Board adopt the consent agenda items as listed*			
7.0	**Audited Financial Statements & Annual Report**			
	7.1 Audited Financial Statements (9:15 am) Blair MacKenzie and Usman Paracha, Hilborn LLP, Auditor	Decision	✓	20
	THAT *the Board approve the Audited Financial Statements for the fiscal year ended May 31, 2025, as presented.* (Allan Freedman)			
	7.2 Draft Annual Report for 2024-2025	Decision	✓	10
	THAT *the Board approve the Annual Report for the 2024-2025 fiscal year for distribution.* (Stacey Anderson)			

	Agenda Item	Objective	Attach	Time (min)
8.0	**Registrar's Report**			
	8.1 Presentation: *2025-2026 Status of Operational Projects* By: Gillian Slaughter, Registrar & CEO	Information		15
	8.2 Code of Ethics **Presentation:** *Code of Ethics Registrant Consultation* By Kim Woodland, Program Director	Decision	✓	10
	THAT *the Board approve the Code of Ethics draft document for public consultation.* (Stacey Anderson)			
	8.3 Presentation: *Follow-Up on 2025-2026 Board Quarterly Reports* By: Kim Woodland, Program Director	Information		10
	8.4 Quarterly Performance Report	Decision	✓	15
	THAT *the Board receive the Q1 FY 2025-2026 Quarterly Performance Report.* (Lucy Kloosterhuis)			
	8.5 Risk Management Report & Risk Register	Decision	✓	20
	THAT *the Board receive the Risk Management Report.* (Lucy Kloosterhuis)			
9.0	**Financial Report**			
	9.1 Fiscal Year 2025-2026 Q1 Financial Summary Report	Decision	✓	10
	THAT *the Board receive the FY2025-2026 Q1 Financial Report, as presented.* (Allan Freedman)			
10.0	**Governance**			
	10.1 Governance Policies	Decision	✓	20
	THAT *the Board approve the amended and/or newly created financial governance policies for incorporation into the College's Governance Manual:* • *6.1 / Financial Planning and Budgeting* - Revised • *6.2 / Financial Condition and Activities* - Revised • *6.3 / Asset Protection* - Revised • *6.4 / Investments* - Revised • *6.5 / External Audit* - Revised • *6.6 / Honoraria* – Revised (Combined Allowable Expense Policy with Honoraria Policy) • *6.7 / Reserve Funds* - Revised • *6.9 / Insurance* – New • *6.10 / Signing Authority* – New • *7.2 / Overseeing Financial Risk* - New (Lucy Kloosterhuis)			

	Agenda Item	Objective	Attach	Time (min)
Lunch (12:00 – 1:00)				
11.0	**Committee Work**			
	11.1 Practice Subcommittee Coroner's Report: Medical Assistance in Dying (MAiD)	Decision	✓	15
	***THAT** the Board review the report and recommendations from the MAiD Death Review Committee (MDRC) 2024-3 and approve the updated practice guidance on Medical Assistance in Dying resource for publication.* (Stacey Anderson)			
	11.2 Practice Subcommittee Coroner's Report on Use of Restraints	Decision	✓	15
	***THAT** the Board approve the proposed practice resource about the safe use of lap belts for publication.* (Stacey Anderson)			
	11.3 Quality Assurance Committee Enhance: QA Practice Activity	Decision	✓	20
	***THAT** the Board approve the Enhance: QA Practice Activity as an addition to the existing QA Assessment Process and approve the proposed change to the QA Policy.* (Adrian Malcolm)			
	11.4 Registration Committee As-of-Right Registration, Practicing Without a Certificate of Registration	Decision	✓	20
	***THAT** the Board approve the draft As-of-Right Registration and the amended Practising without a Certificate of Registration policies, as presented.* (Allan Freedman)			
12.0	**Environmental Scan**			
13.0	**Other Business**			
	13.1 Board Meeting Evaluation for October 30, 2025	Complete & submit	Provided at Meeting	
14.0	**Next Meetings**			
	Board Meeting: Thurs., January 29, 2026, 9:00 a.m. – 3:30 p.m. COTO Boardroom Board Meeting: Thurs., March 26, 2026, 9:00 a.m. – 4:00 p.m. COTO Boardroom Board Meeting: Thurs., June 18, 2026, 9:00 a.m. – 3:30 p.m. COTO Boardroom			
15.0	**Adjournment**			

***Territorial Acknowledgement**

The College of Occupational Therapists of Ontario (COTO) respectfully acknowledges that the organization's staff, provincial registrants, and Board of Directors live, work and play across the ancestral lands of many Indigenous peoples.

COTO's work takes place on traditional Indigenous territories across the province we now call Ontario. COTO's office, located in what is now known as Toronto, is situated on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. It is now home to many diverse First Nations, Inuit and Métis peoples. Toronto is covered by Treaty 13, which was signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.

We honour and acknowledge the First Nations, Inuit and Métis, as the original stewards of the land. We remind ourselves of our responsibility to be accountable for our actions towards connecting with and creating more equitable, inclusive and respectful relationships with everyone who lives here. We are humbled as we reflect upon, and appreciate, the land on which we continue to gather and meet.

REPORT of the Registrar and CEO

Board Meeting of October 30, 2025

Focus of the Board Meeting Today

Staff will share information about our work to advance our strategic priorities. Today, we will be presenting our audited financial statements, and our draft Annual Report for 2024-2025. Staff will detail the new Board Quarterly Reports and will ask the Board for a decision about our finance policies. At the meeting, I am pleased to present the Status of Operational Objectives for 2025/26.

For Your Information:

LEADERSHIP PRIORITY #1: MEANINGFUL ENGAGEMENT

The College builds trust in its role and value through purposeful and meaningful engagement and collaboration.

Communications

- The second edition of the COTO newsletter "Connecting with the College: Employer Edition" was released on September 26, 2025. The publication provides information tailored to employers of occupational therapists. This edition included 'what employers need to know about supervision of new occupational therapy graduates', a new video highlighting how the practice resource service can support employers and address questions, and an article about the benefits of taking on an occupational therapy student. Both the newsletter and the new video will be promoted across social media channels.
- In recognition of October as Occupational Therapy Month, a series of social media posts have been promoted throughout the month.
- A new video highlighting how the practice resource service can assist members of the public has been developed and will be released in the coming weeks.
- The Annual Report for 2024-2025 is finalized and before the Board for review.

Events and Partners

- College staff attended the 2025 OSOT Conference on October 23-24, 2025 at which the College's former Registrar and CEO, Elinor Larney, was honoured for her extraordinary contributions to the profession and the public. Under her leadership, Elinor strengthened the College's collaboration with regulators across Canada, seeking a unified approach to protecting the public. She ably partnered with regulators, educators, practitioners and policymakers across Canada, implemented new measures to promote consistency and quality in occupational therapist licensing and oversight. In multiple ways, Elinor advanced the practice of the profession and has made an indelible mark on occupational therapy and regulation in Canada.

- College staff attended the annual Council for Licensure, Enforcement and Registration (CLEAR) conference in Chicago, IL and online. The conference provided helpful information about trends and practices by Canadian and international regulators.

- College staff and the Chair of the Board attended the annual Canadian Network of Agencies for Regulation (CNAR) Annual Conference in Calgary, AB from October 20-22, 2025. In collaboration with colleagues at two other regulators, the College of Immigration and Citizenship Consultants and Professional Engineers of Ontario, I presented a concurrent session titled, From Bottleneck to Breakthrough Tackling Investigation Backlogs. I co-presented the Fundamentals of Professional Regulation Pre-Conference Workshop on October 20.

LEADERSHIP PRIORITY #2: QUALITY PRACTICE

The College embraces leading regulatory practices to protect the public.

Registration Program

- The College's Registration program staff met with a representative of the Office of the Fairness Commissioner on September 24, 2025. The College's progress in integrating sociodemographic data in its annual renewal process, its work to submit updated registrant data to CIHI, and its collaboration with regulators to create a pan-Canadian standardized competency- based assessment for re-entry to practice, were met with satisfaction.

- The Labour Mobility application process for Canadian Registrants was updated in preparation for implementation of "As of Right" legislation and a new policy as well as updates to an existing policy is before the Board for review and approval at the October 2025 meetings of both the Executive and the Board.

- A new registration policy to support Registration program operations for Professional Liability Insurance is before the Board for review and approval at the October 2025 meeting.

Quality Assurance Program

- The College's QA program has collaborated with the Nova Scotia Occupational Therapy Regulator (NSOTR) to help implement a competency review assessment in the province. We assisted with sharing the process, revising the tools, and training peer assessors. Four of the College's assessors conducted assessments for NSOTR, and NSOTR reports that the competency review assessment is proceeding well.

- A new "Quality Assurance: Enhance: QA Practice Activity was developed and is before the Board for review and approval at the October 2025 meeting.

Investigations and Resolutions

- The I&R program continues to work on implementing an informal resolution process as an alternative to formal investigations for low-risk matters. The I&R Team continues to make efforts to resolve issues faster and increase parties' satisfaction in the resolutions.

Practice

- The College Practice Team presented at the 2025 OSOT Conference as part of a new graduate panel and on the topic of professional boundaries.
- The Office of the Chief Coroner of Ontario released a request regarding Intimate Partner Homicide by Firearm.
- The Practice Subcommittee has provided valuable input on the Draft Code of Ethics 2025; Risk in Practice, Use of Wheelchair Lap Belts; and Medical Assistance in Dying (MAiD).
- The finalized practice guidance about Lap Belts and an update of MAiD guidance is before the Board for review and approval at the October 2025 meetings of both the Executive and the Board.

LEADERSHIP PRIORITY #3: SYSTEM IMPACT

The College collaborates for access to the profession and consistent quality practice.

Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO)

- The ACOTRO Board Meeting was held virtually on September 10, 2025.
  - Kim Woodland of COTO has been actively supporting ACOTRO projects and was part of the SEAS Oversight Committee
  - The allocation of the surplus from the e-learning module project will be allotted to ACOTRO for future projects. ACOTRO will discuss potential future collaboration about e-learning modules
  - The National Registration Competency Assessment as part of Re-Entry to practice process is underway in partnership with ACOTRO members, our Registration team and our Practice team.
  - ACOTRO is exploring options to collaborate on practice standards that can be adopted by each provincial OT regulator.
- ACOTRO's project, funded by the Federal Government, for strengthening the Substantial Equivalency Assessment System (SEAS) started on June 16, 2025. SEAS is recruiting staff and a project manager to assist with implementing the projects. This grant will be for over three million dollars over a three-year period to significantly improve processes and outcomes for this assessment process for internationally educated occupational therapists coming to Canada. SEAS is also taking steps to develop a modern record management system to facilitate ease of tracking and improve timelines for processing applications.
- Staff from the College attended a meeting with Canadian Institute for Health Information (CIHI) and other regulators. Marianne Baird, Registrar of the Alberta College of Occupational Therapists and Chair of ACOTRO, presented how ACOTRO collected race-based data. The other Canadian OT regulators completed the collection and tracking of this data for their annual renewals (except those which are legislatively prohibited from doing so). The next step will be the submission of this data to CIHI.

Occupational Therapy Ontario Collaborative (OTOC)

- OTOC is comprised of the provincial professional association, the Ontario Society of Occupational Therapists (OSOT), and the chairs of each of the five occupational therapy university programs in Ontario. OTOC met on September 25, 2025 to discuss the need for more occupational therapists to work in Ontario and the benefits of supporting occupational therapists who take on student occupational therapists as part of their training.
- The College has agreed to participate in the recognition of occupational therapists who do this important work. This year, occupational therapists who supervise a student will be jointly recognized by the College and the Ontario Society of Occupational Therapists.

Provincial Government

- On September 17, the Ontario Ministry of Health announced proposed changes to expand the scopes of practice for several health professions. The government has opened consultations about four main changes. The government proposes to grant:
    - optometrists the authority to perform minor surgical procedures in the office under local anesthesia, use laser therapy to manage cataracts and glaucoma, order diagnostic tests, and independently treat open-angle glaucoma without referring patients to a physician;
    - psychologists with specialized training and education in psychopharmacology the authority to prescribe certain medications, such as antidepressants, for the management and treatment of mental health conditions and addictions, as well as order and interpret select diagnostic tests such as urinalysis and blood work;
    - dental hygienists, denturists, speech-language pathologists, physiotherapists, chiropractors, and chiropodists the authority to order and perform certain diagnostic imaging procedures, such as x-rays, MRIs and CTs;
    - pharmacists the ability to assess and prescribe for 14 additional ailments.
- The College submitted a response to the Ministry's public consultations supporting the proposed changes and welcoming the opportunity to collaborate on future discussions about scope changes for occupational therapists. The College is currently engaging with the OSOT to discuss the proposed changes to the scopes of practice of several professions and considering the impact of those changes on occupational therapists. The College continues to monitor developments about changes to scopes of practice, as well as their impact on occupational therapists and the public.
- *"As of Right' - Bill 2, Protect Ontario Through Free Trade Within Canada Act, 2025* and Bill 56, *Building a More Competitive Economy Act, 2025*.
    - At the June Board meeting, details were provided about Bill 2, legislation passed by the Ontario government to amend the *Ontario Labour Mobility Act*, *2009*. The law creates an 'As of Right' system by which regulated health professionals from other Canadian provinces and territories would be able to practice immediately in Ontario by applying for registration to the relevant

College. Under this law, occupational therapists registered elsewhere in Canada would be eligible to practice upon arrival in Ontario while their application for registration to the College is pending. Applicants would be required to provide their out-of-province authorizing certificate and meet other prescribed requirements.

  - On October 20, 2025, the government introduced Bill 56, *Building a More Competitive Economy Act, 2025,* to amend the *Regulated Health Professions Act, 1991* and various professions' acts including the *Occupational Therapy Act*. The Bill would require colleges to register an applicant who is registered in another provincial jurisdiction within two days of the date of the application or to refer the matter to the Registration Committee for review. There are specific provisions that would allow colleges to refuse to register applicants or to impose terms, conditions and limitations (TCLs) on their certificates of registration to protect the public if there are conduct or competency concerns such as complaint, criminal, discipline or other proceedings in any jurisdiction, or TCLs on the applicant's registration in another province. Other amendments to the *RHPA* the various professions' acts, and the related regulations about the use of title by the applicants are contemplated. No details about new regulations or amendments to existing regulations have been provided at this time.
  - The College continues to have concerns that an out-of-province OT may begin to practice before the application has been submitted and before their suitability to practice in Ontario has been completed. Delays in submitting required information may result in individuals practicing for up to six months before any issues are identified or addressed.
  - The College will continue to carefully monitor the progress of Bill 56.

LEADERSHIP PRIORITY #4: PERFORMANCE AND ACCOUNTABILITY

The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

- College staff are pleased to provide the Board with the new quarterly reports for the first quarter of the 2025/26 fiscal year. Kim Woodland will introduce the new operational performance measures in the new quarterly reports. The goal of these reports is to provide quantitative and qualitative updates about the College's regulatory programs.
- Our IT projects are continuing in full force.
  - We have selected a vendor to support our Document Management Project. Currently, the College uses multiple platforms for storing documents, and this initiative will consolidate everything into a single, efficient system. The project is on track for completion within this fiscal year.
  - We are also continuing to enhance our Registrant Database. Our team is actively working to integrate additional program areas and automate more functions to improve efficiency and user experience.

- Lastly, the Financial Audit for the fiscal year ending May 31, 2025, resulted in a clean audit opinion. Our auditors will be presenting more details on the findings later today.

I look forward to seeing you on October 30!

Sincerely,

Gillian

BOARD MEETING MINUTES – *DRAFT*

DATE: Wednesday, July 9, 2025 **TIME:** 8:00 a.m. to 9:00 a.m. via Zoom

In Attendance:

DIRECTORS:
Neelam Bal, *Chair*
Stacey Anderson
Mary Egan
Allan Freedman
Jennifer Kerr
Lucy Kloosterhuis
Thuy Luong
Julie Reinhart
Vincent Samuel
Tina Siemens

STAFF:
Elinor Larney, *Registrar & CEO, Scribe*
Seema Singh-Roy, *Director, Finance, People & Corporate Services*

GUESTS:

REGRETS:
Adrian Malcolm
Pathik Shukla
Christine Funk

DRAFT

1.0 Welcome and Call to Order

Chair Neelam Bal welcomed everyone and called the meeting to order at 8:01 a.m.

2.0 Public Protection Mandate

The Chair stated that the role of the Board is to make honourable and ethical decisions in the best interest of the public.

3.0 Declaration of Conflict of Interest

The Chair called for any declarations of conflict of interest. None were made.

4.0 Approval of Agenda

The Chair called for changes to the agenda. None were reported.

MOVED BY: Jennifer Kerr
SECONDED BY: Mary Egan

***THAT** the agenda be approved as presented.*

CARRIED

5.0 Move In Camera

The Chair called for the meeting to move in camera to discuss a confidential human resources matter.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Jennifer Kerr

***THAT** the Board meeting move in camera to discuss a confidential human resources matter.*

CARRIED

The Board came out of camera and the meeting resumed.

6.0 Next Meetings

Board Education Session: Wed., October 29, 2025, 9:00 a.m. – 4:00 p.m. Location TBD

Board Meeting: Thurs., October 30, 2025, 9:00 a.m. – 3:30 p.m., Boardroom

Board Meeting: Thurs., January 29, 2026, 9:00 a.m. – 3:30 p.m., Boardroom

Board Meeting: Thurs., March 26, 2026, 9:00 a.m. – 4:00 p.m., Boardroom

Board Meeting: Thurs., June 18, 2026, 9:00 a.m. – 3:30 p.m., Boardroom

7.0 Adjournment

There being no further business, the meeting was adjourned at 8:20 a.m.

MOVED BY: Lucy Kloosterhuis

***THAT** the meeting be adjourned.*

CARRIED

DRAFT

BOARD MEETING MINUTES - *DRAFT*

DATE: Thursday, June 19, 2025 **TIME:** 9:00 a.m. – 3:00 p.m.

In Attendance:

DIRECTORS:
Neelam Bal, *Chair*
Stacey Anderson
Mary Egan
Allan Freedman
Christine Funk
Jennifer Kerr
Lucy Kloosterhuis
Thuy Luong
Julie Reinhart
Vincent Samuel
Pathik Shukla
Tina Siemens

REGRETS:
Adrian Malcolm

GUESTS:

OBSERVERS:
Dana Lobson, *Ministry of Health of Ontario (MOH)*
Marnie Lofsky, *Ontario Society of Occupational Therapists (OSOT)*

STAFF:
Elinor Larney, *Registrar & CEO*
Enrique Hidalgo, *Manager, IT*
Grace Jacob, *Accounting and Payroll Specialist*
Stamatis Kefalianos, *Director, Regulatory Affairs*
Lesley Krempulec, *Manager, Quality Assurance Program*
Alex Kunovac, *Manager, Registration*
Cara Moroney, *Manager, Investigations & Resolutions*
Seema Singh-Roy, *Director, Finance, People & Corporate Services*
Andjelina Stanier, *Executive Assistant, Scribe*
Nancy Stevenson, *Director, Communications*
Diane Tse, *Practice Consultant*
Kim Woodland, *Program Director*

DRAFT

1.0 Welcome and Call to Order

Chair Neelam Bal called the meeting to order at 9:03 a.m. She welcomed Thuy Luong to her full first meeting, as well as the newly appointed public member, Jennifer Kerr. She invited everyone to introduce themselves.

2.0 Public Protection Mandate

The Chair stated that the role of the Board is to come together to make honourable and ethical decisions in the best interest of the public.

3.0 Territorial Acknowledgement*

Allan Freedman read out the Territorial Acknowledgement statement (Appendix 1).

4.0 Declaration of Conflict of Interest

The Chair called for any declarations of conflict of interest for the items on today's agenda. None were made.

5.0 Approval of Agenda

The Chair called for changes to the agenda. None were reported.

MOVED BY: Pathik Shukla
SECONDED BY: Lucy Kloosterhuis

***THAT** the agenda be approved as presented.*

CARRIED

6.0 **Board Orientation:** *Role of Committees*

Program Managers presented on the role and work of College committees and subcommittees.

7.0 Consent Agenda

The Chair called for the adoption of the following Consent Agenda items.

1. Registrar's Written Report of June 19, 2025
2. Draft Board Minutes of March 27, 2025
3. Draft Board Elections Minutes of March 27, 2025
4. Executive Minutes of March 12, 2025
5. Executive Minutes of April 30, 2025
6. Finance & Audit Minutes of March 10, 2025
7. Governance Minutes of January 13, 2025

MOVED BY: Stacey Anderson
SECONDED BY: Christine Funk

***THAT** the Board adopt the Consent Agenda items as listed.*

CARRIED

8.0 Registrar's Report

8.1 Presentation: *Year in Review – Status of projects for Year 1 of 2024-2027 Strategic Plan*

The Registrar presented on the operational objectives for Y1 of the 2024-2027 strategic plan and responded to questions.

8.2 Quarterly Performance Report

Lucy Klooserhuis stated that the quarterly report provides an update on program and committee activities for the past quarter. The Registrar responded to questions.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Pathik Shukla

***THAT** the Board receive the Q4 FY 2024-2025 Quarterly Performance Report.*

CARRIED

8.3 Risk Management Report

Stacey Anderson explained that the Board oversees the risk management program for the College. The Board has previously delegated this task to the Executive Committee which reviews the entire Risk Register annually while keeping the Board updated quarterly on high or critical risks and changes in status. The entire Risk Register was reviewed by the Executive Committee at its last meeting earlier this month. The Registrar reported that there were no new high nor critical risks to report however with the appointment of a new public member, and the total complement of public members now at an appropriate level, she recommended that the status of this risk be downgraded to low and removed from the report to the Board.

MOVED BY: Stacey Anderson
SECONDED BY: Lucy Kloosterhuis

***THAT** the Board receive the Risk Management Report.*

CARRIED

8.4 Presentation: *Follow up on changes to the 2025-2026 Quarterly Performance Reporting Tool*

Kim Woodland presented on the revised quarterly performance reporting tool which now includes recommendations and feedback from the March 2025 Board meeting. The Board held a short discussion and Kim responded to questions. This tool will be implemented in the new fiscal year.

9.0 Finance

9.1 Fiscal Year 2025-2026 Annual Operating Budget

Allan Freedman, on behalf of the Finance and Audit Committee, presented the proposed operating budget for 2025-2026. The Board held a brief discussion.

MOVED BY: Allan Freedman
SECONDED BY: Julie Reinhart

***THAT** the Board approve the FY2025-2026 Annual Operating Budget, as presented.*

CARRIED

10.0 Governance

10.1 Committee Appointment – Quality Assurance Subcommittee

Lucy Kloosterhuis stated that the Nominations Committee reviewed the qualifications and experience necessary to fill a vacancy on the Quality Assurance Subcommittee and put forth candidate Elizabeth Gartner for appointment.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Tina Siemens

***THAT** the Board appoint Elizabeth Gartner to the Quality Assurance Subcommittee for a three-year term, effective immediately.*

CARRIED

10.2 Committee Composition

Stacey Anderson stated that the Executive Committee reviewed Jennifer Kerr's qualifications and experience and recommends that Jennfier be appointed to fill vacancies on the Patient Relations and Quality Assurance committees. These recommendations, along with Elizabeth Gartner's earlier appointment today, reflect the proposed changes to the 2025-2026 Committee Composition for approval.

MOVED BY: Stacey Anderson
SECONDED BY: Jennifer Kerr

***THAT** the Board approve the revised 2025-2026 Committee Composition, effective immediately.*

CARRIED

10.3 *In Camera* Policy & Procedure

The Registrar explained that the Executive Committee reviewed the current policy and procedure on the recording and storing of *in camera* minutes. Based on best and required practices for regulatory colleges, the policy was revised and presented today for consideration.

MOVED BY: Allan Freedman
SECONDED BY: Lucy Kloosterhuis

***THAT** the Board approve the revised In Camera Policy and Procedure.*

CARRIED

10.4 Registrar/CEO Annual Performance Evaluation Policy & Procedure

Lucy Kloosterhuis and the Registrar explained that the Registrar performance evaluation policy and procedure were reviewed by the Executive Committee and updated. The Board held a brief discussion.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Vincent Samuel

***THAT** the Board approve the Registrar/CEO Annual Performance Evaluation Policy and Procedure.*

CARRIED

10.5 Governance Policies – Training for Board, Committee and Chairs

Mary Egan stated that two new policies were developed which relate to the training of Board Directors and Committee Appointees, and committee chairs. The Board reviewed both policies.

DRAFT

MOVED BY: Mary Egan
SECONDED BY: Christine Funk

***THAT** the Board approve the following new policies: a) Training and Development for Board and Committees, and b) Training for Board Chair and Committee Chairs.*

CARRIED

10.6 Committee Assessment & Evaluation Policy

Christine Funk stated that a new policy was developed to evaluate the effectiveness and outcomes of College committees, to ensure effective governance and fulfillment of their regulatory responsibilities. The Board reviewed the draft policy and both questionnaire templates.

MOVED BY: Christine Funk
SECONDED BY: Stacey Anderson

***THAT** the Board approve the Committee Assessment and Evaluation Policy.*

CARRIED

11.0 Committee Work

11.1 Patient Relations Committee

Stacey Anderson explained that the Patient Relations Committee regularly reviews the policy to administer the Sexual Abuse Fund to account for changes in legal, technological or ethical standards. Revisions to the policy were brought forward today for consideration. The Board held a discussion and provided additional recommendations.

MOVED BY: Stacey Anderson
SECONDED BY: Thuy Luong

***THAT** the Board approve the updated Funding for Therapy, Counselling, and Related Expenses for Clients Alleging Sexual Abuse Policy, 10-10, including today's recommendations.*

CARRIED

12.0 Move *In Camera*

The Chair called for an *in camera* session to approve previous *in camera* meeting minutes, and to discuss a confidential human resources matter. Observers and most staff members left the meeting. Seema Singh-Roy remained, and the Registrar was called back in for a small portion of the session.

MOVED BY: Jennifer Kerr
SECONDED BY: Lucy Kloosterhuis

***THAT** the Board meeting move in camera to discuss a confidential human resources matter.*

CARRIED

DRAFT

The meeting resumed, following the *in camera* session.

13.0 Environmental Scan

Members provided various updates on changes in systems and information of interest that impact the practice of occupational therapy.

14.0 Other Business

14.1 Board Meeting Evaluation for June 19, 2025

The Chair invited members to complete and submit the Board Meeting evaluation for today's meeting.

15.0 Next Meetings

Board Education Session: Wed., October 29, 2025, 9:00 a.m. – 4:00 p.m. Location TBD
Board Meeting: Thurs., October 30, 2025, 9:00 a.m. – 3:30 p.m., Boardroom
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Board Meeting: Thurs., March 26, 2026, 9:00 a.m. – 4:00 p.m., Boardroom
Board Meeting: Thurs., June 18, 2026, 9:00 a.m. – 3:30 p.m., Boardroom

16.0 Adjournment

There being no further business, the meeting was adjourned at 2:40 p.m.

MOVED BY: Allan Freedman

***THAT** the meeting be adjourned.*

CARRIED

DRAFT

APPENDIX 1: * Territorial Acknowledgement

The College of Occupational Therapists of Ontario (COTO) respectfully acknowledges that the organization's staff, provincial registrants, and Board of Directors live, work and play across the ancestral lands of many Indigenous peoples.

COTO's work takes place on traditional Indigenous territories across the province we now call Ontario. COTO's office, located in what is now known as Toronto, is situated on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples. It is now home to many diverse First Nations, Inuit and Métis peoples. Toronto is covered by Treaty 13, which was signed with the Mississaugas of the Credit, and the Williams Treaties signed with multiple Mississaugas and Chippewa bands.

We honour and acknowledge the First Nations, Inuit and Métis, as the original stewards of the land. We remind ourselves of our responsibility to be accountable for our actions towards connecting with and creating more equitable, inclusive and respectful relationships with everyone who lives here. We are humbled as we reflect upon, and appreciate, the land on which we continue to gather and meet.

APPENDIX 2: Status of Implementation of Board Decisions

Board Meeting Date	Decisions	Current Status
June 19, 2025	***THAT*** *the Board approve the updated Funding for Therapy, Counselling, and Related Expenses for Clients Alleging Sexual Abuse Policy, 10-10, including today's recommendations.*	Complete
June 19, 2025	***THAT*** *the Board approve the Committee Assessment and Evaluation Policy.*	Complete
June 19, 2025	***THAT*** *the Board approve the following new policies: a) Training and Development for Board and Committees, and b) Training for Board Chair and Committee Chairs.*	Complete
June 19, 2025	***THAT*** *the Board approve the Registrar/CEO Annual Performance Evaluation Policy and Procedure.*	Complete
June 19, 2025	***THAT*** *the Board approve the revised In Camera Policy and Procedure.*	Complete
June 19, 2025	***THAT*** *the Board approve the revised 2025-2026 Committee Composition, effective immediately.*	Complete

Board Meeting Date	Decisions	Current Status
June 19, 2025	***THAT** the Board appoint Elizabeth Gartner to the Quality Assurance Subcommittee for a three-year term, effective immediately.*	Complete
June 19, 2025	***THAT** the Board approve the FY2025-2026 Annual Operating Budget, as presented.*	Complete
March 27, 2025	***THAT** the Board receive the election report for district 1.*	Complete
March 27, 2025	***THAT** the Board appoint Adam Broad to the Practise Subcommittee, and Katherine LeMay and Diane Brownlee to the Quality Assurance Subcommittee, each for a three-year period, commencing March 28, 2025.*	Complete
March 27, 2025	***THAT** the Board review the Annual Board Evaluation Summary and approve the action plan.*	Complete
March 27, 2025	***THAT** the Board approve the College Performance Measurement Framework for submission to the Ministry of Health and posting on the College website.*	Complete

DRAFT

EXECUTIVE COMMITTEE MINUTES

DATE: Thursday, September 11, 2025 **TIME:** 1:00 p.m. – 4:00 p.m. via zoom

In Attendance:

MEMBERS:
Neelam Bal, *Chair*
Stacey Anderson, *Scribe*
Allan Freedman
Lucy Kloosterhuis

GUESTS:

STAFF:
Gillian Slaughter, *Registrar & CEO*

REGRETS:

1.0 Call to Order

Chair Neelam Bal welcomed everyone and called the meeting to order at 1:30 p.m.

2.0 Public Protection Mandate

The Chair reminded members that the role of the committee is to make honourable and ethical decisions in the best interest of the public.

3.0 Territorial Acknowledgement*

The Territorial Acknowledgement was read by Stacey Anderson (Appendix 1).

4.0 Declaration of Conflict of Interest

The Chair asked if there were any declarations of conflict of interest with the items on the agenda. None were reported.

5.0 Approval of Agenda

The Chair called for changes to the agenda. None were reported and the agenda was approved as presented.

6.0 Business Arising

A motion was made for the meeting to move *in camera*.

MOVED BY: Lucy Kloosterhuis

SECONDED BY: Stacey Anderson

***THAT** Executive move in camera for the remainder of the meeting to deliberate personnel matters or property acquisitions.*

CARRIED

A motion was made for the meeting to move *out of camera*.

MOVED BY: Allan Freedman
SECONDED BY: Lucy Kloosterhuis

THAT *Executive move out of camera.*

CARRIED

7.0 Next Meeting

- Thursday, October 16, 2025, 1:00 – 4:30 p.m., virtual

8.0 Adjournment

There being no further business, the meeting was adjourned at 2:57 p.m.

APPENDIX 1: * Territorial Acknowledgement

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COTO College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

EXECUTIVE COMMITTEE MINUTES

DATE: Wednesday, July 9, 2025 **TIME:** 12:00 p.m. to 1:00 p.m. via Zoom

In Attendance:

DIRECTORS:
Neelam Bal, *Chair*
Stacey Anderson
Allan Freedman
Lucy Kloosterhuis

STAFF:
Seema Singh-Roy, *Director, Finance, People & Corporate Services, Scribe*

GUESTS:
Tanya Todorovic, ODGERS

REGRETS:

1.0 Welcome and Call to Order

Chair Neelam Bal welcomed everyone and called the meeting to order at 12:00 p.m.

2.0 Public Protection Mandate

The Chair stated that the role of the Board is to make honourable and ethical decisions in the best interest of the public.

3.0 Declaration of Conflict of Interest

The Chair called for any declarations of conflict of interest. None were made.

4.0 Approval of Agenda

The Chair called for changes to the agenda. The agenda was changed to move one item to the *in camera* section of the meeting.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Allan Freedman

***THAT** the agenda be approved as amended.*

CARRIED

5.0 Move In Camera

The Chair called for the meeting to move *in camera* to discuss a confidential human resources matter.

MOVED BY: Stacey Anderson
SECONDED BY: Lucy Kloosterhuis

***THAT** Executive move in camera to discuss a confidential human resources matter.*

CARRIED

The Executive Committee came out of camera and the meeting resumed.

6.0 Next Meeting

Wednesday, October 8, 2025, 1:00 p.m. – 4:00 p.m.

Thursday, January 15, 2026, 1:00 p.m. – 4:00 p.m.

7.0 Adjournment

There being no further business, the meeting was adjourned at 1:04 p.m.

MOVED BY: Stacey Anderson

***THAT** the meeting be adjourned.*

CARRIED

EXECUTIVE COMMITTEE MINUTES

DATE: Thursday, June 5, 2025 **TIME:** 1:00 p.m. – 4:00 p.m. via zoom

In Attendance:

MEMBERS:
Neelam Bal, *Chair*
Stacey Anderson
Allan Freedman
Lucy Kloosterhuis

REGRETS:

GUESTS:

STAFF:
Elinor Larney, *Registrar & CEO*
Seema Singh-Roy, *Director Finance, People & Corporate Services* (7.2)
Andjelina Stanier, *Executive Assistant, Scribe*

1.0 Call to Order

Chair Neelam Bal welcomed everyone and called the meeting to order at 12:59 p.m. She stated the meeting would follow an informal decision-making model.

2.0 Public Protection Mandate

The Chair reminded members that the role of the committee is to make honourable and ethical decisions in the best interest of the public.

3.0 Territorial Acknowledgement*

The Chair stated that members have had the opportunity to read and acknowledge the Territorial Acknowledgement statement (Appendix 1).

4.0 Declaration of Conflict of Interest

The Chair asked if there were any declarations of conflict of interest with the items on the agenda: None were reported.

5.0 Approval of Agenda

The Chair called for approval of the agenda as presented. Item 9.6 was moved to become item 7.2, and the agenda was approved as amended.

6.0 Executive Committee Terms of Reference

The Chair stated that the committee terms of reference document was provided as a resource to aid members in preparation for the meeting.

7.0 Approval of Draft Minutes

7.1 Draft Executive Minutes of April 30, 2025

The Chair called for edits to the draft minutes of April 30, 2025. None were reported and the minutes were approved as presented.

7.2 Motion to Move *In Camera*

The Chair called for the meeting to move *in camera* to approve previous *in camera* minutes. The Registrar and Andjelina Stanier left the meeting and returned following this item.

MOVED BY: Allan Freedman

SECONDED BY: Lucy Kloosterhuis

THAT *Executive move in camera to approve the in camera Executive Minutes for: February 28, 2025, and March 27, 2025, and in camera Board Minutes for April 30, 2025, and May 5, 2025.*

CARRIED

MOVED BY: Allan Freedman

SECONDED BY: Lucy Kloosterhuis

THAT *Executive move out of camera.*

CARRIED

8.0 Registrar's Report

8.1 Registrar's Verbal Report

New Public Member:

The ministry has appointed new public member Jennifer Kerr to serve on the Board. She has a background in crisis communications. The Chair and Elinor have already completed her orientation, and she will attend the upcoming Board meeting.

Heath Profession Regulatory Organizations (HPRO)

On June 23, the Registrar will complete her tenure as past chair on the management committee. Her last task will be to conduct the election of the HPRO executive officers on that date.

Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO)

- The project to significantly improve the Substantial Equivalency Assessment System (SEAS) which received a federal grant of just over three million dollars officially began on June 16. The first priority is to recruit staff and a project manager.
- This past May 5-6, the ACOTRO Board met and also held its Annual General Meeting. Officer elections were held and Marianne Baird, registrar for the Alberta college, was elected President. Marianne will also take over Elinor's various board committee assignments and representation with external groups. The vice president and treasurer remain in their roles which will facilitate the transition for the new president.
- The new Re-entry program has begun across the country. Many provinces have already started using it and feedback has been very positive.
- The project in which the College received funding from the Canadian Institute for Health Information (CIHI) is now complete. This project is related to some data improvements,

and the collection and submission to CIHI of race-based data that each OT provincial regulator now collects through their annual renewal process.

- The OT Competency Editorial Committee which met several times over the past year, has incorporated some minor edits to the OT Competencies. The changes to the French version were made to incorporate inclusive language. The committee has now concluded its work, and both the English and French versions are available on the ACOTRO website. The committee will meet annually if necessary. The next planned full review of the competencies will begin in 2029, for completion in 2031.
- The Registrar and Marianne Baird recently presented on *Professional Boundaries* at the CAOT conference in Edmonton, Alberta. It was well attended and well received.
- All provinces have now signed the Memorandum of Understanding (MOU) related to remote work. OTs only need to be registered in the province where they live when working remotely with clients in other provinces. It was noted by the Registrar in PEI that their government expressed positive interest in this MOU.

Ontario Regulators

The College of Social Workers and Social Service Workers (CSWSSW) which is not part of HPRO, organized an event for regulators and senior policy staff to meet each other. The Registrar and Stamatis Kefalianos, Director of Regulatory Affairs, both attended.

Occupational Therapy Ontario Collaborative (OTOC)

This group, comprised of the Ontario Association of Occupational Therapists (OSOT), chairs of the five OT university programs in Ontario, and the College, met recently to discuss the need for more OTs to work in Ontario and how to support OTs who take on student OTs as part of their training. The College will participate in a recognition program along with the other two groups, to acknowledge and thank the OTs who provide this important and valuable student training.

Internal

Two summer students have been hired: One to assist in the finance department, and the other to work on the Enterprise System to help with the development of new dashboards.

8.2 Risk Management Report & Risk Register

Executive reviewed the entire Risk Register, and the Registrar responded to questions. The committee also reviewed the Risk Management Report for the past quarter. No new risks were identified, and their status' remained the same except for the risk on Public Member Complement. Executive held a discussion and agreed that with the recent appointment of a new public member, this risk can be downgraded and removed from the report to the Board.

9.0 Business Arising

9.1 Committee Work Plan

The committee reviewed the status of items on the 2025-2026 work plan. No updates were required.

9.2 Board Meeting Evaluation Feedback for March 27, 2025

Executive reviewed the feedback and held a short discussion. Only six of thirteen members completed the electronic evaluation. For the upcoming meeting, to encourage participation, Executive agreed to return to paper forms and to allot sufficient time for members to complete them directly following the meeting. Electronic forms will still be sent to virtual attendees.

9.3 Committee Assignments for New Public Member

The Registrar explained that the Patient Relations and Quality Assurance committees each have a vacancy for a public member which need to be filled. Given Jennifer Kerr's background and experience, she is deemed a good fit for both. Executive held a discussion and agreed to appoint Jennier Kerr to both committees, effective immediately. This decision will be brought to the Board for ratification at the next meeting.

9.4 Registrar/CEO's Annual Evaluation Policy and Procedure

The Registrar explained that the existing Registrar Evaluation policy and procedure is regularly reviewed and updated. The process has been working well since 2021 however changes are proposed to the policy to align with the language overhaul of the governance policies. Executive provided several recommendations and agreed to bring this forward to the Board for final approval as amended today.

9.5 In Camera Policy and Procedure

The Registrar explained that some clarification was required in follow-up to a previous committee discussion pertaining to the recording and handling of *in camera* minutes. Staff completed some background research to determine the best and required practices for regulatory colleges, which resulted in revisions to the current policy, RL13 *In Camera Policy and Procedure* for consideration. Executive provided additional recommendations and agreed to forward the proposed revisions to the Board for final approval.

9.6 In Camera Session

This item was moved to 7.2 on the agenda.

9.7 June Board Orientation

Executive held a short discussion to finalize the Board orientation session for the next Board meeting.

9.8 Board Education Day Update

The Registrar provided an update regarding topics and speakers for the next Board Education Day in October.

9.9 Draft Board Minutes – March 27, 2025

Executive reviewed the March 27, 2025, draft Board minutes.

9.10 Draft Board Officer Elections Minutes – March 27, 2025

Executive reviewed the March 27, 2025, draft Board Officer Elections Minutes.

9.11 Draft Board Agenda for June 19, 2025

Executive reviewed the June 19, 2025, draft Board Agenda and finalized it.

10.0 Next Meeting

- A doodle will be circulated for the last week of June to tentatively book a 1-hour meeting in the event it is required.
- Wednesday, October 8, 2025, 1:00 – 4:00 p.m. by Zoom.

11.0 Adjournment

There being no further business, the meeting was adjourned at 3:19 p.m.

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FINANCE AND AUDIT COMMITTEE MINUTES

DATE: May 22, 2025 **TIME:** 8:30 a.m. to 10:30 a.m. virtual meeting

In Attendance:

DIRECTORS:
Allan Freedman, *Chair*
Lucy Kloosterhuis
Tina Siemens
Thuy Luong

GUESTS:
Blair MacKenzie, Hilborn LLP
Usman Paracha, Hilborn LLP

OBSERVERS:
None

STAFF:
Elinor Larney, Registrar & CEO
Seema Singh-Roy, Director of Finance, People and Corporate Services
Grace Jacob, Accounting and Payroll Specialist, *Scribe*

REGRETS:

1.0 Call to Order

The Chair Allan Freedman welcomed everyone and called the meeting to order at 8:29 a.m.

2.0 Public Protection Mandate

The committee members were reminded of the public protection mandate of the College.

3.0 Territorial Acknowledgement*

The Chair invited members to silently read the Territorial Acknowledgement (Appendix 1).

4.0 Declaration of Conflict of Interest

The Chair asked if members had a conflict of interest to declare. None was reported.

5.0 Terms of Reference – Finance and Audit Committee

The Chair highlighted the importance of all Committee members understanding the Finance and Audit terms of reference and being aware of the key responsibilities essential to fulfilling the Committee's mandate.

6.0 Approval of Agenda

6.1 May 22, 2025

The Chair called for changes to the agenda. None were made.

MOVED BY: Lucy Kloosterhuis
SECONDED BY: Allan Freedman

THAT *the agenda be approved as presented.*

CARRIED

7.0 Approval of Minutes

7.1 Draft Finance and Audit Minutes of March 10, 2025

The Chair inquired if members of the Committee had any additions or changes to the draft minutes from March 10, 2025.

MOVED BY: Tina Siemens
SECONDED BY: Lucy Kloosterhuis

THAT *the draft Finance and Audit Committee minutes of March 10, 2025, be approved as presented.*

CARRIED

8.0 Pre-Audit

8.1 Pre-audit meeting with Hilborn LLP

Blair MacKenzie provided an overview of the purpose of the annual audit and described the roles of the parties in the process. Following this, Usman Paracha presented the pre-audit communication, detailing the stages and activities scheduled for the upcoming audit.

9.0 Orientation

9.1 Finance and Audit Committee Orientation

Seema presented the orientation material outlining the work and responsibility of the committee.

10.0 Committee Mandate and Work Plan

10.1 Draft FY25/26 Annual Work Plan with Terms of Reference for guidance.

Seema presented the Draft FY25/26 annual workplan and outlined the items that will be presented to the Finance and Audit committee throughout the year.

11.0 Verbal Report

Seema announced that the Registrar and CEO will retire effective July 11, 2025, and that the recruitment process has commenced in line with the succession plan.

12.0 Finance Update

12.1 FY25/26 Annual Operating Budget

Seema presented the FY25/26 Annual Operating budget to the committee members and addressed any questions.

MOVED BY: Tina Siemens
SECONDED BY: Lucy Kloosterhuis

***THAT** the FY25/26 Annual Operating Budget be forwarded to the Board for approval.*

12.2 Review of Financial Policies

Seema stated that no amendments to the Financial Policies were being recommended and invited Committee members to raise any areas they felt needed to be addressed.

MOVED BY: Tina Siemens
SECONDED BY: Thuy Luong

***THAT** the committee reviews the Financial Policies and agrees that no amendments are necessary.*

CARRIED

13.0 Other Business

No other business was discussed.

14.0 Next Meeting

The next Finance and Audit Committee meeting is scheduled for August 18, 2025.

15.0 Adjournment

There being no further business, the meeting was adjourned at 9:32 a.m.

MOVED BY: Tina Siemens

***THAT** the meeting be adjourned.*

CARRIED

APPENDIX 1

* **Territorial Acknowledgement**

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COTO College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

FINANCE AND AUDIT COMMITTEE MINUTES

DATE: August 19, 2025 **TIME:** 8:30 a.m. to 10:30 a.m. virtual meeting

In Attendance:

DIRECTORS:
Allan Freedman, *Chair*
Lucy Kloosterhuis
Tina Siemens
Thuy Luong

GUESTS:

OBSERVERS:
None

STAFF:
Kim Woodland, Interim Registrar & CEO
Seema Singh-Roy, Director of Finance, People and Corporate Services
Grace Jacob, Accounting and Payroll Specialist, *Scribe*

REGRETS:

1.0 Call to Order

The Chair Allan Freedman welcomed everyone and called the meeting to order at 8:30 a.m.

2.0 Public Protection Mandate

The committee members were reminded of the public protection mandate of the College.

3.0 Territorial Acknowledgement*

The Chair invited members to silently read the Territorial Acknowledgement (Appendix 1).

4.0 Declaration of Conflict of Interest

The Chair asked if members had a conflict of interest to declare. None was reported.

5.0 Terms of Reference – Finance and Audit Committee

The Chair highlighted the importance of all Committee members understanding the Finance and Audit terms of reference and being aware of the key responsibilities essential to fulfilling the Committee's mandate.

6.0 Approval of Agenda

6.1 August 19, 2025

The Chair called for changes to the agenda. None were made.

MOVED BY: Thuy Luong
SECONDED BY: Lucy Kloosterhuis

THAT *the agenda be approved as presented.*

CARRIED

7.0 Approval of Minutes

7.1 Draft Finance and Audit Minutes of May 22, 2025

The Chair inquired if members of the Committee had any additions or changes to the draft minutes from May 22, 2025. None noted.

MOVED BY: Tina Siemens
SECONDED BY: Thuy Luong

THAT *the draft Finance and Audit Committee minutes of May 22, 2025, be approved as presented.*

CARRIED

8.0 Verbal Report

Seema informed the committee that the draft audited financial statements would be reviewed today and noted that the audit process went smoothly overall. Seema expressed appreciation to Grace for compiling all the necessary audit information and responding to numerous auditor inquiries.

Seema also announced that Gillian Slaughter will assume the role of Registrar and CEO on September 8, 2025, and commended Kim Woodland for doing an outstanding job as Interim Registrar and CEO.

9.0 Committee Mandate and Work Plan

9.1 Committee Mandate Review and Annual Work Plan

Seema reminded the committee that it is a non-statutory committee, with a mandate to assist the Board in fulfilling its obligations related to financial planning and reporting, internal controls, investments and policies, as outlined in the committee's work plan.

10.0 Audited Financial Statements

10.1 Review of draft financial statements from auditor

Seema provided an overview of the draft audited financial statements prepared by Hilborn, highlighted key areas, and responded to questions. She advised that any additional questions could be raised at the Finance and Audit Committee meeting on September 22, 2025, when the auditors will be in attendance.

11.0 Finance Update

11.1 FY24/25 Q4 Financial Summary Report

Seema provided an overview of the FY24/25 Q4 Statement of Operations results compared to budget, highlighted key factors contributing to the surplus of revenues over expenses, and responded to questions from committee members.

11.2 FY24/25 Q4 Investment Report

Seema provided an overview of the Q4 investment report to the committee members.

12.0 Internal Controls

12.1 Review of Internal Controls Matrix

Seema informed the committee that the internal controls matrix outlines the processes used by the College to mitigate risk and is reviewed and updated annually to reflect changes in processes or employee titles.

13.0 Other Business

No new business was discussed during the Finance and Audit meeting.

14.0 Next Meeting

The next Finance and Audit Committee meeting is scheduled for September 22, 2025.

15.0 Adjournment

There being no further business, the meeting was adjourned at 8:57 a.m.

MOVED BY: Tina Siemens

***THAT** the meeting be adjourned.*

CARRIED

APPENDIX 1

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AGENDA ITEM 7.1

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Finance and Audit Committee

Subject: Audited Financial Statements - Fiscal Year 2024-2025

Recommendation:

***THAT** the Board approve the Audited Financial Statements for the fiscal year ended May 31, 2025, as presented.*

Issue:

The Board is asked to review and approve the annual Audited Financial Statements of the College.

Link to Strategic Plan:

This aligns under Performance and Accountability

The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

4.1 Ensures College governance is proactive, effective, competency-based, and accountable.

Why this is in the Public Interest:

As a self-regulated profession, enhancing accountability, demonstrating stewardship, and providing valuable information publicly will help to build stakeholders and public trust, ideally helping the College to continue to excel as a regulator protecting the public through its operations and programs.

Equity, Diversity, and Inclusion Considerations:

When preparing this report, equity, diversity, and inclusion considerations were made.

Background:

As part of its duties, the Finance and Audit Committee held a discussion with the external auditor, Hilborn LLP, to review the results of their audit and to determine if there were any issues, findings or concerns that needed to be addressed. Noting that there were no issues identified, the Committee recommends that the Board approve the annual Audited Financial Statements.

Discussion:

The Finance and Audit Committee is pleased with the work performed by Hilborn LLP and accepts the external auditor's opinion on the Audited Financial Statements for the fiscal year ended May 31, 2025. Management and the Committee advise the Board to approve the Audited Financial Statements as presented.

Implications:

If approved by the Board, the Audited Financial Statements will be recorded as finalized and incorporated into the Annual Report, which will be distributed to the Minister of Health, registrants, and other interested parties, and published on the College’s website.

Attachments:

1. Audited Financial Statements of the College as at May 31, 2025
2. Audit Findings Communication for the year ended May 31, 2025

COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO

FINANCIAL STATEMENTS

MAY 31, 2025

Draft Statement Subject to Revision

Independent Auditor's Report

To the Board of Directors of the College of Occupational Therapists of Ontario

Opinion

We have audited the financial statements of the College of Occupational Therapists of Ontario (the "College"), which comprise the statement of financial position as at May 31, 2025, and the statements of operations, changes in net assets and cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the College as at May 31, 2025, and the results of its operations and its cash flows for the year then ended in accordance with Canadian accounting standards for not-for-profit organizations.

Basis for Opinion

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

Other Information

Management is responsible for the other information. The other information comprises the information, other than the financial statements and our auditor's report thereon, in the annual report.

Our opinion on the financial statements does not cover the other information and we will not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information identified above and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated.

The annual report is expected to be made available to us after the date of our auditor's report. If, based on the work we will perform on this other information, we conclude that there is a material misstatement of this other information, we are required to report that fact to those charged with governance.

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

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

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

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

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Independent Auditor's Report (continued)

Auditor's Responsibilities for the Audit of the Financial Statements

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

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

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

Draft Statement Subject to Revision

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

We also provide those charged with governance with a statement that we have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on our independence, and where applicable, related safeguards.

Toronto, Ontario
TBD

Chartered Professional Accountants
Licensed Public Accountants

COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO

Statement of Financial Position

May 31	2025 $	2024 $
ASSETS		
Current assets		
Cash	**5,813,319**	5,222,780
Current portion of long-term investments (note 3)	**662,448**	362,817
Prepaid expenses	**52,654**	51,359
	6,528,421	5,636,956
Long-term investments (note 3)	**2,883,253**	3,230,081
Capital assets (note 4)	**197,490**	240,497
	3,080,743	3,470,578
	9,609,164	9,107,534
LIABILITIES		
Current liabilities		
Accounts payable and accrued liabilities (note 5)	**1,005,430**	1,032,148
Deferred registration fees	**4,805,741**	4,645,941
	5,811,171	5,678,089
NET ASSETS		
Invested in capital assets	**197,490**	240,497
Internally restricted for hearings and independent medical exams (note 6)	**400,000**	400,000
Internally restricted for premises (note 7)	**800,000**	800,000
Internally restricted for sexual abuse therapy and counselling (note 8)	**25,000**	25,000
Internally restricted for enterprise wide IT system (note 9)	**100,000**	100,000
Unrestricted	**2,275,503**	1,863,948
	3,797,993	3,429,445
	9,609,164	9,107,534

Draft Statement Subject to Revision

The accompanying notes are an integral part of these financial statements

Approved on behalf of the Board of Directors:

Chair

Director

COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO

Statement of Operations

Year ended May 31	2025 $	2024 $
Revenues		
Registration fees	**4,913,174**	4,691,567
Application fees	**103,158**	94,985
Investment income	**261,846**	241,865
	5,278,178	5,028,417
Expenses		
Salaries and benefits (note 10)	**3,362,503**	3,375,560
Rent	**370,991**	359,677
Information technology	**244,858**	239,715
Programs	**229,888**	246,711
Other office operations	**207,612**	211,243
Professional fees	**124,648**	142,212
Board of Directors	**120,689**	138,517
Communications	**115,822**	92,951
Investigations and resolutions (note 11)	**72,699**	268,384
Amortization	**47,817**	45,713
Operational initiatives	**12,103**	113,779
Enterprise wide IT system (note 9)	**-**	155,871
	4,909,630	5,390,333
Excess of revenues over expenses (expenses over revenues) for year	**368,548**	(361,916)

The accompanying notes are an integral part of these financial statements

Draft Statement Subject to Revision

COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO

Statement of Changes in Net Assets

Year ended May 31, 2025

	Invested in capital assets $	Internally restricted for hearings and independent medical exams $	Internally restricted for premises $	Internally restricted for sexual abuse therapy and counselling $	Internally restricted for enterprise wide IT system $	Unrestricted $	Total 2025 $
Balance, beginning of year	240,497	400,000	800,000	25,000	100,000	1,863,948	**3,429,445**
Excess of revenues over expenses for year	-	-	-	-	-	368,548	**368,548**
Purchase of capital assets	4,810	-	-	-	-	(4,810)	**-**
Amortization of capital assets	(47,817)	-	-	-	-	47,817	**-**
Balance, end of year	197,490	400,000	800,000	25,000	100,000	2,275,503	**3,797,993**

The accompanying notes are an integral part of these financial statements

Draft Statement Subject to Revision

COLLEGE OF OCCUPATIONAL THERAPISTS OF ONTARIO

Statement of Changes in Net Assets

Year ended May 31, 2024

	Invested in capital assets $	Internally restricted for hearings and independent medical exams $	Internally restricted for premises $	Internally restricted for sexual abuse therapy and counselling $	Internally restricted for enterprise wide IT system $	Unrestricted $	Total 2024 $
Balance, beginning of year	223,060	400,000	800,000	25,000	141,120	2,202,181	3,791,361
Excess of expenses over revenues for year (note 9)	-	-	-	-	(141,120)	(220,796)	(361,916)
Purchase of capital assets	63,150	-	-	-	-	(63,150)	-
Amortization of capital assets	(45,713)	-	-	-	-	45,713	-
Internal restriction (note 9)	-	-	-	-	100,000	(100,000)	-
Balance, end of year	240,497	400,000	800,000	25,000	100,000	1,863,948	3,429,445

The accompanying notes are an integral part of these financial statements

Draft Statement Subject to Revision

Statement of Cash Flows

Year ended May 31	2025 $	2024 $
Cash flows from operating activities		
Excess of revenues over expenses (expenses over revenues) for year	**368,548**	(361,916)
Adjustments to determine net cash provided by (used in) operating activities		
Amortization	**47,817**	45,713
Unrealized gain in fair value of long-term investments	**(34,117)**	(27,384)
Interest capitalized on long-term investments	**(42,348)**	(45,352)
Interest received on long-term investments capitalized in prior years	**45,352**	45,360
	385,252	(343,579)
Change in non-cash working capital items		
Decrease (increase) in prepaid expenses	**(1,295)**	4,460
Increase (decrease) in accounts payable and accrued liabilities	**(26,718)**	272,576
Increase in deferred registration fees	**159,800**	216,009
	517,039	149,466
Cash flows from investing activities		
Purchase of long-term investments	**(281,690)**	(1,829,228)
Proceeds from disposal of long-term investments	**360,000**	1,821,713
Purchase of capital assets	**(4,810)**	(63,150)
	73,500	(70,665)
Net change in cash	**590,539**	78,801
Cash, beginning of year	**5,222,780**	5,143,979
Cash, end of year	**5,813,319**	5,222,780

The accompanying notes are an integral part of these financial statements

Draft Statement Subject to Revision

May 31, 2025

Nature and description of the organization

The College of Occupational Therapists of Ontario (the "College") was incorporated as a non-share capital corporation under the Regulated Health Professions Act ("RHPA").

As the regulator and governing body of the occupational therapy profession in Ontario, the major function of the College is to administer the Occupational Therapy Act in the public interest.

The College is a not-for-profit organization, as described in Section 149(1)(l) of the Income Tax Act, and therefore is not subject to income taxes.

1. **Significant accounting policies**

These financial statements have been prepared in accordance with Canadian accounting standards for not-for-profit organizations and include the following significant accounting policies:

(a) **Revenue recognition**

Registration fees

Registration fees are recognized as revenue in the fiscal year to which they relate. The registration year of the College coincides with that of the fiscal year of the College, being June 1 to May 31. Registration fees received in advance of the fiscal year to which they relate are recorded as deferred registration fees.

Application fees

Application fees are recognized as revenue when services are rendered.

Investment income

Investment income comprises interest from cash and investments and unrealized gains and losses in the fair value of investments.

Revenue is recognized on an accrual basis. Interest on investments is recognized over the terms of the investments using the effective interest method.

(b) **Investments**

Investments consist of fixed income investments with maturity dates greater than twelve months from the date of acquisition. Investments that mature within twelve months from the year-end date are classified as current.

Draft Statement Subject to Revision

1. **Significant accounting policies (continued)**

(c) **Capital assets**

The costs of capital assets are capitalized upon meeting the criteria for recognition as a capital asset, with the exception of expenditures on internally generated intangible assets during the development phase, which are expensed as incurred. The cost of a capital asset comprises its purchase price and any directly attributable cost of preparing the asset for its intended use.

Capital assets are measured at cost less accumulated amortization and accumulated impairment losses.

Amortization is provided for, upon commencement of the utilization of the assets, on a straight-line basis at rates designed to amortize the cost of the capital assets over their estimated useful lives. The annual amortization rates are as follows:

Furniture and fixtures	5 years
Computer equipment	3 years

Amortization of leasehold improvements is provided for on a straight-line basis over the remaining term of the lease.

A capital asset is tested for impairment whenever events or changes in circumstances indicate that its carrying amount may not be recoverable. If any potential impairment is identified, the amount of the impairment is quantified by comparing the carrying value of the capital asset to its fair value. Any impairment of the capital asset is recognized in income in the year in which the impairment occurs.

An impairment loss is not reversed if the fair value of the capital asset subsequently increases.

Draft Statement Subject to Revision

May 31, 2025

1. **Significant accounting policies (continued)**

(d) **Financial instruments**

Measurement of financial assets and liabilities

The College initially measures its financial assets and financial liabilities at fair value adjusted by, in the case of a financial instrument that will not be measured subsequently at fair value, the amount of transaction costs directly attributable to the instrument. Transaction costs of those financial assets and financial liabilities subsequently measured at fair value are recognized in income in the year incurred.

The College subsequently measures all of its financial assets and financial liabilities at amortized cost, with the exception of investments, which are measured at fair value. Changes in fair value are recognized in income in the year the changes occur. Fair values are determined by reference to published price quotations in an active market at year end.

Amortized cost is the amount at which a financial asset or financial liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortization of any difference between that initial amount and the maturity amount, and minus any reduction for impairment.

Financial assets measured at amortized cost include cash.

Financial assets measured at fair value include investments.

Financial liabilities measured at amortized cost include accounts payable and accrued liabilities.

Impairment

At the end of each year, the College assesses whether there are any indications that a financial asset measured at amortized cost may be impaired. Objective evidence of impairment includes observable data that comes to the attention of the College, including but not limited to the following events: significant financial difficulty of the issuer; a breach of contract, such as a default or delinquency in interest or principal payments; and bankruptcy or other financial reorganization proceedings.

When there is an indication of impairment, the College determines whether a significant adverse change has occurred during the year in the expected timing or amount of future cash flows from the financial asset.

When the College identifies a significant adverse change in the expected timing or amount of future cash flows from a financial asset, it reduces the carrying amount of the financial asset to the greater of the following:

- the present value of the cash flows expected to be generated by holding the financial asset discounted using a current market rate of interest appropriate to the financial asset; and

- the amount that could be realized by selling the financial asset at the statement of financial position date.

Draft Statement Subject to Revision

May 31, 2025

1. **Significant accounting policies (continued)**

(d) **Financial instruments (continued)**

Impairment (continued)

Any impairment of the financial asset is recognized in income in the year in which the impairment occurs.

When the extent of impairment of a previously written-down financial asset decreases and the decrease can be related to an event occurring after the impairment was recognized, the previously recognized impairment loss is reversed to the extent of the improvement, but not in excess of the impairment loss. The amount of the reversal is recognized in income in the year the reversal occurs.

(e) **Pension plan**

The College is an employer member of the Healthcare of Ontario Pension Plan (the "Plan"), which is a multi-employer defined benefit pension plan. Sufficient information is not available to the College to use defined benefit plan accounting, therefore, the College accounts for the Plan as a defined contribution pension plan. The College expenses pension contributions when made.

(f) **Management estimates**

The preparation of financial statements in conformity with Canadian accounting standards for not-for-profit organizations requires management to make judgments, estimates and assumptions that affect the application of accounting policies and the reported amounts of assets and liabilities and the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the current year. Actual results may differ from the estimates, the impact of which would be recorded in future years.

Estimates and underlying assumptions are reviewed on an ongoing basis. Revisions to accounting estimates are recognized in the year in which the estimates are revised and in any future years affected.

Draft Statement Subject to Revision

2. **Financial instrument risk management**

The College is exposed to various risks through its financial instruments. The following analysis provides a measure of the College's risk exposure and concentrations.

The financial instruments of the College and the nature of the risks to which those instruments may be subject, are as follows:

	Risks				
			Market risk		
Financial instrument	Credit	Liquidity	Currency	Interest rate	Other price
Cash	X			X	
Investments	X			X	
Accounts payable and accrued liabilities		X			

2. **Financial instrument risk management (continued)**

Credit risk

The College is exposed to credit risk resulting from the possibility that parties may default on their financial obligations, or if there is a concentration of transactions carried out with the same party, or if there is a concentration of financial obligations which have similar economic characteristics that could be similarly affected by changes in economic conditions, such that the College could incur a financial loss.

The maximum exposure of the College to credit risk is as follows:

	2025 $	2024 $
Cash	5,813,319	5,222,780
Investments	3,545,701	3,592,898
	9,359,020	8,815,678

Draft Statement Subject to Revision

The College reduces its exposure to the credit risk of cash by maintaining balances with a Canadian financial institution.

The College manages its exposure to the credit risk of investments through its investment policy which restricts the types of eligible investments.

Liquidity risk

Liquidity risk is the risk that the College will not be able to meet a demand for cash or fund its obligations as they come due.

The liquidity of the College is monitored by management to ensure sufficient cash is available to meet liabilities as they become due.

Market risk

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

Currency risk

Currency risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate due to changes in foreign exchange rates.

The College is not exposed to currency risk.

Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instrument will fluctuate due to changes in market interest rates.

2. **Financial instrument risk management (continued)**

Other price risk

Other price risk refers to the risk that the fair value of financial instruments or future cash flows associated with the instruments will fluctuate because of changes in market prices (other than those arising from currency risk or interest rate risk), whether those changes are caused by factors specific to the individual instrument or its issuer or factors affecting all similar instruments traded in the market.

The College is not exposed to other price risk.

Changes in risk

There have been no significant changes in the risk profile of the financial instruments of the College from that of the prior year.

Draft Statement Subject to Revision

3. **Investments**

	2025 $	2024 $
Provincial and municipal bonds	941,556	725,749
Guaranteed investment certificates	2,604,145	2,867,149
	3,545,701	3,592,898
Less: current portion	662,448	362,817
Long-term portion	2,883,253	3,230,081

The investments have effective interest rates ranging from 2.05% to 4.95% (2024 - 2.09% to 5.02%), with maturity dates ranging from June 2025 to June 2030 (2024 - June 2024 to June 2029).

4. **Capital assets**

	Cost $	Accumulated Amortization $	2025 Net $
Furniture and fixtures	323,846	322,358	1,488
Computer equipment	524,441	494,180	30,261
Leasehold improvements	502,091	336,350	165,741
	1,350,378	1,152,888	197,490

	Cost $	Accumulated Amortization $	2024 Net $
Furniture and fixtures	323,846	321,614	2,232
Computer equipment	519,631	465,522	54,109
Leasehold improvements	502,091	317,935	184,156
	1,345,568	1,105,071	240,497

May 31, 2025

5. Accounts payable and accrued liabilities

	2025 $	2024 $
Accounts payable and accrued liabilities	357,268	353,620
Accrued liabilities - investigations and resolutions	132,400	205,641
Government remittances	515,762	472,887
	1,005,430	1,032,148

6. Net assets internally restricted for hearings and independent medical exams

The Board of Directors of the College has internally restricted net assets to cover costs for conducting discipline hearings, fitness to practice hearings, Health Professions Appeal and Review Board appeal hearings, other hearings that may arise related to the regulation of the profession, and independent medical exams.

The internal restriction is subject to the direction of the Board of Directors upon the recommendation of the Finance and Audit Committee.

7. Net assets internally restricted for premises

The Board of Directors of the College has internally restricted net assets to minimize the impact of major expenses related to College property such as leasehold improvements and other capital expenditures.

The internal restriction is subject to the direction of the Board of Directors upon the recommendation of the Finance and Audit Committee.

8. Net assets internally restricted for sexual abuse therapy and counselling

The Board of Directors of the College has internally restricted net assets to cover costs for the funding of therapy and counselling of occupational therapist clients.

The internal restriction is subject to the direction of the Board of Directors upon the recommendation of the Finance and Audit Committee.

Draft Statement Subject to Revision

9. Net assets internally restricted for enterprise wide IT system

The Board of Directors of the College has internally restricted net assets to provide for the cost of implementing and/or maintaining an enterprise-wide, registrant-based information technology system that will support the delivery of the statutory College mandate in an efficient and effective manner.

During the prior year, $155,871 was spent in connection with the enterprise wide IT system with only $141,120 applied against the internally restricted net assets for enterprise wide IT system. This resulted in a decrease in the net assets internally restricted for enterprise wide IT system from $141,120 to nil.

During the prior year, the Board of Directors approved a transfer of $100,000 from unrestricted net assets to net assets internally restricted for enterprise wide IT system. This resulted in an increase in the net assets internally restricted for enterprise wide IT system from nil to $100,000.

The internal restriction is subject to the direction of the Board of Directors upon the recommendation of the Finance and Audit Committee.

10. Multi-employer pension plan

Employees of the College are members of the Plan and will receive retirement benefits based on the member's contributory service, the highest average annualized earnings during any consecutive five-year period, and the most recent three-year average year's maximum pensionable earnings. As at December 31, 2024, the Plan is 111% funded. Contributions to the Plan made during the year ended May 31, 2025 by the College on behalf of its employees amounted to $236,765 (2024 - $237,743) and are recorded in salaries and benefits in the statement of operations. Employee contributions to the Plan during the year ended May 31, 2025 were $187,908 (2024 - $188,685).

11. Investigations and resolutions

	2025 $	2024 $
Costs incurred	145,940	148,842
Adjustment of estimate to resolve open cases	(73,241)	119,542
	72,699	268,384

Investigations and resolutions include an estimate of costs to resolve open cases at year end. These estimates are determined based on historical average costs and relevant case facts available. The actual outcome of each case may differ from the initial estimate.

Draft Statement Subject to Revision

12. Commitment

The College is committed to lease its office premises until September 2033. The future annual lease payments, including an estimate of premises common area expenses, are as follows:

	$
2026	415,486
2027	421,645
2028	433,963
2029	440,122
Subsequent years	1,976,998
	3,688,214

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College of Occupational Therapists of Ontario

AUDIT FINDINGS COMMUNICATION

FOR THE YEAR ENDED

May 31, 2025

A message from Blair MacKenzie to the Finance and Audit Committee

We are pleased to provide you with the findings of our audit of the financial statements of the College of Occupational Therapists of Ontario (the "College") for the year ended May 31, 2025. We have substantially completed our audit, and we expect to issue an unmodified audit opinion on the financial statements for the year ended May 31, 2025.

Key Highlights of our Audit Findings Communication include:

- The status of the audit
- Audit opinion
- Changes to our Audit Plan Communication dated May 13, 2025, if any
- Observations that are significant to your responsibility to oversee the financial reporting process

This communication has been prepared to comply with the requirements outlined in Canadian Auditing Standard 260, *Communication with those Charged with Governance*. The information in this document is intended solely for the use of the Finance and Audit Committee, Board of Directors and management of the College and should not be distributed to others without our consent.

We look forward to discussing our Audit Findings Communication with you as well as any other matters that you may consider appropriate.

Hilborn LLP

Blair MacKenzie, CPA, CA

Partner

Hilborn LLP

September 8, 2025

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YOUR CLIENT SERVICE TEAM

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"We are committed to audit quality and exceptional client service."

Executive Summary

STATUS OF THE AUDIT

We have substantially completed our audit of the financial statements of the College of Occupational Therapists of Ontario for the year ended May 31, 2025, with the exception of the following procedures:

Completion of subsequent events procedures

Receipt of the signed management representation letter

Board of Director's approval of the financial statements

These procedures require completion before we may issue our auditor's report. If we become aware of significant matters after completing these procedures, we will bring them to your attention.

AUDITOR'S REPORT AND REPRESENTATIONS FROM MANAGEMENT

We expect to issue an unmodified opinion. The expected form and content of our report is included in the draft financial statements.

The management representations letter is expected to be consistent with that issued in our Audit Plan Communication dated May 13, 2025. We ask management to sign and return this letter to us before we issue the auditor's report.

INDEPENDENCE

We last communicated our independence to you through our Audit Plan Communication dated May 13, 2025. We have remained independent since that date and through the date of this communication.

SIGNIFICANT DIFFICULTIES ENCOUNTERED

There were no significant difficulties encountered while performing the audit and there are no unresolved disagreements with management. We received full cooperation from management during the audit.

CHANGES FROM THE AUDIT PLAN

Our audit approach was consistent with the approach communicated to you in our Audit Plan Communication dated May 13, 2025.

Final materiality is consistent with preliminary materiality set at $220,000.

Significant Qualitative Aspects of the College's Accounting Practices

Canadian Auditing Standards require that we communicate with you about significant qualitative aspects of the College's accounting practices, including accounting policies, accounting estimates and financial statement disclosures.

ACCOUNTING POLICIES, ACCOUNTING ESTIMATES AND FINANCIAL STATEMENT DISCLOSURES	HILBORN'S RESPONSE AND VIEWS
Management is responsible for the appropriate selection and application of accounting policies under the financial reporting framework of Canadian accounting standards for not-for-profit organizations. Our role is to review the appropriateness and application of these policies as part of our audit. The accounting policies used by the College are described in Note 1, Significant Accounting Policies, in the financial statements.	• There were no significant changes in the previously adopted accounting policies or their application. • Based on the audit work performed, the accounting policies are appropriate for the College and applied consistently.
Management is responsible for the accounting estimates included in the financial statements. Estimates and the related judgements and assumptions are based on management's knowledge of the business and past experience about current and future events.	• We considered whether there was any management bias in preparing the estimates. None was noted. • We believe management's process for making accounting estimates is appropriate and the estimates made by management are reasonable in the context of the financial statements taken as a whole.

Significant Qualitative Aspects of the College's Accounting Practices

ACCOUNTING POLICIES, ACCOUNTING ESTIMATES AND FINANCIAL STATEMENT DISCLOSURES	HILBORN'S RESPONSE AND VIEWS
Management is responsible for disclosures made within the financial statements, including the notes to the financial statements.	• Based on the audit work performed, we are satisfied that the overall presentation, structure, and content of the financial statements, including the disclosures, represent the underlying transactions and events in a manner that achieves fair representation.
Annual report	• We acknowledge that a copy of the College's financial statements for the year ended May 31, 2025 and a copy of our auditor's report related to the financial statements will be included in College of Occupational Therapists of Ontario's annual report. As agreed in our engagement letter, we will review the annual report prior to it being finalized to ensure that there are no inconsistencies with the audited financial statements. • If, based on the work that we will perform on the annual report, we conclude that there is a material misstatement of the annual report we will communicate that fact to you.

Other Significant Matters

In accordance with Canadian Auditing Standards, there are a number of required communications between the auditor and those charged with governance related to the oversight of the financial reporting process. Those communications will primarily be written in the form of our audit plan and audit findings communications. We may also communicate orally through discussions. The table below summarizes the communications required at the conclusion of the audit.

SIGNIFICANT MATTER	DISCUSSION
Summary of uncorrected misstatements	We did not identify any misstatements that remain uncorrected in the financial statements.
Corrected misstatements	During the course of the audit, management and Hilborn LLP worked collaboratively to identify adjustments required to the financial statements. All adjustments proposed were reviewed, approved and recorded by management.

Other Significant Matters

SIGNIFICANT MATTER	DISCUSSION
Significant deficiencies in internal control	An increased risk profile exists at the College relative to the lack of segregation of incompatible duties. Segregation of incompatible duties is a key internal control intended to minimize the occurrence of errors or fraud. The principle of segregating incompatible duties encompasses the division of responsibilities of a key process such that no one individual performs two or more of the functions related to custody, initiation, authorization, execution, recording and reporting. We did not identify any significant deficiencies in internal control. This risk is inherent in small to medium sized organizations and should not be interpreted negatively. From a cost-benefit perspective, it would not be practical to segregate incompatible duties to a sufficient degree to mitigate this risk, as it would require additional personnel that may not be appropriate otherwise.
Fraud and non-compliance with laws and regulations	No fraud or non-compliance with laws and regulations came to our attention during the course of the audit. We would like to reconfirm with the Finance and Audit Committee that you are not aware of any fraud or non-compliance with laws and regulations not previously discussed with us.

Other Significant Matters

SIGNIFICANT MATTER	DISCUSSION
Related party transactions	We did not identify any related party transactions or balances.
Subsequent events	No subsequent events, which would impact the financial statements have come to our attention.

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AGENDA ITEM 7.2

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Executive Committee

Subject: Draft Annual Report for 2024-2025

Recommendation:

***THAT** the Board approve the Annual Report for the 2024-2025 fiscal year for distribution.*

Issue:

The Board is asked to review the annual report and approve it for distribution.

Link to Strategic Plan:

Performance and Accountability: The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

The report summarizes accomplishments for the 2024-2025 fiscal year, which ended on May 31, 2025. This report addresses the first year of the 2024-2027 strategic plan.

Why this is in the Public Interest:

Ensuring that the College meets its public protection mandate and operates in a fiscally prudent manner serves the public interest.

Diversity, Equity, and Inclusion Considerations:

When preparing the Annual Report, the varied audiences that may review the report are considered and attempts are made to reduce the use of complex terminology. Images are selected to represent the diversity of the profession and the clients we serve.

Background:

As per the *Regulated Health Professions Act, 1991*, each College is required to report annually to the Ministry on its activities and financial affairs.

A digital version of the Annual Report has been prepared and is available for review at the following link: https://www.coto.org/wp-content/uploads/modules/annualreports/2025/en/index.html#/

Committee reports are now included, and publicly available, in Board packages and referenced as such in the Annual Report.

Draft financial statements have been provided by the auditor. Following approval of the statements, the auditor will provide final statements for inclusion in the report with signature added and watermark removed.

Discussion:

The Annual Report for the 2024-2025 fiscal year has been prepared and is presented to the Board for approval.

Implications:

If approved by the Board, the report will be distributed electronically to registrants, the Ministry of Health, and interested parties. In addition, it will be posted on the College's website.

Attachments: N/A

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Kimberly Woodland, Program Director

Subject: Code of Ethics

Recommendation:

***THAT** the Board approve the Code of Ethics draft document for public consultation.*

Link to Strategic Plan:

Meaningful Engagement

The College builds trust in its role and value through purposeful and meaningful engagement and collaboration.

- Provides clear information about what to expect when working with occupational therapists.
- Builds opportunities for public and professional collaboration and participation with the College.
- Engages registrants to build understanding of professional obligations, College programs and services.
- Integrates the practices of diversity, equity, and inclusion throughout the College and profession.

Quality Practice

The College embraces leading regulatory practices to protect the public.

- Takes an evidence-informed, risk-based approach to ensuring occupational therapists are competent, safe, effective, and accountable.
- Engages occupational therapists to advance quality practice and the delivery of safe, effective occupational therapy service.

System Impact

The College collaborates for access to the profession and consistent quality practice.

- Collaborates with national partners for further regulatory excellence.

Performance and Accountability

The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

Ensures College governance is proactive, effective, competency-based, and accountable.

Why this is in the Public Interest:
The College intends to update its Code of Ethics (2020) considering the Competencies for Occupational Therapists in Canada (2021) and its updated commitment to equity, diversity and inclusion.

Equity, Diversity, and Inclusion Considerations:
The College Code of Ethics draft 2025 emphasizes expectations for how registrants demonstrate their commitment to culturally safer practice, as required and outlined in the Competencies for Occupational Therapists in Canada (2021). This aligns with the College's commitment to Equity, Diversity and Inclusion.

Background:
At the January 2024 Board meeting, the Board approved the College's new 2024-2027 Strategic Plan with an increased emphasis on equity, diversity and inclusion. A project was planned to update the College Code of Ethics.

National Template

> Last year the Association of Occupational Therapy Regulatory Organizations (ACOTRO) initiated a working group to create a National Code of Ethics (COE) template that integrated the Competencies for Occupational Therapists in Canada. Regulators worked to create a National COE template to be used across the country which has now been finalized.
>
> The National Template includes a:
> - Short one page Code of Ethics
> - Guide which includes regulations, definitions, approaches and resources
> - Checklist for Ethical Practice which can be used by registrants and internally by a regulator for committee decisions.

Regulated Health Professions Act (RHPA) and College Bylaw

The Code of Ethics provides registrants with information about the College's expectations for ethical practice. It outlines a set of values and principles and is intended for use in all contexts and domains of occupational therapy practice, and in all levels of decision making.

It further describes the values occupational therapists embody as members of a self-regulating profession and it can be used to help clients, colleagues and members of the public understand our ethical commitments.

As a critical component of the College's Registration, Practice, Quality Assurance, Investigations and Resolutions (I&R) programs, the Code of Ethics provides information that is crucial to all registrants.

The RHPA, 1991, section 94 (1)(k) provides for a code of ethics to be included in our bylaw. The current College Code of Ethics is included in Schedule "A" of the bylaw. See Appendix A.

Committee Work:

Based on the ACOTRO Scope of Practice template, the College Code of Ethics draft 2025 has been reviewed and recommended for public consultation, by the following committees/subcommittees:

- Patient Relations
- Practice Subcommittee
- Indigenous Insights Advisory Committee
- Equity Perspectives Advisory Committee

Project timeline for consultation:

October 2025	Executive and Board review / approval for public consultation.	If approved, translated for public consultation.
Fall/Winter 2025-26	Public consultation in French and English. Review and revise College Code of Ethics 2025 based on feedback	To be completed by the Program Leadership Team-including Practice, Registration, Quality Assurance and I&R.
March 2025	Final reviews with applicable committees, Executive and final Board approval. Review and approval of supporting resources.	Prepare for launch June 2026

Discussion:

The COTO COE will be updated in 2025-26. In Ontario, the COE forms part of the Bylaw.

Any update to the COE is required to be circulated to every Registrant for feedback. If the Board approves, the COE for consultation, Registrants will have at least 60 days to provide feedback before it is approved by the Board.

This year, the COE will also be used as one guidepost for the project to update the Culture, Equity and Justice practice document. The College COE draft 2025 describes ethical responsibilities for registered occupational therapists in Ontario including guiding principles and values. See the attached.

For Approval:

a. Have you identified any gaps in the College COE draft?
b. Is the information included in the template reflective and helpful for the diverse clients that occupational therapists serve in Ontario (Universally applicable)?

Next Steps

Next steps will include:

- Engagement with registrants with regards to the proposed draft
- Completion of any policy and Bylaw amendments
- Approval by COTO Board

Appendix A: Code of Ethics, 2020

Attachments:

1. Code of Ethics for Occupational Therapists in Ontario *Draft 2025*
2. Guide to Code of Ethics
3. Code of Ethics Checklist

Appendix A:

Bylaw: **Schedule "A" Code of Ethics**

This Code of Ethics provides registrants with information about the College of Occupational Therapists of Ontario's (the College's) expectations for ethical practice. It outlines a set of values and principles and is intended for use in all contexts and domains of occupational therapy practice, and in all levels of decision making. It further describes the values occupational therapists embody as members of a self-regulating profession and it can be used to help clients, colleagues and members of the public understand our ethical commitments. As a critical component of the College's Complaints, Discipline and Quality Assurance Programs, the Code of Ethics provides information that is crucial to all registrants.

Ethical practice defines what is good – and thus, what is right.
The College expects all practitioners to commit to *good* practice. This commitment requires occupational therapists to consciously consider what is *right* in furthering the interests of clients and in protecting the public interest.

The **Code of Ethics** forms the foundation for occupational therapist's ethical obligations. It is the framework for the professional and personal conduct expectations outlined in laws, regulations, College standards and guidelines that govern the practice of occupational therapy. The Code of Ethics articulates the fundamental reference points that guide ethical practice and to which the profession aspires.

Fundamental Values of Occupational Therapists

Values are the ethical building blocks of human behaviour and interaction. They are at the heart of our everyday exchanges, and shape how we relate to and treat others.
Occupational therapists are in a position of duty and authority. They have a duty to the individuals who rely on their knowledge, skill and judgement. They are in a position of authority because they have access to personal and sensitive information and provide services to people who are vulnerable. Consequently, they have a professional responsibility to uphold the professions' fundamental values.

While practice can adopt many forms and take place in a variety of contexts, occupational therapists must always aim for the same common goal – to enable clients to engage in meaningful ways with their world.

Respect and Trust

Occupational therapists are guided by two fundamental values: RESPECT and TRUST.

These core values are as important as the laws, regulations, and College standards and guidelines under which occupational therapists are governed.

Our values relate to the obligations occupational therapists have as self-regulated professionals in whom the public places respect and trust. These values give rise to the **principles of practice** that underpin occupational therapy services.

Respect

- An occupational therapist promotes respect by applying the principles of:

Client-centred practice

- Determine what has meaning and purpose for the client;
- Recognize that clients are diverse and that each client is an individual;

Respect for autonomy

- Recognize each client's right to make choices for themselves;
- Honour the dignity and worth of each individual;

Collaboration and communication

- Practise as a team member with clients and other professionals.

Trust

An occupational therapist promotes trust by applying the principles of:

Honesty

- Truthfulness is a cornerstone of trust;

Fairness

- Practise justice in dealings with others and within the scope of your work by striving to ensure
- diversity, equity and inclusion in the provision of occupational therapy services.

Accountability

- Take responsibility for decisions, actions, professional competence and judgement;
- Actions taken by occupational therapists should serve the client's best interest, by working in a transparent, honest manner and while striving to do no harm.

Transparency

- Full disclosure ensures integrity in relationships with clients, other professionals and society.

Professional Boundaries

- In keeping with the standards of practice, set and manage boundaries relating to personal dignity, self-control, professional relationships, privacy, and confidentiality to ensure that the trust a client has placed in the occupational therapist is maintained.

Conflict of Interest

- Proactively recognize, disclose, prevent, and where that is not possible, take measures to effectively manage any conflicts of interest that arise while providing professional services.

The above principles are neither definitive nor exhaustive. Additional principles may be needed in specific situations such as a pandemic or other emergency.

GUIDE TO CODE OF ETHICS

Purpose

The purpose of the Code of Ethics and the Guide to the Code of Ethics is to set out the ethical principles and values governing the conduct of occupational therapists registered to practice Ontario regardless of role, responsibilities, job title, practice area or practice setting, client population, years in practice or level of experience.

The Code of Ethics and the Guide to the Code of Ethics are not intended to tell registrants exactly how to act in every situation but rather to be used to guide registrants on how to conduct themselves and how to navigate the wide range of ethical scenarios and dilemmas that can arise in practice.

GLOSSARY of TERMS[1]

Accountability

Accepting full responsibility for our actions and decisions, ensuring they align with professional standards and ethical conduct.

Client

Occupational therapists work with people of any age, along with their families, caregivers, and substitute decision makers. Therapists may also work with collectives such as families, groups, communities, and the public at large.

[1] (Competencies for Occupational Therapists in Canada, 2021)

Collaboration

Working cooperatively with colleagues, clients, and stakeholders, recognizing that diverse perspectives lead to better outcomes.

Context

Context strongly influences occupational possibilities and healthcare service. This document looks at three layers of context:

1. 'Micro' context: The client's immediate environment – their own state of health and function, family and friends, the physical environment they move through.

2. 'Meso' context: The policies and processes embedded in the health, education, justice, and social service systems that affect the client.

3. 'Macro' context: The larger socioeconomic and political context around the client – social and cultural values and beliefs, laws, and public policies.

Ethical spaces

When an occupational therapist works with someone who has a different worldview, they seek to create an 'ethical' or neutral space for dialogue. This is a space to "step out of our allegiances, to detach from the cages of our mental worlds and assume a position where human-to-human dialogue can occur" (Ermine, 2007).

Equity

Equity is different from equality. Equality means everyone has the same resources and opportunities. Equity allocates resources and opportunities based on each person's circumstances, so that they can achieve equal outcomes. We need to take an equity approach because so many barriers to equality still exist in our society.

Humility

Cultural and intellectual humility is an approach to working with people that seeks to find common ground and mutual respect. The occupational therapist knows that they cannot fully appreciate another person's culture, and they must not assume that their own culture is superior. They listen deeply to what the client says about their life and experience. They stay open to the possibility that they might need to question their own professional knowledge and beliefs.

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Indicator of Ethical Practice

An indicator of ethical practice is a quantifiable characteristic of practice that is subject to measurement and can be used to describe one or more aspects ethical practice.

Integrity

Upholding honesty, fairness, and consistency in all professional actions, adhering to both the spirit and letter of the law.

Knowing Better and Doing Better

Maya Angelou, a renowned American poet, memoirist, and civil rights activist, once said, “Do the best you can until you know better. Then when you know better, do better” (2014). *Knowing better and doing better* is committing to continuous learning and improvement to ensure that our work is informed by the latest knowledge and practices, striving for excellence and competence.

Minimizing Harm

Acting thoughtfully to minimize harm, considering the impact of our decisions on individuals, communities, and society at large.

Occupational rights

The World Federation of Occupational Therapists (2019) recognizes occupational rights for all people to:

- Take part in occupations that support survival, health, and well-being
- Choose occupations without pressure or coercion, while acknowledging that with choice comes responsibility for others and for the planet
- Freely engage in needed and chosen occupations without risk to safety, human dignity, or equity.

Privilege

In the context of equity, ‘privilege’ refers to unquestioned and unearned advantages that people enjoy when they are members of more dominant groups in a society.

Respect

Treating everyone with dignity, and fairness, recognizing and honoring cultural differences and individual experiences.

Respecting Autonomy

Honouring the right of individuals to make informed decisions by providing them with the information, support, and resources needed to act in line with their values.

Social position and power

The words ‘social position and power’ are used in the competencies to refer to the concept of ‘positionality’. Differences in social position and power shape personal identity and *privilege* in society. Competent occupational therapists know how to analyze their positionality in order to act

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in an unjust world. This means being aware of one's own degree of privilege based on factors such as race, class, educational attainment, and income.

Transparency

Foster trust by communicating openly and honestly, ensuring clarity in all professional interactions.

BACKGROUND

Occupational therapists registered to practice in Ontario are governed by the Regulated Health Professions Act, 1991. The Board of the College of Occupational Therapists of Ontario, *the College,* is required to establish and maintain a Code of Ethics under the provisions if the Health Professions Procedural Code in Ontario and pursuant to section 8.08.4 of the College Bylaw.

This Code of Ethics outlines the ethical responsibilities and expectations for registrant conduct. It is one of the ways that the College fulfills its mandate to promote and protect the public interest. Registrants are required to uphold the Code of Ethics and failure to do so may constitute unprofessional conduct.

This iteration of the Code of Ethics emphasizes expectations for how registrants demonstrate their commitment to culturally safer practice consistent with the College's commitment to Equity, Diversity and Inclusion; and Land and Territorial Acknowledgement.

The following table illustrates where the Code of Ethics are situated within the overall structure of legislated and other governing authorities for the practice of occupational therapy:

Document	Description
Regulated Health Professions Act, 1991	The act that governs the practice of health professions currently regulated in Ontario. It sets out legal requirements relating to registration, continuing competence, and complaints and discipline. Section 94 (1)(k) provides for the scope of practice to be included in our bylaw.
Occupational Therapy Act, 1991	The regulation that governs the profession of occupational therapy. It outlines more detailed provisions regarding register categories, requirements for registration application and renewal, and protected title.
Bylaw, College of Occupational Therapists of Ontario	Schedule "A" Code of Ethics The Bylaw contains the Code of Ethics ("the Code"). The Code provides registrants with information about the College of Occupational Therapists of Ontario's (the College's) expectations for ethical practice
Anti-Racism Act, 2017	An Act creating a provincial anti-racism strategy that aims to eliminate systemic racism and advance racial equity.
Human Rights Code, 1990	The Code prohibits actions that discriminate against people based on a protected ground in a protected social area. Protected grounds are: Age, Ancestry, colour, race, Citizenship, Ethnic origin, Place of origin, Creed, Disability, Family status, Marital status (including single status), Gender identity, & gender expression, Sex (including pregnancy and breastfeeding), Sexual orientation. Protected social areas are: Housing; Contracts; Employment, Good, Services and facilities; Membership in Unions or professional associations.

Document	Description
Code of Ethics (CoE)	The set of values and principles that guide the conduct of occupational therapists registered to practice
Competencies for Occupational Therapists in Canada – ACOTRO, ACOTUP, CAOT (2021)	A nationally adopted document that outlines the broad range of skills and abilities required of all occupational therapists at all stages of their career. Occupational therapists registered to practice in Canada are expected to use the competencies document to inform their practice and competence needs.
Standards of Practice (SoP)	The set of regulatory requirements that define the minimum expectations for the practice of occupational therapy that result in the provision of ethical, accountable and effective services.
Occupational Therapy Statement of Commitment to Indigenous Peoples in Canada – ACOTPA, ACOTRO, ACOTUP, CAOT, COTF, (2023)	The statement prepared to summarize the recommended actions each of the participating organizations has committed to undertake to address the articles in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP, 2007); the Calls to Action from the Truth and Reconciliation Commission of Canada Report (TRC, 2015) and the Calls to Justice from the report on Missing and Murdered Indigenous Women and Girls (MMIWG, 2019).

Risk Management Approaches

A risk-based approach allows occupational therapists to prioritize and address the most significant risks to client occupations, health, and wellness focusing services and enhancing overall risk to a client. Taking a risk-based approach to practicing occupational therapy is part of providing safe, effective and ethical occupational services.

Trauma-Informed Approaches [2]

Trauma-informed approaches are policies and practices that recognize the connections between violence, trauma, negative health outcomes and behaviours. These approaches increase safety, control and resilience for people who are seeking services in relation to experiences of violence and/or have a history of experiencing violence.

Trauma-informed approaches require fundamental changes in how systems are designed, organizations function and practitioners engage with people based on the following key policy and practice principles:

1. Understand trauma and violence, and their impacts on peoples' lives and behaviours
2. Create emotionally and physically safe environments
3. Foster opportunities for choice, collaboration, and connection
4. Provide a strengths-based and capacity-building approach to support client coping and resilience

[2] Trauma and violence-informed approaches to policy and practice - Canada.ca

Health professionals, that do not understand the complex and lasting impacts of trauma may unintentionally re-traumatize. The goal of trauma informed approaches is to *minimize harm to the people you serve*—whether or not you know their experiences.

Embedding trauma-informed approaches into all aspects of policy and practice can create universal trauma precautions, which provide positive outcomes for all people. They also provide a common platform that helps to integrate services within and across systems and offer a basis for consistent and ethical ways of responding to people with such experiences.

Social Media, Virtual Service Provision and Generative AI Usage

The use of social media, virtual care platforms, and generative Artificial Intelligence (AI) can enhance occupational therapy service if used responsibly and ethically.

The Ethical Practice Checklist includes ethical considerations when using social media, virtual service platforms and AI.

HOW TO USE THE CODE OF ETHICS

The Code of Ethics is a resource for registrants and others with whom they interact. For example:

Registrants use the **Code of Ethics** and the **Ethical Practice checklist** to guide ethical conduct and decision making. When resolving ethical issues, registrants consider applicable legislated and governing authority, the Competencies, the Standards of Practice, and other college guidance documents together with what they know about their own practice context (e.g., organization policies and resources, geographic location, client population, etc.) and their clients' context.

Registrants are responsible for their decision making and actions and must, when requested by the college, be able to articulate their rationale for ethical decisions made. Failure to follow the Code of Ethics may be found to constitute unprofessional conduct.

The College, within its legislated mandate of serving and protecting the public interest, uses the Code of Ethics to inform registrants of their ethical responsibilities in daily practice. They are used in the Quality Assurance Program Competence Assessments. They are also used to frame responses to registrant questions or concerns about practice and in addressing complaints of unprofessional conduct.

Clients and the public may refer to the Code of Ethics to gain understanding of how their occupational therapist should be conducting themself.

Employers or supervisors of occupational therapists can use the Code of Ethics to support or assist the evaluation of employee conduct.

Educators and students use the Code of Ethics to inform curriculum content and student placement or entry-to-practice expectations.

Other health professionals/service providers may use the Code of Ethics to provide insight into how they can expect an occupational therapy colleague to conduct themselves.

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HOW TO USE THE ETHICAL PRACTICE CHECKLIST

The Ethical Practice Checklist provides a list of quantifiable characteristics of practice that point to the existence of ethical practice and can be used to describe one or more aspects ethical practice. Users of this resource can use the indicators of ethical practice in the Ethical Practice Check List to guide ethical conduct and decision making. See Appendix 1.

Acknowledgments

The Code of Ethics were coproduced as a template for use across Canada, in consultation and collaboration with registrants, college advisory committees and the Association of Canadian Occupational Therapy Regulatory Organizations (ACOTRO) Code of Ethics working group and board.

ACOTRO respectfully acknowledges the content taken and adapted from the Alberta College of Occupational Therapists (ACOT) building on the Codes of other regulatory organizations in Canada and worldwide.

Questions regarding the College's Code of Ethics and occupational therapy practice can be directed to Practice@COTO.org

SUPPLEMENTAL RESOURCES

Occupational Therapy Statement of Commitment to Indigenous Peoples in Canada. Report from the Occupational Therapy Truth and Reconciliation Task Force. (ACOTPA, ACOTRO, ACOTUP, CAOT, COTF - Sep 2023)

Promoting Occupational Participation: Collaborative Relationship-focused Occupational Therapy (2022)

REFERENCES

Alliance of Canadian Occupational Therapy Professional Associations – ACOTPA Association of Occupational Therapy Regulatory Organizations – ACOTRO; Association of Canadian Occupational Therapy University Programs – ACOTUP; Canadian Association of Occupational Therapists – CAOT; Canadian Occupational Therapy Foundation – COTF (2023). *Occupational Therapy Statement of Commitment to Indigenous Peoples in Canada*. Retrieved September 28, 2023 from https://caot.ca/document/8065/TRC%20Commitment%20statement%20Sept%2028%20 EN.pdf

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APPENDIX 1: Ethical Practice Checklist

Occupational Therapy Practice is ethical when it includes reflection, respect, meaning for the client, collaboration and engagement with the occupational therapy profession.

A. Reflective Practice

Practice is reflective when the occupational therapist:

- ☐ Engages in reflective practice and continuous learning throughout their career to acquire, maintain, and enhance competence in practice.
- ☐ Provides services only in areas of competence and seek support and additional education, training, mentorship or supervision when a gap in competence is identified.
- ☐ Considers degree of privilege and/or experiences of oppression and how they influence the therapist-client relationship.
- ☐ Exercises independent judgment.

B. Respectful and Meaningful Practice

Practice is respectful and meaningful when the occupational therapist:

- ☐ Acknowledges and respects the rights for all people to take part in occupations that support survival, health, and well-being without risk to safety, human dignity, or equity.
- ☐ Serves the client's best interest, by working in a transparent, honest manner and while striving to do no harm.
- ☐ Provides occupational therapy services that upholds the dignity of each client.
- ☐ Provides services to all clients in a respectful, unbiased manner**.** This includes not discriminating or refusing to provide services based on grounds protected under the *Human Rights Code of Ontario.*
- ☐ Seeks to create an 'ethical' or neutral space for dialogue.
- ☐ Provides services that incorporate equity-focused approaches.
- ☐ Respects and supports a client's autonomy to choose whether to proceed with occupational therapy services, including in situations when a client does not have capacity to provide informed consent
- ☐ Respects a client's autonomy to determine their own tolerance for risk in service provision.
- ☐ Incorporates risk management approaches in service provision as appropriate for the client's priorities, needs and circumstances, and the practice situation.
- ☐ Recognizes the power imbalance inherent in the therapist-client relationship and determine and communicate boundaries appropriate for the practice situation.
- ☐ Manages conflicts of interest that cannot be avoided.
- ☐ Implements measures that protect personal information, ensuring these protections when utilizing

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artificial intelligence (AI), social media, and virtual care tools.

C. Collaborative Practice

Practice is collaborative when the occupational therapist:

- Includes practicing collaboratively with colleagues and other key partners to promote coordination and alignment of client services.
- Creates and sustain practice environments that are free from discrimination or oppression.
- Provides mentorship and guidance as needed to colleagues, students and/or persons they are responsible for supervising.
- Seeks and receives and then uses professional judgment when acting on feedback given by colleagues or others regarding the provision of occupational therapy services and/or the registrant's conduct.

D. Professional Practice

Practice is professional when the occupational therapist

- Maintains a level of professional conduct that promotes the respect and integrity of the profession and sustains public confidence.
- Recognizes systems of inequity in their practice context and act within their professional sphere of influence to

  (a) address and prevent racism and other forms of discrimination or oppression,

  (b) minimize the ecological costs of care.
- Acts transparently and with integrity in all professional and business activities (e.g., fees and billing; contracts or terms of agreement with clients or contracting organizations; advertising of professional services; use of social media or other online platforms; response to any real or perceived conflicts of interest; etc.)
- Works effectively within the systems where occupational therapy services are provided (i.e., education, health, social, justice) and the policies, procedures or processes of any funding programs accessed in the provision of services.
- Shows leadership through one or more of the following:
  - contributing to the education of students, assistants or other system partners.
  - mentoring or educating occupational therapists.
  - engaging with professional networks or communities of practice; OR
  - otherwise contributing to the occupational therapy body of knowledge.
- Engages in quality improvement activities that support the provision of quality occupational therapy services.

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CODE OF ETHICS (DRAFT 2025)

The College of Occupational Therapists of Ontario is dedicated to upholding the highest ethical standards in service to the public. This Code of Ethics guides registrants to ensure their actions foster public trust, maintain the profession's integrity, and serve the best interests of clients while reflecting societal values.

ETHICAL PRINCIPLES

Knowing Better and Doing Better Commit to continuous learning and improvement to ensure that our work is informed by the latest knowledge and practices, striving for excellence and competence.

Minimizing Harm Act thoughtfully to minimize harm, considering the impact of our decisions on individuals, communities, and society at large.

Respecting Autonomy Honor the right of individuals to make informed decisions by providing them with the information, support, and resources needed to act in line with their values.

CORE VALUES

Accountability Accept full responsibility for our actions and decisions, ensuring they align with professional standards and ethical conduct.

Collaboration Work cooperatively with colleagues, clients, and stakeholders, recognizing that diverse perspectives lead to better outcomes.

Humility Approach our work with humility, being open to learning, feedback, and acknowledging the value of others' perspectives.

Integrity Uphold honesty, fairness, and consistency in all professional actions, adhering to both the spirit and letter of the law.

Respect Treat everyone with dignity, fairness, and respect, recognizing and honoring cultural differences and individual experiences.

Transparency Foster trust by communicating openly and honestly, ensuring clarity in all professional interactions.

COMMITMENT TO ETHICAL PRACTICE

By following these principles and values, registrants of College of Occupational Therapists of Ontario ensure their conduct serves the public good, fosters trust, and maintains the profession's integrity. Ethical practice requires ongoing reflection and a commitment to growth, ensuring we act in the best interests of those we serve.

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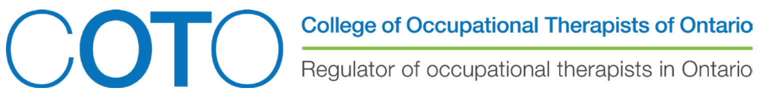


Q1 2025-2026 Quarterly Performance Report

The purpose of this report is to provide quarterly information on program and committee activities that relate to the 2024-2027 identified strategic priorities.

Importantly, this report and its contents are in the public interest as Board oversight of the strategic plan, committees, finance, risk, and Regulated Health Professions Act (RHPA) compliance are vital components of ensuring the public has access to safe, ethical, and quality care from occupational therapists.

General Legend:

Key Performance Indicators (KPIs): Measurable values that demonstrate how effectively an organization is achieving a program or strategic objective.

Benchmark: A benchmark is a standard or point of reference used to measure or compare performance, quality, or progress. It can be applied in various contexts:

a.) Comparison: Other OT regulators (Canadian Institute for Health Information (CIHI) or Health Profession Regulators of Ontario (HPRO) members; Financial Performance against previous year or budget

b.) Government target requirements: Ontario Health (OH) College Performance Measurement Framework (CPMF) or Ontario Fairness Commission (OFC) requirements

c.) Known test or system efficiency results: National Occupational Therapy Certification Exam (NOTCE) results

Baseline: The term **baseline** refers to a starting point or a standard against which future measurements, changes, or outcomes are compared. **For projects** the original scope, schedule, and cost of a project, which serves as a reference to track progress and performance. **For data analysis**, the initial set of data collected before any intervention or change, used to measure the impact of that change. **For Programs and Committees,** the status prior to a change in policy or implementation of a program improvement or system modification.

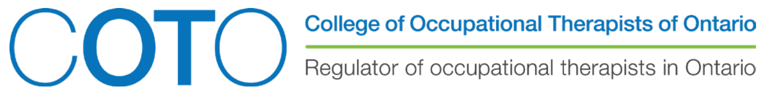
Executive

Chair: Neelam Bal

Strategic Priorities: Public Confidence, Quality Practice

Workplan 2025/2026	Registrar/CEO Role	Complete
	RHPA and/or Governance model changes	Monitor
	Board Orientation	Complete
	Accreditation of University Programs	Underway
	Policy Review	Underway
	Board Education (Annual)	Underway
	Risk Management Process	Complete
	In Camera Process	Complete

Q1	**Committee Activities: Committee Activities:** 1) June 5, 2025: Meeting to discuss Registrar/CEO Evaluation & Role; Board Meeting Evaluations and Board Education (Annual); In camera meeting to approve the in camera Executive Minutes for: February 28, 2025, and March 27, 2025, and in camera Board Minutes for April 30, 2025, and May 5, 2025 2) July 9, 2025: In camera meeting to discuss a confidential human resources matter.
	Decisions Not Requiring Board Approval: 1) Executive reviewed the entire Risk Register and agreed that with the recent appointment of a new public member, this risk could be downgraded and removed from the report to the Board. 2) Decision to encourage participation in board meeting evaluations to return to paper forms directly following and continue electronic forms to virtual attendees.
	Decisions Requiring Board Approval: Board ratification of Committee Assignments for new public member; Registrar/CEO's Annual Evaluation Policy and Procedure; In Camera Policy and Procedure.



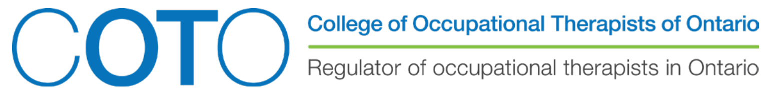
Governance

Chair: Neelam Bal

Strategic Priorities: Public Confidence, System Impact

Workplan 2025/2026	Finalize the governance manual
	Review and update the Code of Conduct and Conflict of Interest Policy
	Enhance onboarding for new Board Directors

Q1	**Committee Activities**: No meetings were held in Q1
	Decisions Not Requiring Board Approval: N/A
	Decisions Requiring Board Approval: N/A



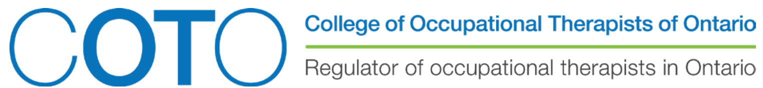
Finance and Audit Committee

Chair: Allan Freedman

Strategic Priorities: Public Confidence, System Impact

Workplan 2025/2026	
	Review quarterly financial reports and annual projected budget for recommendation to the Board
	Review draft audited financial statements for recommendation to the Board
	Review updated five-year financial forecast
	Review internal controls matrix
	Review investment portfolio to determine if policy changes are warranted
	Review and update policies governing financial and investment matters
	Review property/non-liability and liability/crime/E&O insurance coverages to assess sufficiency
	Evaluate auditor performance and determine if re-appointment or selection of new auditor is appropriate; recommend to the Board

Q1	**Committee Activities:** A meeting was held on **August 19, 2025**, during which the committee reviewed its mandate and work plan, draft minutes from the Finance and Audit meeting held on May 22,2025. The committee also reviewed and discussed the FY24/25 draft audited financial statements which were prepared by Hilborn auditors, FY24/25 Q4 Financial Summary Report, FY24/25 Q4 Investment Report, and the Internal Control Matrix.
	Finance Report: FY24/25 draft audited financial statements prepared by Hilborn auditors, FY24/25 Q4 Financial summary report, FY24/25 Q4 Investment Report, and the Internal Control Matrix were presented and reviewed by the Finance and Audit Committee for informational purposes only.
	Decisions Requiring Board Approval: N/A



Registration

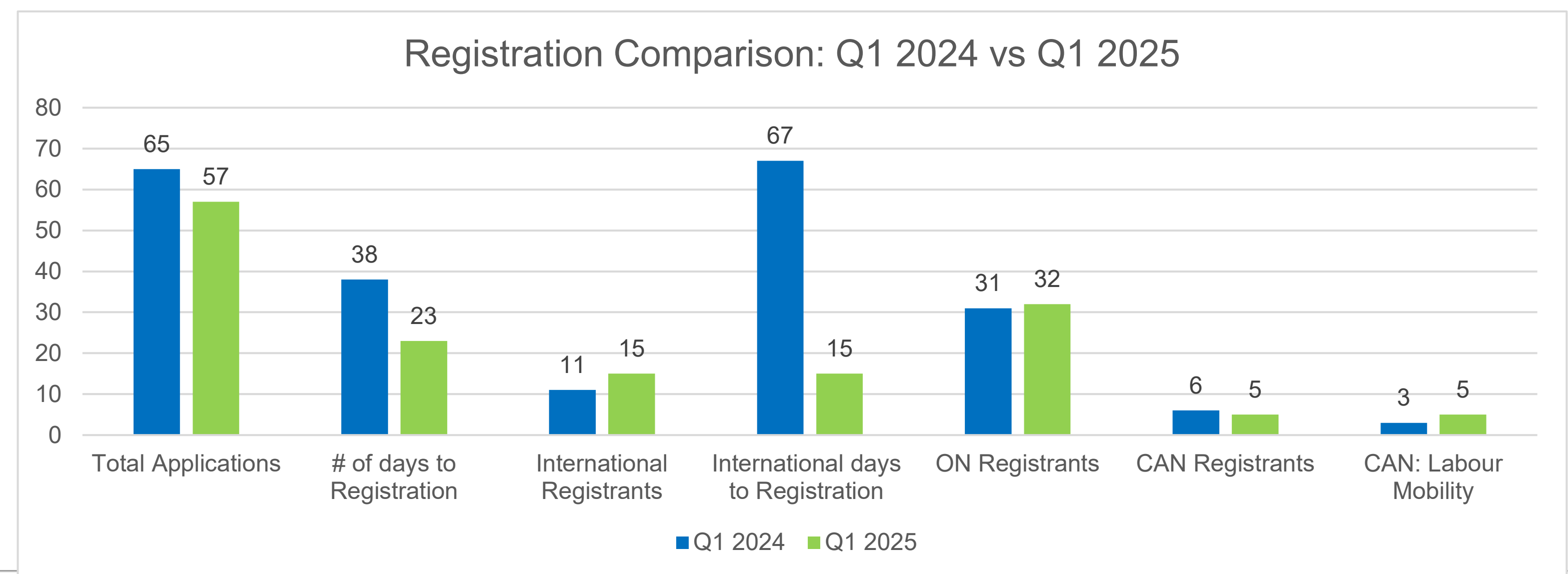
Chair: Christine Farrell

Strategic Priorities: Public Confidence, Qualified Registrants

Workplan 2025/2026	Receive quarterly Registration Performance and Data reports and make recommendations regarding application and registration policy
	Provide quarterly registration and application rulings per registration policies
	Receive quarterly information about RHPA and/or Regulatory changes and make recommendations regarding policy
	Receive Ontario Fairness Commission report(s) and make recommendations regarding policy (Annual)
	Receive report(s) on National Occupational Therapy Certification Examination and make recommendations regarding policy (3 times annually)
	Receive report (s) on University Entry to Practice Program Accreditation(s) (CAOT) and make recommendations regarding policy
	Recommend new Registration Data Report for approval of the board by end of Q4
	Receive information regarding implementation of “As of Right” legislation and make recommendations regarding policy as of Q4

Data Agenda

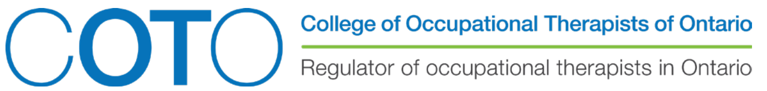
1. Application and Days to Registration



2. Annual Renewal Survey Results Overview

User Satisfaction Metrics

Metric	Percentage
No Technical Issues	85%
Online System Easy to Use	74%
Annual Renewal Requirements Clear	90%
Satisfied with Overall Process	52%



Key Performance Indicators

Q1

Ave. time from application completion to registration

The **average number of days to registration** decreased for many:

- From 38 to 23 days overall
- For international applicants, the time dropped even further to 15 days

The average number of days to registration for Ontario registrants **(new graduates)** and re-entry to practice is 32 days

Outcomes Report: The improvement reflects process optimization, driven by workflow automation and tracking using Microsoft tools. The overall average is influenced by new graduates who can apply early starting in July and are convocated in September. Consideration of a "parallel" process to register new graduates earlier is underway.

Baseline for As of Right: 23 days to registration (2025)

Benchmark: OFC and ON Health - Ave. of 60 days for all applicants**; "As of Right"** Applicants registered in Canadian Jurisdiction can practice for 6 months, before day of registration.

Registration Annual Renewal Results

Baseline Annual Renewal 2025: 52% satisfied with overall process, 90% found the annual renewal requirements to be very clear or mostly clear, 74% said the online system was easy to use and 85% reported no technical issues during the process.

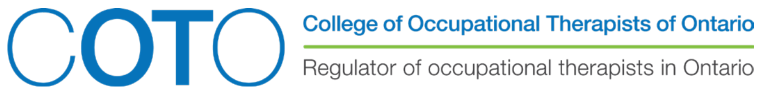
Outcomes Report: This is the first year we have asked registrants about their satisfaction with Annual Renewal. The goal is to support a continuous improvement process, specifically in relation to the renewal experience, technology, and automation.

Benchmark: Compare results to registrant feedback at 2026 Annual Renewal.

Committee Review (s) and Consultations:
Q1 Number of Days to Registration
OFC Risk Compliance Framework
Annual Renewal Survey Results
NOTCE Exam Performance Overview December 2023 - April 2025

The Strategic Plan: Reduction of number of days to registration contributes to public access to services and reduction in system pressures related to health human resources.

	Committee Action: **1. Policy Review Topics** • As-of-Right Registration • Practising without a Certificate of Registration • Insurance **Public Protection:** All occupational therapists, regardless of area of practice or practice status, must have professional liability insurance that assures resources in the event of harm to a member of the public including allegations of sexual abuse. **Registrant Engagement:** Clear, accessible information on registration requirements, including any new insurance obligation should be shared via the organization's website and outreach materials to support transparency and informed participation.
	Decisions requiring board approval: Insurance Policy Requirement; As of Right Policy; Practising without a Certificate of Registration Policy update



Inquiries, Complaints and Reports Committee (ICRC)

Chair: Stephanie Schurr

Strategic Priorities: Public Confidence, Quality Practice

Workplan 2025/2026	By way of the panels, decisions are made on investigations in accordance with s.26(1) of the Health Professions Procedural Code
	Advise the Board on the development policies and procedures governing the inquiries, complaints, and reports processes

Data Agenda

1. New Cases in Investigations & Resolutions

Cases Received: Q1 2025 vs Q1 2024

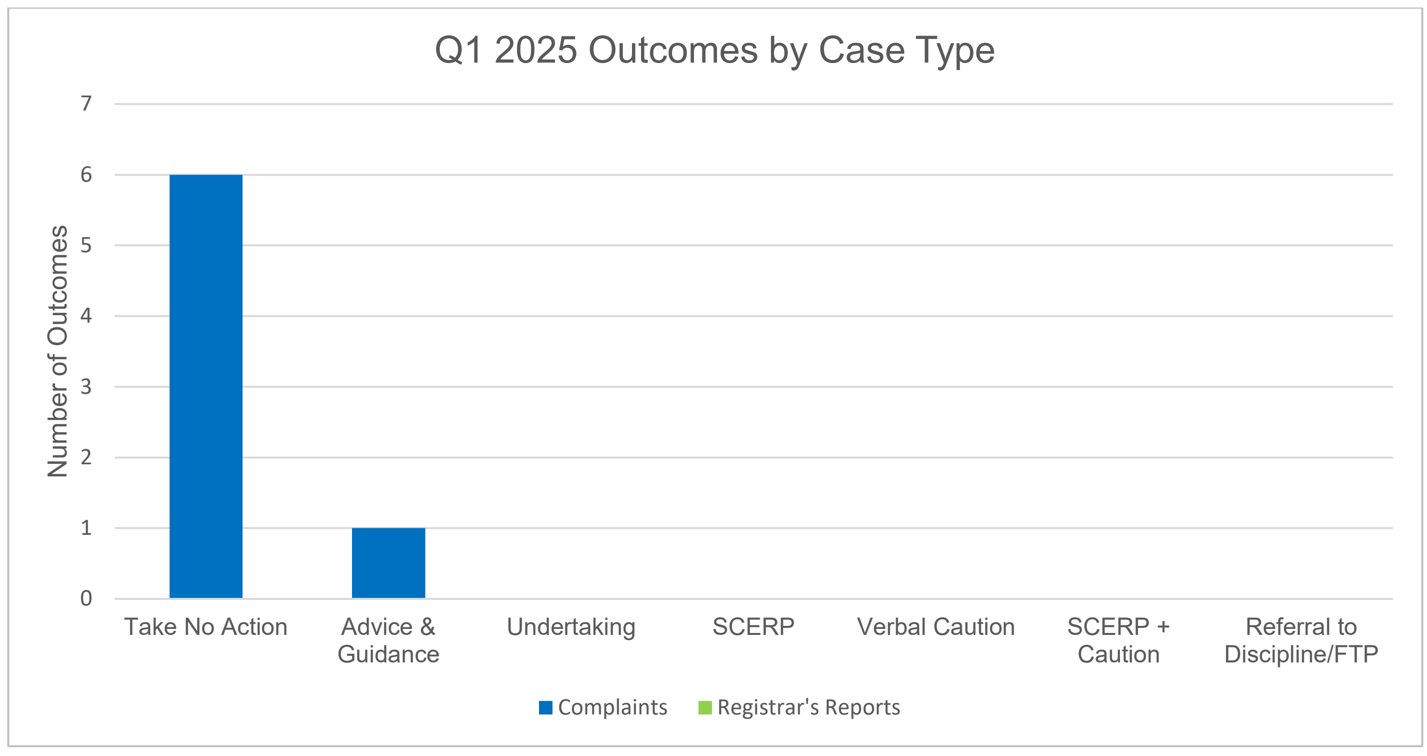
Number of Cases

12
10
8
6
4
2
0

10
3
1
3
0
0

Compaints
Registrar's Investigations
Health Inquiries

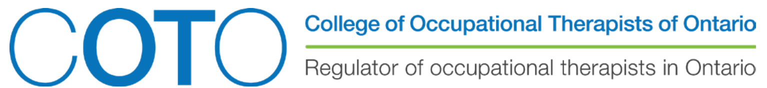
2024
2025



NB: Two of the Take No Actions, were pursuant to s.26(5) to take no action on the basis that the complaint was Frivolous, Vexatious and/or an abuse of the process.

3. HBARB Reviews:

Q1	HPARB Reviews	• 0 new notice of reviews in Q1 • 4 Hearings pending • 1 Notice of Intention not to proceed with a review sent by HPARB to the parties • 1 pending a Decision & Reasons
	Divisional Court Judicial Reviews of Registrar's Reports: 1 ICRC decision quashed by the Court – Decision received June 27, 2025	



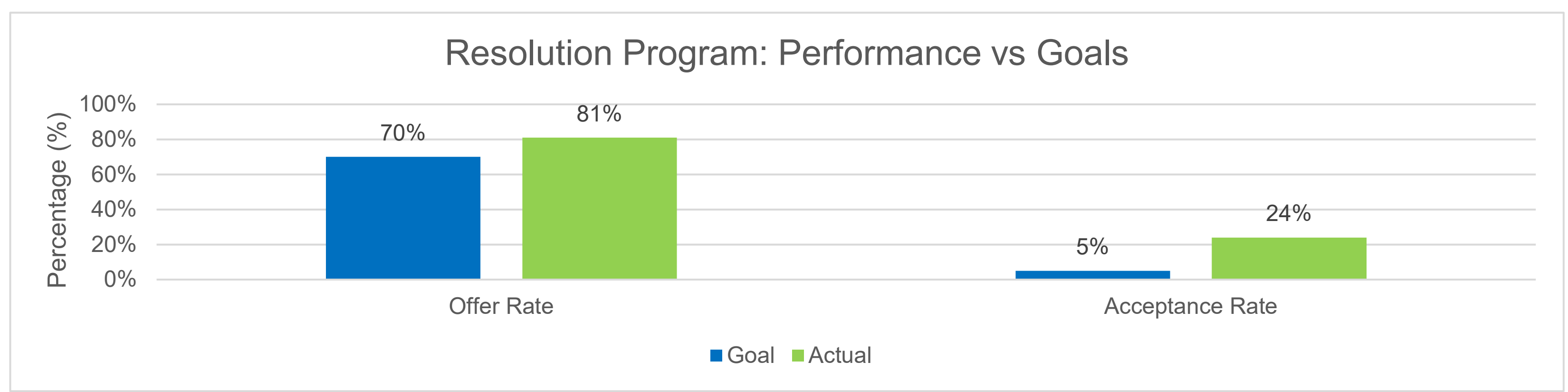
4. Case Completion Times:

Benchmark = 70% of cases completed within 240 Days
Baseline = Average number of days for Q1 was 306 Days

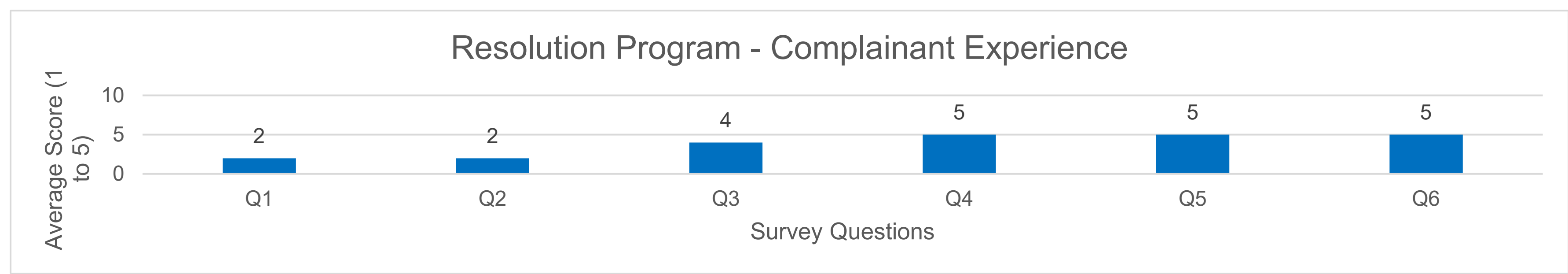
The College experienced a surge of complaints in fiscal year 2024/25 and a reduction in staff, creating a backlog of cases and longer case processing time.

5. The Resolution Program – Complaints

Offer the Resolution Program in 70% of complaints received by the College, with an acceptance rate of 5%



6. The Resolution Program – Complainant Experience Survey Results



Key	**Survey questions were as follows:** Q1 - Did you feel your concerns were heard? (1 being not heard at all, 5 being completely heard) Q2 - Submitting your concern to the College was an easy process (1 being difficult, 5 being easy) Q3 - The Resolution Program was easy to understand (1 being difficult, 5 being easy) Q4 - College staff treated me with dignity and respect (1 being not at all, 5 being yes, completely) Q5 - If I had a concern in the future about an OT, I would be open to resolving it through the Resolution Program (1 being not at all, 5 being yes, completely) Q6 - The Resolution Agreement was clear, and I understood it (1 being not at all, 5 being yes, completely)

Key Performance Indicators

Q1	**Case Completion Times:** Q1 – 41% of complaints were completed within 240 days **Performance Report:** Ensuring that complaint investigations are processed efficiently, and also comprehensively is a measure of public confidence. When investigations take an unnecessary long time, there is a risk that Complainants will feel the College did not take their concerns seriously and their disappointment may be greater, if after a long delay, they receive a disposition they do not like, i.e. Take No Action. In addition, for Registrants, investigations are stressful and having an unresolved case pending resolution for a lengthy period of time does not build confidence in their regulator. **Benchmark:** Target = 70% of cases completed within 240 Days **Baseline**= Average number of days for Q1 was 306 Days **The Resolution Program – Complaints:** *Rate of Offer – 81%. Rate of Resolution = 24%*

Outcomes Report: Investigating complaints takes up most of the time and resources in the Investigations department, and some cases can take up to a year to finish**.** Most investigations result in a “take no action” decision, leaving complainants disappointed and registrants feeling discouraged due to the lengthy investigations process. We are targeting 70% resolved complaints and will track year over year.

Benchmark: Offer the Resolution Program in 70% of complaints received by the College, with an acceptance rate of 5%

Baseline: 0% in 2024-2025

Complainant Experience Survey Results

Baseline: 40% of complainants answered the survey.

Outcomes Report: This is the first year we have asked complainants about their experience. The goal is to support a continuous improvement process, specifically in relation to the complainant experience.

Benchmark: Compare results of complainant feedback at each quarter in 2025-26

Committee Review (s) and Consultations:
Complaints and reports investigations and resolutions
Complaints and reports decisions in the interest of public
Practice risk and learning needs identification

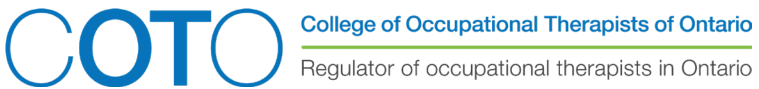
The Strategic Plan: Engagement of OTs and members of public in resolution - measured by rate of resolution and public satisfaction survey after resolution. Reduce resources of public and College on complaint process measured by reduced # of investigations year over year.
Identification of practice risks, resolutions, and learning needs measured by themes emerging from complaints and reports.

Committee Action: Panels made decisions on 7 complaints; no Registrar’s Investigations. All decisions were made using the ICRC’s risk assessment framework to ensure consistent decision making and outcomes are proportional to the risk.

Public Protection: The panels assessed risk and took appropriate action. They issued written Decisions and Reasons to both the Complainant and Registrant in each case outlining the rationale for each decision. Decisions express gratitude to complainants for bringing their concerns forward as it allows the College to ensure OTs are practising according to the standards. Complainants are sent surveys for both investigations and resolutions.

Registrant Engagement: The registrants responded in all seven cases accounting for the services they provided. Registrants are encouraged to be professional and objective when responding.

Decisions requiring board approval: N/A



Quality Assurance (QAC)

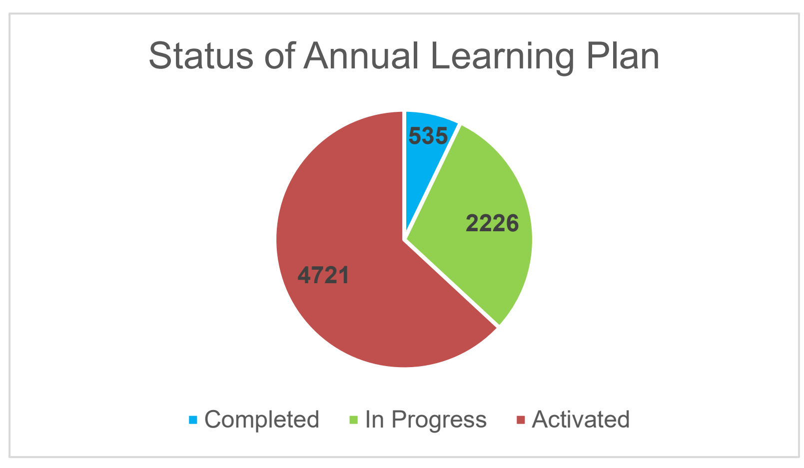
Chair: Heather McFarlane

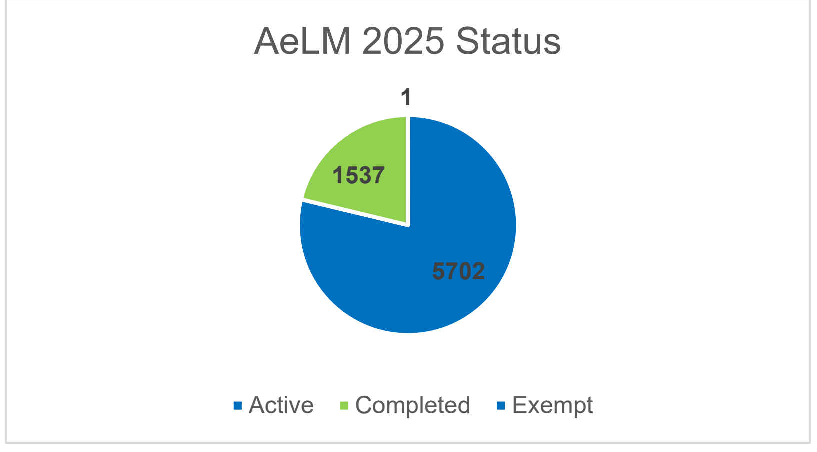
Strategic Priorities: Public Confidence, Quality Practice

Workplan 2025/2026	Competency Assessment: Administer 147 comprehensive competency assessments (2%)
	Competency Assessment: Approve and implement *Enhance: QA Practice Activity (*September-June)
	Competency Assessment: Monitor data and revise risk-based indicators/selection as needed (ongoing)
	Competency Assessment: Decisions on registrant cases (Jan & June)
	Competency Assessment: EDI remediation activity (ongoing)
	Annual Requirements: Approval of 2026 eLearning module content (January)
	Annual Requirements: Approval of 2027 eLearning module topic (January)
	Annual Requirements: Decisions on non-compliance registrant cases (January)
	Policy: Review QA Policy (March)

Data Agenda

1. Annual Requirements: Completion Status and Survey Results (as of September 29th, 2025)





Q1 Registrant Feedback: 2025 Annual eLearning Module

- 81% rate their overall experience with the module as Very Good or Good
- 98% agree that the module prompt reflection about their role in delivering culturally safer service
- 96% say they are somewhat or very likely to continue learning about this topic.

2. Status of Competency Assessments June 2025 - May 2026

2025-2026 Cumulative Competency Assessments Completed/In Progress

Number of Assessments: 0, 20, 40, 60, 80, 100, 120, 140, 160

Timeline	Number of Assessments
September 2025 (Group 5)	82
January 2026 (Group 6) - Projected	65
Total Cumulative	147

Q1 Registrant Feedback: Competency Assessment (Group 4 – response rate = 42%)

100% of participants made a change to your practice after the competency assessment (response rate: 42%)

Top 5 changes registrants have made to their Record Keeping because of the Competency Assessment:

- Ensuring all clinically relevant input from clients/others are included the documentation (20%)
- Consistently explaining abbreviations (15%)
- Consistently including ongoing client consent (14%)
- Ensuring timely completion of documentation (11%)
- Being mindful of how information in documentation will be received by clients and others who read it (9%)

Key Performance Indicators:

Q1	***Status of Annual Requirements*** Every registrant is required to complete the annual requirements by October 31 each year. The purpose is to assure continuous quality improvement in individual registrant practice through completion of an annual learning plan and required learning on a topic approved by the board. **Outcomes Report:** The status by the end of Q1 is typical on an annual basis. By the end of Q2, it is anticipated that upwards of 97% of registrants will have completed all requirements. **Benchmark:** Meet or exceed the previous years completion rate. 100% of registrants are required to complete the annual requirements with some accommodations approved related to individual circumstances. ***Competency Assessments (CA) Completed/In Progress*** This 30-question, peer lead, assessment evaluates an OTs continuing competence. OTs demonstrate their ability to apply the *Competencies for Occupational Therapists in Canada, Standards of Practice* and *Code of Ethics* in their daily work. The purpose is to identify strengths and areas for professional growth. **Outcomes Report:** Fall 2023 marks the first group of registrants to be administered the revised QA competency assessment. Last year 1.5% of registrants (n=103) were assessed using this tool and we are targeting 2% (n=147) for the upcoming 2025-2026 year. There are currently 83 registrants in Group 5 (Fall 2025) and the remaining 64 are scheduled for Group 6 (Winter 2026). Projected to meet or exceed the target. **Benchmark:** Meet or exceed the previous years target number of assessments (and possibly NR OTR pending access to data)
	Committee Reviews and Consultations: In June the QAC confirmed the decision framework to apply to registrants that are non complete for the annual requirements. This will be applied to the upcoming October 31st deadline.

Committee Actions: In June the QAC also deliberated on 10 competency assessment registrant cases.

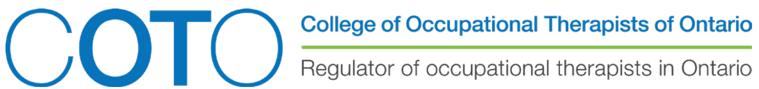
The Strategic Plan: Engagement of OTs in quality practice and Advancing Culture, Equity and Justice in Occupational Therapy Practice

Public Protection: Current QA activities to support OTs continuing competency:

- Competency assessments including follow up remediation for any learning needs identified
- Annual eLearning module: *Cultural, Equity and Justice in Occupational Therapy Practice*
- Annual Learning Plan: conducting a self assessment and formulating a learning plan for professional development
- Data (presented above) from registrants indicate that practical changes are being made to support safe, ethical and effective OT service as a direct result from participating in these activities.

Registrant Engagement: Registrants are encouraged to provide feedback about the competency assessment experience (see latest results above). Two resources were developed for all registrants: *Goal Setting Made Simple* and *Risk Ready: Protecting Clients & Your Practice*

Decisions requiring board approval: Approval of the Enhance: QA Practice Activity (October 2025). This activity will augment (not replace) the overall assessment approach of the QA program by introducing a shorter, reflective, self-directed assessment to be used for a targeted group of registrants**.**



Patient Relations

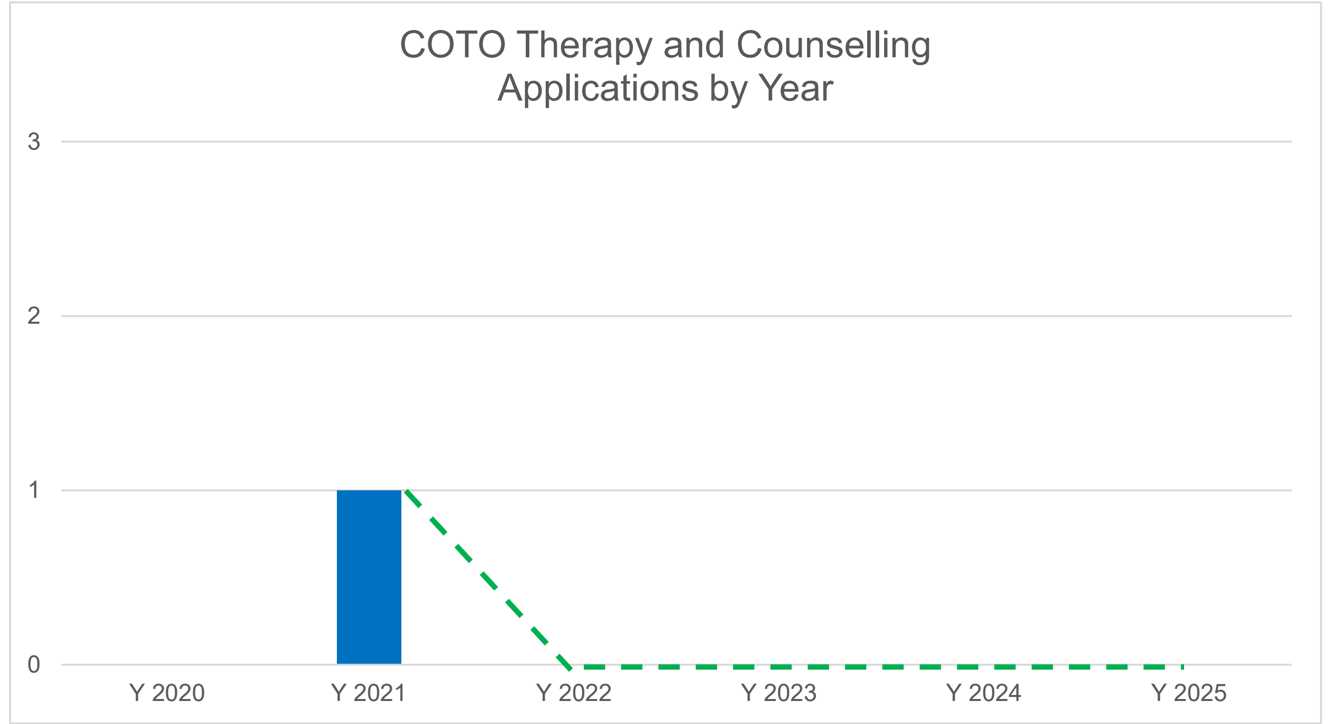
Chair: Amanda Mowbray

Strategic Priorities: Quality Practice, Meaningful Engagement

Workplan 2025/2026	
	Education for Registrants, Public, Board and Staff about the Prevention of Sexual Abuse
	Oversight of the Funding for Therapy and Counselling and Expenses for clients alleging Sexual Abuse
	Focus on increasing awareness of available resources, enhancing engagement with public education materials, and evaluating the direct outcomes of the program.

Data Agenda:

1. **Sexual Abuse Therapy Counselling Fund Applications**



Key Performance Indicator(s):

<table>
<tr><td rowspan="3">Q1</td><td>The number of applications received:
Q1: 0 new applications received

Benchmark N/A – we have received one application in the past five years, no other data available prior to the approval of the 2020 policy.

Outcomes Report: The College is committed to supporting individuals who allege sexual abuse by occupational therapists. To date, one application was received and approved by Patient Relations Committee in 2021. The Patient Relations Committee continues to carry out the mandated role under the RHPA in managing the therapy and counselling fund and providing education to support the prevention of sexual abuse and appropriate professional interactions between clients and occupational therapists.</td></tr>
<tr><td>Committee Action: Patient Relations did not meet in Q1
• Registrant Education: N/A
• Public Education: N/A
• Board Education: N/A</td></tr>
<tr><td>Decisions Requiring Board Approval: N/A</td></tr>
</table>

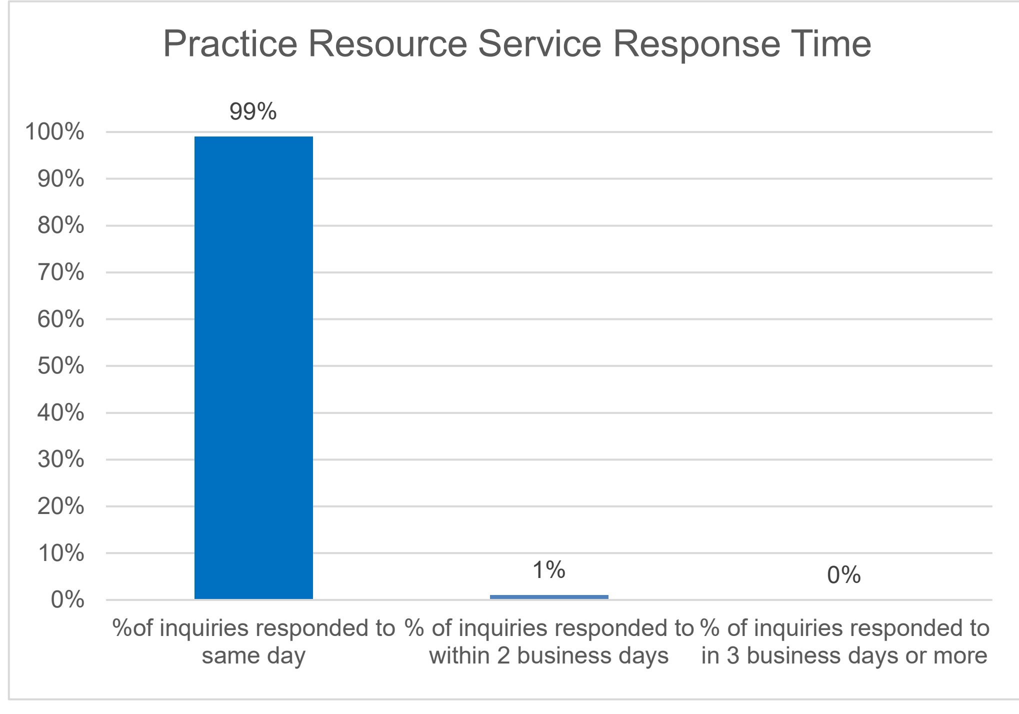
Practice Subcommittee

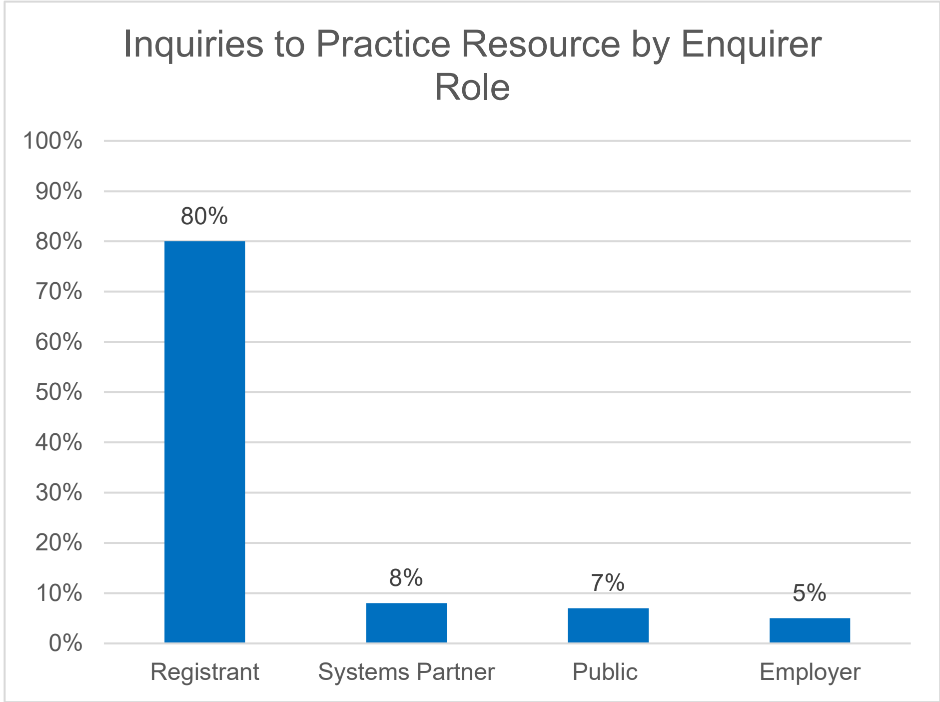
Chair: Stacey Anderson

Strategic Priorities: Quality Practice, System Impact

Workplan 2025/2026	Update all practice guidance documents
	Develop a Risk management guidance document
	Coroner's Report – MAiD, Lap belts, Homicide by Firearm (in progress)

Data:





Key Performance Indicator

Q1

% of Inquiries to Practice Resource and Response Time

70% Occupational Therapists and Practice Resource Response time: 93% within 2 days.

Outcomes Report: Practice Resource Service provides confidential, timely guidance including one-on-one consultations, written resources, Q & As, case studies, based on practice trends observed or data provided by internal programs. Resources are developed to promote quality practice and support consistent, risk-based approach to decision-making that protects the interest of the public and upholds the standards of practice.

Benchmark: The average response time to inquiries is currently 1-2 business days, with a target of same business day response. This performance remains broadly in line with benchmarks observed across comparable regulatory bodies.

Baseline: Registrants are main user of service; Practice team tracks employer (15%) & public inquiries (10%) and system partners (5%) to determine what resources can be developed or shared in the interest of public protection

Outcomes of Program Activities:

1. **Resource Development**:
   Informed consent vs. Knowledgeable consent
   HIC vs. Agent

2. **Cross program consultation, practice support**:
   I & R consultation about OT practice
   Registration re-entry competency assessment interviews and learning contract reviews

3. **Responses to system partners about OT Practice:**
   Service Ontario
   OAP
   Corrections Canada
   Coroner Death Review Committees
   CAOT psychotherapy, scope of practice
   Children’s Treatment Centre
   ACOTRO determining consistent Standards across provinces
   March of Dimes

4. **Outreach:**
   McMaster University

	5. **Registrant Engagement:** Reporting will occur in Q2
	Practice Subcommittee Action: The committee did not meet in Q1
	Decisions requiring board approval: Coroner’s Reports: MAiD, Lap Belts

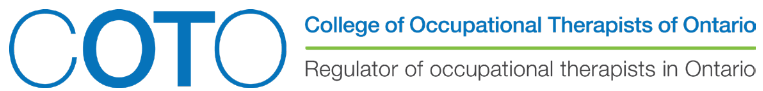
Nominations Committee

Chair: Jennifer Henderson

Strategic Priorities: Public Confidence

Workplan 2025/2026	Selection and Recommendation of Candidates for Committee Appointments
	Board Elections
	Oversight of Executive Officer Nominations Process
	Oversight of Committee Chair Appointment Process

Q1	**Committee Activities:** No meetings were held in Q1
	Decisions Not Requiring Board Approval: N/A
	Decisions Requiring Board Approval: N/A



Indigenous Insights Advisory Committee

Chair: Ian Connolly

Strategic Priorities: Meaningful Engagement, Quality Practice, System Impact

Workplan 2025/2026	To conduct a regular environmental scan on OT practices in relation to the health needs of all Indigenous Peoples
	To identify current practice issues impacting Indigenous Peoples for consideration and possible action by the Executive Committee
	To act as an advisory committee on OT practice & Indigenous Peoples to other committees

Key Performance Indicator:

Q1

To conduct a regular environmental scan on OT practices which:

Benchmark: Achieving the recommendations outlined in the Truth and Reconciliation Report; Cultural Competency Training completed with a focus on Indigenous Insights; Education and guidance on Indigenous Health and Occupational Therapy Practice Issues developed

- Address the distinct health needs of all Indigenous Peoples
- To identify current practice issues impacting Indigenous Peoples for consideration and possible action by the Executive Committee
- To act as an advisory committee on OT practice & Indigenous Peoples to other committees
- To make recommendations for action on specific practice issues related to Indigenous Peoples
- To develop, review and revise College resources related to practice & Indigenous Peoples as directed by Board
- To make recommendations for action on specific patient relations issues related to Indigenous Peoples

Committee Action: Committee met virtually on August 14th, 2025

- Advice about COTO's Territorial Acknowledgement
- Advice to the College about the webpage with information pertaining to Indigenous Peoples and resources
- Advice on the socio-demographic data collection and options for sharing
- Identifying community experts

In progress:

- Codes of Ethics to ensure they align with the principles of self-determination of Indigenous Peoples
- Exploration of practice guidance and resources that acknowledge and support Indigenous Peoples' traditions and decision-making practices within the profession of occupational therapy

Decisions requiring Board approval: N/A

Equity Perspectives Advisory Committee

Chair: Adebimpe Egbeyemi

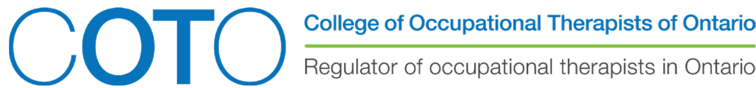
Strategic Priorities: Meaningful Engagement, Quality Practice, System Impact

Workplan 2025/2026	To conduct a regular environmental scan on OT practices that address Equity, Diversity and Inclusion to address the distinct health needs of equity deserving groups
	Identify current practice gaps and barriers impacting EDI and identify appropriate approaches the College can action
	Identify community experts to assist the College and its work

Key Performance Indicator

Q1	*Equity, diversity and inclusion are integrated into policy, process and resources* **Benchmark:** Emerging - measured through outcomes of advice and recommendations
	Committee Action: Equity Perspectives Advisory committee met virtually on July 10th, 2025 and received the annual committee orientation **Committee Review and Recommendations:** • Review and feedback of the draft version of the revised Code of Ethics • Advice on the COTO EDI webpage and resources • Advice on the Socio-demographic data collection and options to share information • Recommendations for future reporting of EDI initiatives • Identifying community experts
	Decisions requiring board approval: N/A

AGENDA ITEM 8.5



BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Gillian Slaughter, Registrar and CEO

Subject: Risk Management Report & Risk Register

Recommendation:

***THAT** the Board receive the Risk Management Report.*

Issue:

The Board, in its policy RL12, requires that information on risks, to aid the Board in discharging its risk management oversight role, shall be complete and appropriate. The Board has delegated the oversight of the Risk Management Program to the Executive Committee. The Executive Committee reviewed the proposed adjustments to the Risk Management Report on October 16, 2025 and recommended that the Board receive the Risk Management Report.

The specific adjustments to the Risk Register have been highlighted for the Board's review.

Link to Strategic Plan:

This aligns under Performance and Accountability.

The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

4.1 Ensures College governance is proactive, effective, competency-based and accountable.

Why this is in the Public Interest:

Managing risks is a fundamental responsibility of the College as it works to regulate the profession of occupational therapy in the public interest. Ensuring the College understands the risks it faces, the plans in place to control, mitigate, avoid, or transfer these risks appropriately is an important oversight responsibility of the Board.

Equity, Diversity, and Inclusion Considerations:

The considerations related to Equity, Diversity and Inclusion are on the risk register for review and action planning, and, while important, have not been categorized as high or critical at this time.

Discussion & Update:

Each risk is listed along with the control procedures and action plan developed to mitigate each risk. Some risks can only be monitored as they are out of the College's control, however, they are important enough to be listed so the College can move into action quickly once more is known.

Recommended changes to the Risk Register:

1. **That** O.11 Human Resources Strategy be reopened and added to the Risk Management Report and based on COTO's transition to a new CEO/Registrar.

2. **That** the Risk Register be adjusted in response to Q1 experience including:

- Status change for S.12: *World events causing domestic upset* to MONITOR as the number of calls from registrants to make public statements that carry a reputational risk have reduced in Q1 2025-26.

- Adjustment to Current Actions for S.13: *Chaos due to significant legislative and regulation changes may decrease public confidence and service related to regulation* to include*:*

    1. Working with ACOTRO/OSOT and CAOT on consistency related to Scope of Practice, Standards of Practice, Code of Ethics and re-entry to practice.
    2. Proactive Adjustments to our Labour Mobility Registration process and policies in preparation for "As of Right" legislative changes to regulation.

- Change Status for *P.4: Client harmed due to substandard record keeping practices* changed to MONITOR. COTO has significant monitoring processes in place including the use of the Standard for Record Keeping for Practice inquiries; Quality Assurance Annual Requirements; and specified continuing education remediation program (SCERP) that may be required because of a committee decision in Registration, Quality Assurance and Investigations and Resolutions (I&R).

- Change Residual Risk Rating for *O.8: Client & /or College harmed due to security breach of IT systems/data* to MODERATE due to increasingly wide use of Generative AI and its utility in causing cybersecurity breaches via phishing and impersonation.

- Additions to Current Actions for *O.11: Human Resources Strategy*:

    1. Reflect implementation of the succession plan and transition planning for the CEO/Registrar role.
    2. Explore options with regards to succession planning for other Key Positions.

- Adjustment to Control Procedures for O.14: *Public is harmed through ineffective management of investigations related to freedom of speech* to include plain language and reference to the Charter of Rights and Freedoms.

Risk Category	STRATEGIC
Risk	**Significant Change in legislation or regulation**
Control Procedure(s)	1. COTO strategic plan incorporates some national projects and thinking 2. We are working on consistency of processes nationally as much as possible to smooth the way for this possibility - re-entry, QA, Registration processes.
Monitoring Process	1. Review of government communications 2. Raising these issues at ACOTRO 3. Raising issues with COTO Board 4. Monitoring "As of Right" legislation or government initiatives for themes about national regulation.
Action Plan	1. Working with ACOTRO/OSOT and CAOT on consistency related to Scope of Practice, Standards, code of ethics and re-entry. 2. Proactive Adjustments to our Labour Mobility Registration process and policies in preparation for "As of Right" legislative changes to regulation.
Risk	**Health Human Resources** Availability of health care personnel has reached a crisis level for governments across the country. Government will be looking for data, ideas and support to implement any HHR strategies. Risk that the strategies may not align or will cause negative unforeseen consequences. E.g. registration of incompetent individuals. The government has introduced new 'As of Right' legislation that will facilitate OTs who are regulated in another province to begin work in Ontario prior to being duly registered. There are risks to the public if someone is leaving their province due to some regulatory action i.e., discipline, and then that individual begins to work without any safeguards put into place for public protection. The risk to the public is that the public may not have access to safe, qualified occupational therapists when needed for appropriate health care.
Control Procedure(s)	1. Membership with Health Profession Regulators of Ontario (HPRO) 2. Establishing and sustaining positive government relationships. 3. Standard processing times for applications for registration.
Monitoring Process	1. HPRO meetings and working group participation. 2. Working with ACOTRO with a goal of labour mobility in Canada 3. Ministry updates, response to Ministry consultation 4. College networking updates 5. Monitoring government processes put in place for other professions.

Risk Category	STRATEGIC
Action Plan	1. Working with the ACOTRO SEAS program to support their timely assessment of international applicants (Federal Project to improve application processing time at SEAS) 2. Leveraging our data. 3. Maintaining open communication with the provincial OT association, universities and government re: any relevant initiatives. 4. Discussion with Ministry of Health Representatives as appropriate. 5. Implementation of 'As of Right' Legislation/Regulations.

Risk Category	STRATEGIC
Risk	**Finances** The College has reviewed its financial health to ensure it can operate effectively now and into the future. Budget deficits were planned for fiscal year 2023/24 and for the 2024/25 year, resulting in decreased reserves as the reserves fund the deficit. A 2% fee increase was implemented for the 2024 and 2025 annual renewal cycles, and the bylaws allow for fee increases of up to 2% for the next three years as determined each year by the Board. The Finance and Audit Committee is closely attending to this matter to determine if a fee increase will be needed for the 2026-27 year. The increase in fees is meant to mitigate the risk to the public that the College will not have the necessary resources to complete its public protection mandate appropriately.
Control Procedure(s)	1. The Finance and Audit Committee have carefully reviewed the budget to ensure their understanding of college finances. 2. Bylaws are in place to support up to 2% increases for the next three years if necessary.
Monitoring Process	Careful attention to budget and spending.
Action Plan	1. The communications plan was implemented during renewal. 2. Finance and Audit Committee to address any future increases in the next year leading up to decisions for next renewal.

Risk Category	STRATEGIC
Risk	**Human Resources Strategy** We have adjusted the Action Plan for the College Human Resources Strategy to reflect implementation of the succession plan and transition planning for the CEO/Registrar role. There is a risk during this transition, that staffing resources may be disengaged or insufficiently optimized, potentially impairing the College's ability to effectively fulfill its public protection mandate during this leadership transition. This affects the College's ability to carry out its public protection mandate.
Control Procedure(s)	1. Recruitment Strategies. 2. Orientation. 3. Professional development. 4. Absentee management. 5. HR policies. 6. Compensation policies. 7. Performance review process. 8. Pension plan in place to aid in recruitment and retention 9. Registrar and CEO Succession Policy
Monitoring Process	Absenteeism rate, job evaluation and salary surveys, benefit benchmarking, professional development plans, goal setting and performance management, staff turnover, exit interviews.
Action Plan	1. Implement HR plan and strategies 2. Integrate the succession plan and transition planning for Registrar and CEO (Governance) with the HR plan and strategies. 3. Explore options for implementing succession plan and policy for other Key Roles.

	Risk ID	Outcome/ Residual Risk	Date Risk Added	Accountability	Responsibility	Public Risk Description	Organization Risk Description	Probability 1-5	Impact 1-5	Overall Risk	Risk Ranking: Low, Mod, High, Critical	Control Procedures	Monitoring Process	Current Action Required to Manage Residual Risks	Status (Open, Monitor or Closed)	Standards, Guidance & Data Management Agenda
COTO Strategic	S.1	Low	22-23	Board	Registrar, Leadership	Public not appropriately protected due focus diverted to inappropriate activities	College not operating within its mandate	3	5	15	Critical	1. College's processes follow legislative obligations; 2. Board Orientation; 3. Governance Policies; 4. Legal Counsel support as needed. 5. Leadership and oversight of staff. 6.Consultation with government and agents when needed. 7. CPMF implemented in 2021.	1. Policies updated as needed; 2. Self-assessment at each Board meeting, 3. Annual Board self-assessment of performance 4. Self assessment and Annual reporting to Government via the CPMF.	Significant issues and risks reported to the Board as appropriate	MONITOR	
COTO Strategic	S.3	Low	22-23	Board	Executive, Board	Public not appropriately protected due to poor committee decisions and poor board decisions	Poor functioning Board and Committees	3	5	15	Critical	1. Orientation and training of members; 2. Legal Counsel support as needed; 3. Board and committee training as needed; 4. Decision support tools; 5. Committee policy and procedures; 6. Communication amongst HPRO brought to committees, and Board; 7. Competency-based non-Board process developed; 8. Ongoing environment scanning by COTO Staff to support Board and Committees; 9. Robust 3-year Strategic Planning process identifies evolving issues; 10. Registrar's reports to Board to keep Board updated; 11. Competency matrix; 12. Pre-election training of prospective Board members to prepare them for appropriate role; 13. Chair training.	1. Annual self assessment by Board members; 2. Yearly committee effectiveness survey; 3. Staff tracking of Board and Committee decisions and outcomes; 4. Risk management report to Board and Executive; 5. Annual performance of Board discussed and plan to close knowledge and skills gap developed and implemented.	No current action required	MONITOR	
COTO Strategic	S.8	Low	22-23	Board	Registrar	Discpline decisions cannot be made when a board is not constituted, therefore an OT could continue to practise without appropriate discipline sanctions	Unconstituted Board due to lack of public appointments, or minimum number of public appointments causing high workload for existing public members.	2	3	10	Moderate	1. Bylaws have provisions to support action through Executive as necessary	1. Continued monitoring of Board appointments and term end dates; 2. Liaise with the public appointments office to determine status of appointments process.	1. Proactive reaching out to ministry as new appointments required.	OPEN	
COTO Strategic	S.9	Low	22-23	Registrar	SLT	Public not appropriatetly protected if the College stops functioning appropriately	Inability to comply with College Performance Measurement as defined by government	2	3	6	Moderate	1. The college met all requirements in the 2023 and 2024 submissions 2. Three reports have been successfully submitted by the College.	1. Continued monitoring of any changes proposed by government.	No current action required	MONITOR	
COTO Strategic	S.10	High	23-24	Registrar	SLT	Public harmed through poor access to occupational therapy services	Availability of health care personnel has reached a crisis level for governments across the country. Government will be looking for data, ideas and support to implement any HHR strategies. Risk that the strategies may not align or will cause negative unforeseen consequences. Eg. registration of incompetent individuals. Government has introduced new 'As of Right' legislation that will facilitate OTs who are regulated in another province to begin work in Ontario prior to being duly registered. There are risks to the public if someone is leaving their province due to some regulatory action ie, discpline, and then that individual begins to work without any safeguards put into place for public protection.	5	3	15	High	1. Membership with Health Professional Regulators of Ontario (HPRO); 2. Establishing and sustaining positive government relationships; 3. Standard processing times for applications for registration; 4. Emergency registration regulations in place; 5. Language test changes in place; 6. Government personnel aware the college is ready and available to assist when needed, with accurate information and data	1. HPRO meetings; 2. Ministry updates and relevant joint working groups; 3. College networking updates; 4. Monitoring happenings at the Canadian level	1. Working with the SEAS Program to support their timely assessment of international applicants; 2. Our new system for registration and data base to maximize efficiency and reporting; 3. Maintaining open communication with the provincial OT association and government re: any relevant initiatives 4. Implement As of Right legislation /regulations	OPEN	

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COTO Strategic	S.11	High	23-24	Registrar	SLT	If we aren't financially healthy, we can't perform our public protection role appropriately	The College has reviewed its financial health to ensure it can operate effectively now and into the future. Budget deficits have been planned for 2 consecutive cycles, resulting in decreased reserves. A 2% fee increase was implemented for the 2024 and 2025 annual renewal cycles; and the bylaws include possible fee increases up to 2% for the next three years as determined each year by the Board- resulting in a negative reaction from registrants.	5	2	10	Critical	1. A communications plan is underway to assist with understanding the rationale. 2. The Finance and Audit Committee has throroughly reviewed the details in the current budget 3. Bylaws in place to support up to 2% increases for the next three years	1. Continued monitoring and careful budgetting and spending. 2. Continued attention to communications	1. Communications plan	OPEN	
COTO Strategic	S.12	Moderate	23-24	Board	Registrar	If we are diverted from our mandate, we can't do our public protection activities.	With world events causing domestic upset, registrants are contacting the college with requests for the college to make public statements. Risk of reputational damage and divisive consequences.	5	4	20	Critical	1. Extensive website review 2. Crisis management handbook 3. EDI webpage 4. EDI consultant 5. EDI messaging templates with Communications	1. Each request is being responded to, sensitively, with what the college is doing related to EDI and taking a non-political stance. 2. The college is not a platform for social or political causes	1. Proactive planning to mitigate a possible Board meeting incident 2. Review of communications policies, specifically related to anonymous communications not related to complaints about OTs	MONITOR	
COTO Strategic	S.13	Moderate	24-25	Board	Registrar	Chaos due to significant legislative and regulation changes may decrease public confidence and service related to regulation.	Risk of system change to organization of regulation across the country or across the province. Ie. National or provincial amalgamation of regulators.	3	5	15	Critical	1. COTO strategic plan incorporates some national projects and thinking 2. We are working on consistency of processes nationally as much as possible to smooth the way for this possibility - re-entry, QA, Registration processes.	1. Monitoring government communications 2. Raising these issues at ACOTRO 3. Raising issues with COTO Board 4. Monitoring "As of Right" legislation or government initiatives for themes about national regulation	1. Working with ACOTRO on consistency related to Standards, code of ethics and re-entry 2. Proactive adjustments to our Labour Mobility Registration process and policies in preparation for "As of Right" changes to regulation.	OPEN	
COTO Strategic	O.14	Low	23-24	Registrar and CEO	SLT Manager I&R	Public is harmed through ineffective management of investigations related to freedom of speech	The College does not effectively manage inquiries related to freedom of speech	3	5	15	Critical	1. Obtain legal advice for ICRC and/or prosecutions that raise *Charter of Rights and Freedoms* issues 2. Communications plan to address college mandate or scope concerns 3. Edit COTO webpage to include plain language information about College scope for off duty conduct concerns	1. Log to monitor inquiries related to freedom of speech; 2. I&R data collection and analysis 3. I and R and Communications to monitor	No current action required	OPEN	related to Jordan Peterson case
Compliance	C.1	Moderate	22-23	Registrar	Manager I&R	Client harmed through undue delay in dealing with formal ICRC complaints and reports	Undue delay in dealing with formal ICRC complaints and reports	3	3	9	Moderate	1. Case compliance monitoring; 2. Staffing levels reviewed and resources managed appropriately; 3. Developed more templates to increase efficiency in processes; 4. Weekly team meetings; 5. Alignment of roles and responsibilities; 6. Benchmarks put in place for all cases opened on June 1, 2019 or later 7. Discipline tribunal will assist team to plan timelines	1. Regular reporting to Registrar and the Board; 2. Quarterly reporting to ICRC on case completion times; 3. I&R program processes streamlined; 4. I&R External legal audit conducted, recommendations implemented	1. Identify over-all system requirements as part of the Enterprise-wide system project; 2. Maximize the College selected document management system's functionality (e.g. template generation); 3. Develop and implement I&R monthly reporting to Registrar once new database is up and running 4. Implementing the use of an early resolution process to speed up matters before a formal process starts.	MONITOR	
Compliance	C.3	Low	22-23	Program Manager	Manager, Registration	Client harmed by registrant admitted to profession in error, as a result of poor registration practices	Non-compliance with requirements of the Fairness Comissioner	2	4	8	Moderate	1. Annual reporting; 2. Biannual assessments; 3. Registration program and Registration Committee complete OFC traning modules; 4. Annual Registration Committee training on principles; 5. Resources allocated to Fairness activities as required; 6. Use of SEAS process for internationally trained applicants to support fair approach to assessment.	1. Fairness commissioner reports/audits; 2.Yearly report completed and shared with Fairness Commissioner and posted on website; 3. Current rating from Fairness Commissioner is LOW RISK - 2024	1. Registration Manager to review and update as necessary re: new OFC requirements	MONITOR	
Compliance	C.4	Low	22-23	Registrar	Director Comms, Director Finance/Ops	Client harmed through an inability to access the website and public register.	Failure to comply with accessibility legislation (AODA, etc.) related to website and public register	4	2	8	Moderate	1. Website design; 2. Website vendor contracts include clause requiring compliance with AODA requirements; 3. Public register design includes AODA compliance mechanisms; 4. AODA compliance resources in use; 5. College exempt from some requirements due to our size - ie. less than 50 employees	1. Monitor changes to legislation 2. Any modifications to website to ensure meeting AODA requirements.	No current action required	MONITOR	

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Compliance	C.5	Low	22-23	Registrar	Communications, Registrar, Manager Regulatory Affairs (Policy)	Client harmed through misinterpretation or failure to understand the current website information.	Misinterpretation or failure to fully apply the French language requirements of the RHPA	3	4	12	Moderate	1. The college endeavors to hire a number of French language speakers during hiring; 2. The College has third party service agreements with two professional French translator service providers; 3. College bylaws and Standards, guidelines and other official documentation are available in French on the College website; 4. Bylaw and regulation consultations are made available to the public and registrants in French; 5. If an applicant wants to complete any process in French, the College will accommodate this; 6. I&R also accommodates any complainant or registrant wanting to complete the process in French; 7. All key program documents are available in French; 8. Competencies in French 9. Roster of French Speaking OT proofreaders established for review of select practice resources. 10. Discpline tribunal supports French hearings	1. Monitor number of staff members fluent in French; 2. Monitor activity and direction of government on this issue.	1. Develop and finalize French language services policy; 2. Monitor demand for provision of French services including access to resources, presentations, complaints; 3. Evaluate ability of new enterprise system to have a French public register; 4. Monitor MOH initiatives and HPRO collaborations.	OPEN	
Compliance	C.6	Low	22-23	Program Manager	Manager, Registration	Client harmed because unqualified practitioners are registered.	Risk to public confidence and reputation when unqualified practitioners are registered due to failure of registration process.	1	4	4	Moderate	1. Registration Program policies; 2. Process to follow up on all outstanding requirements; 3. Audit of any file under review; 4. Qualified third parties to assess qualifications; 5. Information from 3rd parties comes directly to prevent fraud; 6. Checklist of requirements; 7. Policy on graduation from an accredited Canadian University program; 8. Registrar representation on CAOT exam oversight Committees; 9. MOU with CAOT for use of the exam as a registration requirement; 10. MOU with ACOTRO for the SEAS assessment for internationally educated applicants; 11. Participate on SEAS oversight committee	1. Audit of files by different staff; 2. Accreditation Reports from Accreditation Committee; 3. Registration Committee monitoring bi-annual exam report; 4. Registration Committee monitoring of ACOTRO SEAS report; 5. Ability to audit if risk issue is identified	1. Implement criminal record check of currently registered OTs - on operational plan - in 2025-26 year	OPEN	
Practice Risks	P.1	Low	2023-2024	Registrar & Program Director	Program Managers	Client harmed as a result of sexual abuse, sexual misconduct or professional boundary issues	Risk to public confidence and reputation when clients are harmed by sexual abuse, sexual misconduct or professional boundary issues	5	5	12	Critical	1. Code of Ethics; 2. Standards of Practice; 3.Competencies for OT in Canada; 4. Education produced with guidance of Patient Relations and Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee (ICRC) and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints; 8. Evidence-based Practice Guidance and Education; 9. Practice Support and Outreach; 10. QA Annual Requirements and Competency Assessment	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Patient Relations Committee and Practice Subcommittee Quarterly Report; 4. Practice Support; 5. Competency Assessment Process	1. Renewal of Code of Ethics (2020) through collaboration with ACOTRO 2. Patient Relations Education-Staff, committees, board	OPEN	**A. Standard and Date Reviewed:** 1. *Standard* for Professional Boundaries and the Prevention of Sexual Abuse (2023) 2. *Standard* for the Prevention and Management of Conflicts of Interest (2023) B. Complaint and Report Data C. QA Risk Indicators Data D. Quarterly Report-QA, ICRC and Patient Relations

	Risk ID	Outcome/ Residual Risk	Date Risk Added	Accountability	Responsibility	Public Risk Description	Organization Risk Description	Probability 1-5	Impact 1-5	Overall Risk	Risk Ranking: Low, Mod, High, Critical	Control Procedures	Monitoring Process	Current Action Required to Manage Residual Risks	Status (Open, Monitor or Closed)	Standards, Guidance & Data Management Agenda
Practice Risks	P.2	Low	2023-2024	Program Director	Program Managers	Client harmed through OTs failure to adequately supervise OTAs (REHAB assistants) or others	OTs fail to adequately supervise OTAs (REHAB assistants) or others	4	3	12	High	1. Code of ethics; 2. Standards of Practice; 3. Competencies for OT; 4. Education produced with guidance of Patient Relations Committee and Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions; 7. Timely investigation and responses to complaints; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach & Outreach; 10. QA Annual Requirements and Competency Assessment	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Patient Relations Committee and Practice Subcommittee Quarterly Report; 4. Practice Support; 5. Competency Assessment Process	1. Collaboration with ACOTRO, OSOT and CAOT 2. Practice Guidance and Practice Support Development-Newsletter and Resources	OPEN	**A. Standard and Date Reviewed:** 1. Standard for the Supervision of Students and Occupational Therapy Assistants (2023) B. Complaint and Report Data C. QA Risk Indicators Data D. Quarterly Report-Practice; ICRC; QA
Practice Risks	P.3	Low	2023-2024	Program Director	Program Managers	Client harmed during the use of Controlled Act by an OT/ "Controlled Acts" Delegation-Psychotherapy	Client harmed during the use of Controlled Act by an OT/ "Controlled Acts" Delegation-Psychotherapy	4	3	12	High	1. Code of ethics; 2. Standards of Practice; 3.Competencies for OT; 4. Education produced with guidance of Patient Relations Committee and Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach; 10. QA Annual Requirements and Competency Assessment 11. QA annual requirements, 12. Competency assessment	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Patient Relations Committee and Practice Subcommittee Quarterly Report; 4. Practice Support 5. Competency Assessment Process	1. Collaboration with ACOTRO, OSOT and CAOT about resources and guidance for provision of Psychotherapy	OPEN	**A. Standard and Date Reviewed:** 1. Standard for Acupuncture (2023) 2. Standard for Psychotherapy (2023) **B.** Complaint and Report Data C. QA Risk Indicators Data D. Quarterly Report-Practice; ICRC; QA
Practice Risks	P.4	Low	2023-2024	Program Director	Program Managers	Client harmed due to substandard record keeping practices	Client harmed due to substandard record keeping practices	4	5	12	High	1. Code of ethics; 2. Standards of Practice 3.Competencies for OT; 4. Education produced with guidance of Patient Relations Committee and Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach; 10. Advice from Advisory Committiees on EDI Perspectives and Indigenous Insights; 11. QA Annual Requirements and Competency Assessment 12. 2024 E-learning module on record keeping complete	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Patient Relations Committee and Practice Subcommittee Quarterly Report; 4. Practice Support 5. Competency Assessment Process;	No current action required	MONITOR	**A. Standard and Date Reviewed:** 1. Standard for Assessment and Intervention (2023) Standard for Consent (2023) Code of Ethics (2023) B. Practice Support Data C. Complaint and Report Data D. QA Risk Indicators Data E. Quarterly Report-Practice; ICRC; QA; Advisory Committees; Patient Relations
Practice Risks	P.5	Low	2023-2024	Program Director	Program Managers	Client harmed during the use of Artificial Intelligence (AI) for assessment and/or intervention by an OT	Client harmed during the use of Artificial Intelligence (AI) for assessment and/or intervention by an OT	4	3	12	Critical	1. Code of ethics; 2.Competencies for OT; 4. Information on website; 5. Evidence based Practice Guidance and Education; 6. Practice Outreach; 7. Guidance Document developed for AI 2024	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Practice Subcommittee Quarterly Report; 4. Practice Support 5. Competency Assessment Process; 6. Practice Subcommittee Workplan	1. Study Annual QA Requirements data about registrant experience with AI; 2. Collaboration with HPRO & CNAR Partners on development of emerging resources.		**A. Standard and Date Reviewed:** 1. Standard for Record Keeping (2023) B. Standard for Consent (2023) C. **C**omplaint and Report Data D. QA Risk Indicators Data E. Code of Ethics F. Quarterly Report-Practice; ICRC; QA G. AI Guidance 2024

	Risk ID	Outcome/ Residual Risk	Date Risk Added	Accountability	Responsibility	Public Risk Description	Organization Risk Description	Probability 1-5	Impact 1-5	Overall Risk	Risk Ranking: Low, Mod, High, Critical	Control Procedures	Monitoring Process	Current Action Required to Manage Residual Risks	Status (Open, Monitor or Closed)	Standards, Guidance & Data Management Agenda
Practice Risks	P.6	Moderate		Program Director	Program Managers	Client harmed by Registrant practicing while incapacitated	Client harmed by Registrant practicing while incapacitated	4	3	12	High	1. Code of ethics; 2. Standards of Practice: 3.Competencies for OT; 4. Education produced with guidance of Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints, fitness to practice concerns; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach; 10. QA Annual Requirements and Competency Assessment 11. Registration processes to identify applicants and registrants with suitability to practice concerns	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Practice Subcommittee Quarterly Report; 4. Practice Support 5. Competency Assessment Process;	No current action required	OPEN	**A. Standard and Date Reviewed:** 1. Standard for Assessement and Intervention (2023) 2. Standard for Consent (2023) B. Complaint and Report Data C. Practice Support Data E. QA Risk Indicators Data F. Quarterly Report-Practice; ICRC; QA
Practice Risks	P.7	Low		Program Director	Program Managers	Client's privacy compromised due to OTs fail to safeguard Personal Health Information and/or gain knowlegeable consent	Client's privacy compromised due to OTs fail to safeguard Personal Health Information and/or gain knowlegeable consent	4	3	12	High	1. Code of ethics; 2. Standards of Practice; 3.Competencies for OT; 4. Education produced with guidance of Patient Relations Committee and Practice Subcommittee; 5. Information on website; 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach; 10. QA Annual Requirements and Competency Assessment	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Patient Relations Committee and Practice Subcommittee Quarterly Report; 4. Practice Support 5. Competency Assessment Process			**A. Standard and Date Reviewed:** 1. Standard for Assessement and Intervention (2023) 2. Standard for Consent (2023) 3. Standard for Record Keeping (2023) B. Complaint and Report Data C. QA Risk Indicators Data D. Quarterly Report-Practice; ICRC; QA
Practice Risks	P.9	Low	2023-2024	Program Director	Program Managers	Client harmed or feels culturally unsafe due to OT practices	Client harmed or feels culturally unsafe due to OT practices	4	5	12	High	1. Code of ethics 2. Standards of Practice 3.Competencies for OT 4. Education produced with guidance of Patient Relations Committee and Practice Subcommittee 5. Information on website, 6. The Investigations, Complaints and Resolutions Committee and Panels deliberations and decisions by ICRC and QA; 7. Timely investigation and responses to complaints; 8. Evidence based Practice Guidance and Education; 9. Practice Outreach 10. Advice from Advisory Committiees on EDI Perspectives and Indigenous Insights 11. QA Annual Requirements and Competency Assessment	1. Case review and decisions by panels of ICRC, and QA 2. Quarterly Registrar's report 3. Patient Relations Committee and Practice Subcommittee Quarterly Report 4. Practice Support 5. Competency Assessment Process 6. Equity Perspectives and Indigenous Insights Advisory Committee Workplans; COTO EDI and Indigenous Insights Plans	1. Production of National E-Learning Module 2025-Cultural Humility and OT Practice 2. Education-Staff, committees, board 3. Socio Demographic Data Collection Project	OPEN	**Standard and Date Reviewed:** **1.** Standard for Assessment and Intervention 2. Standard for Consent Code of Ethics **Complaint and Report Data** **QA Annual Requirement Data** **Quarterly Report-**Practice; ICRC; QA; Advisory Committees; Patient Relations
Practice Risks	P.10	Low	2023-2024	Program Director	Program Managers	Client harmed through unsafe OT services for Equipment/Safety or failure to adequately train others on use of equipment	Risk of harm to public due to OT services for Equipment/Safety and training others on use of equipment	4	3	12	High	1. Code of Ethics; 2. Standards of Practice; 3. Competencies for OT in Canada; 4. Education produced with guidance of Patient Relations and Practice Subcommittee; 5. Information on website; 7. The Investigations, Complaints and Resolutions Committee (ICRC) and Panels deliberations and decisions by ICRC and QA; 8. Timely investigation and responses to complaints; 9. Evidence based Practice Guidance and Education; 10. Practice Support and Outreach; 11. QA Annual Requirements and Competency Assessment 12. Governement and Coroner Reports and Communication about equipment and Assistive Devices Program Registration Data	1. Case review and decisions by panels of ICRC and QA; 2. Quarterly Registrar's report; 3. Practice Subcommittee Quarterly Report; 4. Practice Support; 5. Competency Assessment Process; 6. Practice Subcommittee Workplan	1. Response to Coroner's Reports 2. Provide Assistive Devices Program Registration Data		**A. Standard and Date Reviewed:** 1. *Standard* for Assessment and Intervention **B. Registration Data** **C. Complaint and Report Data** **QA Risk Indicators Data** **Quarterly Report-**Registration, QA, ICRC and Patient Relations

	Risk ID	Outcome/ Residual Risk	Date Risk Added	Accountability	Responsibility	Public Risk Description	Organization Risk Description	Probability 1-5	Impact 1-5	Overall Risk	Risk Ranking: Low, Mod, High, Critical	Control Procedures	Monitoring Process	Current Action Required to Manage Residual Risks	Status (Open, Monitor or Closed)	Standards, Guidance & Data Management Agenda
Quality	Q.1	Low	22-23	Program Director	QAC, QA Manager - Exec	Client harmed due to failure of the college to identify and address OTs who might pose a risk to clients	Risk based selection and appoach does not lead to continuous quality improvement	5	1	5	Moderate	1. Compliance metrics monitored through database (MyQA); 2. Competency enhancement in place for all OTs, (annual requirements in place); 3. Non-compliance being addressed by staff/QAC; 4. Peer assessment process in place; 5. Competency assessment process now in continuous quality improvement phase; 6. Psychometric analysis of results	1. Bi-annual compliance case review by QAC; 2. Quarterly registrar's report; 3. Priority Performance Reporting.	1. Review and revise selection based on analysis and data.	OPEN	
Quality	Q.4	Low	22-23	Program Director	QA Manager, Manager Registration and Manager I&R - Exec	Client harmed due to incompetent practices	Competency assessment, education and remediation tools are not valid and reliable (QA,).	3	3	9	Moderate	1. New evidence-informed competency assessment process has been determined; 2. Peer interviews; 3. Data Analysis; 4. Continuous Program Improvement based on feedback from Peer Assessors and Registrants; 5. Rubric developed for grading peer interviews, and remediation submissions.	1. Ongoing review of new evidence to inform program development	1. Review and revise assessment tools on analysis and data. 2. Codesign	OPEN	
Quality	Q.6	Low	22-23	Program Director	Leadership Team	Risk to public when reliable data is unavailable to guide decision making	Inability to reliably and consistently collect and analyze data related to trends in OT practice required to make informed decisions.	4	3	12	High	1. Tracking of data in all programs; 2. More similar tracking data across programs; 3. Identifed solutions for consideration; 4. Integrate use of new ES system for reporting and analysis.	KPIs have been developed for programs, to be monitored with new system. CPMF has requirements, Quarterly report.	Review data to enhance reporting and information.	OPEN	
Quality	Q.7	Moderate	22-23	Program Director	Manager Registration, Quality Assurance	Client harmed due to new to practice, practice re-entry, or practice isolation	Risk of harm to public due to new to practice, practice re-entry, or practice isolation	3	3	9	Moderate	1. National dialogue about currency taking place; 2. Re-entry program updated and consistent with several other OT regulators in Canada; 3. QA program identifies risks to practice, including isolation risks and completes assessments of these registrants	1. Operationalize improvements to re-entry program based on new evidence from national project 2. Monitor QA statistics related to risk of practice isolation.	Implementing ACOTRO project to harmonize re-entry programs.	OPEN	
Quality	Q.8	Low	22-23	Program Director	Manager Regulatory Affairs, Manager Registration, Manager I&R, QA Manager, Practice Team	Client harmed by regulatory rules guided by out of date regulation.	College regulations are out of date or not meeting college operational needs.	5	3	15	High	1. Policy analyst reviews legislation changes and provides updates Program managers; 2. Program managers review compliance with regulations and identify any issues/gaps.	1. Monitor changes to legislation that may impact College regulations.	Strategic plan includes a review of all regulations. A revision plan to be developed. Gain support of MOH prior to any work being done.	OPEN	March 2021 - our regulations are outdated. Professional Misconduct regs not updated since 2007, General reg since 2012 and contains QA where the program has been updated, Advertising Reg needs a review for relevancy.
System Partners	SH.5	Low	22-23	Program Manager	Practice Team	Client harmed by services provided in a void of appropriate guidance to OTs	Lack of appropriate guidance to OTs on and in standards relating to practice	1	4	4	Moderate	1. Regular review schedule for standards; 2. All new standards circulated to OTs for consultation; 3. Legal review of content; 4. Standards approved by Board; 5. Standards posted on website; 6. Education provided through case studies (eBlast and website posting); 7. Environmental scanning; 7. OT access to Practice Resource Service; 8. Consultation with external agencies; 9. Document development process in place.	1. Practice issues and Executive Committee review of workplan.	Ongoing review and revision of materials as needed.	MONITOR	
System Partners	SH.6	Low	22-23	Program Manager	Practice Team	Client harmed by system that fails to understand their individual needs or experiences.	Reputational risk that is the Perception that the College does not support diversity and or inclusion and or equity	3	4	12	High	1. Code of ethics; 2. Standards - Professional Boundaries; 3. Competencies for OT have section on Culture Equity and Justice (CEJ) guidance; 4. 2025 e-learning module on cultural competency 5. Statement on website; 6. Socio demographic questions on annual renewal; 7. Land acknowledgement at meetings; 8. Equity Perspectives and Indigenous Insights Advisory Committees.	1. Monitoring media; 2. Monitoring registrant and public inquiries	EDI plan incorporated into w strategic plan. Operational initiatives have EDI incorporated	OPEN	
COTO Operational	O.2	Moderate	22-23	Corp Services	Manager of IT	Client harmed due to failure of our public register to flag risks or provide accurate information	Database contains incomplete and/or inaccurate information. Data used for inapproriate activities, such as appropriation of OT credentials.	3	5	15	Critical	1. Programming logic to minimize errors; 2. Use of expert consultants; 3. Appropropriate training of staff; 4. Policies support accurate and complete recording.	1. Anomoly reports; 2. Data integrity queries	1. Continue processes to monitor data quality; 2. Develop new reports; 3. Correct issues as soon as they are identified 4. Investigate the implications of removing registrant registration numbers off the public register.	OPEN	

RISK REGISTER vOCT 16, 2025

	Risk ID	Outcome/ Residual Risk	Date Risk Added	Accountability	Responsibility	Public Risk Description	Organization Risk Description	Probability 1-5	Impact 1-5	Overall Risk	Risk Ranking: Low, Mod, High, Critical	Control Procedures	Monitoring Process	Current Action Required to Manage Residual Risks	Status (Open, Monitor or Closed)	Standards, Guidance & Data Management Agenda
COTO Operational	O.8	Moderate	22-23	Director Finance and Corporate Services	Manager of IT, Director of Communications	Client harmed due to Security breach of IT systems/data	Security breach of IT systems/data	3	5	15	Critical	1. Use of Generative AI Policy 2. Antivirus reports; 3. Reports identifying windows updates; 4. Phishing emails training, blocking of spam emails; 5. Cyber insurance; . Always applying critical security updates; 6. Multi-factor identity; 7. Link with stakeholder networks to keep us informed; 8. Third party review of security systems to identify any weaknesses.	1. Monitor for policy breaches 2. Monitor for security breaches; 3. Monitor and update systems as required	Develop a procedural document for system breaches; and integrate with the Strategic Technology Plan regular penetration testing of our systems; Implementation of AI Champions Staff Group	OPEN	
COTO Operational	O.9	Low	22-23	Program Manager	Manager of Registration, Director of Communications, Manager QA, Manager I&R	Client harmed by breach of privacy, to personal health information.	Breach of Privacy	3	5	15	Critical	1. Systems and processes in place to prevent privacy breaches; 2. Staff training and review; 3. Internal Reporting mechanisms; 4. Policy; 5. Website updated; 6. Use of Titan File	1. Monitor number of privacy breaches; 2. Log to monitor privacy breaches created; 3. Program manager is privacy officer.	1. Monitor	MONITOR	
COTO Operational	O.10	Low	22-23	Director Finance and Corporate Services -	IT Specialist	Loss of records leads to harm to clients or groups of clients, ie, ICRC processes delayed.	Loss of records due to failure of the records management system, financial systems or disaster (fire, pandemic, bomb threat).	3	5	15	Critical	1. Use computer systems with back ups; 2. Use of recognized storage companies; 3. Recording of archives; 4. Record retention policies; 5. On-line banking; 6. Credit cards; 7. Annual audit; 8. Disaster planning; 9. Cloud systems and back up	1. Planned testing of back-up systems and disaster recovery plans; 2. Develop and implement business continuity plan	1. Develop a process for regular disaster recovery testing; 2. Perform REGULAR disaster recovery test	OPEN	
COTO Operational	O.11	Moderate	22-23	Director Finance and Corporate Services	Director of Finance and Corporate Services	Public is at risk when the college cannot perform its role adequately.	Human Resource Strategy - staffing resources disengaged or not appropriately optimized.	3	3	9	High	1. Recruitment Strategies; 2. Orientation; 3. Professional development; 4. Absentee management; 5. HR policies; 6. Compensation policies; 7. Performance review process; 8. Pension plan in place to aid in recruitment and retention	Absenteeism rate, job evaluation and salary surveys, benefit benchmarking, professional development plans, goal setting and performance management, staff turnover, exit interviews.	Implement HR plan and strategies	OPEN	
COTO Operational	O.13	Moderate	22-23	Director of Finance and Corporate Services	IT Specialist	Public is at risk when the college cannot perform its role adequately.	Unplanned downtime of mission critical registrant IS system (member login, MY QA). Business interruption	3	5	15	Critical	1. Responsive IT support; 2. Testing prior to implementing system changes; 3. Staff Training 4. Business Continuity Plan complete.	Informal monitoring in place.	1. Review management of maintenance processes to ensure following industry standards (for e.g. ITIL); 2. Develop a plan to monitor down time and implement; 3. AI working group reviewing organizational processes for safety and risk.	OPEN	

AGENDA ITEM 9.1

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Finance and Audit Committee

Subject: Fiscal Year 2025/2026 Q1 Financial Summary Report

Recommendation:

***THAT** the Board receive the FY2025/2026 Q1 Financial Report, as presented.*

Issue:

To review the year-to-date financial results of the College for fiscal year 2025/2026 and advise the Board of any issues.

Link to Strategic Plan:

This aligns under Performance and Accountability

The College maintains strong corporate and governance structures and fosters a culture of continuous improvement.

4.1 Ensures College governance is proactive, effective, competency-based, and accountable.

Why this is in the Public Interest:

The College has a duty to ensure that it has the financial resources to meet its public protection mandate and to use those resources responsibly.

Equity, Diversity, and Inclusion Considerations:

When preparing this report, all elements of equity, diversity and inclusion were considered.

Background:

This Financial Report contains three sections:

1. Financial Statement Highlights
2. Summary of Statutory Remittances and Filings
3. Financial Statements:
    - Statement of Financial Position as at August 31, 2025
    - Statement of Operations for the period June 1, 2025, to August 31, 2025
    - Statement of Reserve Funds as at August 31, 2025

Discussion:

Highlights of Statement of Financial Position:
(Please refer to the attached Statement of Financial Position as at August 31, 2025).
Items to note with respect to the changes to assets includes:

- The balance in the investments will not align with the monthly BMO Investment Reports for interim financial reporting as standard audit adjustments (i.e. to recognize accrued interest and to reclassify certain items between cash and investments) are recorded at fiscal year-end. Variances to prior year reflect changes in the investment portfolio, including investments matured and reinvested, recognizing the interest reinvested in the balance.
- The decrease in property and equipment year-over-year is due to depreciation from the leasehold improvements, furniture, and the server. No additions or disposals have taken place this fiscal year.

Items to note with respect to liabilities for the period include:

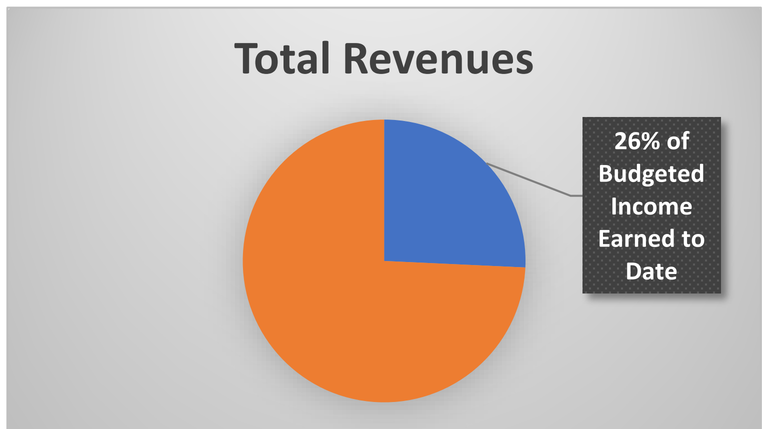
- The deferred registration fees recorded in the Statement of Financial Position, as at August 31, 2025, represent the portion of the annual renewal fees collected for fiscal year 2025/2026. These funds will be moved out of the Statement of Financial Position quarterly and recognized in the Statement of Operations as Registration fees. Annual renewal funds collected on or after June 1, 2025, are automatically recorded directly under Registration fees on the Statement of Operations for the current fiscal year.

The Net Assets section on the Statement of Financial Position reflects the following:

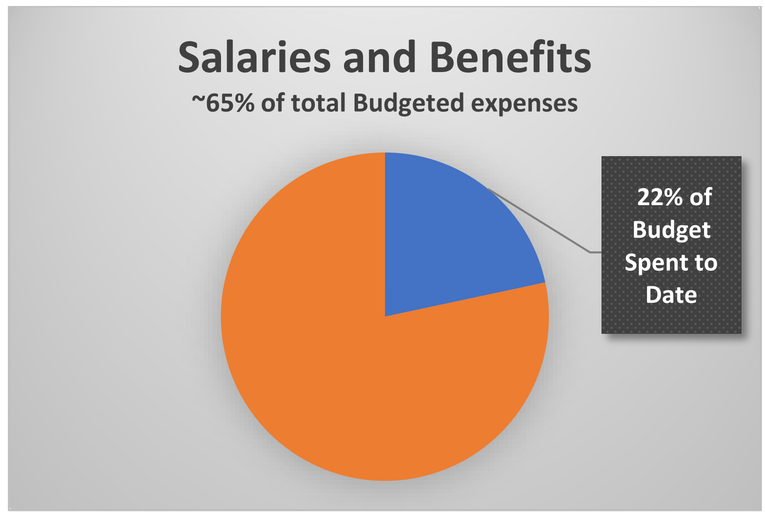
- The decrease in Invested in Fixed Assets is due to the depreciation.
- The excess of revenues over expenses for the period is due primarily to lower expenditure, due to delayed timing, in various areas.

Highlights of Statement of Operations:
(Please refer to the attached Statement of Operations for the period of June 1, 2025, to August 31, 2025).

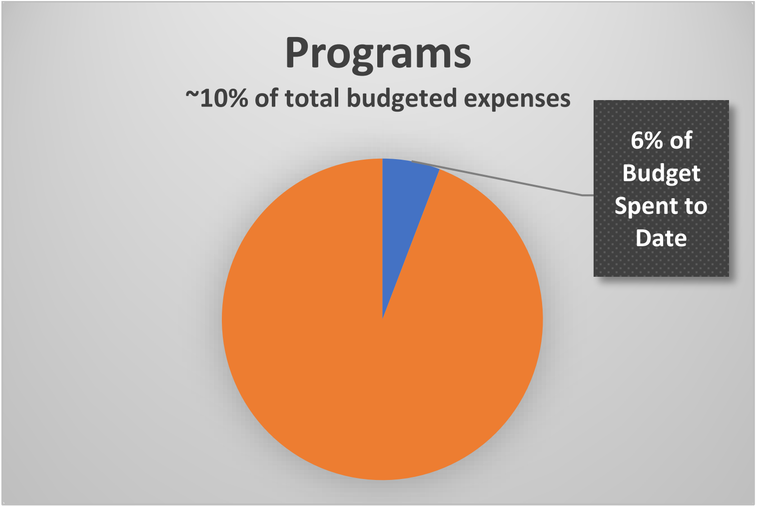
The excess revenues over expenses for the period June 1, 2025, to August 31, 2025, is $441,399. The College is in a surplus position, and the below charts provide some additional detail for each category.



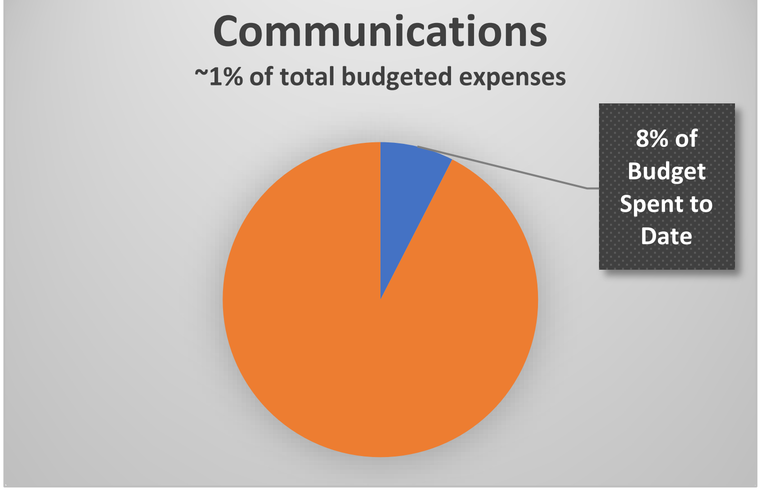
- Status: Favourable to budget
- Revenue is primarily derived from returning and new registrant fees, as well as application fees, and represents one-quarter of the 2025/2026 annual renewal fees recognized.



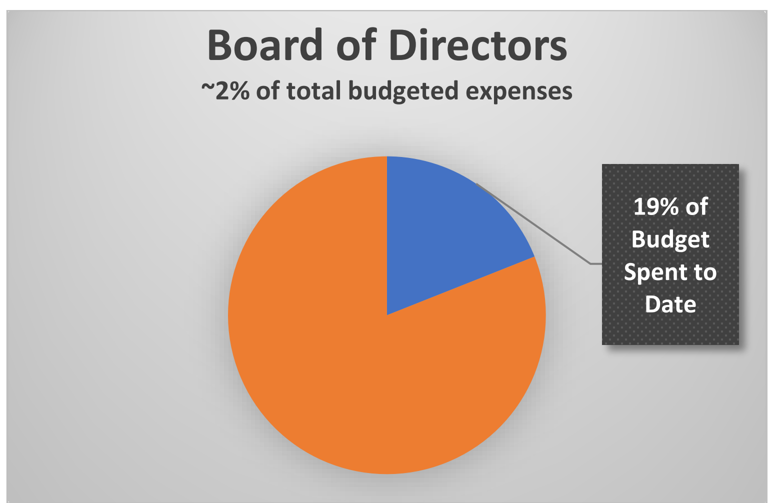
- Status: Favourable to budget
- Salaries and benefits are slightly under budget. Anticipate alignment to budget in next quarter.



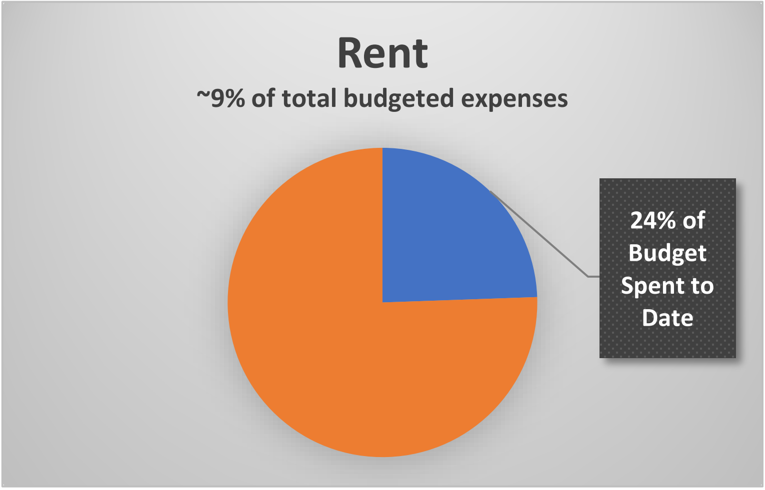
- Status: Favourable to budget
- Program expenses are underbudget primarily due to timing of College activities.
- Variance to the statement of operations as there we have included the reversal of an I&R year-end accrual.



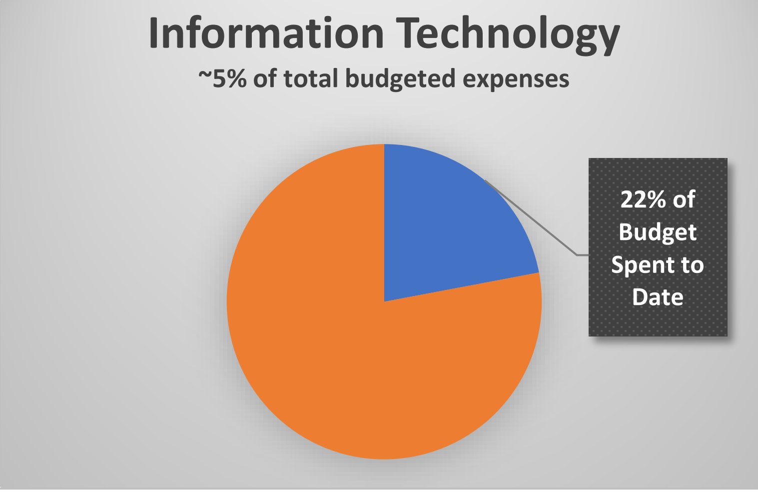
- Status: Favourable to budget
- Communications costs are under budget as most costs are incurred in the fourth quarter.



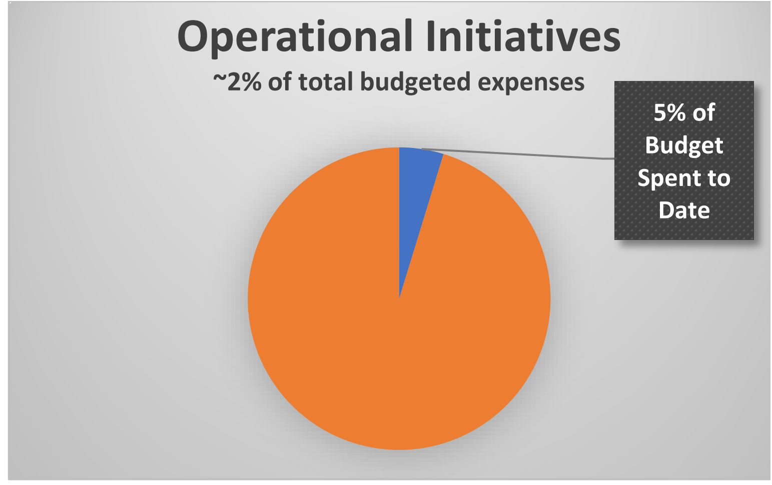
- Status: Favourable to budget
- Board of Director expenses are under budget due to timing.



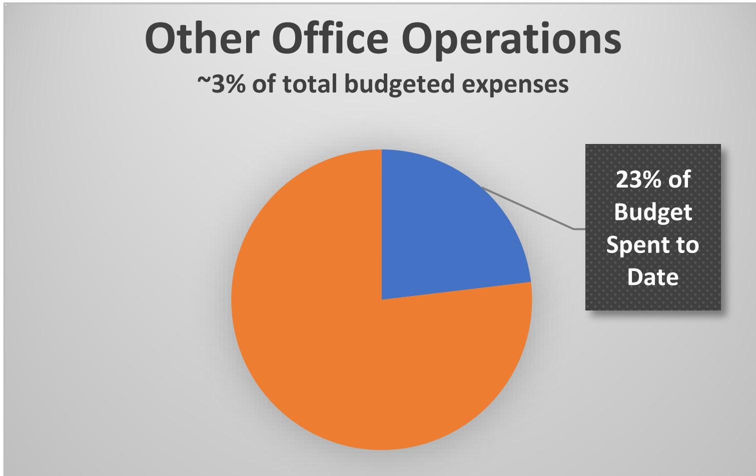
- Status: On Target
- Included here is rent and insurance.



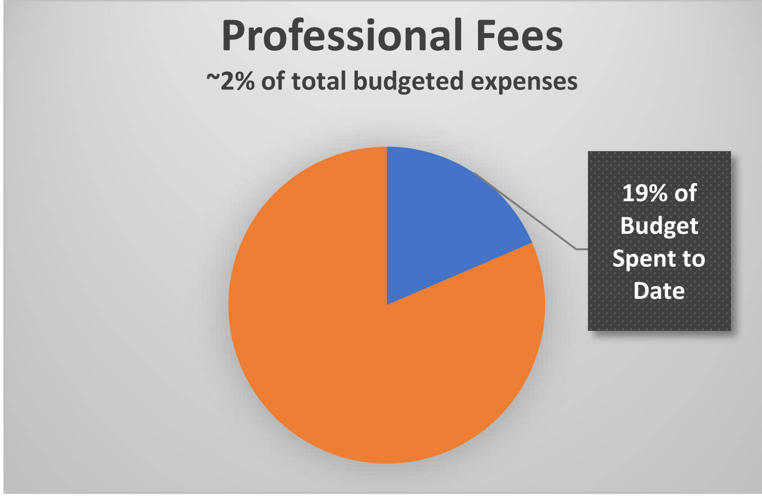
- Status: Favourable to Budget
- Information Technology is slightly under budget due to delayed timing of invoices.



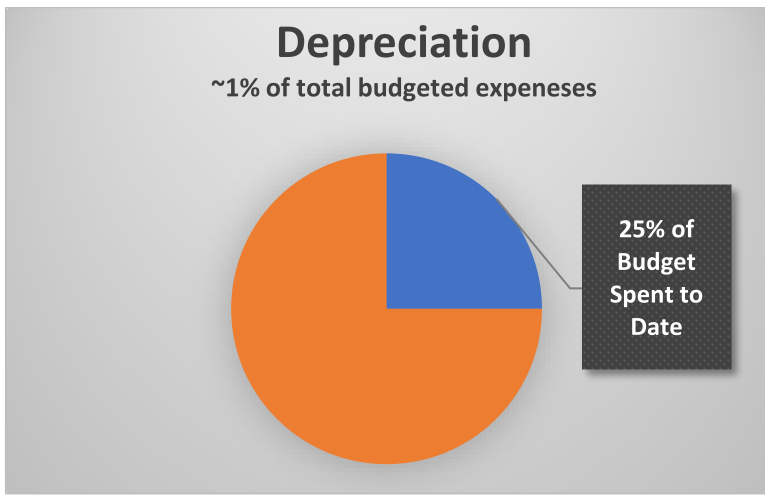
- Status: Favourable to budget
- Operational initiatives are under budget with only 5% of budget spent to date. Expenditures are expected to increase as planned projects proceed in the coming months.



- Status: Favourable to budget
- Other Office Operations are under budget due to delayed timing of invoices and costs.



- Status: Favourable to budget
- Professional Fees are under budget due to delayed timing of activities.



- Status: On Target

Highlights of Statement of Reserves:
(Please refer to the attached Statement of Reserves as at August 31, 2025)

In addition to expenses incurred during the regular course of operations, certain expenditures are made against the designated reserve funds in accordance with approved Board Guidelines for Establishing and Maintaining Reserve Funds.

Through to the end of August, the following expenses have been incurred:

- $11,954 has been allocated to the Invested in Fixed Assets Fund amount and is reflective of the accumulated depreciation.

Statutory Remittances and Filings:

The College is required to remit various taxes and filings to the government.

Description	Frequency/Timing	Status
Remittance of payroll withholding taxes (CPP, EI, Income Tax)	Bi-weekly	Up to date
Remittance of CPP on Council per diems	Monthly	Up to date
Remittance of Employer Health Tax	Payroll over $1,000,000 will have EHT applied at 1.95% during the calendar year.	Up to date
Filing of Harmonized Sales Tax return (Monthly)	Monthly Upcoming Filing Due Dates: October 31, 2025 November 30, 2025	Up to date
Filing of T4, T4A returns	Annually based on calendar year. Due last day of February.	Up to date
Filing of Corporate Income Tax Return (T2)	Annually based on fiscal year. Due November 30, 2025.	Up to date
Filing of Non-Profit (NPO) Information Return (T1044)	Annually based on fiscal year. Due November 30, 2025.	Up to date

College of Occupational Therapists of Ontario
STATEMENT OF FINANCIAL POSITION
As at August 31, 2025

	31-Aug-25	31-Aug-24
ASSETS		
Current assets		
Cash	3,951,426	3,630,123
Accounts receivable and prepaid expenses	62,707	83,688
Total current assets	4,014,133	3,713,811
Investments	3,864,702	3,698,575
Property and equipment, net of accumulated amortization	185,535	228,943
TOTAL ASSETS	**8,064,370**	**7,641,329**
LIABILITIES		
Current Liabilities		
Accounts payable and accrued liabilities	220,672	- 217,638
HST payable	-	421,155
Deferred registration fees	3,604,306	3,484,455
Total current liabilities	3,824,978	3,687,972
Total liabilities	3,824,978	3,687,972
NET ASSETS		
Reserve funds	1,325,000	1,325,000
Invested in fixed assets	185,536	228,944
Unrestricted	2,287,457	1,875,501
Excess of revenues over expenses for the period	441,399	523,912
Total net assets	4,239,392	3,953,357
TOTAL LIABILITIES AND NET ASSETS	**8,064,370**	**7,641,329**

College of Occupational Therapists of Ontario
STATEMENT OF OPERATIONS
June 2025 to August 2025

	3 Months Actuals ended August 2025 $	12-Month Budget FY25/26 $	Percentage of Spend to Budget %
REVENUES			
Registration fees	1,389,893	5,161,193	27%
Application fees	31,220	110,852	28%
Interest & other income	24,219	196,045	12%
TOTAL REVENUES	1,445,332	5,468,090	26%
EXPENSES			
Salaries and benefits	781,948	3,610,540	22%
Programs	(68,136)	535,911	-13%
Communications	4,973	66,012	8%
Board of Directors	26,272	138,404	19%
Rent & Leases	125,683	514,188	24%
Information technology	64,260	291,671	22%
Other office operations	34,871	150,892	23%
Operational initiatives	3,982	84,000	5%
Professional fees	18,126	97,742	19%
Depreciation	11,954	47,817	25%
TOTAL EXPENSES	1,003,933	5,537,177	18%
EXCESS OF REVENUES OVER EXPENSES FOR THE PERIOD	441,399	(69,087)	

STATEMENT OF RESERVE FUNDS

	Opening Balance June 1, 2025 $	Spent to Date/Change $	Closing Balance Aug 31, 2025 $
Hearings and independent medical exam fund	$ 400,000	-	400,000
Sexual abuse therapy fund	$ 25,000	-	25,000
Premises fund	$ 800,000	-	800,000
IT Technology Fund	$ 100,000	$ -	100,000
Invested in fixed assets	$ 197,490	$ (11,954)	$ 185,536
Unrestricted	$ 2,275,503	$ 11,954	2,287,457
Excess of revenues over expenses for the period	$ -	441,399	441,399
TOTAL RESERVES	3,797,993	441,399	4,239,392

Implications:

By receiving the FY2025/2026 Q1 Financial Report, the Board is formally acknowledging that the report has been presented and reviewed. This action records the report in the official Board minutes and demonstrates fulfillment of the Board’s fiduciary responsibility for financial oversight.

Attachments: N/A

AGENDA ITEM 10.1

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Finance and Audit Committee

Subject: Finance Governance Policies

Recommendation:

THAT *the Board approve the amended and/or newly created financial governance policies for incorporation into the College's Governance Manual:*

- *6.1 / Financial Planning and Budgeting* - Revised
- *6.2 / Financial Condition and Activities* - Revised
- *6.3 / Asset Protection* - Revised
- *6.4 / Investments* - Revised
- *6.5 / External Audit* - Revised
- *6.6 / Honoraria* – Revised (Combined Allowable Expense Policy with Honoraria Policy)
- *6.7 / Reserve Funds* - Revised
- *6.9 / Insurance* – New
- *6.10 / Signing Authority* – New
- *7.2 / Overseeing Financial Risk* - New

Issue:

As part of the broader governance policy review, ten financial governance policies are presented to the Board for final approval. These policies collectively strengthen the College's financial oversight framework and support the Board in fulfilling its fiduciary responsibilities.

Link to Strategic Plan:

This aligns under:

Performance and Accountability

4.1 Ensures College governance is proactive, effective, competency-based and accountable.

4.2 Maintains the expertise and resources to address evolving demands caused by changes in the regulatory or practice environment.

Why this is in the Public Interest:

Strengthened financial governance through the adoption of these policies will enhance transparency, accountability, and responsible stewardship of College resources. This ensures long-term financial sustainability in alignment with the College's public protection mandate.

Equity, Diversity and Inclusion Considerations:

The policies have been developed with EDI principles embedded, ensuring that financial practices support and align with initiatives that promote inclusion and address barriers experienced by equity-seeking groups.

Background:

As part of the strategic activities for this fiscal year, the College is embarking on a comprehensive review and modernization of its Governance Manual. This will ensure all the policies are up to date and, where necessary, new ones developed.

The finance governance policies presented for review reflect leading practices and provide a structured framework to guide decision-making by the Board and the Finance and Audit Committee.

Discussion:

The ten financial governance policies have been designed to promote strong financial stewardship and long-term sustainability by establishing clear roles and responsibilities across the College. They provide a consistent and transparent framework for financial practices, support effective risk management, and ensure appropriate protection of the College's assets.

Additionally, these policies are aligned with the College's broader governance framework, reinforcing accountability and good governance. Together, they equip the Finance and Audit Committee and the Board with the tools and guidance needed to confidently and effectively fulfill their fiduciary responsibilities.

Implications:

Upon approval by the Board, the policies will be formally integrated into the updated Governance Manual. This will represent a significant step toward modernizing the College's governance framework and enhancing organizational accountability.

Attachments:

1. 6.1 / Financial Planning and Budgeting *DRAFT*
2. 6.2 / Financial Condition and Activities *DRAFT*
3. 6.3 / Asset Protection *DRAFT*
4. 6.4 / Investments *DRAFT*
5. 6.5 / External Audit *DRAFT*
6. 6.6 / Honoraria *DRAFT*
7. 6.7 / Reserve Funds *DRAFT*
8. 6.9 / Insurance *DRAFT*
9. 6.10 / Signing Authority *DRAFT*
10. 7.2 / Overseeing Financial Risk *DRAFT*

Policy Type:	Section 6: Finance
Policy Title:	**Financial Planning and Budgeting - *DRAFT***
Reference:	**6.1**
Date Prepared:	December 2009
Date Revised:	March 2010, June 2019, June 2022, June 2024
Date Reviewed:	June 2016, June 2023, October 2025

Purpose

To establish the Board's responsibility for overseeing financial management that will ensure adequate resources are available to support the College's mandate and strategic directions. To achieve this, financial planning for any fiscal year or the remaining part of any fiscal year will be aligned with leadership outcomes and be derived from a financial plan.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

The Board is ultimately responsible for ensuring that appropriate strategies, policies, and processes are in place to support prudent financial stewardship. Financial planning and budgeting is an important part of this responsibility.

Procedure

The Finance and Audit Committee will ensure that the Registrar and CEO's financial planning and budgeting:

1. Contains information to enable credible projection of revenues and expenses, and separates capital and operational items, cash flow, and disclosure of planning assumptions.
2. Provides adequate cash flow to support operations throughout the year and to support reserves without Board approval.
3. Allocates sufficient funds to satisfy operational requirements.
4. Appropriately balances resources, human, technological and financial, between the budget and the expected leadership outcomes.
5. Provides sufficient resources to support the Board's ability to perform its leadership role.
6. Conservatively projects a Balanced Budget that does not deviate (+/-) from revenues by more than 3% in any fiscal year, unless otherwise directed by the Board.

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Appendix A

BOARD REFERENCE MATERIAL

Guide for Review of Financial Information

This guide is provided for Board Directors to use as a reference in their review of standard financial information that is provided in their council meeting packages.

The Financial Report provided, typically includes highlights of the financial statements, an update on statutory remittances and filings, and updated financial statements. The checklist provides general tips on what to look for when reviewing the Financial Report and also provides general tips regarding financial responsibility.

CHECKLIST FOR REVIEWING FINANCIAL INFORMATION

Financial Report:

- ✓ Review the Highlights of the Financial Statements for a summary of the overall financial picture.
- ✓ Check that the status of remittance payments is being reported.
  (Note: Remittance payments are those payments a company is required to make to government. This includes HST and payroll remittances (EI, CPP, Income Tax).
- ✓ Review spending in Reserve Funds on the Statement of Reserve Funds.

Financial Statements:

- ✓ Check HST Payable on the Statement of Financial Position (verify that number is changing quarterly).
- ✓ Review the Deferred Revenue balance. If it is going down each reporting period within the fiscal year, then it is being allocated to operations on a regular basis.
- ✓ Check that the College has the funds to cover its debts.
- ✓ Ask about any negative numbers.

General:

- ✓ Feel free to ask general question at the Board meeting e.g. verify no conflict of interests exists with auditor relationship or that of any other stakeholder.

Revised: June 2019, June 2022, June 2024

Reviewed: June 2023

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Policy Type:	Section 6: Finance
Policy Title:	**Financial Condition and Activities - *DRAFT***
Reference:	**6.2**
Date Prepared:	December 2009
Date Revised:	March 2010, June 2019, June 2022,
Date Reviewed:	June 2016, June 2023, June 2024, October 2025

Purpose

To establish the Board's responsibility for overseeing financial management that will ensure there are laid down financial procedures and rules to guide the Finance and Audit Committee and the Registrar & CEO in carrying out their financial responsibilities.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

The Finance and Audit Committee will ensure that the College's financial condition and activities remain aligned with approved expenditures and support the achievement of leadership outcomes.

Procedure

The Finance and Audit Committee will ensure the Registrar & CEO:

1. Spend only those funds that have been received to date, unless the debt guideline (below) is met or unless directed by the Board.

2. Indebt the College in any amount, only if approved by the Board.

4. Follow all financial policies.

5. Settle payroll and debts.

6. Ensure tax payments or other government-ordered payments or filings are filed on time and accurately.

Debt Guidelines – Board Tolerance

1. Balanced budget plus/minus 3%.

2. Comply with any covenants stipulated by the bank (if any).

3. Zero tolerance to external debt unless approved by the Board.

Policy Type: Section 6: Finance
Policy Title: **Asset Protection - *DRAFT***
Reference: **6.3**
Date Prepared: December 2009
Date Revised: March 2010, June 2019, June 2022, June 2024
Date Reviewed: June 2016, June 2023, October 2025

Purpose

The purpose of this policy is to ensure the assets of the College are effectively protected and adequately maintained.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

As part of its financial oversight responsibilities, the Board through the Finance and Audit Committee will ensure that all College assets are well protected, secure and adequately maintained.

Procedure

The Finance and Audit Committee will ensure the Registrar & CEO:

1. Insure against theft and casualty losses to at least 80% of replacement value and against liability losses to Board members, non-Board members of Board committees, staff, and the College itself.
2. Maintain an appropriate insurance policy and general liability insurance policy for the College.
3. Not unnecessarily expose the College, its Board, or staff to claims of liability.
4. Make purchases only when:
    a. appropriate safeguards are in place to prevent conflicts of interest.
    b. for services over $30,000 with a new supplier, comparative pricing and quality reviews have been obtained where prudent; and
    c. there is assurance of a balanced consideration between long-term quality and cost.
5. Protect intellectual property and information from inappropriate access, loss, or significant damage.
6. Receive, process, or disburse funds under controls which are sufficient, and meet the Board appointed auditor's standards.

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7. Act in the best interest of the College with respect to the College's investments.
8. Use funds of the College appropriately and ensure others do as well.
9. Not purchase, mortgage, or dispose of real property (i.e., land or buildings).
10. Obtain Executive Committee and Board approval before entering into a lease agreement for property (i.e., land or buildings).

COTO College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

Policy Type: Section 6: Finance
Policy Title: **Investments - *DRAFT***
Reference: **6.4**
Date Prepared: December 2009
Date Revised: March 2010, June 2019, June 2022,
Date Reviewed: June 2016, June 2023, October 2025

Purpose

The purpose of this policy is to ensure the College's investments are protected, adequately maintained, and not unnecessarily risked.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

To ensure sound financial stewardship, the Board through the Finance and Audit Committee will ensure that all College investments are protected, adequately maintained, and not unnecessarily risked.

Procedure

The Finance and Audit Committee will ensure the Registrar & CEO:

1. Invest in funds that allow for the preservation of capital, where "capital" is defined as the cost of the investment.
2. Maintain liquidity necessary to meet the day-to-day cash requirements for College operations and planned capital investments.
3. Invest or hold funds identified as surplus in:
    a. Investments having a term of not more than ten years
    b. Short-term investments
4. Present annually the investment outcomes to the Finance and Audit Committee.
5. Present annually the investment outcomes to the Board.
6. Invest in funds that are in Canadian dollars and issued by a Canadian institution.

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COTO College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

Policy Type: Section 6: Finance
Policy Title: **External Audit - *DRAFT***
Reference: **6.5**
Date Prepared: December 2009
Date Revised: March 2010, June 2019, June 2022,
Date Reviewed: June 2016, June 2023, June 2024, October 2025

Purpose

The purpose of this policy is to ensure that an external financial audit is undertaken yearly.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

To ensure accountability, transparency, and sound financial stewardship, the Board through the Finance and Audit Committee will ensure an external neutral third party annually perform a financial audit.

Procedure

The Finance and Audit Committee will ensure the Registrar & CEO:

1. Provide for an annual external audit of financial performance by auditors appointed by the Board.
2. Provide a review of the auditor appointment at least every five years unless directed by the Board.
3. Support and manage the audit process.
4. Allow for reasonable additional external audits if, or when, the Board requests it.

DRAFT

Policy Type:	Section 6: Finance
Policy Title:	**Honoraria Policy - *DRAFT***
Reference:	**6.6**
Date Prepared:	May 1994
Date Revised:	January 2016(per diems), March 2018, January 2019(preparation Time Rate), January 2020 (km travel rate), January 2021, January 2022, January 2023 (km travel rate), June 2023 (added 1 hr rate), January 2024 (km travel rate), January 2025 (max/day meal rate)
Date Reviewed:	January 1997, June 1999, October 2000, March 2002, June 2002, August 2004, October 2004, March 2008, June 2008, July 2010, June 2012, January 2013, January 2021, January 2024, June 2024. January 2025, October 2025

Purpose

The purpose of this policy is to provide guidelines on how an elected Board Director, Academic Appointee or Committee Appointee who prepares for and attends meetings or who incurs allowable expenses while conducting College business, will be paid an honorarium or reimbursed, respectively.

Application

The policy applies to

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** supports the Board by conducting detailed reviews of financial matters, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Definitions:

Honoraria: refers to token payments to elected Board Director, Academic Appointee or Committee Appointee who provide services to the College for which a traditional fee or payment is not typically charged or expected. These payments are expressions of appreciation and goodwill for voluntary services elected Board Director, Academic Appointee or Committee Appointee provide to the College.

Allowable Expenses: These include accommodations, meals, gratuities, travel, internet charges and dependent care.

Policy

An elected Board Director, Academic Appointee or Committee Appointee who prepares for and attends meetings respecting College business will be paid an honorarium.

An elected Board Director, Academic Appointee or Committee Appointee who incurs allowable expenses while conducting College business will be reimbursed. The Director or appointee is required to consider economy and necessity when incurring expenses.

Honorarium payments should always be gratuitous. The decision to provide an honorarium should have no influence on the decision of the individual to participate or volunteer their time. There is no legal obligation to make the payment, and the recipient has no legal right to the payment.

These payments are typically made to recognize or thank individuals for their contributions, particularly when traditional compensation is not expected or legally required. The policy aims to ensure fair and consistent practices while adhering to relevant regulations and ethical considerations.

Honoraria Claim Procedure

1. Board members or Committee Appointees shall submit their honoraria and reimbursement claims using the third-party online vendor platform, provided by the College.
2. Honoraria may be claimed for attendance, and preparation time. Preparation time will be paid when an elected Board Director, Academic Appointee or Committee Appointee are required to review materials that are distributed by the College in advance of the meeting.
3. Travel per diems shall only be claimed when travel meets the following two conditions:
    a. Travel must occur on the date prior to the scheduled meeting date.
    b. The distance travelled in one direction must be equal to or greater than 250 km one way.
4. The per diem amount of Chair or Vice-Chair is payable only when acting in the capacity of Chair or Vice-Chair of the Board, or as Chair of a statutory or standing committee, for the meeting of the specific committee or Board. All other participation will be remunerated at the standard rate.
5. If a full day meeting is cancelled by the College without 48 hours of notice, elected Board Directors, Academic Appointees or Committee Appointees will be entitled to be reimbursed at half of the applicable Attendance rate. Full-day meetings that are cancelled will be reimbursed at half of the full-day Attendance rate; and half-day meetings will be reimbursed at half of the half-day rate. Only elected Board Directors, Academic Appointees or Committee Appointees who are scheduled to attend and who request reimbursement shall receive it. elected Board Directors, Academic Appointees or Committee Appointees are permitted to submit a reimbursement claim for preparation time as per the limits set out in this policy for their meeting.
6. Onsite meetings or remote meetings that are scheduled for less than one hour will be paid a $60.00 per diem. Preparation time is included in the attendance rate for meetings of less than 1 hour. When the duration of a meeting is one hour or more, preparation time may be claimed in addition to the per diem.
7. Per diem rates and policy will be reviewed annually by the Finance and Audit Committee. All changes to the per diem rates will be approved by the Board before coming into effect the following fiscal year, to allow for appropriate budgeting.

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8. Elected Board Directors, Academic Appointees or Committee Appointees can claim both a preparation per diem and travel per diem on the same date.
9. All expense claims must be submitted prior to the end of the fiscal year applicable. elected Board Directors, Academic Appointees or Committee Appointees are encouraged to submit their expenses as soon as possible to assist the College with providing elected Board Directors, Academic Appointees or Committee Appointees with accurate tax records (e.g.: T4 and T4A).

Per Diems:

The College offers up to three types of per diems:

- Attendance,
- Preparation, and
- Travel.

Each per diem is governed by their unique conditions. Attendance and preparation per diems are payable per scheduled meeting with the exception of meetings less than one hour as noted in #6. Multiple distinct meetings are permitted per calendar day; however, only one travel per diem is payable per trip into Toronto. (See specific condition for each per diem below)

Attendance:

The attendance per diem is a fixed rate payable for scheduled onsite or remote work periods.

There are three fixed rates available:

- One-hour rate of $60.00: Equal to or less than one hour (1 hour).
- Half-day rate: Equal to or less than three hours and thirty minutes (3.5 hours) but more than one hour.
- Full-day rate: More than three hours and thirty minutes (3.5 hours) to a maximum per day of seven hours and thirty minutes (7.5 hours).

If a meeting is scheduled for one hour but goes over the scheduled length of time, the College will pay Board Directors or Committee Appointees the half-day rate.

If a meeting is scheduled for half a day but goes over the scheduled length of time, the College will pay Board Directors or Committee Appointees the full-day rate.

If a meeting is scheduled for a full day but less time is required to complete the work, the College will pay Board Directors or Committee Appointees the full day rate.

Travel:

When travel in excess of 250 km is required, Board Directors and Committee Appointees are advised to travel the day prior to the meeting and claim the travel per diem. Same day travel as the date of attendance will not be reimbursed regardless of distance travelled.

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Preparation Time:

All preparation time is based on a fixed hourly rate.

Board, Executive, Subcommittee and Working Group Meetings:

Board Directors and Committee Appointees can claim a maximum of two hours of preparation time for Board, Executive, Subcommittee and working group meetings.

When an exceptionally large volume of reading material is distributed, the meeting Chair will advise Board Directors or Committee Appointees if there is an increase to the maximum allowance for preparation time. This is left at the discretion of the Chair.

ICRC, Hearings, Registration, Quality Assurance, and decision writing:

Preparation time is not to exceed the maximum scheduled length of the meeting, unless approved by the Chair.

Rates:

Full-rate Attendance:

- Standard rate: Board and Committee Appointees $250.00
- Chairperson (Board or Chair of Statutory or Standing Committee) $325.00
- Vice-Chair $275.00

Half-rate Attendance:

- Standard rate: Board and Committee Appointees $125.00
- Chairperson (Board or Chair of Statutory or Standing Committee) $162.50
- Vice-Chair $137.50

Preparation time: $45 per hour.

Travel: $150 per reimbursement claim (distance traveled one way must be equal to or greater than 250 km).

Allowable Expenses Claim Procedure

1. The Board Director or Committee Appointee shall submit allowable expenses using the third-party online vendor platform, provided by the College. Receipts for expenses must be included, with the exception of mileage claims.
2. Forms will be reviewed by the Registrar, Program Director, or other appropriate College staff member on submission prior to approval. Incomplete forms will be returned to the claimant.
3. Forms will be paid according to the payroll schedule of the College on the 15th day of each month. The deadline to submit for payment is the 9th day of each month.

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Travel:

Rate: 0.70/km

1. Travel includes Economy airfare, bus, train (including VIA 1), local public transportation, taxi or private automobile.
2. In each case, only the cost of the most economical and/or practical mode of travel may be claimed. Wherever possible, members are encouraged to take advantage of advance bookings, "seat sale" fares, or other discounts offered.
3. Costs for parking will be reimbursed with a receipt.
4. Individuals will not be reimbursed for traffic and parking violations.

Accommodation:

1. Hotel arrangements can be made at College approved hotels to ensure that the College receives the benefit of the corporate rate. However, if a more economical alternative is found, that is acceptable also.
2. Except for Board and Executive Committee meetings, members are to make arrangements for their own accommodation as per policy provided.
3. Private accommodation may be used in lieu of the approved hotel where a member can stay with friends or relatives. A maximum of $40.00 per night may be claimed.
4. No reimbursement shall be made where the member resides within fifty (50) kilometers of the meeting venue unless the member is required to attend on two or more consecutive days. Only 1 night will be reimbursed between meeting days.
5. Charges of a personal nature made at a hotel, such as laundry, in-house movies, or personal phone calls will not be reimbursed.
6. Internet charges will be reimbursed in the event they are not included in the cost of the accommodation.

Meals:

Rate: The daily maximum rate is $100.00, which includes breakfast, lunch and dinner.

1. Meal claims are to be made based on actual expenses incurred.
2. Gratuities can be claimed where the total cost is within the daily maximum.

Internet Charges

Board Directors or Committee Appointees will be reimbursed for the cost of additional hotel internet charges related to College business. Receipts are required.

Dependent Care:

Rate: The maximum hourly rate for which Board Directors or Committee Appointees will be reimbursed is not more than minimum wage, for up to the maximum number of hours scheduled for the meeting plus one hour traveling time. Claims for dependent care expenses should not be submitted unless they are actually incurred.

1. Costs for dependent care will be reimbursed where they are incurred over and above the regularly scheduled provision of care.

Policy Type: Section 6: Finance
Policy Title: **Reserve Funds - *DRAFT***
Reference: **6.7**
Date Prepared: February 1997
Date Revised: October 2017, June 2019, March 2020, June 2022, June 2024
Date Reviewed: October 2000, March 2007, October 2010, June 2012, January 2013, January 2016, January 2019, June 2023, October 2025

Purpose

The purpose of this policy is to outline how the College sets aside and manages funds for future needs or unexpected expenses while providing guidelines to the Board on maintaining specific reserve funds.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** supports the Board by conducting detailed reviews of financial matters, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

Reserve funds are important in maintaining financial stability and helping the College to manage risks, address future needs, and ensure long-term sustainability of College mandate.

Procedure

To cover these variable and/or unforeseen costs and expenses, the College shall establish and maintain specific reserve funds.

1. Reserve Funds will be established for:

    a. Hearings and Independent Medical Exam Reserve Fund
    The Hearings and Independent Medical Exam Reserve Fund is designated to cover costs, including legal costs, for conducting discipline hearings, fitness to practice hearings, the Health Professions Appeal and Review Board registration appeal hearings, other hearings that may arise related to regulating the profession, and independent medical exams. The amount to be maintained in this fund is $400,000 or such other amount as may be determined by the Board.

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b. Sexual Abuse Therapy and Counselling Reserve Fund

   The Sexual Abuse Therapy and Counselling Reserve Fund is designated to cover costs for funding for therapy and counselling. The amount to be maintained in this fund is $25,000 or such other amount as may be determined by the Board.

c. The Premises Fund

   The Premises Fund is designated to minimize the impact on the operating budget for major expenses related to College property. It would cover such costs as lease hold improvements, and furniture. The minimum amount of $500,000 or such other amount as may be determined by the Board.

d. Technology Fund

   The Technology Fund is designated to provide for the cost of any technological improvements that will support the delivery of the statutory College mandate in an efficient and effective manner. The minimum amount to be maintained in this fund is $100,000 and maximum amount to be maintained in this fund is $500,000 or such other amount as may be determined by the Board.

2. Appropriations from the annual operating surplus to the approved levels of reserve funds shall be authorized by the Registrar and CEO.

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Policy Type:	Section 6: Finance
Policy Title:	**Insurance - *DRAFT***
Reference:	**6.9**
Date Prepared:	September 2025
Date Revised:	
Date Reviewed:	October 2025

Purpose

The purpose of this policy is to ensure that the College of Occupational Therapists of Ontario maintains adequate and appropriate insurance coverage to protect the organization, its Board, and staff from financial loss and liability.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

The College shall maintain insurance coverage that is prudent and sufficient to manage its risks in alignment with best practices for health regulatory bodies. This includes but is not limited to general liability, directors and officers' liability, cyber liability and property.

Procedure:

The College shall maintain the following types of insurance coverage, at minimum:

- Liability (including Cyber) and Crime Insurance
- Property Insurance
- Travel and Occupational Accident Insurance

The Finance and Audit Committee shall review this policy and the College's insurance coverage annually and make recommendations to the Board.

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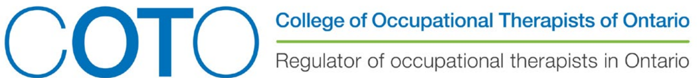

Policy Type:	Section 6: Finance
Policy Title:	**Signing Authority *DRAFT***
Reference:	**6.10**
Date Prepared:	September 2025
Date Revised:	
Date Reviewed:	October 2025

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Purpose

Accountability, transparency, and sound financial stewardship are foundational principles of the College. In carrying out its public protection mandate, the College engages in a variety of financial activities including entering contracts, purchasing services, approving payments, and managing investments.

To ensure responsible management of funds, this policy outlines the delegation of signing authority, approval thresholds, and related procedures. Designated individuals are entrusted with the authority to approve commitments on behalf of the College and are accountable for doing so in accordance with applicable policies, by-laws, and the Board-approved budget.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** which supports the Board by conducting detailed financial reviews, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

The purpose of this policy is to:

- Identify the individuals authorized to sign legally binding agreements, contracts, and financial transactions on behalf of the College.
- Establish consistent financial authorization thresholds.
- Ensure that the College's financial practices are aligned with its governance framework and fiscal responsibilities.
- Promote transparency and accountability in the use of College funds.

Definitions

Board approved budget commitments: Contracts included during the annual budgeting process and that have been approved at the Board meeting.

Contract: Any written document, or instrument, with a third party that legally binds the College to make a payment or to purchase goods or services. (Oral contracts are strictly prohibited). This includes, but is not limited to, any agreement, purchase order, contract, subcontract, letter of intent, memorandum of understanding, memorandum of agreement, lease, deed, transfer, instrument, assignment, obligation, certificate or other document, the provision of which may be binding upon the College.

Invoice: A list of goods or services provided by a vendor for products purchased or services

rendered with corresponding payment obligations outlined Invoices must be addressed to the College and include the name of the seller, description and price of goods or services, and the terms of payments.

Non-Board approved budget commitments: Contracts that were not included as part of the budgeting and planning process for the fiscal year operating budget. These items have not been approved by Board and are over the threshold as outlined in this policy.

Payments: The paying of an invoice from a vendor, which can take the form of a cheque or direct payment via the bank.

Signing Authority: The individual(s) authorized to sign contracts that commit the College to a legal relationship and contractual obligations. Also refers to the individual(s) allowed to approve invoices, cheques, and release bank funds for payment.

Vendor: Refers to suppliers, service providers, consultants, and third parties.

Procedure

1. Delegation of Authority

Signing authority may be exercised only by individuals designated under this policy. Authority is limited by role, value threshold, and nature of the transaction. Certain transactions may require dual signatures to ensure appropriate oversight and control.

2. Contracts and Agreements

All contracts must comply with the Board-approved budget unless otherwise authorized. Multi-year agreements and those involving high-value or strategic importance require Board-level approval. Contracts affecting staff employment and benefits are strictly excluded under this policy. Thresholds are outlined in Appendix A – Contracts.

3. Payments and Invoices

Payments must follow appropriate approval processes and be aligned with the approved budget. Thresholds and required signatories are listed in Appendix B – Payment and Invoice Approval.

4. Banking and Financial Transactions

All College payments must be made by cheque or through approved electronic banking platforms. Online payments require pre-authorization and dual approval by designated signing officers, in accordance with platform controls.

5. Limitations

- The Registrar may not authorize any payment where:
  - Expenditures are split to circumvent thresholds.
  - Due diligence has not been exercised regarding conflicts of interest.

Operational Procedures

1. Initiation and Review

- College staff initiate contracts or invoices and verify budget availability.
- The designated authority reviews and confirms compliance with this policy before signing.

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2. Approval and Signing

- Individuals must sign in accordance with their delegated authority, as detailed in the appendices.
- Where two signatures are required, both signatories must independently verify compliance.

3. Documentation

- All executed documents must be stored in the College's designated records system with appropriate supporting documentation.

4. Monitoring

- The Finance and Audit Committee oversees compliance with this policy and will review it at least once every three years.

Appendix A – Contracts

Contracts/Agreements	Threshold (Per contract before taxes)	Required Signature	
		One of Signature 1	**One of Signature 2**
Board approved budget commitments	Less than $50,000	Registrar and CEO Director, Regulatory Affairs Director of Finance, People and Corporate Services Program Director Director, Communications	
	$50,000 and greater	Registrar and CEO	Director, Regulatory Affairs Director of Finance, People and Corporate Services Program Director Director, Communications
Non-Board-approved budget commitments	Less than $50,000	Registrar and CEO	Director, Regulatory Affairs Director of Finance, People and Corporate Services Program Director Director, Communications
	$50,000 and greater	Registrar and CEO	Finance and Audit Committee (including notification to Board)
Agreements for five years and longer	Any value	Board	

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Appendix B – Payment and Invoice Approval

Payment Processes	Threshold (Single transaction before taxes)	Required Signature	
		Signature 1	One of Signature 2
Online Direct Deposits	Less than $15,000	Director of Finance, People and Corporate Services	Registrar and CEO
	$15,000 and greater	Registrar and CEO and Director of Finance, People and Corporate Services	Chair of the Board Vice-Chair of the Board Chair, Finance and Audit Committee Member at Large, Executive Committee
Cheques	Less than $5,000	Registrar and CEO or Director of Finance, People and Corporate Services	
	$5,000 to $14,999	Director of Finance, People and Corporate Services	Registrar and CEO
	$15,000 and greater	Registrar and CEO or Director of Finance, People and Corporate Services	Chair of the Board Vice-Chair of the Board Chair, Finance and Audit Committee Member at Large, Executive Committee

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<table>
<tr><th rowspan="2">Payment Processes</th><th rowspan="2">Threshold (Single transaction before taxes)</th><th colspan="2">Required Signature</th></tr>
<tr><th>Signature 1</th><th>One of Signature 2</th></tr>
<tr><td rowspan="3">Invoices (per invoice)</td><td>Less than $5,000</td><td>Manager</td><td></td></tr>
<tr><td>$5,001 to $29,999</td><td>Manager</td><td>Registrar and CEO

Director, Regulatory Affairs

Director of Finance, People and Corporate Services

Program Director

Director, Communications</td></tr>
<tr><td>$30,000 and greater</td><td>Registrar and CEO

Director, Regulatory Affairs

Program Director

Director, Communications</td><td>Director of Finance, People and Corporate Services</td></tr>
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DRAFT

Policy Type:	Section 7: Oversight and Risk Management - *DRAFT*
Policy Title:	Overseeing Financial Risks
Reference:	**7.2**
Date Prepared:	September 2025
Date Revised:	
Date Reviewed:	October 2025

Purpose

To establish the Board's responsibility for overseeing financial risk and ensure that adequate resources are available to support the College's mandate and strategic directions. This policy outlines how financial risk is identified, managed, and mitigated through effective governance, oversight, and accountability mechanisms.

Application

The policy applies to:

- All **Board Directors** who are ultimately responsible for financial oversight and risk management.
- The **Finance and Audit Committee** supports the Board by conducting detailed reviews of financial matters, providing recommendations, and overseeing specific financial policies.
- The **Registrar & CEO** who is accountable for implementing financial decisions, maintaining effective financial controls, and reporting to the Board.

Policy

The Board oversees the financial management with a view to identify and mitigate risk in key areas related to financial planning, its investment policy, registrant fee structure and an auditing process that includes its appointment of external auditors.

The Board ensures that a financial planning process is part of the overall strategic planning process of the College and considers the financial implications of any new policy, action or direction prior to approving it for implementation.

Definitions:

Financial Risk: Any risk that may impact the financial health, sustainability, or compliance of the College, including but not limited to:

- Budgetary risk (e.g., overspending or revenue shortfalls)
- Investment risk (e.g., market volatility)
- Liquidity risk (e.g., inability to meet obligations)
- Compliance risk (e.g., failure to follow accounting or regulatory standards)
- Fraud or misuse of funds

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Procedure

Role of the Board:

The Board is ultimately responsible for the oversight of financial risk, ensuring that appropriate strategies, policies, and processes are in place to support prudent financial stewardship. Specifically, the Board will:

- Oversee the development and approval of the annual operating and capital budgets.
- Approve and regularly review the College's investment policy and surplus fund strategy.
- Appoint external auditors and receive annual audited financial statements and reports.
- Ensure that financial planning is integrated into the strategic planning process.
- Consider the financial implications of new policies, initiatives, or strategic directions before approving them.
- Oversee the adequacy of insurance coverage aligned with identified and assumed risks.
- Promote transparency and engage with system partners when financial decisions may impact them.
- Following Board approval of the audited financial statements, the Chair of the Finance and Audit Committee and the Board Chair shall sign them.

Role of the Finance and Audit Committee:

The Finance and Audit Committee acts on behalf of the Board to:

- Review and recommendation for Board approval:
    - Annual operating and capital budgets.
    - Investment goals, strategy, and performance.
    - Fee structure and changes.
    - Auditor's reports and recommendations.
- Develop financial policies.
- Following Board approval of the audited financial statements, the Chair of the Finance and Audit Committee and the Board Chair shall sign them.
- Meet with external auditors before and after the annual audit.

Role of the Registrar & CEO and Management:

Under the direction of the Board, the Registrar & CEO and Management are responsible for:

- Providing effective financial administration and internal controls.
- Ensuring timely, accurate, and complete financial reporting to the Board and the Finance and Audit Committee.
- Collaborating with the Finance and Audit Committee to support implementation of Board-approved financial policies.
- Establishing and maintaining internal financial policies in accordance with sound accounting principles.

DRAFT

- Maintaining a financial risk register or equivalent documentation to support ongoing monitoring and mitigation.

Procedures for Financial Risk Oversight:

The Board fulfills its financial oversight responsibilities through the following actions:

- Approves the annual operating and capital budgets for each fiscal year.
- Appoints external financial auditors and receives their reports annually.
- Approves the College's investment policy and periodically reviews it for relevance and effectiveness.
- Ensures appropriate insurance is maintained based on the College's risk profile.
- Receives regular financial reporting (e.g., quarterly or as required) to monitor actual performance against the budget and flag emerging risks.
- Reviews recommendations from the Finance and Audit Committee and makes final decisions on material financial matters.

Monitoring and Review:

This policy shall be reviewed at least every three years, or earlier if required due to legislative, regulatory, or operational changes. The Finance and Audit Committee is responsible for initiating the review and recommending updates to the Board.

DRAFT

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Executive Committee

Subject: Coroner's Request: Medical Assistance in Dying, MAiD

Recommendation:

THAT *the Board review the report and recommendations from the MAiD Death Review Committee (MDRC) 2024-3 and approve the updated practice guidance on Medical Assistance in Dying resource for publication.*

Issue:

The College received a letter from the Ontario Chief Coroner's Office requesting a College response to the newly established MDRC's report outlining the following recommendation #7:

7. To the College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario

The College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario to consider employing this MDRC review to inform practice guidelines for clinicians providing care in the MAiD process, particularly related to navigating complex social needs in the Track 2 process.

Link to Strategic Plan:

- Meaningful Engagement - The College builds trust in its role and value through purposeful and meaningful engagement and collaboration:
    - Provides clear information about what to expect when working with occupational therapists.
    - Engages registrants to build understanding of professional obligations, College programs and services.
- Quality Practice - The College embraces leading regulatory practices to protect the public:
    - Engages occupational therapists to advance quality practice and the delivery of safe, effective occupational therapy services.

Why this is in the Public Interest:

The College, in carrying out its role, protects the public through effective regulation. The College can contribute to public safety by alerting, issuing and developing guidance for occupational therapists working in settings where occupational therapy services may be requested as part of the MAiD process. Ensuring information and guidance is available to all occupational therapists, clients and the public, supports the safe, ethical, and competent practice of occupational therapists in Ontario.

Diversity, Equity, and Inclusion Considerations:

To advance quality and ethical practice, developing resource documents ensures public confidence in occupational therapy regulation. During this development process, careful consideration was given to diversity, equity, and inclusion (DEI) principles that align with the Competencies of Occupational Therapy Practice in Canada (2021) and Standards of Practice.

Background:

The Office of the Chief Coroner established the MAiD (Medical Assistance in Dying) Death Review Committee to review concerns resulting from MAiD in the province. The Committee identified several issues related to system inequities, coercion, and lack of access to alternate care options for vulnerable clients, especially those with complex conditions, with non-reasonably foreseeable natural deaths, referred to as Track 2.

COTO issued guidance on MAiD in 2016. In 2021, COTO guidance was updated to reflect the legislative amendments to expand MAiD to include people suffering solely from a mental health disorder - implementation has been delayed until 2027. Since 2016, the practice resource service has received fewer than ten questions about MAiD. During the September 12th, 2025, meeting the practice subcommittee approved the updated MAiD practice guidance document. Below is a brief summary of the document review:

Document Review Timeline:

Date	Individual(s)/Committee(s)	Action
Feb 2025	Late Oct 2024 received letter and from MDRC 2024-3 report from the Coroner. Agenda item added to Practice Subcommittee meeting. Subject matter expert attended PSC meeting and discussed the OT role in MAiD and also provided insights on the role of the MAiD Death Review Committee. A draft practice	Following subject matter discussion subcommittee noted that the initial resource was too simplified, the section on conscientious objection needed to be fleshed out in the resource, and the proposed decision-tree did not align with the sensitivity of the subject matter.

Date	Individual(s)/Committee(s)	Action
	resource was presented and reviewed by Subcommittee.	
May 2025	Staff spoke with Executive Lead of the MDRC from the Coroner's office	Staff communicated with the Executive Lead with the Chief Coroner's office, based on that discussion, the appropriate course of action is to update the 2021 published practice guidance. The Executive Lead was satisfied with the proposed plan and timelines to ensure the recommendation put forth by the MAiD Death Review Committee is addressed.
May 2025	Subcommittee reviewed the updated draft MAiD practice guidance (2025)	Subcommittee provided minor feedback on terminology and reorganization of content
June 2025	Staff attended meeting with the Chief Coroner's Office about the MDRC recommendations on MAiD.	OCC office intends to make changes to clarify recommendations. Executive and Board were notified that the MAiD response to the Coroner will be reviewed at the October Board meeting.
Jul 2025	MAiD practice guidance editorial review	Completed
Sept 2025	Practice Subcommittee Decision	Committee consensus obtained to forward the updated draft MAiD guidance to Executive and then to the Board for review and approval

Discussion:

The Board is asked to review and approve the updated draft practice guidance on MAiD (2025) for publication.

Implications:

This updated practice guidance will address the recommendation from the MDRC 2024-3 report to the College of Occupational Therapists of Ontario. The updated document addresses the role of occupational therapists in MAiD. Unlike other coroner's recommendation this document is not intended to prevent deaths, but rather to ensure that the MAiD processes are carried out in compliance with legal and ethical protocols. This guidance document may need to be updated to align with future MDRC reports or pending legislation changes. Once approval is received

from the Board, a final copy will be sent to the Executive Lead at the OCC office to address the MDRC 2024-3 report recommendation. As part of our communication plan, the updated guidance will be published and made available to all registrants along with education to support awareness and proper implementation.

Attachments:

1. MAiD Death Review Committee (MDRC) 2024-3
2. Open link to access the Current MAiD guidance (2021) https://www.coto.org/resources/medical-assistance-in-dying/
3. Draft revised MAiD practice guidance document (2025)

2024

MAiD Death Review Committee Report 2024 - 3

Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths

Ministry of the Solicitor General | Office of the Chief Coroner

BACKGROUND

Under the *Coroners Act*, physicians and nurse practitioners who provide Medical Assistance in Dying (MAiD) are required to notify the Office of the Chief Coroner (OCC) of the death and provide relevant information to support MAiD death review, oversight, and Health Canada mandatory reporting requirements. Ontario has an established team of highly skilled nurse coroner investigators (MAiD Review Team) who retrospectively review every reported MAiD death in Ontario. A structured feedback approach for practitioners is followed to respond to concerns with statutory requirements, regulatory policies, and/or professional practice when identified during the review process. Further investigation is undertaken as required in accordance with the *Coroners Act* and with the Chief Coroner.

Reflecting the more mature state of MAiD practice, in January of 2023, the OCC modernized its approach to MAiD death review and oversight. Through the modernization process, the OCC review and oversight approach has continued to evolve to include, when indicated, enhanced expert review to respond to increasing social and systemic complexities within the contexts and circumstances surrounding MAiD practice, care, and legislation. Ontario is the first province in Canada to develop a multi-disciplinary expert death review committee to provide enhanced evaluation of MAiD deaths and to explore end-of-life complexities that have systemic and practice implications. Ontario continues to be a leader in high-quality and innovative MAiD death oversight and review.

The MAiD Death Review Committee (MDRC) was established in January of 2024. The committee is comprised of 16 members from across multiple disciplines (law, ethics, medicine, social work, nursing, mental health and disability experts, and a member of the public) who bring a diverse background of expertise in providing advisory support to MAiD oversight in Ontario.

The MDRC seeks to provide recommendations and guidance that may inform the practice of MAiD through the evaluation and discussion of topics, themes, and trends identified by the MAiD Review Team (MRT).

Committee Aim

The MDRC provides multidisciplinary expert review of MAiD deaths in Ontario with legislative, practice, health, social, and/or intersectional complexities identified through the oversight and review process. MDRC members review and evaluate the contextual circumstances that impact MAiD and inform the ecology of care for persons, families, and communities. MDRC members review relevant MAiD trends, topics, or issues and offer insights, perspectives, or interpretations and assist in formulating recommendations to inform system improvements (e.g., education of MAiD

practitioners, review of regulatory body policies) with a goal to support quality practice and the safety of patients and MAiD practitioners.

Acknowledging there is public discourse regarding MAiD, the MDRC is committed to increasing public transparency of the MAiD oversight and review process through the dissemination of reports.

Acknowledgement of Persons, Families, and Communities

The MDRC acknowledges the deaths of persons who have experienced profound suffering at end-of-life. We acknowledge the losses to partners, families, close relations, and communities.

During the death review process the OCC protects the personal biographies of the persons who have accessed MAiD. In this report, while some personal information was included for a small number of MAiD deaths, efforts were taken to maintain privacy for persons and their families by sharing only the necessary details and circumstances of their death to support understanding of the issues explored. When we identified that a person’s particular circumstance may be identifiable to a person’s close relations, we have made efforts to inform their next of kin. We are respectful to the persons whose aspects of their lives are shared in the information presented.

In alignment with the OCC’s motto to “speak for the dead to protect the living”, the MDRC approaches this important work to learn from each MAiD death. By examining these deaths and presenting this information, we aim to support continued improvement for how MAiD is provided in the province of Ontario.

Acknowledgement of MAiD Practitioners

We extend recognition to clinicians who provide dignified care to persons who have requested MAiD. We respect the clinicians who commit to on-going learning and integrate evolving MAiD practice improvements into their approaches to care. We also acknowledge that clinicians are navigating care for persons accessing MAiD within the limitations of our health and social systems. We further recognize that the OCC MAiD oversight process is an additional step in the provision of MAiD; we are appreciative of the important role of clinicians in the Ontario MAiD oversight process.

Approach to MDRC Review

Through the OCC MAiD death review process, we have observed that only a small number of MAiD deaths in Ontario have identified concerns. MAiD deaths illustrative of specific circumstances, identified during review by the MRT, are provided to the Committee. The Committee review approach is to gain understanding of the circumstances of the deaths and any issues arising, with the goal to inform

improvements to MAiD care. While the circumstances of the deaths reviewed are not representative of most MAiD deaths, the themes identified during the review are not uncommon within the MAiD review process and likely have implications for emerging MAiD practice. The deaths selected are chosen for the ability to generate discussion, thought, and considerations for practice improvement. Reporting of the review discussions is largely focused on identifying areas where there may be opportunities to prompt such improvements.

These deaths are intended to initiate discussions around areas of MAiD practice and encourage practitioners, policymakers, and other stakeholders to explore the issues presented that are relevant to their scope of decision-making. We have selected topics and deaths that depict circumstances that often represent divergence from typical practice and thereby allow new and possibly emerging practice concepts to be evaluated.

Practice considerations and recommendations may have varying levels of transferability to broader MAiD practice and policy. Some practice considerations raised by the Committee should be considered by care teams integral to the delivery of healthcare, more generally (e.g., primary care, mental health services, specialty care teams). Moreover, all persons experiencing profound suffering would likely benefit from improved access to comprehensive care which may require investments in health and social systems to meet the rising expectations of MAiD practices.

Approach to MDRC Report

The Committee reports include, where possible and appropriate, a diversity of thought and perspectives from committee members. Statements do not reflect the views of individual members. We did not aim to establish consensus – we recognize that MAiD practice in Ontario is evolving and may benefit from this varied discourse. Committee member opinion, in favor of or in opposition to, a particular recommendation, discussion point or idea, were not collated or counted and we have employed qualifiers such as “few, some, many, and most” to acknowledge the extent of support by committee members. We do not intend for these qualifiers to reflect the validity of some of these statements – some members of the Committee offer more unique expertise and may prompt the reader to consider differing perspectives. Moreover, a variety of statements included in this report may have varying significance for different stakeholders.

Recommendations provided in the report have been informed by and developed from the Committee’s written and verbal discussions. Recommendations are addressed to the organizations that are believed to be positioned to effect change and support MAiD practice and policy. The recommendations are specifically provided and disseminated by the OCC accompanied by a request for a response from the recipient.

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INTRODUCTION

The enactment of Bill C-7 in March of 2021 repealed the legislative requirement for a person's natural death to be reasonably foreseeable and created two sets of safeguards (track one [Track 1] – for persons with reasonably foreseeable natural deaths [RFND] and track two [Track 2] – for persons with non-reasonably foreseeable natural deaths [NRFND]). The Parliament of Canada indicated that amendments to MAiD eligibility criteria and safeguards must balance respect for individual autonomy with the protection of vulnerable persons. The MDRC reviewed three purposively selected MAiD deaths where the persons accessing MAiD belonged to groups who potentially experienced marginalization and structural inequities. This review was intended to examine these issues within illustrative cases posing specific circumstances of vulnerability. While these deaths are not representative of frequent reasons for accessing MAiD, nor are the circumstances representative of most MAiD Track 2 deaths, the themes identified during this review are not uncommon within the MAiD review process. Moreover, MDRC members reviewed only a small sample of MAiD Track 2 deaths, representing a notable limitation of this review. This review has been released concurrently with "MDRC Report 2024-2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths".

The Office of the Chief Coroner (OCC) acknowledges that many persons in civil society object to being labelled as "vulnerable". It has been recognized that this term has been misused to shift the focus of unmet social needs from societal and policy shortcomings to the individual level. In this review, the MDRC employs the term 'vulnerable' in the context of the protection of marginalized persons who are at greater risk of experiencing systemic, structural or intersectional inequities. This approach reflects the language employed in the preamble of Bill C-7[i].

In this review, MDRC members discussed opportunities where changes to MAiD practice, in alignment with legislative criteria and safeguards, could be considered to improve protection for those experiencing social disenfranchisement. Aligned with legislative responsibilities and practice standards[ii], MAiD practitioners are required to evaluate MAiD requests for possible intersectional or structural inducement towards an assisted death. The aim of this MDRC review was to evaluate selected examples of MAiD deaths where social and structural vulnerability were necessary considerations within the assessment of voluntariness. The MDRC aims to continue discussions to inform improvements in MAiD practice and safety through learnings arising from these case reviews.

Aligned with human rights experts[iii], MDRC members who advocate for vulnerable persons presented that a goal of this review should be the consideration of equitable access to health and social care systems. They emphasize that persons who access MAiD with a NRFND should have comprehensive care options to mitigate suffering,

including appropriate medical care, counselling, disability and mental health supports, and community-enriching activities. MDRC member advocates positioned that MAiD should not be the solution for societal and policy failures. Some other members stated that societal and policy deficiencies should not disenfranchise persons from accessing MAiD provided that reasonable attempts were made to access services.

Accessing MAiD with Self-Identified Disability

Persons with self-identified disabilities were included as a vulnerable group within this review. In January 2023, Health Canada expanded its data collection to include self-disclosed sociodemographic characteristics for the identification of persons with disability. Health Canada's definition of disability was adapted from the Canadian Survey on Disability[iv], a national survey administered by Statistics Canada. Health Canada defined disability "as a functional limitation in any one of the following ten areas, which cannot be corrected with the use of aids: seeing, hearing, mobility, flexibility, dexterity, pain-related, learning, developmental, mental health related or memory". A disability may be a pre-existing condition or acquired because of the requestor's current illness or disease or its associated complications.

Health Canada has indicated that the quality and reliability of self-identified disability data is limited due to variations in data collection approaches across jurisdictions, inconsistency in interpretation of the term "disability", and reluctance from individuals to self-identify, due to concerns about how this could impact their request.

MDRC members with expertise arising from a lived experience position that appropriate self-identification of disability is necessary to prompt MAiD practitioners to explore a person's intersectional membership within a particular social and cultural disability community. Self-identification of disability (i.e., as per Ontario Human Rights Code[v]), via a definition that reflects intersectional and social lived experiences, should cue MAiD practitioners to consider the intersection of disability with other marginalized identities and systemic factors that may shape a person's request for MAiD and their experiences within health and social systems. Moreover, a social and intersectional definition of disability better positions MAiD assessment and care within inclusive clinical care practices, exploring care options to alleviate suffering outside of the traditional medical model (e.g., humility-oriented anti-ableist care options[1][vi]).

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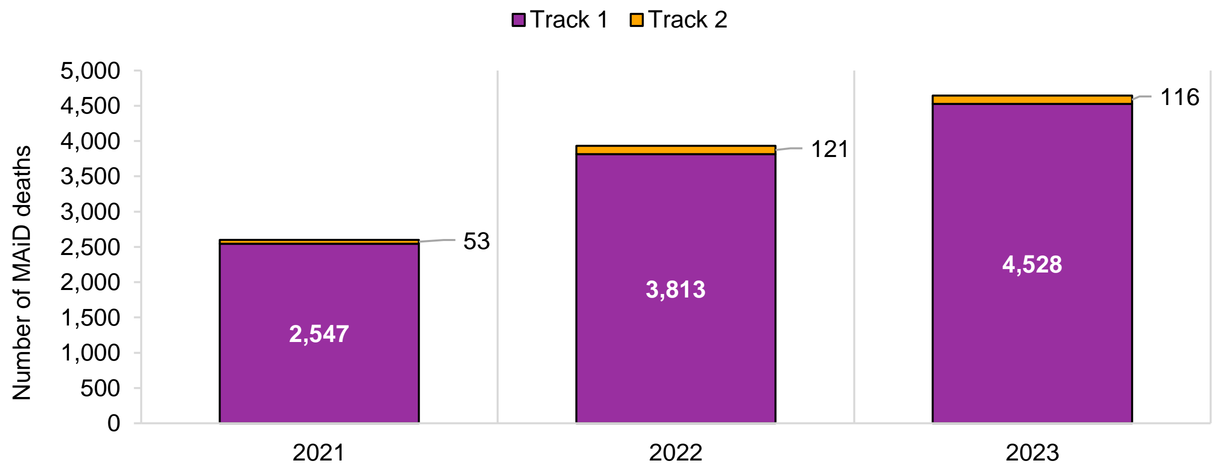
[1] A humility-oriented, anti-ableist care approach acknowledges how historical structures have limited care options and undermined the dignity of persons with disabilities. In healthcare, a holistic approach recognizes the limitations of traditional medical perspectives, especially those rooted in ableism. This care model prioritizes respect for the lived experiences of the disability community and its experts, affirming that disability is not synonymous with suffering. Additionally, this approach requires healthcare providers to acknowledge that they may not have all the necessary knowledge or tools to alleviate suffering. As such, they must consult with and collaborate with individuals who have direct experience with disability, as well as specialists in evidence-based chronic care.

This review provides an opportunity for MAiD practitioners to develop an enhanced awareness of social vulnerabilities in the context of MAiD. Further considerations provided in this report will support MAiD practitioners to avoid exclusively applying a medical model analysis to their assessments and instead, consider a social and intersectional model of disability when evaluating requests for MAiD with the involvement of those with applicable expertise, while aiming to avoid ableist interpretations of MAiD eligibility and safeguards.

TOPIC OVERVIEW

Since 2021, when Bill C-7 was legislated, 2.6% of all MAiD provisions have been completed following Track 2 safeguards, for persons with NRFNDs. In 2023, there were a total of 4,644 MAiD provisions, 116 deaths were Track 2 (Figure 1).

Figure 1. Annual Number of MAiD Deaths in Ontario by Track, 2021 - 2023



In this report, a focused presentation of sociodemographic characteristics for Track 2 MAiD deaths is presented. The characteristics are variables that could be contributing to a potentially higher degree of vulnerability at an individual level. Using data drawn from the MAiD Death Report we have presented characteristics, such as age and sex, geography, housing, and social network, that may offer considerations for the level of marginalization experienced by some groups of Track 2 recipients. A review of health and disability characteristics is discussed in "MDRC Report 2024 – 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths". The reader should recognize that these analyses were completed with relatively small numbers of Track 2 MAiD deaths in contrast to Track 1 deaths. In addition, recognition that Track 1 and 2 MAiD recipients appear to be distinct populations with different illness journeys that may impact potential comparisons.

Age and Sex Distributions

Persons who access MAiD with a RFND and NRFND differ by age and sex assigned at birth (Tables 1, 2). Track 2 recipients were more commonly female (61%).

Persons under the age of 60 years represent a higher proportion of Track 2 MAiD deaths. Nearly 17% of Track 2 MAiD deaths were female recipients aged 18 to 59 years, while 7.5% were Track 1 MAiD deaths in this age range. The same finding was observed for males, with 18% of Track 2 recipients among those in the younger age group, compared to seven percent of Track 1 recipients.

Table 1. Number and Percent of Track I MAiD Deaths in Ontario by Age and Sex, 2023[2]

Sex Assigned at Birth	Age Group	Number of Track 1 MAiD Deaths	Percent (%) of Deaths within Sex	Percent (%) of all Deaths
Female	18-59	168	7.5	3.7
	60-69	358	16.0	7.9
	70-79	608	27.2	13.4
	80-89	631	28.3	13.9
	90+	468	21.0	10.3
	ALL AGES	**2,233**	**100.0**	**49.3**
Male	18-59	156	6.8	3.4
	60-69	443	19.3	9.8
	70-79	706	30.8	15.6
	80-89	711	31.0	15.7
	90+	278	12.1	6.1
	ALL AGES	**2,294**	**100.0**	**50.7**

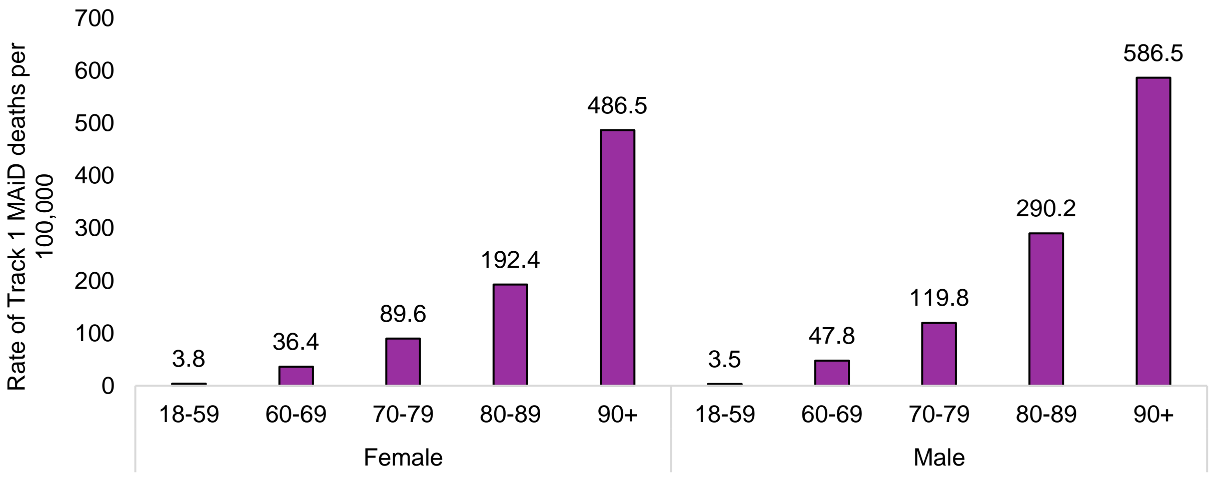
[2] Excludes deaths where information was not completed.

Table 2. Number and Percent of Track 2 MAiD Deaths in Ontario by Age and Sex, 2023[1]

Sex Assigned at Birth	Age Group	Number of Track 2 MAiD Deaths	Percent (%) of Deaths within Sex	Percent (%) of all Deaths
Female	18-59	12	16.9	10.3
	60-69	10	14.1	8.6
	70-79	20	28.2	17.2
	80-89	18	25.4	15.5
	90+	11	15.5	9.5
	ALL AGES	**71**	**100.0**	**61.2**
Male	18-59	8	17.8	6.9
	60-69	10	22.2	8.6
	70-79	15	33.3	12.9
	80-89	8	17.8	6.9
	90+	4	8.9	3.4
	ALL AGES	**45**	**100.0**	**38.8**

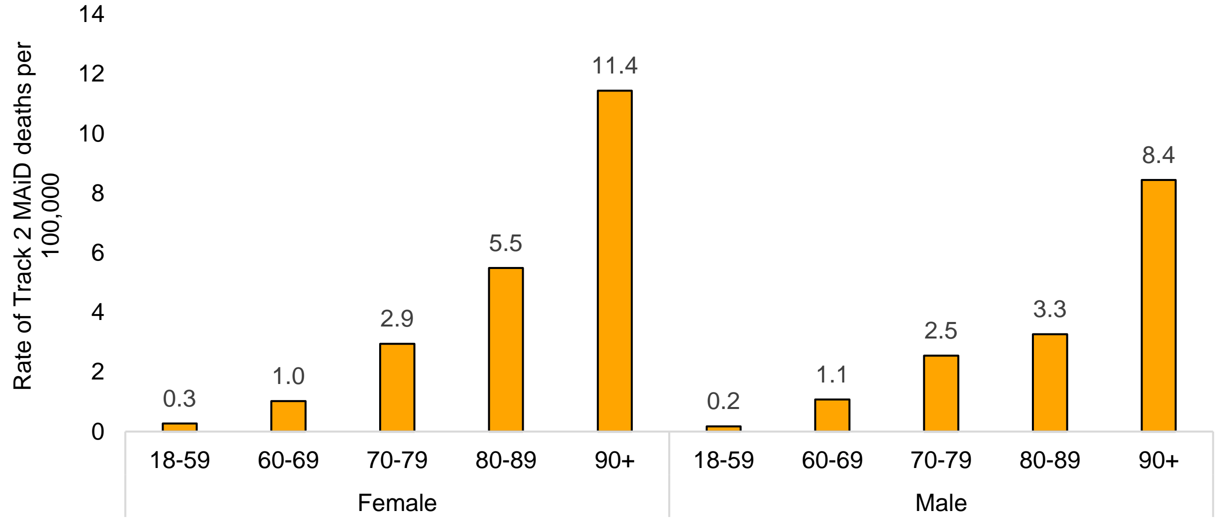
To support comparison across different population sizes, rates of MAiD provisions per 100,000 persons aged 18 years and older were calculated. Overall, the rate of MAiD recipients increased substantially with age (Figures 2,3). Among Track 1 recipients, higher rates were seen among males for nearly all age groups when compared to females. The highest rate was seen in males aged 90 years and older, with 587 deaths per 100,000 males in 2023 (Figure 2).

Figure 2. Rate per 100,000 of Track 1 MAiD Deaths in Ontario by Age and Sex, 2023



In contrast, rates of Track 2 provisions were higher among females for most age groups. The highest rate was for females aged 90 years and older, with 11 deaths per 100,000 females (Figure 3).

Figure 3. Rate per 100,000 of Track 2 MAiD Deaths in Ontario by Age and Sex, 2023



Geographic Distribution

The geographic distributions of Track 1 and Track 2 MAiD deaths illustrate that the public health units (PHU) in Ontario with higher rates of Track I deaths – Grey Bruce, Haliburton, Kawartha Pine Ridge, Huron Perth, Leeds, Grenville and Lanark, North Bay Parry Sound, Southwestern, and Timiskaming PHUs – are not consistent with the locations that show higher levels of Track 2 deaths (Haliburton Kawartha Pine Ridge, Huron Perth, Simcoe Muskoka, Sudbury and District, and Thunder Bay PHUs). Lower rates for both Track 1 and Track 2 were seen in the Greater Toronto Area (Figures 4,5). Geographic variations may be due to a number of factors and merits further investigation.

Figure 4. Rate of Track 1 MAiD Deaths per 100,000 Population (aged 18+) by Public Health Unit, 2023

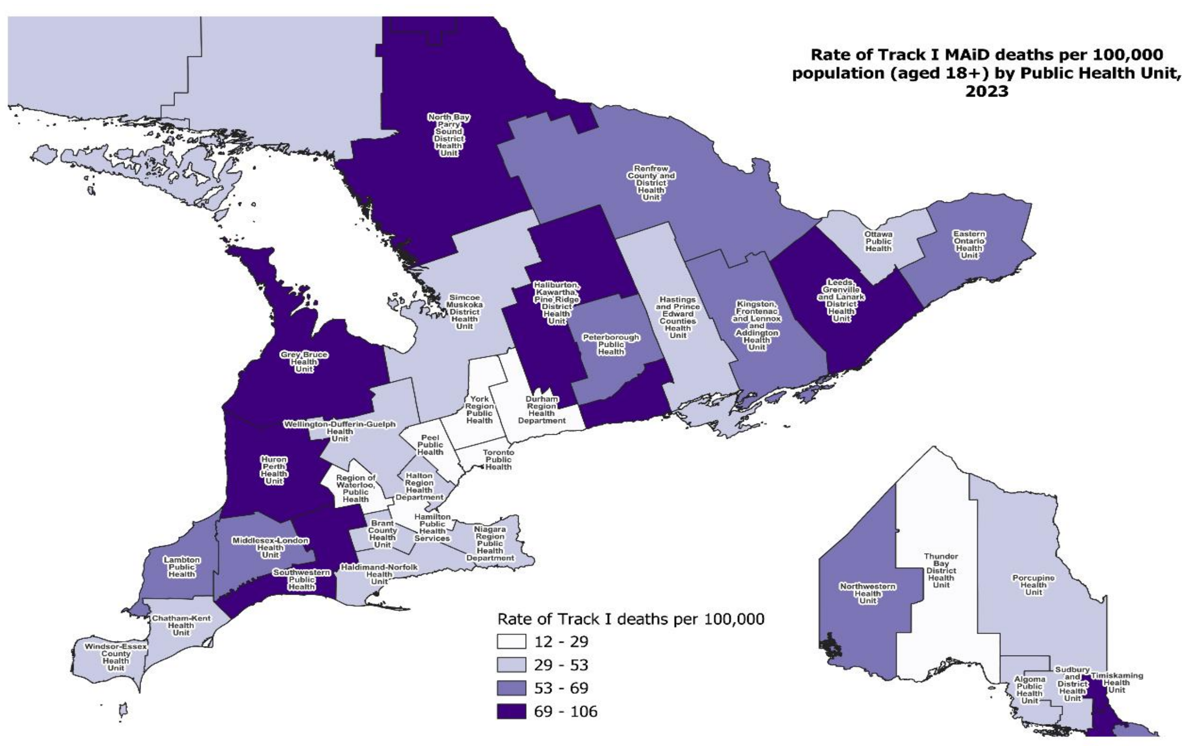
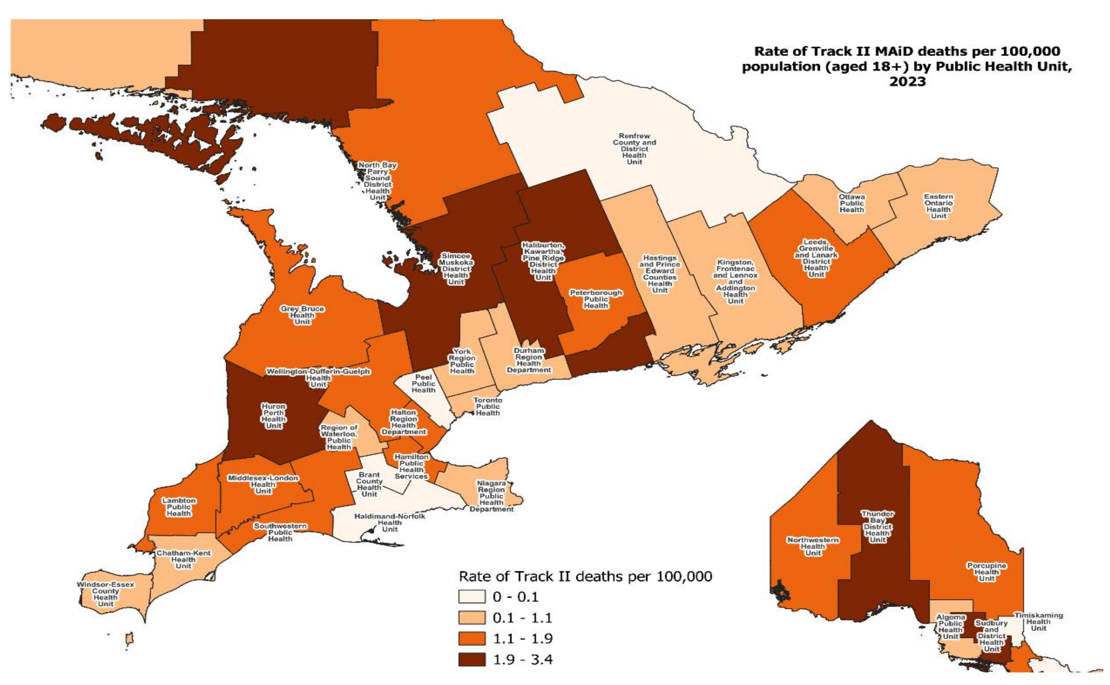


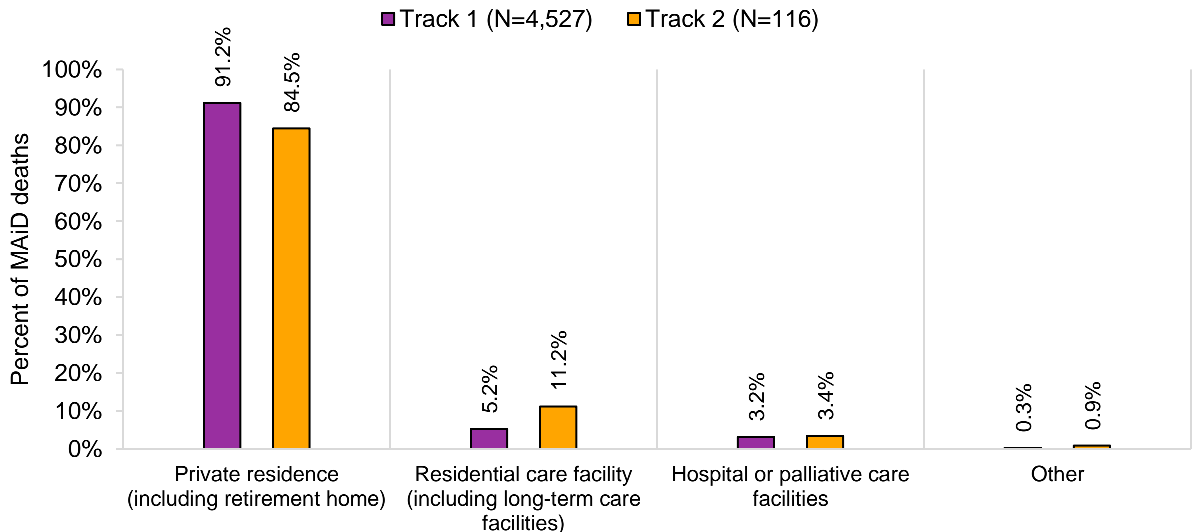
Figure 5. Rate of Track 2 MAiD Deaths per 100,000 Population (aged 18+) by Public Health Unit, 2023



Housing

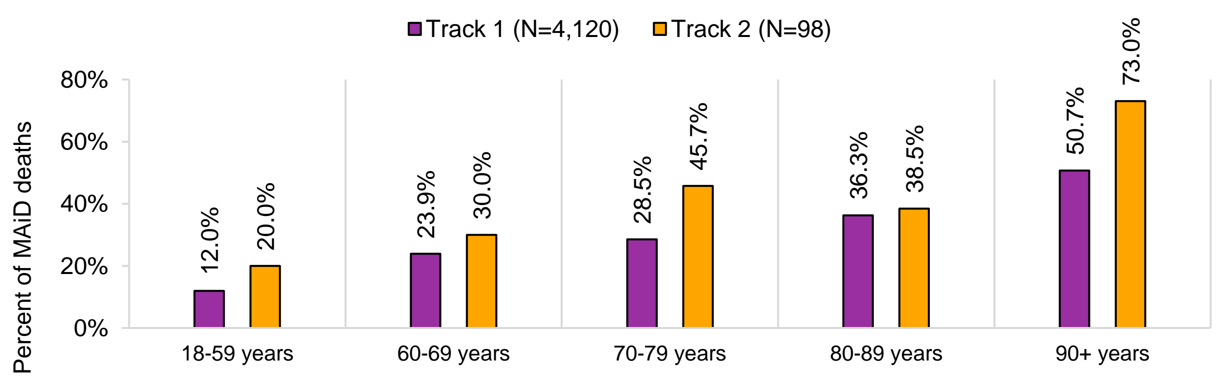
Mandatory reporting for MAiD requires the type of housing and living situations for all recipients of MAiD be specified. The majority of persons who accessed MAiD via both tracks were living in private residences, including retirement homes (Figure 6). A slightly higher proportion of Track 2 recipients resided in residential care facilities (long-term care and assisted living). Persons who accessed MAiD resided in hospitals, palliative care facilities, or in ‘other’ locations (correctional facilities, shelters, group homes, and hotels/motels) in similar proportions across both safeguard tracks.

Figure 6. Distribution of Residence Type for MAiD Deaths in Ontario, by Track, 2023



Track I and Track 2 recipients differed in the percentage of each population living alone. Track 2 recipients more commonly lived alone at all ages (Figure 7).

Figure 7. Proportion of MAiD Recipients in Ontario Living Alone, by Age Group and Track, 2023



Social Network

Track 2 MAiD recipients were more likely to be living alone (see Figure 7). Data gathered as related to the next of kin (NOK) relationship was also evaluated (Figures 8,9). These data showed apparent variations in the types of relationships that MAiD recipients relied upon when selecting a NOK.

Ninety percent of Track I MAiD recipients provided an immediate family member (spouse, sibling, or child) as their NOK, compared to 73% of Track 2 recipients. Those who accessed MAiD via Track 2 safeguards were more likely to have provided a friend, extended family member, or other person, such as a case worker, lawyer, or health care provider.

Figure 8. Distribution of Track 1 MAiD Recipients (N=4,528) 'Next of Kin' by Relationship, 2023

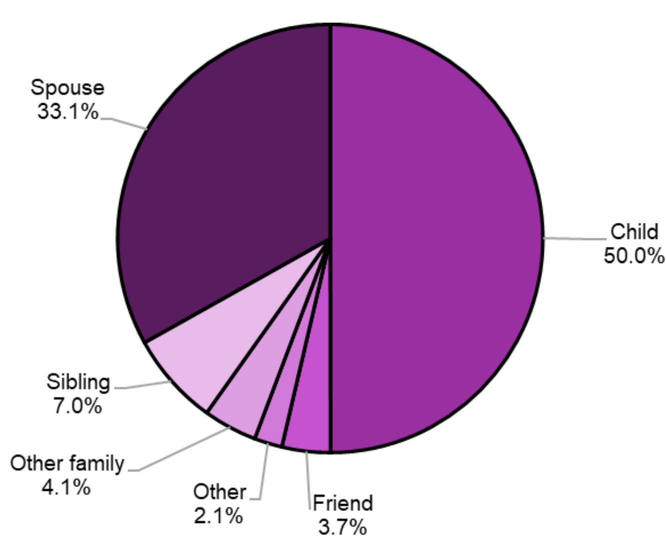
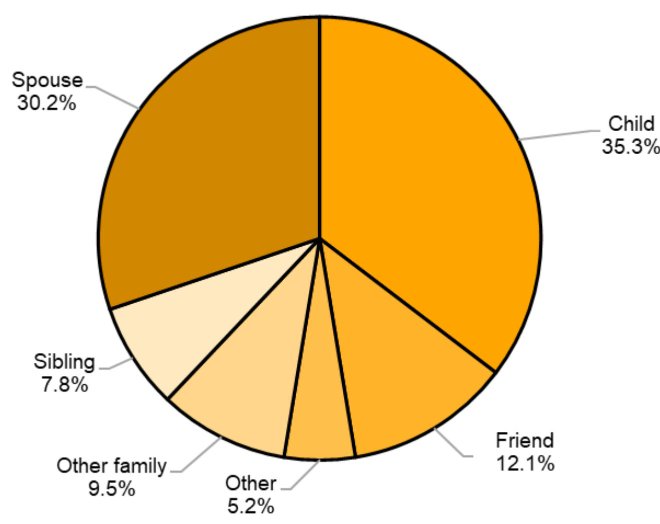


Figure 9. Figure 9. Distribution of Track 2 MAiD Recipients (N=116) 'Next of Kin' by Relationship, 2023



Marginalization

While the information collected about individual MAiD recipients does not include socioeconomic data, using the residential neighbourhood where an individual lived may provide insight into the level of marginalization associated with that neighborhood and therefore a greater risk for vulnerability. Public Health Ontario, The Centre for Urban Health Solutions, and St. Michael's Hospital have developed an index which identifies the level of marginalization associated with residential/community geography based upon a number of metrics. Please refer to "Medical Assistance in Dying (MAiD): Marginalization Data Perspectives" report from the Office of the Chief Coroner for additional detail and perspectives regarding marginalization and MAiD recipients.

There are four dimensions in the index: material resources; households and dwellings; age and labour force; and racialized and newcomer populations. Details about the indicators used for each dimension as well as its limitations can be found in the User Guide [3].

A comparison of Track 1 and Track 2 recipients for each of the four dimensions are presented in Figures 10 to 13. For the Material Resources dimension (Figure 10), which is most closely associated with poverty, Track 2 recipients are more likely to reside in areas of the province with high levels of marginalization (28.4%) than Track 1 recipients (21.5%).

While both the Households and Dwellings dimension (Figure 11) and the Age and Labour Force dimension (Figure 12) show that MAiD recipients were more likely to reside in areas with high marginalization, the indicators which define these dimensions are highly correlated with age and disability. Therefore, the results may not provide meaningful information beyond confirming what is known about the age and health status of those seeking MAiD.

Finally, the Racialized and Newcomer dimension (Figure 13) demonstrates that MAiD recipients in both Tracks were predominantly non-racialized populations.

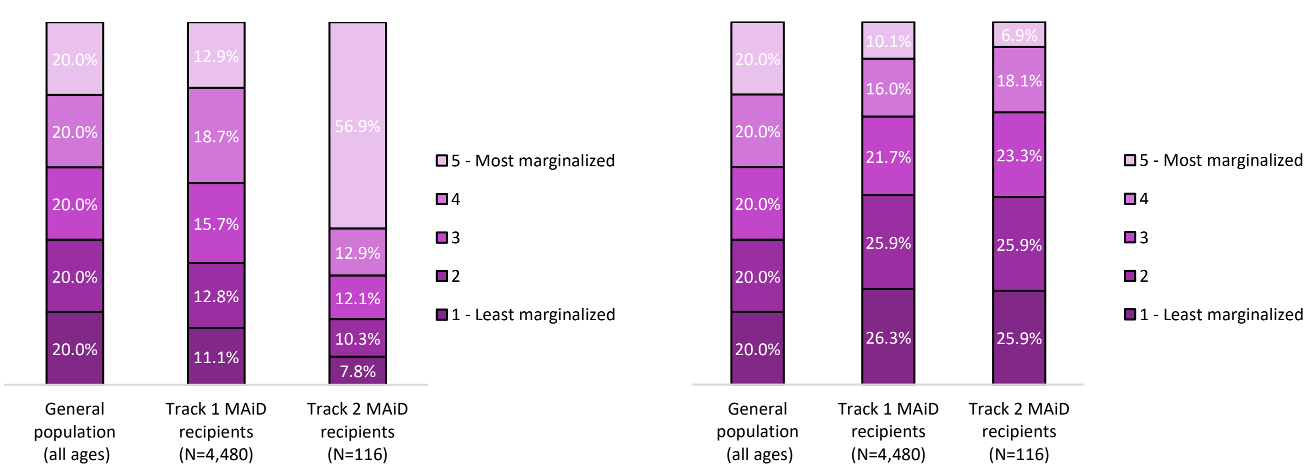
[3] https://www.publichealthontario.ca/en/Data-and-Analysis/Health-Equity/Ontario-Marginalization-Index

Figure 10. Distribution of MAiD Recipients by Level of Marginalization: **Material Resources Dimension**, 2023

Figure 11. Distribution of MAiD Recipients by Level of Marginalization**: Households and Dwellings Dimension**, 2023

Figure 12. Distribution of MAiD Recipients by Level of Marginalization: **Age and Labour Force Dimension**, 2023

Figure 13. Distribution of MAiD Recipients by Level of Marginalization: **Racialized and Newcomer Population Dimension**, 2023



When considering the increased likelihood of MAiD recipients – particularly those in Track 2 – residing in areas with higher levels of material deprivation, it is important to understand the relationship between illness, disability, and marginalization.

Figure 14 demonstrates the levels of marginalization described for the residential community of MAiD recipients who have experienced disability by the length of time with a disability. Figure 15 shows a similar relationship for MAiD recipients experiencing a serious illness for ten or more years. Given that the Material Resources dimension is representative of community aggregates, the level of deprivation for each individual MAiD recipient cannot be directly determined. Material deprivation is likely multi-factorial, potentially including direct impacts of the illness or disability, such as employment opportunities.

Overall, these comparisons are predicated on generalized measures for vulnerability and not direct individual level reporting (Figure 14, 15). Therefore, the reader should recognize limitations to the analyses. Individuals seeking MAiD under Track 2 have features which often include a significantly longer disease and disability burden to those seeking MAiD under Track 1.

Figure 14. Distribution of MAiD Recipients by Level of Marginalization: Material Resources Dimension, and Length of Time with Disability, 2023

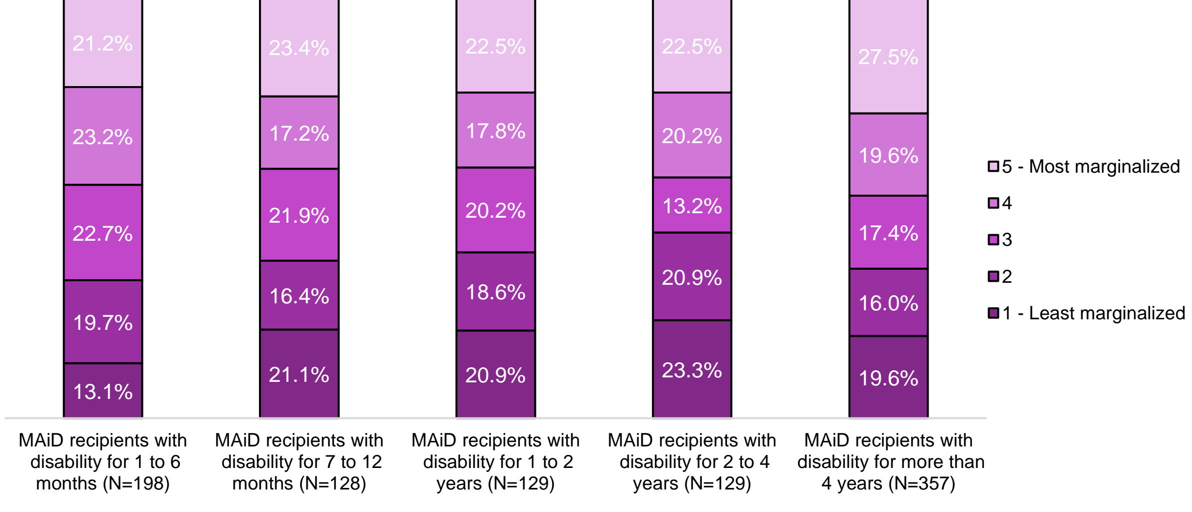
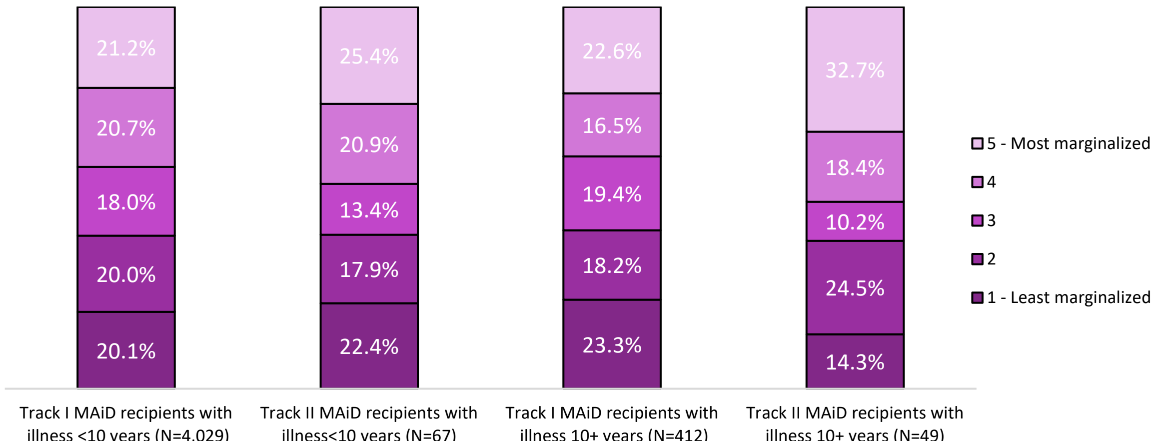


Figure 15. Distribution of MAiD Recipients by Level of Marginalization: Material Resources Dimension, and Length of Time with Serious Illness, 2023



COMMITTEE REVIEW

CASE A

SOCIAL VULNERABILITY

Case Overview

Mr. A was a male in his 40s with inflammatory bowel disease. He received extensive treatment for this illness. It was reported that partly due to the course of his illness, Mr. A did not have an active social network: he could not maintain employment, he found personal relationships difficult to sustain, and he was dependent on family for housing and financial support. As a result, Mr. A lived with reduced social supports. He had declined multiple social support programs and psychosocial services.

Mr. A had a history of mental illness, previous episodes of suicidality, and on-going alcohol and opioid misuse. He lost his driver's license secondary to his addictions. During a psychiatry assessment, the psychiatrist asked him if he was aware of MAiD and presented information on the option. While Mr. A was believed to have maintained decisional capability, his substance use was not explored in the MAiD assessments, and he was not offered addiction treatments.

During the MAiD process, there was no documented input from Mr. A's family, nor a statement about why there was no engagement with family. The MAiD provider documented that the family had concerns about his request for MAiD.

The MAiD provider personally transported Mr. A in their vehicle to an external location for the provision of MAiD.

Discussion

The MAiD death was reported to the OCC by the involved MAiD practitioners as deemed to have met eligibility within legislative parameters; eligibility was primarily determined on the incurable condition of inflammatory bowel disease with advanced state of irreversible decline and intolerable suffering. Multiple MDRC members expressed concerns of the limited exploration of medical and social issues experienced by Mr. A. The MAiD assessors' focused evaluations were reported as problematic for many members – the approach did not address significant concerns regarding mental health and addictions, social well-being and support, and family involvement.

Mental Health & Substance Use Disorder

Some members expressed concerns about mental illness being a significant driver of Mr. A's MAiD request. Some MDRC members expressed that Mr. A's mental illness was not fully examined for remediation. Many MDRC members believed that there was a need and importance to address his mental health concerns, which were a significant driver of his suffering. Specifically, some members identified that Mr. A may not have received sufficient care through mental health and social services. MDRC members agree that special consideration and care is required to determine whether mental illness may be a significant driver of a MAiD request (see MDRC Report 2024 - 2).

Given Mr. A's history with mental illness and previous episodes of suicidality, some members were concerned about the potential risks of a psychiatrist providing information on MAiD during a mental health assessment. These members identified that introducing MAiD to patients, particularly when they are not approaching their natural death, raises concerns of the impact on voluntariness, given the power imbalance in a healthcare provider and patient relationship (framed in terms of potential coercion or undue influence). Mr. A appeared to have been socially vulnerable and isolated – it is important to consider the weight of a physician's advice in a person's decision making. A few members discussed that bringing forward MAiD in this context may undermine a person's resilience and confirm an impression that their life is not worth living. MDRC members with both psychiatric and MAiD expertise provided another view. These members identified that discussions of MAiD can be clinically informed and well-timed when fully considering a person's treatment history and suffering, albeit respecting continual professional guidance on this issue.

An additional mental health concern recognized by most MDRC members was the apparent limited treatment of Mr. A's concomitant substance use disorder. Most members advised that substance use often complicates physical and mental disorders and strains relationships. It is important that concerns of substance use be comprehensively explored and addressed, particularly through psychiatry and other experts (e.g., mental health and addiction counsellors). Most MDRC members agreed

that evaluation of substance use should not be solely limited to a determination of decision-making capability. Rather, substance use should be explored in relation to eligibility. A few members of the committee thought that untreated substance use should preclude MAiD eligibility. Pragmatically acknowledging these views, some MDRC members determined that MAiD practitioners should have evidence that the decision to access MAiD was not significantly influenced by the person's substance use. This determination may be informed over multiple interactions between the requestor and the MAiD practitioners, during periods of abstinence, and in consultation with experts.

Social Vulnerability

Many MDRC members opined that Mr. A may have benefited from greater consideration of social and mental health supports to address unresolved issues during the MAiD process. MAiD data demonstrates that interventions employed to alleviate the suffering of persons accessing MAiD with NRFNDs are proportionally higher as pharmacological options, with a smaller percentage of interventions focused on healthcare services, such as palliative care, disability and social services, and mental health supports (see MDRC Report 2024 – 2). Community services, including housing and income support, were offered to a low proportion of persons. Community life[vii], supports and purpose are strong determinants of well-being. A few MDRC members raised the importance of the potential for undue influence and vulnerability[viii] of persons who are without social supports and community networks in their requests for MAiD and their experiences of suffering.

Many MDRC members recognized limited family engagement as a concern within the navigation of the MAiD process. Strained familial relationships may have been a driver of suffering for Mr. A. Most MDRC members felt there would have been benefit for the MAiD practitioners to further address this concern. Pausing MAiD assessments and facilitating measures and interventions to reduce social isolation may have been a valuable and beneficial approach when seeking options to alleviate suffering for this person. Family engagement, especially when they are the main caregivers of a person, could have potentially provided a more comprehensive perspective of life circumstances and the requester's health journey and trajectory. Some MDRC members discussed how family caregivers often have an important role in assisting MAiD practitioners in identifying issues that require and would benefit from further consideration and enhanced care and support.

Some members felt enhanced family engagement would have facilitated understanding of Mr. A's decision to access MAiD and the determination of eligibility. Some members acknowledged that when differences and perspectives between the requestor and family are irreconcilable, the decision remains with the person accessing MAiD. However, increased understanding of the MAiD process and improved family

awareness or understanding of the requestor's decision to access MAiD may alleviate some distress for the family. More importantly, many MDRC members noted that family consultation might provide an opportunity to potentially repair previously fractured relationships, allowing for greater support for the individual. Additionally, the MAiD practitioner may use these interactions to facilitate access to support and counselling for family members.

Professional Boundaries

Multiple MDRC members raised concern about the action of a MAiD provider transporting the requestor to their MAiD provision location. MDRC members shared that this action may have created pressure and gave rise to a perception of hastening a person towards death. Others disagreed, indicating their perspectives that the physician's actions were helpful and compassionate. Some MDRC members suggested that there should be consideration for limits on the ancillary services provided by MAiD practitioners in support of a MAiD death (e.g., chauffeur, shopping, etc.) to protect against perceptions of influencing final consent. MDRC members discussed how MAID practitioners should maintain a professional boundary from the persons they assess. Driving patients to a place to receive MAiD was felt to be a transgression of such boundaries by some MDRC members. MAiD practitioners should ensure that the MAiD process remains self-directed and provision arrangements are guided by the requestor.

Practice Considerations

To address social vulnerability:

- Community life, supports and purpose are strong determinants of well-being. Isolated persons should be offered connection to their local community (e.g., disability community, spiritual or ethnic communities), especially during the MAiD process. If these offers of support are not accepted, there should be clear documentation.

Engagement of family and/or close relations:

- Engagement with family and/or close relations in the MAiD process should aim to be a key component of MAiD practice[ix]. Challenges with navigating family involvement and relationships may be supported by social workers or others with suitable skill/competencies. Approach to and rationale for family engagement (or lack thereof) should be documented.
- When permitted by the requestor, supportive discussions with family and close relations may:
    - provide a more comprehensive perspective of life circumstances, health journey and trajectory, and identify areas that require further consideration and care; and/or

- encourage a relational approach to care; and/or
- facilitate a family's understanding of the decision to access MAiD and the determination of eligibility; and/or
- provide an opportunity to repair previously fractured relationships allowing for greater support for the individual.

- Close relations should be offered support throughout and after the MAiD process (e.g., counselling, access to a social worker or other support personnel).

In consideration of substance use:

- Substance use often complicates physical and mental disorders and contributes to social isolation. As such, substance use should be comprehensively explored and addressed, particularly through psychiatry and other experts (e.g., mental health and addiction counsellors). Evaluation of substance use should not be limited solely to a determination of decision-making capability.
- There should be offers of treatment for substance use (e.g., psychosocial support, addiction counselling, pharmacological options). Care needs should be facilitated via an appropriate care provider to support the assessment process. These should be clearly documented.
- MAiD assessors should document their reasons for determining that the decision to access MAiD was not unduly influenced by the person's substance use (e.g., consistent decision-making and reasoning). This determination can be strengthened over multiple interactions, during periods of abstinence, and, where possible, in consultation with others with expertise if needed.

CASE B

HOUSING VULNERABILITY

Case Overview

Ms. B was a female in her 50s with multiple chemical sensitivity syndrome (MCSS). She had a history of psychiatric hospital care for depression, anxiety, suicidality, and post-traumatic stress disorder, related to childhood trauma.

Ms. B had difficulty securing housing that met her medical needs. After years of attempts to secure appropriate housing, the Human Rights Tribunal issued a ruling to allocate funds to renovate her apartment. These renovations did not satisfactorily address her MCSS symptoms. A remaining option presented was to live in a small hypoallergenic space (i.e., a bubble). As a result of her housing situation and conditions, necessary to address her MCSS, Ms. B experienced social isolation, which greatly contributed to her suffering and request for MAiD.

Discussion

MDRC members recognized the complexity of assessment when the requestor is seeking MAiD with psychosocial suffering. The MAiD practitioners involved with the MAiD process determined eligibility from Ms. B's medically confirmed MCSS. MDRC members expressed differing opinions regarding her condition and eligibility. Some members cautioned that a social issue, housing, was at the forefront of this request, not in keeping with a medical condition. Other members differed, stating that her condition (MCSS), and related suffering, would have persisted even with further housing options. Some members indicated that with a significant psychiatric history, some psychiatrists would perceive the presentation of MCSS to be more in keeping with a psychiatric diagnosis, namely a somatic symptom disorder.

Consensus was not achieved amongst MDRC members about whether Ms. B was eligible for MAiD. Many members confirmed that they would not have considered Ms. B eligible for MAiD, either arising from the belief that psychiatric issues were predominately underlying the MAiD request or on the basis of an unmet social need. Other members more cautiously identified that while there was suitable clinical evidence to support eligibility based on her condition of MCSS, they felt that special consideration is required when persons present with significant psychosocial challenges and mental health issues.

Most MDRC members acknowledged that the MAiD practitioners made significant efforts to navigate the core psychosocial and housing issues identified. However, there was a lack of consensus about how to proceed when suffering is mainly or entirely driven by psychosocial factors. Significant efforts had been made to pursue alternate options for housing; however, a few members believed there were other outstanding housing options to explore (e.g., small trailer in a more rural setting). Most MDRC members believed that Ms. B's MCSS presentation required her to continue living in isolation in a small hypoallergenic environment and hypothesized that other housing arrangements would not have led to the resolution of her suffering. Almost all members agreed that social needs, such as housing, should be foremost approached with an attempt to address unresolved issues, acknowledging that navigating social issues would likely take longer than the minimum 90-day assessment period. Some members considered that social needs may be considered irremediable if all acceptable and available options have been explored. Others felt that MAiD is not a solution for all society and policy failures, furthering social injustices, and strongly dissented to this approach. Overall, most MDRC members agreed that the MAiD process should give way to urgent social services intervention and maximize supportive healthcare options to reduce symptoms and suffering prior to proceeding with MAiD.

MDRC members agreed that MAiD practice should emphasize assessing and alleviating suffering in a care-based approach to MAiD practice. The statutory 90-day assessment period was introduced as an arbitrary timeline to approach complex issues. There may be benefit for MAiD assessors to pause or defer assessments while consultant, social, and other care takes place. A multi-disciplinary approach to support assessment of patients, specifically for vulnerability, and identifies options to live and recover was agreed upon. There may be benefit for the multi-disciplinary members to be primarily independent from the MAiD team (see Recommendations 3).

Practice Considerations

- See “MDRC Review 2024 - 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths” for discussion and considerations for the involvement of expert consultants (e.g., psychiatrists, social workers) for complex psychosocial issues.
- Psychosocial needs, such as housing, should be foremost approached with an attempt to address unresolved issues. Navigating these issues may take longer than the regulatory minimum 90-day assessment period. Some members considered that social needs may be considered addressed if all acceptable and available options have been explored.
- The MAiD process should be deferred while the person is waiting to access appropriate social services or healthcare. This approach to practice recognizes the importance of addressing and resolving suffering in contrast to procedurally qualifying for a MAiD death.

CASE C

DISABILITY

Case Overview

Mr. C was a male in his 40s living with quadriplegia following a motor vehicle collision. The COVID-19 pandemic may have contributed to vulnerability in his medical journey (e.g., social isolation). Mr. C received rehabilitation without physical or functional gains. Due to his complex medical conditions, returning home with supports was not feasible.

The MAiD assessors considered his death non-reasonably foreseeable, thereby proceeding with Track 2 safeguards. However, one of the MAiD assessors considered the 90-day assessment period to be a “waiting period” and documented the possibility of “reducing the timeline should his natural death become reasonably foreseeable” (e.g., untreated septicemia).

Mr. C was separated from his family while receiving on-going complex continuing care. He was distressed about perceived limits of maintaining an ongoing relationship with his

young children. Mr. C was a member of a racialized and religious community, with associated challenges with acceptance of MAiD.

Discussion

Mr. C had experienced a catastrophic event and accessed MAiD within two years of injury. The committee discussed Mr. C's period of adjustment to living with disability. Most MDRC members agreed that eligibility for MAiD should be considered within the context of emerging evidence and best practices relevant to the condition in question during periods of transition, ongoing physical and psychosocial adaptation, and times of heightened suicidality[x]. A few members brought forward that the spinal cord community may not agree with finding a person eligible for MAiD within the first two years[xi] of a spinal cord injury. Persons with a spinal cord injury require an opportunity to navigate profound adjustments and recovery with the possibility of returning to meaningful community life. A few MDRC members discussed how MAiD practitioners may benefit from improved awareness of ableism biases[xii] that may influence clinical interpretations of recovery and the presentation and evaluation of options to alleviate suffering. Other members identified that Mr. C's request for MAiD was informed by untreatable medical sequalae (i.e., pressure injuries to the skin) and avoiding associated suffering. These members expressed that eligibility should be person specific. Adhering to specific timelines for adjustment may not account for their medical experiences and associated issues.

Some members were concerned that one of the MAiD assessors approached the Track 2 legislative safeguard for the minimum 90-day assessment period without a purposeful approach for navigating expertise and offering care options (i.e., approached as a "waiting period"; see also MDRC Report 2024 – 2). The primary assessor also communicated to Mr. C that the 90-day period could be reduced should his natural death become reasonably foreseeable.

Legislatively, the 90-day assessment period may only be shortened for risk of imminent loss of capacity. Some MDRC members expressed their concerns that persons with increased vulnerability are at risk of accessing MAiD without adherence to safeguards in place to promote safety and quality care (e.g., 90-day assessment period). Also, multiple members identified concerns that 'track switching' might be occurring, with limited opportunity to identify potential legislative breaches.

Aligning with heightened consideration of needs during a period of adjustment following a catastrophic injury, MDRC members recognized the importance of navigating consultation with those who have expertise in the requestor's condition, engaging the person's existing care team in the MAiD process, and facilitating peer support. The MDRC agreed that navigating complex circumstances requires a multidisciplinary

approach to care. In the determination of MAiD eligibility for Mr. C, the MAiD practitioners relied heavily on review of records. Members believed that there would have been benefit for a multidisciplinary case conference with Mr. C's existing care team (i.e., physiatry, occupational and physiotherapy, nursing, social work) to ensure that all treatment and care options were explored. Similarly, expert consultation should align with the requestor's core issues. The MAiD practitioners did not document engagement with physiatry or rehabilitation specialists in the expertise consultation process. A comprehensive consultation process is required to ensure the standard of care is met and options to relieve suffering extend beyond pharmacological interventions. Most members agreed that failing to explore disability, mental health, and community support services is not in keeping with quality practice. Mr. C may have benefited from additional therapeutic approaches for his suffering, such as peer mentoring, psychosocial guidance for navigating his relationship with his children, and social solutions for enhanced community and cultural engagement.

Multiple MDRC members noted the importance of cultural considerations within the MAiD process. Gathering information about the person's cultural community may facilitate additional understanding of the personal meaning one attributes to living with disability, as well as further perspectives regarding their request for MAiD. Greater cultural awareness also extends to surviving family members who, due to religious or cultural beliefs and values, will be left to navigate the impact of the decision to pursue an assisted death and may ultimately affect the support system that they need to rely on. Social, cultural and family issues should be part of MAiD assessments, particularly when there is potential for future relational conflict. Consensus amongst MDRC members was that cultural considerations should be discussed early in the MAiD process.

Practice Considerations

- MAiD assessors must be familiar with and adhere to established legislative safeguards. Resources available to enhance learning of Track 2 safeguards and management include Health Canada's "Implementing the Framework" and The Office of the Chief Coroner's "Medical Assistance in Dying Lessons Learned: Track 2 Non-Reasonably Foreseeable Natural Death (NRFND)".
- Efforts should be made to ensure a requestor has received the recognized standard of care for their condition. Engaging with the person's interprofessional and multi-disciplinary care team (i.e., via case conferencing) may assist in determining if the standard of care has been achieved.
- Access to and engagement with peer support[xiii] is an integral component of care for persons living with disability following a catastrophic event.
- Review of healthcare documentation may not always offer the most comprehensive insight and understanding of the requestor's medical trajectory of

disability. It would be beneficial for healthcare professionals involved in the requestor's care to be given an opportunity to consult and collaborate in the MAiD process (e.g., social workers, occupational therapists, and physiotherapists) to ensure all avenues of care have been explored.

- MAiD assessors should seek guidance from those with expertise to evaluate requests for MAiD during periods of transition and/or during a period of ongoing physical and psychosocial adaptation.

SUMMARY

MAiD practitioners should consider this review as a preliminary discussion of some issues of vulnerability and continue to build upon the practice approaches presented in this review to address person-specific circumstances. MDRC members encourage MAiD practitioners to continue to explore and document issues of vulnerability within the MAiD process.

MDRC members also recognize that the subject of vulnerability is positioned within broader health and social policy issues. MDRC members encourage continued discussion of these issues from broader perspectives and at all levels. Specific analysis of social and health policies is outside of the aim and scope of the MDRC.

MDRC discussion of the provision of MAiD with potentially marginalized persons brought forward issues of structural inequities that may exist and that may influence aspects of the MAiD process, particularly when considering the potential for structural coercion or undue influence of the request for MAiD and equitable access to care. There were differing views on how to assess and respond to requests for MAiD where a person may be vulnerable to social inequity across both MDRC reviews (see "MDRC Report 2024 – 2: Complex Conditions with Non-Reasonably Foreseeable Natural Deaths"), most members expressed their views that vulnerable persons would benefit from a multi-disciplinary and interprofessional model of care. The role of this approach (see Recommendation 3) would be to evaluate potential structural inequities and navigate remedial options. A patient advocate could assist in ensuring options have been explored to live with dignity in their community, aligned with their unique social, cultural, and environmental contexts. When necessary, suitable time should be provided, including beyond the 90-day assessment period, to explore identified complexities.

A multidisciplinary and interprofessional approach to care would help to address some concerns identified by MDRC members for the most ideal navigation of complex Track 2 cases.

1. The presentation of Ontario's MAiD data (MDRC Reports 2024 - 2 & 2024 - 3) showed regional differences in the provision of MAiD. In rural and remote

regions, benefit could arise from improved access to a provincially resourced assessment and care team including addressing concerns of accessibility to care and expertise consultation.

2. A few MDRC members expressed concerns regarding the higher rate of repeated requests for MAiD in Track 2 cases (see MDRC Report 2024 – 2). Nearly eight percent of Track 2 MAiD deaths were persons who had previously requested MAiD and in nearly half of those previous requests the person was found ineligible. Although there could be a number of reasons for this finding, a few MDRC members expressed concerns of ‘doctor shopping for approval’ in both Track 2 and Track 1 assessments.
3. An interprofessional assessment service would ensure that requests for MAiD in Track 2 requests with complex circumstances are reviewed from multifaceted perspectives, alleviate the burden of responsibility of MAiD practitioners to solely determine eligibility in complex conditions, and ensure expert guidance when structural inequities are identified.
4. Some MDRC members expressed their concern that pharmacological interventions are more frequently offered (see MDRC Report 2024 – 2) compared to health care services including palliative care, disability support, and mental health support, for the alleviation of suffering. More comprehensive care options to alleviate suffering are likely to be identified within an interprofessional model of care.
5. Many MDRC members expressed the benefit of more robust guidelines and standards of care for MAiD. An expected outcome of a multidisciplinary and interprofessional assessment and care model would be to guide quality care indicators and guidelines for the provision of MAiD, including the consideration of psychosocial factors recognized in this review (see Recommendation 3).

A few MDRC members expressed strong concerns and objections for the lack of utilization of current evidence and standards of care to guide MAiD practice. In response to reviewing the selected MAiD deaths in vulnerable persons and broad perspectives garnered from available Ontario data, some MDRC members called for a paradigm shift in MAiD practice. Members encouraged a shift from a procedural-focused to a care-focused approach to MAiD. In alignment with a care-focused approach to MAiD practice, MAiD practitioners evaluating MAiD requests for persons with NRFND should have, or involve others with, the necessary knowledge, skill, and expertise to competently identify the unique care needs of persons with disability. MAiD Track 2 care-focused practice should be situated within an understanding of the social and intersectional model of disability, adopting disability communities’ social and cultural frameworks. There would be benefit for multi-disciplinary care in MAiD practice, particularly during the minimum 90-day assessment period, with consideration of expertise outside of the traditional medical model (i.e., peer support and/or disability

advocates). These providers may help to ensure ableist perspectives of care options, potentially limiting exploration of options to alleviate suffering, do not go unchallenged. Disability-affirming psychosocial approaches to care, community integration, and psychosocial support are reflective of quality care practices.

RECOMMENDATIONS

The MDRC collaborates with the MRT to inform MAiD oversight in Ontario. The MDRC seeks to inform potential changes to MAiD practice and safety through system recommendations. The Office of the Chief Coroner (OCC) will disseminate this report to MAiD practitioners and other relevant organizations in Ontario to inform potential MAiD practice improvements.

MDRC guidance issued in this report will inform approaches to MAiD oversight in Ontario. Based on feedback from the MDRC, the Office of the Chief Coroner MAiD Review Team (MRT) will explore modification of MDR reporting procedures to capture circumstances of increased vulnerability to support comprehensive review of these MAiD deaths.

The MRT will consider changes to the "MAiD Legislative Oversight Framework" in response to issues and recommendations brought forward in these reports (MDRC Reports 2024 - 2 & 2024 - 3). The MRT will collaborate with respective regulatory bodies to review and if indicated, revise the framework, specifically, for our responses to legislative and significant practice deviations.

The OCC has identified recipients and recommendations to inform improvements to the MAiD system in Ontario. These recommendations were formulated from MDRC discussions specific to this topic and review; however, some recommendations would benefit from consideration and implementation across all MAiD practices (Track I and Track 2) and for persons who experience profound suffering and are considering an assisted death. Moreover, these recommendations should be situated within broad health and social system improvements and considered with a summative understanding of this report.

1. **To Health Canada:**

    1.1 Health Canada (HC), supported by engagement with persons with lived experience of disability and their advocacy and support groups, to consider providing guidance on how to approach Track 2 legislation and safeguards within a disability care framework.

1.2 Health Canada to consider providing additional guidance on how to approach Track 2 legislative criteria and safeguards when navigating vulnerability within the MAiD assessment process, including:

- how to approach MAiD requests when suffering is predominately derived from an unmet social need (e.g., housing arrangements), and
- how to approach differing determinations of safeguard assignments (Track I vs Track 2) to best assess and facilitate care within the MAiD process for persons experiencing vulnerability.

1.3 Health Canada to consider increasing data collection related to vulnerability to better evaluate requests for - and access to – MAiD, and to consider actionable changes to health and social policy.

2. To Ontario Ministry of Health (MOH):

2.1 The Ontario Ministry of Health (MOH) to consider revising Clinician Aid A:

- by engaging with persons with lived experience of disability and their advocacy and support groups, to adopt mechanisms for consistent data collection and reporting of self-identification of disability.
- to include opportunities for self-identification of other key areas of vulnerability to aid MAiD providers and assessors in recognizing potential complex circumstances and needs.

3. To Ontario Ministry of Health and Ontario Health:

3.1 The MOH and Ontario Health (OH) to consider identifying and disseminating this report with communities of practice or other healthcare agencies engaged in MAiD initiatives to improve care, coordination, and/or practice.

3.2 The MOH and OH to consider the development of a provincially coordinated MAiD care system[4], to include the following:

- Care coordination to facilitate information gathering, arranging consultations, and navigating care to ensure persons with complex needs are provided with access to services to facilitate comprehensive assessment and care.
- A consultation service or community of practice to support MAiD practitioners navigating complex MAiD requests and facilitate expert consultation for persons with complex medical conditions and/or circumstances. An

[4] The MDRC did not evaluate a particular model-of-care. The MDRC acknowledges the necessary considerations of feasibility and equitable integration of a MAiD model-of-care within the current healthcare system.

interprofessional and multidisciplinary community of practice, comprised of members with diverse expertise (e.g., physicians, lawyers, ethicists, social workers), may be beneficial.

- Regional multi-disciplinary and interprofessional care teams (e.g., physicians, nurses, social workers, occupational therapists, physiotherapists, peer-support, community-life specialists) to assist in the navigation of complex care needs of persons who have requested MAiD.

3.3 As an outcome of MDRC reviews 2024.2 and 2024.3, the MOH and OH to consider in their development of a provincially coordinated MAiD care system that persons presenting with the following characteristics or experiences may benefit from enhanced MAiD care coordination:

- social vulnerability (e.g., limited social network),
- unmet or underserviced social needs (e.g., housing),
- self-identified care inequities (i.e., due to intersectional issues),
- complex comorbid medical conditions, such as substance use
- complex diagnostic determinations due to concomitant and interrelated psychiatric conditions, including trauma,
- accessing MAiD with identified deviations from receiving the standard of care or outside of evidenced based care parameters (e.g., requesting MAiD following a known transient period of psychosocial adaptation following severe disability),
- lack of access to care that is informed by palliative principles and approaches (e.g., barriers to access palliative care services due to end-of-life parameters).

3.4 MOH and OH to consider developing practice standards for a provincially coordinated MAiD care system. Consider collaborating with academic networks to evaluate this MAiD model-of-care.

4. To Toronto Academic Health Science Network:

4.1 The Toronto Academic Health Science Network to collaborate with provincial partners to support the evidence-based development of MAiD models-of-care, a community of practice, and/or MAiD Assessment Service.

5. To Canadian Association of MAiD Assessors and Providers:

5.1 The Canadian Association of MAiD Assessors and Providers (CAMAP) to consider issues identified in this report to inform their ongoing review and revision of MAiD education and practice guidelines.

5.2 CAMAP to consider engaging with disability service agencies, advocates, and persons with lived experience to develop core competencies and competency-oriented tools for MAiD practitioners assessing and providing care to persons with disability (e.g., how to navigate unique care needs to alleviate suffering for persons with disability (e.g., peer supports and community life specialists)).

6. **To College of Physicians and Surgeons of Ontario and College of Nurses of Ontario:**

6.1 The College of Physicians and Surgeons of Ontario (CPSO) and the College of Nurses of Ontario (CNO) to consider:

- employing this MDRC Report to inform MAiD practice guidelines for navigating the Track 2 MAiD process with persons with vulnerability.
- provide guidance on the existence of evidence relevant to physical and psychosocial adjustment to illness and disability and how it can be considered in the process of discussing, assessing for, and potentially providing MAiD.

7. **To the College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario**

7.1 The College of Social Workers and Social Service Workers, College of Psychologists of Ontario, and College of Occupational Therapists of Ontario to consider employing this MDRC review to inform practice guidelines for clinicians providing care in the MAiD process, particularly related to navigating complex social needs in the Track 2 process.

8. **Canadian Medical Protection Association & Canadian Nurses Protective Society:**

8.1 The Canadian Medical Protection Association (CMPA) and Canadian Nurses Protective Society (CNPS) to consider employing this MDRC Report to inform medico-legal advice provided to MAiD practitioners.

RESOURCES

Consider the following resources to inform MAiD practice:

Health Canada (2023). Advice to the Profession: Medical Assistance in Dying (MAID) - Canada.ca

Inclusion Canada (2020). Position on Medical Assistance in Dying

MAiD Review Team (2023). Voluntariness Lessons Learned[5]

MAiD Review Team (2024). Medical Assistance in Dying Lessons Learned: Track 2 Non-Reasonably Foreseeable Natural Death[5]

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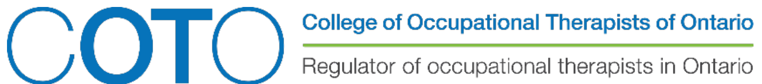

Medical Assistance in Dying

Updated October 2025

Originally Issued July 6, 2016

Introduction

Medical assistance in dying (MAiD) was legalized in Canada in 2016. MAiD allows eligible individuals to voluntarily request and receive assistance in ending their life if they meet eligibility criteria. Occupational therapists who are involved in the MAiD process can play a critical role in supporting clients, families, and healthcare teams. Occupational therapists must understand the legal, ethical, and procedural aspects of MAiD to ensure that safeguards are in place to support vulnerable individuals throughout end-of-life planning.

MAiD is defined as follows:

> **(a)** the administering by a medical practitioner or nurse practitioner of a substance to a person, at their request, that causes their death; or
>
> **(b)** the prescribing or providing by a medical practitioner or nurse practitioner of a substance to a person, at their request, so that they may self-administer the substance and in doing so cause their own death. (*Criminal Code of Canada*, s. 241.1)

Physicians and nurse practitioners are permitted to provide an individual with assistance in dying in two ways:

1. Directly administer a substance that causes an individual's death
2. Provide or prescribe a substance for an individual to self-administer to cause their own death

This document provides an overview of occupational therapists' legal, ethical, and professional roles related to MAiD. It also provides direction for occupational therapists who conscientiously object to aiding in the provision of this process with clients.

MAiD Legislation

Background

Since the inception of MAiD, the legislation has undergone several amendments. In addition to physicians and nurse practitioners, the *Criminal Code of Canada* (the "Criminal Code") now allows other healthcare providers to aid clients in this process provided that healthcare providers follow the rules of the legislation, applicable provincial requirements, and professional standards. Table 1 provides an overview of the MAiD legislation and its amendments.

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Table 1. Legislative Timeline for MAiD in Canada

Date	Legislation/Event	Description
June 17, 2016	Bill C-14 passed (Parliament of Canada, n.d.-a)	Legalized MAiD in Canada. Allowed practitioners to administer or prescribe substances to assist with death upon request.
March 17, 2021	Bill C-7 passed (Parliament of Canada, n.d.-b)	• Revised MAiD eligibility. Removed the requirement for a person's natural death to be reasonably foreseeable. Extended insurance coverage to ensure that benefits are not denied based only on MAiD. • Introduced protections from civil liability for healthcare professionals when lawfully providing MAiD. • Protected the privacy of healthcare providers and organizations that give MAiD. • Required reporting on and monitoring of MAiD. • Established a care coordination service to assist individuals and caregivers in accessing additional information and services for MAiD and other end-of-life options.
January 1, 2024	Reporting data	As part of recent federal updates to MAiD regulations, new reporting requirements have been introduced to better understand who is accessing MAiD and under what conditions. These changes aim to identify and address potential inequities, including systemic discrimination. Occupational therapists play a key role in supporting clients through this process, ensuring informed consent, protecting client rights, and promoting equitable access to care.
February 29, 2024	Bill C-62 passed	Postponed eligibility for individuals with mental illness as the sole condition until March 17, 2027.
Ongoing Monitoring	Parliamentary Special Joint Committee review	Reviewing expansion of MAiD to include mature minors, advance requests, and palliative care access and protection for Canadians living with disabilities.

What Are the Legal Safeguards for MAiD?

In Canada, MAiD includes several legal safeguards to ensure that the process is ethical, voluntary, and

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appropriate. For example, in 2021, the MAiD legislation was amended to introduce a two track system, enabling people who are suffering intolerably but whose deaths are not reasonably foreseeable to apply for MAID. People whose natural deaths are reasonably foreseeable are considered Track 1, Reasonably Foreseeable Natural Death, while those whose natural deaths are not reasonably foreseeable are considered Track 2, Non-Reasonably Foreseeable Natural Death. For an overview of the Track 1 and Track 2 system, see the Appendix.

Other safeguards include confirming that the individual is eligible under the law, which involves meeting specific criteria such as being an adult with a grievous and irremediable medical condition, making a voluntary request that is not the result of external pressure, and providing informed consent. Two independent healthcare professionals must assess the individual and confirm eligibility. Specific procedural steps also exist, including a written request signed by the individual and witnessed by an independent person. If the individual is unable to sign, a proxy may do so under certain conditions. For those whose natural death is not reasonably foreseeable, additional safeguards apply, such as a 90-day assessment period and consultations with experts in the individual's condition.

Additionally, in Ontario, the Office of the Chief Coroner established the MAiD Death Review Committee to examine issues of vulnerability within MAiD in the province. The Committee is tasked with identifying gaps and concerns within the system and making recommendations to improve the MAiD process. To this end, the Committee recently released a report, *Navigating Vulnerability in Non-Reasonably Foreseeable Natural Deaths* (n.d.).

Who Is Eligible for MAiD?

To be eligible for MAiD, a person must meet all the criteria set out in the legislation:

- Be eligible for publicly funded healthcare services in Canada.
- Be at least 18 years of age and mentally competent.
- Have a grievous and irremediable medical condition.
- Voluntarily request MAiD. The request must not result from outside pressure or influence.
- Give informed consent for MAiD. Advance consent or substitute decision-maker consent is **not** permitted. However, MAiD can be administered to a person who has lost the capacity to consent if death is reasonably foreseeable and the person entered into an agreement with the physician or nurse practitioner consenting to MAiD before losing capacity. It can also be administered to a person who has lost capacity to consent because of self-administration of a substance provided by a physician or nurse practitioner for the purpose of MAiD.
- Have one independent witness to the signature of a person on their written request for MAiD. The independent witness can be someone who provides paid health or personal care services to them.

People with mental illness may be eligible if they meet all the eligibility criteria. However, people suffering solely from a mental illness are not eligible at this time and will not be eligible until the legislation is amended.

Occupational Therapists' Involvement in MAiD

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Occupational therapists must understand that they are **not permitted** to determine eligibility for MAiD. Under the legislation, occupational therapists are permitted to assist physicians or nurse practitioners in the MAiD process by providing supportive care to clients and families or healthcare teams.

Occupational therapists who may be providing supportive care to clients under Track 2 should refer to the recommendations outlined in the Chief Coroner's MAiD Death Review Committee's Report (n.d.). Occupational therapists working in this capacity should be mindful of the increasing health, social, and intersectional complexities that may influence clients accessing MAiD and should consider how their own clinical knowledge and expertise may address these complexities within their scope of practice.

Practise Ethically

Occupational therapists are expected to practise within their scope and adhere to the College's Code of Ethics in all practice areas and settings. The Code of Ethics is particularly important in establishing expectations for occupational therapists regarding MAiD because the fundamental values and principles of occupational therapy inform the College's position on MAiD.

In dealing with the sensitive nature of MAiD, occupational therapists are expected to treat all clients with dignity; demonstrate respect for client choice; employ culturally safer practices; and remain non-judgmental about the decision of clients, families, and other care providers.

Understand MAiD Legislation

Occupational therapists are expected to know and understand the national and provincial legislation and regulations that pertain to MAiD, monitor changes to these, and understand and apply the legislation and regulations to the College's standards of practice and service delivery.

Under the legislation, occupational therapists are **not permitted** to determine client eligibility for MAiD but may provide occupational therapy services, including assessment, treatment, and consultation to help determine eligibility.

Follow Organizational Policies

In addition to the legislation and College expectations, occupational therapists must be aware of their employer's position on MAiD and understand any organizational policies or procedures that apply. Occupational therapists are encouraged to seek clarification of organization policies if positions are unclear. Some organizations may decline to provide MAiD on the grounds of conscientious objection or religious beliefs.

Follow Standards of Practice

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Following the College's Standards of Practice is critical when supporting individuals who choose MAiD. The standards help ensure that occupational therapists maintain professional boundaries, provide accurate and unbiased information, support informed decision-making, and respect client autonomy, allowing for professional, compassionate, non-judgmental care during an emotionally complex and deeply personal time in a client's life.

Understand and Apply the Occupational Therapist's Role

Respond to a Client's Request for MAiD

Occupational therapists who are the first point of contact for clients requesting MAiD must:

- Respect client autonomy, remain client-centred, and treat clients with dignity regardless of the occupational therapist's personal beliefs and values
- Inform clients of the occupational therapist's role in response to the request, including that occupational therapists cannot determine eligibility
- Obtain consent to direct clients seeking information about MAiD to the appropriate professionals, such as a physician, a nurse practitioner, or the local MAiD Care Coordination service
- Proceed with clients' occupational therapy service plan as appropriate

Respond to a Request to Act as an Independent Witness or Proxy

A person who provides healthcare services or personal care as their primary occupation and who is paid to provide that care to the requestor is permitted to act as an independent witness so long as they are not involved in the assessment or provision of MAiD to the requestor. Hence, an occupational therapist may act as a witness for a client completing the Request for Medical Assistance in Dying Application form. They may also sign and date the Patient Request Record as a proxy if the client is physically unable to do so.

An occupational therapist serving in these roles must meet specific legal and procedural requirements. Before acting as a witness or proxy, the occupational therapist must comply with all relevant laws and employer policies.

Contribute to MAiD Assessments

Given the complexity of assessing capacity to consent to MAiD, medical assessors may consult occupational therapists for input on clients' cognitive status or other information pertaining to social or functional abilities. Occupational therapists should remain current in this area of practice by using evidence-informed practices and completing appropriate training to maintain knowledge, skills, and judgement.

Provide End-of-Life Planning

Occupational therapists support clients throughout the lifespan, including those receiving end-of-life care. They provide client-centred, culturally safer services that promote comfort, independence, and dignity.

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These services may involve:

- Helping clients access their environment and manage discomfort—for example, by assisting with equipment requirements and comfort measures.
- Supporting clients with maintaining relationships and making choices.
- Occupational therapists may help clients participate in valued activities for a last time.
- Educating clients and families about other options for end-of life care and available resources.
- Being attentive to the needs of caregivers, who may require strategies for providing care or support with grief and bereavement during the palliative or MAiD process.

Throughout this work, occupational therapists must adhere to standards related to obtaining informed consent, maintaining professional boundaries, protecting client information, and supervising occupational therapy assistants.

Conscientious Objection

The legislation on MAiD respects the personal convictions of healthcare providers. Due to conscience or religion, occupational therapists may elect not to participate or aid in the provision of MAiD.

Occupational therapists who conscientiously object to MAiD are expected to:

- Do so transparently while meeting the responsibilities and accountabilities of the Standards of Practice
- Respect client autonomy, remain client-centered, and treat clients with dignity regardless of the occupational therapist's personal beliefs and values
- Not withhold information or impede access to MAiD
- Direct clients to available services and resources
- Obtain consent to refer clients to an alternative service provider who will address client requests for MAiD, as appropriate
- Continue with the occupational therapy service components that are not directly related to the request for assisted dying, as appropriate, until care can be successfully transferred to another occupational therapist or alternative service provider

When determining whether continuing care would be appropriate, occupational therapists must be confident in their own beliefs and know that their values will not present a conflict of interest that may prevent them from acting in a client's best interests. Occupational therapists must also ensure that discontinuing care will not compromise client safety or planned intervention outcomes. The discontinuation of the professional services needed is addressed under *Ontario Regulation 95/07: Professional Misconduct* and outlined in the Discontinuing Services Practice Guidance Document.

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Summary

This Practice Guidance Document provides an overview of MAiD legislation in Canada. Although occupational therapists do not determine eligibility for MAiD, they can play a key role in enhancing clients' quality of life, by addressing complex social needs and exploring options for end-of-life care in individuals with complex social factors. Occupational therapists can support client autonomy, ensure that safeguards are in place, and work collaboratively with MAiD care teams. Occupational therapists in any practice area may be asked about MAiD. By understanding the legislation and the process to initiate MAiD, and maintaining ethical and professional standards, occupational therapists can provide client-centred, compassionate care for those navigating the complexities of making end-of-life decisions.

Appendix: MAiD Track 1 and Track 2 Systems

Track 1 **Reasonably Foreseeable Natural Death**	**Track 2** **Non-Reasonably Foreseeable Natural Death**
Assessment by at least two independent nurse practitioners or physicians is required. The requestor must meet all the following criteria: • Have a serious and incurable illness, disease, or disability • Be in an advanced state of irreversible decline in capability • Have enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions they consider acceptable • Be at a point where natural death has become reasonably foreseeable, considering all their medical circumstances, without a prognosis necessarily having been made as to the length of time they may have remaining The requestor must have one independent witness to their own signature on their written request for MAiD. The independent witness can be someone who provides paid health or personal care services to the requestor. If the requestor is approved for MAiD, there is no wait time. The individual can schedule the procedure with the MAiD provider. The requestor can withdraw the request at any time.	Assessment by at least two independent nurse practitioners or physicians is required. One health practitioner must have expertise in the condition causing the requestor's suffering or must consult with a practitioner who does have expertise and share the results of that consultation. The requestor must meet all the following criteria: • Have a serious and incurable illness, disease, or disability • Be in an advanced state of irreversible decline in capability • Have enduring physical or psychological suffering that is intolerable to them and cannot be relieved under conditions they consider acceptable The requestor must be informed of available services and offered consultations on available means to relieve suffering, such as counselling services and palliative care. All parties must agree that the requestor has seriously considered those means, although they do not have to follow up with the information given. The requestor must have one independent witness to their own signature on their written request for MAiD. The independent witness can be someone who provides paid health or personal care services to the requestor. The physician or nurse practitioner administering MAiD must consult with another medical practitioner if the first practitioner does not have expertise on the condition of the person seeking MAiD, and ninety days must pass between the first assessment of MAiD eligibility criteria and the day on which it is administered. However, this period can be shortened if the requestor is about to lose the capacity to make healthcare decisions as long as assessments by two independent health practitioners have been completed. The requestor can withdraw the request at any time.

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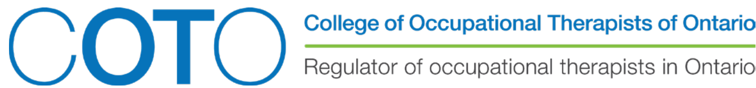
AGENDA ITEM 11.2



BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Executive Committee

Subject: Coroner's Request on Use of Restraints

Recommendation:

***THAT** the Board approve the proposed practice resource about the safe use of lap belts for publication.*

Issue:

The College received a written request from the Chief Coroner's Office of Ontario to respond to a recommendation from the Geriatric and Long-Term Care Review Committee's (GLTCRC) report OCC file: 2023-21025 (GLTCRC 2024-03).

> "**Recommendation: To the College of Occupational Therapists of Ontario**
> When prescribing a lap belt, a "wearing schedule" or instructions on use should also be provided. Alternatives to a lap belt for positioning should be considered such as wedge cushions and tilt wheelchairs. Occupational Therapists should assess the user's ability to release the belt buckle, and if unable, then remove the lap belt or initiate the facility restraint policy."

Link to Strategic Plan:

- Meaningful Engagement - The Colleges builds trust in its role and value through purposeful and meaningful engagement and collaboration:
    - Provides clear information about what to expect when working with occupational therapists.
    - Engages registrants to build understanding of professional obligations, College programs and services.
- Quality Practice - The College embraces leading regulatory practices to protect the public:
    - Engages occupational therapists to advance quality practice and the delivery of safe, effective occupational therapy services.

Why this is in the Public Interest:

The College, in carrying out its role, protects the public through effective regulation. The College can contribute to public safety by alerting, issuing and developing guidance for occupational therapists working in settings where this type of equipment may be recommended and there may be potential risks. Ensuring this information is available to all occupational therapists, clients and the public, supports the safe, ethical, and competent practice of occupational therapists in Ontario.

Diversity, Equity, and Inclusion Considerations:

To advance quality and ethical practice, developing resource documents ensures public confidence in occupational therapy regulation. During this development process, careful consideration was given to diversity, equity, and inclusion (DEI) principles that align with the Competencies of Occupational Therapy Practice in Canada (2021) and Standards of Practice.

Background:

The College received the request in January 2025 and was required to respond to the Coroner by July 2025. The College responded to the Coroner's Office advising the practice resource document was under development with the anticipated approvals to be in place by October 2025.

Key themes in the Coroner's request

- Defining lap or positioning belts on wheelchairs
- Patient Restraints Minimization Act, 2001
- Facility restraint use and policy
- Risk evaluation by occupational therapists
- Instructions to be provided with prescription of devices

Discussion:

Seeking Board approval for publication for occupational therapists so occupational therapists can provide appropriate assessments and education to their clients.

Implications:

This document provides considerations for occupational therapists if recommending wheelchair lap belts, to mitigate risk of harm to clients. A copy of the resource will be sent to the Executive Lead at the OCC's Office in response to the GLTCRC report OCC file: 2023-21025 (GLTCRC 2024-03).

Recommendation: The practice resource will be published on the College website, followed by a communications plan to notify registrants about this resource.

Attachments:

1. Coroner’s letter to the College
2. Geriatric and Long-Term Care Review Committee’s (GLTCRC) report
3. College’s Response to the Coroner’s Report

Ministry of the Solicitor General

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Ontario Forensic Pathology Service

Forensic Services and
Coroners Complex
25 Morton Shulman Avenue
Toronto ON M3M 0B1

Telephone: (416) 314-4000
Facsimile: (416) 314-4030

Ministère du Solliciteur général

Bureau du coroner en chef
Service de médecine légale de l'Ontario

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Via E-mail to: elarney@coto.org

January 23, 2025

Elinor Larney, CEO
College of Occupational Therapists of Ontario
20 Bay Street, Suite 900
PO Box 78
Toronto, ON, M5J 2N8

Dear Ms. Larney:

Re: Geriatric and Long-Term Care Review Committee

OCC File No.: 2023-21025 (GLTCRC 2024-03)

Please find enclosed a copy of the report and recommendations prepared by the Geriatric and Long-Term Care Review Committee (GLTCRC) concerning the above-mentioned case.

The purpose of the Geriatric and Long-Term Care Review Committee is to assist the Office of the Chief Coroner in the investigation, review and development of recommendations towards the prevention of future deaths relating to the provision of services to elderly individuals and/or individuals receiving geriatric and/or long-term care within the province.

Upon reviewing this case and preparing recommendations towards the prevention of future deaths, the GLTCRC has indicated that your organization may be in a position to implement recommendation **#3**. I would appreciate your response to this recommendation by **July 23, 2025.**

If you feel the recommendation has been assigned incorrectly, your suggestions as to where to direct the recommendation would be greatly appreciated.

Please be advised that your response will be considered a public document and may be released to interested parties upon request.

GLTCRC recommendations are not legally binding; however, we trust they will be given careful consideration for implementation and, if not implemented, that your organization provides an explanation.

Please direct your response to:

Executive Lead – Committee Management
Office of the Chief Coroner
occ.deathreviewcommittees@ontario.ca

Thank you for participating in this important process. Please contact us if you have any questions.

Yours truly,

Roger Skinner, MD CCFP(EM)
Provincial Medical Officer

Rejean Duwyn MD CCFP(EM) FCFP
Regional Supervising Coroner,
Operations

Chairs – Geriatric and Long-Term Care Review Committee

RS:cw

Enclosure

GERIATRIC AND LONG-TERM CARE REVIEW COMMITTEE

This document is produced pursuant to section 15(4) of the *Coroners Act*, R.S.O. 1990, c. 37, on the basis that it is to be used for the sole purpose of a Coroner's investigation, and not for any litigation or other proceedings unrelated to the Coroner's investigation. Moreover, the opinions expressed herein do not necessarily take into account all of the facts and circumstances surrounding the death. The final conclusions of the Coroner's investigation may differ significantly from the opinions expressed herein.

Date of Birth: January 5, 1932
Date of Death: July 27, 2023
Age: 91 years
OCC file: 2023-21025 (GLTCRC 2024-03)

Reason for Review:
The committee was asked to review this death of a 91-year-old male with advanced dementia who died following a near asphyxia episode while in a wheelchair with a lap belt. He was being cared for in an Alternate Level of Care (ALC) unit of an acute care hospital. The coroner and family raised concerns about the use of restraints in the hospital.

Documents for Review:
1. Coroner's Investigation Statement
2. Hospital Quality-of-Care Review Request and Response
3. Acute Care and ALC Unit Medical Records
4. Hospital Incident Report
5. Hospital 'Nursing Policy and Procedure' Document
6. Email related to Health Canada submission, with photos of restraints
7. Health Canada Online Submission Confirmation
8. Geriatric and Long-Term Care Review Committee Referral Letter

Cause of Death:
Complications of a near asphyxia episode (Medical Device- Restraints).

Other Conditions:
Advanced dementia.

Manner of Death:
Accident

History:
The decedent was a 91-year-old male resident of a retirement home. He was admitted to the retirement home with his wife in 2017. He was moved to the memory floor of the retirement home in early June 2023 due to increasing confusion and falls. Personal Support Worker (PSW) support increased from twice weekly to twice daily at the beginning of June 2023. At the time of transfer, he was ambulatory without a gait aid. Medications were administered by staff. He had reportedly been declining in function since January 2023.

Past Medical History:

- Hearing Impairment
- Osteopenia
- Cognitive Decline since 2014
- Dementia diagnosed 2018 following the death of his wife.
- Montreal Cognitive Assessment (MoCA) in 2018 was 18/30
- Pulmonary Embolism 2018
- Factor V Leiden
- Hypertension
- Anemia
- Hypothyroidism
- Urinary Retention due to Benign Prostatic Hyperplasia (BPH)
- Venous Insufficiency
- Remote Treatment for Tuberculosis (TB)
- 25 pack per year Smoker
- Appendectomy, Prostatectomy, Bilateral Cataract Extractions

Social History:

- Widowed 2018
- Three adult children.
- Decedent was a writer for the CBC News.

On June 16, 2023, the decedent was found on the floor in his room at the retirement home and was sent to hospital. He had also suffered a fall four days prior. He was found to have urine retention with 800cc. A urinary catheter was inserted. A transurethral resection of the prostate (TURP) was not within the treatment plan, given the decedent's goals of care and the catheter

remained in place on discharge. He had worsening bilateral leg edema thought to be related to venous insufficiency and not due to cardiac issues.

While in hospital, the decedent was seen by geriatric psychiatry for an agitated delirium with paranoia and delusions secondary to behavioural and psychologic symptoms of dementia (BPSD). Neuroleptic agents were administered and adjusted. His stay was further complicated by a Citrobacter urinary tract infection (UTI) with bacteremia treated with ciprofloxacin. His functional status continued to decline and in discussions with his family, his care plan was changed to a comfort care approach.

On June 22, 2023, the decedent was assessed by an Occupational Therapist (OT) in the acute care hospital for a seating and wheelchair assessment. Recommendations were given to his family. Chair measurements and cushion recommendations were made. Position belt to "auto" which means a buckle with a button that can be pushed to release. This chair was to be a rental with Assistive Devices Programme (ADP) assessment post discharge. There are no notes to indicate if the OT assessed whether the decedent could undo the belt. There were no notes as to when the belt should be used.

On June 22, 2023, Physiotherapy (PT) assessed the decedent and found him "in OT issued manual wheelchair, working at lap belt." The PT documented the decedent saying "'I can't seem to get this thing undone' (referring to lap belt on wheelchair)." This deems this belt as a restraint.

On June 29, 2023, PT did an assessment for rehab suitability. The PT documented "transfers lie to sit- 2 maximum assistance. Sit to stand-unable to perform. Required assist x 3 to transfer back to bed from wheelchair. Recommend mechanical lift for safe transfers with staff. Not appropriate for sub-acute rehab."

The decedent was transferred to an ALC unit managed by the same hospital on July 6, 2023. At the time of discharge, a stage 2 coccyx ulcer was present.

Medications on Transfer:

- Furosemide 40 mg daily
- Acetaminophen 650 mg twice daily, and four times per day as needed.
- Trazodone 25 mg twice daily as needed.
- Amlodipine 5 mg daily
- Dimenhydrinate 25-50 mg daily as needed
- Risperidone 0.25 mg at bedtime
- Topical Voltaren as needed
- Apixaban 5 mg twice daily
- Glycerine suppository every 12 hours as needed
- Ferrous fumarate 300 mg at bedtime

On July 16, 2023, an incident of near asphyxia occurred.

Timeline as per Progress Notes/Incident Report:

- 0815 hrs: Vital Signs 127/68 HR 72 T 36.8C (Recorded at 1647 hrs by the Primary nurse)
- 0900 hrs: Meal assessment. Took 75% meal. Total feed. (Recorded at 1500 hrs by the Primary nurse)
- 1000 hrs: Turn and reposition. (Recorded at 1501 hrs by the Primary nurse)
- 1044 hrs: Vital Signs 97/61, HR 74, T 36.5C (Recorded at 1045 hrs by the Primary nurse)
- 1200 hrs: Turn and reposition. (Recorded at 1501 hrs by the Primary nurse)
- 1300 hrs: Meal assessment. Took 50% of his lunch. (Recorded at 1504 hrs by the Primary nurse)
- ~1300 hrs: The decedent's daughters visited and took him off the unit in his wheelchair. (From Incident report)
- 1350-1435 hrs: The primary nurse was off on lunch break and during that time the decedent was returned to his room by the family. Staff were not aware of his return to the unit. (From incident report)
- 1400 hrs: Turn and reposition. (Recorded at 1504 hrs by the Primary nurse)
- 1505 hrs: Primary nurse returned to the decedent's room at 1505 to administer medications. The decedent was awake and comfortable at that time. He was upright in his chair. (From Incident report)
- 1600 hrs: Turn and reposition. (Recorded at 1931 hrs by the Primary nurse)

The family returned to the room at ~1600 hrs and found the decedent had slid down from his chair and was trapped by the seat belt around his chest. He was holding the lap belt with both hands trying to relieve some of the pressure. His daughter, who is a nurse, reported to the coroner that the decedent's face, lips and ears were cyanotic. The decedent was repeatedly saying "please do not let me die" and he reportedly looked 'absolutely terrified'. The seat belt was taut, and they were unable to depress the button to liberate him. They supported the decedent by his buttocks and called for help. Staff were able to release the belt and lift the decedent into the bed. His primary care nurse was not present.

- 1639 hrs: Vital Signs BP 89/55, HR 66, T 37C. (Recorded at 1642 hrs by the Primary nurse)
- 1642 hrs: Post Fall Assessment (Recorded at 1642 hrs by the Second nurse)

Incident report was completed by the primary nurse although he did not witness the event. There were concerns raised by the family regarding the medication safety practices of the primary nurse, but they are outside the scope of this review.

The on-call physician was not notified of the incident that day. The most responsible physician (MRP) discharge summary states "the decedent was restrained without authorization of a physician". He also stated, "the indications of use of the restraint is not clear but presumably inferred to have been used to mitigate falls risk." Discharge summary also stated that the physician could not find any signs of physical trauma from the incident but he "did observe an accelerated medical decline there-after."

Following the incident on July 16, 2023, the decedent continued to decline and died with his family by his side on July 27, 2023.

Discussion:

The decedent was a 91-year-old male with advanced dementia who died following a near asphyxia episode while in a wheelchair with a lap or positioning belt. These belts assist with hip positioning and are not in place to stop the user being ejected from the seat as would be needed in a car seat belt. These belts are a standard on wheelchairs, even if not prescribed. It seems the care team did not recognize this lap belt, that could not be removed by the decedent, was a restraint.

In Ontario in 2001, the *Patient Restraints Minimization Act, 2001, Bill 85* was enacted with a goal to minimize the use of physical and chemical restraints and encourage the use of alternatives. The Registered Nursing Association of Ontario (RNAO) developed guidelines for restraint minimization in 2008 (*Promoting Safety: Alternative Approaches to the Use of Restraints* guideline) in response to a Coroner's Inquest recommendation following a death related to the use of a restraint (1). These RNAO Guidelines recommend a "move towards restraint-free care in diverse settings such as acute, long-term and home healthcare." Restraint use is not a safe intervention to prevent falls (2).

Despite these widespread guidelines and intensive staff education, healthcare providers and families continue to view restraints as way to prevent falls, and hence, injury. It is clear from the RNAO guidelines, WHO: World Fall Prevention Guidelines (3), and the experience of this committee, that restraints do not prevent falls, and most certainly, do not always prevent injury. There was no physician's order as required by the hospital restraint policy. The physiotherapist documented that the decedent could not undo the belt but did not raise a red flag for the team or ask the OT to reassess the belt or seating for alternatives such as a chair alarm or wedge cushion. There is no mention of initiation of the restraint policy or need for increased supervision. The hospital restraint policy states "Patients who require a waist belt would need a pelvic strap applied to prevent injury." No pelvic strap was in place. The hospital policy also states clearly: "Use of restraints will increase the risk of falls."

The policy gives clear guidelines for monitoring of patients in 4-point restraints, but only recommends that for non-emergent restraints: "Provide restraint-free opportunities for

ambulating, toileting, exercising and all other care **at least 10 minutes every 2 hours**, if safe to do so." The decedent had slid down from his chair and was trapped by the seat belt around his chest in less than 2 hours from last being seen.

The hospital's quality review of this incident pointed out that they "generally are liberal in use of seatbelts and other restraints in patients at risk" and that this is not the case in long-term care settings. Restraint use in acute care is under reported. The hospital will be reviewing their policies on restraint use. It should be recognized that there is likely a greater risk of injury due to restraints in an acute care setting as patients are more likely to be delirious, agitated and using seating that has not been prescribed for them. RNAO and WHO recommendations apply to both acute care and long-term care settings.

Occupational therapists prescribe many devices for patient use (splints, braces etc.) and usually provide a "wearing schedule" or instructions on use. These types of instructions could also be given for the use of a lap belt. It should only be used when adequately supervised. Families should be given information on the safety and proper use of restraints including lap belts.

The Regional Supervising Coroner, in their report, stated "I sincerely believe that what happened to the decedent should be a never event. I would like to recommend to Health Canada that this kind of belt be banned and that a 3-point belt be used instead when restraints are required." Unfortunately, the care team did not recognize this lap belt as a restraint, and therefore did not follow the hospital's own policy on the use of a pelvic strap. The committee supports the Regional Supervising Coroner's plan to notify Health Canada of this incident.

Recommendations:

To the Ministry of Health (MOH), Ministry of Long-Term Care (MLTC) and Ontario Hospital Association (OHA):

1. Education regarding restraints should be directed to the entire health care team and not just focused on nursing. A process should be developed to communicate concerns regarding restraint safety when identified.

2. Hospitals and LTC homes should advise families to return their family member to the nursing station or common area after being off the unit to ensure appropriate safety measures are put in place when returning to their room/bed.

To the College of Occupational Therapists of Ontario:

3. When prescribing a lap belt, a “wearing schedule” or instructions on use should also be provided. Alternatives to a lap belt for positioning should be considered such as wedge cushions and tilt wheelchairs. Occupational Therapists should assess the user’s ability to release the belt buckle, and if unable, then remove the lap belt or initiate the facility restraint policy.

To Health Canada (including wheelchair lap belt manufacturers and vendors):

4. A lap belt should not be provided with a wheelchair unless requested by the prescribing therapist.

5. Health Canada should request that manufacturers of lap belts explore release mechanisms that are easier to release.

To the Hospital Involved:

6. This report should be reviewed by Quality Committee.

References:

1. RNAO. Clinical Best Practice guidelines. Promoting Safety: Alternative Approaches to the Use of Restraints.
https://rnao.ca/bpg/guidelines/promoting-safety-alternative-approaches-use-restraints

2. RNAO Best Practices Evidence Booster, March 2024. Implementation Impact: Screening for Falls and Reducing the Incidence of Falls.
Becoming restraint-free - The impact on falls rate | RNAO.ca

3. WHO: Step Safely: Strategies for preventing and managing falls across the life-course April 2021

2025 College Response to the Coroner's Report:

Death Related to Wheelchair Lap Belt

At the request of the Office of the Chief Coroner of Ontario, the Geriatric and Long-Term Care Review Committee (GLTCRC) released a report on the death of a hospital patient following a near asphyxia episode while in a wheelchair with a lap belt.

Summary of Case Review

The GLTCRC reviewed the death of a 91-year-old male with advanced dementia who died in July 2023 following a near asphyxia episode while in a wheelchair with a lap belt.

The patient was seen by an occupational therapist in an acute care hospital for a seating and wheelchair assessment. Recommendations were provided to his family about wheelchair measurements, cushion and an "auto" positioning belt which means a buckle with a button that can be pushed to release. The wheelchair was intended to be a rental, to be used while he was in hospital and for the Assistive Devices Program (ADP) assessment post discharge. There was no documentation by the occupational therapist to indicate whether the patient could undo the belt or when the belt should be used. The physiotherapist documented that the patient could not undo the belt, but the care team did not recognize that this deemed the lap belt a restraint.

The patient was transferred to an Alternative Level of Care (ALC) unit managed by the same hospital. The family entered his room to find that he had slid down from the wheelchair and was trapped by the seat belt around his chest. He was holding the lap belt with both hands trying to relieve some of the pressure. Staff were able to release the belt and lift the patient to bed. Following this incident, the patient continued to medically decline, and he died 11 days later. The physician's discharge summary states "the decedent was restrained without authorization of a physician". The physician's summary also stated, "the indications of use of the restraint is not clear but presumably inferred to have been used to mitigate falls risk."

GLTCRC recommendation to the College:

When prescribing a lap belt, a "wearing schedule" or instructions on use should also be provided. Alternatives to a lap belt for positioning should be considered such as wedge cushions and tilt wheelchairs. Occupational Therapists should assess the user's ability to release the belt buckle, and if unable, then remove the lap belt or initiate the facility restraint policy.

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COTO College of Occupational Therapists of Ontario
Regulator of occupational therapists in Ontario

Use of wheelchair lap belts

A lap belt (also commonly known as seat belt or safety belt) is a device that is worn over a person's lap to help position their pelvis in a wheelchair to optimize seating posture. The lap belt is attached to the wheelchair and has a front buckle with a push button to release. A lap belt may be included as a standard part of the wheelchair from the manufacturer. It can also be ordered separately to be installed on a wheelchair. While lap belts and wheelchairs are usually prescribed by a health professional for people in facilities such as hospitals or long-term care homes, they can also be purchased by clients and caregivers without input from a health professional from home medical supply stores.

Benefits of using lap belts	Risks of using lap belts
• Promote postural support and alignment in the wheelchair by positioning the pelvis. • Increase sitting tolerance and stability in a wheelchair which in turn can enhance function, engagement and independence. • Promote safety and security in the wheelchair when being transported outdoors, moving in a power wheelchair or while riding on public transit.	• May be deemed a restraint (as defined under legislation in certain settings) for individuals who cannot release the lap belt independently, which can cause harm, injury and even death. • Improper fit or changes in the belt's positioning can cause harm such as pressure points, discomfort, skin irritation/abrasions, or even entrapment and death. • Improper use for purposes it was not intended for, such as restrict movement to mitigate falls, can cause harm such as agitation, mental distress and physical injury.

College Response

Occupational therapists are trained healthcare professionals with the knowledge and skills to assess clients and their environments and identify the risks and benefits of appropriate equipment and devices to optimize safety, functioning and well-being.

When assessing clients and implementing intervention plans, occupational therapists are expected to follow the Standard for Assessment and Intervention, 2023:

- Manage risks, and collaborate and communicate with clients, other professionals, partners, and interested parties to support evidence-informed decision-making.
- Communicate assessment and intervention effectively such as results, opinions, recommendations, and updates.

- Review and evaluate plans regularly in partnership with clients.
- Know and follow workplace policies and applicable legislation.

Considerations

The following reflective questions can help occupational therapists in their assessment and intervention process when recommending devices such as a lap belt:

Step 1: Understanding wheelchair lap belts

- Do I have the competencies (knowledge, skills, judgement and training) to assess, recommend and implement lap belts or alternatives?
- Do I have knowledge about lap belts and their potential risks including being deemed a restraint in some settings?
- What legislation applies to my practice? For example:
  - Patient Restraints Minimization Act, 2001, S.O. 2001, c. 16
  - Long-Term Care Homes Act, 2007, S.O. 2007, c. 8
  - Fixing Long-Term Care Act, 2021, S.O. 2021, c. 39, Sched. 1
- What workplace or facility policies apply to my practice? For example, restraint policies or equipment policies in the community.
- Are there any legislative and policy requirements for a physician to provide a medical order for an occupational therapist to assess for a device or restraint?
- Is there evidence to support the use of lap belts or alternatives based on the client's condition/status?
- Is there any manufacturer's information about intended use, set up and risks of their product?
- What should I consider for clients and families who purchase their own wheelchairs with lap belts who are not in hospitals, long term care or retirement homes?

Step 2: Assessment

- What is the occupational issue being addressed?
- Why is a device such as a lap belt being considered for the client?
- Does this client have any limitations (physical, cognitive, behavioural) that could impact their ability to use a lap belt safely?
- Does the client's abilities or functional status change or fluctuate?
- Can the client independently and reliably undo the buckle and release the lap belt? If not, is there a restraint policy and protocol need to be followed in the facility?
- Is the lap belt positioned properly with the client in the wheelchair and serving its purpose?
- Are there opportunities when the client or the lap belt may shift position over time?
- Are there other factors (social, environmental, cultural) that could impact the safe use of a lap belt?

- Are other options and alternatives such as wedge cushions or tilt wheelchairs being considered?
- Does the client, family and caregivers understand the risks and have the capacity to monitor the safe use of the lap belt over time?

Step 3: Analysis/Collaboration

- Is a lap belt appropriate for the client and environment?
- Are there any contraindications for recommending a lap belt for this client?
- Could a lap belt be a restraint or become a restraint for this client?
- Is there additional information from the interdisciplinary team that can guide decision-making, such as the effect of medications, fluctuations in condition, or history of falls.
- Is there any information from the manufacturer about recommended installation and intended use?
- Have all options been considered to ensure the minimization of restraining in hospitals, long term care and retirement homes?
- If a restraint is required, should another device be used (for example: 3-point belt or harness)?
- Has education been provided to clients and caregivers? Education should include
    - instructions on how to use and position the lap belt
    - a wearing schedule on when the client should use the lap belt and duration
    - information about its intended use (for example: to promote sitting alignment) and the risks when used improperly for other purposes (for example: to restrict movement)
- What is the plan to monitor the client's safety and use of lap belt?
- When will the device be re-assessed?

Step 4: Monitoring and Re-evaluation

- Have I reassessed the client using the lap belt within the planned timeframe?
- Are adjustments to the lap belt positioning or wearing schedule needed?
- Should the lap belt be removed if no longer safe or indicated?
- Is further training to the client and caregivers necessary?
- Is there clear accountability for ongoing monitoring of device use
- Is there clear documentation of the processes involved?

Summary

The Office of the Chief Coroner of Ontario has requested the College educate occupational therapists about the risks of lap belts on wheelchairs. It is important that occupational therapists understand the legislative and policy requirements of their practice setting, perform thorough assessments, and collaborate with all parties involved, including the client, their family, and other healthcare professionals to address safety risks. Providing education is key to prevent any future deaths from the use of this type of equipment.

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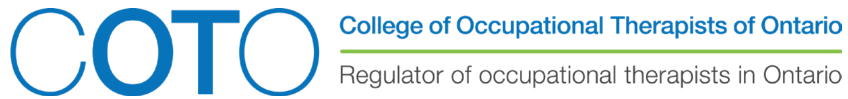

General implications for occupational therapy practice

While the recommendations from the Coroner's report focus on hospitals and long term care settings, it has implications for other practice areas. Occupational therapists also work with clients in homes, schools and the community where they may prescribe wheelchairs and lap belts. They may also encounter clients who have purchased their own lap belt for use without the input from a health professional. Any equipment or device can have the potential to become a restraint. Occupational therapists are encouraged to use the reflective questions to guide their practice when recommending devices to clients and caregivers.

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BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Quality Assurance Committee

Subject: Enhance: QA Practice Activity

Recommendation:

THAT *the the Board approve the Enhance: QA Practice Activity as an addition to the existing QA Assessment Process and approve the proposed change to the QA Policy.*

Issue:

The Quality Assurance (QA) program has successfully developed and implemented a comprehensive competency assessment (CCA). While the College is mandated to conduct these assessments, many occupational therapists do not require an extensive evaluation and can benefit from a shorter, self-directed reflection on their practice.

To augment this overall assessment approach, a new QA practice activity has been designed to support a specific group of registrants (those that did not complete annual requirements on time).

Link to Strategic Plan:

Quality Practice

The College embraces leading regulatory practices to protect the public.

- Takes an evidence-informed, risk-based approach to ensuring occupational therapists are competent, safe, effective, and accountable.
- Engages occupational therapists to advance quality practice and the delivery of safe, effective occupational therapy service.

Why this is in the Public Interest:

Enhancing an occupational therapist's knowledge and understanding of regulatory expectations can lead to valuable changes in daily work with clients and their caregivers.

Equity, Diversity, and Inclusion Considerations:

The criteria for selection to participate in this activity will be done in a fair and transparent way and with consideration of any unintended bias. There is also a process for registrants to defer participation due to extenuating circumstances. Insights from an Equity Impact Assessment have been considered.

Background:

The CCA is a behavioural based assessment that includes 30 questions that span the continuum of an OTs practice from initiation to discontinuation and is facilitated by a trained OT peer assessor. Preliminary results indicate that this assessment is effective in promoting change in individual practice. Most registrants have 1-2 areas for learning that are addressed in their written response and about 10% have multiple learning needs and are required to do additional remedial activities. Because this process is individualized and relies on peer assessors for facilitation of the interview, it does require valuable time and cost.

So, to augment the overall assessment approach by COTO QA, it is proposed that a shorter assessment be developed to enhance professional growth through self-reflection. The activity will be administered electronically to a specified group of registrants, for example those who:

- did not complete their annual requirement(s) on time (will begin with this group) or,
- perform higher risk activities in their practice e.g., controlled act or delegation or,
- have a higher risk-based indicator score

Tool development

The activity was developed based on a variety of sources of data including:

- Environmental scan and consultation with other regulators (Nov 2024- March 2025)
- QA Competency assessment data identifying top areas for learning needs (May 2025)
- Investigations & Resolutions data: main areas for mandatory complaints submitted (July 2025)
- Key Informant Survey to peer assessors, QA subcommittee and COTO Practice staff (July 2025)
- Quality Assurance Subcommittee review (Aug 2025)

Proposed QA Practice Activity

The proposed QA activity consists of a shorter two-part online questionnaire administered to a selected group of registrants (both clinical and non-clinical). Upon submission, responses are reviewed online by a trained peer assessor, who evaluates the registrant's competencies—specifically their knowledge, skills, and judgment related to a set of questions— and their ability to engage in meaningful self-reflection. This evaluation is guided by predetermined scoring criteria to ensure consistency and fairness.

Part 1 replicates the Record Keeping component currently used in the CCA.

Part 2 introduces a new set of 8-10 questions, informed by program data and subject matter experts, designed to prompt registrants to reflect on their competencies in relation to specific aspects of their daily practice.

Part 3 would involve a virtual "peer circle" discussion group, offering registrants an opportunity to explore the topics in greater depth through facilitated dialogue. This may be considered for future implementation.

Scoring: The response to each question will be evaluated by a peer assessor using a scoring matrix to determine successful completion, or whether the registrant would benefit from additional action which can include:

1) Correction provided/add goal to learning plan
2) Consultation with QA staff
3) Directed to a competency assessment (determined by QAC)

Details of both Part 1 and Part 2 are provided in Appendix A. Please note this draft version of the activity will undergo some changes based on feedback to improve its utility e.g., include examples for non-clinical registrants.

Potential Benefits of the Activity

Enhanced Self-Awareness: Encourages registrants to critically reflect on their practice, promoting deeper insight into their strengths and areas for growth which can be integrated with their Annual Learning Plan (ALP).

Targeted Professional Development: Helps identify specific learning needs, enabling more focused and relevant continuing education.

Flexible and Accessible Format: Online delivery allows registrants to engage with the activity independently and at their own pace.

Peer-Informed Evaluation: Assessment by trained peer assessors ensures relevance, fairness, and professional credibility.

Scalable and Adaptable: The modular design allows for future enhancements, such as the addition of peer discussion groups, to further enrich the learning experience.

Supports Regulatory Requirements: Aligns with the College's mandate to assess competency while offering an easy-to-administer alternative to the CCA.

Pilot Implementation of the Enhance: QA Practice Activity

The proposed pilot for the *Enhance: QA Practice Activity* will first target registrants who do not complete one or both 2026 annual Quality Assurance (QA) requirements by the deadline of **October 31, 2026**. It is estimated that this group will include approximately **50 to 150 occupational therapists**.

In accordance with regulatory requirements, any changes to QA assessments must be communicated publicly at least three months prior to implementation, including website updates

and newsletter communications. These communications will clearly state that failure to meet the October 31st deadline will result in the requirement to complete the *Enhance: QA Practice Activity.*

Approval

In September, the Quality Assurance Committee provided feedback and approved the tool for Board review and approval. Pending approval from the Board, the QA program will continue with development and training towards 2026 implementation.

Timelines

Development of this tool began in summer 2025 and will continue based on the schedule below:

- submit for Board review and approval (October 2025)
- portal implementation (Jan – March 2026)
- assessor training (April 2026)
- pilot (May – June 2026)
- communication plan (June – October 2026)
- administer (October 2026)
- data analysis & review/revise (Spring 2027)

The timelines for this project are dependent on the resources required for portal implementation.

Discussion:

Please review the attachment and consider the following questions:

1) What is your overall impression of the *Enhance: QA Practice Activity*?
2) Do the questions cover a broad range of important areas of OT practice?
3) Are there any problems that you can foresee?
4) Do you have other comments?

Implications:

This tool will be an addition to the existing QA Assessment Process and will require change to the QA policy if approved. Below is the proposed language to be added to the QA policy:

Enhance: QA Practice Activity - *DRAFT*

Purpose

To augment the overall approach to assessment, the goal of this shorter assessment is to enhance accountability and professional growth through self-reflection. It provides an alternative to the CCA described above.

The activity includes a: professional reflection on record keeping (part 1) and an open-ended questionnaire (part 2).

Participation

Registrants are directed to participate in this activity if they do not complete one or both annual requirements by the due date (October 31st).

Scoring

Responses are reviewed and scored by a trained peer assessor using a scoring matrix.

Outcome

The following outcomes are available for QAC to consider:

- Successful completion
- Successful completion (with correction)
- Requires consultation
- Directed to a competency assessment

Attachments:

1. Appendix A Enhance: QA Practice Activity *DRAFT*
2. QA Overview Presentation - Board June 2025

ENHANCE: QA Practice Activity

Setting the Stage

Just a few questions about your practice to get started:

1. Which best describes your role:
2. Which best describes your practice setting:
3. Which type of service do you primarily provide:
4. Which best describes the nature of practice:

* Use same response options from professional reflection form

Part 1: Record Keeping Reflection (clinical only)

Client records are the legal documents that describe the entirety of the occupational therapy service. Records help to communicate health information with clients, enable interprofessional collaboration and support timely and smooth continuity of care. The record is a way to demonstrate that an OT has provided safe, ethical and effective service.

Good record keeping requires sophisticated skills in judgement, objectivity, accuracy, attention to detail, and security. It is also an area that OTs can sometimes find challenging. This self-reflective activity will take you through the essentials of record keeping and help you identify areas of strength and areas to enhance in your record keeping practices.

Step 1. Review the Standard for Record Keeping which outline the expectations and then complete the Record Keeping Review Tool for **three** charts (do not include the charts or review tool).

When selecting charts:

- Choose charts from three recent clients
- The charts should be from clients who represent the broadest scope of your practice
- The charts should be from clients who are discharged from your service
- If you work in more than one setting include charts from each setting

Step 2. After completing the step 1, please reflect and respond to these questions:

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Q1. What did you learn from this exercise (i.e., areas of strength, areas to enhance and other main takeaways?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Q2. How have or will you use this learning in your practice?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Part 2: Practice Reflection (clinical & non-clinical)

As we each continue to develop in our careers, setting aside dedicated time to reflect on work can lead to small tweaks and valuable changes in practice.

Your responses to questions 1-8 are reviewed by a peer assessor for understanding and the degree of self-reflection. Let's get started.

These resources can assist as you work through the questions:

- Competencies & Standards
- Practice Guidance.

**A note to occupational therapists in non-clinical roles: when answering questions, please consider the term "client" in its broadest sense, which can be extended to client groups, communities, organizations etc. Some questions have a modified, non-clinical version included.*

Q1. Incorporating evidence and best practice into day-to-day work is key to providing safe, ethical and effective occupational therapy service.

How do you continue to have an **evidence-informed practice**?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Non-clinical examples: supporting accreditation goals, EDI

Q2. Work is busy, complex and filled with competing demands.

Describe how you manage **competing work demands**, so you can meet the needs of the clients in your care and keep up with other professional responsibilities?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

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Q3. There is often inherent **risk for clients** when participating in occupational therapy services. How have you adapted or changed from a routine practice in order to reduce risk and enhance safety?

From the list below, choose 2 types of risk to clients in your practice and provide an example of the steps you took to minimize the risk.

Physical (e.g., falls and other mobility-related injury, overexertion with recommended exercises, positioning and skin integrity) (provide non clinical examples for each)

Equipment (e.g., improper fit of assistive devices, unsafe use of transfer and mobility equipment, improper sanitation of equipment or assessments tools)

Environmental (e.g., unsafe or inaccessible home setups, lack of safe supervision, triggering or overstimulating environments, home environmental hazards)

Cognitive (e.g., cognitive fatigue, confusion and disorientation, impaired judgment and risk awareness)

Emotional (e.g., re-traumatization, harm to self or others, heightened anxiety

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Q4. Occupational therapists both acknowledge and respond to the history, cultures, and social structures that influence health and occupation. Incorporating humility and culturally safer practice is a lifelong endeavour.

Describe some of the ways, you incorporate **cultural humility** and **culturally safer practices** into your work?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Q5. Many OTs are utilizing emerging **technology** in their practice. How does technology benefit clients/ caregivers in your practice?

What steps do you take to manage the risks to clients associated with the use of this technology?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

DRAFT

Occupational therapists are required to obtain two types of consent for their services: knowledgeable consent and informed consent.

Q6. In Ontario, occupational therapists must obtain **informed consent** before providing any treatment or occupational therapy service (*Health Care Consent Act 1996*).

In order to obtain informed consent, the occupational therapist should explain to the client which of the following:

A. **What** the proposed treatment, procedure, or service is
B. **Why** it is recommended (the purpose and benefits)
C. **Who** is involved (any students, assistants, other providers)
D. **What are the risks** (including any serious or common side effects)
E. **What alternatives** are available (including taking no action)
F. **Clients right** to ask questions and say yes or no
G. All of the above
H. A, B, C, D only

Q6b. What aspect(s) of the consent process is challenging in your setting? How do you manage this challenge?
(0- none, 1- developing/sufficient, 2- advanced)

Knowledgeable consent is a specific legal requirement for how a person's health information can be collected, used, or shared (*Personal Health Information Protection Act, 2004*),

Knowledgeable consent emphasizes the importance of clients knowing what is happening with their personal health information.

To obtain knowledgeable consent, the occupational therapist should explain to the client which of the following:

A. **What** personal health information is being collected or shared,
B. **Who** is the personal health information being shared with,
C. **Why** is the personal health information being shared or used (the purpose),
D. The **clients right** to ask questions and say yes or no
E. All of the above
F. A & B only

**Non clinical: how do you or staff/students/researchers within your setting describe what happens with personal health information?*

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Q7b. How do you explain to clients what happens with their personal health information (PHI)?

(0- none, 1- developing/sufficient, 2- advanced)

Q8. Occupational therapists recognize the value of communication with client and caregivers amidst increasing demands and clinical complexities.

Describe a recent example when you showed **empathy** or **compassion** in your practice. What impact do you think it had?

Score: Level of self-reflection (0- none, 1- developing/sufficient, 2- advanced)

Putting it all together

Thank you for taking the time to reflect on these areas of your practice.

Based on your experience answering these questions, please note one aspect of your work that you perform well and one area to enhance with further learning. Please consider adding this further learning area to your Annual Learning Plan.

Area of strength:
Area of learning:

Open ended (max 150 words)

Thank you for your participation. We welcome your thoughts on this activity, and you can provide feedback though the “Feedback” button.

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Scoring matrix (assessor use)

2	**Advanced**	• The response demonstrates in-depth self-reflection. • Includes insightful and detail-oriented reflection to guide future behavior and growth. • Response addresses all aspects of the question • Includes one or more changes to practice • Highly contextualized to their practice • Recognizes the importance of clinical documentation (record keeping question)
1	**Developing**	• The response demonstrates basic self-reflection • Response addresses at least one aspect of the question (strength, area of improvement) • Includes one change to practice • Somewhat contextualized to their practice • Demonstrates some awareness of the importance of clinical documentation and impact to practice (record keeping question)
0	**Non-Reflective**	• No meaningful reflection in the response • Response does not address any aspect of the question

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Quality Assurance

Welcome

June 19th, 2025 Board Presentation

1

The Quality Assurance (QA) Program

To support and evaluate **continuing competence:**

- annual learning module
- annual learning plan
- competency assessment

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2

QA Committees

Quality Assurance Committee

- make decisions on registrant outcomes
- develop decision frameworks
- appoint peer assessors
- policy development
- select annual eLearning module topic
- recommend for Board approvals

Quality Assurance Subcommittee

- insights into OT practice
- eLearning module development
- tool development
- tool and testing

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QA Principles

Quality Practice	Promote professional growth and continuing competence
Fair	Create processes that are objective and effective
Transparent	Communicate expectations in ways that are easily understood
Just Right	Make decisions that match the level of risk
Responsive	Listen and adapt to changing environments
Reciprocal	Share insights so we learn and grow together
Respectful	Approaches that are collegial, timely, and sensitive

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Work Plan (June 25 -May 26)

Competency assessment:

	Monitor data and revise risk-based indicators/selection as needed
	Approve and implement *Enhance : QA Practice Tool* (ongoing)
	⇧ target to 147 competency assessments (2% of registrants) (June)
	Review registrant cases that meet QAC threshold (Jan & June)
	EDI remediation activity (ongoing)

Annual requirements:

	Approval of 2026 eLearning module content (January)
	Approval of 2027 eLearning module topic (January)
	Review of non-compliance registrant cases (January)

Policy:

	Review policy annually (March)

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About Annual Requirements

2025 Annual Learning Plan (ALP):

This self directed activity promotes professional growth using self-assessment, goal attainment and professional reflection.

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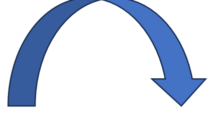
QA Requirement: Annual Learning Plan

Growth Areas for OTs



Impact

- **Culture, equity & justice:** Promote culturally safer practice

- **Record keeping:** Maintain professional documentation

- **Contribute:** Contribute to the learning of OTs and others
- **Learn:** Ongoing learning and professional development

- **Leadership:** Show leadership in the workplace

- Better client **outcomes**

- Improved client **safety**

- More **collaboration**

- Enhanced therapeutic **rapport**

- Increased **evidence-based** practice

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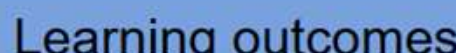
QA Requirement: Annual eLearning Module

Welcome to The 2025 National eLearning Module:

Advancing Culture, Equity and Justice in Occupational Therapy Practice



By the end of this module, OTs will:

- Better understand Domain C of the *Competencies for Occupational Therapy Practice in Canada ("the Competencies")*, and important concepts related to culture, equity, and justice in occupational therapy practice.
- Gain insight into the vast diversity across Canada's population and how this diversity relates to health equity and outcomes.
- Understand and be able to apply individual and collective strategies for culturally safer and equitable practice to real life occupational therapy situations.

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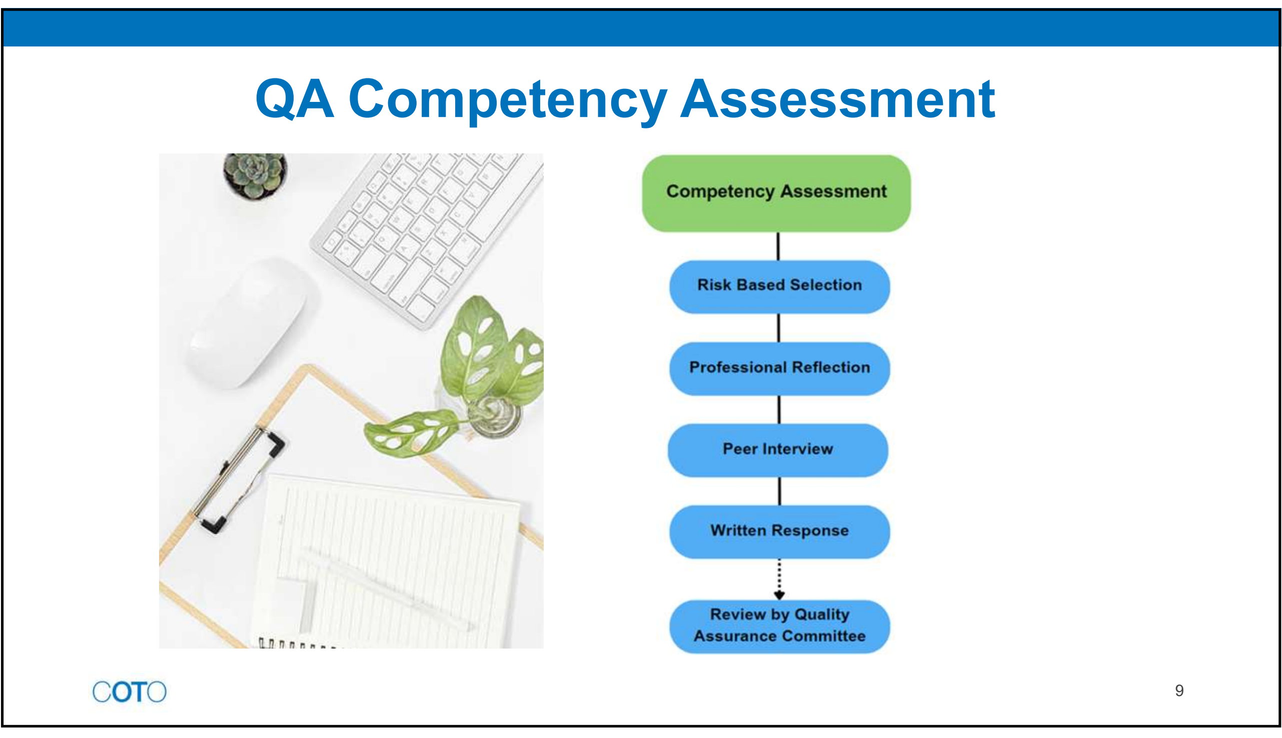

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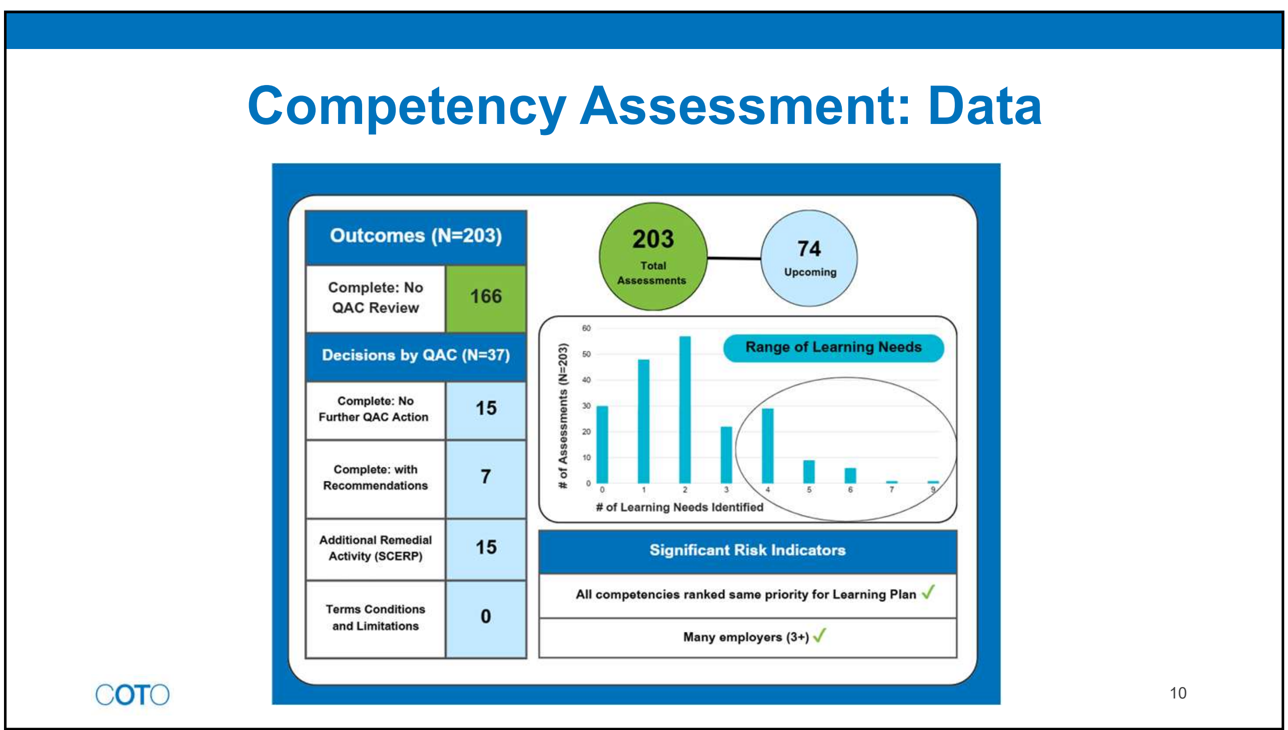

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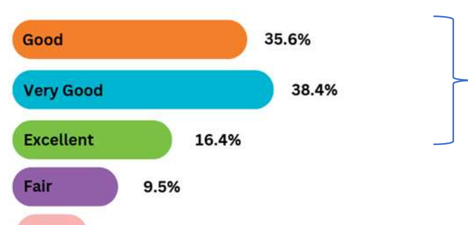
Competency Assessment: Registrant Experience

How would you rate your overall experience with the competency assessment?



90% of respondents said their experience was either:

Good
Very good
Excellent

Have you made a change in your practice because of the assessment? **Yes 100%**

"I think the interview provided opportunity to explore my clinical reasoning as having practiced for many years, often you perform or make decisions automatically, but it is good to reflect and understand the rationale for the decisions and be able to provide justification."

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Enhance QA Practice Activity (Oct. 2025) (Brief Practice Assessment, June 2025)

To augment the overall assessment approach by COTO QA, a brief practice assessment is being developed which can be administered separately to a specified group of registrants e.g., those that do not complete the annual requirements by due date.

Part 1: same self-reflective activity on record keeping

Part 2: 8-10 data driven questions and emerging trends

- privacy
- risk
- diversity and inclusion
- emerging technology
- enabling change

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12

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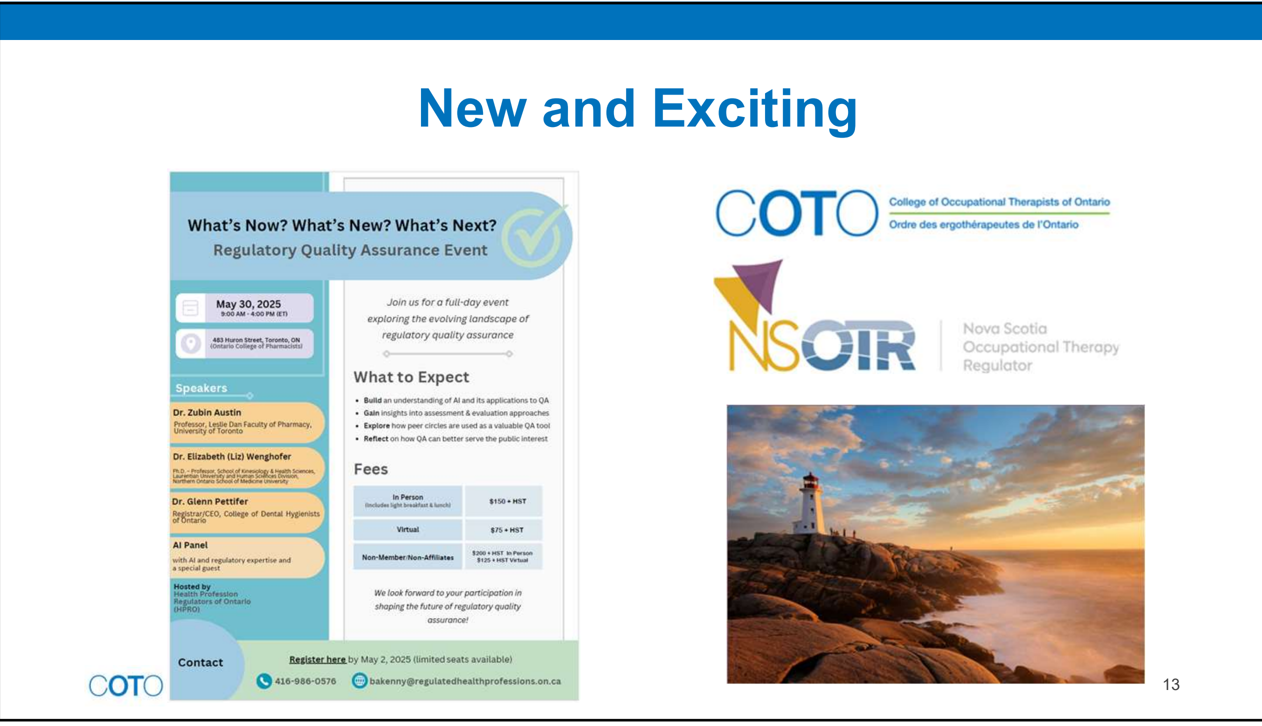

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Partnering with Nova Scotia Occupational Therapy Regulator

- In 2025 we began a formal arrangement between COTO & NSOTR to implement a competency assessment.
- March-May implementation involved the orientation and adaptation of competency assessment tools and processes
- Trained 4 COTO peer assessors
- Administered 20 assessments in July - August
- Provided tools for Quality Assurance Committee review on outcomes and remediation to assist NOSTR
- Completed contract in August
- Continue to provide support NOSTR as needed

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AGENDA ITEM 11.4

BOARD MEETING BRIEFING NOTE

Date: October 30, 2025

From: Registration Committee

Subject: As-of-Right Registration and Practising Without A Certificate of Registration Policies

Recommendation:

***THAT** the Board approve the draft As-of-Right Registration and the amended Practising without a Certificate of Registration policies, as presented.*

Issue:

The Board is asked to recommend the draft *As-of-Right Registration* and the amended *Practising without a Certificate of Registration* policies which will support the College in ensuring effective and efficient processing of out-of-province applicants.

Link to Strategic Plan:

<u>Meaningful Engagement</u>

The College builds trust in its role and value through purposeful and meaningful engagement and collaboration.
1.1 Provides clear information about what to expect when working with occupational therapists.
1.3 Engages registrants to build understanding of professional obligations, College programs and services.

<u>Quality Practice</u>
2.1 takes an evidence-informed, risk-based approach to ensuring occupational therapists are competent, safe, effective and accountable

<u>System Impact</u>
The College collaborates for access to the profession and consistent quality practice.
3.1 Supports efforts to increase the number of licensed occupational therapists in Ontario to address the health human resource crisis.
3.2 Ensures occupational therapy scope of practice is optimized in Ontario.

Why this is in the Public Interest:

Bill 2, *Protect Ontario Through Free Trade Within Canada Act, 2025,* was passed in the Ontario Legislature with a goal of making Ontario economy more competitive and open to trade and

investment by removing barriers with other provinces and territories, including through the expansion of labour mobility.

It will be in the public interest for the College to quickly and seamlessly authorize and when requirements are met, register occupational therapists from other provinces and territories to sustain the supply of qualified occupational therapists available to serve the public.

Equity, Diversity and Inclusion Considerations:

Expansion of labour mobility will allow occupational therapists including those from equity-deserving groups to easily seek opportunities in other provinces and be able to start working immediately.

Background:

In June 2025, the Ontario Government passed, *Protect Ontario Through Free Trade Within Canada Act, 2025* that amended the *Ontario Labour Mobility Act, 2009.* This amendment provides for the deemed certification of individuals already certified by an out-of-province regulatory authority to practice a regulated occupation in Ontario in certain circumstances for a one-time six-month period. (As-of-Right).

In addition, the amendment establishes timelines within which Ontario regulatory authorities must respond to applications for certification from individuals already certified by another Canadian regulatory authority.

The amendment further requires Ontario regulatory authorities to publish certain information respecting applications for certification by individuals who are already certified by another Canadian regulatory authority.

Discussion:

These policies are expected to further support the College in ensuring Canadian applicants who are registrants in good standing from other jurisdictions can practice for a period of 6 months before registering. The *Practising without a Certificate of Registration* policy has been amended to reflect this new provision.

When an applicant presents all the required documents, and they are received and confirmed, it takes 1 to 2 business days for them to be registered. This means the College is ahead of the prescribed timelines in the amended legislation. The expectation is the majority of applicants will continue to use our regulator registration route and only a small percentage of registrants will use As-of-Right registration process.

Attachments:

1. Draft As-of-Right Registration Policy
2. Draft Amended, Practising without a Certificate of Registration Policy

AS-OF-RIGHT REGISTRATION POLICY - *DRAFT*

Section 8 **8-240**

Section: Registration

Applicable to: Staff

Approved by: Registration Committee

Date Established: October 2025

Date Reviewed:

Purpose:

The purpose of this policy is to support the College staff and the Registration Committee in ensuring effective and efficient processing of applicants from out-of-province, in accordance with the legislation.

Principle(s):

This policy has been developed in compliance with the enacted, *Protect Ontario Through Free Trade Within Canada Act, 2025.* The goal of this legislation is to make Ontario's economy more competitive and open to trade and investment by removing trade barriers with other provinces and territories, including through the expansion of labour mobility.

Policy:

"As of Right" legislation in Ontario allows qualified occupational therapists from out-of-province to work in Ontario temporarily while completing their registration with College of Occupational Therapists of Ontario (COTO). Canadian applicants who are registrants in good standing from other jurisdictions are authorized to practice for a period of 6 months before registering.

Procedure:

1. An applicant completes Attestation Form
2. If the completed attestation form indicates they meet all the requirements, they pay the application fee.
3. Their name is then entered on the register, as "Authorized to Practice pursuant to the As-of- Right Legislation" with an end date 6 months from their application date.
4. The automated email they receive gives them the regular registration list (checklist) of items the College requires to register them in the general class.
5. Once their checklist is complete, they receive an invitation to register, and pay their registration fee which can be paid any time before their 6-month end date.

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6. If the applicant does not complete the registration checklist and submit all required documentation within the 6 -month authorization period, they will not be eligible to proceed to full registration.
7. If they do not register fully by the 6-month end date, they receive notice that their authorization to practice has ended and they are no longer eligible to practice in Ontario.
8. Their name and authorization to practice, are removed from the register
9. If they pay the registration fee late, they will be required to pay the usual late fee
10. If a complaint or report is received at any time during this process, clients will be referred to the regulator in the province where they are registered.

Applicable Legislation:

Bill 2, *Protect Ontario Through Free Trade Within Canada Act, 2025*

Practising Without a Certificate of Registration

8-140

Section:	Registration
Applies to:	All applicants for all classes of registration and suspended registrants
Approved by:	Registration Committee
Date Established:	May 2009
Date Revised:	October 2011, September 2016, September 2021, October 2025

Purpose

This policy describes the steps the College takes when an individual has been practising occupational therapy:

- before the College has issued a certificate of registration, or
- when their certificate of registration was suspended.

Principles

Only registrants of the College with a certificate of registration can use the title “occupational therapist” (or any variation, abbreviation or equivalent in another language) or holds themselves out as qualified to practice as an occupational therapist in Ontario.

Exemption

An individual is exempted from this policy if they satisfy the following conditions:

- The individual is registered with a regulatory authority in a Canadian jurisdiction, other than Ontario, and holds in that jurisdiction the equivalent of a certificate of registration in the general class in Ontario.
- The individual has submitted to the College an application for a certificate of registration under the as-of-right legislation, prior to providing professional services.
- Six months have not elapsed since the day they first began to provide professional services in Ontario.

Policy

Practising and/or using the title occupational therapist without authorization are serious conduct issues. Individuals found to be practising or using title without a certificate of registration issued by the College, could result in a review of the individual’s suitability to practice.

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Process for the review

The Registrar will review all cases where a person may have misused the title occupational therapist or held themselves out to be qualified to practice as an occupational therapist when they did not have a certificate of registration.

The Registrar will consider factors such as:

- the strength of the evidence that the person engaged in the conduct
- whether the person willfully engaged in the conduct
- how long the person engaged in the conduct
- the attitude or remorse expressed about the conduct
- any consequences they have already received, such as loss of a job or criminal charges
- the risk to the public posed by the conduct
- any actual harm caused by the conduct.

Depending on the seriousness of the conduct, the Registrar can take one of three courses of action:

1. Refer the matter to the Registration Committee if the Registrar has doubts about whether the applicant will practise safely and ethically. The Committee will review the applicant's suitability to practise.
2. Require the applicant to sign an undertaking before being issued a certificate of registration. The undertaking could include:
    - Writing a letter acknowledging the conduct
    - Completing a Prescribed Regulatory Education Program module
    - Paying fees that would have been payable had they been registered with the College during the period they were practising without authority.
3. Refer the matter to the Inquiries, Complaints, and Reports Committee if a person engaged in the conduct while their registration was suspended.

Legal requirement

Occupational Therapy Act, 1991, s. 7

Ontario Regulation 226/96: General, under the Occupational Therapy Act, 1991, s. 35(1)4

Ontario Regulation 95/07: Professional Misconduct, under the Occupational Therapy Act, 1991

Protect Ontario through Free Trade within Canada Act, 2025

Related policies

Determining Suitability to Practise at Registration (8-72)

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