College of Chiropodists of Ontario

Regulating Chiropodists and Podiatrists in Ontario

COUNCIL MEETING

Thursday, May 21, 2026

19th Floor Conference Room
180 Dundas Street W, Toronto, ON M5G 1Z8

College of Chiropodists of Ontario

Council Meeting Agenda

Date: Thursday, May 21, 2026 | Time: 9:00 am – 4:00 p.m.
Location: 180 Dundas Street West, Toronto – 19th Floor Conference Room

8:30am – 9:00am		Breakfast	Page # N/A
		A hot breakfast will be served in the Conference Room.	

9:00am – 9:10am	1.0	Call to Order – Peter Stavropoulos, President	Page #
	1.1	Call to Order Appointment of Secretary Land Acknowledgement: "The members and staff of the College of Chiropodists of Ontario respectfully acknowledge that we are situated on the traditional territories of the fourteen First Nation peoples of Ontario – the Anishinaabe (A-ni-shi-naa-be), the Haudenosaunee-Onk we hone (How-den-o-sew-knee-Onk-we hone), the Mush ke gowuk Cree (Mush-go-wuk-Cree), the Mohawk, the Tus ca rora (tus-ca-rora), the Seneca, the Cayuga, the Oneida, the Delaware, the Mississauga, the Chippewa, the Pot ta wa tami, the Algonquin and the Odawa peoples. We also acknowledge the presence of the Métis and Inuit as well as Indigenous peoples and First Nations peoples living off-reserve and in urban areas." Approval of Professional Member Prep Time **Motion:** *That Council approve the preparation time for professional members*.	**N/A**
	1.2	Approval of Agenda **Motion:** *That Council approve the agenda for the May 21, 2026 Council meeting.*	**N/A**
	1.3	Declaration of Conflict of Interest**	**1 – 6**
	1.4	Approval of Minutes of the January 29, 2026 Council Meeting ** **Motion:** *That Council approve the January 29, 2026 Council meeting minutes.*	**7 – 12**
	1.5	Welcome to Council, Guests and Observers	**N/A**
	1.6	Council Evaluation	**N/A**

9:10am – 9:15am	2.0	Consent Agenda Items	Page #
		A consent agenda is a bundle of items that is voted on, without discussion, as a package. It differentiates between routine matters not needing explanation and more complex issues needing examination. The Chair will ask if anyone wishes to remove an item from the consent agenda. Any Council member may request an item be removed so it can be discussed. To test whether an item should be included in the consent agenda, ask: 1. Is this item self-explanatory and uncontroversial? Or does it contain an issue that warrants board discussion?	**N/A**

		2. Is this item for information only? Or is it needed for another meeting agenda issue? **Motion:** *That Council approve consent agenda items 2.1, 2.2. and 2.3.*	
	2.1	Survey Results from the January 29, 2026 Council Meeting**	**13 – 16**
	2.2	Practice Advisor Report**	**17**
	2.3	**Committee Reports**	
	2.3.1	OCPDT (Discipline Tribunal) Report**	**18 – 19**
	2.3.2	ICRC Report**	**20 – 22**
	2.3.3	QAC Report**	**23**
	2.3.4	Registration Exam Committee Report**	**24**
	2.3.5	Standards and Guidelines Committee Report**	**25**
	2.3.6	Registration Committee Report**	**26**
	2.3.7	Patient Relations Committee Report**	**27**
	2.3.8	Fitness to Practise Committee Report**	**28**
	2.3.9	Technical Committee Report**	**29**
	2.3.10	Elections Committee Report**	**30**
	2.3.11	Strategic Planning Committee Report**	**31**
	2.3.12	Registrar's Performance and Compensation Committee Report**	**32**

9:15am – 10:00am	**3.0**	**Decision Items**	**Page #**
	3.1	Amendments to By-Law 1 (General) for more clarity around Council election terms** **Motion:** *That Council approve the amendments to the By-Law 1 (General) that provide more clarity around Council election terms.*	**33 – 35**
	3.2	Extracorporeal Shock Wave Therapy Guideline – Revised** **Motion:** *That Council approve the revised Extracorporeal Shock Wave Therapy Guideline.*	**36 – 41**
	3.3	Office Medical Emergencies Guideline – Revised** **Motion**: *That Council approve the revised Office Medical Emergencies Guideline.*	**42 – 75**
	3.4	Safety and the Practice Environment Standard – Revised** ***Motion**: That Council approve the revised Safety and the Practice Environment Practice Standard.*	**76 – 82**
	3.5	Administering Inhaled Substances and the Use of Sedation Standard – Revised** **Motion**: *That Council approve the revised Administering Inhaled Substances and the Use of Sedation Practice Standard.*	**83 – 128**
	3.6	Laser Guideline – Revised ** **Motion**: *That Council approve the revised Laser Guideline.*	**129 – 172**
	3.7	Patient Relations Standard – Revised** **Motion**: *That Council approve the revised Patient Relations Standard.*	**173 – 183**

10:00am – 11:00am	**4.0**	**Presentation: Role of the Office of the Fairness Commissioner in Health Regulation**	**Page #**
		Irwin Glasberg, Fairness Commissioner	**N/A**

11:00am – 11:40am	5.0	Presentation: Supervising Chiropody Students Standard	
		Nicole Zwiers, Registrar and CEO	**N/A**

11:40am – 12:00pm	3.0	Decision Items (continued)	Page #
	3.8	Consultation Feedback: Supervising Chiropody Students Standard – NEW** **Motion**: *That Council approve the proposed Supervising Chiropody Students Standard.*	**184 – 219**
	3.9	College Website Revamp Project – Light Brand Refresh ** **Motion**: *That Council approve the proposed change order for a light brand refresh for the College website.*	**220 – 226**

12:00pm – 1:00pm		Lunch Break	

1:00pm – 1:20pm	3.0	Decision Items (continued)	Page #
	3.10	Approval of the 2025 Audit Report and draft Audited Financial Statements ** **Motion**: *That Council approve the audited financial statements for the year ended December 31, 2025.*	**227 – 242**
	3.11	Approval of the RFP for the Auditors for the College for the 2026 Audit **Motion**: *That Council approve the RFP for the Auditors for the College for the 2026 Audit.*	**N/A**

1:20pm – 1:40pm	6.0	Presentation: New Continuing Education Modules – Communication Series	Page #
		Nicole Zwiers, Registrar and CEO Shruti Tantry, Manager, Communications and Engagement	**N/A**

1:40pm – 2:30pm	7.0	Discussion Items	Page #
	7.1	Registrar's Report** – Nicole Zwiers	**243 – 245**
	7.2	President's Report (verbal) – Peter Stavropoulos	**N/A**
	7.3	2025 HPDT Annual Report: ***Click this link to read the report*** **	**N/A**
	7.4	Key Performance Indicators (KPIs) Dashboard**	**246 – 247**

2:30pm – 3:50pm	8.0	In-Camera	Page # N/A
	8.1	Motion to move in camera **Motion:** *That Council move in camera pursuant to section 7(2)(b) and (e) of the Health Professions Procedural Code on the basis that financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public and on the basis that instructions will be given to or opinions received from the solicitors for the College.*	

	8.2	Approval of in camera Minutes of the January 29, 2026 Council Meeting** **Motion:** *That Council approve the in-camera minutes of the January 29, 2026 Council meeting.*	
	8.3	**In-Camera Discussion Items**	
	8.3.1	National Conference Updates	
	8.3.2	Legal/Financial Updates	
	8.3.3	System Partner Updates	
	8.3.4	Government Relations Updates	
	8.4	**In-Camera Decision Items**	
	8.4.1	College Investments	
	8.4.2	National Presence	

3:50pm – 4:00pm	**9.0**	**Next Meeting**	**Page # N/A**
	9.1	Council Meeting: October 1, 2026	
	9.2	Council Survey Reminder	
	9.3	Proposed Agenda Items for Next Council Meeting	

4:00pm	**10.0**	**Adjournment**	**Page # N/A**
		Motion: *That Council adjourn the meeting.*	

College of Chiropodists of Ontario

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Conflict of Interest Disclosure Form

Meeting Date:

Council/Committee:

Meeting type: ◉ Plenary ○ Panel

I acknowledge and agree that an actual or perceived conflict of interest can undermine confidence in the College and its ability to fulfill its public interest mandate. I have read and understood the College's by-laws on conflict of interest, the Code of Conduct for Members of Council and its Committees, the **Conflict of Interest Worksheet** and the **Process for Considering & Declaring a Conflict of Interest**.

I agree to take all reasonable steps to avoid any actual or perceived conflict of interest from arising and, if one cannot be avoided, I undertake to declare any real, perceived, or potential conflict of interest and to recuse myself from any consideration of the matter at issue.

☐ I have NO conflict of interest to report regarding any of the agenda items to be discussed at the above noted meeting.

☐ I declare a conflict of interest with one or more of the agenda items to be discussed at the above noted meeting.

I certify that the information above is true and complete to the best of my knowledge.

Signature:

Date:

Code of Conduct For Members of Council and Its Committees

Preamble

For the College to command the confidence of the government, the public and the profession, it is necessary that Council, as the profession's governing body, adopt appropriate standards of conduct for members of Council and its Committees in order to ensure that they properly perform their duties with integrity and in a manner that promotes the highest standard of public trust.

Each member of Council and its Committees is therefore required to comply with the following Code of Conduct (Code) understanding that a breach of the Code could result in the Council member being removed from Council or the Committee member being removed from all Committees, in accordance with the By-laws of the College.

The Code

1. Council and Committee members shall be familiar with and comply with the provisions of the Regulated Health Professions Act, 1991 (RHPA), its Health Professions Procedural Code and its regulations, the Chiropody Act, 1991 and its regulations, and the by-laws and policies of the College.
2. Council and Committee members, when acting in that capacity, shall act in a diligent manner, including preparing for meetings/hearings, attending meetings/hearings on time, and actively participating.
3. Council and Committee members, when acting in that capacity, shall participate in all deliberations and communications in a respectful, courteous and professional manner, recognizing the diverse background, skills and experience of members on Council.
4. Council and Committee members, when acting in that capacity, shall conduct themselves in a manner that respects the integrity of the College by striving to be fair, impartial and unbiased in their decision making.
5. Council and Committee members shall place the interests of the College and Council above their personal interests or any other interests. Council and Committee members shall avoid engaging in conduct that interferes with the ability of the College to achieve its public protection mandate.
6. Council and Committee members shall avoid any appearance of or actual conflict of interest or bias.
7. Council and Committee members shall uphold the decisions made by Council and its Committees, regardless of the level of prior individual disagreement. Council and Committee members shall not publicly oppose or speak against a policy, position, decision, by-law or other matter made or adopted by Council or a Committee.
8. Council and Committee members shall refrain from engaging in any discussion in relation to the business of Council and/or Committees with other Council or Committee members that takes place outside the formal Council/Committee decision making process.
9. Council and Committee members shall refrain from communicating with Committee members on Statutory Committees in circumstances where this could be perceived as an attempt to influence a member or members of a Statutory Committee, unless he or she is a member of the panel or, where there is no panel, of the Statutory Committee dealing with

the matter. This would include, but not be limited to, matters involving the Registration of applicants and matters involving members involved with the Inquiries, Complaints and Reports Committee, the Quality Assurance Committee, the Disciplinary Committee or the Fitness to Practise Committee.

10. Council and Committee members shall respect the confidentiality of information identified as confidential and acquired solely by virtue of their Council/Committee member position.
11. Council and Committee members shall ensure that confidential information is not disclosed except as required for the performance of their duties, or as directed by Council or the Executive Committee acting on behalf of Council.
12. Council and Committee members shall not use their positions as members of Council or any Committee to obtain or attempt to obtain employment at the College or preferential treatment for themselves, family members, friends or associates.
13. Council and Committee members shall not include or reference Council or Committee titles or positions held at the College in any business promotional materials, advertisement or business cards.
14. Council and Committee members shall respect the boundaries of staff, recognizing that a staff member's role is not to report to or work for individual Council or Committee members. Council and Committee members will, therefore, not directly contact staff members, other than the Registrar, except on matters where the staff member has been assigned to provide administrative support to that Committee, without the prior approval of the Registrar or the Executive Committee.
15. Council and Committee members shall be respectful of each other and staff and not engage in conduct or behaviour towards fellow Council or Committee members or staff that might reasonably be perceived as verbal, physical or sexual abuse or harassment.

Adopted by Council: December, 2016

Amended by Council: May 31, 2024

WORKSHEET: Conflict of Interest

What is a conflict of interest?

A conflict of interest is defined as any financial, personal, professional or emotional interest that could reasonably be perceived as interfering with the exercise of a person's public duties, for example as a COCOO Council, committee or panel member.

Self-screening Questions

Not sure if you are in a conflict of interest? In assessing for conflicts of interest, know that each situation will vary and have its own specific context. Consider the following questions & examples:

Financial interest

Do you stand to be affected financially by the outcome of this decision?

Example: Council is discussing whether it would find College-provided iPads mounted in the meeting room for each Council member to be helpful. One Council member owns a small number of shares of Apple, Inc. Since the financial implication for the Council member is negligible or non-existent, they do not declare a conflict of interest.

Personal or professional relationship

Have you had a personal or professional relationship, e.g. friend, family, instructor, student, supervisor, supervisee, employer, employee, colleague, with any of the individuals involved in the matter?

Example: A Registration Committee panel member taught at the education program from which an applicant obtained some of their education. They declare a conflict of interest.

Example: An Inquiries, Complaints and Reports Committee panel member attended a two-day workshop seven years ago with the respondent's clinical supervisor. Since the contact was brief and occurred long ago, they do not declare a conflict of interest.

Professional bias

Do you have a private or publicly stated opinion that could reasonably be perceived as interfering with your ability to consider one or more of the issues with an open mind?

Example: An Inquiries, Complaints and Reports Committee panel member has published work about the harms of breaching therapist-client boundaries. They are reviewing a complaint involving an alleged breach of boundaries. Since there is no reasonable disagreement within the profession, and assuming they are not emotionally biased, they do not declare a conflict of interest.

Emotional bias
For whatever reason, do your ideas or emotions prevent you from considering one or more of the issues with an open mind?

Example: Based on personal experience, an Examination Committee member has an emotional reaction to a candidate's rationale for needing to extend the normal timeframe within which to write the exam. They declare a conflict of interest.

Example: A panel of the Inquiries, Complaints and Reports Committee is dealing with serious allegations of misconduct. After discussing and processing the emotional impact of reviewing the materials, they all reassure themselves that they can consider the situation with an open mind.

Interests of Related Persons
Are you aware that your parent, child, spouse or sibling has any of the about interests respecting Council, committee or panel business?

Example: A Registration Committee member's child is attending a program coming before the Committee to seek recognition. They declare a conflict of interest.

Example: An Inquiries, Complaints and Reports Committee panel is considering a complaint by a firefighter. One panel member's spouse is also a firefighter. Assuming there is no emotional bias, the profession of the panel member's spouse would not reasonably be seen as interfering with the panel member's duties. They do not declare a conflict of interest.

Threshold analysis
Would a reasonably well-informed person perceive that the above interest could interfere with the exercise of your public duties?

Example: A Discipline Committee panel member was employed at the same large clinic at the time the alleged misconduct occurred. While the panel member had no prior knowledge of the alleged events, the panel member is close colleagues with a key witness in the case. There was a reasonable apprehension of bias on the part of the panel member.

Example: A complainant appeals a decision of the Inquiries, Complaints and Reports Committee taking no action against a registrant. Through Google, the complainant discovered that a panel member was a LinkedIn contact of the respondent. The panel member clarified they only met once briefly three years ago. Even though it may have been preferable for that panel member not to participate, this was not found to be a conflict of interest.

Process for Considering & Declaring Conflicts of Interest

The following are steps taken by the College in addressing conflicts of interest.

Staff pre-screening

- Staff will pre-screen agenda items for obvious conflicts of interest on the part of Council, committee or panel members.
- If a conflict is identified, staff will alert the Chair and materials will not be sent to the conflicted member.
- The matter will either be assigned to a different panel, or the conflicted member will be alerted in advance that they will not be present for the entire meeting.

Council, committee or panel member self-screening

- Go through the above self-screening.
- If a concern is identified that does not rise to the threshold of a conflict of interest, consider making a courtesy declaration at the meeting to reassure the Council, committee or panel that you have considered the issue.
- If unsure, consult with staff, legal counsel or the Chair. It is preferable to consult with staff or legal counsel before the Chair to avoid the risk of tainting the Chair.
- In close cases, consider the potential benefit of declaring a conflict to avoid later disputes about whether or not there was a conflict of interest.
- If you identify a conflict of interest, do not review the meeting materials further and securely delete them. Alert the Chair and support staff in advance of the meeting. Always declare in a general manner so as not to cause emotional bias on the listener's part.
- Subsequently, declare the conflict at the meeting itself. Do not take part in or attempt to influence the deliberation and leave the room while deliberation is taking place. The general nature of conflict will be recorded in the minutes.

Council, committee or panel discussion of possible conflicts of interest

- Occasionally, you may become aware that another member may have a conflict. If that member does not declare a conflict, or if they are unsure, all members are responsible at the meeting for raising the concern and discussing whether it constitutes a conflict of interest.
- In rare cases of disagreement, a majority of those present can vote to find there is a conflict and exclude the conflicted member from considering the matter.
- Post Meeting Conduct: After recusing yourself on a matter, use professional discretion and avoid revisiting the issue with colleagues, even if the decision is on the public register or you have seen the meeting minutes.[1]

1 Council minutes are public documents (aside from in camera portions). Regarding committee and panel minutes, normally it be considered that viewing minutes by a panel member who has declared a conflict poses a risk of improperly affecting the College's decision. However, occasionally confidentiality and risk management may require that panel minutes not be viewed by a member who has declared a conflict of interest.

College of Chiropodists of Ontario

Minutes of the Council Meeting
Thursday, January 29, 2026, at 9:00 a.m.
180 Dundas St. W., 19th Floor Conference Room

Council Members Present:

- Itraf Ahmad, Public Appointee
- Chad Bezaire, Professional Member
- Edward Chung, Professional Member
- Jinyu Gu, Professional Member
- Allan Katz, Public Appointee
- Mary Ellen Kennedy-Mitchell, Professional Member
- Andrew Klayman, Professional Member
- Tomy Kokkat, Public Appointee (until 2:00 p.m.)
- Tobi Mark, Selected Member
- Chad McCleave, Public Appointee (until 10:55 a.m.)
- Murtuza Najmudin, Professional Member
- Reshad Nazeer, Public Appointee
- Jannel Somerville, Professional Member
- Peter Stavropoulos, Professional Member (Chair)
- Jessica Tsung, Professional Member

Regrets:

- None.

Staff in Attendance:

- Nicole Zwiers – Registrar and CEO
- Meghan Clarke – Deputy Registrar and Director, Professional Conduct (recorder)
- Nawaz Pirani – Director, Registration and Regulatory Programs

Guests:

- Erica Richler, Legal Counsel, Steinecke Maciura LeBlanc
- Jessica Harding, Senior Policy Analyst, Ministry of Health
- Raeann Rideout, Director, Strategic Partnerships, Elder Abuse Prevention Ontario
- Bruce Ramsden, OPMA

1. Call to Order

1.1 Call to Order, Appointment of Secretary, Land Acknowledgement, Approval of Professional Member Prep Time

The Chair, P. Stavropoulos, called the meeting to order at 9:00 a.m., confirmed that notice was properly given and quorum was present, and welcomed Council members and guests.

M. Clarke was appointed as Secretary.
A. Katz delivered a land acknowledgement to honour and remember the original inhabitants of the land.

A. Klayman proposed three hours of preparation time for professional members of Council.

Motion: To approve three hours of preparation for professional members.
Moved by: A. Klayman | **Seconded by:** T. Mark
Status: CARRIED

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1.2 Approval of Agenda

Motion: To approve the agenda for the January 29, 2026 Council meeting.
Moved by: J. Gu | **Seconded by**: M. Kennedy-Mitchell.
Status: CARRIED.

1.3 Declaration of Conflict of Interest

T. Mark identified a conflict of interest regarding item 3.4. No other conflicts were declared.

1.4 Approval of Minutes - October 9, 2025 Council Meeting

Motion: To approve the minutes of the October 9, 2025 Council meeting.
Moved by: C. Bezaire | **Seconded by**: J. Gu
Status: CARRIED.

1.5 Welcome to New Council Members

N. Zwiers welcomed Chad McCleave and Tomy Kokkat, recently appointed Public Members.

P. Stavropoulos noted the reappointment of I. Ahmad, public member, and the revocation of Sue McArthur's appointment in December 2025.

1.6. Welcome to Council, Guests and Observers

N. Zwiers welcomed Jessica Harding from the Ministry of Health and Deidre Callery, a registrant.

2. Consent Agenda Items

Motion: To approve consent agenda items 2.1, 2.2. and 2.3.
Moved by: A. Katz | **Seconded by**: R. Nazeer
Status: CARRIED

3. Decision Items

3.1 2026 Operating Budget

Motion: That Council approve the College's 2026 operating budget.
Moved by: C. Bezaire | **Seconded by**: A. Katz
Status: CARRIED.

N. Zwiers presented to Council on the 2026 operating budget (see item 5.1)

3.2 Appointment of Public Member to the ICRC and OCPDT

Motion: That Council appoint Tomy Kokkat to the Inquiries, Complaints and Reports Committee and the Ontario Chiropodists and Podiatrists Discipline Tribunal.
Moved by: M. Najmudin| **Seconded by**: A. Katz
Status: CARRIED.

3.3 Administering a Substance by Injection Standard - Revisions

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Motion: That Council approve the revised Administering a Substance by Injection standard of practice.
Moved by: E. Chung| **Seconded by**: J. Somerville
Status: CARRIED.

3.4 Supervising Chiropody Students Standard - NEW

Motion: That Council approve the new Supervising Chiropody Students standard, in principle, and direct that the proposed amendments be circulated to registrants, the public and system partners for feedback for 60 days before it is returned to Council.
Moved by: A. Katz| **Seconded by**: J. Gu
Status: CARRIED.

T. Mark left the room for the discussion of item 3.4 due to a conflict.

M. Najmudin asked why consultation was required. N. Zwiers explained that feedback is not required but this draft standard was proposed for feedback because, given the nature of the standard, feedback from system partners, including registrants who have experience supervising students, may be valuable in assisting Council in its decision making.

3.5 Consent Guideline - NEW

Motion: That Council approve the new Consent Guideline to replace the Guide to the Health Care Consent Act and the Guideline for Treating Incapable Patients.
Moved by: C. Bezaire| **Seconded by**: R. Nazeer
Status: CARRIED.

3.6 Safety and the Manufacturing and Modification of Orthotics Standard - Revisions

Motion: That Council approve the revised Safety and the Manufacturing and Modification of Orthotics standard of practice.
Moved by: M. Najmudin| **Seconded by**: J. Somerville
Status: CARRIED.

3.7 Revisions to By-law 2 (Fees) re: Registration Examination Costs

Motion: That Council approve the proposed changes to By-law 2: Fees regarding the registration examination costs.
Moved by: I. Ahmad| **Seconded by**: M. Najmudin
Status: CARRIED.

3.8 Patient Relations Standard

Motion: That Council approve the revised Patient Relations Standard.
Moved by: R. Nazeer| **Seconded by**: J. Tsung
Status: DEFEATED.

Council engaged in discussion once the motion was tabled and, in particular, discussed potential concerns with the proposed draft of the revised standard including:

- Cultural differences that may need to be considered in respect of gift-giving
- Addressing any necessary definitions to ensure clarity (e.g. “token” referring to gifts)
- Consideration of the concerns raised for registrants in small communities who may socialize with patients

Motion: That Council return the Patient Relations Standard to the Standards and Gui Back to Agenda review in consideration of the concerns raised by Council.
Moved by: C. Bezaire | **Seconded by**: J. Gu
Status: CARRIED.

3.9 Line of Credit

Motion: That Council approve opening a line of credit for the College.
Moved by: C. McCleave | **Seconded by**: I. Ahmad
Status: CARRIED.

C. McCleave explained that the line of credit is being proposed to mitigate the risk around liquidity. Most of the College's funds are tied up in GIC's, which makes accessing the funds more challenging. There is no cost to open a line of credit.

3.10 Reserve Fund Expense

Motion: That Council approve the use of the reserve fund for a website update.
Moved by: C. Bezaire | **Seconded by**: E. Chung
Status: CARRIED.

Discussion:

- N. Zwiers explained that the reserve fund is to be used for expenses outside the regular operating budget.
- The College's website has not been updated in more than a decade, and it requires modernization.
- An RFP was issued and submissions have been reviewed.
- The reserve fund is also being used to move the database to the cloud ($60,000-$80,000).
- The reserve fund is $700,000. It may need to be replenished after these two expenses.

5.1 Presentation: Factors Impacting the College's Operating Budget

N. Zwiers presented to Council on the 2026 operating budget. She reviewed the factors that impact the College's budget, including the relatively small number of registrants as that number drives the College's main source of revenue and the relatively high number of complaints which correlate to a high cost. Despite being one of the smallest regulators in Ontario (by number of registrants), the College is required to meet all the same legislative requirements as larger regulators. The College meets these requirements with only four full-time staff – less than any other regulator.

The College is also required to deliver registration exams at least once a year, and a supplemental exam if there is interest. Although the College strives for cost neutrality for its exams, it has no control over the number of examinees at a particular sitting. The number of examinees directly impacts the space requirements for the exams and, by extension, the rental costs for such space.

The College also regulates two professions, which make consultation and regulation more costly. Naturally, lifting the ban on registering DPMs as podiatrists in Ontario would help to increase the number of registrants of the College thereby reducing the need for further increases to annual dues.

The College has a high number of cases that go before the Ontario Chiropodists and Podiatrists Discipline Tribunal, and legal cost recovery is not guaranteed. At most, the College is likely to recoup 60% of its legal costs when it is successful.

N. Zwiers reviewed some innovative ways the College manages costs that do not expose the College to greater risk:

- The College hosted a national conference for footcare regulators and, although the event was not included in the budget, N. Zwiers managed to reduce costs such that the very successful event did not negatively impact the budget.

- Use of College premises for registration examinations at no additional cost. However, Nicole noted that there is limited spacing available on the College's premises and, if the number of examinees increases, this space will no longer be suitable.
- Hosted a plain language conference for other regulators with no budget and full cost recovery. This was an important event for the College as a contributor to the education and knowledge-sharing required of RHPA Colleges.
- Use of internal resources to develop continuing education modules. The College has continued to develop and release high quality CE modules at very reasonable costs.
- In-house training for committees on a regular basis. This helps to ensure that College committees are well informed and current on matters impacting decision-making.

5.2 Presentation: College Consultation Process – Expectations and Value Feedback

N. Zwiers presented to Council on the expectations for consultation feedback whenever Council invites submissions:

- Any registrant has a duty to act in good faith, including by way of any submissions or feedback provided.
- Registrants and other system partners must ensure they are correctly relying on facts and not spreading misinformation.
- Feedback should be responsive to the questions asked, and
- Feedback should support Council's governance role rather than address operational matters.

The proposed increase to the registration examination fees was circulated for consultation because it requires a by-law amendment. The consultation included specific questions to guide the feedback. The feedback sought was not about whether a specific amount was appropriate. Rather, it was whether exam fees should be covered entirely by applicants or whether they should be subsidized by the College.

5.3 Presentation: Diabetes-Related Lower Limb Amputations and Complications

N. Zwiers presented national data on diabetes-associated lower limb amputations and the associated costs. N. Zwiers thanks Ed Chung and Millicent Vorkapich-Hill for their work in summarizing the research that N. Zwiers was presenting. E. Chung noted that Matthew Andrade was to be thanked for bringing the source of the research to the College's attention.

In particular, N. Zwiers cited data showing that nationally up to 85% of lower limb amputations are preventable. This suggests that with greater numbers of footcare specialists, a reduction in lower limb amputations could be realized.

N. Zwiers explained that the data is on the College's website, and it will be included in a future Footprint newsletter.

5.4 Presentation: Ageism in Health Care and Elder Abuse Prevention

Raeann Rideout, Director, Strategic Partnerships, from Elder Abuse Prevention Ontario presented to Council on ageism in health care and elder abuse prevention.

6. Discussion Items

6.1 Registrar's Report

No questions were raised on the Registrar's written report.

6.2 Reserve Fund

N. Zwiers reported that C. McCleave (Audit Committee) recommended increasing the College's reserve fund. He noted that the CRA permits non-profit organizations to hold reserve funds equivalent to their annual operating budget, which

for the College is approximately $2 million. N. Zwiers confirmed that the current reserve amount of $700,000 is likely sufficient at this time but agreed that it may be appropriate for Council to consider whether a higher reserve amount is warranted at a future date.

C. McCleave has experience on the Council of the College and Kinesiologists of Ontario, which maintains a larger reserve fund.

The College's surplus this year is estimated at this time to be approximately $140,000; however, this level of surplus cannot be assumed in future years. Any increase in the reserve fund would need to come either from reallocating GICs or increasing annual fees.

In response to a question from M. Kennedy-Mitchell regarding replenishment, N. Zwiers clarified that the reserve fund policy is static and does not automatically adjust. Any change to the reserve amount would require Council direction. Decisions about replenishing the reserve are also at Council's discretion.

6.3 President's Report (verbal)

The President thanked Council and committee members, as well as staff, for their ongoing work.

6.4 Key Performance Indicators (KPIs) Dashboard

Council reviewed the new KPI dashboard for the first time, following approval in October 2025.

7. In Camera

Motion: That Council move in camera pursuant to section 7(2)(b) and (e) of the *Health Professions Procedural Code* on the basis that financial or personal or other matters may be disclosed of such a nature that the harm created by the disclosure would outweigh the desirability of adhering to the principle that meetings be open to the public and on the basis that instructions will be given to or opinions received from the solicitors for the College.
Moved by: P. Stavropoulos | **Seconded by**: M. Najmudin
Status: CARRIED.

Motion: That Council move out of camera at 3.:47 p.m.
Moved by: M. Najmudin | **Seconded by**: C. Bezaire
Status: CARRIED.

8.1 Next Meetings

- Thursday, May 21, 2026 (** Date Change)
- Thursday, October 1, 2026
- Thursday, January 28, 2027
- Thursday, May 20, 2027
- Thursday, September 30, 2027

8.2 Council Survey Reminder

8.3 Proposed Agenda Items for Next Meeting

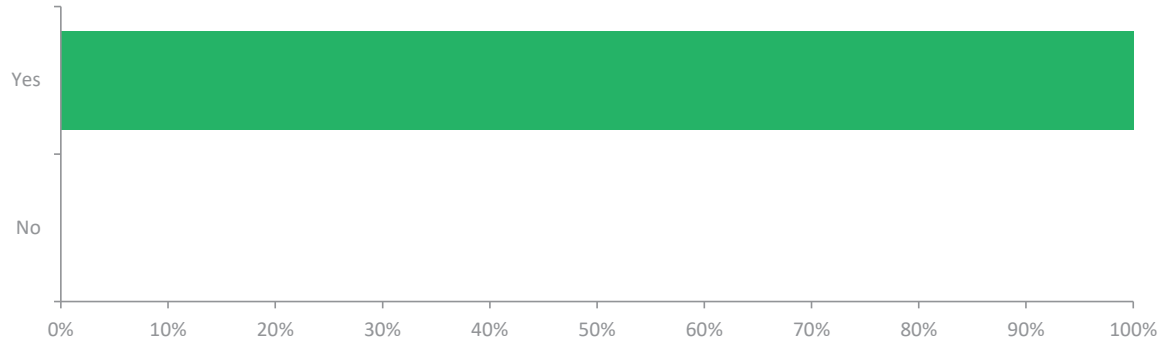
9. Adjournment

Motion: That Council adjourn the meeting.
Moved by: E. Chung| **Seconded by**: C. Bezaire
Status: CARRIED.

The meeting was adjourned at 3:47 p.m.

Q1: Was the meeting effective in achieving the goals of the meeting?

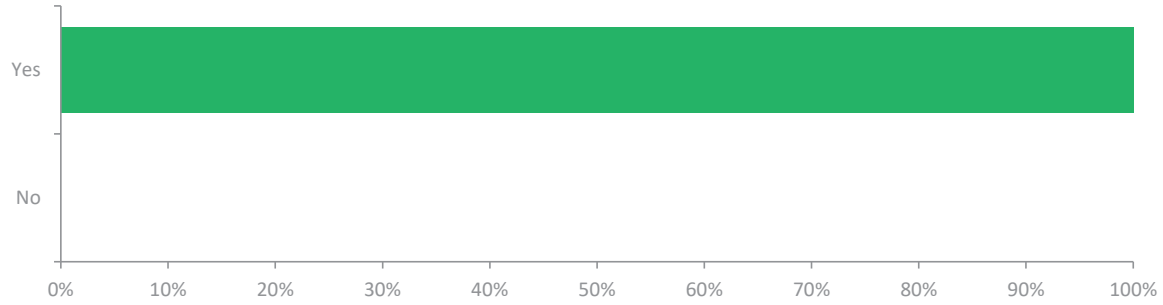
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q2: Did the chair run an efficient and effective meeting?

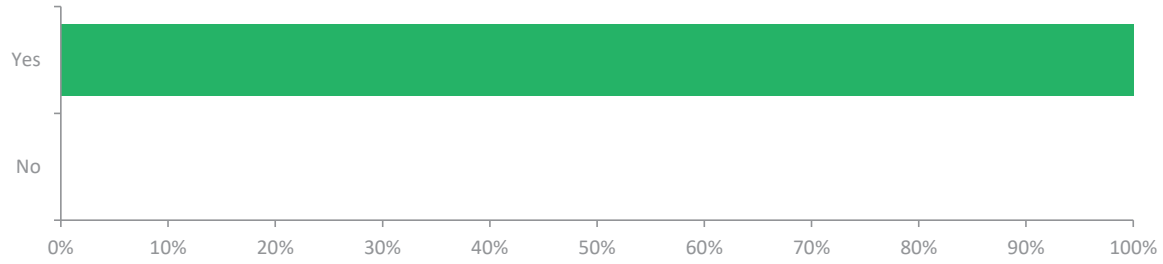
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q3: Did you receive the materials in sufficient time to be adequately prepared for the meeting?

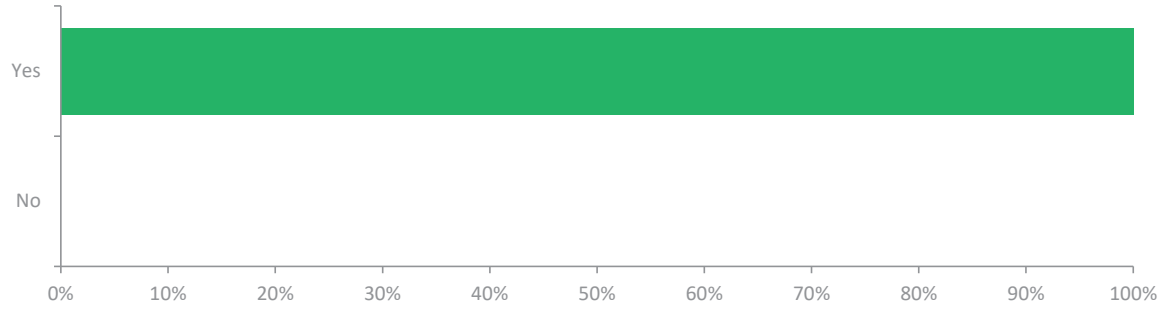
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q4: Did all members appear reasonably prepared for the meeting?

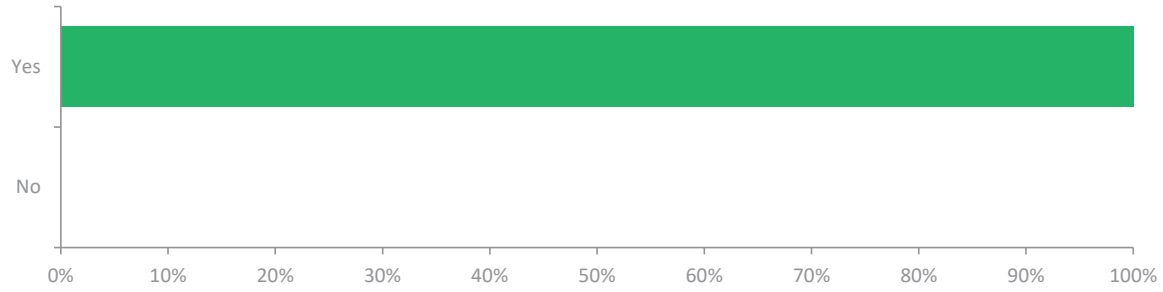
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q5: Did all members participate in the meeting appropriately?

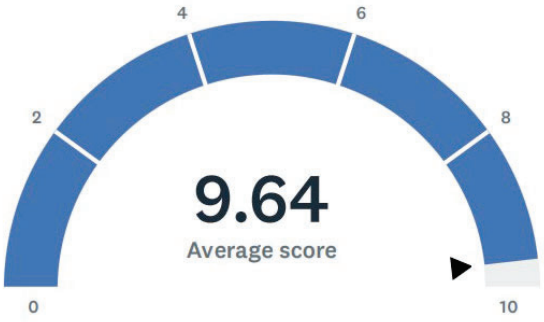
Answered: 14 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	100.00%	14
No	0.00%	0
TOTAL		14

Q6: On a scale of 1-10, how would you rate your overall experience for the meeting?

Answered: 14 Skipped: 0



Q7 Please provide any comments, questions, concerns, or feedback that we can do differently at the next meeting.

Answered: 10 Skipped: 4

#	RESPONSES	DATE
1	Overall, it went well and was a good experience.	2/3/2026 8:45 PM
2	I felt that some of the presentations were not directly linked to governance. Also, many members come in from outside of the GTA and have to go through rush out traffic to get home. It took me 3 hours to get back to Niagara Falls. Are we able to adjust the start times either earlier or later so that members can avoid some of the traffic from the downtown core?	2/3/2026 5:35 PM
3	Good meeting.	2/1/2026 5:01 PM
4	So far all good and continuously improving	1/30/2026 5:24 PM
5	Meeting was well organized and efficient with strong council input.	1/30/2026 3:01 PM
6	There was great discussions on operating budgets, reasons for licensing fees, the college exams and the progress made on the podiatry model.	1/30/2026 2:21 PM
7	Less material to review in advance or use more summary formats	1/30/2026 12:11 PM
8	No recommended changes. I greatly enjoyed the informative presentations provided by Nicole and Reann.	1/30/2026 11:38 AM
9	Thank you!	1/30/2026 7:50 AM
10	I would like to hear from an expert on how AI be incorporated and used in a small College, and if it can reduce the burden on heavy projects or tasks.	1/29/2026 5:23 PM

RESPONSES	DATE
Reshad Nazeer	2/3/2026 8:45 PM
Murtaza Najmudin	2/3/2026 5:35 PM
Mary Ellen Mitchell	2/1/2026 5:01 PM
Ed Chung	2/1/2026 3:19 PM
Itraf Ahmad	1/30/2026 5:24 PM
Chad Bezaire	1/30/2026 3:01 PM
Jessica Tsung	1/30/2026 2:21 PM
Jannel Somerville	1/30/2026 1:35 PM
Chad McCleave (new Chad)	1/30/2026 12:11 PM
Peter Stavropoulos	1/30/2026 11:38 AM
Allan Katz	1/30/2026 11:29 AM
Jinyu	1/30/2026 11:25 AM
Tobi Mark	1/30/2026 7:50 AM
Andrew Klayman	1/29/2026 5:23 PM

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.2

PRACTICE ADVISOR REPORT

May 21, 2026 Council Meeting

Acting Practice Advisor:
Peter Stavropoulos, DPM – Podiatrist

Purpose:

To provide Council with an overview of the Practice Advisor (PA) activities since the last meeting of Council. The PA provides professional practice advice on behalf of the College, supporting registrants to help them make sound and ethical clinical decisions that comply with the Standards of Practice and College policies and guidelines. The PA does not provide legal advice.

Public Interest:

The PA service responds to inquiries from multiple health system partners and stakeholders, including the public. The PA is also available to support the public and other stakeholders with questions about the practice of chiropodists and podiatrists in Ontario.

Data breakdown from January 2, 2026 to April 30, 2026, inclusive:

- Received **286** phone calls and emails relating to the practice advisory service during the above stated period.
- Sources of inquiries during this cycle included: Members of the public, registrants, Public Health Ontario/MOH, clinic managers/owners, regulated health Colleges, committees of the College, other regulated health professionals (for example, pharmacists), College staff, other College PAs, and third-party insurance companies.

Ongoing work:

Seeking to improve the PA service to registrants and health system partners by:

- Continuing to increase awareness of the services provided by the PA.
- Enhance learning resources available on the College website.
- Encouraging registrants to avail themselves of guidance through the PA service.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.1

ONTARIO CHIROPODISTS AND PODIATRISTS DISCPLINE TRIBUNAL REPORT

May 21, 2026 Council Meeting

TRIBUNAL MEMBERS

Chair: David Wright, Experienced Adjudicator

Vice Chair: Cesar Mendez, Chiropodist

Professional Members (Council):
Chad Bezaire, Chiropodist
Edward Chung, Podiatrist
Jinyu Gu, Chiropodist
Mary Ellen Mitchell, Chiropodist
Murtuza Najmudin, Chiropodist
Jannel Somerville, Chiropodist
Peter Stavropoulos, Podiatrist
Jessica Yen-Ling Badyal, Chiropodist

Public Appointees:
Itraf Ahmad, Public Appointee
Allan Katz, Public Appointee
Tomy Kokkat, Public Appointee
Chad McCleave, Public Appointee
Reshad Nazeer, Public Appointee

Professional Members (Non-Council):
Matthew Andrade, Chiropodist
Melanie Atkinson, Chiropodist
Brooke Mitchell, Chiropodist
Stephanie Shlemkevich, Chiropodist
Ruth Thompson, Chiropodist
Eliot To, Chiropodist
Shael Jeffrey Weinberg, Podiatrist

Selected Member:
Tobi Mark, Chiropodist

Experienced Adjudicators:
Raj Anand
Sherry Liang
Sophie Martel
Jennifer Scott
Jay Sengupta

ROLE OF THE COMMITTEE:

The Ontario Chiropodists and Podiatrists Discipline Tribunal (OCPDT) supports the College's public protection mandate by conducting hearings to decide cases of alleged professional misconduct or incompetence by registrants.

MEETINGS:

- The Tribunal met on January 28, 2026 and May 20, 2026 for training.

HEARINGS:

- **Completed:** Two uncontested hearings between December 2025 and March 2026.
- **Scheduled:** No hearings scheduled.

CASE MANAGEMENT CONFERENCES (CMC):

- **Completed:** 13 CMCs between December 2025 and March 2026.
- **Scheduled**: Four upcoming CMCs.

Completed Matters – December 2025 to March 2026

Disciplinary matters are resolved by way of uncontested or contested hearings. Outcomes include:

- All allegations are withdrawn or dismissed;
- No findings of professional misconduct and/or incompetence are made by a panel;
- Findings of professional misconduct and/or incompetence are made and a penalty is ordered;
- Reinstatement requests are granted, not granted or abandoned; and
- Removal of information requests are granted, not granted or abandoned.

Back to Agenda

COCOO v. Paul Scotti (March 16, 2026)

The registrant committed professional misconduct in four ways in his treatment of a patient. First, his records were insufficient. Second, his invoices were misleading: one indicated that he used "3D plaster casting" when in fact he used a foam box and the other indicated that orthotics were manufactured by an "independent" lab, when he owned the lab that made them. Third, the use of a foam box for casting is contrary to the College's standards. Fourth, when dispensing the orthotics, the registrant failed to provide adequate break-in instructions and advice about follow-up.

After finding the registrant guilty of professional misconduct, the Panel ordered:

- An oral reprimand
- 5-month suspension
- PROBE Course
- U of T Records Course
- 4-month restriction on imaging, casting, prescribing, constructing, fitting, dispensing or ordering the fabrication of orthotics.
- Mentorship for 18 months
- Employer notification for 12 months.

The registrant was also ordered to pay costs to the College in the amount of $35,000.

COCOO v. Vincent Ku (March 24, 2026)

The registrant was found guilty of professional misconduct in that they: failed to meet or contravened a standard of practice of the profession; practised in the employment of or in association with a commercial business; contravened the Chiropody Act, 1991, the Regulated Health Professions Act, 1991 or the regulations under either of those Acts, including, Ont. Reg. 203/94 and Ont. Reg. 830/93, and; engaged in conduct or performed an act, in the course of practising the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable, or unprofessional.

After finding the registrant guilty of professional misconduct, the Panel ordered:

- An oral reprimand
- 3-month suspension (2 remitted)
- U of T Records Course
- Registrant will be required for a period of two years to provide any supplier in which he has a financial interest with a copy of the Tribunal's decision and have the supplier forward confirmation to the College within thirty (30) days confirming that they have received the Tribunal's decision and agree to notify the Registrar immediately if they become aware that the Registrant is not complying with College standards;
- Employer notification for 24 months
- Mentorship for 12 months

The registrant was also ordered to pay costs to the College in the amount of $15,000.

Outstanding Referrals

- One referral from the ICRC to the OCPDT.
- Six cases currently in progress. Details are posted on the College's website.

Appeals: None outstanding.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.2

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Cesar Mendez, Chiropodist

Professional Members (Council):
Chad Bezaire, Chiropodist
Edward Chung, Podiatrist
Jinyu Gu, Chiropodist
Mary Ellen Mitchell, Chiropodist
Murtuza Najmudin, Chiropodist
Jannel Somerville, Chiropodist
Peter Stavropoulos, Podiatrist
Jessica Yen-Ling Badyal, Chiropodist

Professional Members (Non-Council):
Matthew Andrade, Chiropodist
Melanie Atkinson, Chiropodist
Allen Frankel, Podiatrist
Brooke Erin Lee Mitchell, Chiropodist
Stephanie Shlemkevich, Chiropodist
Ruth Thompson, Chiropodist
Eliot To, Chiropodist
Shael Jeffrey Weinberg, Podiatrist

Public Appointees:
Itraf Ahmad, Public Appointee
Allan Katz, Public Appointee
Tomy Kokkat, Public Appointee
Chad McCleave, Public Appointee
Reshad Nazeer, Public Appointee

Selected Member:
Tobi Mark, Chiropodist

ROLE OF THE COMMITTEE

The ICRC investigates complaints and reports about the conduct and practice of chiropodists and podiatrists in Ontario. It addresses concerns to protect the public and maintain professional standards.

MEETINGS

Business meetings were held on January 28, 2026 and May 20, 2026.

Complaints

- **Sources**: Most complaints come from patients or the public, but they can also come from insurance companies, registrants, or other health care professionals.
- **Process**: The ICRC investigates most complaints with the consent of the patient/complainant to obtain relevant health information. If needed, the Registrar can appoint an investigator with authority to issue a summons.

Back to Agenda

A. Complaints – Intake

- December 2025 to March 2026: Six complaints received, which is less than last year at the same time. See chart 1 below for comparison.

Chart 1

	December 2023 – March 2024	April – July 2024	August – November 2024	December 2024 – March 2025	April – July 2025	August – November 2025	December 2025 – March 2026
Complaints	9	6	10	9	11	7	6
Registrar's Investigations	4	1	1	3	1	3	0

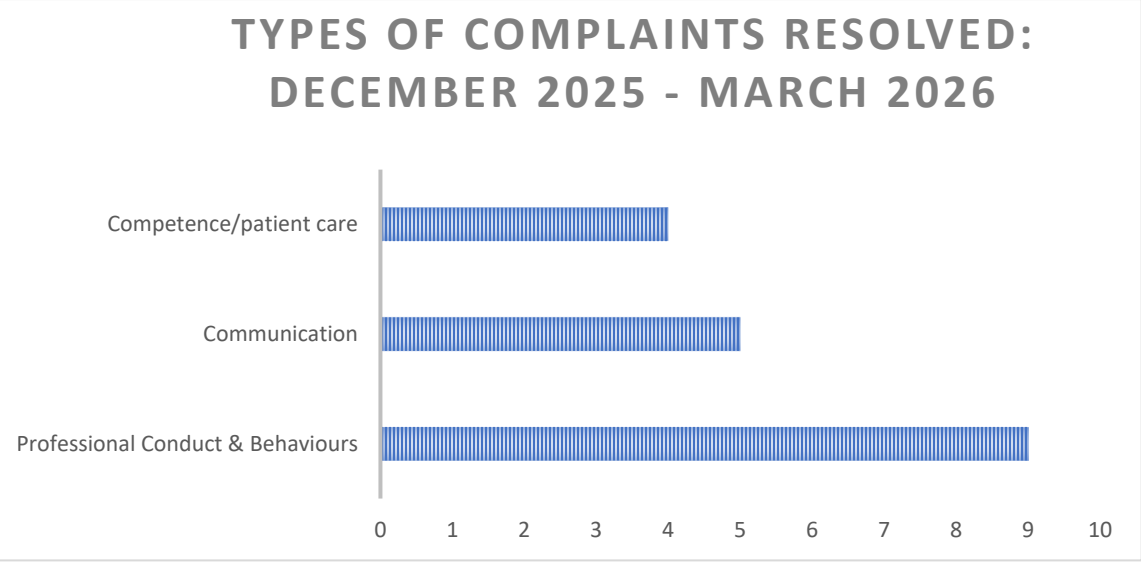
B. Dispositions - Complaints

- **9 complaints resolved**:
  - **6**: no further action was taken
  - **1**: referral to the OCPDT (Discipline Committee)
  - **1**: Frivolous and vexatious
  - **1**: SCERP and caution

Average time to resolve: 137.5 days

- This is below the 150-day benchmark outlined in the Health Professions Procedural Code.
- The average was slightly higher this period because of one complex investigation initiated in 2024.

Chart 2: Disposition of Complaints by Concerns



C. Interim Orders

No interim orders were issues during this period.

D. Appeals

No appeals to the Health Professions Appeal and Review Board (HPARB) during this period.

Reports - Registrar Investigations

- **Sources**: Reports come from employers, facility operators, registrants, and others.
- **Process**: The Registrar reviews information and decides on next steps (remediation or appointing an investigator)

A. Investigator Appointments

- No new Registrar Investigations opened between December 2025 and March 2026.

B. Dispositions - Reports

- One Registrar Investigation resolved with a caution.

C. Interim Orders

- No interim orders were issues during this period.

Quality Assurance Committee Referrals

The ICRC can also request a Registrar's investigator appointment if it receives a report about a registrant's conduct or practice from the Quality Assurance Committee (QAC).

The ICRC did receive any QAC referrals during this period.

Health Inquiries

The ICRC conducts inquiries into whether a registrant has a mental or physical condition or disorder that impacts the registrant's capacity to practice safely. The ICRC makes inquiries and may require the registrant to undergo medical examinations and suspend the registrant's certificate of registration if he or she does not attend or comply. The ICRC, after reviewing the results of its inquiries, may refer the matter to the Fitness to Practise Committee.

No health inquiries completed during this period.

Ongoing Files

- **Complaints:** Six ongoing complaints (average 69 days open).
- **Reports:** Three ongoing Registrar investigations (average 162.6 days open).

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.3

QUALITY ASSURANCE COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Millicent Vorkapich-Hill, Podiatrist

Professional Members (Council):
Andrew Klayman, Podiatrist

Professional Members (Non-Council):
Lisa Balkarran, Chiropodist
Matthew Doyle, Chiropodist
Julie Fraser, Chiropodist
Brooke Mitchell, Chiropodist
Ruth Thompson, Chiropodist
Andrea Di Croce, Chiropodist
Melanie Atkinson, Chiropodist

Public Appointees:
Reshad Nazeer

ROLE OF THE COMMITTEE

The Quality Assurance Committee (QAC) provides regulatory oversight through annual practice assessments and continuing education opportunities to ensure that Chiropodists and Podiatrists in Ontario are practicing in accordance with the College's standards.

Practice Assessments

Practice Assessments afford the College with an opportunity to provide collegial, focused and relevant feedback and direction to registrants. In addition, the practice assessments allow broader concerns to be addressed that can potentially eliminate the need for future complaints and enhance registrants' focus on public safety.

The Practice Assessment tool was updated to include the new advertising standard of practice and re-introducing orthotic manufacturing/modification. Forty-six registrants were selected to complete an assessment in 2026 and they are underway.

Continuing Education

The 2025 CE Audit is also underway. The College's Continuing Education policy is currently being updated.

NEXT MEETING

None scheduled at this time.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.4

REGISTRATION EXAMINATION COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Stephanie Shlemkevich, Chiropodist

Professional Members (Council):
Jinyu Gu, Chiropodist
Murtuza Najmudin, Chiropodist

Professional Members (Non-Council):
Brooke Mitchell, Chiropodist
Julie Fraser, Chiropodist
Lisa Balkarran, Chiropodist
Andrea Janine Di Croce, Chiropodist

Public Appointees:
N/A

ROLE OF THE COMMITTEE

Individuals wishing to practice as a Chiropodist in Ontario must be registered with the College of Chiropodists of Ontario, in accordance with the *Chiropody Act*, (1991) and its Regulations. New applicants wishing to register are required to sit a two-part examination. A pass standing of the exam is required by the College to fulfill a portion of the registration requirements and become a registrant of the College. The exam is composed of a written and a clinical (OSCE) component.

MEETINGS

Since the last Council meeting, the Committee and its Exam-Writing Subcommittee have met several times. In March and April, the College hosted its biannual in-person meeting, which provided new Committee members with item-writing training and allowed the group to review and develop new questions for both the Core Competency and Jurisprudence exams.

To prepare for the Spring registration exam, Committee panels met virtually on multiple occasions in March and April to review and select exam items. In addition, an in-person standard-setting meeting was held to evaluate the new items and establish the cut score on May 15, 2026. This session was facilitated by the College's psychometrician, Dr. Anthony Marini.

FALL REGISTRATION EXAM

The College is holding the Spring registration exams on Friday, May 15, and Saturday, May 16 with 43 applicants expected to participate. Once completed, the exam results will be shared with applicants following receipt of the results from the College's psychometrician, Dr. Anthony Marini who reviews the exams.

NEXT MEETING
Planning for Fall exams.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.5

STANDARDS AND GUIDELINES COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Brooke Mitchell, Chiropodist

Professional Members (Council):
Chad Bezaire, Chiropodist
Edward Chung, Podiatrist
Jannel Somerville, Chiropodist
Peter Stavropoulos, Podiatrist

Public Appointees:
Reshad Nazeer, Public Appointee

Professional Members (Non-Council):
Julie Fraser, Chiropodist
Brooke Mitchell, Chiropodist

Selected Member:
Tobi Mark, Chiropodist

ROLE OF THE COMMITTEE

The Standards and Guidelines Committee is a standing committee charged with developing, reviewing, updating, and managing standards, guidelines, advisories, and other documents as requested by the Executive Committee. The Committee relies on legal expertise and advice from other committees in developing practice resources.

MEETINGS

The Committee met on March 6, 2026 and May 6, 2026.

DECISION/OUTCOMES

The S&G Committee reviewed and approved changes to the following standards and guidelines: Safety and the Practice Environment, Extracorporeal Shockwave Therapy, Laser Guideline, Inhalation and Office Medical Emergencies. These documents are before Council for review.

The Committee also reviewed further changes to the Patient Relations standard.

NEXT MEETING

The Committee has a meeting scheduled August 19, 2026.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.6

REGISTRATION COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Matthew Doyle, Chiropodist

Professional Members (Council):
Peter Stavropoulos, Podiatrist

Public Appointees:
Reshad Nazeer, Public Appointee
Allan Katz, Public Appointee
Chad McCleave, Public Appointee

Professional Members (Non-Council):
Deepka Duggal, Chiropodist
Tejinder Singh Sahota, Chiropodist
Ruth Ellen Thompson, Chiropodist
Melanie Atkinson, Chiropodist
Matthew Andrade, Chiropodist
Julie Fraser, Chiropodist

ROLE OF THE COMMITTEE

The Registration Committee supports the College's public protection mandate by developing, establishing, and maintaining standards of qualification for applicants seeking a certificate of registration with the College.

MEETINGS

The Registration Committee met on the following dates to review applications for registration with the College:

- April 24, 2026: The Committee reviewed an application from an individual who had previously been refused registration after making a false declaration on the College Declaration form by failing to disclose outstanding charges in the United States.
- April 9, 2026: The Committee reviewed a former registrant's return-to-practice application following the Committee's November 13, 2025 decision to issue a certificate of registration with terms, conditions, and limitations requiring the completion of 200 supervised clinical hours (with a supervisor approved by the College) due to an absence from practice of more than two years. The Committee was satisfied that the former registrant successfully completed the required hours and could practise safely, and directed the Registrar to remove the terms, conditions, and limitations from the certificate of registration.
- March 13, 2026: The Committee reviewed an applicant's request to make a third attempt at the College's Core Competency Written Examination. The Committee approved the request, conditional on the applicant providing proof of successful completion of a clinical pharmacology course within one year of the decision.
- February 9, 2026: The Committee reviewed an application from an individual who had previously been refused registration for failing to report an investigation by the College of Massage Therapists of Ontario to the College, for having been subject to two decisions of the CMTO's Inquiries, Complaints and Reports Committee requiring remediation that has not been completed, and based on inconsistent explanations provided to the College over several years.

NEXT MEETING:

The next Committee meeting will be scheduled as needed.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.7

PATIENT RELATIONS COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Peter Stavropoulos, Podiatrist

Professional Member (Council):
Peter Stavropoulos, Podiatrist

Public Appointees:
Allan Katz, Public Appointee
Reshad Nazeer, Public Appointee

Professional Members (Non-Council):
Matthew Doyle, Chiropodist
Pauline Looi, Chiropodist
Brooke Mitchell, Chiropodist

ROLE OF THE COMMITTEE

This Committee reviews and oversees the Patient Relations Program and supports the College's commitment to address concerns about a registrant's conduct. The *Regulated Health Professions Act, 1991* outlines two specific roles for the PRC:

- advise Council with respect to the patient relations program (PRP), which must include measures for preventing and dealing with patient sexual abuse;
- administer funding for therapy and counselling for patients who are named in a sexual abuse complaint or report.

MEETINGS

The Committee has not met since the last Council meeting.

DECISION/OUTCOMES

N/A

NEXT MEETING

None scheduled.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.8

FITNESS TO PRACTISE COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Brooke Mitchell, Chiropodist

Professional Members (Council):
N/A

Public Appointees:
Reshad Nazeer, Public Appointee

Selected Member:
Tobi Mark, Chiropodist

Professional Members (Non-Council):
Matthew Doyle, Chiropodist
Deepka Duggal, Chiropodist
Pauline Looi, Chiropodist
Cesar Mendez, Chiropodist
Kimberley Resmer, Chiropodist
Eliot To, Chiropodist

ROLE OF THE COMMITTEE

The Fitness to Practise Committee supports the College's public protection mandate by conducting hearings to assess whether a registrant is incapacitated, after the matter has been referred by the Inquires, Complaints and Reports Committee.

MEETINGS

None

DECISION/OUTCOMES

None

NEXT MEETING

There are no meetings or hearings scheduled at this time.

Back to Agenda

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.9

TECHNICAL COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Edward Chung, Podiatrist

Professional Members (Council):
Chad Bezaire, Chiropodist

Professional Members (Non-Council):
Matthew Doyle, Chiropodist
John Lanthier, Podiatrist

Public Appointees:
N/A

ROLE OF THE COMMITTEE

The Technical Committee was established by Council as an ad hoc committee. Its mandate is to support Council by responding to questions relating to the acceptability of practice modalities and emerging technologies.

MEETINGS

The Committee has not met since the January 2026 Council meeting.

NEXT MEETING

At present, there are no future meetings scheduled. The Committee will reconvene as needed when new questions or issues arise that require its expertise and recommendations.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.10

ELECTIONS COMMITTEE REPORT

May 21, 2026 Committee Meeting

COMMITTEE MEMBERS

Chair: Allan Katz, Public appointee

Professional Members (Council):
Matthew Doyle, Chiropodist

Professional Members (Non-Council): none

Public Appointees:
Allan Katz
Reshad Nazeer

ROLE OF THE COMMITTEE

The Elections Committee is a standing committee of the College, which is mandated by the College's General By-law. The Elections Committee deals with disputes relating to the election of Council members and other matters provided in the by-laws, other disputes or issues referred to it by Council or the Executive Committee and it studies and makes recommendations to Council for improving the election process.

MEETINGS

The Election Committee has not met as no election issues have arisen requiring the Committee's attention.

DECISION/OUTCOMES

None.

NEXT MEETING

No meetings are scheduled at this time.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.11

STRATEGIC PLANNING COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Millicent Vorkapich-Hill, Podiatrist

Professional Members (Council):

Ed Chung, Podiatrist
Peter Stavropoulos, Podiatrist

Professional Members (Non-Council):

Matt Doyle, Chiropodist
Jannel Somerville, Chiropodist
Millicent Vorkapich-Hill, Podiatrist

Public Appointees:

Allan Katz
Reshad Nazeer

ROLE OF THE COMMITTEE

The Strategic Planning Committee's role is to ensure that the College's two main objectives of sustainability and the adoption of the podiatry model in Ontario, are attainable over the next 3 to 5 years. The College's current strategic plan is in effect from 2022 to 2027.

MEETINGS

The Committee has not met since its last meeting prior to October 2025 Council meeting.

DECISION/OUTCOMES

None.

NEXT MEETING

None currently scheduled.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 2.3.12

REGISTRAR'S PERFORMANCE AND COMPENSATION COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Allan Katz, Public Appointee

Professional Members (Council):
Chad Bezaire, Chiropodist
Ed Chung, Podiatrist
Peter Stavropoulos, Podiatrist (ex-officio)

Professional Members (Non-Council):
None

Public Appointee Members:
Allan Katz

ROLE OF THE COMMITTEE

The Registrar's Performance and Compensation Review Committee's responsibilities include, but are not limited to:

1. Providing input and support to Council President on mid-year (May-June) performance review and annual (Dec-Jan) performance review, goal planning and compensation;

2. As required, conducting compensation and benefits market review, normally done through engagement of an external consultant, and with the prior approval of the Executive Committee;

3. Presenting to Council the results of all compensation reviews conducted by the Registrar's Performance and Compensation Review Committee, along with any recommendations it has in connection with changes to the Registrar's compensation.

MEETINGS

The Committee met on December 11, 2025, to review the Registrar's Performance for 2025 and produced a report. The Committee Chair reported to the Executive Committee in-camera at its meeting on December 14, 2025, and reported Executive's support to Council on January 29, 2026, in camera.

DECISION/OUTCOMES

Council unanimously supported the recommendation from the Executive Committee, in camera.

NEXT MEETING

There are no meetings scheduled at this time.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.1

COUNCIL BRIEFING NOTE
RE: AMENDMENT TO BY-LAW 1 (GENERAL) TO CLARIFY COUNCIL MEMBERS' TERM OF OFFICE

Background:

By-law 1 (General) contains information that guides the College's Council Elections and other governance processes. This information is reviewed on a regular basis as part of ongoing efforts to improve internal operations and governance practices.

As part of this review, the language in the **Definitions** and **sections 48.02, 52.02, and 53.03** related to terms of office and the elections process was revised to clearly state that the term of an elected Councillor, selected Councillor and non-Council committee member is approximately three years, given the acceptance of the selection or the appointment may not take place at the First Council Meeting. The timing of the Elections was also clarified.

These amendments do not change existing internal operations or Council Election procedures; rather, they are intended to provide greater clarity regarding term lengths and to support more streamlined and consistent processes going forward.

Council is asked to approve these amendments of the sections (provided below), which relate to the term lengths of Councillors and the timing of the Council Elections.

1. DEFINITIONS

"election of councillors" means the election which takes place ~~in June of~~ each year in accordance with the by-laws of the College and, except where the context otherwise requires, includes a by-election;

"First Council Meeting" means the first regular Council meeting held after the ~~June~~ annual **election of councillors**;

48. ELECTED COUNCILLORS

Term of Office

48.02 Except in the case of a vacancy, the term of office of an **elected councillor** is three years commenc~~es~~ing at the **First Council Meeting** following their election and end~~s~~ing at the commencement of the **First Council Meeting** in the third year after their election~~which is more than two calendar years following that election~~.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

49. TIMING OF ELECTIONS

49.01 Separate elections for **elected councillors** shall be held simultaneously as follows:

i) in May of the year 2025 and in May of every third year thereafter for each of electoral districts 1 and 2 for the election of **chiropodist councillors** and for the combined electoral districts 1 and 2 (also referred to as combined district 1) for the election of a **podiatrist councillor**;

52. SELECTED COUNCILLOR

52.01 For clause 7(1)(c) of the **Act**, one **councillor** shall be selected by Council from the Faculty of the Michener Institute for Applied Health Sciences (Ontario) in accordance with the process set out in **Schedule 2**.

52.02 Except in the case of a vacancy being filled, the term of office of a **selected councillor** ~~shall be~~is approximately three years commencing on ~~from~~ the date of the acceptance of the selection by the selected **councillor** and ending at ~~until~~ the commencement of the **First Council Meeting** in the third year after the appointment~~which is more than two calendar years following that appointment~~.

53. COMMITTEE MEMBERS

Term of Office – Non-Council Committee Members

53.03 The term of office of a **non-council committee member** is approximately three years commencing ~~shall be from~~on the date of appointment and ending ~~until~~at the **First Council Meeting** ~~which is more than two calendar years following that appointment~~in the third year after the appointment.

Public Interest Rationale for Decision:

Regularly reviewing, updating, and modernizing governance documents and processes supports transparency, accountability, and effective oversight, all of which are fundamental to the College's mandate to act in the public interest. Clear and consistent by-law provisions help ensure that the College's governance processes, such as the Council Elections, operate smoothly and efficiently.

Recommended Motion:

That Council approve the revised By-law 1 (General):

Mover: _____

Seconder: _____

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.2

COUNCIL BRIEFING NOTE

RE: REVISIONS TO THE EXTRACORPOREAL SHOCK WAVE THERAPY GUIDELINE

Background:

The Standards and Guidelines Committee is undertaking a comprehensive review of all the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the look and format of the documents

As part of this review, the Extracorporeal Shock Wave Therapy Guideline has revised to improve clarity, align with current regulatory requirements, and reflect contemporary practice expectations.

This guideline was originally approved by Council in 2012 and required updating to ensure it remains current and relevant.

Public Interest Rationale for Decision:

Regular review ensures standards and guidelines reflect current expectations and are clearly communicated. This helps:

- Registrants understand what is required for safe and ethical practice
- The public understand what they can expect from registrants

Recommended Motion:

That Council approve the revised Extracorporeal Shock Wave Therapy Guideline.

Mover: _____

Seconder: _____

Appendix A – redlined version
Appendix B – newly formatted standard

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EXTRACORPOREAL SHOCK WAVE THERAPY

Guideline for Registrants of the College of Chiropodists of Ontario

Approved by Council: June 8, 2012
Amended:

Approved by Council on June 8, 2012

~~Guideline for the Profession~~
~~Extracorporeal Shock Wave Therapy~~

Introduction

Extracorporeal shockwave therapy (ESWT), or shockwave therapy, is a non-invasive treatment that uses high-energy sound waves to stimulate healing and reduce pain in targeted areas.

Regulatory Context

The **Regulated Health Professions Act, 1991** prohibits anyone from applying or ordering certain types of energy listed in **Ontario Regulation 107/96**, unless they are a registrant of a regulated health profession authorized to use that energy. For example, the regulation restricts some uses of electricity but specifically allows registrants to use it for electrocoagulation and fulguration.

The regulation also restricts the use of soundwaves, but only for the purpose of **ultrasound** and **lithotripsy**. Lithotripsy is not defined in the regulation but is generally understood to involve breaking up stones or calculi, usually in the kidney or gallbladder.

Guidelines for Registrants using ESWT

~~***The Regulated Health Professions Act, 1991***~~
~~The College has received several inquiries over the years about whether members are allowed to use extracorporeal shock wave therapy in their practice. Council understands that this therapy involves the use of soundwaves[1] but that the energy is not used to break down calcifications or other hard deposits. As such members~~ Registrants ~~may employ this t~~can use ESWT~~herapy for their patients~~ provided ~~all of~~ the following conditions ~~have been~~are met:

1. Training

~~[1] The Regulated Health Professions Act, 1991 prohibits applying or ordering the application of certain specified energies which energies are listed in a regulation under that Act ("Regulation"), unless the person is a member of a Regulated Health Profession who is authorized to use that form of energy. For example, that Regulation controls certain uses of electricity but specifically allows our members to apply energy for electrocoagulation and fulguration. The use of soundwaves is also controlled in that Regulation but only for the purpose of "ultrasound" and "lithotripsy". Lithotripsy is not defined in the legislation but is commonly understood to involve the breaking up of stones or calculi (usually in the kidney or gallbladder).~~

Approved by Council on June 8, 2012

~~1.~~ ~~The member~~ Registrants ~~has~~ must have appropriate training to ~~determine~~ assess the need for ~~this form of treatment~~ ESWTand to~~in the~~ ~~administe~~administer~~ring~~ ~~of~~ the therapy safely.

2. Clinical Appropriateness

~~The treatment is one which a~~The treatment must be ~~prudent member would consider to be~~ appropriate ~~having regard to~~ for the patient's condition, considering any contraindications, and it must be delivered at appropriate intervals.

3. Informed Consent

~~2.~~

~~The member~~ Registrants ~~has~~ must obtain~~ed~~ ~~an informed~~informed consent from the patient in compliance with the **Health Care Consent Act, 1996**. This includes:

- Explaining the nature of the treatment, including the expected benefits, the material risks and side effects, alternative courses of action, and the likely consequences of not having the treatment.
- Answering any questions; and,
- Ensuring the patient (or their substitute decision maker) understands the information, taking reasonable steps to facilitate that understanding.

4. Documentation

Registrants must appropriately document the use of ESWT in the patient's chart, including:

- Device model and parameters (such as time, power, level)
- Area treated
- Date of treatment and the date of symptom onset

~~3.~~• Any complications or adverse outcomes

References

Assessment and Management
Regulated Health Professions Act, 1991
O. Reg. 107/96: CONTROLLED ACTS
Health Care Consent Act, 1996, S.O. 1996, c 2.
Consent
Competence
Records

Approved by Council on June 8, 2012

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College of Chiropodists of Ontario

EXTRACORPOREAL SHOCK WAVE THERAPY

Guideline for Registrants of the College of Chiropodists of Ontario

Approved by Council: June 8, 2012
Amended:

Introduction

Extracorporeal shockwave therapy (ESWT), or shockwave therapy, is a non-invasive treatment that uses high-energy sound waves to stimulate healing and reduce pain in targeted areas.

Regulatory Context

The **Regulated Health Professions Act, 1991** prohibits anyone from applying or ordering certain types of energy listed in **Ontario Regulation 107/96**, unless they are a registrant of a regulated health profession authorized to use that energy. For example, the regulation restricts some uses of electricity but specifically allows registrants to use it for electrocoagulation and fulguration.

The regulation also restricts the use of soundwaves, but only for the purpose of **ultrasound** and **lithotripsy**. Lithotripsy is not defined in the regulation but is generally understood to involve breaking up stones or calculi, usually in the kidney or gallbladder.

Guidelines for Registrants using ESWT

Registrants can use ESWT provided the following conditions are met:

1. **Training**

Registrants must have appropriate training to assess the need for ESWT and to administer the therapy safely.

2. **Clinical Appropriateness**

The treatment must be appropriate for the patient's condition, considering any contraindications, and it must be delivered at appropriate intervals.

3. **Informed Consent**

Registrants must obtain informed consent from the patient in compliance with the **Health Care Consent Act, 1996**. This includes:

- Explaining the nature of the treatment, including the expected benefits, the material risks and side effects, alternative courses of action, and the likely consequences of not having the treatment.
- Answering any questions; and,
- Ensuring the patient (or their substitute decision maker) understands the information, taking reasonable steps to facilitate that understanding.

4. Documentation

Registrants must appropriately document the use of ESWT in the patient's chart, including:

- Device model and parameters (such as time, power, level)
- Area treated
- Date of treatment and the date of symptom onset
- Any complications or adverse outcomes

References

- Assessment and Management
- Regulated Health Professions Act, 1991
- O. Reg. 107/96: CONTROLLED ACTS
- Health Care Consent Act, 1996, S.O. 1996, c 2.
- Consent Guideline
- Competence
- Records

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.3

COUNCIL BRIEFING NOTE
RE: REVISIONS TO THE OFFICE MEDICAL EMERGENCIES GUIDELINE

Background:

The Standards and Guidelines Committee is conducting a comprehensive review of all the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the look and format of the documents

The revised guideline provides updated guidance to registrants on how to prepare their clinic and staff for office medical emergencies.

This guideline was originally approved by Council in 2012 and required updates to align with current practice.

Public Interest Rationale for Decision:

Regular review ensures standards and guidelines reflect current expectations and are clearly communicated. This helps:

- Registrants understand what is required for safe and ethical practice
- The public understand what they can expect from registrants

Recommended Motion:

That Council approve the revised Office Medical Emergencies Guideline.

Mover: _____

Seconder: _____

Appendix A – redlined version
Appendix B – newly formatted guideline

Approved by Council on June 8, 2012

Revised and Updated: X

Office Medical Emergencies Guideline ~~in the Podiatry and Chiropody Office Setting~~

Introduction

Medical emergencies, though rare, can happen in any office setting and may be life-threatening. All clinics must be prepared to manage such situations until emergency medical services arrive.

To ensure readiness, **all registrants are required to have the following in place at every clinic where they practise**:

1. A Written Office Medical Emergency Response Plan
    - Tailored to the specific risk profile of the clinic.
    - Must be updated regularly to reflect current evidence and practice changes.
2. Readily Available Basic Emergency Equipment and Supplies
    - Should be appropriate for the type of practice and patient population (see breakdown below).
    - Includes items like oxygen tanks, blood pressure monitors, and AEDs (if applicable).
    - Equipment must be tested regularly and maintained in working order.
3. Readily Available Basic Emergency Medication
    - Examples include epinephrine, nitroglycerin, glucose and antihistamines.
    - All medication must be within expiry and stored properly.
    - The selection should reflect the clinic's risk profile and patient demographics (see breakdown below).

Clinics are **not expected to function like hospital emergency rooms**, but they must be equipped to handle basic emergencies in a manner consistent with what a reasonably prudent practitioner would be expected to do in that setting.

~~Podiatrists and Chiropodists~~Registrants ~~should be aware that acute and potentially life-threatening medical emergencies can and do occur in the office setting. Accordingly, all offices should be prepared for these unfortunate and often unpredictable events with the goal of effectively managing these patients until care can be appropriately transferred to trained medical emergency personnel. In preparation for these potential events, all Podiatry and Chiropody offices should~~ registrants are required to ensure that all clinics where they practise ~~have the following three elements in place: a written office medical emergency response plan, readily available basic emergency equipment and supplies, and readily available basic emergency medications. Specifics regarding the emergency response plans, equipment and supplies, and medications, should be designed and tailored to meet the risk profile of each office. It is not necessary for Podiatrists and Chiropodists~~registrants ~~to have the drugs, equipment and skills found in an emergency room, but it is necessary to have a basic medical emergency response plan and have available all equipment and supplies that a reasonably prudent practitioner would be expected to need and use in the type of practice carried out in a particular office setting.~~

Office Medical Emergency Plan

To support preparedness and patient safety, the following three recommendations ~~he three following **recommendations** are offered~~provide ~~as~~ a framework for ~~the development and implementation of~~ an effective office medical emergency plan.

Recommendation 1: Develop and Maintain a Comprehensive Policy Manual

- Every office should have a policy and procedures manual that includes:
    - ~~It is recommended that all offices develop and maintain a policy and procedures manual (including an office~~ A medical emergency response plan
    - ~~and a~~ A list of specific medical emergency equipment, supplies, and ~~drugs~~medications~~)~~
- The manual should be:
    - Tailored to the clinic's risk profile and practice type ~~specific for the risk profile of that office location and practice type b~~
    - Based on current research and ~~evidence~~best practices.
    - ~~This should be~~ Reviewed and updated ~~on an ongoing basis~~regularly to reflect changes in ~~research and~~ evidence and ~~to capture changes in the practice parameters.~~clinical operations.

Recommendation 2: Train Staff and Conduct Regular Emergency Drills

- **All staff must:**
    - ~~It is recommended that all staff u~~Understand~~s~~ their specific role~~s~~ during an emergency
    - ~~and p~~Participate~~s~~ in regular training, including ~~office~~ emergency scenario workshops and/or drills (including an office medical emergency response plan)~~ conducted on an ongoing basis~~.

Recommendation 3: Maintain Emergency Equipment and Medications

- ~~It is recommended that all o~~Offices should adopt a policy ~~that~~ to ensure~~:s~~
    - ~~that~~ emergency equipment is tested regularly ~~and all drugs~~
    - medications are checked and replaced before expiry~~in the emergency kit are kept current on an ongoing basis.~~
- This policy should include~~:, but is not limited to:~~
    - Routine testing of equipment (e.g. the oxygen machine/tank)
    - Scheduling ~~and contacting the supplier to arrange for~~ on-site inspections and calibrations of the machine/tank~~, replacing emergency drugs upon expiry, and developing equipment m~~
    - ~~aintenan~~Maintaining ~~ce schedule and~~ logbooks for equipment checks and drug inventory.~~.~~

Office Risk Classification for Medical Emergencies~~Risk Profile~~

While every practice is unique, clinics can be categorized based on the **likelihood of a medical emergency occurring** and the **potential severity of its outcome**. This classification helps guide the level of preparedness required. ~~While it is understood that all practices are unique, Podiatry and Chiropody offices can be classified on the basis of their likelihood of experiencing a medical emergency and the potential risk of the medical emergency having an adverse outcome.~~

Low Risk Offices:

- Low ~~volume of~~ patient volume~~s~~
- Few high~~-~~risk patients (low morbidity of patient load)
- Urban location with efficient EMS services and proximity to an emergency room
- Limited scope of practice (e.g. physical therapy modalities, biomechanics, etc.)
- No parenteral medications ~~given~~administered
- No procedures performed in office

Moderate Risk Offices:

- High patient volume ~~of patients~~
- Many high risk patients (high morbidity of patient load)
- Rural/remote location with:
  - Limited or delayed EMS
  - ~~no~~ No ~~local~~ nearby hospital ~~and/or poor or inefficient access to EMS leading to delays in transfer to emergency room~~
  - ~~Possible exposure to~~Potential for severe weather that ~~leading to~~t impacts emergency response ~~delays in transfer to emergency room~~
- Parenteral medications ~~given~~are administered
- Minimally invasive procedures performed in the office (e.g. nail procedures, simple cutaneous procedures, etc.)

High Risk Offices:

- High patient volume ~~of patients~~
- Many high risk patients (high morbidity ~~of patient load~~)
- Rural ~~or/remote~~or remote location with poor EMS access and no ~~local hospital and/or poor or inefficient access to EMS leading to delays in transfer to emergency room~~nearby hospital

- ~~Possible exposure to~~Risk of severe weather ~~leading to delays in transfer to emergency room~~delaying emergency response
- ~~Parenteral medications given~~administered
- ~~and/or~~
- Invasive procedures performed in the office, such as:
  - ~~(e.g. c~~Complex cutaneous procedures involving larger surface areas~~, soft~~
  - Soft tissue procedures at or below the subcutaneous tissue ~~layer, osseous~~layer osseous procedures, etc.)
- May involve minimal sedation

~~Practices performing minimal or moderate sedation through the administration of inhaled sedative agents and/or oral sedative agents would be considered high risk regardless of any of the other practice parameters. These practices should adhere to the specific guidelines for the use of these sedation modalities (including all emergency drugs and emergency equipment which must be readily available). Specific guidelines and recommendations can be found in their entirety elsewhere.~~

Office Medical Emergency Equipment, Supplies, and Medications

While specific lists of ~~essential~~ emergency drugs and equipment are ~~included~~ provided ~~in the following tables~~below, ~~one should~~ it's important to remember that the foundation of all emergency care is Basic Life Support (BLS)/CPR.

CPR Certification

- ~~A primary management of all medical emergencies is Basic Life Support/CPR. While t~~The College currently requires that a~~A~~ll ~~members~~ registrants are required to renew their Basic Life Support/CPR certification (CPR Level HCP – CPR Level for Health Care Providers), as a minimum, every 3 years.~~, and an~~

- An annual review of emergency protocols is strongly recommended.

Medication Use in Emergencies

- The recommended emergency medications should only be administered:
    - **By routes** the practitioner is trained and comfortable with
    - In **dosages** the practitioner is competent to manage
- Practitioners must **never exceed their training** when administering emergency drugs.

Reviewing Medical History

- A thorough **Medical Health History review** is the **most critical step** in identifying potential risks before treatment.

- Registrants must:
    - Be **fully familiar** with each patient's medical history and current conditions
    - Use this information to **prevent emergencies** during or after care
    - Update and review histories regularly to ensure safe and appropriate treatment

~~The following agents are recommended for use during a medical emergency in the office setting; however, these drugs should only be administered by routes and in dosage forms that each practitioner is personally comfortable with and competent to administer.~~

~~One should also always keep in mind that the Medical Health History review is considered the most important exercise in identifying potential risks during the provision of any healthcare service and in preventing a medical emergency during or after treatment. Podiatrists and Chiropodists~~ Registrants ~~must be completely familiar with each patient's comprehensive Medical History and current conditions to provide care safely and minimize the development of a potentially harmful or life-threatening situation.~~

Emergency Supplies for Low-Risk Clinics

Even in low-risk settings, it's important to be ready for unexpected medical situations. Here's what you should **consider** having on hand in a low-risk clinic.

Emergency Medication/Agents

These are the basic medications or agents you should keep in your emergency kit:

- **Oxygen**
  Used in almost all medical emergencies to help with breathing. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.

- **Aspirin (160-325 mg, chewable, non-coated)**
  Helps if someone is having a heart attack. Only for adult use.

- **Glucose tablets**
  Used to treat low blood sugar in conscious patients.

Emergency Equipment and Supplies

These tools help you respond quickly and effectively:

- A working **telephone** to call 911
- A **stethoscope** and **blood pressure cuff**
- **Basic wound care supplies** (like gauze and bandages)
- A **bag-valve-mask** (manual resuscitator) for both adults and children

It is **strongly recommended** that all Podiatry and Chiropody offices—regardless of risk level—are equipped with an **Automated External Defibrillator (AED)**.

An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Essential Agents for Inclusion in Office Emergency Kits of Low Risk Podiatry and Chiropody Officessic Emergency Supplies for Low Risk Clinics

Primary/Required (Essential) Agents				
Generic	Proprietary	Indications	Initial Adult Dose	Pediatric Dose
Primary/Required (Essential) Equipment/Supplies				
Oxygen	Oxygen	Most medical emergencies	100% inhalation	100% inhalation
Acetylsalicylic	Many	Acute myocardial	325 mg non-enteric coated	Not indicated

~~acid (Aspirin)~~		~~infarction~~	~~tablet to be chewed~~	
~~Glucose Tablets~~	~~Dex4 Glucose Tablets~~	~~Hypoglycemic event (conscious patient)~~	~~1-2 tablets chewed as needed in conscious patient~~	~~1-2 tablets chewed as needed in conscious patient~~

~~Essential Equipment/Supplies for Inclusion in Office~~

Primary/Required (Essential) Equipment/Supplies

Emergency Kits of Low Risk Podiatry and Chiropody Offices

Emergency Supplies for Moderate-Risk Clinics

Emergency Medication/Agents

If you practice in a moderate risk clinic, you should include these medications/agents in your emergency kit. However, they should only be used by practitioners trained and comfortable with their administration:

- **Oxygen** – For most medical emergencies. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:
  - Severe allergic reactions (anaphylaxis)
  - Asthma attacks not responding to inhalers
  - Cardiac arrest
- **Diphenhydramine (Benadryl)** – For allergic reactions

- **Aspirin (160-325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendations**:**

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis
- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Emergency Equipment and Supplies

A moderate-risk clinic should have the following on hand:

- **Working telephone to call 911**
- **Stethoscope** and **blood pressure cuff**
- **Basic wound care supplies**
- **Bag-valve-mask** (manual resuscitator) for adults and children
- **Parenteral supplies**, including:
  - Syringes (1cc, 3cc, 10cc, 60cc)
  - Needles (14, 18, 23, 25 gauge)
  - Butterfly needles (19 and 23 gauge)
  - Alcohol swabs
  - Tourniquet
- **Glucometer** (for checking blood sugar)

It is **strongly recommended** that all clinics—regardless of risk level—are equipped with an

Automated External Defibrillator (AED).

An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Essential Agents for Inclusion in Office Emergency Kits of Moderate Risk Podiatry and Chiropody Offices

Primary/Required (Essential) Agents				
Generic	**Proprietary**	**Indications**	**Initial Adult Dose**	**Pediatric Dose**
Oxygen	Oxygen	Most medical emergencies	100% inhalation	100% inhalation
Epinephrine 1:1000 Solution	Adrenalin	Anaphylaxis	0.1 mg IV or 0.3-0.5 mg IM	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
		Asthmatic bronchospasm unresponsive to salbutamol/albuterol	0.1 mg IV or 0.3-0.5 mg IM	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
		Cardiac arrest	1 mg IV	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
Diphenhydramine	Benadryl	Allergic reactions	50 mg IV or IM	1 mg/kg (total pediatric dose not to exceed adult dose of 50 mg)

Nitroglycerin	Nitrostat Nitromist	Angina pectoris	0.3 or 0.4 mg sublingual tablet or metered spray	No pediatric dose
Salbutamol *(Int)* Albuterol *(US)*	Ventolin Proventil	Asthmatic bronchospasm	2 puffs (100 micrograms per puff)	1 puff (100 micrograms per puff)
Acetylsalicylic acid (Aspirin)	Many	Acute myocardial infarction	325 mg non-enteric coated tablet to be chewed	Not indicated
Hydrocortisone	Many	Allergic reactions and/or adrenal insufficiency crisis	Hydrocortisone 100 mg or equivalent dose IM or IV Eg. Dexamethasone 4 mg PO, IM, IV\	Hydrocortisone 1-5 mg/kg or equivalent dose IM or IV Eg. Dexamethasone 0.2 mg/kg (maximum dose 4 mg)

Glucose Tablets	Dex4 Glucose Tablets	Hypoglycemic event (conscious patient)	1-2 tablets chewed as needed in conscious patient	1-2 tablets chewed as needed in conscious patient
50 % Dextrose Solution	50 % Dextrose Solution	Hypoglycemic event (unconscious patient)	50 mL IV in unconscious patient	50 mL IV in unconscious patient

Secondary/Recommended (Non-Essential) Agents				
Generic	**Proprietary**	**Indications**	**Initial Adult Dose**	**Pediatric Dose**
Aromatic ammonia or other respiratory stimulant	Aromatic ammonia or other respiratory stimulant	Syncope episode	Inhaled as needed	Inhaled as needed
Midazolam	Versed	Seizures/convulsions	5 mg IM	0.1-0.25 mg/kg IM (not to exceed adult dose of 5 mg)

~~Essential Equipment/Supplies for Inclusion in Office Emergency Kits of Moderate Risk Podiatry and Chiropody Offices~~

~~Primary/Required (Essential) Equipment/Supplies~~
~~Telephone, Stethoscope, Blood pressure cuff, Basic dressing supplies, Bag-valve-mask ventilation device (adult and pediatric)~~
~~Parenteral Supplies:~~ ~~Syringes (1cc, 3cc, 10cc, 60cc)~~ ~~Needles (14, 18, 23, 25 gauge)~~ ~~Butterfly Needles (19 and 23 gauge)~~ ~~Alcohol Swabs~~ ~~Tourniquet~~
~~Glucometer~~

Emergency Supplies for High-Risk Clinics

In a high-risk clinic, these medications should be included in your emergency kit and used only by trained professionals:

Emergency Medications/Agents

- **Oxygen** – For most medical emergencies. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:
    - Severe allergic reactions (anaphylaxis)
    - Asthma attacks not responding to inhalers
    - Cardiac arrest
- **Diphenhydramine (Benadryl)** – For allergic reactions
- **Aspirin (160-325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendation:

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis
- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Required Equipment & Supplies

A high-risk clinic should have the following on hand:

- Working **telephone**
- **Stethoscope** and **blood pressure cuff**
- **Basic wound care supplies**
- **Bag-valve-mask** (manual resuscitator) for adults and children
- **Parenteral supplies**, including:
    - Syringes (1cc, 3cc, 10cc, 60cc)
    - Needles (14, 18, 23, 25 gauge)
    - Butterfly needles (19 and 23 gauge)
    - Alcohol swabs
    - Tourniquet
    - **Glucometer**
- **Automated External Defibrillator (AED) -** An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Recommended Equipment & Supplies

- **Intubation equipment**:
    - Laryngoscopes (2 sizes)
    - Endotracheal tubes (sizes 3–8)
    - Suction device
- **IV supplies**:
    - Catheters (14, 18, 22, 25 gauge)
    - Normal saline
    - IV pole and tubing

Additional Medications for Clinics Using Sedation

If your clinic uses **minimal sedation** (e.g., nitrous oxide or oral sedatives), you must also include **reversal agents** in your emergency kit:

- **Naloxone (Narcan)** – Reverses opioid overdose
- **Flumazenil (Romazicon)** – Reverses benzodiazepine overdose

Essential Agents for Inclusion in Office Emergency Kits of High Risk Podiatry and Chiropody Offices

Primary/Required (Essential) Agents				
Generic	**Proprietary**	**Indications**	**Initial Adult Dose**	**Pediatric Dose**
Oxygen	Oxygen	Most medical emergencies	100% inhalation	100% inhalation
Epinephrine 1:1000 Solution (1mg/ml)	Adrenalin	Anaphylaxis	0.1 mg IV or 0.3-0.5 mg IM	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
		Asthmatic bronchospasm unresponsive to salbutamol/albuterol	0.1 mg IV or 0.3-0.5 mg IM	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
		Cardiac arrest	1 mg IV	0.01 mg/kg (total pediatric dose not to exceed adult dose of 0.3 mg/kg)
Diphenhydramine	Benadryl	Allergic reactions	50 mg IV or IM	1 mg/kg (total pediatric dose not to exceed adult dose of 50 mg)

Nitroglycerin	Nitrostat Nitromist	Angina pectoris	0.3 or 0.4 mg sublingual tablet or metered spray	No pediatric dose
Salbutamol *(Int)* Albuterol *(US)*	Ventolin Proventil	Asthmatic bronchospasm	2 puffs (100 micrograms per puff)	2 puff (100 micrograms per puff)
Acetylsalicylic acid (Aspirin)	Many	Acute myocardial infarction	325 mg non-enteric coated tablet to be chewed	Not indicated
Hydrocortisone	Many	Allergic reactions and/or adrenal insufficiency crisis	Hydrocortisone 100 mg or equivalent dose IM or IV	Hydrocortisone 1-5 mg/kg
Glucose Tablets	Dex4 Glucose Tablets	Hypoglycemic event (conscious patient)	1-2 tablets chewed as needed in conscious patient	1-2 tablets chewed as needed in conscious patient
50 % Dextrose Solution	50 % Dextrose Solution	Hypoglycemic event (unconscious patient)	50 mL IV in unconscious patient	50 mL IV in unconscious patient

Secondary/Recommended (Non-Essential) Agents				
Generic	Proprietary	Indications	Initial Adult Dose	Pediatric Dose
Aromatic ammonia or other respiratory stimulant	Aromatic ammonia or other respiratory stimulant	Syncope episode	Inhaled as needed	Inhaled as needed
Midazolam	Versed	Seizures/convulsions	5 mg IM	0.1-0.25 mg/kg IM (not to exceed adult dose of 5 mg)

Essential Equipment/Supplies for Inclusion in Office Emergency Kits of High Risk Podiatry and Chiropody Offices

Primary/Required (Essential) Equipment/Supplies	
Telephone, Stethoscope, Blood pressure cuff, Basic dressing supplies, Bag-valve-mask ventilation device (adult and pediatric)	
Parenteral Supplies:	Syringes (1cc, 3cc, 10cc, 60cc) Needles (14, 18, 23, 25 gauge) Butterfly Needles (19 and 23 gauge) Alcohol Swabs Tourniquet
Glucometer	

Secondary/Recommended (Non-Essential) Equipment/Supplies	
Intubation Equipment:	Laryngoscopes (two sizes) Endotracheal tubes (sizes 3-8) Suction device
Intravenous Supplies:	Catheters (numbers 14, 18, 22, 25) Normal Saline IV pole and tubing

Any practices performing minimal or moderate sedation through the use of inhaled sedative agents and/or oral sedative agents, would be considered high risk and in addition to all previously listed high risk agents should include reversal agents in their emergency kits. These practices should adhere to the specific guidelines for the use of these sedation modalities (including all emergency drugs and emergency equipment which must be readily available). Specific guidelines and recommendations can be found in their entirety elsewhere.

~~Essential Agents for Inclusion in Office Emergency Kits of All Podiatry and Chiropody Offices Administering Minimal-Moderate Sedation* (Nitrous Oxide/Oxygen Sedation and/or a Single Oral Sedative Drug)~~

*The American Society of Anaesthesiologists (ASA) has defined minimal and moderate depths of sedation as follows:

Minimal Sedation:

- Normal response to verbal stimulation
- Cognitive function and coordination may be impaired
- Ventilatory and cardiovascular functions are unaffected

Moderate Sedation:

- Drug induced depression of consciousness
- Patient responds purposefully to verbal commands
- Airway is patent, and spontaneous ventilation is adequate
- Cardiovascular function is usually unaffected

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Safety and the Practice Environment

ITEM

College of Chiropodists of Ontario

OFFICE MEDICAL EMERGENCIES

Guideline for Registrants of the College of Chiropodists of Ontario

Approved by Council: June 8, 2012
Revised and Updated: XX

INDEX

Introduction

Medical emergencies, though rare, can happen in any office setting and may be life-threatening. All clinics must be prepared to manage such situations until emergency medical services arrive.
To ensure readiness, all registrants are required to have the following in place at every clinic where they practise:

1. A Written Office Medical Emergency Response Plan
    - Tailored to the specific risk profile of the clinic.
    - Must be updated regularly to reflect current evidence and practice changes.

2. Readily Available Basic Emergency Equipment and Supplies
    - Should be appropriate for the type of practice and patient population (see breakdown below).
    - Includes items like oxygen tanks, blood pressure monitors, and AEDs (if applicable).
    - Equipment must be tested regularly and maintained in working order.

3. Readily Available Basic Emergency Medication
    - Examples include epinephrine, nitroglycerin, glucose and antihistamines.
    - All medication must be within expiry and stored properly.
    - The selection should reflect the clinic's risk profile and patient demographics (see breakdown below).

Clinics are **not expected to function like hospital emergency rooms**, but they must be equipped to handle basic emergencies in a manner consistent with what a reasonably prudent practitioner would be expected to do in that setting.

Office Medical Emergency Plan

To support preparedness and patient safety, the following three recommendations provide a framework for an effective office medical emergency plan.

Recommendation 1: Develop and Maintain a Comprehensive Policy Manual

- Every office should have a policy and procedures manual that includes:
  - A medical emergency response plan
  - A list of specific medical emergency equipment, supplies, and medications

- The manual should be:
  - Tailored to the clinic's risk profile and practice type
  - Based on current research and best practices.
  - Reviewed and updated regularly to reflect changes in evidence and clinical operations.

Recommendation 2: Train Staff and Conduct Regular Emergency Drills

- All staff must:
  - Understand their specific roles during an emergency
  - Participate in regular training, including emergency scenario workshops and/or drills (including an office medical emergency response plan).

Recommendation 3: Maintain Emergency Equipment and Medications

- Offices should adopt a policy to ensure:
  - emergency equipment is tested regularly
  - medications are checked and replaced before expiry.

- This policy should include:
  - Routine testing of equipment (e.g. the oxygen machine/tank)
  - Scheduling on-site inspections and calibrations of the machine/tank
  - Maintaining logbooks for equipment checks and drug inventory.

Office Risk Classification for Medical Emergencies

While every practice is unique, clinics can be categorized based on the **likelihood of a medical emergency occurring** and the **potential severity of its outcome**. This classification helps guide the level of preparedness required.

Low Risk Offices:

- Low patient volume
- Few high-risk patients (low morbidity of patient load)
- Urban location with efficient EMS services and proximity to an emergency room
- Limited scope of practice (e.g. physical therapy modalities, biomechanics, etc.)
- No parenteral medications administered
- No procedures performed in office

Moderate Risk Offices:

- High patient volume
- Many high risk patients (high morbidity of patient load)
- Rural/remote location with:
    - Limited or delayed EMS
    - No nearby hospital
    - Potential for severe weather that impacts emergency response
- Parenteral medications are administered
- Minimally invasive procedures are performed in the office (e.g. nail procedures, simple cutaneous procedures, etc.)

High Risk Offices:

- High patient volume
- Many high risk patients (high morbidity)
- Rural or remote locations with poor EMS access and no nearby hospital
- Risk of severe weather delaying emergency response
- Parenteral medications administered
- Invasive procedures performed in the office, such as:
    - Complex cutaneous procedures involving larger surface areas
    - Soft tissue procedures at or below the subcutaneous tissue layer osseous procedures, etc.)
- May involve minimal sedation

Office Medical Emergency Equipment, Supplies, and Medications

While specific lists of emergency drugs and equipment are provided below, it's important to remember that the foundation of all emergency care is Basic Life Support (BLS)/CPR.

CPR Certification

- All registrants are required to renew their Basic Life Support/CPR certification (CPR Level HCP – CPR Level for Health Care Providers), as a minimum, every 3 years.
- An annual review of emergency protocols is strongly recommended.

Medication Use in Emergencies

- The recommended emergency medications should only be administered:
    - **By routes** the practitioner is trained and comfortable with
    - In **dosages** the practitioner is competent to manage
- Practitioners must **never exceed their training** when administering emergency drugs.

Reviewing Medical History

- A thorough **Medical Health History review** is the **most critical step** in identifying potential risks before treatment.

- Registrants must:
    - Be **fully familiar** with each patient's medical history and current conditions
    - Use this information to **prevent emergencies** during or after care
    - Update and review histories regularly to ensure safe and appropriate treatment

Emergency Supplies for Low-Risk Clinics

Even in low-risk settings, it's important to be ready for unexpected medical situations. Here's what you should **consider** having on hand in a low-risk clinic.

Emergency Medication/Agents

These are the basic medications or agents you should keep in your emergency kit:

- **Oxygen**: Used in almost all medical emergencies to help with breathing. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Aspirin (160-325 mg, chewable, non-coated)**
  Helps if someone is having a heart attack. Only for adult use.
- **Glucose tablets**
  Used to treat low blood sugar in conscious patients.

Emergency Equipment and Supplies

These tools help you respond quickly and effectively:

- A working **telephone** to be able to call 911
- A **stethoscope** and **blood pressure cuff**
- **Basic wound care supplies** (like gauze and bandages)
- A **bag-valve-mask** (manual resuscitator) for both adults and children

It is **strongly recommended** that all Podiatry and Chiropody offices—regardless of risk level—are equipped with an **Automated External Defibrillator (AED)**.

An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Emergency Supplies for Moderate-Risk Clinics

Emergency Medication/Agents

If you practice in a moderate risk clinic, you should include these medications/agents in your emergency kit. However, they should only be used by practitioners trained and comfortable with their administration:

- **Oxygen** – For most medical emergencies. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:

    - Severe allergic reactions (anaphylaxis)
    - Asthma attacks not responding to inhalers
    - Cardiac arrest
- **Diphenhydramine (Benadryl)** – For allergic reactions
- **Aspirin (160-325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendations:

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis
- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Emergency Equipment and Supplies

A moderate-risk clinic should have the following on hand:

- **Working telephone to call 911**
- **Stethoscope** and **blood pressure cuff**
- **Basic wound care supplies**
- **Bag-valve-mask** (manual resuscitator) for adults and children
- **Parenteral supplies**, including:
    - Syringes (1cc, 3cc, 10cc, 60cc)
    - Needles (14, 18, 23, 25 gauge)
    - Butterfly needles (19 and 23 gauge)
    - Alcohol swabs
    - Tourniquet
- **Glucometer** (for checking blood sugar)

It is **strongly recommended** that all clinics—regardless of risk level—are equipped with an **Automated External Defibrillator (AED)**.

An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Emergency Supplies for <u>High-Risk</u> Clinics

In a high-risk clinic, these medications should be included in your emergency kit and used only by trained professionals:

Emergency Medications/Agents

- **Oxygen** – For most medical emergencies. A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:
  - Severe allergic reactions (anaphylaxis)
  - Asthma attacks not responding to inhalers
  - Cardiac arrest
- **Diphenhydramine (Benadryl)** – For allergic reactions
- **Aspirin (160-325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendations**:**

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis
- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Required Equipment & Supplies

A high-risk clinic should have the following on hand:

- Working **telephone**
- **Stethoscope** and **blood pressure cuff**
- **Basic wound care supplies**
- **Bag-valve-mask** (manual resuscitator) for adults and children
- **Parenteral supplies**, including:
  - Syringes (1cc, 3cc, 10cc, 60cc)
  - Needles (14, 18, 23, 25 gauge)
  - Butterfly needles (19 and 23 gauge)
  - Alcohol swabs
  - Tourniquet
  - **Glucometer**
- **Automated External Defibrillator (AED) -** An AED can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

Recommended Equipment & Supplies

- **Intubation equipment**:
  - Laryngoscopes (2 sizes)
  - Endotracheal tubes (sizes 3–8)
  - Suction device

- **IV supplies**:
  - Catheters (14, 18, 22, 25 gauge)
  - Normal saline
  - IV pole and tubing

Additional Medications for Clinics Using Sedation

If your clinic uses **minimal sedation** (e.g., nitrous oxide or oral sedatives), you must also include **reversal agents** in your emergency kit:

- **Naloxone (Narcan)** – Reverses opioid overdose
- **Flumazenil (Romazicon)** – Reverses benzodiazepine overdose

*The American Society of Anesthesiologists (ASA) has defined minimal and moderate depths of sedation as follows:

Minimal Sedation:

- Normal response to verbal stimulation
- Cognitive function and coordination may be impaired
- Ventilatory and cardiovascular functions are unaffected

Moderate Sedation:

- Drug induced depression of consciousness
- Patient responds purposefully to verbal commands
- Airway is patent, and spontaneous ventilation is adequate
- Cardiovascular function is usually unaffected

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.4

COUNCIL BRIEFING NOTE

RE: REVISIONS TO THE SAFETY AND THE PRACTICE ENVIRONMENT STANDARD

Background:

The Standards and Guidelines Committee is undertaking a comprehensive review of all the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the look and format of the documents

As part of this review, the Safety and the Practice Environment Standard has been revised. The updated standard clarifies registrants' responsibilities to ensure that their practice site(s) are appropriately equipped, well maintained, and supported by procedures that protect the health and safety of patients, staff, and others in the practice environment.

This standard was originally approved by Council in 2002 and required updating to align with current practice expectations and regulatory standards.

Public Interest Rationale for Decision:

Regular review ensures standards and guidelines reflect current expectations and are clearly communicated. This helps:

- Registrants understand what is required for safe and ethical practice
- The public understand what they can expect from registrants

Recommended Motion:

That Council approve the revised Safety and the Practice Environment standard.

Mover: _____

Seconder: _____

Appendix A – redlined version
Appendix B – newly formatted standard

Back to Agenda

CATEGORY: Standards of Practice

SECTION: Standards of Practice

SUBJECT: Safety and the Practice Environment

STATUS:

APPROVED: **DATE APPROVED:**

Safety and the Practice Environment

Standard of Practice for Registrants of the College of Chiropodists of Ontario

Approved by Council: 2002

Revised and Updated:

POLICY Introduction

It shall be the responsibility of each member to Registrants are responsible for ensure ensuring that their practice site(s) be are properly equipped, and well-maintained, and that have procedures are in place, to assure protect the health and safety for of both patients and staff.

This Standard should be read together with other applicable standards and guidelines that address specific safety issues, such as infection prevention and control, orthotics manufacturing, office medical emergencies, inhalation and sedation, and laser use.

Purpose

To establish criteria of Safety and the Practice Environment by which a member must practise.

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PROCEDURE

CRITERIA:

Requirements

1. **Legal Compliance**

1. The premisesPractice sites must be in current compliance comply with any all current provincial and municipal requirements regulations including, among others:

- **Occupational Health and Safety Act (OHSA)**and any regulations applicable to the practice environment
  - Ensures a safe and healthy work environment.
  - Requires employers to take reasonable precautions to protect workers, provide training, and maintain safety equipment.

a)○ Applies to all workplaces, including healthcare settings.

- The **Healing Arts Radiation Protection Act (HARP)**
  - Regulates the use of x-ray equipment in healthcare facilities.
  - Requires approval for installation, registration of equipment, and adherence to safety standards.

b)○Mandates shielding, inspections, and designation of a Radiation Protection Officer.

2. **Equipment Safety**

- All pPotentially hazardous equipment used for examination and treatment is to must be serviced and inspected by a qualified technician to ensure for ssafety, efficacy, andand where applicable, calibrated for aaccuracy (where applicable through calibration). Servicing must be conducted in accordance with:
  - as specified by mManufacturer specifications,
  - Applicable government guidelines, or at a minimum, every five years.

2.

3. **Service Records**

- AKeep a written record for every piece of n equipment service record shall be kept that sets out the servicing for every potentiallythat could be hazardous. Records must show all maintenance and servicing done on any piece of equipment used to examine, treat or render provide any service care to patients.

3.

4. **Address Deficiencies**

- Equipment Deficiencies deficiencies in equipment or unsafe conditionsare tomust be brought up to standardaddressed promptly.
- Employers are required to correct Hhazards should be corrected immediately to protect workers from injury or illness.

and other deficiencies corrected within 21 days.

4.

5. **Policies and Manuals**

- All pPolicy statementsdocuments, procedures and equipment manuals, are to

must be kept on site in the office manuals, and must be available easily accessibleat all times.

5.

6. **CPR Certification**
   - The member will Registrants must be certified maintain **Basic Life Support (BLS)** certification (CPR Level HCP – CPR level for health care providers) in C.P.R.as a minimum. annually BLS certification must be renewed every three years. and s
   - Support staff should be encouraged to seek obtain certification.

6.

7. **Hazardous Materials**
   - Store Hazardous hazardous materials[1] are to be stored in a specific, safe and , controlled area.
   - Clearly label materials and include current handling instructions.
   - Review and initial instructions annually and keep them in the office manual.
   - Follow Workplace Hazardous Materials Information System (WHMIS) guidelines.

7. Hazardous materials are to be labelled, and detailed current handling instructions must be reviewed, initialled annually and kept in the office manual. WHMIS guidelines are recommended additions.

8. **Sharps Policy**
   - A Written written "sharps" policy and procedures are to must be kept in the office manual.

8.

9. **Pharmaceutical and Clinical Supplies**
   - Inspect supplies for expiry dates and dispose of them appropriately Pharmaceutical and clinical supplies will be inspected for expiry dates and disposed of appropriately where necessary.

9.

[1] "hazardous material" means a biological or chemical agent named or described in the regulations as a hazardous material; - *Occupational Health and Safety Act*, subsection 1(1)

PRACTICE STANDARD

DRAFT VERSION

College of Chiropodists of Ontario

Safety and the Practice Environment

Approved by Council: 2002

Revised and Updated:

Back to Agenda

Introduction

Registrants are responsible for ensuring their practice site(s) are properly equipped, well-maintained, and have procedures in place to protect the health and safety of patients and staff.

This Standard should be read together with other applicable standards and guidelines that address specific safety issues, such as infection prevention and control, orthotics manufacturing, office medical emergencies, inhalation and sedation, and laser use.

Requirements

1. **Legal Compliance**
   Practice sites must comply with all current provincial and municipal regulations including, among others:
   - **Occupational Health and Safety Act (OHSA)**
     - Ensures a safe and healthy work environment.
     - Requires employers to take reasonable precautions to protect workers, provide training, and maintain safety equipment.
     - Applies to all workplaces, including healthcare settings.
   - **Healing Arts Radiation Protection Act (HARP)**
     - Regulates the use of x-ray equipment in healthcare facilities.
     - Requires approval for installation, registration of equipment, and adherence to safety standards.
     - Mandates shielding, inspections, and designation of a Radiation Protection Officer.

2. **Equipment Safety**
   - All potentially hazardous equipment used for examination and treatment must be serviced and inspected by a qualified technician to ensure safety, efficacy, and accuracy (where applicable through calibration).
   - Servicing must be conducted in accordance with:
     - Manufacturer specifications,
     - Applicable government guidelines, or at a minimum, every five years.

3. **Service Records**
   - Keep a written record for every piece of equipment that could be hazardous. Records must show all maintenance and servicing done on any equipment used to examine, treat or provide care to patients.

4. **Address Deficiencies**
   - Equipment deficiencies or unsafe conditions must be addressed promptly.
   - Employers are required to correct hazards immediately to protect workers from injury or illness.

5. **Policies and Manuals**

- All policy documents, procedures and equipment manuals must be kept in the office and must be easily accessible.

6. **CPR Certification**
   - Registrants must maintain **Basic Life Support (BLS)** certification (CPR Level HCP – CPR level for health care providers) as a minimum. BLS certification must be renewed every three years.
   - Support staff should be encouraged to obtain certification.

7. **Hazardous Materials**
   - Store hazardous material[1] in a safe and controlled area. Clearly label materials and include current handling instructions.
   - Review and initial instructions annually and keep them in the office manual.
   - Follow Workplace Hazardous Materials Information System (WHMIS) guidelines.

8. **Sharps Policy**
   - A written "sharps" policy and procedures must be kept in the office manual.

9. **Pharmaceutical and Clinical Supplies**
   - Inspect supplies for expiry dates and dispose of them appropriately.

[1] "hazardous material" means a biological or chemical agent named or described in the regulations as a hazardous material. Occupational Health and Safety Act, subsection 1(1)

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.5

COUNCIL BRIEFING NOTE

RE: REVISIONS TO THE ADMINISTERING INHALED SUBSTANCES AND THE USE OF SEDATION STANDARD

Background:

The Standards and Guidelines Committee is conducting a comprehensive review of all the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the look and format of the documents

The revised standard outlines the minimum standards of practice for administering inhaled substances and using sedation in practice.

This standard was originally approved by Council in 2017 and required some updates to align with current practice.

Public Interest Rationale for Decision:

Regular review ensures standards and guidelines reflect current expectations and are clearly communicated. This helps:

- Registrants understand what is required for safe and ethical practice
- The public understand what they can expect from registrants

Recommended Motion:

That Council approve the revised Administering Inhaled Substances and the Use of Sedation Standard.

Mover: _____

Seconder: _____

Appendix A – newly formatted standard

Back to Agenda

ADMINISTERING INHALED SUBSTANCES AND THE USE OF SEDATION

Standards of Practice for Registrants of the College of Chiropodists of Ontario

Approved by Council: June 23, 2017

Reviewed and Updated:

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INTRODUCTION

This document outlines the minimum standards of practice for administering inhaled substances and using sedation in practice. Any registrant who uses sedative agents or sedation modalities must:

- Be appropriately trained,
- Have an inhalation certification and/or prescribing privileges, as outlined below,
- Regulate their practice in accordance with this standard, the **Chiropody Act, 1991**, its regulations, and the **College by-laws**.

This standard must be read in conjunction with Ontario Regulation 203/94, under the Chiropody Act, 1991, By-Law 5: Inhalation and Sedation, and the College's Office Medical Emergencies Guideline.

CONTENTS

DEFINING SEDATION LEVELS

Sedation and general anesthesia exist along a **continuum**, from mild anxiety relief with little or no drowsiness (minimal sedation) to complete unconsciousness (general anesthesia).

Patient responses to sedation can vary, and it may be difficult to clearly distinguish between levels—such as minimal vs. moderate sedation, or the transition into deep sedation and general anesthesia. Given this variability, sedation must be used carefully and with a wide margin of safety to minimize the risk of unintended loss of consciousness.

In practice, minimal sedation can help reduce anxiety and make treatment more comfortable, with less physical and psychological stress.

Responsibilities of Registrants Administering Sedation

Registrants who administer sedation must be able to:

- Recognize and manage the physiological effects of sedation, and
- Rescue patients if sedation becomes deeper than intended level (beyond minimal sedation).

This requires:

- Proper training and clinical skills,
- Access to emergency drugs and equipment, and
- The ability to manage the situations until the patient either:
  - Returns to the intended level of sedation without airway or cardiovascular complications, or
  - Is transferred to emergency medical services.

CONSCIOUS SEDATION

- Conscious sedation is a minimally to moderately depressed level of consciousness that allows the patient to independently and continuously maintain their airway and respond appropriately to physical stimulation and verbal commands. It may be achieved through pharmacological, non-pharmacological, or combined methods.
- Conscious sedation is further classified into:
  - Minimal sedation
  - Moderate sedation

These classifications are defined in the document *Characteristics of the Levels of Sedation and General Anesthesia* (see Appendix I).

MINIMAL SEDATION

Regardless of the sedation modality or combination used, **registrants must limit the depth of sedation to minimal sedation only**.

Minimal sedation is a **minimally depressed level of consciousness** induced by pharmacological means. Under minimal sedation:

- The patient retains the ability to **independently and continuously maintain their airway**.
- The patient can **respond normally to tactile stimulation and verbal commands**.
- **Cognitive function and coordination** may be mildly impaired.
- **Ventilatory and cardiovascular functions remain unaffected**.
- Minimal sedation is usually achieved using one of the following approaches:
    1. Administration of nitrous oxide and oxygen.
    2. Administration of nitrous oxide and oxygen with a [single][1] sedative drug.
    3. Oral administration of a [single][2] sedative drug.

MODERATE SEDATION

- **Moderate sedation** is a **drug-induced depression of consciousness** in which patients respond **purposefully to verbal commands**, either alone or accompanied by **light tactile stimulation**.
- No interventions are required to **maintain a patent airway**, and **spontaneous ventilation is adequate**.
- **Cardiovascular function is usually maintained**.

Moderate sedation is typically achieved using one of the following modalities:

- **Oral administration of multiple sedative drugs**, with or without **nitrous oxide and oxygen**.
- **Parenteral administration** of sedative drug(s), including:
    - Intravenous (IV)
    - Intramuscular (IM)
    - Subcutaneous (SC)
    - Submucosal
    - Intranasal routes

DEEP SEDATION

[1] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.
[2] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

- A controlled state of depressed consciousness, characterized by a partial loss of protective reflexes, including the inability to respond purposefully to verbal commands.

    - During deep sedation:
        - The ability to independently maintain ventilatory function may be impaired.
        - Patients may require assistance in maintaining a patent airway.
        - Spontaneous ventilation may be inadequate.
        - Cardiovascular function is usually maintained

GENERAL ANAESTHESIA

General anesthesia is a **controlled state of unconsciousness** accompanied by a **partial or complete loss of protective reflexes**, including:

- The **inability to maintain an airway independently**, and
- The **inability to respond purposefully** to physical stimulation or verbal commands.

PART 1 – ADMINISTERING OXYGEN

When used alone, **oxygen is not considered a sedative agent**.

While oxygen administration is most commonly associated with emergency situations—such as resuscitation, anaphylaxis, syncope, shock, or convulsions—it may also be appropriate in **non-emergent situations**, depending on the specific needs of the patient.

The decision to administer oxygen should be based on the **individual circumstances of the patient** and is at the **discretion of the registrant**. Registrants must also exercise clinical judgment in determining the **appropriate oxygen concentration and flow rate**, with the goal of maintaining or restoring normal physiological oxygen saturation levels:

- **94–98%** for most patients
- **88–92%** for patients with **chronic obstructive pulmonary disease (COPD)**

PART 2 – GENERAL STANDARDS FOR ALL MODALITIES OF SEDATION

This section outlines the general requirements for sedation that apply to any modality.

Sedation may be appropriate in the following situations:

- To manage patient anxiety and pain associated with treatment.
- To enable treatment for patients with cognitive impairment or motor dysfunction that prevents adequate care.
- To treat patients below the age of reason.
- To manage traumatic conditions.
- To alleviate anxiety and pain during invasive or prolonged procedures.

Sedation should only be used when clinically indicated and should serve as an adjunct to appropriate non-pharmacological methods of patient management. It is the registrant's responsibility to assess and determine which patients are suitable candidates for the various sedation modalities and pharmacological agents.

Any registrant who wishes to administer sedation must:

- Obtain **informed consent** from the patient, and
- Ensure compliance with the requirements outlined below, including those related to:
    - **Office and facility requirements**, and
    - **Sedation protocols** applicable to **all sedation modalities**

These requirements are essential to ensure safe, ethical, and compliant practice.

OFFICE AND FACILITY REQUIREMENTS

Before treating a patient who is to be sedated, the registrant must:

1. Ensure that their office is equipped with all required sedation and emergency equipment and drugs necessary to meet the requirements of this standard of practice.

2. Ensure that the facility complies with all applicable building codes, including:
    - Fire safety regulations,
    - Electrical standards
    - Access requirements.

    The size and layout of the facility must be sufficient to:
    - Support the safe performance of all procedures
    - Allow for the safe evacuation of patients in the event of an emergency.

3. Make sure the clinical setting is suitably staffed and equipped for the specific type of sedation being used.

EMERGENCY DRUG AND EQUIPMENT REQUIREMENTS

Emergency equipment and medications must **always be available** when sedation is performed.

A) DRUGS

All drugs must be:

1. **Current** (i.e., not expired)
2. **Clearly labeled** and
3. **Stored in an organized and easily identifiable manner** (e.g., in labeled trays or bags)

Registrants using sedation should include and be prepared to use the following medications/agents in an emergency kit:

- **Oxygen** – For most medical emergencies. This should include an adjustable regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:
    - Severe allergic reactions (anaphylaxis)
    - Asthma attacks not responding to inhalers
    - Cardiac arrest
- **Diphenhydramine ((for parenteral emergency use))** – For allergic reactions
- **Aspirin (325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendations (only to be used by practitioners trained and comfortable with their administration)**:**

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis

- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Safeguarding Sedative Agents

A registrant who uses sedative agents in their practice must take reasonable precautions to prevent any unauthorized access and use of these substances for recreational or other improper purposes by office staff or any individuals with access to the premises or equipment. Preventative strategies must include the following:

- **Inventory Management**
  Maintain a written log of all monitored and controlled drugs in the clinic. These include, but are not limited to, sedative agents (eg. benzodiazepines), narcotics, and nitrous oxide. The log must include:
  - The specific substance acquired
  - Supplier name
  - Date of acquisition
  - Name of the individual confirming receipt
  - Total amount acquired
  - Expiry date (if applicable)

  This inventory must be reconciled regularly and kept on file for review by the College upon request by the Registrar or the College's Sedation Committee.
- **Secure Storage**
  These agents must be stored safely in a locked cupboard or secure storage unit, with access only available to authorized staff.
- **Usage Log**
  Maintain a separate log that accurately records the use of these agents within the practice.
  This log must include:
  - The specific substance used
  - Date of use
  - Total amount administered
  - Correlating patient identifier
  - Name of the individual who administered the substance

This usage log must also be kept on file and made available for review by the College upon request.

- **Prescription Pad Security**
  Exercise strict control over blank prescription pads. Never pre-sign blank prescriptions.
- **Staff Education and Awareness**
  Conduct and document regular staff training sessions to:
  - Discuss the dangers of drug and substance misuse
  - Reinforce office safeguards and protocols
  - Provide information on wellness resources available to staff
  - Reporting procedures for errors or misuse

Record the dates and duration of these sessions to demonstrate compliance if requested by the College.

B) EQUIPMENT

It is the **registrant's responsibility** to ensure that the practice setting where sedation is administered is equipped with the required emergency supplies, including:

- Pulse oximeter, approved by Health Canada;
- Appropriately sized sphygmomanometers and stethoscopes;
- Appropriately sized full-face masks and connectors; and
- An **Automated External Defibrillator (AED)**, which can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

A written record of the equipment's annual maintenance/servicing and emergency drugs must be kept on file and provided to the College when requested by the Registrar or the College's Sedation Committee.

SEDATION PROTOCOL (APPLICABLE TO ALL MODALITIES)

1. Obtain and document informed consent before giving any oral sedative drug and/or nitrous oxide and oxygen.

2. Take an adequate, clearly recorded, current medical history for each patient before administering any form of sedation. This history must include:

   - Present and past illnesses,
   - Hospital admissions,
   - Current prescription and non-prescription medication
   - Herbal supplements (including dosage)
   - Allergies, particularly to medications

- Functional inquiry and a physical examination
  For medically compromised patients, it may be necessary to consult their primary healthcare provider. If a consultation occurs, it must be documented in the patient record, consistent with the requirements in **Appendix II**.

At every sedation appointment, review the patient's medical history for any changes and record it in their chart. This will help the registrant decide if the patient is a suitable candidate for in-office use of a particular sedation modality or agent.

3. Before giving any sedation, determine the patient's American Society of Anesthesiologists (ASA) Physical Status Classification (see **Appendix III**) and record it in their chart. Also evaluate any other factors that could affect whether the patient is a good candidate for sedation must be conducted.

4. Patients classified as ASA IV and higher (see **Appendix III**) are not candidates for sedation outside of a hospital. Oxygen can be given at the registrant's discretion. If a patient is ASA III or higher, registrants must consult with their primary healthcare provider before administering sedation.

5. Registrants must always ensure sedation stay at a minimal level (see **Definitions of Sedation Levels**). Using one drug at a well-planned dose is the safest way to achieve this.

6. If the patient becomes more than mildly sedated (overly drowsy or unresponsive), stop treatment right away. Support the patient until they return to mild sedated, or call emergency services if needed.

7. Always consider the maximum safe dose of local anaesthetic, especially for children, older adults, and people with health issues. If sedation is also being used, the maximum safe dose may need to be lowered even more to ensure patient safety.

8. Registrants must not be alone when treating a sedated patient.

9. After minimal sedation, the patient must leave with a responsible adult. The only time a registrant can decide if someone can leave alone is when nitrous oxide and oxygen were the only sedation used. No matter what type of sedation was given, the registrant who administered the sedation must confirm and document that the patient is safe and ready to go before discharge.

PART 3 - SPECIFIC STANDARDS FOR PARTICULAR MODALITIES

Registrants must follow the College's standard of practice when providing minimal sedation to a patient using any modality, including:

the administration of nitrous oxide and oxygen alone or the administration of nitrous oxide and oxygen with a [single][3] sedative drug; and

A. the oral administration of a [single][4] sedative drug.

[3] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.

[4] This standard does not anticipate any circumstance in which a registrant would administer more than one sedative drug concurrently

A. ADMINISTERING NITROUS OXIDE AND OXYGEN OR NITROUS OXIDE AND OXYGEN WITH A SINGLE SEDATIVE DRUG

In addition to the requirements listed in **Part 2**, the following standards of practice apply when nitrous oxide and oxygen sedation or nitrous oxide and oxygen sedation with a [single] sedative drug are being used to induce minimal sedation.

REGISTRANT QUALIFICATIONS

Registrants must meet the following requirements to administer nitrous oxide and oxygen sedation or nitrous oxide and oxygen sedation with a [single] sedative drug:

1. Obtain an Inhalation Certificate from the College (for details, see the College's By-law 5: Inhalation and Sedation).

2. Successfully complete a training program, approved by the College, that teaches how to competently administer nitrous oxide and oxygen, with or without a [single][5] sedative drug.[6]

3. Successfully complete a comprehensive pharmacology course, approved by the College, that covers general clinical pharmacological principles and overall systems pharmacology, and gives the registrant the ability to prescribe the relevant sedative and emergency drugs in n Ontario Regulation 203/94: General or as may otherwise be required for appropriate patient care.[7]

4. Maintain competence by completing ongoing training, courses, and/or other educational programs.

5. Make sure all clinical staff, including Authorized Sedation Monitors, know how to recognize and manage adverse reactions to sedation and have access to the necessary emergency equipment and drugs.

Establish written emergency protocols s and review them regularly with staff. Keep a record of these protocols on file. **You must provide this record to the College is requested by the Registrar or the College's Sedation Committee.**

[5] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.
[6] This program will include: indications, contraindications, patient evaluation, patient selection, pharmacology of relevant drugs, administration of sedation agents and modalities, and management of potential adverse reactions, as they relate to the relevant sedation agents and modalities.
[7] The registrant must meet the standard of practice set out in Ontario Regulation 203/94, made under the *Chiropody Act, 1991*, for prescribing sedative drugs.

6. All clinical staff, including Authorized Sedation Monitors, must be trained and able to perform basic life support (BLS). Registrants who provide sedation must maintain BLS certification (CPR Level HCP – CPR Level for Health Care Providers) as a minimum and renew it at least every three years.

AUTHORIZED SEDATION MONITOR

Because it's difficult to safely provide foot care and administer nitrous oxide and oxygen sedation, **there must always be at least two people present when nitrous oxide and oxygen are used, whether or not an oral sedative drug is being administered at the same time**[8]

Individual One: The first person in the room during sedation is mainly responsible for providing foot care to the patient. They must be registered with the College and must also be authorized by the College to administer a substance to a patient by inhalation (nitrous oxide and oxygen).[9]

Individual Two: The second person in the room is the Authorized Sedation Monitor. This person administers the sedation under the direction of the registrant and must closely monitor the patient to make sure the sedation is working safely. This person must be ready to respond to any problems or side effects from the sedation.

To be an **Authorized Sedation Monitor**[10], a person must meet specific qualifications:

- Another College registrant who is authorized to administer a substance to a patient by inhalation, or:
- A Registered Nurse (RN) currently registered with the College of Nurses of Ontario acting under an order from a registrant, or;
- A Registered Practical Nurse (RPN) currently registered with the College of Nurses of Ontario, who has obtained a two-year diploma in Practical Nursing from a Community College of Applied Arts or completed an enhanced medication course in the administration and monitoring of minimal sedation, acting under an order from a registrant.

The registrant must ensure the Authorized Sedation Monitor has current BLS certification (CPR Level HCP – CPR Level for Health Care Providers) and is competent to perform the tasks being assigned.

[8] Please note that this standard of practice has not been designed for the circumstance where a registrant arranges for a physician to provide sedation as the registrant provides foot care.
[9] Individual One would not be required to be authorized by the College to administer a substance by inhalation where Individual Two was a registrant currently registered with the College who is authorized by the College to do so.
[10] This standard does **not** apply where a registrant arranges for a physician to provide sedation while the registrant provides foot care.

In the case of a nurse, the registrant performing foot care must always be present in the office suite and available **immediately** in the event of an emergency.

GAS DELIVERY SYSTEM REQUIREMENTS

Gas delivery systems used for nitrous oxide and oxygen sedation must meet the following standards:

1. **Fail-safe oxygen:** The system must have a fail-safe feature so it never delivers less than 30% oxygen in the gas mixture.

2. **Secure connections:** Pipeline inlet fittings or pin-indexing, must prevent mixing up oxygen and nitrous oxide connections.

3. **Regular maintenance:** The system must be checked regularly by trained staff, work reliably and accurately, and maintained according to manufacturer's instructions or annually, whichever is more frequent. A written record of this maintenance must be kept and provided to the College if requested.

4. **Standard outlet:** The system must have a common gas outlet that fits

5. **Backup oxygen supply:** A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator (capable of delivering oxygen at flow rates up to 15 liters per minute), flowmeter, connectors, tubing, and a reservoir bag for positive pressure resuscitative ventilation with 100% oxygen using a full-face mask.

   Disposable masks: Only single use disposable masks with scavenging capability should be used to prevent cross-contamination and safely remove exhaled gases.

6. **Scavenging system:** The system must include a properly functioning scavenging setup installed per manufacturer's specifications. It should have an accurate flowmeter, scavenging masks, and a vacuum system that removes gases at a rate of at least **45 L per minute,** venting them in compliance with local regulations.

7. **Single-patient components: A**ll components that touch the patient must be single-use. Parts that do not touch the patient must be cleaned and disinfected in accordance with the manufacturer's instructions.

SEDATION PROTOCOL

1. The patient's medical history (as described in **Part 2** and **Appendix II**) must be reviewed for any changes at each sedation appointment.

2. Pre-operative and written post-operative instructions must be provided to the patient or their guardian.

3. No fasting is necessary before (minimal) sedation using nitrous oxide and oxygen or sedation using the administration of a [single] sedative drug with or without nitrous oxide and oxygen. Registrants may, however, recommend that the patient only eat a light meal within two hours of nitrous oxide being administered.

4. A flow rate of 5 to 6 liters per minute is generally acceptable for most patients. The flow rate should be adjusted by observing the reservoir bag.

5. Start with 100% oxygen for 1 to 2 minutes, then gradually add nitrous oxide in 10% intervals.

6. Nitrous oxide and oxygen should be increased slowly to achieve **minimal** sedation, with continuous and careful monitoring of the patient's level of consciousness, unless there is a justified reason to do otherwise.[11]

7. The concentration of nitrous oxide should not exceed 50% when aiming for minimal sedation, except in justifiable circumstances.[12]

8. Increase nitrous oxide during more stimulating procedures (e.g. injection of local anaesthetic) and/or decreased during periods of less stimulation (e.g. ongoing anxiolysis once local anaesthetic has had effect). Adjusting to the patient's needs helps prevent overmedication, reduces adverse side effects, and improves the overall sedation experience.

   Patients receiving nitrous oxide and oxygen sedation must never be left unattended and must be continuously monitored by an **Authorized Sedation Monitor**. Monitoring must include:
   - Continuous observation of consciousness and vital signs (heart rate, blood pressure, respiration) before, during and after the procedures.
   - Use a pulse oximetry throughout.
   - Record monitoring details at least **every 15 minutes.**

9. After stopping nitrous oxide, **100% oxygen must be delivered for 3 to 5 minutes.**

10. The patient's recovery status must be **assessed and documented** following the administration of sedation. The decision to discharge a patient after receiving **nitrous oxide and oxygen sedation** must be made by a **registrant of the College** who is:
    - **Currently registered** with the College, and

[11] In these cases, the patient record must reflect the reasons for these circumstances.
[12] In these cases, the patient record must reflect the reasons for these circumstances.

- **Authorized** to administer the specific sedation agent or modality.

This registrant must **remain on-site** until the patient is deemed **fit for discharge**.

11. Only patients who are fully recovered may be considered for unaccompanied discharge. If a patient exhibits any residual symptoms, they must be discharged with a responsible adult to ensure their safety and continued recovery.

12. The patient record must include:
    - **Indication(s) for the use of sedation**
    - **Rationale for the choice of sedative agent administered**

13. In cases where **nitrous oxide and oxygen** are administered, the record must also include:
    - Name of the **Authorized Sedation Monitor**
    - **Dosage details**: percentage of nitrous oxide and oxygen, and flow rate
    - **Duration** of administration
    - **Post-treatment oxygenation procedures**
    - **Monitoring records**: pre-operative, intra-operative, and post-operative
    - **Discharge summary**
    - Documentation of **any adverse effects**

ADDITIONAL SEDATION PROTOCOLS – [SINGLE] USE DRUG

1. For the purposes of this standard, the administration of an oral sedative intended to induce sedation refers to a single oral dose administered to the patient while in the registrant's office. The administration of this dose must consider:
   - The time required for drug absorption
   - The potential interactions with other concurrently used medications that may influence the clinical effects of the sedative

   It is recommended that the full effect of the administered oral sedative be realized before initiating treatment or beginning any procedure.

2. There are two exceptions to the recommendation that the oral sedative be administered in the registrant's office:

   - If the registrant decides the patient needs an oral sedative to sleep the night before treatment or a procedure.
   - If the patient's anxiety is so high that sedation is needed before arriving at the registrant's office.

   In these two situations, additional requirements apply:

   - The reason a registrant instructed a patient to take a sedative drug prior to arriving at the office must be clearly documented in the patient record.
   - The patient must be screened at a prior appointment, including a comprehensive medical history, as outlined in **Part 2** and **Appendix II**).
   - Only **one sedative drug** should be prescribed at a time, preferably a benzodiazepine or an antihistamine. Opioids must not be used as pre-operative or intra-operative sedative drugs.
   - The patient must be instructed not to drive and must be accompanied to and from the registrant's office by a responsible adult.
   - Clear written instructions must be provided to the patient or their legal guardian. The instructions must include: how to take the medication; the need to be accompanied to the appointment, and the expected effects from the drug.

3. It is essential to understand the oral sedative's onset time, peak response, and duration to avoid over-sedation.

4. Never exceed the maximum recommended dose during any single appointment, as outlined in **Appendix IV**. Because sedation occurs on a continuum, patient responses can vary. Registrants are encouraged to administer the lowest effective dose necessary to achieve the desired sedative effect.

5. If an oral sedative is given, make sure its full clinical effect has occurred before administering nitrous oxide.

6. When combing nitrous oxide and oxygen after an oral sedative, increase slowly to reach minimal sedation. Monitor the patient's level of consciousness continually, unlesss there is a justified reason not to.[13]

7. The patient must be discharged into the care of a responsible adult. Prior to discharge, the patient must demonstrate: orientation to time, place, and person, relative to their pre-anesthetic condition; ability to ambulate independently; stable vital signs; increasing alertness.

   Written post-sedation instructions must be provided to the patient. The patient must be advised not to drive a vehicle, operate hazardous machinery, or consume alcohol for a minimum of 18 hours, or longer if symptoms such as drowsiness or dizziness persist.

8. When oral sedation is administered, the patient record must include:
   - **Indication(s)** for the use of sedation
   - **Rationale** for the choice of sedative agent(s)
   - **Dosage** of all oral sedative drugs
   - **Time of administration** of all oral sedative drugs

9. In cases where **nitrous oxide and oxygen** are administered, the record must also include:
   - Name of the **Authorized Sedation Monitor**
   - **Dosage details**: percentage of nitrous oxide and oxygen, and flow rate
   - **Duration** of administration
   - **Post-treatment oxygenation procedures**
   - **Monitoring records**: pre-operative, intra-operative, and post-operative
   - **Discharge summary**
   - Documentation of **any adverse effects**

[13] In these cases, the patient record must reflect the circumstances.

B. ORAL ADMINISTRATION OF A SINGLE SEDATIVE DRUG (NO NITROUS OXIDE IS USED)

In addition to the requirements listed in **Part 2**, the following standards of practice apply when a [single][14] oral dose of a sedative drug is administered via the oral route. This also applies to medication taken under the tongue (sublingual).

REGISTRANT QUALIFICATIONS

For a registrant to administer a [single][15] sedative drug, they are required to meet the following requirements:

1. Successfully complete a pharmacology course, approved by the College, that covers general clinical pharmacological principles and overall systems pharmacology. Registrants must also meet the requirements to prescribe the relevant sedative and emergency drugs in Ontario Regulation 203/94: General or as may otherwise be required for appropriate patient care.

   Maintain competence by completing ongoing training, courses, and/or other educational programs.

2. Ensure that clinical staff are prepared to recognize and treat adverse responses using emergency equipment and drugs.

3. Establish written protocols for emergency procedures and review them regularly with staff. **A written record must be kept on file and presented to the College when requested by the Registrar or the College's Sedation Committee.**

4. Ensure that clinical staff have the training and ability to perform basic life support (BLS) techniques. A registrant providing sedation must maintain BLS certification (CPR Level HCP – CPR Level for Health Care Providers) as a minimum.[16] BLS certification must be renewed at least every three years.

SEDATION PROTOCOL

The patient's medical history (as described in **Part 2** and **Appendix II**) must be reviewed for any changes at each sedation appointment.

[14] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.
[15] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.
[16] It is strongly recommended that all registrant s, whether or not intending to induce sedation, maintain current BLS certification (CPR Level HCP – CPR Level for Health Care Providers).

- For the purposes of this standard, the administration of an oral sedative intended to induce sedation refers to a [single][17] oral dose administered to the patient while in the registrant's office. The administration of this dose must consider:

    - the time required for drug absorption
    - potential interactions with other concurrently used medications that may impact the clinical effects of the sedative.

It is recommended that the full effect of the administered oral sedative be realized before initiating treatment or beginning a procedure.

- There are two exceptions to the recommendation that the oral sedative be administered in the registrant's office:

    - If the registrant determines the patient requires an oral sedative to sleep the night before treatment or a procedure.
    - If the patient's anxiety is so high that sedation is needed before arriving at the registrant's office.

    In these two situations, additional requirements apply:

        - The reason a registrant instructed a patient to take a sedative drug prior to arriving at the office must be clearly documented in the patient record.
        - The patient must be screened at a prior appointment, including a comprehensive medical history, as outlined in **Part 2** and **Appendix II**.
        - Only one sedative drug should be prescribed at any one time, preferably a benzodiazepine or an antihistamine. Opioids must not be used as pre-operative or intra-operative sedative drugs.
        - The patient must be instructed not to drive and must be accompanied to and from the registrant's office by a responsible adult.
        - Clear written instructions must be provided to the patient or their legal guardian. The instructions must include: how to take the medication; the need to be accompanied to the appointment, and the expected effects from the drug.

- Knowing the oral sedative's time of onset, peak response, and duration of action is essential to avoid over-sedation.

- Never go over the maximum recommended dose of an oral sedative during any single appointment as outlined in **Appendix IV**. Because sedation works on a continuum, patient responses can vary. Registrants are encouraged to administer the lowest effective dose necessary to achieve the desired sedative effect

[17] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

- Patients must be monitored at all times. However, an Authorized Sedation Monitor is not required - other qualified clinical staff may perform the monitoring.

- Children, older adults, and medically compromised individuals, including patients taking prescribed medication with sedative properties, require appropriate dose adjustments to ensure the intended level of sedation is not exceeded. For these patients, the following practices are strongly recommended:

    - Continuous monitoring, including the use of pulse oximetry during the pre-operative, intra-operative, and post-operative phase.
    - Inclusion of an Authorized Sedation Monitor, while not required, is strongly recommended for these patients.
      If monitoring is conducted, documentation must include recorded observations at a minimum of every 15 minutes.

The patient's post-operative recovery status must be assessed and recorded. The decision to discharge a patient following the administration of a [single][18] oral sedative drug must be made by a registrant.

- The patient must be discharged to the care of a responsible adult. Prior to discharge, the patient must demonstrate: orientation to time, place, and person, relative to their pre-anesthetic condition; ability to ambulate independently; stable vital signs; increasing alertness.

- Written post-sedation instructions must be provided to the patient. The patient must be advised not to drive a vehicle, operate hazardous machinery, or consume alcohol for a minimum of 18 hours or longer if drowsiness or dizziness persists.

- Specific to sedation, the patient record must include the following:

    - Indication(s) for the use of sedation,
    - Rationale for the choice of sedation agent administered,
    - Dosage of all oral sedative drugs,
    - Time of administration of all oral sedative drugs,
    - Monitoring records: pre-operative, intra-operative, and post-operative monitoring,
    - Discharge summary,
    - Documentation of any adverse effects.

[18] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

APPENDIX I

Characteristics of the Levels of Sedation and General Anesthesia[19]

	MINIMAL SEDATION	***MODERATE SEDATION***	***DEEP SEDATION***	***GENERAL ANESTHESIA***
CONSCIOUSNESS	maintained	maintained	obtunded	unconscious
RESPONSIVENESS	to **either** verbal command **or** tactile stimulation	may require either one of or **both** verbal command and tactile stimulation	response to repeated or painful stimuli	unarousable, even to pain
AIRWAY	maintained	no intervention required	intervention may be required	intervention usually required
PROTECTIVE REFLEXES	intact	intact	partial loss	assume absent
SPONTANEOUS VENTILATION	unaffected	adequate	may be inadequate	frequently inadequate
CARDIOVASCULAR FUNCTION	unaffected	usually maintained	usually maintained	may be impaired
REQUIRED MONITORING	basic	increased	Advanced	advanced

[19] This information is based on the Royal College of Dental Surgeons of Ontario's *Standard of Practice: Use of Sedation and General Anesthesia in Dental Practice*(November 2018). Registrants are responsible for checking and following any updates to this information.

APPENDIX II

Medical History and Patient Evaluation

An adequate, current, clearly recorded, and signed (by the registrant who will be inducing sedation) medical history must be taken for each patient. The history is part of the patient's permanent record. It forms a database from which the registrant can determine the appropriate sedation modality or modalities. The medical history must be kept current. This information must be organized and contain, **at a minimum**, the information described in this section.

- **Vital Statistics:** This includes the patient's full name, date of birth, sex, and emergency contact. In the case of a minor or a mentally disadvantaged patient, the name of the parent or guardian must be recorded.

- **Core Medical History:** The core medical history must be a system-based review of the patient's past and current health status and must specifically fulfill the following two basic requirements:

  1) It must elicit the core medical information to enable the registrant to assign the correct ASA Physical Status Classification (see **Appendix III**) to assess risk factors in relation to sedation choices.
  2) It must provide written evidence of a logical process of patient evaluation.

- **Core Physical Examination:** A current, basic physical examination, suitable for determining information that may be significant to sedation and appropriate to the modality or modalities being used, must be carried out for each patient.

  At a minimum, all modalities of sedation require the evaluation and recording of significant positive findings related to:
  - general appearance, noting obvious abnormalities;
  - an appropriate airway assessment;
  - the taking and recording of vital signs, i.e. heart rate and blood pressure.

  This core physical examination can be carried out by the registrant.

APPENDIX III

American Society of Anesthesiologists Physical Status Classification System[20]

ASA I: A normal healthy patient
ASA II: A patient with mild systemic disease
ASA III: A patient with severe systemic disease
ASA IV: A patient with severe systemic disease that is a constant threat to life
ASA V: A moribund patient who is not expected to survive without the operation
ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes
ASA 2: Although pregnancy is not a disease, the parturient' s physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA 2 for a woman with uncomplicated pregnancy.
ASA E: The addition of **E** denotes emergency surgery (an emergency surgery is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

[20] This is the current version as of December 13, 2020. Registrants are responsible for ensuring updates to information.

APPENDIX IV

Benzodiazepines for Oral Use[21]): for the purpose of treatment of anxiety before and during surgical procedures and to provide minimal sedation during surgical procedures:

- **Diazepam** —individual dosing range of 2.5-10 mg, with 10 mg being the maximum individual dose, every 6-12 hours. Maximum total dosage not to exceed 40 mg within 24 hours. Maximum total duration not to exceed 24 hours
- **Lorazepam** — individual dosing range of 0.5-1 mg, with 1 mg being the maximum individual dose, every 12 hours. Maximum total dosage not to exceed 2 mg within 24 hours. Maximum total duration not to exceed 24 hours
- **Triazolam** — individual dosing range of 0.125 to 0.25 mg, with 0.25 mg being the maximum individual dose, limited to a single dose, with the total dosage not to exceed 0.25 mg per day, for a maximum duration of 1 day
- **Alprazolam** — individual dosing range of 0.25 to 0.5 mg, with 0.5 mg being the maximum individual dose, limited to a single dose, with the total dosage not to exceed 0.5 mg per day, for a maximum duration of 1 day

Commented [1]: Perhaps include this reference in a footnote?

It is important to note that sedation is produced along a continuum, and it is not always possible to predict how specific individual patients will respond to any dose of a sedative drug. Registrants are encouraged to use the lowest effective dose to achieve the desired sedative effect.

[21] SCHEDULE 3-DRUGS THAT MAY BE PRESCRIBED BY A MEMBER (Anti-Anxiety), C*hiropody Act, 1991*, ONTARIO REGULATION 203/94, GENERAL

APPENDIX V

References

Anaesthesia Organizations

American Society of Anesthesiologists
www.asahq.org

Association of Anaesthetists of Great Britain and Ireland
www.aagbi.org/publications

Australian and New Zealand College of Anaesthetists
www.anzca.edu.au/resources

Australian Society of Anaesthetists
www.asa.org.au

Canadian Anaesthesiologists' Society
www.cas.ca

European Society of Anaesthesiology
www.euroanesthesia.org

European Society for Paediatric Anaesthesiology
www.euroespa.com

Royal College of Anaesthetists
www.rcoa.ac.uk

Société Française d'Anesthésie et de Réanimation
www.sfar.org

Society for Pediatric Anesthesia
www.pedsanesthesia.org

World Federation of Societies of Anaesthesiologists
www.anaesthesiologists.org

Other Organizations

Royal College of Dental Surgeons of Ontario
www.rcdso.org

National Guideline Clearinghouse
http://www.guideline.gov/content.aspx?id=15256

American Dental Association
www.ada.org

American Academy of Pediatrics and the American Academy of Pediatric Dentistry
www.aapd.org/media/Policies_Guidelines/G_Sedation.pdf

Canadian Institute for Health Information
www.cihi.ca

CSA Group
www.csagroup.org

College of Physicians and Surgeons of Ontario
www.cpso.on.ca

Health Canada
www.hc-sc.gc.ca

Public Health Agency of Canada
www.phac-aspc.gc.ca

Royal College of Physicians and Surgeons of Canada
www.royalcollege.ca

Patient Safety Organizations

Anesthesia Patient Safety Foundation
www.apsf.org

Canadian Patient Safety Institute
www.patientsafetyinstitute.ca

National Patient Safety Foundation (USA)
www.npsf.org

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College of Chiropodists of Ontario

PRACTICE STANDARD

Administering Inhaled Substances and the Use of Sedation

Approved by Council: June 23, 2017
Reviewed and Updated:

INDEX

Introduction

This document outlines the minimum standards of practice for administering inhaled substances and using sedation in practice. Any registrant who uses sedative agents or sedation modalities must:

- Be appropriately trained,
- Have an inhalation certification and/or prescribing privileges, as outlined below,
- Regulate their practice in accordance with this standard, the **Chiropody Act, 1991**, its regulations, and the **College by-laws**.

This standard must be read in conjunction with Ontario Regulation 203/94, under the Chiropody Act, 1991, By-Law 5: Inhalation and Sedation, and the College's Office Medical Emergencies Guideline.

Defining Sedation Levels

Sedation and general anesthesia exist along a **continuum**, from mild anxiety relief with little or no drowsiness (minimal sedation) to complete unconsciousness (general anesthesia).

Patient responses to sedation can vary, and it may be difficult to clearly distinguish between levels—such as minimal vs. moderate sedation, or the transition into deep sedation and general anesthesia. Given this variability, sedation must be used carefully and with a wide margin of safety to minimize the risk of unintended loss of consciousness.

In practice, minimal sedation can help reduce anxiety and make treatment more comfortable, with less physical and psychological stress.

Responsibilities of Registrants Administering Sedation

Registrants who administer sedation must be able to:

- Recognize and manage the physiological effects of sedation, and
- Rescue patients if sedation becomes deeper than intended level (beyond minimal sedation).

This requires:

- Proper training and clinical skills,
- Access to emergency drugs and equipment, and
- The ability to manage the situations until the patient either:
    - Returns to the intended level of sedation without airway or cardiovascular complications, or
    - Is transferred to emergency medical services.

Conscious Sedation

- Conscious sedation is a minimally to moderately depressed level of consciousness that allows the patient to independently and continuously maintain their airway and respond appropriately to physical stimulation and verbal commands. It may be achieved through pharmacological, non-pharmacological, or combined methods.
- Conscious sedation is further classified into:
    - Minimal sedation
    - Moderate sedation

These classifications are defined in the document Characteristics of the Levels of Sedation and General Anesthesia (see **Appendix I**).

Minimal Sedation

Regardless of the sedation modality or combination used, **registrants must limit the depth of sedation to minimal sedation only**.

Minimal sedation is a **minimally depressed level of consciousness** induced by pharmacological means. Under minimal sedation:

- The patient retains the ability to **independently and continuously maintain their airway**.
- The patient can **respond normally to tactile stimulation and verbal commands**.
- **Cognitive function and coordination** may be mildly impaired.
- **Ventilatory and cardiovascular functions remain unaffected**.
- Minimal sedation is usually achieved using one of the following approaches:
    1. Administration of nitrous oxide and oxygen.
    2. Administration of nitrous oxide and oxygen with a [single][1] sedative drug.
    3. Oral administration of a [single][2] sedative drug.

Moderate Sedation

- **Moderate sedation** is a **drug-induced depression of consciousness** in which patients respond **purposefully to verbal commands**, either alone or accompanied by **light tactile stimulation**.
- No interventions are required to **maintain a patent airway**, and **spontaneous ventilation is adequate**.
- **Cardiovascular function is usually maintained**.

[1] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.
[2] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

Moderate sedation is typically achieved using one of the following modalities:

- **Oral administration of multiple sedative drugs**, with or without **nitrous oxide and oxygen**.
- **Parenteral administration** of sedative drug(s), including:
    1. Intravenous (IV)
    2. Intramuscular (IM)
    3. Subcutaneous (SC)
    4. Submucosal
    5. Intranasal routes

Deep Sedation

- A controlled state of depressed consciousness, characterized by a partial loss of protective reflexes, including the inability to respond purposefully to verbal commands.
- During deep sedation:
    1. The ability to independently maintain ventilatory function may be impaired.
    2. Patients may require assistance in maintaining a patent airway.
    3. Spontaneous ventilation may be inadequate.
    4. Cardiovascular function is usually maintained.

General Anesthesia

General anesthesia is a **controlled state of unconsciousness** accompanied by a **partial or complete loss of protective reflexes**, including:

- The **inability to maintain an airway independently**, and
- The **inability to respond purposefully** to physical stimulation or verbal commands.

Part 1 – Administering Oxygen

When used alone, **oxygen is not considered a sedative agent**.

While oxygen administration is most commonly associated with emergency situations—such as resuscitation, anaphylaxis, syncope, shock, or convulsions—it may also be appropriate in **non-emergent situations**, depending on the specific needs of the patient.

The decision to administer oxygen should be based on the **individual circumstances of the patient** and is at the **discretion of the registrant**. Registrants must also exercise clinical judgment in determining the **appropriate oxygen concentration and flow rate**, with the goal of maintaining or restoring normal physiological oxygen saturation levels:

- **94–98%** for most patients
- **88–92%** for patients with **chronic obstructive pulmonary disease (COPD**

Part 2 – General Standards for All Modalities of Sedation

This section outlines the general requirements for sedation that apply to any modality.

Sedation may be appropriate in the following situations:

- To manage patient anxiety and pain associated with treatment.
- To enable treatment for patients with cognitive impairment or motor dysfunction that prevents adequate care.
- To treat patients below the age of reason.
- To manage traumatic conditions.
- To alleviate anxiety and pain during invasive or prolonged procedures.

Sedation should only be used when clinically indicated and should serve as an adjunct to appropriate non-pharmacological methods of patient management. It is the registrant's responsibility to assess and determine which patients are suitable candidates for the various sedation modalities and pharmacological agents.

Any registrant who wishes to administer sedation must:

- Obtain **informed consent** from the patient, and
- Ensure compliance with the requirements outlined below, including those related to:
    - **Office and facility requirements**, and
    - **Sedation protocols** applicable to **all sedation modalities**

These requirements are essential to ensure safe, ethical, and compliant practice.

Office and Facility Requirements

Before treating a patient who is to be sedated, the registrant must:

1. Ensure that their office is equipped with all required sedation and emergency equipment and drugs necessary to meet the requirements of this standard of practice.
2. Ensure that the facility complies with all applicable building codes, including:
    - Fire safety regulations,
    - Electrical standards
    - Access requirements.
3. The size and layout of the facility must be sufficient to:
    - Support the safe performance of all procedures
    - Allow for the safe evacuation of patients in the event of an emergency.
4. Make sure the clinical setting is suitably staffed and equipped for the specific type of sedation being used.

Emergency Drug and Equipment Requirements

Emergency equipment and medications must **always be available** when sedation is performed.

A) DRUGS

All drugs must be:

1. **Current** (i.e., not expired)
2. **Clearly labeled** and
3. **Stored in an organized and easily identifiable manner** (e.g., in labeled trays or bags)

Registrants using sedation should include and be prepared to use the following medications/agents in an emergency kit:

- **Oxygen** – For most medical emergencies. This should include an adjustable regulator capable of delivering oxygen at flow rates up to 15 liters per minute.
- **Epinephrine (for parenteral emergency use)** – For:
  - Severe allergic reactions (anaphylaxis)
  - Asthma attacks not responding to inhalers
  - Cardiac arrest
- **Diphenhydramine ((for parenteral emergency use))** – For allergic reactions
- **Aspirin (325 mg chewable) –** For suspected heart attacks
- **Glucose tablets –** For low blood sugar in conscious patients

Additional recommendations (only to be used by practitioners trained and comfortable with their administration)**:**

- **Aromatic ammonia** – For fainting
- **Midazolam (Versed)** – For seizures
- **Hydrocortisone** or equivalent agent (E.g. Dexamethasone 4 mg PO, IM, IV) – For allergic reactions or adrenal crisis
- **50% Dextrose solution (IV) or Glucagon (IM) –** For low blood sugar in unconscious patients
- **Salbutamol/Albuterol (Ventolin/Proventil) –** For asthma attacks
- **Nitroglycerin (Nitrostat/Nitromist) –** For chest pain (angina)

Safeguarding Sedative Agents

A registrant who uses sedative agents in their practice must take reasonable precautions to prevent any unauthorized access and use of these substances for recreational or other improper purposes by office staff or any individuals with access to the premises or equipment. Preventative strategies must include the following:

- **Inventory Management**: Maintain a written log of all monitored and controlled drugs in the clinic. These include, but are not limited to, sedative agents (eg. benzodiazepines), narcotics, and nitrous oxide. The log must include:
  - The specific substance acquired
  - Supplier name
  - Date of acquisition
  - Name of the individual confirming receipt
  - Total amount acquired
  - Expiry date (if applicable)
- This inventory must be reconciled regularly and kept on file for review by the College upon request by the Registrar or the College's Sedation Committee.
- **Secure Storage**: These agents must be stored safely in a locked cupboard or secure storage unit, with access only available to authorized staff.
- **Usage Log**: Maintain a separate log that accurately records the use of these agents within the practice. This log must include:
  - The specific substance used
  - Date of use
  - Total amount administered
  - Correlating patient identifier

- Name of the individual who administered the substance

This usage log must also be kept on file and made available for review by the College upon request.

- **Prescription Pad Security:** Exercise strict control over blank prescription pads. Never pre-sign blank prescriptions.
- **Staff Education and Awareness**: Conduct and document regular staff training sessions to:
  - Discuss the dangers of drug and substance misuse
  - Reinforce office safeguards and protocols
  - Provide information on wellness resources available to staff
  - Reporting procedures for errors or misuse

Record the dates and duration of these sessions to demonstrate compliance if requested by the College.

B) EQUIPMENT

It is the **registrant's responsibility** to ensure that the practice setting where sedation is administered is equipped with the required emergency supplies, including:

- Pulse oximeter, approved by Health Canada;
- Appropriately sized sphygmomanometers and stethoscopes;
- Appropriately sized full-face masks and connectors; and
- An **Automated External Defibrillator (AED)**, which can be lifesaving in the event of a sudden cardiac arrest and is designed to be used by non-medical personnel with minimal training. Having one readily available significantly improves the chances of survival while waiting for emergency medical services to arrive.

A written record of the equipment's annual maintenance/servicing and emergency drugs must be kept on file and provided to the College when requested by the Registrar or the College's Sedation Committee.

Sedation Protocol (Applicable to All Modalities)

1. Obtain and document informed consent before giving any oral sedative drug and/or nitrous oxide and oxygen.
2. Take an adequate, clearly recorded, current medical history for each patient before administering any form of sedation. This history must include:
   - Present and past illnesses,
   - Hospital admissions,
   - Current prescription and non-prescription medication
   - Herbal supplements (including dosage)
   - Allergies, particularly to medications
   - Functional inquiry and a physical examination
3. For medically compromised patients, it may be necessary to consult their primary healthcare provider. If a consultation occurs, it must be documented in the patient record, consistent with the requirements in **Appendix II**.

4. At every sedation appointment, review the patient's medical history for any changes and record it in their chart. This will help the registrant decide if the patient is a suitable candidate for in-office use of a particular sedation modality or agent.
5. Before giving any sedation, determine the patient's American Society of Anesthesiologists (ASA) Physical Status Classification (see **Appendix III**) and record it in their chart. Also evaluate any other factors that could affect whether the patient is a good candidate for sedation must be conducted.
6. Patients classified as ASA IV and higher (see **Appendix III**) are not candidates for sedation outside of a hospital. Oxygen can be given at the registrant's discretion. If a patient is ASA III or higher, registrants must consult with their primary healthcare provider before administering sedation.
7. Registrants must always ensure sedation stay at a minimal level (see **Definitions of Sedation Levels**). Using one drug at a well-planned dose is the safest way to achieve this.
8. If the patient becomes more than mildly sedated (overly drowsy or unresponsive), stop treatment right away. Support the patient until they return to mild sedated, or call emergency services if needed.
9. Always consider the maximum safe dose of local anaesthetic, especially for children, older adults, and people with health issues. If sedation is also being used, the maximum safe dose may need to be lowered even more to ensure patient safety.
10. Registrants must not be alone when treating a sedated patient.
11. After minimal sedation, the patient must leave with a responsible adult. The only time a registrant can decide if someone can leave alone is when nitrous oxide and oxygen were the only sedation used. No matter what type of sedation was given, the registrant who administered the sedation must confirm and document that the patient is safe and ready to go before discharge.

Part 3 – Specific Standards for Particular Modalities

Registrants must follow the College's standard of practice when providing minimal sedation to a patient using any modality, including:
the administration of nitrous oxide and oxygen alone or the administration of nitrous oxide and oxygen with a [single][3] sedative drug; and

A. the oral administration of a [single][4] sedative drug; and
B. the oral administration of a [single][5] sedative drug

Administering Nitrous Oxide and Oxygen OR Nitrous Oxide and Oxygen with a Single Sedative Drug

In addition to the requirements listed in **PART 2**, the following standards of practice apply when nitrous oxide and oxygen sedation or nitrous oxide and oxygen sedation with a [single] sedative

[3] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.
[4] This standard does not anticipate any circumstance in which a registrant would administer more than one sedative drug concurrently
[5] This standard does not anticipate any circumstance in which a registrant would administer more than one sedative drug concurrently

drug are being used to induce minimal sedation.

REGISTRANT QUALIFICATIONS

Registrants must meet the following requirements to administer nitrous oxide and oxygen sedation or nitrous oxide and oxygen sedation with a [single] sedative drug:

1. Obtain an Inhalation Certificate from the College (for details, see the College's By-law 5: Inhalation and Sedation).
2. Successfully complete a training program, approved by the College, that teaches how to competently administer nitrous oxide and oxygen, with or without a [single][6] sedative drug.[7]
3. Successfully complete a comprehensive pharmacology course, approved by the College, that covers general clinical pharmacological principles and overall systems pharmacology, and gives the registrant the ability to prescribe the relevant sedative and emergency drugs in n Ontario Regulation 203/94: General or as may otherwise be required for appropriate patient care.[8]
4. Maintain competence by completing ongoing training, courses, and/or other educational programs.
5. Make sure all clinical staff, including Authorized Sedation Monitors, know how to recognize and manage adverse reactions to sedation and have access to the necessary emergency equipment and drugs.
6. Establish written emergency protocols s and review them regularly with staff. Keep a record of these protocols on file. **You must provide this record to the College ifcombin requested by the Registrar or the College's Sedation Committee.**
7. All clinical staff, including Authorized Sedation Monitors, must be trained and able to perform basic life support (BLS). Registrants who provide sedation must maintain BLS certification (CPR Level HCP – CPR Level for Health Care Providers) as a minimum and renew it at least every three years.

AUTHORIZED SEDATION MONITOR

Because it's difficult to safely provide foot care and administer nitrous oxide and oxygen sedation, **there must always be at least two people present when nitrous oxide and oxygen are used, whether or not an oral sedative drug is being administered at the same time**[9]

Individual One: The first person in the room during sedation is mainly responsible for providing foot care to the patient. They must be registered with the College and must also be authorized by the College to administer a substance to a patient by inhalation (nitrous oxide and oxygen).[10]

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[6] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug in combination with nitrous oxide and oxygen.
[7] This program will include: indications, contraindications, patient evaluation, patient selection, pharmacology of relevant drugs, administration of sedation agents and modalities, and management of potential adverse reactions, as they relate to the relevant sedation agents and modalities.
[8] The registrant must meet the standard of practice set out in Ontario Regulation 203/94, made under the *Chiropody Act, 1991*, for prescribing sedative drugs.
[9] Please note that this standard of practice has not been designed for the circumstance where a registrant arranges for a physician to provide sedation as the registrant provides foot care.
[10] Individual One would not be required to be authorized by the College to administer a substance by inhalation where Individual Two was a registrant currently registered with the College who is authorized by the College to do so.

Individual Two: The second person in the room is the Authorized Sedation Monitor. This person administers the sedation under the direction of the registrant and must closely monitor the patient to make sure the sedation is working safely. This person must be ready to respond to any problems or side effects from the sedation.

To be an **Authorized Sedation Monitor**[11], a person must meet specific qualifications:

- Another College registrant who is authorized to administer a substance to a patient by inhalation, or;
- A Registered Nurse (RN) currently registered with the College of Nurses of Ontario acting under an order from a registrant, or;
- A Registered Practical Nurse (RPN) currently registered with the College of Nurses of Ontario, who has obtained a two-year diploma in Practical Nursing from a Community College of Applied Arts or completed an enhanced medication course in the administration and monitoring of minimal sedation, acting under an order from a registrant.

The registrant must ensure the Authorized Sedation Monitor has current BLS certification (CPR Level HCP – CPR Level for Health Care Providers) and is competent to perform the tasks being assigned.

In the case of a nurse, the registrant performing foot care must always be present in the office suite and available **immediately** in the event of an emergency.

GAS DELIVERY SYSTEM REQUIREMENTS

Gas delivery systems used for nitrous oxide and oxygen sedation must meet the following standards:

1. **Fail-safe oxygen:** The system must have a fail-safe feature so it never delivers less than 30% oxygen in the gas mixture.
2. **Secure connections:** Pipeline inlet fittings or pin-indexing, must prevent mixing up oxygen and nitrous oxide connections.
3. **Regular maintenance:** The system must be checked regularly by trained staff, work reliably and accurately, and maintained according to manufacturer's instructions or annually, whichever is more frequent. A written record of this maintenance must be kept and provided to the College if requested.
4. **Standard outlet:** The system must have a common gas outlet that fits
5. **Backup oxygen supply:** A portable "E" size oxygen cylinder must be ready for immediate use. It should include a regulator (capable of delivering oxygen at flow rates up to 15 liters per minute), flowmeter, connectors, tubing, and a reservoir bag for positive pressure resuscitative ventilation with 100% oxygen using a full-face mask.
6. **Disposable masks:** Only single use disposable masks with scavenging capability should be used to prevent cross-contamination and safely remove exhaled gases.
7. **Scavenging system:** The system must include a properly functioning scavenging setup installed per manufacturer's specifications. It should have an accurate flowmeter,

[11] This standard does **not** apply where a registrant arranges for a physician to provide sedation while the registrant provides foot care.

scavenging masks, and a vacuum system that removes gases at a rate of at least **45 L per minute,** venting them in compliance with local regulations.

8. **Single-patient components:** All components that touch the patient must be single-use. Parts that do not touch the patient must be cleaned and disinfected in accordance with the manufacturer's instructions.

SEDATION PROTOCOL

1. The patient's medical history (as described in **Part 2** and **Appendix II**) must be reviewed for any changes at each sedation appointment.
2. Pre-operative and written post-operative instructions must be provided to the patient or their guardian.
3. No fasting is necessary before (minimal) sedation using nitrous oxide and oxygen or sedation using the administration of a [single] sedative drug with or without nitrous oxide and oxygen. Registrants may, however, recommend that the patient only eat a light meal within two hours of nitrous oxide being administered.
4. A flow rate of 5 to 6 liters per minute is generally acceptable for most patients. The flow rate should be adjusted by observing the reservoir bag.
5. Start with 100% oxygen for 1 to 2 minutes, then gradually add nitrous oxide in 10% intervals.
6. Nitrous oxide and oxygen should be increased slowly to achieve **minimal** sedation, with continuous and careful monitoring of the patient's level of consciousness, unless there is a justified reason to do otherwise.[12]
7. The concentration of nitrous oxide should not exceed 50% when aiming for minimal sedation, except in justifiable circumstances.[13]
8. Increase nitrous oxide during more stimulating procedures (e.g. injection of local anaesthetic) and/or decreased during periods of less stimulation (e.g. ongoing anxiolysis once local anaesthetic has had effect). Adjusting to the patient's needs helps prevent overmedication, reduces adverse side effects, and improves the overall sedation experience.
9. Patients receiving nitrous oxide and oxygen sedation must never be left unattended and must be continuously monitored by an **Authorized Sedation Monitor**. Monitoring must include:
    - Continuous observation of consciousness and vital signs (heart rate, blood pressure, respiration) before, during and after the procedures.
    - Use a pulse oximetry throughout.
    - Record monitoring details at least **every 15 minutes.**
10. After stopping nitrous oxide, **100% oxygen must be delivered for 3 to 5 minutes.**
11. The patient's recovery status must be **assessed and documented** following the administration of sedation. The decision to discharge a patient after receiving **nitrous oxide and oxygen sedation** must be made by a **registrant of the College** who is:
    - **Currently registered** with the College, and
    - **Authorized** to administer the specific sedation agent or modality.
12. This registrant must **remain on-site** until the patient is deemed **fit for discharge**.
13. Only patients who are fully recovered may be considered for unaccompanied discharge. If a patient exhibits any residual symptoms, they must be discharged with a responsible adult to ensure their safety and continued recovery.
14. The patient record must include:

[12] In these cases, the patient record must reflect the reasons for these circumstances.
[13] In these cases, the patient record must reflect the reasons for these circumstances.

- **Indication(s) for the use of sedation**
- **Rationale for the choice of sedative agent administered**

15. In cases where **nitrous oxide and oxygen** are administered, the record must also include:
    - Name of the **Authorized Sedation Monitor**
    - **Dosage details**: percentage of nitrous oxide and oxygen, and flow rate
    - **Duration** of administration
    - **Post-treatment oxygenation procedures**
    - **Monitoring records**: pre-operative, intra-operative, and post-operative
    - **Discharge summary**
    - Documentation of **any adverse effects**

ADDITIONAL SEDATION PROTOCOLS – [SINGLE] USE DRUG

1. For the purposes of this standard, the administration of an oral sedative intended to induce sedation refers to a single oral dose administered to the patient while in the registrant's office. The administration of this dose must consider:
    - The time required for drug absorption.
    - The potential interactions with other concurrently used medications that may influence the clinical effects of the sedative.

It is recommended that the full effect of the administered oral sedative be realized before initiating treatment or beginning any procedure.

2. There are two exceptions to the recommendation that the oral sedative be administered in the registrant's office:
    - If the registrant decides the patient needs an oral sedative to sleep the night before treatment or a procedure.
    - If the patient's anxiety is so high that sedation is needed before arriving at the registrant's office.

    In these two situations, additional requirements apply:

    - The reason a registrant instructed a patient to take a sedative drug prior to arriving at the office must be clearly documented in the patient record.
    - The patient must be screened at a prior appointment, including a comprehensive medical history, as outlined in **Part 2** and **Appendix II**).
    - Only **one sedative drug** should be prescribed at a time, preferably a benzodiazepine or an antihistamine. Opioids must not be used as pre-operative or intra-operative sedative drugs.
    - The patient must be instructed not to drive and must be accompanied to and from the registrant's office by a responsible adult.
    - Clear written instructions must be provided to the patient or their legal guardian. The instructions must include: how to take the medication; the need to be accompanied to the appointment, and the expected effects from the drug.

3. It is essential to understand the oral sedative's onset time, peak response, and duration to avoid over-sedation.

4. Never exceed the maximum recommended dose during any single appointment, as outlined in **Appendix IV**. Because sedation occurs on a continuum, patient responses can vary. Registrants are encouraged to administer the lowest effective dose necessary to achieve the desired sedative effect.
5. If an oral sedative is given, make sure its full clinical effect has occurred before administering nitrous oxide.
6. When combining nitrous oxide and oxygen after an oral sedative, increase slowly to reach minimal sedation. Monitor the patient's level of consciousness continually, unless there is a justified reason not to.[14]
7. The patient must be discharged into the care of a responsible adult. Prior to discharge, the patient must demonstrate: orientation to time, place, and person, relative to their pre-anesthetic condition; ability to ambulate independently; stable vital signs; increasing alertness.
8. Written post-sedation instructions must be provided to the patient. The patient must be advised not to drive a vehicle, operate hazardous machinery, or consume alcohol for a minimum of 18 hours, or longer if symptoms such as drowsiness or dizziness persist.
9. When oral sedation is administered, the patient record must include:
    - **Indication(s)** for the use of sedation
    - **Rationale** for the choice of sedative agent(s)
    - **Dosage** of all oral sedative drugs
    - **Time of administration** of all oral sedative drugs
10. In cases where **nitrous oxide and oxygen** are administered, the record must also include:
    - Name of the **Authorized Sedation Monitor**
    - **Dosage details**: percentage of nitrous oxide and oxygen, and flow rate
    - **Duration** of administration
    - **Post-treatment oxygenation procedures**
    - **Monitoring records**: pre-operative, intra-operative, and post-operative
    - **Discharge summary**
    - Documentation of **any adverse effects**

Oral Administration of a Single Sedative Drug (no Nitrous Oxide is Used)

In addition to the requirements listed in **Part 2**, the following standards of practice apply when a [single][15] oral dose of a sedative drug is administered via the oral route. This also applies to medication taken under the tongue (sublingual).

REGISTRANT QUALIFICATIONS

For a registrant to administer a [single][16] sedative drug, they are required to meet the following requirements:

1. Successfully complete a pharmacology course, approved by the College, that covers general clinical pharmacological principles and overall systems pharmacology. They must also meet the requirements to prescribe the relevant sedative and emergency drugs in *Ontario Regulation 203/94: General* or as may otherwise be required for appropriate patient care.

[14] In these cases, the patient record must reflect the circumstances.
[15] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.
[16] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

2. Maintain competence by completing ongoing training, courses, and/or other educational programs.
3. Ensure that clinical staff are prepared to recognize and treat adverse responses using emergency equipment and drugs.
4. Establish written protocols for emergency procedures and review them regularly with staff. **A written record must be kept on file and presented to the College when requested by the Registrar or the College's Sedation Committee.**
5. Ensure that clinical staff have the training and ability to perform basic life support (BLS) techniques. A registrant providing sedation must maintain BLS certification (CPR Level HCP – CPR Level for Health Care Providers) as a minimum.[17] BLS certification must be renewed at least every three years.

SEDATION PROTOCOL

The patient's medical history (as described in **Part 2** and **Appendix II**) must be reviewed for any changes at each sedation appointment.

- For the purposes of this standard, the administration of an oral sedative intended to induce sedation refers to a [single][18] oral dose administered to the patient while in the registrant's office. The administration of this dose must consider:
    - the time required for drug absorption
    - potential interactions with other concurrently used medications that may impact the clinical effects of the sedative.

It is recommended that the full effect of the administered oral sedative be realized before initiating treatment or beginning a procedure.

- There are two exceptions to the recommendation that the oral sedative be administered in the registrant's office:
    - If the registrant determines the patient requires an oral sedative to sleep the night before treatment or a procedure.
    - If the patient's anxiety is so high that sedation is needed before arriving at the registrant's office.

In these two situations, additional requirements apply:

- The reason a registrant instructed a patient to take a sedative drug prior to arriving at the office must be clearly documented in the patient record.
- The patient must be screened at a prior appointment, including a comprehensive medical history, as outlined in **Part 2** and **Appendix II**.
- Only one sedative drug should be prescribed at any one time, preferably a benzodiazepine or an antihistamine. Opioids must not be used as pre-operative or intra-operative sedative drugs.
- The patient must be instructed not to drive and must be accompanied to and from the registrant's office by a responsible adult.
- Clear written instructions must be provided to the patient or their legal guardian. The instructions must include: how to take the medication; the need to be accompanied to the appointment, and the expected effects from the drug.

[17] It is strongly recommended that all registrant s, whether or not intending to induce sedation, maintain current BLS certification (CPR Level HCP – CPR Level for Health Care Providers).
[18] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.

- Knowing the oral sedative's time of onset, peak response, and duration of action is essential to avoid over-sedation.
- Never go over the maximum recommended dose of an oral sedative during any single appointment as outlined in **Appendix IV**. Because sedation works on a continuum, patient responses can vary. Registrants are encouraged to administer the lowest effective dose necessary to achieve the desired sedative effect
- Patients must be monitored at all times. However, an Authorized Sedation Monitor is not required - other qualified clinical staff may perform the monitoring.
- Children, older adults, and medically compromised individuals, including patients taking prescribed medication with sedative properties, require appropriate dose adjustments to ensure the intended level of sedation is not exceeded. For these patients, the following practices are strongly recommended:
    - Continuous monitoring, including the use of pulse oximetry during the pre-operative, intra-operative, and post-operative phase.
    - Inclusion of an Authorized Sedation Monitor, while not required, is strongly recommended for these patients.

If monitoring is conducted, documentation must include recorded observations at a minimum of every 15 minutes.

The patient's post-operative recovery status must be assessed and recorded. The decision to discharge a patient following the administration of a [single][19] oral sedative drug must be made by a registrant.

- The patient must be discharged to the care of a responsible adult. Prior to discharge, the patient must demonstrate: orientation to time, place, and person, relative to their pre-anesthetic condition; ability to ambulate independently; stable vital signs; increasing alertness.
- Written post-sedation instructions must be provided to the patient. The patient must be advised not to drive a vehicle, operate hazardous machinery, or consume alcohol for a minimum of 18 hours or longer if drowsiness or dizziness persists.
- Specific to sedation, the patient record must include the following:
    - Indication(s) for the use of sedation,
    - Rationale for the choice of sedation agent administered,
    - Dosage of all oral sedative drugs,
    - Time of administration of all oral sedative drugs,
    - Monitoring records: pre-operative, intra-operative, and post-operative monitoring,
    - Discharge summary,
    - Documentation of any adverse effects.

Appendix I

Characteristics of the Levels of Sedation and General Anesthesia[20]

[19] This standard does not anticipate any circumstance where a registrant would use more than one sedative drug.
[20] This information is based on the Royal College of Dental Surgeons of Ontario's *Standard of Practice: Use of Sedation and General Anesthesia in Dental Practice* (November 2018). Registrants are responsible for checking and following any updates to this information.

	MINIMAL SEDATION	*MODERATE SEDATION*	*DEEP SEDATION*	*GENERAL ANESTHESIA*
CONSCIOUSNESS	maintained	maintained	obtunded	unconscious
RESPONSIVENESS	to **either** verbal command **or** tactile stimulation	may require either one of or **both** verbal command and tactile stimulation	response to repeated or painful stimuli	unarousable, even to pain
AIRWAY	maintained	no intervention required	intervention may be required	intervention usually required
PROTECTIVE REFLEXES	intact	intact	partial loss	assume absent
SPONTANEOUS VENTILATION	unaffected	adequate	may be inadequate	frequently inadequate
CARDIOVASCULAR FUNCTION	unaffected	usually maintained	usually maintained	may be impaired
REQUIRED MONITORING	basic	increased	advanced	advanced

Appendix II

Medical History and Patient Evaluation

An adequate, current, clearly recorded, and signed (by the registrant who will be inducing sedation) medical history must be taken for each patient. The history is part of the patient's permanent record. It forms a database from which the registrant can determine the appropriate sedation modality or modalities. The medical history must be kept current. This information must be organized and contain, **at a minimum**, the information described in this section.

- **Vital Statistics:** This includes the patient's full name, date of birth, sex, and emergency contact. In the case of a minor or a mentally disadvantaged patient, the name of the parent or guardian must be recorded.
- **Core Medical History:** The core medical history must be a system-based review of the patient's past and current health status and must specifically fulfill the following two basic requirements:
  1) It must elicit the core medical information to enable the registrant to assign the correct ASA Physical Status Classification (see **Appendix III**) to assess risk factors in relation to sedation choices.
  2) It must provide written evidence of a logical process of patient evaluation.
- **Core Physical Examination:** A current, basic physical examination, suitable for determining information that may be significant to sedation and appropriate to the modality or modalities being used, must be carried out for each patient.

At a minimum, all modalities of sedation require the evaluation and recording of significant positive findings related to:

- general appearance, noting obvious abnormalities;
- an appropriate airway assessment;
- the taking and recording of vital signs, i.e. heart rate and blood pressure.

This core physical examination can be carried out by the registrant.

Appendix III

American Society of Anesthesiologists Physical Status Classification System[21]
ASA I: A normal healthy patient
ASA II: A patient with mild systemic disease
ASA III: A patient with severe systemic disease
ASA IV: A patient with severe systemic disease that is a constant threat to life
ASA V: A moribund patient who is not expected to survive without the operation
ASA VI: A declared brain-dead patient whose organs are being removed for donor purposes
ASA 2: Although pregnancy is not a disease, the parturient' s physiologic state is significantly altered from when the woman is not pregnant, hence the assignment of ASA 2 for a woman with uncomplicated pregnancy.
ASA E: The addition of **E** denotes emergency surgery (an emergency surgery is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)

Appendix IV

Benzodiazepines for Oral Use[22]): for the purpose of treatment of anxiety before and during surgical procedures and to provide minimal sedation during surgical procedures:

- **Diazepam** — individual dosing range of 2.5-10 mg, with 10 mg being the maximum individual dose, every 6-12 hours. Maximum total dosage not to exceed 40 mg within 24 hours. Maximum total duration not to exceed 24 hours
- **Lorazepam** – individual dosing range of 0.5-1 mg, with 1 mg being the maximum individual dose, every 12 hours. Maximum total dosage not to exceed 2 mg within 24 hours. Maximum total duration not to exceed 24 hours
- **Triazolam** — individual dosing range of 0.125 to 0.25 mg, with 0.25 mg being the maximum individual dose, limited to a single dose, with the total dosage not to exceed 0.25 mg per day, for a maximum duration of 1 day
- **Alprazolam** — individual dosing range of 0.25 to 0.5 mg, with 0.5 mg being the maximum individual dose, limited to a single dose, with the total dosage not to exceed 0.5 mg per day, for a maximum duration of 1 day

References

Anaesthesia Organizations

American Society of Anesthesiologists: www.asahq.org
Association of Anaesthetists of Great Britain and Ireland: www.aagbi.org/publications
Australian Society of Anaesthetists: www.asa.org.au
Canadian Anaesthesiologists' Society: www.cas.ca
European Society for Paediatric Anaesthesiology: www.euroespa.com
Royal College of Anaesthetists: www.rcoa.ac.uk

[21] This is the current version as of December 13, 2020. Registrants are responsible for ensuring updates to information.
[22] SCHEDULE 3-DRUGS THAT MAY BE PRESCRIBED (Anti-Anxiety), *Chiropody Act, 1991*, ONTARIO REGULATION 203/94, GENERAL

Société Française d'Anesthésie et de Réanimation: www.sfar.org
Society for Pediatric Anesthesia: www.pedsanesthesia.org

Other Organizations

Royal College of Dental Surgeons of Ontario: www.rcdso.org
American Dental Association: www.ada.org
American Academy of Pediatrics and the American Academy of Pediatric Dentistry
Canadian Institute for Health Information: www.cihi.ca
CSA Group: www.csagroup.org
College of Physicians and Surgeons of Ontario: www.cpso.on.ca
Health Canada: www.hc-sc.gc.ca
Public Health Agency of Canada: www.phac-aspc.gc.ca
Royal College of Physicians and Surgeons of Canada: www.royalcollege.ca

Patient Safety Organizations

Anesthesia Patient Safety Foundation: www.apsf.org
Healthcare Excellence Canada: https://www.healthcareexcellence.ca/
Institute for Healthcare Improvement: www.npsf.org

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.6

COUNCIL BRIEFING NOTE
RE: REVISIONS TO THE LASER GUIDELINE

Background:

The Standards and Guidelines Committee is conducting a comprehensive review of all the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the look and format of the documents

The revised Guideline sets out guidance to support the safe and effective use of lasers by College registrants. It emphasizes best practices, safety precautions, and compliance with regulatory requirements for laser types commonly used in chiropody and podiatry.

This Guideline was originally approved by Council in 2017 and required some updates to align with current laser use.

Public Interest Rationale for Decision:

Regular review ensures standards and guidelines reflect current expectations and are clearly communicated. This helps:

- Registrants understand what is required for safe and ethical practice
- The public understand what they can expect from registrants

Recommended Motion:

That Council approve the revised Laser Guideline.

Mover: _____

Seconder: _____

3.2.1 Appendix A – redlined version
3.3.2 Appendix B – newly formatted guideline

~~COCOO LASER~~ Laser ~~STANDARD~~ Guideline ~~(2025)~~

Purpose

~~Provide~~

This document sets out guidance to support the safe and effective use of lasers by College registrants.

~~This document provides guidance to College registrants provides clear and comprehensive standards to ensure for the safe and effective use of lasers by members, College registrants of the College of Chiropodists of Ontario (COCOO)~~. ~~This standard~~ standard ~~emphasizes~~It emphasizes best practices, safety precautions, and ~~regulatory~~ compliance with regulatory requirements for ~~different~~ laser types commonly used in chiropody and podiatry.

~~See~~Refer to ~~the chart~~ attached ~~below entitled,~~ **Laser Classification and Safety Guide~~,~~** for a general listing of ~~the~~laser types ~~of lasers our~~used by registrants ~~use~~.

LOW LEVEL LASER ~~THERAPY (~~THERAPY (LLLT) – Class 3B Laser ~~(“Cold Laser”)~~

~~Class 3 laser (See Laser Class Guide – Page XX)~~

~~LLLT is~~LLLT is ~~a~~Also called ~~entitled~~ **photobiomodulation**, LLLT~~. It utilizes) uses~~ uses red or near-infrared (NIR) light to reduce pain and inflammation and ~~to~~ promote tissue healing.

~~See~~Refer to ~~the chart~~ Appendix A: LLT Parameter Indications for Wound Healing and Musculoskeletal Injuries~~attached entitled, “LLLT INDICATIONS FOR WOUND HEALING AND MUSCULOSKELETAL INJURIES”. (Change chart title from “recommendations” to “indications” and identify it as for reference only?)~~

Red light (≈630–660 nm) penetrates only superficial tissues (on the order of ~5–10 mm depth)[1], making it suitable for surface-level injuries.

Near-infrared light (≈800–900 nm) penetrates much deeper (up to ~30–40 mm) into tissue[2], reaching muscles and joints.

Applications:

- Musculoskeletal therapy
- , inflammation Inflammation reduction
- , wWound healing.

Assignment:

- Registrant mMay **assigned** this act according to the College's of Chiropodists's **Assignment, Orders and Delegation Policy**.
- If not treating the patient directly, the Registrants registrant must perform prepre- and post- treatment checks with patient, if not treating patient directly.
- Registrants must specifically obtain and document patient consent to assignment of the procedure being performed by someone other than the registrant.

Training courses:

- Registrants must have appropriate training to administer LLLT safely.
  Recommended, not required. (insert course recommendation)

Personal Protective EquipementEquipment (PPE):

- Wavelength-specific protective goggles required for both patient and practitioner.

Documentation:

- Signed informed consent
- Charting must include: type of laser, wavelength, power density, location of application and session duration. Note any adverse effects or clinical findings.

Protocol:

- Post a Laser laser warning sign posted
- Ensure Patient patient informed to keeps laser safety glasses on until treatment is over.
- Be cognizant of contraindications for treatment

QUESTIONS: What is legal requirement of training (if any)
LINK TO REFERENCE TABLE

FUNGAL NAIL LASER THERAPYS – Class IV Laser

Laser therapy has emergedis used as an adjunct or alternative to antifungal drugs for to treat onychomycosistreat onychomycosis.

Important:

Some laser devices have obtained Health Canada approval for use to provide **temporary cosmetic improvement** in nail appearance (i.e. increased clear nail growth), not to cure fungal nail infections: (See link to **July 2019 Health Canada Bulletin** provided below.) , aiming to destroy fungal elements in the nail via photothermal or photochemical effects. Multiple laser devices have obtained FDA 510(k) clearance or CE-mark for **temporary cosmetic improvement** in nail appearance (i.e. increased clear nail growth). While no laser is FDA-approved as a definitive **fungicidal** cure, clinicians use several classes of lasers in practice.

> "Health Canada is clarifying that, while some laser-based medical devices are licensed in Canada to temporarily increase the clarity of the nail in patients with a fungal nail infection, none have been licensed to cure these infections."

Health Canada clarification: laser-based medical devices are not licensed in Canada to cure fungal nail infections - Canada.ca

Registrants must be clearly in their communicateions withthis patientsto patients in this regard when obtaining informed consent before initiating treatment.

Please find attached arefer to Appendix CB: COMPARISON CHART OF LASER THERAPIES FOR ONYCHOMYCOSIS, for reference use only.

Application:

- Improving the aesthetic appearance of mycologically infected nail plates and nail beds of the feet., provided the treatment is medically necessary.

Assignment:

- ~~Registrant m~~May **be assigned** ~~this act~~ according to the College ~~of Chiropodists~~ **Assignment, Orders and Delegation Policy**.
- Registrants must perform pre and post-~~-~~treatment checks with patient, if not treating the patient directly~~Registrant may assign the duty of applying the laser to mycologically infected nails only of the person being assigned the task has acquired level 4 laser training~~ .
- Registrants must specifically obtain and document patient consent to assignment of the procedure being performed by someone other than the registrant.

Training: ~~i~~

- ~~It is the registrant's responsibility to~~Registrants must ensure ~~that they are~~ competence~~t~~ with the specific~~use of the specific~~ laser, ~~they are using, fully apprised of any~~understand ~~contraindications~~contraindications, ~~-~~and know how to ~~treat~~manage any adverse effects ~~that might occur from treatment.~~ ~~s the training required for the registrant or are they considered competent with their license? – assignee training? – only for class 4 lasers due to risk ?~~

PPE:

- Laser specific protective goggles ~~to~~must be worn by~~for all individuals~~everyone in the treatment room~~surgical site~~
- ~~N95 Mask~~
- ~~Plume evacuator~~
- Gloves
- No plume is generating in this application
  - ~~Wet gauze / towel for fire mitigation.~~

Documentation:

- ~~The registrant must outline the r~~Risks and benefits of the proposed treatment must be explained and documented, consistent with the College's~~Inform consent including risks of treatment must be delivered consistent with COCOO's~~ ***~~Informed~~*** **Consent ~~Standard~~Guideline**.~~standards and regulations (provide link ?)~~
- ~~Consistent with the requirements of the College's~~ ***~~Records Standard~~***~~, the m~~Medical record ~~Charting~~ must include: type of laser, wavelength, power density, location of application and session duration, and other such parameters, ~~- Note~~ any adverse effects or clinical findings.
-

Protocol:

- Post ~~Laser~~ laser warning sign ~~posted~~
- Ensure ~~Patient~~ patient ~~informed to keep laser~~wears safety glasses ~~on~~ until treatment is over.

- ~~Avoid contraindications for treatment~~
- P~~atient p~~rovided follow-up appointment.

~~LINK TO REFERENCE TABLE~~

SURGICAL LASERS - Class IV Laser~~ are we inserting this into the surgical standard?~~

~~. Surgical Lasers (Is this section more appropriately included as part of the Surgical Competencies Standard?)~~

~~**Appropriate Use**~~

Applications:

- Cutting and ablation of soft tissue lesions~~ and tissue.~~ (e.g.~~For example~~, warts, nail root matrices).~~x and so on.), Soft tissue cutting and ablation of soft tissuewart removal, matrixectomy, ulcer debridement.~~

~~• **Assignment:** Procedures must be conducted by COCOO members; Assignment strictly for supportive tasks.~~

Training

- Only registrants ~~that have the~~with demonstrated knowledge, skills and judgement ~~as outlined~~ for **Class A** procedures under the College's Surgical Competencies Standard, ~~**https://cocoo.on.ca/pdf/standards/Standard-surgery.pdf** ,~~ ~~should~~can ~~be utilizing~~use surgical lasers.
- Registrants ~~should~~must have ~~full~~partial prescribing privileges.

Assignment:

- ~~These p~~Procedures must be performed by registrants.
- Assignment ~~is strictly for~~limited to supportive tasks, for example, attending to the plume evacuator equipment.

~~• Level 4 training required for clinical procedures, patient care, informed consent.~~
~~• Recommended: Medical Laser Safety Officer (MLSO) online training via Laser Institute of America (LIA). https://www.lia.org/training/medical-laser-safety-officer-~~

training?v=13282 https://canadianlasersafety.com/courses/medical-laser-safety-officer-training

- Registrants should have full prescribing privileges.

Hazards :Hazards:

- **Eye Injury**: High risk from direct/diffuse reflections.
- **Skin/Tissue Burns**: Significant risk requiring careful beam management.
- **Laser Plume**: Contains hazardous airborne materials.
- **Fire Risk**: Elevated near flammable materials.

PPE :PPE:

- High optical density, wavelength-specific goggles.
- High-filtration (N95) masks mandatory.
- Flame-resistant attire; wet gauze or towels.
- Mandatory smoke plume evacuation systems.
-

Protocol

- Comprehensive pre-surgery checklist.
- Clear eEmergency protocols (fire/misfire procedures).
- Rigorous informedInformed consent has been obtained.detailing benefits, risks, alternatives.

Regulatory and Legal Obligations

- **Ontario OHSA**: Appoint Laser Safety Officer; mandatory training.
- **Health Canada**: Licensed medical laser devices only.
- **CSA Z386**: Adhere to safety guidelines, training, PPE, signage.
- **ANSI Z136.1/Z136.3**: Compliance with Class 3B/4 safety standards.

Record-Keeping

- Maintain aAccurate logs for training, of sServicing and mMaintenance.
- Document Equipment equipment maintenance and safety checks – Appendix A
- treatments (i.e charting notes)

Commented [1]: See Link provided to Laser Institute of America Plus Canadian Authority

Commented [2]: Ask Meghan Clarke for explanation of legal requirements.

Commented [3]: This requirement of a Laser Safety Officer parallels MOH requirement for Xray taking Radiation Protection Officer. We need to fully explore this requirement.

- ~~Include laser type, Class, Anatomical description of application site, duration of application, power of application,~~
- ~~Incident reporting Appendix E~~
- ~~Clearly document informed consent. -See applicable Standard and Regulation and Records standard~~

Incident Management

- Complete formal incident reports immediately.
- ~~Notify LSO for corrective action promptly.~~

RESOURCES

Laser warning signs Click here
- Provides signage for laser types

~~Maximum Permissible Exposure (MPA) and Nominal Hazard Zone (NHZ) Click here~~

~~Laser plume Safety Click Here~~
~~Lasers in Healthcare Click here~~
~~Incident Reporting Health Canada Guidelines Click here~~

Appendix A

LLLT PARAMETER INDICATIONS FOR WOUND HEALING AND MUSCULOSKELETAL INJURIES

Table 1: LLLT Parameters for Wound Healing Applications

Wound Type	**Recommended Wavelength(s)**	**Power Density (mW/cm^2)**	**Energy Dose (J/cm^2)**	**Session Frequency & Duration**	**Application Notes / Outcomes**
Diabetic Foot Ulcer	Red (~660 nm) or NIR (~890 nm)[1]	~50 mW/cm^2[2]	~2 J/cm^2[2]	e.g. daily or 3×/week; ~30 sec irradiation per point (non-contact, ~1 cm from wound)[2][3]; typically continued for several weeks (up to 8–12+ weeks) or until closure[3]	Significantly accelerates healing: meta-analysis shows LLLT doubled complete ulcer healing rate and reduced ulcer area/time to closure vs controls. No adverse effects reported; effective as adjunct to standard wound care in chronic non-healing DFUs (Li et al., 2018).
Pressure Ulcer (Bed Sore)	Red (~650 nm) diode[5]	*N/A* (100 mW output in scanning mode)[6] *(≈30–50 mW/cm^2)*	~4 J/cm^2[6]	~2×/week (every 3 days) for ~4 weeks; ~125 sec per session covering wound bed (non-contact scanning)[5] (≈6 sessions total)	Improved wound bed granulation and reduced slough noted; after 6 LLLT sessions the chronic ulcer bed was well-prepared for closure (healthy granulation tissue). No infections or adverse effects observed during LLLT course (Nishad et al., 2020).
Surgical Wounds (Incisions & Scars)	Red (660 nm) or NIR (~830 nm) laser[9][10]	<100 mW/cm^2 (low-level, non-thermal)	~4–6 J/cm^2 per treatment[9][10]	Typically 3×/week for ~3–4 weeks post-op[9] (or daily for 1–2 weeks in some protocols[10]); ~60 sec irradiation per point along incision line[9] (multiple spots to cover entire scar)	Shown to promote faster incision healing and improved scar outcomes. For example, 660 nm LLLT thrice-weekly for 4 weeks significantly enhanced median sternotomy wound healing vs control. Similarly, 830 nm LED therapy has been used to reduce post-thyroidectomy scar formation (better cosmetic scar appearance vs sham) (Helmy et al., 2019; Kim et al., 2022).
Burn Wounds (2nd-degree)	Red (~650 nm) GaAs diode[11]	— (100 mW device, non-contact scanning)[12]	~4 J/cm^2[12]	~2×/week (≥3-day intervals) until healed[11]; ~125 sec per treatment covering burn area[12] (on average ~3–4 sessions for superficial burns)	Achieved markedly faster re-epithelialization: superficial second-degree burns healed in ~11–12 days on average with LLLT (vs ~2–3 weeks normally). Patients treated with 650 nm LLLT showed reduced infection and an accelerated healing timeline, with no reported adverse effects (Gupta et al., 2018).

Wound Type	Recommended Wavelength(s)	Power Density (mW/cm^2)	Energy Dose (J/cm^2)	Session Frequency & Duration	Application Notes / Outcomes
Skin Lesions (General wounds/ulcers)	Visible red (600–700 nm) or NIR (800–900 nm)[15]	~5–50 mW/cm^2[15]	~1–4 J/cm^2[15]	Typically 2–3×/week (or even daily for acute lesions) for several weeks or until healed (depending on lesion severity)	Appropriate LLLT dosing in this range has been most effective at stimulating tissue repair – promoting collagen synthesis, angiogenesis and faster wound closure. Studies indicate that using these parameters, LLLT can significantly enhance healing rates of various skin wounds (e.g. venous or leprosy ulcers) compared to standard care (Taha et al., 2024; Woodruff et al., 2004).

Table 2: LLLT Parameters for Musculoskeletal Injury Applications

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm^2)	Energy Dose (J/cm^2)	Session Frequency & Duration	Application Notes / Outcomes
Tendinopathies (e.g. Achilles tendinitis, lateral epicondylitis)	NIR (780–860 nm) or 904 nm[16]	<100 mW/cm^2 (for superficial tendons)[17] *(up to ~600 mW/cm^2 for deep tendons)*[16]	~4–8 J per point (total dose per tendon in range 4–8 J)[16] *(deeper tendon protocols use ~3–9 J)*[16]	Daily for ~2 weeks, or every other day for 3–4 weeks[18] (typical treatment course ~6–12 sessions); apply to multiple points along the tendon (cover lesion area)	Proven to reduce chronic tendon pain and improve function when proper dose used. A 2022 meta-analysis found LLLT significantly reduced pain (~15 mm on 100 mm VAS) and disability in Achilles, patellar, and plantar tendinopathies in the short-to-medium term. Dosage matters: using at least ~2 J/point (904 nm) or equivalent yields

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm^2)	Energy Dose (J/cm^2)	Session Frequency & Duration	Application Notes / Outcomes
					superior outcomes. No adverse effects reported in trials (Naterstad et al., 2022; World Association for Laser Therapy, 2010).
Muscle Strains (tears, muscle injuries)	Red or NIR (660 nm for superficial, 808–830 nm for deeper muscle)[21]	~50–100 mW/cm^2 (moderate intensity for penetration)	~4–8 J/cm^2 per site (some protocols up to ~10–20 J for large muscle groups)[22]	Daily or alternate days for 1–2 weeks (acute phase); 1–2 min irradiation per point (depending on power) over injured muscle belly	Mixed evidence; LLLT may accelerate muscle recovery and reduce soreness. Some studies show improved muscle performance and faster post-exercise recovery with LLLT[23]. However, in acute muscle tears, not all trials show faster return-to-play – e.g. one RCT found similar rehab time (~23 days vs 24 days) with or without LLLT[24]. Optimal timing (immediate post-injury) and adequate energy seem key to efficacy in muscle healing.
Joint Pain / Osteoarthritis (e.g. knee OA, chronic joint disorders)	NIR (780–904 nm)[25]	~100 mW/cm^2 (for small/medium joints) *(up to 600 mW/cm^2*	~4 J per point (treat multiple spots; e.g. ~8–12 J	~3×/week for 3–6 weeks (8–15 treatments typical);	When applied within recommended dose ranges, LLLT produces significant

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
		for large joints like shoulder)[16]	total to cover a knee joint)[26]	~30–60 sec per point around the joint	analgesic effects in chronic joint conditions. A review found ~30 mm VAS greater pain reduction in chronic knee/TMJ/neck joints with LLLT vs placebo (when using optimal dosing). Follow-up analyses noted that trials adhering to WALT dose guidelines saw consistently better pain relief outcomes. Patients often report improved joint function and reduced stiffness after a course of LLLT, though results can vary with severity and technique (Dima et al., 2017).
Ligament Sprains (e.g. acute ankle sprain)	IR laser (904 nm GaAs superpulsed, or 820 nm diode)[29][30]	Low average irradiance (e.g. ~40 mW/cm² avg. with pulsed 25 W peak)[30]	~0.5–5 J/cm² per treatment area (doses in this range have been tested)[31]	Daily treatments for 1–2 weeks; in some studies, 2×/day in first 3 days post-injury for anti-inflammatory effect[32]. Usually	Some evidence of expedited acute recovery: one study (47 athletes) showed that adding LLLT (820 nm, ~40 mW, pulsed) to RICE significantly reduced edema volume at 24–72 h post grade II ankle sprain vs RICE alone. However,

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm^2)	Energy Dose (J/cm^2)	Session Frequency & Duration	Application Notes / Outcomes
				combined with standard acute care (RICE).	high-quality trials have found no significant improvement in pain or long-term function over placebo – in one RCT, neither low nor high dose 904 nm LLLT improved outcomes, and the placebo group even had slightly better early functional scores. Thus, LLLT for sprains may aid inflammation reduction (swelling), but its impact on overall recovery is still inconclusive (Stergioulas, 2004; de Bie et al., 1998).
Soft Tissue Trauma (contusions, bruises, hematomas)	Red/NIR (e.g. 808–904 nm for deeper tissue penetration)[35]	~50–150 mW/cm^2 (moderate-high intensity)	~4–6 J/cm^2 per area (acute phase dosing)	Daily treatments during acute phase (first 3–5 days post-injury); brief irradiations (1–3 min) over injured area	LLLT can mitigate acute inflammatory reactions in soft-tissue injuries. Light at 800–900 nm has been shown to decrease edema formation and hemorrhage, reduce oxidative stress markers, and provide analgesia when applied soon after trauma. Clinically,

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm^2)	Energy Dose (J/cm^2)	Session Frequency & Duration	Application Notes / Outcomes
					this can translate to quicker resolution of bruising and pain. Early photobiomodulation is considered a useful adjunct to standard care for minimizing tissue damage in contusions (with essentially no side-effects) (Woodruff et al., 2004).

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Appendix B~~A~~

Laser Classification and Safety Guide

~~A concise r~~Reference for laser safety, classifications, and required PPE in clinical and technical environments.

Class 3R	Medium-power (1–5 mW). Direct eye exposure potentially hazardous but low probability of injury under short exposure.	Some presentation pointers, low-power therapeutic lasers.	Avoid eye exposure; use OD-rated goggles when aligning beams; restrict access during use.
Class 3B	Moderate power (5–500 mW). Direct or specular reflection can cause retinal injury; diffuse reflection typically safe. (ANSI Z136.1-2020; IEC 60825-1:2014).	Physiotherapy and podiatric LLLT units (e.g., Erchonia EVRL 635 nm). (FDA, 2023).	Protective eyewear required for operator and patient; controlled area and non-reflective instruments; warning signage required. (Laser Institute of America, 2023).
Class 4	High-power (> 500 mW). Dangerous to eyes and skin from direct or diffuse reflections; may ignite materials and produce plume. (ANSI Z136.1-2020; IEC 60825-1:2014).	Surgical, dermatologic, dental, and podiatric lasers (e.g., Nd:YAG 1064 nm, CO_2 10.6 µm, Diode 980 nm). (FDA, 2023).	Mandatory OD-rated eyewear, plume evacuation (N95 or ULPA filter), warning signage, restricted access, remove reflective jewelry, ensure flammables are cleared, operator trained in Class 4 laser safety. (Laser Institute of America, 2023).

~~Class 3B~~	~~Moderate power (5–500 mW). Direct or specular reflection can cause retinal injury; diffuse reflection typically safe.~~	~~Physiotherapy and podiatric LLLT units (e.g., Erchonia EVRL 635 nm).~~	~~Protective eyewear required for operator and patient; controlled area and non-reflective instruments; warning signage required.~~
~~Class 4~~	~~High-power (> 500 mW). Dangerous to eyes and skin from direct or diffuse reflections; may ignite materials and produce plume.~~	~~Surgical, dermatologic, dental, and podiatric lasers (e.g., Nd:YAG 1064 nm, CO_2 10.6 µm, Diode 980 nm).~~	~~Mandatory OD-rated eyewear, plume evacuation (N95 or ULPA filter), warning signage, restricted access, remove reflective jewelry, ensure flammables are cleared, operator trained in Class 4 laser safety.~~

APPENDIX A

Sample Laser Safety Checklist

✓	PROCEDURE	NOTES (MUST BE INITIALED BY OPERATOR)
	Record laser type to be used?	
	Who is the laser operator?	
	Laser Safety goggles – available and 'OK' for use?	
	OD label on goggles adequate?	
	Correct wavelength on goggles?	
	Have "Warning" notices been posted?	
	Laser area secure?	
	Permanent location of 'safety key'?	
	Name person holding 'safety key'?	
	Patient protection performed?	
	Emergency contact?	
	Anaesthetic machine has been inspected?	
	Fire Extinguisher, water available if fire?	
	Operator's Manual available?	
	Contact information of manufacturer?	
	Preventative maintenance current?	
	Smoke evacuation working?	
	Masks available?	
	Emergency shutdown procedure posted?	
	Laser treatment area clear of unauthorized personnel?	

APPENDIX B

Laser Plume Contents, Sources, Potential Health, and Safety Hazards, & Control Measures

Laser Plume Content	Source	Potential Health and Safety Hazard	Controls
Dust	Procedures using CO_2 lasers	- Lung damage	- Appropriate masks - Plume scavenging systems (PSS)
Toxic Chemicals*	Laser beam contact with human or animal tissues, plastics, perfluoro-polyethylene polymer (e.g., Teflon), coated products	- Fire - Irritation - Carcinogenic, mutagenic and teratogenic potential	- Respiratory protection suitable for plume composition - Plume scavenging systems (PSS)
Biological Agents	Laser beam contact with tumours, HIV, culture medium, bacteria, warts, treated skin	- Infection	- Respiratory protection suitable for plume composition - Protective clothing and gloves - Plume scavenging systems (PSS)
Smoke (general)	Laser beam vaporization, incision, CO_2 laser beam contact with skin	- Respiratory damage - Eye damage - Irritation - Obstruction of workers' field of vision	- Scavenging of smoke near the source - Suitable eye and respiratory protection

** Toxic Chemicals can include: benzene, formaldehyde, acrolein, aldehydes, polycyclic aromatic hydrocarbons, cyanides, and methane hydrogen cyanide.*

APPENDIX C

Sample Laser Utilization Record

Fotona XP 1064nm Nd YAG Laser Serial Number:

Hand-Piece Serial Number:

Date	**Patient**	**Operator & Room**	**Procedure:** *VP, O.Myc, Other*	**Parameters:** *Power (Watts), Energy (Joules), Pulse width, Frequency. Pulses delivered*	**Signature**	**Shutdowns** *Y/N* **

** Attach separate notes to detail

APPENDIX D

Sample Laser Accident And Malfunction Report Form

Laser: Model #: Date Purchased:

Wavelength and power at time of incident:

Date Reported: Date of Incident:

PERSONNEL IN THE NOMINAL HAZARD ZONE

Investigator:

FACTUAL DESCRIPTION OF INCIDENT:

MEDICAL FOLLOW-UP:

LSO: Date Reviewed:
(Signature)

APPENDIX E

Commonly Used Lasers in Health Care

Type	Radiation Type/Wavelength in Nanometres (nm)	Examples of Application
Carbon dioxide (gas laser)	Infrared/ 10,600	Surgery: Incision and excision by vaporization
Argon (gas laser)	Visible, blue/ 488	Sealing blood vessels in retina, plastic surgery
Argon (gas laser)	Visible, green/ 514	Sealing blood vessels in retina, plastic surgery
Krypton KPT 532 (gas laser)	Visible, green/ 532	Surgery: Cutting, coagulation, and vaporization of tissues
Nd:YAG* (continuous wave - solid state laser)	Infrared/ 1,064	General surgery
Nd:YAG* (Q-switched - solid state laser)	Visible, red/ 632	Ophthalmology: cutting tissues
Helium-Neon (gas laser)	Visible, red/ 632	Alignment: for aiming invisible beams
Ruby (solid state laser)	Visible, red/ 694	Plastic surgery, Dermatology: Destroying tissues
Rhodamine 6G Dye (Tunable - dye laser)	Visible/ 570-650	Treatment of malignant tissues; red (630 nm) commonly used

*Neodymium-doped Yttrium Aluminum Garnet

APPENDIX F

MPE Limits for Selected Surgical/Medical Lasers

Laser Type	Wavelength (nm)	Exposure Time (seconds)			
		0.25*	10**	600***	30,000****
		MPE ($mW \cdot cm^{-2}$)			
ArF	193	--	--	--	0.0001
XeCl	308	--	--	--	0.0013
XeF	351	--	--	--	0.0333
Argon	514	2.5	--	0.0167	0.001
Krypton	530 568 647	2.5 2.5 2.5	--	0.0167 0.031 0.363	0.001 0.00186 0.0285
Dye Laser [a]	630	2.5	--	0.263	0.0158
He-Ne	633	2.5	--	0.293	0.0176
GaAs (CW) (diode)	840	--	1.9	0.69	0.610
Nd:YAG Q-switched [b]	1064	--	0.017	0.0061	0.0023
Nd:YAG (CW)	1064	--	5.1	1.82	1.6
Nd:YAG (CW)	1330	--	40	14.5	13
CO_2	10,600	--	100	100	100

[a] Argon laser pumped Rhodamine 6-G dye laser used in PDT therapy.

[b] Repetitively pulsed @ 11 Hz, 12 ns pulses.

* Aversion response time.

** Unintentional viewing at wavelengths greater than 700 nm, with no visible component.

*** Intentional viewing of diffuse reflections from small sources (less than α_{min}). **** Cumulative exposure, 8-hour working day.

Appendix ~~C~~B

COMPARISON ~~CHART~~ OF LASER THERAPIES FOR ONYCHOMYCOSIS

This~~e~~ table ~~below~~ compares the main laser types ~~employed~~used in clinical practice, including their classification: (For Reference Only)

Laser Type	**Laser Class & Wavelength**	**Regulated Devices (FDA/CE-Cleared Examples)**	**PPE and Safety Requirements**	**Contraindications**
Nd:YAG Laser (1064 nm)	Class IV (high-power); 1064 nm (near-infrared)[3][4] Deep tissue penetration (targets nail bed)	Multiple FDA-cleared 1064 nm Nd:YAG systems (since 2010): e.g. **PinPointe™ FootLaser** (NuvoLase), **Cutera GenesisPlus™**, **Sciton JOULE ClearSense™**, **Candela GentleMax™**, etc.[5]	**Class IV** laser precautions: all present must wear **1064 nm protective eyewear** (invisible beam)[3]; avoid direct beam exposure to eyes/skin (burn hazard). Non-ablative (no plume), but a **warming sensation** may be felt during treatment[6].	**Not advised in**: Pregnancy (safety unproven)[7]; patients with **peripheral neuropathy or poor circulation** (risk of burns, impaired healing)[8]; **active nail bed infections or trauma** (wait until resolved)[9]. Use caution in immunocompromised patients (response may be reduced)[10].

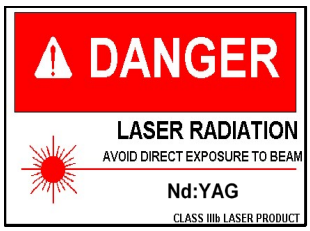
Diode Lasers (810–980 nm)	Class IV (high-power); typically 810–980 nm (near-IR spectrum)[11] Often used in dual wavelengths (e.g. 870/930 nm)	**Noveon®** dual-wavelength laser (870/930 nm diode) and **HyperBlue 1530** multiuse diode laser are examples of cleared systems[2][12]. Others include various 810 nm or 980 nm podiatry diode lasers (FDA product code GEX).	**Class IV** safety as above: require appropriate **protective goggles** for 810–980 nm; no reflective objects or jewelry during use. These lasers emit heat to kill fungus[13], so use **skin cooling or pulsed modes** to prevent burns. **No significant plume** unless used at high settings or to ablate.	**Similar to Nd:YAG** – avoid in **pregnant** patients[7]; use caution in **diabetic neuropathy or vascular insufficiency** (reduced pain sensation and healing)[8]. Ensure nail bed has no open wounds or severe inflammation. If using in combination with photosensitizing drugs (e.g. for photodynamic therapy), follow specific contraindications of that protocol.
CO_2 Lasers (10,600 nm)	Class IV (surgical laser); 10,600 nm (far-infrared) – strongly absorbed by water, **ablative** action on nail[14]	Certain fractional **CO_2 laser systems** (originally for skin surgery) have FDA clearance for temporary clear nail increase[15][14]. *Examples:* medical CO_2 lasers used in podiatry/dermatology (e.g. Lumenis Ultrapulse® CO_2) to drill microchannels or thin the nail plate for antifungal treatment.	**Class IV / ablative** laser precautions: **protective eyewear** for 10.6 µm (typically polycarbonate shields) for everyone in the room. Use a **smoke evacuator and high-filtration mask** – ablating nail can release fungal spore-	**Contraindicated in patients with poor wound healing** or **severe peripheral vascular disease** (ablative laser creates tissue injury that may not heal well)[8]. **Not for use on pregnant** patients (no studies). Avoid treating nails with **active bacterial infection** or cellulitis until resolved (to prevent spreading via plume). Use caution if patient has very

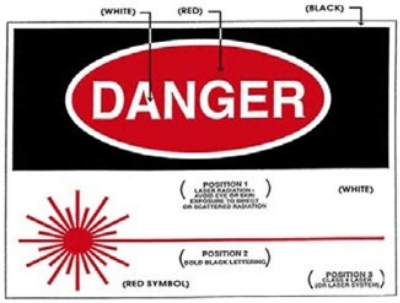
			laden plume[16]. Operate in a controlled area (laser warning signage); avoid flammable materials (alcohol prep must dry.	thin nails or minimal nail plate (to avoid excessive bed injury).
Lunula Laser (405 + 635 nm)	Class II laser device; dual-wavelength low-level laser (non-thermal phototherapy) – 405 nm (violet) + 635 nm (red)[3]	**Erchonia LunulaLaser®** – first and only **non-thermal** "cold" laser cleared by FDA for onychomycosis (uses 405/635 nm simultaneously)[17]. CE-marked in EU (Class 2a medical device)[18]. No other laser in this category (unique LLLT device for nails).	**Low-level laser (Class II)** – **minimal PPE** needed. Device includes safety glasses, but risk of eye injury is low (visible low-power beams)[19]. **No heat or burning** – completely painless[3]. No smoke/plume generated (no tissue ablation). Can be operated unattended once properly set up[20].	**No known significant contraindications** – the Lunula is very safe (no reported side effects)[6]. Standard precautions apply: it is generally recommended to avoid elective laser therapy during **pregnancy** due to lack of research[7]. Patients with **photosensitivity** disorders or on photosensitizing medications should use caution (405 nm is within visible spectrum).
~~**Laser Type**~~	~~**Laser Class & Wavelength**~~	~~**Regulated Devices (FDA/CE-Cleared Examples)**~~	~~**PPE and Safety Requirements**~~	~~**Contraindications**~~
~~**Nd:YAG Laser (1064 nm)**~~	~~Class IV (high-power); 1064 nm (near-infrared)[3][4] De~~	~~Multiple FDA-cleared 1064 nm Nd:YAG systems~~	~~**Class IV** laser precautions:~~	~~**Not advised in:** Pregnancy (safety unproven)[7];~~

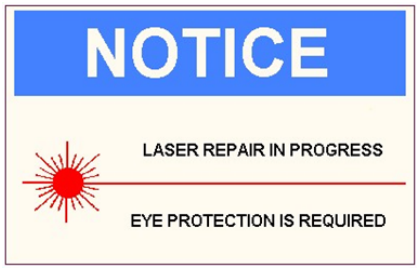
	ep tissue penetration (targets nail bed)	(since 2010): e.g. **PinPointe™ FootLaser** (NuvoLase), **Cutera GenesisPlus™, Sciton JOULE ClearSense™, Candela GentleMax™,** etc.[5]	all present must wear **1064-nm protective eyewear** (invisible beam)[3]; avoid direct beam exposure to eyes/skin (burn hazard). Non-ablative (no plume), but a **warming sensation** may be felt during treatment[6].	patients with **peripheral neuropathy or poor circulation** (risk of burns, impaired healing)[8]; **active nail bed infections or trauma** (wait until resolved)[9]. Use caution in immunocompromised patients (response may be reduced)[10].

APPENDIX DCAG

SAMPLE ANSI Z535 COMPLIANT LASER SAFETY SIGNS







~~**Glossary/ Definitions**~~

~~**ALARA -** as Low as Reasonably Achievable~~

~~**ANSI:** the American National Standards Institute - a private, non-profit organization that administers the US voluntary standardization and conformity assessment system.~~

Authorized personnel: Individuals approved by management (business owner) to operate, maintain, service or install laser equipment.

Baseline eye examination: an eye examination that used to establish a basis for comparison in the event of an accidental laser injury.

Beam: the pulsed or continuous output from a laser.

Cataract: clouding of the lens of the eye.

College or COCOO - College of Chiropodists of Ontario

Coherent: a beam of light characterized by a fixed phase relationship or single wavelength (i.e. monochromatic).

Danger: indicates an imminently hazardous situation which, if not avoided, will result in death or serious injury e.g. retinal burn from direct exposure to the laser beam

Diffuse reflection: change of the spatial distribution of a beam of radiation when it is reflected from a rough surface in many directions

Direct beam: the output beam from the laser, prior to any reflection or absorption.

Electromagnetic radiation: the flow of energy at the speed of light in the form of electric and magnetic fields. Gamma rays, X-ray, ultraviolet, visible, infrared, and radio waves occupy various portions of the electromagnetic spectrum and differ only in frequency, wavelength, and photon energy.

Health-care laser - Any laser product designed, manufactured, intended, or promoted for the purposes of diagnostic, surgical, aesthetic, or therapeutic laser irradiation of any part of the human body

Incidental personnel: those whose work makes it possible (but unlikely) that they will be exposed to laser energy sufficient to damage their eyes or skin (i.e. clerical or supervisory personnel who do not work directly with lasers).

Infrared radiation (IR): invisible radiation wavelengths from about 700 nm to 1,000,000 nm (1 millimeter). Hair removal lasers operate between 700 and 1400 nm.

Irradiance: the radiant power incident per unit area upon a surface, expressed in W/cm^2 (Symbol: E).

Joule (J): the unit used to measure the energy of a laser pulse.

kW/cm^2: a kilowatt per square centimetre [see Watt].

Laser: acronym for Light Amplification by Stimulated Emission of Radiation.

Laser controlled area: an area that is appropriately enclosed so that no laser radiation above the maximum permissible exposure inadvertently escapes to injure unsuspecting persons. This area is subject to the control and supervision of the laser safety officer and must contain the nominal hazard zone (NHZ) unless special safety features are incorporated into the room.

Laser personnel: those who work routinely in the laser environment and are normally fully protected by engineering controls and/or administrative procedures (i.e. operators or service providers).

Laser safety officer (LSO): a person who is authorized by management (business owner) to be responsible for the laser safety program in the facility. The LSO is responsible for monitoring and overseeing the control of laser hazards.

Light: electromagnetic radiation having wavelengths between approximately 400 to 700 nm and which are perceptible to human vision (aka "visible light").

Melanin: a group of naturally occurring dark pigments found in skin and hair which absorb infrared laser radiation.

Maximum Permissible Exposure (MPE): the level of laser radiation to which an unprotected person may be exposed without adverse biological changes in the eye or skin i.e. injury

Member: Registered member of the College of Chiropodists of Ontario' including BOTH the Chiropodist and Podiatrist class of registrant

Nanometers (nm): a unit of length equal to one thousand millionth of a meter (10-9 m) and used in the measure of wavelengths of optical radiation i.e. ultraviolet, visible, and infrared radiation.

Nd:YAG: notation for one of the lasing media in some lasers which produces the infrared radiation i.e. neodymium: yttrium-aluminum-garnet.

Nominal Hazard Zone (NHZ): the space within which the level of the direct, reflected, or scattered radiation during normal operation exceeds the applicable maximum permissible exposure. This zone is usually smaller than and within the laser controlled area.

Nominal ocular hazard area (NOHA): The area within which the beam irradiance or radiant exposure exceeds the appropriate corneal maximum permissible exposure (MPE), including the possibility of accidental misdirection of the laser beam.

Optical density (OD): a material's ability to absorb laser radiation, as used in protective eyewear.

OD number: a measure of the safety of protective eyewear by how much the laser radiation is reduced when it passes through the protective eyewear.

Radiation: Emission and propagation of energy in the form of particles or waves.

Retina: The delicate multilayered light-sensitive membrane lining the inner posterior chamber of the eyeball that contains the rods and cones, and is connected by the optic nerve to the brain.

Risk assessment: A thorough analysis of potential risks and hazards (beam and non-beam) associated with the use of health-care lasers; the process of risk assessment includes: a. identification of physical, chemical, and biological hazards based on tissue interaction, dosimetry, delivery system, and practice setting, b. analysis or evaluation of the risks associated with

those hazards, c. determination of appropriate control measures to eliminate or control the hazards.

Specular reflection: change of the spatial distribution of a beam of radiation when it is reflected from a mirror-like surface in one direction

Visible light: electromagnetic radiation having wavelengths between approximately 400 and 700 nm and which are perceptible to human vision (aka "light").

Wavelength: The distance between one peak or crest of a wave of light or other electromagnetic radiation and the next corresponding peak or crest. nm or- λ

Watt/cm^2: a watt per square centimetre.

Watt (W): a unit of power equal to one joule per second.

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ITEM

College of Chiropodists of Ontario

LASER

Guideline for Registrants of the College of Chiropodists of Ontario

Approved by Council: February 24, 2017

Revised and Updated: XX

INDEX

Purpose

This document sets out guidance to support the safe and effective use of lasers by College registrants. It emphasizes best practices, safety precautions, and compliance with regulatory requirements for laser types commonly used in chiropody and podiatry.

Refer to **Appendix A: Laser Classification and Safety Guide** for a general listing of laser types used by registrants.

Low Level Laser Therapy (LLLT) – Class 3B Laser

Also called **photobiomodulation**, LLLT uses red or near-infrared (NIR) light to reduce pain and inflammation and promote tissue healing.

See **Appendix B:** LLT Parameter Indications for Wound Healing and Musculoskeletal Injuries.

Applications:

- Musculoskeletal therapy
- Inflammation reduction
- Wound healing.

Assignment:

- May be assigned according to the College's **Assignment, Orders and Delegation Policy**.
- If not treating the patient directly, the registrant must perform pre- and post-treatment checks.
- Registrants must specifically obtain and document patient consent to assignment of the procedure being performed by someone other than the registrant.

Training:

- Registrants must have appropriate training to administer LLLT safely.

Personal Protective Equipment (PPE):

- Wavelength-specific protective goggles required for both patient and practitioner.

Documentation:

- Signed informed consent
- Charting must include: type of laser, wavelength, power density, location of application and session duration. Note any adverse effects or clinical findings.

Protocol:

- Post a laser warning sign
- Ensure patient keeps laser safety glasses on until treatment is over.

Refer to **Appendix A** B: LLLT Parameter Indications for Wound Healing and Musculoskeletal Injuries.

Fungal Nail Laser Therapy – Class IV Laser

Laser therapy is used as an adjunct or alternative to antifungal drugs to treat onychomycosis.

Important:

- Some laser devices have obtained Health Canada approval to provide **temporary cosmetic improvement** in nail appearance (i.e. increased clear nail growth), not to cure fungal nail infections.
- Health Canada has clarified that, while some laser-based medical devices are licensed in Canada to temporarily increase the clarity of the nail in patients with a fungal nail infection, none have been licensed to cure these infections.
- Registrants must clearly communicate this to patients when obtaining informed consent before initiating treatment.

Refer to **Appendix C:** Comparison Chart of Laser Therapies for Onychomycosis.

Application:

- Improving the appearance of infected nail plates and nail beds, provided the treatment is medically necessary.

Assignment:

- May be assigned according to the College Assignment, Orders and Delegation Policy.
- Registrants must perform pre- and post-treatment checks with patient, if not treating the patient directly.
- Registrants must specifically obtain and document patient consent to assignment of the procedure being performed by someone other than the registrant.

Training:

- Registrants must ensure competence with the specific laser, understand contraindications, and know how to manage any adverse effects.

PPE:

- Laser specific protective goggles must be worn by everyone in the treatment room
- Gloves
- No plume is generating in this application

Documentation:

- Risks and benefits of the proposed treatment must be explained and documented, consistent with the College's Consent Guideline.
- Medical record must include: type of laser, wavelength, power density, location of application and session duration, and other such parameters, any adverse effects or clinical findings.

Protocol:

- Post laser warning sign
- Ensure patient wears safety glasses until treatment is over.
- Provided follow-up appointment.

Surgical Lasers - Class IV Laser

Application

- Cutting and ablation of soft tissue lesions (e.g., warts, nail root matrices).

Training

- Only registrants with demonstrated knowledge, skills and judgement for Class A procedures under the College's Surgical Competencies Standard, can use surgical lasers.
- Registrants must also have partial prescribing privileges.

Assignment

- Procedures must be performed by registrants.
- Assignment limited to supportive tasks, for example, attending to the plume evacuator equipment.

Hazards

- Eye Injury: High risk from direct/diffuse reflections.
- Skin/Tissue Burns: Significant risk requiring careful beam management.
- Laser Plume: Contains hazardous airborne materials.
- Fire Risk: Elevated near flammable materials.

PPE

- High optical density, wavelength-specific goggles.
- High-filtration (N95) masks mandatory.
- Flame-resistant attire; wet gauze or towels.
- Mandatory plume evacuation systems.

Protocol

- Comprehensive pre-surgery checklist.
- Emergency protocols (fire/misfire procedures).
- Informed consent has been obtained.

Regulatory and Legal Obligations

- Ontario OHSA: Appoint Laser Safety Officer; mandatory training.
- Health Canada: Licensed medical laser devices only.
- CSA Z386: Adhere to safety guidelines, training, PPE, signage.
- ANSI Z136.1/Z136.3: Compliance with Class 3B/4 safety standards.

Record-Keeping

- Maintain accurate logs of servicing and maintenance.
- Document equipment safety checks.

Incident Management

- Complete formal incident reports immediately.

Appendix A

Laser Classification and Safety Guide

Reference for laser safety, classifications, and required PPE in clinical and technical environments.

Class 3R	Medium-power (1–5 mW). Direct eye exposure potentially hazardous but low probability of injury under short exposure.	Some presentation pointers, low-power therapeutic lasers.	Avoid eye exposure; use OD-rated goggles when aligning beams; restrict access during use.
Class 3B	Moderate power (5–500 mW). Direct or specular reflection can cause retinal injury; diffuse reflection typically safe. (ANSI Z136.1-2020; IEC 60825-1:2014).	Physiotherapy and podiatric LLLT units (e.g., Erchonia EVRL 635 nm). (FDA, 2023).	Protective eyewear required for operator and patient; controlled area and non-reflective instruments; warning signage required. (Laser Institute of America, 2023).
Class 4	High-power (> 500 mW). Dangerous to eyes and skin from direct or diffuse reflections; may ignite materials and produce plume. (ANSI Z136.1-2020; IEC 60825-1:2014).	Surgical, dermatologic, dental, and podiatric lasers (e.g., Nd:YAG 1064 nm, CO_2 10.6 µm, Diode 980 nm). (FDA, 2023).	Mandatory OD-rated eyewear, plume evacuation (N95 or ULPA filter), warning signage, restricted access, remove reflective jewelry, ensure flammables are cleared, operator trained in Class 4 laser safety. (Laser Institute of America, 2023).

Appendix B

LLLT Parameter Indications for Wound Healing and Musculoskeletal Injuries

Table 1: LLLT Parameters for Wound Healing Applications

Wound Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
Diabetic Foot Ulcer	Red (~660 nm) or NIR (~890 nm)[1]	~50 mW/cm²[2]	~2 J/cm²[2]	e.g. daily or 3×/week; ~30 sec irradiation per point (non-contact, ~1 cm from wound)[2][3]; typically continued for several weeks (up to 8–12+ weeks) or until closure[3]	Significantly accelerates healing: meta-analysis shows LLLT doubled complete ulcer healing rate and reduced ulcer area/time to closure vs controls[4]. No adverse effects reported; effective as adjunct to standard wound care in chronic non-healing DFUs[4].
Pressure Ulcer (Bed Sore)	Red (~650 nm) diode[5]	*N/A* (100 mW output in scanning mode)[6] *(≈30–50 mW/cm²)*	~4 J/cm²[6]	~2×/week (every 3 days) for ~4 weeks; ~125 sec per session covering wound bed (non-contact scanning)[5] (≈6 sessions total)	Improved wound bed granulation and reduced slough noted; after 6 LLLT sessions the chronic ulcer bed was well-prepared for closure (healthy granulation tissue)[7]. No infections or adverse effects observed during LLLT course[8].

Wound Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
Surgical Wounds (Incisions & Scars)	Red (660 nm) or NIR (~830 nm) laser[9][10]	<100 mW/cm² (low-level, non-thermal)	~4–6 J/cm² per treatment[9][10]	Typically 3×/week for ~3–4 weeks post-op[9] (or daily for 1–2 weeks in some protocols[10]); ~60 sec irradiation per point along incision line[9] (multiple spots to cover entire scar)	Shown to promote faster incision healing and improved scar outcomes. For example, 660 nm LLLT thrice-weekly for 4 weeks significantly enhanced median sternotomy wound healing vs control[9]. Similarly, 830 nm LED therapy has been used to reduce post-thyroidectomy scar formation (better cosmetic scar appearance vs sham)[10].
Burn Wounds (2nd-degree)	Red (~650 nm) GaAs diode[11]	— (100 mW device, non-contact scanning)[12]	~4 J/cm²[12]	~2×/week (≥3-day intervals) until healed[11]; ~125 sec per treatment covering burn area[12] (on average ~3–4 sessions for superficial burns)	Achieved markedly faster re-epithelialization: superficial second-degree burns healed in ~11–12 days on average with LLLT[13] (vs ~2–3 weeks normally[14]). Patients treated with 650 nm LLLT showed reduced infection and an accelerated healing timeline, with no reported adverse effects[13].
Skin Lesions (General wounds/ulcers)	Visible red (600–700 nm) or NIR (800–900 nm)[15]	~5–50 mW/cm²[15]	~1–4 J/cm²[15]	Typically 2–3×/week (or even daily for acute lesions) for several weeks or until healed (depending on lesion severity)	Appropriate LLLT dosing in this range has been most effective at stimulating tissue repair[15] – promoting collagen synthesis, angiogenesis and faster wound closure. Studies indicate that using these parameters, LLLT can significantly enhance healing rates of various skin wounds (e.g. venous or leprosy ulcers) compared to standard care[15].

Table 2: LLLT Parameters for Musculoskeletal Injury Applications

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
Tendinopathies (e.g. Achilles tendinitis, lateral epicondylitis)	NIR (780–860 nm) or 904 nm[16]	<100 mW/cm² (for superficial tendons)[17] *(up to ~600 mW/cm² for deep tendons)*[16]	~4–8 J per point (total dose per tendon in range 4–8 J)[16] *(deeper tendon protocols use ~3–9 J)*[16]	Daily for ~2 weeks, or every other day for 3–4 weeks[18] (typical treatment course ~6–12 sessions); apply to multiple points along the tendon (cover lesion area)	Proven to reduce chronic tendon pain and improve function when proper dose used. A 2022 meta-analysis found LLLT significantly reduced pain (~15 mm on 100 mm VAS) and disability in Achilles, patellar, and plantar tendinopathies in the short-to-medium term[19]. *Dosage matters:* using at least ~2 J/point (904 nm) or

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
					equivalent yields superior outcomes[20]. No adverse effects reported in trials[19].
Muscle Strains (tears, muscle injuries)	Red or NIR (660 nm for superficial, 808–830 nm for deeper muscle)[21]	~50–100 mW/cm² (moderate intensity for penetration)	~4–8 J/cm² per site (some protocols up to ~10–20 J for large muscle groups)[22]	Daily or alternate days for 1–2 weeks (acute phase); 1–2 min irradiation per point (depending on power) over injured muscle belly	Mixed evidence; LLLT may accelerate muscle recovery and reduce soreness. Some studies show improved muscle performance and faster post-exercise recovery with LLLT[23]. However, in acute muscle tears, not all trials show faster return-to-play – e.g. one RCT found similar rehab time (~23 days vs 24 days) with or without LLLT[24]. Optimal timing (immediate post-injury) and adequate energy seem key to efficacy in muscle healing.
Joint Pain / Osteoarthritis (e.g. knee OA, chronic joint disorders)	NIR (780–904 nm)[25]	~100 mW/cm² (for small/medium joints) *(up to 600 mW/cm² for large joints like shoulder)*[16]	~4 J per point (treat multiple spots; e.g. ~8–12 J total to cover a knee joint)[26]	~3×/week for 3–6 weeks (8–15 treatments typical); ~30–60 sec per point around the joint	When applied within recommended dose ranges, LLLT produces significant analgesic effects in chronic joint conditions. A review found ~30 mm VAS greater pain reduction in chronic knee/TMJ/neck joints with LLLT vs placebo (when using optimal dosing)[27]. Follow-up analyses noted that trials adhering to WALT dose guidelines saw consistently better pain relief outcomes[28]. Patients often report improved joint function and reduced stiffness after a course of LLLT, though results can vary with severity and technique.
Ligament Sprains (e.g. acute ankle sprain)	IR laser (904 nm GaAs superpulsed, or 820 nm diode)[29][30]	Low average irradiance (e.g. ~40 mW/cm² avg. with pulsed 25 W peak)[30]	~0.5–5 J/cm² per treatment area (doses in this range have been tested)[31]	Daily treatments for 1–2 weeks; in some studies, 2×/day in first 3 days post-injury for anti-inflammatory effect[32]. Usually combined with standard acute care (RICE).	Some evidence of expedited acute recovery: one study (47 athletes) showed that adding LLLT (820 nm, ~40 mW, pulsed) to RICE significantly reduced edema volume at 24–72 h post grade II ankle sprain vs RICE alone[32]. However, high-quality trials have found no significant improvement in pain or long-term function over placebo – in one RCT, neither low nor high dose 904 nm LLLT improved

Injury Type	Recommended Wavelength(s)	Power Density (mW/cm²)	Energy Dose (J/cm²)	Session Frequency & Duration	Application Notes / Outcomes
					outcomes, and the placebo group even had slightly better early functional scores[33][34]. Thus, LLLT for sprains may aid inflammation reduction (swelling), but its impact on overall recovery is still inconclusive.
Soft Tissue Trauma (contusions, bruises, hematomas)	Red/NIR (e.g. 808–904 nm for deeper tissue penetration)[35]	~50–150 mW/cm² (moderate-high intensity)	~4–6 J/cm² per area (acute phase dosing)	Daily treatments during acute phase (first 3–5 days post-injury); brief irradiations (1–3 min) over injured area	LLLT can mitigate acute inflammatory reactions in soft-tissue injuries. Light at 800–900 nm has been shown to decrease edema formation and hemorrhage, reduce oxidative stress markers, and provide analgesia when applied soon after trauma[35]. Clinically, this can translate to quicker resolution of bruising and pain. Early photo biomodulation is considered a useful adjunct to standard care for minimizing tissue damage in contusions (with essentially no side-effects)[35].

Appendix C

Comparison of Laser Therapies for Onychomycosis (Fungal Nail Infections)

Note: All laser treatments for onychomycosis are intended to **increase clear nail growth** and reduce fungal burden, but reinfection remains possible[21]. Laser therapy is often used in conjunction with topical or oral antifungals for best results. Proper **eye protection and safety protocols** must be followed, especially with Class IV lasers, to prevent accidents. Always consult device-specific manuals for detailed safety and contraindication information. Several laser modalities have been used to manage onychomycosis. The table below compares the main laser types employed in clinical practice, including their classification, examples of FDA/CE-cleared devices, required safety measures, and key contraindications[1][2].

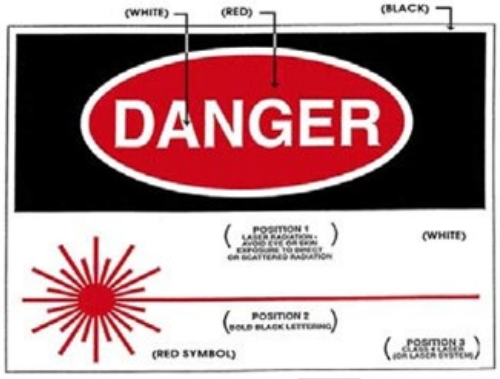
Laser Type	Laser Class & Wavelength	Regulated Devices (FDA/CE-Cleared Examples)	PPE and Safety Requirements	Contraindications
Nd:YAG Laser (1064 nm)	Class IV (high-power); 1064 nm (near-infrared)[3][4] Deep tissue penetration	Multiple FDA-cleared 1064 nm Nd:YAG systems (since 2010): e.g. **PinPointe™ FootLaser** (NuvoLase), **Cutera GenesisPlus™**,	**Class IV** laser precautions: all present must wear **1064 nm protective eyewear** (invisible beam)[3]; avoid direct beam exposure to	**Not advised in**: Pregnancy (safety unproven)[7]; patients with **peripheral neuropathy or poor circulation** (risk of burns, impaired healing)[8]; **active nail bed infections or trauma** (wait

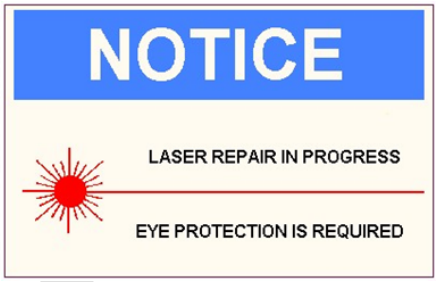
Laser Type	Laser Class & Wavelength	Regulated Devices (FDA/CE-Cleared Examples)	PPE and Safety Requirements	Contraindications
	(targets nail bed)	**Sciton JOULE ClearSense™**, **Candela GentleMax™**, etc.[5]	eyes/skin (burn hazard). Non-ablative (no plume), but a **warming sensation** may be felt during treatment[6].	until resolved)[9]. Use caution in immunocompromised patients (response may be reduced)[10].
Diode Lasers (810–980 nm)	Class IV (high-power); typically 810–980 nm (near-IR spectrum)[11] Often used in dual wavelengths (e.g. 870/930 nm)	**Noveon®** dual-wavelength laser (870/930 nm diode) and **HyperBlue 1530** multiuse diode laser are examples of cleared systems[2][12]. Others include various 810 nm or 980 nm podiatry diode lasers (FDA product code GEX).	**Class IV** safety as above: require appropriate **protective goggles** for 810–980 nm; no reflective objects or jewelry during use. These lasers emit heat to kill fungus[13], so use **skin cooling or pulsed modes** to prevent burns. **No significant plume** unless used at high settings or to ablate.	**Similar to Nd:YAG** – avoid in **pregnant** patients[7]; use caution in **diabetic neuropathy or vascular insufficiency** (reduced pain sensation and healing)[8]. Ensure nail bed has no open wounds or severe inflammation. If using in combination with photosensitizing drugs (e.g. for photodynamic therapy), follow specific contraindications of that protocol.
CO_2 Lasers (10,600 nm)	Class IV (surgical laser); 10,600 nm (far-infrared) – strongly absorbed by water, **ablative** action on nail[14]	Certain fractional **CO_2 laser systems** (originally for skin surgery) have FDA clearance for temporary clear nail increase[15][14]. *Examples:* medical CO_2 lasers used in podiatry/dermatology (e.g. Lumenis Ultrapulse® CO_2) to drill microchannels or thin the nail plate for antifungal treatment.	**Class IV / ablative** laser precautions: **protective eyewear** for 10.6 µm (typically polycarbonate shields) for everyone in the room. Use a **smoke evacuator and high-filtration mask** – ablating nail can release fungal spore-laden plume[16]. Operate in a controlled area (laser warning signage); avoid flammable materials (alcohol prep must dry fully).	**Contraindicated in patients with poor wound healing** or **severe peripheral vascular disease** (ablative laser creates tissue injury that may not heal well)[8]. **Not for use on pregnant** patients (no studies). Avoid treating nails with **active bacterial infection** or cellulitis until resolved (to prevent spreading via plume). Use caution if patient has very thin nails or minimal nail plate (to avoid excessive bed injury).
Lunula Laser (405 + 635 nm)	Class II laser device; dual-wavelength low-level laser (non-thermal phototherapy) – 405 nm (violet) + 635 nm (red)[3]	**Erchonia LunulaLaser®** – first and only **non-thermal** "cold" laser cleared by FDA for onychomycosis (uses 405/635 nm simultaneously)[17]. CE-marked in EU (Class 2a medical device)[18]. No other laser in this category (unique LLLT device for nails).	**Low-level laser (Class II)** – **minimal PPE** needed. Device includes safety glasses, but risk of eye injury is low (visible low-power beams)[19]. **No heat or burning** – completely painless[3]. No smoke/plume generated (no tissue ablation). Can be operated unattended once properly set up[20].	**No known significant contraindications** – the Lunula is very safe (no reported side effects)[6]. Standard precautions apply: it is generally recommended to avoid elective laser therapy during **pregnancy** due to lack of research[7]. Patients with **photosensitivity** disorders or on photosensitizing medications should use caution (405 nm is within visible spectrum).

Appendix D

SAMPLE ANSI Z535 COMPLIANT LASER SAFETY SIGNS

Laser warning signs





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COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.7

COUNCIL BRIEFING NOTE
RE: REVISIONS TO THE PATIENT RELATIONS STANDARD

Background:

The Standards and Guidelines Committee is undertaking a comprehensive review of the College's standards, guidelines, and policies to:

- Remove redundancies
- Update content to reflect best practices
- Modernize language (e.g. replacing "member" with "registrant," using they/them pronouns, active voice, and plain language)
- Standardize the format and presentation of College documents

As part of this work, the Patient Relations Standard has been revised to strengthen and clarify expectations related to communication, confidentiality, professional conduct and accountability, professional boundaries and the prevention of abuse.

At its October 2025 meeting, Council approved the proposed revisions in principle and directed that the draft be circulated for a 60-day consultation period. Feedback received during the consultation was reviewed by Council at its January 2026 meeting. Based on that feedback, Council directed that the draft be returned to the Standards and Guidelines Committee for further review and revision.

A newly revised Patient Relations Standard has now been prepared and is being brought forward for Council's consideration.

Public Interest Rationale for Decision:

Regular review and updating of standards ensures that they reflect current professional expectations and are clearly communicated. This supports the public interest by:

- Helping registrants understand their obligations for safe, ethical, and respectful practice
- Helping the public understand the standard they can expect from registrants

A strong Patient Relations Standard supports public protection by setting out expectations related to communication, professional boundaries, and respectful conduct in patient interactions.

Recommended Motion:

That Council approve the revised Patient Relations standard.

Mover: _____

Seconder: _____

Appendix A – revised Patient Relations Standard

Back to Agenda

PRACTICE STANDARD

College of Chiropodists of Ontario

Patient Relations

Approved by Council: DATE
Reviewed and Updated:

INDEX

Introduction

This Practice Standard sets out the College's expectations for registrants when interacting with **patients**. Registrants must treat patients with **respect**, dignity, fairness, and safety at all times, and must provide **patient-centered care**.

The Standard applies in all practice settings and throughout the practitioner-patient relationship, including in-person, online, and virtual interactions.

Registrants are expected to:

- Communicate clearly and respectfully.
- Protect patient privacy and confidentiality.
- Act professionally, ethically, and in accordance with the law.
- Maintain appropriate professional **boundaries;** and
- Protect patients from abuse.

Bolded terms are defined in the definition section at the end of this document.

Therapeutic Communication

Registrants must communicate respectfully and effectively to establish, maintain, and appropriately end professional relationships with patients.

Registrants meet the standard by:

1. Introducing themselves by name and professional designation.
2. Addressing patients using their preferred name, title and pronouns.
3. Communicating professionally in all formats, including in person, electronically, and on social media.
3. Giving patients enough time to explain their concerns and listening attentively, without minimizing their feelings or prematurely offering advice.
4. Being aware of how verbal and non-verbal communication may be perceived by patients.

5. Adjusting communication to meet patient needs, including language, literacy level, development stage, or cognitive ability.
    - If a registrant cannot communicate in a language the patient understands, reasonable efforts must be made to arrange for interpretation at future visits.
6. Providing clear and accurate information to support informed decision-making.
7. Avoiding personal self-disclosure unless it clearly serves a specific therapeutic purpose.
8. Reflecting on patient interactions and taking steps to continually improve communication.
10. Taking reasonable steps to ensure patients understand:
    - Assessment findings,
    - Clinical impressions,
    - Diagnoses (where authorized within the scope of practice),
    - Treatment options and plans, and
    - Expected outcomes.
11. Ending the therapeutic relationship appropriately by discontinuing services or transferring care in accordance with the Discontinuation of Services Guideline.

Confidentiality

Registrants must protect patient confidentiality at all times.

Registrants meet the standard by:

1. Not disclosing patient information unless directly related to care, with consent of the patient or the patient's authorized representative, or as required by law.
2. Conducting case discussions, consultations, examinations, and treatment occur in private settings.
3. Obtaining patient consent before allowing anyone not directly involved in care (including students) to be present during assessment or treatment.
4. Sharing only necessary information when consulting with colleagues.
5. Keeping patient records secure and confidential when in use and when stored.
6. Allowing access to patient health records only as authorized by law.
7. Maintaining private assessment and treatment areas, including:
    - Doors that separate treatment areas from public spaces.
    - Appropriate privacy for removing clothing.
8. Discussing patient information by phone or virtually in private locations.
9. Sharing patient information with other healthcare providers only in appropriate professional contexts.

Professional Conduct and Accountability

Registrants must meet all ethical and legal requirements of professional practice.

Registrants meet the standard by:

1. Practising in accordance with applicable legislation, regulations, and College's standards, guidelines and policies.
2. Being accountable for their actions and decisions.
3. Practising within the limits of their education, experience and scope of practice.
4. Not providing treatment that they know, or should know, is harmful, inappropriate or not clinically indicated.
5. Discontinuing treatment when it is no longer clinically indicated or effective**.**
6. Informing the College if a physical or mental condition or disorder has affected, or is likely to affect, their ability to practise safely or competently.
7. Acting in accordance with the Human Rights Code.
8. Avoiding unfair or unsubstantiated criticism of another registrant's qualification or care, except where required to protect patient safety.
9. Charging reasonable fees that reflect the service or devices provided.
10. Not charging for services that were not performed.
11. Not selling or transferring a professional account to a third party.
12. Fully cooperating with any investigation and respecting the confidentiality of the investigation.
13. Recognizing their position of influence in complaint, discipline or fitness to practise matters and not interfering with complainants or witnesses.
14. Complying with the mandatory reporting obligations under the Health Professions Procedural Code.[1] Additional guidance is available in the College's Mandatory Reporting Guide.
15. Understanding and meeting all self-reporting requirements.
16. Notifying the College of any changes to practice location, contact information, registration or licenses in another jurisdiction, or any other required information, by updating the online portal within 30 days.

Professional Boundaries

Registrants must establish and maintain professional **boundaries** to protect patients.

Registrants meet the standard by:

1. Setting clear boundaries and helping patients understand when requests and conduct fall outside the therapeutic or professional relationship.
2. Taking additional precautions in practice settings that create higher boundary risks, such as home visits.
3. Explaining procedures in advance and obtaining informed consent, especially when examinations extend beyond the foot. For example, biomechanical or dermatological assessments.
4. Not interfering with a patient's personal relationships.
5. Avoiding personal self-disclosure unless it meets a clear therapeutic purpose.
6. Managing **dual relationships** to avoid conflicts of interest or compromised judgment.
7. Never using patient information for personal, financial, or material gain.
8. Never engaging in financial transactions with patients or their families that are unrelated to care.

Gifts

[1] Health Professions Procedural Code (HPPC), Schedule 2 to the Regulated Health Professions Act, 1991 (RHPA).

Registrants must:

9. Not solicit gifts or donations or offer gifts to patients.
10. Not accept gifts of more than **nominal** value.
11. Use professional judgment to assess whether accepting a gift has the potential to blur boundaries.
12. Ensure that any accepted gift does not create expectations or alter the therapeutic relationship by influencing clinical decision-making or the standard of care.
13. Be aware that in some situations, refusing to accept a gift could offend the patient (for example, an expected practice in some cultures to offer a small gift as a gesture of appreciation) and harm the patient-practitioner relationship.
14. Decline a gift respectfully when appropriate.
15. Never offer or accept incentives or other benefits in exchange for referrals.
16. Consider developing a clear office policy on gift-giving and receiving.

Managing Dual Relationships with Patients

Registrants must:

17. Maintain professional boundaries and avoid friendships or social relationships with patients.
18. Carefully assess the risks of treating friends or family when no alternatives exist (for example, in small or remote communities)
19. Acknowledge dual roles when treating friends or family and transfer care to another health care provider when possible.
20. Manage the risks of creating a dual relationship with a patient and re-establish boundaries as necessary. For example, if a patient asks for treatment advice in a social or public setting, the conversation should be deferred to a scheduled clinic visit.
21. Avoid personal use of electronic communication and **social media** with patients. For example, registrants must refrain from connecting with patients, following patients, privately messaging patients, or accepting friend requests from patients on their personal social media accounts.
22. Consult colleagues when unsure about boundary issues.
23. Document any concerns about **boundary violations** in the patient record.
24. Avoid situations that may reasonably put patients at risk and act in the best interests of patients.

Protecting Patients from Abuse

Registrants must prevent, stop and report any form of discrimination and abuse.

Registrants meet the standard by:

1. Recognizing their position of trust and responsibility and ensuring that power is never abused.

Registrants must **never**:

2. Engage in physical, verbal, emotional, or non-verbal abuse towards a patient.

3. Communicate, verbally or non-verbally, with or about a patient in ways that may be perceived as disrespectful, discriminatory, insulting or humiliating.
4. Engage in behaviour or make comments towards a patient that may be perceived as violent, threatening or intended to cause physical, psychological, spiritual or emotional harm.
5. Fail to treat patients with respect in all interactions, including online and through **social media**.
6. Engage in activities that could result in an improper personal, financial, or material gain at the patient's expense.
7. Accept power of attorney for personal care or property for a patient or former patient, unless the patient is an immediate family member.
8. Influence, or attempt to influence, a patient's will or estate.

Intervention and Reporting

Registrants must:

9. Intervene and report abusive, threatening, or violent behaviour to the appropriate authorities, employers, the College and other regulatory authorities, when required.
10. Intervene and report behaviour or remarks that may be perceived as romantic, sexually suggestive, exploitative or sexually abusive.
17. Comply with the mandatory reporting obligations under the Health Professions Procedural Code.[2] Additional guidance is available in the College's Mandatory Reporting Guide.

Sexual Abuse

Registrants must **never**:

11. Engage in sexual intercourse or touching of a sexual nature[3] with a patient, even if it is consensual.[4]
12. Make sexual remarks and engage in sexualized behaviour toward a patient. Sexual behaviour and remarks include, but are not limited to:
    - disrobing or draping practices that reflect a lack of respect for the patient's privacy or bodily autonomy.
    - deliberately watching a patient dress or undress.
    - sexual comments about a patient's underclothing.
    - criticism of the patient's sexual orientation.
    - discussion of the patient's sexual performance.
    - conversations regarding the sexual preferences or fantasies of the registrant or patient.
    - kissing.

Relationships with Former Patients

Registrants must:

[2] Health Professions Procedural Code (HPPC), Schedule 2 to the Regulated Health Professions Act, 1991 (RHPA).
[3] 'Sexual nature' does not include touching, behaviour or remarks of a clinical nature appropriate to the care provided.
[4] Subsection 1(3) of the HPPC, Schedule 2 to the RHPA.

13. Wait at least **one year** after the professional relationship has ended before entering any personal, romantic, or sexual relationship with a former patient.
14. If a non-professional relationship begins after at least one year has passed, be able to demonstrate that the former patient was not exploited, pressured, or influenced in any way, whether intentionally or unintentionally.
15. Be cautious about relationships (friendship, romantic or sexual) with former patients or their significant other where power imbalance or dependency may continue well after the professional relationship has ended.

References

- Assessment and Management
- Chiropody Act, 1991
- Code of Ethics
- Competence
- Consent
- Fee, Billing and Accounts Guideline
- Health Care Consent Act, 1996, S.O. 1996, c 2.
- Human Rights Code, RSO 1990, c H.19.
- Personal Health Information Protection Act, 2004, SO 2004, c 3.
- Records
- Regulated Health Professions Act, 1991, SO 1991, c 18.

Definitions

Boundary: Boundaries define the limit of a safe and effective professional relationship between a registrant and a patient. Boundaries are based on trust, respect, and the appropriate use of power, recognizing that patients are vulnerable and registrants have a duty to act in the best interest of patients.

Boundary Violations: Boundary violations occur when a registrant does not establish and/or maintain the boundaries of a professional relationship with their patient and/or abuses their power. A boundary violation is the point at which a relationship changes from professional and clinical to unprofessional and inappropriate. Boundary violations exploit the power imbalance inherent in the registrant-patient relationship and may be sexual or non-sexual in nature.

Dual Relationship: Dual relationships occur when a registrant has a secondary personal or professional relationship with a patient in addition to the treating relationship. Dual relationships can complicate the treating relationship, risk undermining the provision of safe and effective care, and increase the risk of boundary violations.

Nominal: A nominal gift is a gift of very low monetary value that is modest, infrequent, and unlikely to influence professional judgment, decision-making, or behaviour.

A nominal gift:

- has minimal financial value,
- is given as a gesture of courtesy or appreciation, and
- does not create a sense of obligation, expectation, or preferential treatment.

Patient-centered care: In this approach, a patient is viewed as a whole person. Patient-centered care involves advocacy, empowerment and respect for the patient's autonomy, voice, self-determination and participation in decision-making.

Patient: Although the RHPA's definition of "patient" is not exhaustive,[5] it makes it clear that, at a minimum, a person is considered a registrant's patient for the purpose of the sexual abuse provisions if there is direct interaction and any of the following has happened:

- The registrant has, in respect of a health care service provided by the registrant to the person, charged or received payment from the person or a third party on behalf of the individual;
- The registrant has contributed to a health record or file for the person;
- The person has consented to a health care service recommended by the registrant;[6] or
- The registrant has prescribed a drug to the person for which a prescription is needed.[7]

The only situation in which a person who falls within the definition above may not be classified as a patient is if **all** the following conditions are met:

- There is an existing sexual relationship between the person and the registrant at the time the health care service is provided;
- The health care service provided to the person by the registrant was minor in nature or was provided in an emergency; and
- The registrant has taken reasonable steps to transfer the person's care, or there is no reasonable opportunity to transfer care.[8]

The Code also establishes a minimum period of **one year** after a person ceases to be a health care professional's patient, during which time a sexual relationship between registrants and former patients is prohibited. The one-year period runs from the date the registrant-patient relationship is formally terminated, which does not necessarily coincide with the date the patient last received health care services from the registrant. Termination often requires the registrant to take active steps to end the professional-patient relationship and to make reasonable efforts to arrange alternative or replacement services.

Engaging in a sexual relationship with a patient before waiting the full year after terminating the registrant-patient relationship can lead to a finding by the Ontario Chiropodists and Podiatrists Discipline Tribunal (Discipline Committee) of professional misconduct for sexual abuse of a patient. A finding may require a mandatory penalty of revocation of the registrant's certificate of registration.

[5] Subsection 1(6) of the HPPC, Schedule 2 to the RHPA
[6] Health Care Consent Act, 1996
[7] Subsection 1.1 of O. Reg. 260/18 under the RHPA
[8] Subsection 1.2 of O. Reg. 260/18 under the RHPA

Registrants are permitted to treat their **spouses** without it constituting sexual abuse of a patient, provided the registrant's spouse meets the statutory definition of "spouse"[9] (see below). The registrant must keep the sexual relationship entirely out of the office setting. While treating a spouse, registrants must follow professional standards and maintain the same professional distance they would for any other patient.

Respect: Treating someone positively through actions and words that show esteem for the individual. Respect in a diversity, equity and inclusion context involves understanding and valuing differences.

Sexual Abuse: Sexual abuse of a patient by a registrant is defined as: [10]

- Sexual intercourse or other forms of sexual relations between the member (registrant) and the patient;
- Touching of a sexual nature, of the patient by the member (registrant); or
- Behaviour or remarks of a sexual nature, by the member (registrant) towards the patient.

Sexual abuse does not include touching, behaviour, or remarks that are clinically appropriate to the service being provided.

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

Spouse: An individual that is married to the registrant or has lived with the registrant in a common-law relationship outside of marriage continuously for at least three years. [11]

Appendix A: Abusive behaviours

Abuse can be verbal, emotional, physical, sexual, neglectful, or financial.

Examples include:

Verbal and emotional abuse:

- Sarcasm, intimidation, threats
- Teasing, taunting, or swearing;
- Insensitivity to the patient's preferences
- Racism, discrimination, harassment and exclusion
- Dismissive or impatient tone.

Physical abuse

- Hitting, pushing, slapping, shaking
- Using unnecessary touching, force and handling a patient in a rough manner

[9] Subsection 1(6) of the HPPC, Schedule 2 to the RHPA
[10] Subsection 1(3) of the HPPC, Schedule 2 to the RHPA
[11] Subsection 1(6) of the HPPC, Schedule 2 to the RHPA

Neglect

- Denying or delaying care
- Ignoring the patient
- Withholding communication

Sexual abuse (consensual and non-consensual)

- Sexually demeaning, seductive, suggestive, exploitative, derogatory or humiliating behaviour or comments
- Sexual touching or touching that may be perceived by the patient or others to be sexual;
- Sexual intercourse or other forms of sexual contact with a patient
- Non-physical sexual activity such as sexting, sharing photos, or viewing pornographic websites with a patient.

An individual is a **patient** for the purposes of sexual abuse when there is an interaction between the individual and the registrants, and:

- the registrant has issued billings or received payment in connection with a health care service provided, or
- the registrant has contributed to the individual's record or file, or
- the individual has consented to receive a health care service recommended by the registrant, or
- the registrant prescribed a drug to the individual.

An individual is a patient while receiving care and for a period of **one year** after the professional relationship ends.

Financial abuse

- Borrowing money or property, withholding finances, using influence, pressure or coercion to obtain the patient's money or property
- Soliciting gifts
- Having financial trusteeship, power of attorney or guardianship
- Abusing a patient's bank accounts and credit cards
- Assisting with the patient's financial affairs

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.8

COUNCIL BRIEFING NOTE
RE: SUPERVISING CHIROPODY STUDENTS STANDARD

Background:

Registrants provide supervision to chiropody students enrolled in the Michener Institute's chiropody program during their clinical placements. Clinical placements are an essential part of the curriculum because they allow students to apply their knowledge and skills in clinical practice under direct supervision by registrants of the College.

It is important that registrants acting as supervisors understand their responsibilities and meet eligibility criteria. The student/supervisor relationship is, by its nature, a relationship with a tendency towards an inherent power imbalance. Students are in a potentially vulnerable position when they are engaging with registrants who are clinical supervisors in clinical placements. While clinical placements provide important opportunities for registrants and students, there is a natural power imbalance that exists in the dynamic that warrants additional safeguards by the regulator.

This new standard of practice sets clear requirements for registrants who supervise students. Its purpose is to:

- Protect the public by ensuring that students are properly supervised during clinical placements.
- Clarify expectations for registrants acting as supervisors.
- Ensure patients are informed about student involvement and receive safe, competent care.

Public Interest Rationale for Decision:

It is in the public interest that students entering the chiropody profession are trained by competent registrants with no disciplinary history and with sufficient clinical experience. The College must clearly outline the criteria and expectations for registrants acting as supervisors to maintain safety and quality of care. The College must also ensure that students and patients, who are both members of the public the College is required to protect, are adequately protected in the context of a clinical placement.

Factual Inaccuracies in Feedback Received:

Although the College is not required to circulate a proposed standard for feedback, the College Council voted to do so in respect of the proposed supervision standard at its January 29, 2026 Council meeting. The purpose of the circulation was to provide an opportunity for system partners to provide feedback for consideration by Council in advance of voting whether to approve the proposed standard at its May 21, 2026 meeting. There are some factual inaccuracies in the feedback received that require correction. These are outlined below:

No other regulator in the province has a supervision standard:

This is not correct. There are a number of professional health regulators in Ontario that have supervision standards governing their registrants when acting as clinical placement supervisors or when supervising students. In fact, in addition to relying on legal advice and direction on the draft standard, the College considered other regulators' supervision standards in drafting the College's proposed supervision standard.

The College does not have jurisdiction to make a supervision standard:
This is not correct. The College, similar to other health regulators, has jurisdiction over its registrants in respect of

practicing chiropody and podiatry. This includes regulating registrants who are clinical supervisors for chiropody students during clinical placement. Standards are an effective and well-established mechanism that allow a regulator to communicate its expectations of registrants directly to registrants and the public it serves to protect. The College has jurisdiction to draft and pass standards relating to registrants of the College.

The College is attempting to regulate students by its proposed supervision standard:

The is not correct. The College, similar to other regulators with a supervision standard, is proposing to use a supervision standard to appropriately communicate its expectations of registrants who are engaging directly with students as clinical supervisors. Although the proposed supervision standard will, if approved by Council, impact students by helping to ensure that their clinical experience is safe and ethical, it remains a standard that must be adhered to by registrants. Students are not responsible for adhering to College standards although the College does have a duty to protect students, as members of the public, in their interactions with registrants. The expectation is that students will be positively impacted by the proposed supervision standard but the fact that a standard impacts students does not amount to regulation of students. Should a student become a registrant of the College, they will then be responsible for adhering to the College's standards as a registrant.

The Proposed Standard Does Not Reflect Right Touch Regulation:

This is not correct. The principle of "Right Touch Regulation" in the context of professional regulation is one where the amount of risk drives the amount of resources applied to a given aspect of regulation to ensure proportionality. For example, where risk is low, minimum regulatory force and resources are applied proportionately to the risk identified. In contrast, where risk is higher, further regulatory force and resources are warranted. In respect of the supervision of chiropody students, in 2025 the College spent almost $50,000 in prosecuting a registrant who admitted to engaging in professional misconduct while acting as a clinical student supervisor for a Michener chiropody student. Given that the College's annual operating budget is just over $2 million dollars, a one-time expenditure of $50,000 prosecuting misconduct that occurred during clinical supervision by a registrant is a significant cost to the College. Thus, the 2025 disciplinary matter represents a high risk to the College both from a cost and resource perspective as well as from a concern that students may be at risk of inappropriate clinical supervision. Inadequate student supervision can undermine the purpose of clinical placements, which is to ensure that students have sufficient clinical experience before graduation. When students are exposed to breaches of the College's standards, such as improper orthotics prescribing, there is a significant risk to public protection.

A supervision standard is a reasonable and common standard that a number of Ontario health regulators employ to ensure registrants engage with students they are supervising in a clinical setting in an appropriate manner. The College's standard is proportionate to the identified risk of harm and aligns with existing supervision standards relied upon by other health regulators. The proposed standard is not unduly restrictive but instead places clear expectations on registrants who choose to act as clinical supervisors. Accordingly, the proposed standard is proportionate to the risk of harm identified and an appropriate response by the College.

Recommended Motion:

That Council approve the proposed Supervising Chiropody Students standard.

Mover: _____
Seconder: _____

3.8.1 Appendix A – formatted standard

Back to Agenda

PRACTICE STANDARD

DRAFT

College of Chiropodists of Ontario

Supervising Chiropody Students

Approved by Council: DATE

Reviewed and Updated:

INDEX

Introduction

This Standard of Practice applies to registrants of the College who supervise or provide clinical education (**Supervisor**) to chiropody students or trainees (**Students**) in Ontario outside an educational institution.

Its purpose is to:

- Protect the public by ensuring that Students are properly supervised during clinical placements.
- Clarify expectations for registrants acting as Supervisors.
- Make sure patients are informed about Student involvement and receive safe, competent care.

Supervisor Eligibility

To act as a Supervisor, a registrant must:

- Hold a General Class certificate of registration in good standing.[1]
- Have at least three consecutive years of chiropody practice in Ontario or another regulated jurisdiction.
- Meet all continuing competency and quality assurance requirements of the College.
- Have no terms, conditions or limitations on their certificate of registration that prevent them from supervising Students.

The Supervisor must maintain these requirements throughout the Student's placement. If these requirements are no longer met, or supervision is no longer in the public interest, the Supervisor must stop supervising and advise the Student to find a new Supervisor.

[1] For the purposes of this Standard, "good standing" means that the Supervisor must not be the subject of any prior discipline or fitness to practise order; any prior decision of the Inquiries Complaints and Reports Committee other than a decision to take no further action; any current discipline proceeding or investigation by the College; any interim order; or any agreement entered into as a result of a complaint, investigation or proceeding.

Supervision Agreement

Supervision is a formal relationship between the Supervisor and the Student. Supervisors must have a **written agreement** that includes:

- The goals and purpose of supervision.
- Responsibilities of both Supervisor and Student.
- Who has ultimate responsibility for patient care.
- How supervision will occur (frequency, direct vs. indirect, meeting arrangements).
- Confidentiality and consent requirements.
- Emergency contact and contingency plan if the Supervisor becomes unavailable.
- Expectations for sharing patient information and confidentiality.
- Expectations about liability coverage.
- Requirement to report any concerns about a Student to the educational institution.

Supervision Requirements

A Supervisor must:

- Understand the Student's learning objectives and curriculum, including course content, expectations, and the goals of the Student's placement.
- Orient the Student to the facility, protocols, and department and/or program where the clinical placement is taking place (including equipment, protocols and documentation requirements).
- Only assign tasks the Supervisor has the knowledge, skill, and judgment to perform.
- Inform patients when a Student is involved in their care. Explain that the Student is not a registrant of the College, and confirm that the Supervisor is ultimately responsible for the patient's care.
- Ensure students wear nametags with their name and title.
- Obtain informed consent for Student involvement in the patient's care. If informed consent is obtained, explain the Student's role.
- Assign tasks appropriate to the Student's knowledge and skill level.
- Provide fair and honest performance assessments
- Maintain professionalism and boundaries (no harassment, discrimination, or sexual behaviour).

Determining the Level of Supervision

The level of supervision depends on:

- **Patient risk:** Higher-risk tasks require closer supervision.
- **Student competence:** Less experienced Students need more direct oversight.
- **Task complexity:** Controlled acts and invasive procedures require **direct supervision**.

Definitions:

- **Direct supervision:** Supervisor is physically present and observing the procedure.
- **Indirect supervision:** Supervisor is on-site and immediately available for consultation.

Examples:

- **Casting/scanning for orthoses:** Must be reviewed by the Supervisor before the **patient leaves the treatment room**.
- **Controlled acts (e.g., cutting into subcutaneous tissue):** Student may perform only under **direct supervision**.

Controlled Acts

Students may perform the following controlled acts **only under direct supervision**:

- Cutting into subcutaneous tissue of the foot.
- Administering substances by injection into the foot.
- Prescribing drugs designated in the *Chiropody Act, 1991*.

Recordkeeping and Billing

- All patient records completed by the Student must include their full name and title.
- All documentation must be co-signed by the Supervisor and meet the College's Records Standard.
- Bills and receipts must be accurate and reviewed by the Supervisor.
- Supervisors must keep a supervision log with:
    - Names of Supervisor and Student.
    - Dates and hours of supervision.
    - Issues discussed or directions given.
    - Any controlled acts performed by the Student.

Restrictions on Supervision

A Supervisor must not supervise a Student if there is a **conflict of interest**.

A conflict of interest exists when a Supervisor's personal interests, or those of a relative or a related business, could affect their professional judgment or interfere with their duty to supervise in the best interest of patients and the public.

Examples of conflicts include supervising someone with whom the Supervisor has a close or personal relationship, such as:

- Spouse or common-law partner;[2]
- Parent or Child;
- Sibling;

[2] For the purposes of this Standard, common-law partners are people who have lived together as a couple for at least one (1) year, or who have a child together, or who have entered into a cohabitation agreement.

- Through marriage (parents-in-law, children-in-law, siblings-in-law, stepparents, stepchildren or stepsiblings); or
- Through adoption (adoptive parents or siblings, adopted children).

To maintain safety and quality, a Supervisor may not supervise more than one Student at the same time.

Accountability and Responsibility

The Supervisor is fully responsible for the Student's work, including all assessments and treatments. This means:

- The Supervisor must ensure that all care provided by the Student meets the College's Standards of Practice.
- If a complaint is made about the Student's conduct or actions, the College may investigate the Supervisor's role and oversight.

Appendix B: 3.8.2

Consultation: Supervising Chiropody Students

(Feedback received from February 4, 2026, to April 5, 2026)

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[1] 02-07-2026

I have read and reviewed the proposed draft for the Supervising Chiropody Students Standard and believe this document constitutes a positive step for the College of Chiropodists of Ontario.

[2] 02-10-2026

I generally agree with the intent and content of this draft Standard of Practice and support its stated goals of public protection, clarification of supervisory responsibilities, and transparency for patients receiving care involving students or trainees.

I would, however, encourage the College to consider adding wording that allows for a **supervised practice framework for recent graduates of the Ontario Chiropody Program who have completed their academic and clinical training and examinations but are awaiting formal registration documentation from the College**.

There is often a transitional period following graduation and successful completion of examinations during which new graduates are not yet eligible to practice independently due to administrative timelines outside their control. During this period, these individuals are fully trained, competent, and exam-qualified, yet unable to contribute clinically despite a clear workforce need across Ontario.

Many other regulated health professions permit **conditional, provisional, or supervised practice** for recent graduates during this interim phase. Allowing a similar model in chiropody where recent graduates may be employed and practice **only under direct supervision of a registrant in good standing**, and within clearly defined scope and accountability parameters would:

- Maintain strong public protection through mandated supervision and oversight
- Support continuity of patient care and access to services
- Facilitate smoother transition to independent practice for new graduates
- Assist clinics in workforce planning and mentorship
- Align chiropody regulation with comparable health professions in Ontario

Such a framework could include clear eligibility criteria (e.g., completion of program requirements and examinations), explicit supervisory responsibilities, limits on independent decision-making, and mandatory patient disclosure—fully consistent with the objectives of this Standard.

I believe incorporating this consideration would strengthen the Standard, enhance practical implementation, and support both public interest and professional sustainability without compromising patient safety.

UHN Michener Institute of Education

April 4, 2026

Response to new Practice Standard

As collaborative partners, both Michener and the College are committed to excellent and safe foot care for Ontarians. It was, therefore, a surprise that as a key stakeholder, Michener was not directly contacted to provide input on the proposed Practice Standard, Supervising Chiropody Students. Michener Institute of Education at UHN, is the only education provider in Ontario, educating Chiropody students. We are disappointed that the College did not consult directly. We are providing input and commentary on the posted new draft practice standard for Supervising Chiropody Students.

The proposed Practice Standard has no comparator at any of Ontario's other regulatory colleges. No other regulated College in Ontario has a Practice Standard for Supervising Students. The College has jurisdiction over its registrants, not students. This is how the College serves to protect the Ontario public.

Our first concern is related to the proposed Supervisor Eligibility Standard. In comparison to Ontario other regulatory colleges, COCOO has a comparatively small number of registrants. All registrants are deemed competent. As you know, there are two classes of registrants: chiropodists and podiatrists. Registrants are not classified by their consecutive years of chiropody practice in Ontario or another regulated jurisdiction. Therefore, the proposed standard, should not limit any registrant activity, including supervision of students, based on consecutive years of chiropody practice in Ontario or another regulated jurisdiction.

Furthermore, the eligibility criteria for supervisors as proposed are unnecessarily restrictive. A blanket exclusion of any registrant does not reflect a risk-based approach and may disqualify capable clinicians who are well-positioned to support student learning. A case by case approach would better align with contemporary regulatory practice and avoid unnecessary regulatory overreach into areas traditionally governed by academic institutions. The implications for equity, access, and service provision in underserved communities are equally concerning. Many clinical placements in rural, remote, and marginalized areas rely on a small number of clinicians who generously support student learning despite limited resources. Narrow eligibility criteria may discourage or prevent these clinicians from continuing to supervise students, reducing placement availability in precisely the communities where exposure is most needed. Such reductions could limit students' opportunities to work with diverse populations and diminish the likelihood that future graduates will choose to practice in areas of high need. Given the College's stated commitments to equity, diversity, inclusion, and improved access to care, the proposed standard risks unintentionally working against these goals.

As the educational institution responsible for preparing future chiropodists through rigorous academic and clinic training, we share the College's commitment to public protection, high quality education, and the development of competent & ethical practitioners. We appreciate the College's intention to clarify expectations for registrants who supervise students, however, after reviewing the proposed standard, we have significant concerns that several elements extend beyond the appropriate scope of regulatory oversight and may unintentionally hinder the delivery of clinical education.

Educational institutions already operate under comprehensive quality assura
curriculum design, clinical placement structures, and student evaluation. The College's new proposed standard introduces prescriptive requirements in these areas, which risks duplicating or superseding established academic governance.

We therefore oppose any introduction of the proposed Practice Standard as beyond the scope of the regulatory college.

Furthermore, clarification is needed regarding the scope and setting outlined in the proposed standard. The draft indicates that it applies to registrants supervising chiropody students "in Ontario outside an educational institution", yet all clinical placements operate within hybrid environments such as hospitals, community health centres, and private practices with formal affiliation agreements. These settings do not fit neatly into a binary distinction of "inside" or "outside" an educational institution. Without clearer definitions, inconsistent interpretation across sites is likely, creating uncertainty for both supervisors and students. Explicit guidance on how the proposed standard applies within affiliated clinical settings would help to avoid confusion.

A foundational component of our clinical education model is the use of formal clinical affiliation agreements with all partner sites. This has been the practice for decades and is consistent with all other educational institutions where regulated health professionals are trained. The affiliation agreements used, in conjunction with one-on-one meetings, clearly outline the responsibilities of the institution, the clinical site, the supervisor, and the student, establishing expectations, communication pathways, and accountability structures. As a core element of our quality assurance framework, this single, comprehensive agreement ensures that supervision occurs within a coherent and collaboratively governed structure.

Introducing a separate regulatory standard that imposes additional or conflicting requirements would result in two parallel sets of expectations: one academic and one regulatory. This will create uncertainty regarding which requirements prevail in cases where there may be a discrepancy. Again, this is an overreach by the regulatory College regarding governance of clinical education. It is important to note that all expectations related to student supervision is contained within one unified framework. The existing affiliation agreement structure is a standard practice and the College should recognize that robust safeguards for student learning and patient safety are already in place.

In summary, Michener continues to support the College's role as regulator and oversight for registrants. We are unable to endorse the proposed, new draft practice standard for Supervising Chiropody Students.

We respectfully recommend that the College and its Executive consider existing best practices defining expected roles for registrants in a self regulated College such as the CAN Meds framework. The role of Educator is one that is embraced by registrants at other Regulatory Colleges. The framework has breadth that is appreciated and understood by registrants and the public alike. It also avoids a prescriptive approach which cannot capture all circumstances and often results in unintended restrictions rather than promoting best practice. Michener continues to strive to work collaboratively with all COCOO registrants to support and promote the best learning experience and outcomes for learners.

April 5th, 2026

Registrar & Chief Executive Officer
Council Chair and Members of Council
College of Chiropodists of Ontario
180 Dundas Street West, Suite 1901
Toronto, ON M5G 1Z8

Re: Consultation Submission - Draft Practice Standard "Supervising Chiropody Students"

The Ontario Society of Chiropodists (OSC) thanks the College of Chiropodists of Ontario (COCOO) for the opportunity to provide input on the draft practice standard *Supervising Chiropody Students*. OSC appreciates Council's commitment to public protection and to ensuring that regulatory approaches remain effective, proportionate, and aligned with the College's statutory mandate.

OSC fully supports the importance of safe, appropriate clinical supervision of students. Our submission focuses on whether the proposed standalone, prescriptive standard is necessary, proportionate, and consistent with COCOO's stated commitment to Right-Touch Regulation.

Enclosed for Council's consideration are:

- *An Executive Summary*
- *A detailed Consultation Submission*
- *A Comparative Regulatory Analysis (Appendix A)*
- *A Clinical Affiliation Agreement reference (Appendix B)*
- *An RHPA Regulatory Authority Analysis (Appendix C)*
- *A consolidated list of Sources*

OSC offers this submission in a constructive spirit and with respect for Council's role and discretion. Given the absence of demonstrated risk, the duplication of existing oversight mechanisms, and the need for a proportionate, evidence-based approach under the RHPA, OSC respectfully recommends that Council **defer approval** of the draft standard. A transparent proportionality assessment, supported by stakeholder feedback and analysis of less restrictive alternatives, is essential to ensuring that any future supervisory expectations both protect the public and sustain the workforce required to deliver care.

OSC remains committed to working collaboratively with the College to support a regulatory framework that protects the public, aligns with RHPA norms, and sustains Ontario's chiropody training pathway.

Respectfully submitted,

Sasha Kozera-Faye

Sasha Kozera-Faye BSc, DCh
Interim President
Ontario Society of Chiropodists

EXECUTIVE SUMMARY

The College of Chiropodists of Ontario (COCOO) has circulated a draft practice standard proposing detailed eligibility requirements, administrative obligations, and operational restrictions for registrants supervising chiropody students.

OSC supports the objective of safe student supervision. The central question is whether a **standalone, prescriptive standard** is necessary and proportionate within the existing regulatory and institutional framework.

Key Findings

1. Not Aligned with Sector Norms

A review of Ontario health regulators shows that standalone student-supervision standards are **not typical**. Colleges such as CNO, CPSO, CPO, CRTO, and CMLTO rely on:

- existing standards (e.g., consent, documentation, accountability), and
- institutional oversight through clinical affiliation agreements.

2. Duplicates Existing Oversight

Michener's Clinical Affiliation Agreement already governs:

- supervisory roles
- liability
- evaluation
- patient-safety mechanisms

No regulatory gap has been demonstrated that requires a new prescriptive standard.

3. Risks to Clinical Placement Capacity

Proposed requirements, including a one-student limit and mandatory co-signing, would significantly reduce placement capacity and deter registrants from supervising. This threatens Ontario's sole chiropody training pathway.

4. Eligibility Criteria May Be Overly Broad

The draft's definition of "good standing" excludes registrants based on historical, resolved matters unrelated to current competence or safety. This departs from RHPA principles of current risk and proportionality *(Appendix C)*.

Conclusion

While student supervision is essential, the proposed standard may represent a disproportionate regulatory response. OSC recommends that Council defer approval of the draft standard pending a transparent, evidence-base proportionality assessment.

FULL CONSULTATION RESPONSE

1. Introduction

OSC appreciates the opportunity to provide feedback on COCOO's Draft Practice Standard *Supervising Chiropody Students*. OSC supports COCOO's public-protection mandate and agrees that appropriate supervision of students is essential to safe, ethical, and competent care.

OSC's submission focuses on whether a standalone, prescriptive standard is necessary, proportionate, and aligned with COCOO's Right-Touch Regulation commitments.

2. Existing Oversight Mechanisms Already Address Identified Risks

2.1 Clinical Affiliation Agreements *(Appendix B)*

Michener's Clinical Affiliation Agreement defines:

- supervisory roles
- responsibilities of clinical sites
- evaluation processes
- mechanisms for addressing concerns, including removal from placement

This framework already manages student-related risks.

2.2 Existing COCOO Standards and Enforcement Tools

Registrants supervising students are already accountable under standards related to:

- consent
- documentation
- professionalism
- boundaries
- patient safety

COCOO has demonstrated its ability to address supervision failures using existing tools. In *COCOO v. Wilson (2025 ONCPDT 8)*, the Discipline Tribunal imposed suspension, practice restrictions, remediation, mentorship, and mandatory reporting, confirming that current mechanisms are effective.

2.3 Sector Norms

Most Ontario health regulators do not rely on standalone student-supervision standards. Regulators set principles; educational institutions and clinical sites operationalize procedures *(Appendix A)*.

3. COCOO's Right-Touch Regulation Commitments

3.1 Strategic Plan

COCOO identifies Right-Touch Regulation as a core regulatory philosophy focused on:

- risk prioritization
- proportionality
- evidence-informed decision-making

3.2 Key Performance Indicators

COCOO's KPIs commit to:

- applying Right-Touch practices
- ensuring regulatory actions are proportionate to risk
- using risk-based decision-making

3.3 Right-Touch in Practice

COCOO's Annual Report associates Right-Touch with targeted, transparency-enhancing initiatives, not broad prescriptive rule-making.

4. Application of Right-Touch Principles to the Draft Standard

Key questions remain insufficiently addressed:

- *What specific risk is not already addressed through existing mechanisms?*
- *How are those risks currently managed through Michener's framework and COCOO's standards?*
- *Why is a standalone, prescriptive standard the most proportionate response?*

The draft does not demonstrate that the proposed requirements represent the *minimum regulatory intervention necessary.*

5. Foreseeable Impact on Registrant Willingness to Supervise

5.1 Expanded "Good Standing" Restrictions

The draft excludes registrants based on historical, resolved matters unrelated to current competence. **This departs from RHPA principles and reduces the pool of eligible supervisors.**

5.2 Duplicative Administrative Requirements

Individualized supervision agreements, logs, and documentation structures duplicate:

- Michener's placement agreements
- institutional policies
- existing COCOO standards

This increases administrative burden without reducing risk.

5.3 One-Student-Only Limit

No Ontario health regulator imposes a blanket 1:1 student ratio. **This requirement would significantly reduce placement capacity.**

5.4 Mandatory Co-Signing

Requiring supervisors to co-sign all student documentation exceeds RHPA expectations and conflicts with institutional workflows.

5.5 Cumulative Impact

Collectively, these requirements would:

- deter registrants from supervising
- reduce placement capacity
- constrain the training pipeline
- affect future access to podiatric care services for the public

6. Cumulative Impact and Public-Interest Consequences

The proposed standard introduces a new regulatory layer in an area where risks are already managed. The foreseeable consequences include:

- reduced supervision uptake
- decreased placement capacity
- strain on Ontario's sole chiropody training pathway
- long-term workforce shortages

These outcomes conflict with RHPA's public-interest mandate *(Appendix C).*

7. Conclusion and Recommendations

OSC agrees that student supervision is essential and supports clear expectations that promote safe, effective learning and high-quality patient care. However, given the existing oversight through Michener's clinical education agreements, current COCOO standards and enforcement tools, and the College's commitments under Right Touch Regulation, it is not evident that a new standalone standard is necessary to achieve these objectives.

System-Level Workforce Consequences

The Michener Institute is the primary entry-to-practice pathway for chiropodists in Ontario and, in several provinces, the recognized academic foundation for registration as a podiatrist under full-scope models. It plays a central role in training and supplying Canada's podiatric workforce. Introducing new barriers to clinical placements would therefore have consequences beyond Ontario. The proposed standard would constrain an already limited workforce pipeline and disrupt national labour mobility by restricting the supply of graduates eligible for podiatric practice in jurisdictions that rely on Michener-trained clinicians. Any policy that narrows access to clinical education risks reducing access to podiatric care for Ontarians and weakening the broader Canadian workforce.

Regulatory Alignment, Evidence Requirements, and MOH Expectations

COCOO has not presented evidence of harm, risk trends, or gaps in existing oversight that would justify a new binding standard. Under Right Touch Regulation, any new requirement must be proportionate, evidence-based, and demonstrably the least restrictive means of achieving public-interest protection. The Ministry of Health has similarly emphasized that regulatory colleges must avoid imposing unnecessary administrative or operational burdens that do not clearly enhance patient safety or access to care. Introducing a new supervisory standard without a documented risk profile or analysis of less restrictive alternatives would be difficult to reconcile with these expectations, particularly given the College's stated intention to advance a full-scope podiatry model and support national alignment, objectives that depend on maintaining, not constraining, the country's primary training pipeline.

Health Human Resources and Modernization

Ontario is facing a well-documented health human resources crisis, with provincial priorities focused on expanding training capacity, accelerating entry to practice, and improving access to care. Regulators play a critical role in supporting these objectives by ensuring that oversight does not create unnecessary barriers to entry. By constraining clinical placements within the country's primary chiropody training program, the proposed

standard risks functioning as an unintended barrier at a time when Ontario urgently needs to strengthen (not narrow) its podiatric workforce. A stable primary-care podiatric workforce is foundational to system modernization, including any future development of advanced or surgical roles.

This issue also intersects with provincial modernization priorities, including the evolution toward a podiatry model and the potential establishment of a surgical podiatry class. A modernized system depends on a strong and stable primary-care podiatry workforce that enables Ontarians to receive the right care at the right time. Ontario's domestic program already supplies the majority of new practitioners and enables graduates to practise as podiatrists in several provinces with expanded scope. Constraining Michener's clinical education capacity would weaken the very primary-care infrastructure required for modernization of both current chiropodists and podiatrists and risk creating gaps that other system partners will inevitably fill.

OSC respectfully recommends that Council:

1. **Defer approval** of the draft standard at this time.
2. Undertake and publicly share a **Right Touch Regulation analysis**.
3. Leverage **existing oversight mechanisms** (Michener agreement, COCOO standards, QA, discipline tools).
4. Assess the proposal against COCOO's **proportionality and risk-based commitments**.
5. Consider **lighter-touch alternatives**, such as guidance or clarification within existing standards.
6. Expand **CE modules and Practice Advisory guidance** on supervision.
7. Commit to a **full RTR analysis and consultation** before making supervisory expectations binding.

Final Takeaway

OSC offers this submission in a constructive spirit and with respect for Council's role and discretion. Ultimately, the public interest is best served when regulatory decisions both protect patients and sustain the workforce required to deliver care.

Appendix A: Comparative Regulatory Practice Table

College	Standalone Student Standard?	Primary Regulatory Mechanism	Key Oversight Features & Restrictions
College of Chiropodists of Ontario (COCOO-Proposed)	**Yes (Prescriptive)**	**Standalone Practice Standard**	**Outlier: Imposes a strict 1:1 student ratio, 3-year practice minimum, and permanent exclusion based on historical matters.**
College of Physiotherapists of Ontario (CPO)	No	General Supervision Standard	A broad standard for all personnel (PTAs, students, clinic support staff); does not impose unique eligibility or student limits.
College of Nurses of Ontario (CNO)	No- student supervision expectations are integrated across multiple practice standards, not isolated in a stand-alone standard	Integrated across multiple existing practice standards	Rely on broad standards and leave operational details to schools and placement sites. Support safe learning and workforce pipeline,
College of Medical Laboratory Technologists of Ontario (CMLTO)	Yes (Guideline)	*Guidelines for the Supervision of Students*	Uses non-binding guidelines to support professional judgment. Explicitly refers conduct matters to the school first.
College of Respiratory Therapists of Ontario (CRTO)	No (Guideline)	*Professional Practice Guideline (PPG)*	They rely on affiliation agreements for specifics. Guideline to support professional judgement and expectations for role modeling.
College of Physicians and Surgeons of Ontario (CPSO)	No	Integrated policies and institutional frameworks	Supervision frameworks for physicians supervising other physicians (not students) Institutional supervision frameworks that are enabling, include supervision expectations that are context-based, not prescriptive checklists.
College of Midwives of Ontario (CMO)	Yes (Principle-Based)	*Professional Responsibilities When Supervising Students*	No strict ratios. Requires a formal Regulatory Impact Assessment (RIA) to prove a standard is the “minimum intervention necessary”.
Opticians (COO)	No	Intern & Mentor Requirements	Uses a mentorship model for interns rather than prescriptive ratios.

Appendix B: Clinical Affiliation Agreement

Provided separately.

Appendix C: RHPA Regulatory Authority Analysis

Purpose of This Annex

To summarize OSC's concerns that elements of COCOO's draft standard may exceed the College's statutory authority under the Regulated Health Professions Act, 1991 (RHPA) and related legislation.

1. RHPA Defines the College's Regulatory Mandate

COCOO's 2024 Annual Report states:

"The role and authority of the College are set out in the RHPA, the Health Professions Procedural Code, the Chiropody Act, 1991…"

Under the RHPA, COCOO's authority is limited to:

- *Regulating registrants*
- *Ensuring competent, ethical practice*
- *Acting reasonably and proportionately*
- *Protecting the public interest*
- ***Avoiding unnecessary barriers to practice***
- ***Avoiding interference with the jurisdiction of educational institutions, employers, and placement agreements***

2. Areas Where the Draft Standard Risks Exceeding COCOO's Mandate

A. Regulating Academic Program Operations

The draft requires supervision agreements, logs, and oversight structures that fall under:

- *Ministry of Colleges & Universities frameworks*
- *Michener Institute placement agreements*
- *Institutional clinical education policies*

Regulating academic operations lies outside COCOO's RHPA scope.

B. Over-Broad "Good Standing" Restrictions

The draft would bar supervisors based on:

- *Historical ICRC outcomes*
- *Past SCERPs, cautions, advice, undertakings*
- *Resolved matters unrelated to competence*

*RHPA focuses on **current** risk. Permanent disqualifiers based on historical issues may not align with the RHPA's intent, which requires regulatory action to be tied to present-day risk.*

C. Duplication and Conflict with Existing Legal Frameworks

Student involvement in patient care is already governed by:

- *PHIPA*
- *HCCA*
- *Controlled Acts provisions*
- *Placement contracts and institutional documentation policies*
- *Existing COCOO Standards of Practice*

Duplicating or extending these frameworks risks misalignment with RHPA principles.

3. RHPA Requires Proportionality and Public-Interest Protection

RHPA-aligned regulation must be:

- *Necessary*
- *Risk-proportionate*
- *Reasonable*
- *Evidence-based*
- *Supportive of public access to care*

The draft standard, as written, would:

- *Reduce clinical placement capacity (potentially by 50% or more)*
- *Exclude many competent supervisors*
- *Impede the only domestic chiropody training pathway*
- *Reduce Ontario's future foot-care workforce*

These impacts risk contradicting RHPA's public-interest requirement.

4. RHPA-Based Conclusion

Based on RHPA principles and COCOO's own statutory mandate, the draft standard appears to extend beyond what the RHPA's risk-based framework contemplates. It introduces requirements that duplicate existing oversight mechanisms and may create unintended public-interest impacts without demonstrated evidence of harm. OSC therefore recommends that the standard, in its current form, not be adopted.

Sources

1. ***College of Chiropodists of Ontario (COCOO).***
   Draft Practice Standard: Supervising Chiropody Students. February 2026.
2. ***The Michener Institute of Education at UHN.***
   Clinical Affiliation Agreement – Template.
3. ***College of Chiropodists of Ontario (COCOO).***
   2024 Annual Report.
4. ***College of Chiropodists of Ontario (COCOO).***
   Key Performance Indicators, October 2025 – October 2026.
5. ***College of Chiropodists of Ontario (COCOO).***
   Standards of Practice for Chiropodists and Podiatrists.
6. ***College of Chiropodists of Ontario (COCOO).***
   Quality Assurance Program; Complaints, Investigations, and Discipline Processes.
7. ***Government of Ontario.***
   Regulated Health Professions Act, 1991.
8. ***Government of Ontario.***
   Chiropody Act, 1991.
9. ***College of Nurses of Ontario (CNO).***
   Professional Responsibilities When Supervising Students.
   (Professional-Responsibilities-When-Supervising-Students-Approved-Sept-22-EN.pdf)
10. ***College of Physiotherapists of Ontario (CPO).***
    Supervision Policy for Applicants and Students.
    (Supervision_Policy_for_Applicants_and_Students.pdf)
11. ***College of Occupational Therapists of Ontario (COTO).***
    Guidelines for the Clinical Supervision of Students.
    (Guidelines-for-the-Clinical-Supervision-of-Students.pdf)
12. ***College of Respiratory Therapists of Ontario (CRTO).***
    Providing Education: Respiratory Therapists Providing Education.
13. ***College of Opticians of Ontario (COO).***
    Transparency, Performance and Accountability Framework.

CLINICAL AFFILIATION AGREEMENT

BETWEEN

THE MICHENER INSTITUTE OF EDUCATION AT UHN

("MICHENER")

AND

XXXXXXXXXXX

("SITE")

DATED: XX/XX/XXXX

PREAMBLE

1. MICHENER wishes to provide clinical placements in order that students enrolled in full-time, part-time, distance education, and Continuing Education programs at MICHENER, including, without limitation, programs for international and exchange students, may obtain their practical clinical education at clinical placement sites, providing the necessary learning opportunities for the development of the Students' clinical competence.

2. MICHENER may also wish to use clinical placement sites for the purpose of clinical professional development for Michener faculty to maintain currency in their discipline and also to allow such faculty to co-supervise or evaluate clinical students placed at clinical placement sites.

3. The SITE has agreed to act as a clinical placement site for MICHENER students and faculty as described above, and MICHENER wishes to use the SITE's facilities and other resources for such purposes, on the terms set out in this Agreement.

NOW THEREFORE the parties hereby agree as follows:

1. DEFINITIONS and INTERPRETATION

(a) **Definitions**

Clinical Adjunct Professor is a status-only appointment and is awarded to individuals from affiliated clinical sites in recognition of their commitment to the clinical education of Students. Clinical Adjunct Professors may concurrently hold the status-only appointment of Clinical Coordinator at a particular site.

Clinical Coordinator is a status-only appointment and is awarded to an individual from the SITE who is responsible for overall scheduling, coordinating and evaluating the Students' clinical education at the SITE. The Clinical Coordinator will work closely with all levels of clinical staff to effectively integrate Student activities into the routine of the clinical environment. He/she will attend Faculty Liaison Committee meetings and will be the operational department link with MICHENER.

Clinical Educator is a status-only appointment and is awarded to individuals from the SITE identified by the SITE to work with, teach, supervise and/or evaluate Students during their clinical placements.

Clinical Liaison Officer is a MICHENER employee who acts as a link between the Clinical Coordinators and Program Chair. The Clinical Liaison Officer will visit established clinical sites at least once every two years, and more frequently if the site is experiencing problems or requests a visit. In addition, the Clinical Liaison Officer will maintain regular personal contact with the Clinical Coordinators and Students.

Faculty are full-time or part-time MICHENER employees or persons otherwise under contract to MICHENER who are responsible for the academic instruction of Students and who may be placed at a clinical site for professional development purposes or to supervise or evaluate Students.

Program means the respective MICHENER program in which a Student is enrolled or participates and for which the SITE is to provide the clinical component as provided for herein.

Program Chair is a MICHENER employee who has overall responsibility for the respective Program, including providing an effective learning environment for Students, providing a safe, healthy and challenging work environment for Faculty and for ensuring that all professional standards are met.

Director, Student Success Network and Clinical Education (The Director) is a MICHENER employee who is responsible for maintaining positive working relationships with the SITE through effective communication. The Director is also responsible for managing all operational aspects of the Office for Clinical Education and has responsibility for clinical placement confirmation from sites and placement assignment for Students.

Student means an individual who is enrolled in a Program and placed at a clinical site in order to complete the clinical component of his/her education, and shall include, without limitation, international and exchange students.

(b) **Interpretation**

(i) This Agreement shall not be interpreted or applied so as to fetter or interfere with the respective authority, duties or responsibilities of MICHENER or the SITE under their respective legislation, statutory obligations, by-laws or policies, and MICHENER and the SITE have the right and the authority to make decisions and to exercise their discretionary authority regarding their respective resource allocations, programmatic changes and/or use of or access to their respective premises or facilities.

(ii) Where any position is referred to, the person holding such position may delegate his/her responsibilities to another suitably qualified person at, as the case may be, MICHENER or the SITE, provided the other party hereto is informed of such delegation.

(iii) References to specific legislation in this Agreement include any amendments to such legislation and shall include any regulations made under such specific legislation, as amended from time to time.

(iv) The division of this Agreement into Articles, subsections and other subdivisions and the insertion of headings are for convenience of reference only and will not affect the construction or interpretation of this Agreement.

2. INTRODUCTION

(a) **Objectives of Clinical Education**

MICHENER and the SITE agree that Students are expected to apply the knowledge learned during the didactic and practical phases of a Program in a clinical setting to gain clinical competence and confidence. In addition, clinical placements represent part of the defined mandate of accreditation (where applicable). The needs of the Students during clinical placement are focused on

achievement of clinical competence, graded clinical responsibility and the development of a commitment to ongoing continuing education.

(b) **Basis for Affiliation**

MICHENER and the SITE have a mutual interest in the enhancement of education of health professionals, research and evidence-based practice. For MICHENER to offer health care programs, it must have access to the facilities and professional staff of healthcare institutions and organizations, so that it may offer clinical experience to Students enrolled in the Programs. The SITE has resources necessary for the support of clinical teaching and has agreed to make them available to MICHENER for clinical teaching purposes as provided for in this Agreement. MICHENER has resources and services necessary for the support of teaching and has agreed to make them available to the SITE as appropriate. Both MICHENER and the SITE recognize the role and the responsibility of the SITE in the provision of health care in the fulfillment of the SITE's obligation in providing the teaching resources. While, both MICHENER and the SITE recognize the importance of academic freedom and the need to safeguard the intellectual independence of all faculty members, including SITE appointed or employed staff who have MICHENER status appointments, all Faculty shall be subject to applicable ethical and clinical guidelines or standards, laws and regulations and to MICHENER's and the SITE's relevant policies or by-laws, as appropriate. This Agreement provides a foundation upon which MICHENER, and the SITE may collaborate and cooperate in their efforts to accomplish their respective objectives.

3. APPLICABILITY OF POLICIES TO THE SITE

The SITE acknowledges and agrees that Students and Faculty are bound by the MICHENER policies. The SITE will endeavour to avoid conflicts between these policies and SITE policies and procedures and to advise MICHENER of potential conflicts. While Students need to adhere to MICHENER policies, they may also be required to comply with the SITE's own policies, and such policies may supersede MICHENER policies where a more conservative standard is applied. If MICHENER proposes to implement any new policy, procedure or guideline which could have an impact on the SITE's or MICHENER's obligations under this Agreement, MICHENER will advise the SITE. MICHENER and the SITE will each use their best efforts to inform their appointees and staff of their respective policies and of the importance of adhering to them. The SITE may access the following MICHENER policies via the link to MICHENER's Internet site, http://michener.ca/discover-michener/policies.

i. Accommodation Policy
ii. Attendance Policy & Procedure
iii. Harassment, Sexual Harassment & Discrimination Policy & Procedure
iv. Health & Safety Policy
v. Privacy Policy

4. STATUS APPOINTMENT OF SITE STAFF

The aim of defining the roles, responsibilities and benefits of three progressive levels of status-only appointments for clinical staff (Clinical Educators, Clinical Coordinators and Clinical Adjunct Professors) who play an active role in the education of Students is to strengthen the relationship between MICHENER and the SITE and to formally acknowledge the roles and

contributions of these individuals. All SITE staff who work directly with Students are encouraged to hold a current status appointment and adhere to MICHENER's academic policies as outlined on MICHENER's website through the following link to MICHENER's Internet site: http://michener.ca/discover-michener/policies.Status appointment holders from the SITE must comply with the requirements and are entitled to specific benefits, depending on the level of appointment, as outlined in "Criteria and Processes for Status Appointment of Clinical Partners", available online via the following link to MICHENER's Internet site: http://michener.ca/partners/clinical/the-office-for-clinical-education-centralizing-functions-in-support-of-clinical-education/resources-for-clinical-partners/criteria-processes-status-appointments-clinical-partners/

5. COMMITMENT TO CLINICAL EDUCATION

(a) Shared Responsibility for Clinical Education/Future Opportunities

The SITE acknowledges that MICHENER is primarily responsible for the Programs in which Students are enrolled whether those Programs are located on or off MICHENER's property. As well, the SITE recognizes MICHENER's ultimate authority regarding decisions made with respect to the Programs. MICHENER acknowledges the valuable role and specific functions carried out by SITE professional staff who engage in the clinical supervision and evaluation of Students enrolled in Programs as well as the use of SITE premises and access to the SITE's patient populations for clinical teaching and therefore will involve the SITE in these processes as appropriate. Both the SITE and MICHENER also acknowledge that it may be appropriate to consider and co-operate to develop future opportunities for research, scholarships and assessments that could benefit from and be compatible with their respective expertise and facilities.

(b) Site Commitment for Clinical Education

The SITE agrees to cooperatively engage with MICHENER in implementation of the Student placements. The SITE undertakes to foster a productive learning-centred environment for Students and Faculty and agrees as follows:

(i) Appointment of Clinical Personnel

The SITE will select an appropriate and qualified Clinical Coordinator and appropriate and qualified Clinical Educators for each Program that uses the SITE's facilities.

(ii) Achievement of Educational Objectives

The SITE will work towards established educational objectives for the Program within the framework of the SITE's existing human resources, equipment and facilities. The curriculum content and competencies will be provided by MICHENER for each Program. The SITE will contact the Program's Clinical Liaison Officer regarding any questions or feedback pertaining to Program clinical competencies and objectives. If deficiencies are identified, this issue must be discussed with the Clinical Liaison Officer as soon as possible so that supplementary or alternative clinical experiences can be arranged for the Students

placed at the SITE. When necessary, the SITE may be asked to implement a course of remedial study for a Student who is identified as "at risk" of not achieving required competencies as outlined in the Program's course outlines. In these instances, the Program's Clinical Liaison Officer will work with the SITE to establish the goals of the remedial/learning plan. If circumstances warrant, it may be necessary to move the Student to an alternate clinical site to optimize the Student's learning experience.

(iii) Student Evaluation

The SITE's clinical staff will continuously monitor Student performance and communicate progress to the Clinical Liaison Officer. If a Student is felt to be having difficulty meeting the course expectations, the Clinical Coordinator will bring this to the immediate attention of the Clinical Liaison Officer. Evaluations will be completed on an ongoing basis as well as at the end of each clinical course, as per Program course requirements. In Programs where this is not possible, MICHENER staff will work with the SITE to find suitable solutions for the evaluation of Students. MICHENER reserves the right to assist in evaluations with any of the Students and, in some Programs some of the clinical evaluations may be performed by Faculty. Where practicable, the SITE will encourage evaluation from a variety of the SITE's health care professionals.

(iv) Confidentiality of Student Information

In keeping with privacy law, MICHENER's academic policies consider all Student records to be personal information and are therefore confidential. The SITE's Clinical Coordinator and other staff who have access to Student information will not release any information pertaining to a Student placed at the SITE without the written consent of the Student. All official documentation related to Students while undertaking their clinical experience is the property of MICHENER and will be returned to MICHENER immediately following the clinical year, as per The Storage and Return of Student Documentation from Clinical Partners Policy and Procedure documents via http://michener.ca/discover-michener/policies/

(v) Support of Student Evaluation of Clinical Experience

To provide optimal clinical experiences for Students, the SITE will encourage Students to offer feedback with respect to their placement experience through the End of Rotation Student Evaluation of Clinical Placement Survey, which will be sent to their Michener email.

(vi) Provision of a Safe Environment

The SITE will provide a safe environment in which Students and Faculty will work and will not place Students or Faculty in areas that are deemed to be or might reasonably be considered to be unsafe. In the event of a pandemic or similar situation, the SITE will not expect Students to work outside of their normal scope

of responsibility and may elect to suspend clinical placement on a temporary basis, until the pandemic or similar situation is resolved or it is decided by the SITE (with the concurrence of MICHENER) that Students may return to their clinical placement.

(vii) Provision of Computer and Internet Access

Where available and appropriate, the SITE will provide Students and Faculty with computer access and Internet connection to be used for educational purposes. MICHENER will advise Students and Faculty to adhere to the SITE's computer use policies.

(viii) Participation in Program Accreditation

Where applicable, the SITE will participate with MICHENER in Program accreditation and, in preparation for accreditation the SITE will provide information as required by the accrediting body. If requested, the SITE staff will agree to be interviewed by members of the survey team during the Program visit component of the accreditation process.

(ix) Access to Patients/Clients

The SITE will allow Students, for educational purposes, access to its patients/clients and their personal health information, subject to such restrictions as are imposed by the SITE staff for clinical or legal (including under privacy law) reasons and/or by the patients themselves, including any exercise of their right to refuse Student access. The SITE will use its reasonable best efforts to provide the necessary mix of patients to meet the educational needs of the Students. In exceptional circumstances, if the SITE ascertains that it will not be able to meet Students' needs in any Program or area as previously agreed upon, it will promptly advise the Clinical Liaison Officer and assist in ensuring alternate arrangements are made for the Students.

(x) Liability Insurance

The parties shall, throughout the term of this Agreement, carry and keep in place comprehensive general liability insurance in an amount not less than $2,000,000 Canadian dollars per occurrence or in the aggregate. Upon request, MICHENER shall provide evidence of its insurance within a reasonable period of time and shall agree to notify SITE with at least thirty (30) days prior written notice in the event of any cancellation or material change in the insurance which could affect rights granted hereunder.

The SITE will carry general liability and professional liability insurance (minimum $2 million limit per occurrence) that will cover Michener and Michener Students and Faculty as "additional insureds" for all claims arising from the instruction, supervision or direction of the SITE and defence of same, including but not limited

to claims arising from injury, death, property and other alleged damage. Such insurance to include a cross-liability clause. Evidence of such insurance will be provided to MICHENER upon request. The SITE will provide Michener with 30 days prior written notice of any material change to, cancellation or non-renewal of such insurance.

(c) **Michener Commitment for Clinical Education**

(i) Student Preparation for Clinical Placement

MICHENER will provide written documentation to the SITE indicating that all Students to be placed at the SITE have completed the following requirements prior to commencing placements:

- Immunizations
- Vulnerable Sector Check (VSC) or Criminal Reference Check (CRC) as required by the respective Program
- CPR and First Aid certification, as required by the respective Program
- Mask Fit Testing, as required by the respective Program
- WHMIS Training
- Ontario Ministry of Labour: e-Learning Modules-Worker Health & Safety Awareness

MICHENER will not allow Students to enter clinical placement without fulfilling the above requirements and MICHENER will advise Students to self-declare to the SITE should there be any issues arising from a VSC.

(ii) Adherence to Privacy Laws

MICHENER will comply with all applicable privacy laws, including the Personal Health Information Protection Act, 2004 and agrees that it will require Students and Faculty to comply with all applicable privacy laws and applicable SITE policies and procedures.

(iii) Support of Student Input and Evaluation of the Program

MICHENER will routinely collect data for its key performance indicators and will share this data with the SITE in order to improve the quality of the Students' clinical experience.

(iv) Provision of Educational Opportunities for Clinical Coordinators

MICHENER will provide opportunities for SITE staff such that they can remain informed about academic directions and expect them to carry the message to other professionals in their own clinical environments. MICHENER will offer annual

professional development seminars and workshops for Clinical Coordinators/Educators to develop their skills as clinical educators.

(v) Participation in Program Accreditation

Where applicable, MICHENER will participate with the SITE in program accreditation. MICHENER will be responsible for the overall coordination and submission of required documentation to the accrediting body and will pay all associated accreditation fees.

(vi) Travel Support

Annually, MICHENER will pay reasonable travel and accommodation expenses for Ontario SITE Clinical Coordinators to attend the following meetings:

- Program Faculty Liaison Committee
- Annual Clinical Educators' Professional Development Day

Annually, MICHENER will pay reasonable travel and accommodation expenses for non-Ontario SITE Clinical Coordinators to attend one of the above listed meetings. Other meetings attended by site representatives will be at the expense of the SITE.

(vii) Access to Michener's Intranet

Michener will provide full access to my.Michener to all SITE staff who work with Students.

(viii) Liability Insurance/Workers' Compensation

MICHENER will carry liability insurance (minimum $5 million limit per occurrence) for both Students and Faculty while in the clinical environment. This policy covers:

- bodily injury/personal injury
- damage to property of others
- professional liability

Copies of Certificate of Insurance will be provided to the SITE upon request.

Students and Faculty on clinical placement from MICHENER are covered under MICHENER's Workers' Compensation (WSIB) policy.

6. STUDENT PLACEMENT

(a) Confirmation of Student Placement and Numbers

(i) In order to provide placement assignment to Students in a collaborative and timely fashion while balancing the mutual benefits with the realities of both parties and to be considerate of the SITE's annual budgeting/planning process, MICHENER and the SITE will work together in a mutual planning process to determine the appropriate number of Student clinical placements by Program on a yearly basis.

(ii) MICHENER will provide to the SITE an outline of the clinical curriculum that needs to be delivered and proposed clinical Student placements at least 10 months in advance of the start of each academic year (which ordinarily commences September 1). The SITE will consider whether they can accommodate MICHENER's needs, and the SITE and MICHENER will work together in good faith to reach agreement on the proposed clinical Student placements at least 8 months in advance of the start of each academic year. Any subsequent changes to confirmed placements will be agreed upon between the Office for Clinical Education at MICHENER (primarily through the Clinical Placement Coordinator) and the designated department or other central SITE department at least 4 months in advance of the start of the academic year. If agreement cannot be reached, the appropriate senior administration at the SITE and MICHENER will intervene to achieve a suitable solution. The MICHENER curriculum, the required number of Student placements and the SITE's ability to place Students may change from year to year for various reasons, and these factors will be addressed in the determination of the annual clinical Student placements. The SITE agrees that any educational placement or teaching of students from other educational institutions will not compromise its ongoing teaching commitment to MICHENER and Students.

(b) SITE Employees as Students

When an employee of the SITE is placed at the SITE as a Student, the employee/Student will continue to adhere to all MICHENER academic and other policies and will follow a pre-determined schedule that is shared with the Program Clinical Liaison Officer.

(c) Transfer of Students

The SITE will transfer Students assigned to it for clinical training and experience to another SITE or clinical facility only in collaboration with and with approval of the appropriate Program Chair or designate. MICHENER may transfer a Student from the SITE to another site if the Student is unable to achieve required competencies at the SITE and MICHENER will inform the SITE immediately upon making this decision.

(d) Termination of Student Placement for Unacceptable Behaviour

(i) MICHENER recognizes the right of the SITE, after consultation with the appropriate MICHENER Program Chair, to terminate the placement in the SITE of an individual Student, if the Student's behaviour or activities are considered by the

SITE to be unacceptable. If the behaviour, conduct or activities of a Student are considered to be unacceptable, that Student will be treated by MICHENER in accordance with MICHENER's academic policies.

(ii) If, in its sole discretion, the SITE determines that a Student's behaviour or activities place patient safety at risk, or unreasonably interferes with the operation of the SITE's programs or services, the SITE may remove the Student from patient contact immediately and, after contacting the appropriate Program Chair so that MICHENER can take interim measures under its policies, may terminate the Student's placement.

7. USE OF SITE BY FACULTY FOR CLINCIAL PROFESSIONAL DEVELOPMENT

The SITE acknowledges and agrees that in addition to having access to the SITE's resources and facilities to carry out their responsibilities to the Students, MICHENER may request that certain members of Faculty have access to the SITE for the Faculty's own professional development activities. If such a request is made and the SITE can reasonably accommodate the request, the SITE will, on the same terms as for its Students as provided for in this Agreement, make available its staff, resources and facilities to members of Faculty as reasonably required by MICHENER for this purpose. The SITE and MICHENER will co-operate and work together to establish schedules, objectives and competencies that will achieve this within the SITE's existing human resources, equipment and facilities.

8. HEALTHCARE DELIVERY

In supporting the SITE in achieving its objectives and carrying out its responsibilities in healthcare delivery and patient care, the parties acknowledge that the SITE is solely responsible for all healthcare delivery and patient care that occurs on the SITE's premises or under the SITE's jurisdiction. Nevertheless, the SITE recognizes that MICHENER has an interest in patient care and healthcare delivery, as they impact on the teaching of Students. The SITE will involve MICHENER as it considers appropriate in the planning and review of procedures for patient care and the delivery of health care. MICHENER will support the SITE in its efforts and requirements to maintain excellence in its standards of patient care and healthcare delivery particularly regarding such processes as accreditation and review, and through the offering of constructive evaluation to the SITE.

9. GENERAL TERMS AND CONDITIONS

(a) Temporary Suspension of Clinical Education - Force Majeure

The parties acknowledge that in the event of circumstances beyond the control of either party such as community disaster, strike, fire, infectious outbreak or other situation in which the continued provision of facilities or assignment of students under this Agreement would substantially interfere with the SITE's primary duty of care to its patients or its research obligations or with MICHENER's teaching or research obligations, each party reserves the right to suspend performing its obligations under this Agreement immediately without penalty and until such time as the party reasonably determines that its clinical, teaching, and research facilities are again

suitably available for use, or, in the case of MICHENER, its Students and Faculty are again available. The SITE will determine and communicate with MICHENER when clinical education can be resumed.

(b) **Indemnification**

(i) MICHENER will indemnify and save harmless the SITE, its servants, agents and employees from all claims, defence costs and other losses of every kind in respect of injury, loss or damage resulting from the negligence, omission or other fault Michener Students or Faculty while at or assigned to the Site, except to the extent that the injury, loss or damage is caused or contributed to by the negligence, omission or other fault of the SITE, its servants, agents or employees.

(ii) The SITE will indemnify and save harmless MICHENER, its Students, Faculty, servants, agents and employees from all claims, defence costs and other losses of every kind in respect of injury, loss or damage resulting from the SITE's negligence, omission or other fault, except to the extent that the injury, loss or damage is caused or contributed to by the negligence, omission or other fault of MICHENER, its Students, Faculty, servants, agents or employees.

(c) **Entire Agreement**

The terms and provisions of this Agreement, its attachments, exhibits and amendments, represent the entire understanding of the parties and supersedes and overrides any prior or other written or oral agreements, representations, warranties, understandings and explanations between the parties with respect to the subject matter of this Agreement.

(d) **Notification/Notices**

(i) Unless otherwise specified in this Agreement, where the SITE is required to give notification to or consult with the MICHENER, communication with the Director, Student Success Network and Clinical Education will meet that requirement. Unless otherwise specified in this Agreement, where the MICHENER is required to give notification to or consult with the SITE, communication with **TO BE COMPLETED BY SITE** will meet that requirement. With respect to obligations of officials identified in this Agreement, if the SITE or MICHENER reassigns or reorganizes responsibilities within the institution such that the identified official is no longer appropriate to carry out the obligations assigned in this Agreement, the SITE or MICHENER, as the case may be, will notify the other party of the change to the official carrying out the obligation under the Agreement.

(ii) All notices sent to the other party pursuant to this Agreement which are required to be in writing shall be delivered by hand; or by registered mail, postage prepaid, return receipt requested; or by overnight courier; or by fax, as follows:

If to **MICHENER**: If to **SITE**:

Dean of Students
Michener Institute of Education at UHN
222 St. Patrick Street
Toronto, Ontario M5T 1V4
Phone: (416) 596-3141
Fax: (416) 596-7214

TO BE COMPLETED BY SITE

(e) **Term, Termination and Amendment of this Agreement**

The term of this Agreement is XXX XX XXXX, to XXX XX XXXX MICHENER and the SITE will commence discussions regarding renewing this Agreement no later than three (3) months before its expiry date, or, as applicable, before the expiry date of each subsequent one-year term as provided below. If, at the end of the original five (5) year term, a new agreement has not been executed and neither party has given three (3) months prior written notice of their intention not to renew this Agreement, then this Agreement will continue and survive for subsequent one year terms until such time as either a new agreement is executed or either party terminates this Agreement to be effective at the end of a one year term by giving to the other party at least three (3) months' prior written notice. Should either party terminate this Agreement, it shall not relieve either party from its obligation to allow the enrolled Students to complete the Program in which they are enrolled. No change to this Agreement shall be valid or binding unless it is set forth in writing and duly executed by the authorized representatives of the Parties hereto.

(f) **Assignment and Enurement**

This Agreement and the rights and obligations hereunder are not assignable by either party without the prior written consent of the other party. This Agreement shall enure to the benefit of and be binding upon MICHENER and the SITE and their successors and permitted assigns.

(g) **Independent Contractors**

The parties are independent contractors, and no agency, partnership, joint venture, employee-employer, or franchisor-franchisee relationship is intended or created by this Agreement.

(h) **Governing Law**

The laws of the Province of Ontario and applicable Canadian law shall govern the terms of this Agreement and the parties agree to submit to the exclusive jurisdiction of the courts of the Province of Ontario for any legal proceedings arising out of this Agreement.

(i) **Waiver of Rights**

No exercise, or failure to exercise, or delay in exercising any right, power or remedy vested in any Party under or pursuant hereto shall constitute a waiver by that Party of that or any other right, power or remedy.

(j) **Severance**

If any provision of this Agreement shall be determined by any court of competent jurisdiction to be illegal, invalid or unenforceable, that provision will be severed from this Agreement and the remaining provisions shall remain in full force and effect.

(k) **Authority**

Each Party represents to the other that it has full authority to enter into and secure performance of this Agreement, and that the person signing this Agreement on behalf of the party has been properly authorized to enter into this Agreement.

(l) **Counterparts, Facsimile**

This Agreement may be signed in several counterparts, each of such counterparts so signed shall constitute an original, and all counterparts together shall constitute a single instrument. Any signature page delivered via facsimile transmission or electronic mail (pdf format) shall be binding to the same extent as an original signature page. Any Party who delivers such a signature page agrees to subsequently deliver an original counterpart to any Party that requests it, but any failure to deliver such original counterpart will not affect the previous sentence.

IN WITNESS WHEREOF the parties have caused this Agreement to be executed by their duly authorized representatives.

THE MICHENER INSTITUTE OF EDUCATION AT UHN	**SITE**
Brian Hodges, MD, PhD, FRCPC EVP and Chief Medical Officer, UHN	Title of Authorized Signing Officer
Signature of EVP and Chief Medical Officer, UHN	Signature of Authorized Signing Officer
Date:	Date:

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.9

COUNCIL BRIEFING NOTE
RE: COLLEGE WEBSITE REVAMP AND LIGHT BRAND REFRESH

Background:

As part of the Website Revamp Project, which was approved by Council in January, the College has been reviewing its website content and information architecture to ensure content is shared online in a user-friendly, easily navigable, accessible, and visually appealing way for the College's diverse user groups and audiences. The Creative Brief is included (**3.9.1 Appendix A**) for Council's review, as it outlines the overall project plan.

Additionally, the vendor has recommended a light refresh to the website's visual design to better align with the College's brand identity. The current brand identity is not coherent or aligned with modern practices. The proposed visual refresh will include creating a modern, clear, and simplified logo that better represents foot care, along with brand assets such as style guides and templates that can be used consistently across College documents and other content. This work will take place alongside other project activities so that the new website's look, feel, and functionality are updated in a coordinated and cohesive manner. Integrating the brand and visual refresh into the broader content and layout revamp project for the website is cost-effective and supports a consistent user experience aligned with industry best practices.

Council is asked to review and approve the proposed change order (**3.9.2 Appendix B**) for the light brand refresh as part of the overall website revamp project, which will be taken out of the College Reserve Fund.

Public Interest Rationale for Decision:

College websites should provide patients and the public clear, readable, and accessible information that supports the College's public interest mandate and strategic goals. A cohesive visual identity also builds trust and helps users and various audience groups recognize that they are accessing current and relevant information from a credible healthcare regulatory body. Aligning the refreshed design and visual identity with the updated content, layout and information architecture of the website will make it easier for Ontarians to find important guidance on accessing safe, effective, and competent foot care in the province.

Recommended Motion:
That Council approve the Change Order for a light brand refresh as part of the Website Revamp Project:

Mover: _____

Seconder: _____

3.9.1 Appendix A – C(Group Creative Brief for Overall Project (FYI)
3.9.2 Appendix B – C(Group Change Order for Brand Refresh

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C R E A T I V E B R I E F

Client Name:	College of Chiropodists of Ontario (CoCoO)
Contact Name:	Shruti Tantry
Project #:	9518
Project Name:	Website Redesign & Build
Author:	Geordie Allen
Date:	March 17, 2026
Version:	2
Attachments:	Attachment A - Case for a “Light” Brand Refresh

BACKGROUND

The College of Chiropodists of Ontario (CoCoO) is the regulatory body responsible for governing the practice of chiropody and podiatry in Ontario. Through registration, standards-setting, quality assurance, and public accountability mechanisms, CoCoO ensures that practitioners practice safely, competently, and ethically in the public interest.

This project aims to redesign and rebuild CoCoO’s website to better serve its multiple audiences, modernize its digital presence, and resolve existing technical, usability, and accessibility limitations. The new site will prioritize clarity, reliability, and performance – particularly search, navigation, and registrant lookup – while meaningfully strengthening CoCoO’s professional and approachable brand expression.

The website has evolved piecemeal over time without a coherent design vision or formal brand standards, resulting in a functional but dated and visually inconsistent experience. The redesign represents the organization’s first significant, intentional investment in its digital presence, and is an opportunity to establish a modern, cohesive platform that properly reflects the College’s mandate, values, and forward direction.

At a high level, the goals of the project are to:

- Improve findability of essential regulatory documents and tools
- Deliver fast, accurate search and clear, audience-based navigation
- Elevate accessibility to WCAG 2.2 / AODA compliance without overlays
- Strengthen technical performance and backend efficiency
- Modernize digital brand expression and reduce visual fragmentation
- Create a professional, more purposeful homepage experience
- Enable clearer audience pathways (public, registrants, applicants)
- Support timely communications and seasonal priorities
- Improve integration of forms and administrative workflows
- Establish a site-hosted “News & Resources” content model

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VISION & MISSION

Vision – To achieve and maintain public confidence in the practice of chiropody and podiatry through excellence in regulation.

Mission – To regulate chiropodists and podiatrists to ensure safe, ethical, and competent care for the people of Ontario.

KEY AUDIENCES

The site serves four primary audiences: the **public and patients** seeking care or practitioner verification; **registrants** accessing standards, policies, forms, and renewal requirements; **applicants** navigating registration pathways and exam requirements; and **internal stakeholders** including staff, council, and communications teams.

KEY ATTRIBUTES / CHARACTERISTICS

The website should communicate the following qualities through its visual and experiential design:

- Credible and trustworthy
- Professional and authoritative
- Approachable and human-centered
- Modern and efficient
- Clear and structured

PRIMARY USER OUTCOMES (MUST-HAVES)

CoCoO's digital presence must balance two roles simultaneously:

- Public protection: providing clear, trustworthy, and accessible regulatory information to patients, insurers, and the public seeking to verify practitioners
- Registrant support: making professional requirements, tools, and resources easy to find and use for licensed chiropodists and podiatrists

The site should make it easy to:

- Find essential documents (standards of practice, guidelines, policies, forms)
- Locate QA reporting materials and deadlines
- Access the "Practitioner Search" tool quickly and intuitively
- Navigate clearly based on audience (public vs. registrant vs. applicant)
- Surface time-sensitive items (registration renewals, QA, exams) when relevant
- Access content effectively on mobile devices
- Engage with updates via an integrated newsletter or "News & Resources" section

NAVIGATION & INFORMATION ARCHITECTURE DIRECTION

The site should:

- Be structured around primary audiences (public, registrants, applicants) at the top navigation level
- Reduce deep nesting and hidden content, particularly in the registration area – identified as the most complex and confusing section
- Replace fragmented and duplicated content with single, authoritative sources
- Use universal or mega-style menus that reveal structure clearly

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- Make “Practitioner Search” a prominent, high-visibility feature
- Establish clear visual hierarchy on interior pages – prioritizing top actions and reducing the “all equally important” effect of current page layouts

HOMEPAGE DIRECTION

The homepage should:

- Be calmer, more breathable, and less cluttered than the current version
- Feature clear, high-priority callouts (e.g., “Find a Practitioner”)
- Use dynamic components to surface timely actions without overwhelming users
- Present CoCoO as professional, credible, and approachable
- Incorporate a newsletter-style visual rhythm – alternating imagery, iconography, and text blocks – to break up content and guide the eye

IMAGERY & VISUAL DIRECTION

The current site relies on ad-hoc stock photography and offers little visual hierarchy or personality. The redesign should:

- Use curated, contextually relevant imagery: practitioner-patient interactions, professional care environments, and tasteful, well-composed clinical imagery (including foot care where appropriate)
- Ensure imagery supports messaging rather than filling space
- Introduce iconography and visual devices to break up text-heavy pages
- Adopt a newsletter-inspired block layout (alternating colour bands, icons, and imagery) to create rhythm and reduce cognitive load

COMPARATORS

The following peer organization websites were identified as reference points for visual and functional inspiration.

- College of Pharmacists of Ontario (OCP) – professional, clean, and confident; strong “News & Resources” model
- Royal College of Dental Surgeons of Ontario (RCDSO) – noted for similarities in scope and registrant services
- College of Physiotherapists of Ontario – identified as a peer for visual and functional benchmarking
- College of Dental Hygienists of Ontario (CDHO) – calm, breathable homepage with a prominent practitioner finder

OVERARCHING CREATIVE AMBITION

The redesigned CoCoO website should feel like the digital home of a modern, confident regulator: structured, clear, and authoritative – yet approachable, helpful, and easy to navigate. It should make compliance and public protection easier to understand, while materially improving day-to-day usability for registrants, applicants, and the public.

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ATTACHMENT A

CASE FOR A "LIGHT" BRAND REFRESH

Based on stakeholder input gathered during the strategy session, C(GROUP recommends proceeding with a "light rebrand" of CoCoO's visual identity as a foundational component of the website redesign.

The rationale is clear: the current visual identity – a traditional heraldic crest accompanied by the organization's name – was not purpose-designed, lacks proper vector assets, and does not effectively communicate the values the College wishes to project: modern, trustworthy, efficient, and professional. As described by stakeholders, the existing identity reflects a history of limited design investment rather than an intentional brand position. Building an entirely new digital experience on this foundation would be a missed opportunity if not a mistake.

Importantly, this is not a recommendation for a full rebrand. A light rebrand approach would:

- Retain the institutional blue that has become associated with CoCoO – stakeholders identified this as a meaningful and recognizable anchor
- Move away from the heraldic crest, which was acknowledged to carry dated, colonial associations and limited scalability across digital touchpoints
- Develop a clean, contemporary wordmark or symbol-based logo that is properly engineered for web, mobile, print, and co-branding contexts
- Introduce a refined, complementary colour palette to support the primary blue
- Establish a concise Brand Style Guide covering: logo usage and clear space, primary and secondary colour palette, approved typography, and application guidelines for web, documents, and social media
- Ensure visual consistency between the new website and the IMUS public register portal through the provision of updated style sheets

Precedent within the regulatory college sector supports this direction. Organizations such as the College of Psychologists and Behavioural Analysts of Ontario have successfully transitioned from traditional crests to purpose-built modern identities – retaining institutional continuity while meaningfully updating their visual positioning.

The light rebrand will be scoped and priced separately but is strongly recommended as a prerequisite to – or parallel workstream with – the website design phase, to ensure the site is built on a considered and durable visual foundation.

It is important to note that undertaking a light rebrand in conjunction with the website redesign is both cost-effective and strategically sound. Creative discovery – defining visual values, colour palette, typography, and brand personality – is completed once and applied to both deliverables simultaneously rather than repeated as a separate engagement. Stakeholder time, briefing sessions, and approval cycles serve double duty, and the already-mobilized project team absorbs the rebrand with minimal additional overhead. The result is a meaningfully lower cost of entry than a standalone rebrand – and a website that launches rooted in a considered visual identity rather than one that needs to be retrofitted later.

ITEM 3.9.2

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C H A N G E O R D E R

To: **College of Chiropodists of Ontario**
180 Dundas St W., #1901, Toronto, ON M5G 1Z8

From: Geordie Allen
Date: March 30, 2026
Project #: 9518 – Website Design & Build
Change Order #: 1

We are pleased to submit the following Change Order for additional services requested on Project #9518 Website Design & Build. The pricing below assumes this project is combined with the strategic and design phases of the website project to achieve maximum efficiency and resulting cost-savings as follows:

Scope of Additional Services & Fees

Description	Fee
PHASE I – ASSESSMENT & POSITIONING • Interviews, meetings and discussions with leadership/stakeholders • Assess relevant comparators and peers • Distill and synthesize creative vision for the identity • Development of Creative Brief document for branding *As a stand-alone project: $3,750* *If combined with website project: $0*	$0
PHASE II – VISUAL IDENTITY DESIGN • Generation and exploration of identity design concepts • Internal reviews and critiques • Refinement and detailed design of selected designs (3-5) • Presentations, meetings and discussion to facilitate selection and approvals • Creation of artwork (all formats) for 1 final chosen design *As a stand-alone project: $6,000* *If combined with website project: $4,200*	$4,200
PHASE III – BRAND GUIDELINES • Development standards for logo usage • Development of an extended visual brand language • Production of a Brand Guide in PDF format. Actual sections will be determined based on discussion/need. Consider: - Brand Voice / Introduction - Approved Logo Artwork - Primary and Secondary Colour Palette - Minimum Logo Space and Size Requirements - Preferred Logo Application - Approved Typography - Sample Marketing Applications - And so on, based on discussion and approval. *Priced per page @ $350 (assumes 10)*	$3,500
Project Total	**$7,700**

Summary of Additional Terms:

1. Applicable taxes are additional.
2. Assumes English only.
3. Hourly rates for this project for all resources has been discounted to $175/hr. This rate supersedes our Standard Hourly Rates.
4. The purchase of custom or stock photography or illustration is additional.
5. The Standard Terms and Conditions of the master contract apply to this Change Order.

Billing Schedule

All fees will be invoiced by C(GROUP according to the following schedule. Thank you for waiting to receive the invoice(s) before sending payment.

Invoice Due Date	Amount
Upon approval/signing of this Change Order	50% of Fees + Taxes
Upon presentation of design concepts	25% of Fees + Taxes
Upon delivery of brand standards guide (first draft)	Balance of Fees + Taxes

Authorization

The signature of the client on this Change Order denotes the client's approval of the work and its related and authorizes C(Group to commence the work outlined herein. The parties hereto have caused this Change Order to be executed by their duly authorized and empowered officers and representatives.

College of Chiropodists of Ontario:

_____
Signature

_____
Name

_____
Date

C(GROUP Ltd.:

Signed ***GEORDIE ALLEN***
_____
Signature

Geordie Allen

March 30, 2026

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COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 3.10

AUDIT COMMITTEE REPORT

May 21, 2026 Council Meeting

COMMITTEE MEMBERS

Chair: Chad Bezaire, Professional Member

Professional Members (Council):
Ed Chung, Podiatrist

Professional Members (Non-Council):
None

Public Appointee:
Reshad Nazeer
Chad McCleave

ROLE OF THE COMMITTEE

To assist Council in the consideration of the College's audited financial statements, including meeting with the College's auditors at least once before the audited annual financial statements are presented by the Committee for approval of Council. The Audit Committee also reviews the proposed draft operating budget each year, makes recommendations and approves the draft prior to presenting the budget to Council for approval.

MEETINGS

The Audit Committee met with the College's Auditors on May 11, 2026 to review and discuss the Audit Report and Audited financial statements.

DECISION/OUTCOMES

The Audit Committee passed a motion recommending that Council accept the Audit Report and approve the Audited Financial Statements provided.

NEXT MEETING

N/A

COLLEGE OF CHIROPODISTS OF ONTARIO

INDEPENDENT AUDITOR'S REPORT ON SUMMARY FINANCIAL STATEMENTS

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TO THE COUNCIL OF THE COLLEGE OF CHIROPODISTS OF ONTARIO

Opinion

The summary financial statements of the College of Chiropodists of Ontario (the "College"), which comprise the summary statement of financial position as at December 31, 2025, and the summary statement of operations for the year then ended, are derived from the audited financial statements of the College for the year ended December 31, 2025.

In our opinion, the accompanying summary financial statements are a fair summary of the audited financial statements of the College for the year ended December 31, 2025, except that information in respect of changes in net assets and cash flows has not been presented and notes to the summary financial statements have not been prepared as further described in the *Summary Financial Statements*.

Summary Financial Statements

The summary financial statements do not contain all the disclosures required by Canadian accounting standards for not-for-profit organizations. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements of the College and the auditor's report thereon. The summary financial statements and the audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on the audited financial statements

The Audited Financial Statements and Our Report Thereon

We expressed an unmodified audit opinion on the audited financial statements in our report dated May XX, 2026.

Management's Responsibility for the Summary Financial Statements

Management is responsible for the preparation of a summary of the audited financial statements in accordance with Canadian accounting standards for not-for-profit organizations, except that information in respect of changes in net assets and cash flows has not been presented and notes to the summary financial statements have not been prepared.

Auditor's Responsibility for the Summary Financial Statements

Our responsibility is to express an opinion on whether the summary financial statements are a fair summary of the audited financial statements based on our procedures, which were conducted in accordance with Canadian Auditing Standard (CAS) 810, "Engagements to Report on Summary Financial Statements".

Toronto, Ontario

CHARTERED PROFESSIONAL ACCOUNTANTS
Licensed Public Accountants

SUMMARY STATEMENT OF FINANCIAL POSITION
AS AT DECEMBER 31, 2025

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		2025		2024
ASSETS				
Cash	**$**	**416,853**	$	231,048
Investments		**1,328,687**		1,336,908
Accounts receivable and prepaid expenses		**76,920**		104,984
Equipment		**1,505**		2,881
		1,823,965		1,675,821
LIABILITIES				
Accounts payable and accrued expenses and deferred revenue		**343,026**		289,245
NET ASSETS				
Abuse therapy fund		**10,000**		10,000
General reserve fund		**661,220**		700,000
Unrestricted balance		**809,719**		676,576
		1,480,939		1,386,576
	$	**1,823,965**	$	1,675,821

SUMMARY STATEMENT OF OPERATIONS
YEAR ENDED DECEMBER 31, 2025

		2025		2024
Revenues				
Annual general and other fees	**$**	**2,053,875**	$	1,950,220
Other income - expense recoveries, interest		**292,126**		263,977
		2,346,001		2,214,197
Expenses				
Salaries and benefits		**900,211**		809,648
Office, general and other		**147,338**		192,802
Legal		**535,675**		683,726
Council and committee expenses		**330,985**		249,419
Rent		**106,728**		103,617
Photocopy, postage, printing and telephone		**3,947**		2,796
Repairs and maintenance		**25,799**		21,485
		2,050,683		2,063,493
Special projects - Consulting fees, inhalation course and registration exam development		**162,175**		163,296
Cloud migration		**38,780**		-
		2,251,638		2,226,789
Excess (deficiency) of revenues over expenses for the year	**$**	**94,363**	$	(12,592)

Complete audited financial statements are available upon request from the office of the Registrar.

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COLLEGE OF CHIROPODISTS OF ONTARIO

FINANCIAL STATEMENTS

December 31, 2025

HILBORN LLP

Independent Auditor's Report

To the Council of College of Chiropodists of Ontario

Opinion

We have audited the financial statements of College of Chiropodists of Ontario (the "College"), which comprise the statement of financial position as at December 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 December 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.

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.

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
Date to be determined

Chartered Professional Accountants
Licensed Public Accountants

COLLEGE OF CHIROPODISTS OF ONTARIO

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Statement of Financial Position

December 31, 2025

	2025	2024
ASSETS		
Current assets		
Cash *(note 2)*	**$ 416,853**	$ 231,048
Short-term investments *(note 3)*	**841,045**	869,934
Accounts receivable *(note 4)*	**41,200**	60,500
Prepaid expenses	**30,720**	44,484
	1,329,818	1,205,966
Accounts receivable - long-term portion *(note 4)*	**5,000**	-
Furniture and equipment *(note 5)*	**1,505**	2,881
Long-term investments *(note 3)*	**487,642**	466,974
	494,147	469,855
	1,823,965	1,675,821
LIABILITIES		
Current liabilities		
Accounts payable and accrued expenses *(note 6)*	**208,241**	158,145
Deferred revenue	**134,785**	131,100
	343,026	289,245
NET ASSETS		
Abuse therapy fund	**10,000**	10,000
General reserve fund	**661,220**	700,000
Unrestricted balance	**809,719**	676,576
	1,480,939	1,386,576
	$ 1,823,965	$ 1,675,821

The accompanying notes are an integral part of these financial statements.

Approved on behalf of the Council:

President

Member

COLLEGE OF CHIROPODISTS OF ONTARIO

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Statement of Operations

Year ended December 31, 2025

	2025 Actual	2025 Budget	2024 Actual
Revenues			
Annual general fees	$ 1,707,500	$ 1,750,700	$ 1,636,000
Other fees - initial, application, examination and others	346,375	330,625	314,220
	2,053,875	2,081,325	1,950,220
Other income			
Interest	60,276	85,000	89,867
Miscellaneous	45,350	38,000	31,110
Expense recoveries *(note 4)*	186,500	195,000	143,000
	2,346,001	2,399,325	2,214,197
Expenses			
Accounting and audit	31,132	30,000	28,815
Bad debt *(note 4)*	-	-	6,000
Bank and credit card charges	38,115	36,000	33,706
Council and committee expenses			
Per diem	77,844	314,150	86,202
Travel expenses	37,211	-	35,556
General and committee	174,856	-	43,009
Complaints investigation	41,073	-	84,652
Depreciation	1,377	3,200	1,679
Computer software and maintenance	25,799	25,000	21,485
General and office	37,297	39,480	18,538
Insurance	9,620	10,000	14,316
Legal	535,675	620,000	683,726
Photocopy and printing (recovery)	190	500	288
Postage and mailing	1,331	500	-
Rent	106,728	155,000	103,617
Salaries and benefits *(note 8)*	900,211	900,000	809,648
Settlement costs	-	-	32,500
Telephone	2,426	2,700	2,508
Web site	29,798	30,000	57,248
	2,050,683	2,166,530	2,063,493
Special one-time projects - Registration exam development	162,175	154,800	163,296
- Database development	38,780	35,000	-
Total expenses	2,251,638	2,356,330	2,226,789
Excess (deficiency) of revenues over expenses for the year	$ 94,363	$ 42,995	$ (12,592)

The accompanying notes are an integral part of these financial statements.

COLLEGE OF CHIROPODISTS OF ONTARIO

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Statement of Changes in Net Assets

Year ended December 31, 2025

	Abuse Therapy Fund	General Reserve Fund	Unrestricted Net Assets	Total 2025
Balance - at beginning of year	**$ 10,000**	**$ 700,000**	**$ 676,576**	**$ 1,386,576**
Excess of revenues over expenses for the year	**-**	**(38,780)**	**133,143**	**94,363**
Balance - at end of year	**$ 10,000**	**$ 661,220**	**$ 809,719**	**$ 1,480,939**

	Abuse Therapy Fund	General Reserve Fund	Unrestricted Net Assets	Total 2024
Balance - at beginning of year	$ 10,000	$ 500,000	$ 889,168	$ 1,399,168
Deficiency of revenues over expenses for the year	-	-	(12,592)	(12,592)
Allocation to General Reserve Fund	-	200,000	(200,000)	-
Balance - at end of year	10,000	700,000	676,576	1,386,576

The accompanying notes are an integral part of these financial statements.

COLLEGE OF CHIROPODISTS OF ONTARIO

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Statement of Cash Flows

Year ended December 31, 2025

	2025	2024
Cash flows from operating activities		
Annual general and other fees received	**$ 2,057,560**	$ 1,905,020
Interest received	**60,276**	89,867
Expense recovery and miscellaneous income received	**246,150**	248,360
Cash paid to employees and suppliers	**(2,186,401)**	(2,317,934)
	177,585	(74,687)
Cash flows from investing activity		
Purchase of investments	**(861,714)**	(1,336,908)
Redemption of investments	**869,934**	-
Purchase of furniture and equipment	**-**	(1,494)
	8,220	(1,338,402)
Change in cash during the year	**185,805**	(1,413,089)
Cash - at beginning of year	**231,048**	1,644,137
Cash - at end of year	**$ 416,853**	$ 231,048

The accompanying notes are an integral part of these financial statements.

COLLEGE OF CHIROPODISTS OF ONTARIO

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Notes to Financial Statements

Year ended December 31, 2025

The College of Chiropodists of Ontario (the "College") has a duty to serve and protect the public interest. The College ensures that the public receives competent care from chiropodists and podiatrists by:

- Regulating the practice of the profession and governing the members in accordance with the Chiropody Act, 1991, the Regulated Health Professions Act, and the regulations and by-laws.
- Establishing standards of practice.
- Establishing educational requirements for entry to practice and continuing competence.
- Addressing any concerns from the public.
- Educating and providing information to the public about chiropody and podiatry.

The College is the governing body established by the provincial government to regulate the practice of chiropody and podiatry in Ontario under the Regulated Health Professions Act and was enacted by statute under the Chiropody Act (1991). The College is a not-for-profit corporate body without share capital and, as such, is generally exempt from income taxes.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These financial statements have been prepared using Canadian accounting standards for not-for-profit organizations and are in accordance with Canadian generally accepted accounting principles. These financial statements have been prepared within the framework of the significant accounting policies summarized below:

(a) Basis of Presentation

Operations

The statement of operations reflects the day-to-day activities of the College financed by annual general fees as well as other fees.

Abuse Therapy Fund

In accordance with The Regulated Health Professions Act, the College has set up the Abuse Therapy Fund to provide therapy and counselling for persons who, while patients, were sexually abused by a member(s). This fund will be expended on persons who satisfy the College's eligibility criteria.

General Reserve Fund

The College has set up the general reserve fund for the specific purpose of covering operating expenses in the event of unanticipated financial expenditures or occurrences.

In fiscal 2021, the Council approved a motion to increase the general reserve fund over the next three years with the target amount of $300,000 by the end of 2022, $500,000 by the end of 2023 and $700,000 by the end of 2024. During the year, the College spent $38,780 on IT upgrades, which were paid with the funds from the general reserve fund.

(b) Revenue Recognition

Annual general fees are recognized as revenue in the year to which fees relate. Fees received in advance are deferred and recognized in the related period.

All other fees and income are recognized as revenue when the services are provided or as earned.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

(c) **Financial instruments**

Measurement of financial assets and liabilities

The College initially measures its financial assets and liabilities at fair value.

The College subsequently measures all of its financial assets and financial liabilities at amortized cost.

Financial assets and liabilities measured at amortized cost include cash, accounts receivable, investments and accounts payable and accrued expenses.

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.

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.

Impairment

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.

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.

(d) Investments

Investments consists of guaranteed investment certificates (GICs). GICs with maturity dates within one year after the year-end date are classified as short-term investments. GICs with maturity dates beyond one year after year-end date are classified as long-term investments.

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (continued)

(e) Furniture and Equipment

Furniture and equipment is recorded at cost. Depreciation is provided on a straight-line basis over the estimated useful lives of the assets at the following annual rates:

Computer	- 33 1/3%
Furniture and equipment	- 20%

The above rates are reviewed annually for ongoing appropriateness. Any changes to these estimates are adjusted on a prospective basis. If there is an indication that the property and equipment assets may be impaired, an impairment test is performed that compares carrying amount to net recoverable amount. There were no impairment indicators in 2025.

(f) Employee future benefits

The College contributes to the Healthcare of Ontario Pension Plan (the "Plan" or "HOOPP") which is a multi-employer defined benefit pension plan. A majority of the employees of the College are members of HOOPP.

In accordance with CPA Handbook section 3642, the multi-employer defined benefit plan is accounted using defined contribution plan accounting due to sufficient information not available to use defined benefit plan accounting.

The College's policy is to expense the contributions in the year in which the contributions are made to the Plan.

(g) Use of Estimates

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

Key areas where management has made difficult, complex or subjective judgment, include provisions for legal claims and allowance for doubtful accounts. Actual results could differ from these and other estimates, the impact of which would be recorded in future affected periods.

2. FINANCIAL INSTRUMENTS AND RISK EXPOSURE

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.

Credit Risk

Credit risk is the risk that one party to a transaction will fail to discharge an obligation and cause the other party to incur a financial loss. The College's main credit risks relate to cash, accounts receivable and investments. The College maintains its cash and investments at a federally regulated schedule I bank. The College mitigates credit risk by monitoring the accounts on a regular basis and provides provisions whenever collection is in doubt. As at the end of the year, $83,299 ($83,299 - 2024) has been provided for doubtful accounts.

Liquidity Risk

Liquidity risk is the risk that the College will not be able to meet its financial obligations when they become due to its creditors. The College is exposed to this risk mainly in respect of its accounts payable and accrued liabilities. The College expects to meet these obligations as they come due by generating sufficient cash flow from operations.

2. *FINANCIAL INSTRUMENTS AND RISK EXPOSURE (continued)*

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 comprises three types of risk: currency risk, interest rate risk and other price risk. The College is not exposed to currency or other price risks. The College is exposed to interest rate risk.

Interest rate risk is the risk that changes in market interest rates will cause fluctuations to the fair values and cash flows of the College's investments in interest bearing financial instruments. The College is exposed to interest rate risk with respect to its deposit account at the bank and investments in GICs. As at the end of the year, the College held an interest bearing bank account in a total of $137,254 ($141,606 - 2024), which is included in Cash. Details of investments in GICs are disclosed in note 3.

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.

3. INVESTMENTS

	2025	2024
Short-term		
MTCC 388 Day GIC - 5.20%, due March 21, 2025	$ -	$ 52,201
BNS Long Term Non-Redeemable GIC - 5.00%, due August 27, 2025	-	104,233
BNS Cashable GIC - 2.25%, due February 27, 2026 (4.70%, due February 27, 2025 - 2024)	732,179	713,500
SMC Long Term Non-Redeemable GIC - 4.70%, due August 27, 2026)	108,866	-
	841,045	869,934
Long-term		
SMC Long Term Non-Redeemable GIC - 4.70%, due August 27, 2026)	-	103,979
MTCC Long Term Non-Redeemable GIC - 4.50%, due February 27, 2027	108,481	103,810
BNS Long Term Non-Redeemable GIC - 2.96%, due February 27, 2027	108,728	
NTC Long Term Non-Redeemable GIC - 4.40%, due February 28, 2028	108,289	103,725
BNS Long Term Non-Redeemable GIC - 4.30%, due February 27, 2029	162,145	155,460
	487,643	466,974
	$ 1,328,688	$ 1,336,908

4. EXPENSE RECOVERIES

The Discipline Committee of the College orders members to pay the College towards its costs and expenses for investigating and hearing complaints/matters against the members. The expense recoveries include $186,500 ($143,000 - 2024) from members and accounts receivable includes $129,499 ($143,799 - 2024) from members for such orders. An allowance of $83,299 ($83,299 - 2024) has been set up for which collections are not reasonably assured.

5. PROPERTY AND EQUIPMENT

2025	***Cost***	***Accumulated Depreciation***	***Net Book Value***
Computer equipment	**$ 21,671**	**$ 20,166**	**$ 1,505**
Office furniture	**23,340**	**23,340**	**-**
	$ 45,011	**$ 43,506**	**$ 1,505**

2024	*Cost*	*Accumulated Depreciation*	*Net Book Value*
Computer equipment	$ 21,670	$ 19,159	$ 2,511
Office furniture	$ 23,340	$ 22,970	$ 370
	$ 45,010	$ 42,129	$ 2,881

Total depreciation of $1,377 ($1,679 - 2024) has been included in the Statement of Operations.

6. ACCOUNTS PAYABLE AND ACCRUED EXPENSES

Accounts payable and accrued expenses include government remittances totaling $NIL ($NIL - 2024).

7. COMMITMENTS

Leases

The College is committed to annual minimum rental payments under operating lease for premises, which has two renewal options upon expiry, each for 5 years starting from April 1, 2024 and April 1, 2029. In the prior year, the College excised the renewal option for 5 years from April 1, 2024 to March 31, 2029. In addition, the college has an equipment lease expiring June 30, 2027. The minimum payments for the next five years are as follows:

	Premises	***Equipment***	***Total***
2026	$ 48,563	$ 4,109	$ 52,672
2027	48,951	2,055	51,006
2028	50,116	-	50,116
2029	12,626	-	12,626
	$ 160,256	$ 6,164	$ 166,420

In addition, the College is also committed to pay its proportionate share of taxes, utilities and operating costs of the premises, which is $53,170 ($51,375 - 2024).

7. COMMITMENTS (continued)

Software License

The College has signed an agreement with Advanced Solutions International for iMIS usage with a term of two years from September 1, 2025 to August 31, 2027 under which, the College committed to pay licensing fees of $16,026 in 2026 and $11,103 in 2027.

Consulting

Subsequent to the year end, the College has signed a consulting contract in connection with the 2026 examination process in the amount of $69,300 plus applicable taxes covering the service period from January 1, 2026 to December 31, 2026.

8. PENSION PLAN

The College is a participating employer of the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer, defined benefit pension plan. During the year, a total of $132,769 ($125,983 - 2024) was contributed to HOOPP, of which $73,572 ($66,568 - 2024) was contributed by the College and included in salaries and benefits in the statement of operations.

9. CONTINGENCIES

From time to time, in connection with the College's operations, the College receives complaints from its clients or employees or is party to legal and regulatory proceedings. A provision is recorded when a loss is likely and the amount is determinable. There is no provision for 2025.

COLLEGE OF CHIROPODISTS OF ONTARIO

Regulating Chiropodists and Podiatrists in Ontario

ITEM 7.1

Registrar's Report: May 21, 2026

The 2026 year has been off to a busy start in professional regulation with the College engaged in many collaborative exercises with its peers in regulation as well as system partners. The College has also been busy with internal operations. At our May meeting the College will present its audited financial statements for approval by Council and that means I, along with our accountant, have been busy with the College auditors ensuring they have access to all documents requested to complete the audit.

I have now celebrated my 5-year anniversary serving as Registrar & CEO to the College and Council. One of my longstanding commitments and goals in fulfilling my role as Registrar has been to increase the profile of the College both at a provincial and national level. It's recognized that in increasing the profile of the College and the critical contributions of College registrants in primary care for Ontarians, the public we serve to protect will be aware of the role of the College, its registrants and understand how to access the College's resources. We have continued to focus on supporting registrants with continuing education modules and meaningful engagement to help registrants offer the best care to their patients.

National Conference of Footcare Regulators:
In early May the College was pleased to attend and engage with footcare regulators from across Canada discussing matters of common interest and importance. Attendees recognize the importance of national meetings and engagement particularly in light of labour mobility across Canada. Plans are underway for the next national meeting of footcare regulators.

I am humbled and encouraged by my footcare regulatory peers' shared commitment to national alignment across jurisdictions in support of the advancement of protecting the public interest. When I initially proposed an inaugural national conference in April 2025, footcare regulators across the country participated and came together with a willingness to collaborate and communicate in furtherance of our shared mandates of public protection. This year, our regulatory colleagues in Manitoba hosted the second Annual National Conference and created the opportunity for rich and meaningful discussion. We are looking forward to the next conference with our national peers.

HPRO Education Conference:
On May 1, 2026 the Education Committee of the Health Profession Regulators of Ontario (HPRO) held an all-day conference focusing on governance matters. Attendees from across the health colleges as well as affiliate colleges, came together to learn from esteemed speakers about topics relevant for Council and Committee members as well as the staff who support them. As the Chair of the Education Committee, I, along with HPRO"s Executive Director, Beth Ann Kenny and Education Committee members Margaret Drent, Registrar & CEO of the College of Audiologists and Speech Language Pathologists of Ontario, and Kelly Dobbin, Registrar & CEO of the College of Midwives, organized the event and were very pleased with the quality of guest speakers and attendee participation.

Meeting with Michener Students:
I attended at the Michener twice this year to meet with second and third-year Michener Chiropody students. I always enjoy having an opportunity to meet with Chiropody students and discuss their future as registrants

of a regulatory body. I am also always impressed by the questions raised by students about professional regulation and the future of foot care in Ontario. Staff, including the College's new Manager, Registration and Regulatory Programs, Erin Simpson, joined me in my most recent meeting with third-year students and we answered questions about the upcoming registration exams.

The President, Peter Stavropoulos, and I attended at The Michener Institute's award ceremony at the end of April to present The Michener Institute's 2026 *College of Chiropodists of Ontario's (COCOO) Scholarship in Memory of David Weston, D.P.M*. to recipient and Chiropody student, Ibrahim Sulaiman.

Registration Examinations:
The College will be hosting the Spring Registration Examinations on May 15 and May 16. The College has 43 applicants who are registered for the exams this Spring. I want to acknowledge the hard work and dedication of the College's Registration Examination Committee and Exam Setters under the leadership of Committee Chair, Stephanie Shlemkevic, with support from Manager, Erin Simpson. The registration exams would not be the success they are without the help of our many registrants who give their time generously in participating in the exams.

Council on Licensure, Enforcement and Regulation (CLEAR) Toronto Symposium:
I was invited to sit on the planning committee for CLEAR's Toronto Symposium on May 14. As a group representing regulators in Ontario and the U.S., we met over the course of the winter months to plan a one-day symposium focusing on professional regulation. We have finalized the speakers list and I will be the Emcee for the event as well as a guest speaker speaking about how our College has taken active steps to increase access to foot care by First Nations communities. Attendees will come from across the regulatory system in the Toronto area.

Spring Town Hall June 2, 2026:
Once again the College will host a Town Hall meeting with registrants to discuss relevant, timely topics. Since becoming Registrar, I have held two Town Hall meetings annually with one in the Spring and one in the Winter. The upcoming Town Hall will be held virtually on Tuesday, June 2, 2026. Registrants are encouraged to attend.

More Continuing Education Modules:
Our next suite of CE modules will focus on communication issues that arise in professional health regulation. The aim of the modules is to assist registrants in understanding the common pitfalls of poor communication with suggested methods for improving communication in treating patients. This will in turn improve patient safety and overall satisfaction. Within professional regulation communication issues give rise to the largest number of complaints with many being readily avoided with careful attention to effective communication practices. Registrants should look for further CE modules as the College produces more modules aimed at helping registrants.

College of Chiropodists of Ontario

Key Performance Indicators

October 2025 to October 2026

Key Performance Indicator	Metric Used	Desired Outcome	Status
Annual review of financial reserves to ensure sufficiency of funds in compliance with the College's Financial Reserve Policy.	Registrar's regular reporting to Council on the status of the Reserve Fund.	The maintenance of the Reserve Fund in compliance with the Reserve Fund Policy.	✓
Continuous improvement of the College's performance in the College Performance Measurement Framework (CPMF) metrics.	Tracking CPMF submissions year over year to determine rate of compliance with CPMF requirements.	Full compliance with the CPMF requirements.	✓
Financial reporting by the Registrar at each Council Meeting.	A written or oral report from the Registrar to Council at each Council Meeting regarding the most recent financial status.	Sound financial stewardship of the College by the Registrar with proper oversight by Council.	✓
Annual onboarding and orientation of new Councillors, Chairs and Committee Members before the first Council Meeting. **Exit interviews of Council members.**	Planned and executed onboarding and orientation for new Councilors, Chairs and Committee members. Exit interviews requested upon departure of Councillors.	Properly prepared and oriented Councilors, Chairs and Committees who are well placed to conduct College business in protecting the public. The College collects feedback from those who have recently engaged in College work on Council to improve orientation and training for Councilors.	✓
Maximize value of College's membership in the Health Professions Regulators of Ontario (HPRO) with regular engagement by Registrar and Staff, where appropriate.	Regular engagement (attendance at meetings and events) by the Registrar and staff with other health regulators through HPRO.	Ensure the College maintains currency in trends in professional health regulation, fosters good relationships with other HPRO regulators and elevates the profile of the College through participation in the provincial health profession landscape.	✓
Ongoing engagement by the College and Registrar with the Ministry of Health, HPRO, other health regulators, associations, and organizations with a view to increasing the profile of the College, its mandate and Strategic Plan.	Regular reporting by Registrar to Council regarding engagements with system partners.	Fulfillment of the College towards its mandate of protecting the public by active engagement with system partners in support of its strategic plan.	✓
Establish and update the foundational competencies for the Full Scope Podiatry Model (FSPM) to ensure the College's agility and responsiveness upon the adoption of the FSPM.	A complete list of all anticipated competencies for registrants with expanded scopes of practice pursuant to the FSPM.	Ensure the College is best positioned to be responsive upon the adoption of the FSPM.	✓

Key Performance Indicator	Metric Used	Desired Outcome	Status
Development of the College's procedural plan for implementation of the FSPM, including identifying critical system partners and necessary steps towards implementation.	A sound procedural plan in place for the College to follow in the event the FSPM is adopted in the province.	The College has established a well-considered plan to implement the FSPM and smoothly transition to the new model of footcare.	
The College applies Right-Touch Regulation practices to ensure its regulatory actions are proportionate to the level of risk to the public, including the application of risk-based considerations to best protect the public.	The College approaches all regulatory practices through the lens of Right-Touch Regulation.	The College adheres to Right-Touch Principles in its Regulatory practices.	
The College will embody and promote the principles of diversity, equity, and inclusion through: • **Increasing our awareness and understanding of the diversity of our registrants and of the communities they serve through engagement and consultation;** • **Acknowledging where improvements in diversity, equity and inclusion can be achieved; and** • **Addressing identified issues such as systemic racism and bias that may create barriers to effective foot care.**	The College regularly monitors its EDI practices to ensure EDI principles are promoted.	The College embraces EDI principles as part of its mandate.	
The College demonstrates its commitment to developing continuing education materials, including modules, to assist registrants in improving their practices.	Ongoing development of, and improvement to, the College's continuing educational materials for registrants. Tracking access to College materials by users.	The College is a trusted resource for registrants in maintaining competency through continuing educational resources.	
The College strives to continually enhance its social media engagement on the College's social media platforms as a key metric of success. **The College's content will focus on foot care excellence and public protection.**	Tracking Social Media clicks, likes, shares and follows.	The College is a reliable Social Media content creator producing and sharing relevant material related to foot care and public protection.	
Regular assessments and review of Council's oversight and accountability and the College's support of Council in achieving their oversight obligations.	Regular feedback from Councillors following every Council meeting to ensure sufficiency of materials with adequate time to review to make informed decisions. Evaluation of Council's functioning by an external auditor with expertise in governance every 3-5 years.	The College Council is a well-functioning board that engages in appropriate oversight of the College with corresponding accountability to system partners.