BOARD OF DIRECTORS

POLICY & PROCEDURE MANUAL

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Gary Fortin
Chair, Board of Directors

France Dallaire
Chief Executive Officer

SENSENBRENNER HOSPITAL

BOARD OF DIRECTORS

POLICY AND PROCEDURE MANUAL

I N D E X

* LEGEND	
N YY/MM	**-New**
R YY/MM	**-Revised**
YY/MM	**-Reviewed**

Revised: December 2018

SENSENBRENNER HOSPITAL
BOARD OF DIRECTORS
POLICY & PROCEDURE MANUAL

POLICY NO.: 02-010
PAGE 1 of 1

ISSUED BY: ETHICS COMMITTEE/
BOARD OF DIRECTORS

MANUAL DISTRIBUTION:
BOARD OF DIRECTORS

APPROVED BY: CEO

CATEGORY: N/A

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ORIGINAL DATE OF ISSUE:
February 6, 2008

REVIEW/REVISION (YY/MM):

BOARD ACCOUNTABILITY STATEMENT

BOARD ACCOUNTABILITY

The Sensenbrenner Hospital board is accountable to members of the hospital for acting consistently with the Articles of Incorporation, the by-laws, applicable legislation, the common law as it governs hospitals and the achievement of its mission and vision. The directors exercise the power vested in them in good faith and honesty in order to further the purposes for which the hospital was created. They act in what they consider to be the best interests of the hospital, each exercising his or her unfettered discretion in decision making. Appointed directors fulfil the same duty to the corporation, placing the interests of their nominator or group subordinate to those of the corporation. Directors do not place themselves in a position where their personal interests conflict with those of the hospital.

The directors establish objectives that are within the capacity of the hospital's plant and resources. The board strikes to maintain a balance within its medical and other staff to ensure a broad base of expertise while attaining the most efficient utilization of the facilities and resources of the hospital.

In choosing between competing demands on scarce resources, the board has established the following accountabilities:

To Members of the Corporation	For acting consistently with the Articles of Incorporation, the by-laws, applicable legislation, the common law as it governs corporations and the achievement of its mission and vision.
To Patients/Clients	For safe, family-centred care and best practices.
To Ministry of Health and Long-Term Care (MOHLTC) and Local Health Integration Network (LHIN)	For expenditure management compliance with policies and regulations, data quality and performance management.
To the Foundation	For donor stewardship and support.
To Staff, Volunteers and Physicians	For transparent processes.
To Partners	For collaboration.
To Communities We Serve	For advocacy, communication and expectation management.

SENSENBRENNER HOSPITAL
BOARD OF DIRECTORS
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POLICY NO.: 02-020
PAGE 1 of 2

ISSUED BY: EXECUTIVE COMMITTEE/ BOARD OF DIRECTORS

MANUAL DISTRIBUTION: BOARD OF DIRECTORS

APPROVED BY: BOARD OF DIRECTORS

CATEGORY: N/A

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(Mr. Gary Fortin, Board Chair)

ORIGINAL DATE OF ISSUE:
September 20, 2017

REVIEW/REVISION (YY/MM):

CONSENT AGENDA

Purpose

To ensure the efficiency and effectiveness of board meetings.

To provide an efficient process for approval of regular or routine issues that come before the board, or matters where no debate is anticipated.

Policy

Content of Agenda

The agenda for board meetings will distinguish between the following types of matters:

- Motion/Decision
- Discussion
- Information

Only decision items will require a motion, seconder and a vote.

Items requiring a decision that are expected to require no discussion or debate may, at the Chair's option, be placed on the agenda under the heading "Consent Agenda".

Materials and motions proposed to be dealt with under the consent agenda portion of the agenda shall be clearly identified as falling under the consent agenda in the meeting packages. Board members should review the consent agenda items prior to the meeting on the expectation that no discussion will take place during the board meeting.

BOARD MEETINGS - FORMAT

Approval of Agenda

The agenda will be approved by the board at the beginning of each meeting.

Members of the board may request that matters be added, deleted or that the order of items be moved and the Chair shall make a decision on each such request. Any such decision may be subject to challenge and reversed by the board.

Items may be moved out of the consent agenda section at the request of any member of the board prior to approval of the agenda. No motion or vote of the board is required with respect to a request to move an item out of the consent agenda.

When a member of the board requests that an item be moved out of the consent agenda section, the Chair shall decide where to place that item on the agenda.

When only one item in a committee report does not qualify as a consent agenda item or is requested to be moved, that item shall be moved out of the consent agenda and the rest of the items in the report shall remain in the consent agenda.

Approval of the agenda by the board constitutes approval of each of the items listed under the consent agenda portion of the meeting. No separate vote to approve the consent agenda portion is required.

Minutes

Minutes of the meeting will include the full text of resolutions adopted under the consent agenda portion of the meeting.

Amendment

This policy may be amended by the Board.

ISSUED BY: EXECUTIVE COMMITTEE/ BOARD OF DIRECTORS

MANUAL DISTRIBUTION: BOARD OF DIRECTORS

APPROVED BY: BOARD CHAIR

CATEGORY: N/A

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Ray (Ted) Thompson, Board Chair

ORIGINAL DATE OF ISSUE:
April 2, 1997

REVIEW/REVISION (YY/MM): R07/07, R12/04

BOARD MEETINGS - FORMAT

PURPOSE

Meetings of Sensenbrenner Hospital's Board of Directors are, unless otherwise stated, open to the public. The policy for open meetings is intended to facilitate the conduct of the Board's business in an open and transparent manner; generate trust, openness and accountability while also ensuring that the Hospital maintains a close relationship with the public, media, stakeholder groups and community partners. Meetings of Board Committees are not open to the public.

POLICY

Members of the public are welcome to attend the meetings of the Board in accordance with the following policy:

1. Notice of Meetings: A schedule of the date, location and time of the Board's regular meetings will be available from the Administration Office and will be posted on the Hospital's website. Changes in the schedule will be posted on the website.
2. Attendance: To ensure adequate space is available, individuals wishing to attend must give at least 24 hours' notice to the Chief Executive Officer (CEO). The Board may limit the number of attendees if space is insufficient.
3. Conduct During an Open Meeting: Members of the public may not address the Board or ask questions of the Board without the permission of the Chair. Individuals who wish to raise questions with the Board must contact the CEO seven (7) days in advance of the meeting for inclusion on the agenda upon approval of the Chair.

   Members of the public may be asked to identify themselves. Recording devices, videotaping and photography are prohibited. The Chair may require anyone who displays disruptive conduct to leave.

BOARD MEETINGS - FORMAT

4. Agendas and Board Materials: Agendas will be distributed at the meeting and may be obtained from the Administrative Office prior to the meeting. Supporting materials will be distributed only to the Board.
5. *In-Camera* or Closed Session: The Board may move *in-camera*, close the meeting to the public or hold special meetings that are not open to the public where it determines it is in the best interest of the hospital to do so. The Chair may order that the meeting move *in-camera* or be closed. Any Board member may request that a matter be considered *in-camera* at which time a vote will be taken and if a majority of the Board supports the motion, the matter shall be dealt with *in-camera*.

   The following list of matters (not exhaustive) may, at the discretion of the Board, be dealt with *in-camera*:

   a) Matters involving security of property:
   b) Matters involving the disclosure of personal or financial information in respect of individuals person;
   c) Matters involving the acquisition or disposition of real or personal property;
   d) Matters involving labour relations or employment matters;
   e) Matters involving the credentialing of physicians;
   f) Matter involving discussions protected by solicitor-patient/client privilege;
   g) Matters involving actual or potential litigation;
   h) Matters involving sensitive contractual or business matters; or
   i) Matters involving other legal matters.

ISSUED BY: FINANCE COMMITTEE/
BOARD OF DIRECTORS

MANUAL DISTRIBUTION: BOARD OF DIRECTORS

APPROVED BY: BOARD CHAIR

CATEGORY: N/A

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ORIGINAL DATE OF ISSUE:
February 6, 2008

REVIEW/REVISION (YY/MM):

CONFLICT OF INTEREST

PURPOSE

All directors have a duty to ensure that the trust and confidence of the public in the integrity of the decision-making processes of the Board are maintained by ensuring that they and other members of the Board are free from conflict or potential conflict in their decision-making. It is important that all directors understand their obligations when a conflict of interest or potential conflicting interest arises.

APPLICATION

All directors including appointed directors and all non-board members of committees.

POLICY

Directors and non-board committee members shall avoid situations in which they may be in a position of conflict of interest. The by-laws contain provisions with respect to conflict of interest that must be strictly adhered to. In addition to the by-laws, the process set out in this policy shall be followed when a conflict or potential conflict arises.

DESCRIPTION OF CONFLICT OF INTEREST

The situations in which potential conflict of interest may arise cannot be exhaustively set out. Conflicts generally arise in the following situations:

1. *Interest of a Director "Wearing Two Hats"*
   When a director transacts with the corporation directly or indirectly. When a director has a significant direct or indirect interest in a transaction or contract with the corporation.
2. *Interest of a Relative*
   When the corporation conducts business with suppliers of goods or services or any other party of which a relative or member of the household of a director is a principal, officer or representative.

CONFLICT OF INTEREST

3. *Gifts*
When a director or a member of the director's household or any other person or entity designated by the director, accepts gifts, payments, services or anything else of more than a token or nominal value from a party with whom the corporation may transact business (including a supplier of goods or services) for the purposes of (or that may be perceived to be for the purposes of) influencing an act or decision of the Board.
4. *Acting for an Improper Purpose*
When directors exercise their powers motivated by self-interest or other improper purposes. Directors must act solely in the best interest of the corporation. Directors who are nominees of a particular group must act in the best interest of the corporation even if this conflicts with the interests of the nominating party.
5. *Appropriation of Corporate Opportunity*
When a director diverts to his or her own use an opportunity or advantage that belongs to
6. *Duty to Disclose Information of Value to the Corporation*
When directors fail to disclose information that is relevant to a vital aspect of the corporation's affairs.

PROCESS FOR RESOLUTION OF CONFLICTS AND ADDRESSING BREACHES OF DUTY

Disclosure of Conflicts

A director who is in a position of conflict or potential conflict shall immediately disclose such conflict to the Board by notification to the Chair or Vice-Chair of the Board. The disclosure shall be sufficient to disclose the nature and extent of the director's interest. Disclosure shall be made at the earliest possible time and prior to any discussion and vote on the matter.

Abstain from Discussions

The director shall not be present during the discussion of the matter in which he or she has a conflict and shall not attempt in any way to influence the voting.

PROCESS FOR RESOLUTION OF CONFLICTS AND ADDRESSING BREACHES OF DUTY

All directors shall comply with the requirements of the by-laws. It is acknowledged that not all conflicts or potential conflicts may be satisfactorily resolved by strict compliance with the by-laws. There may be cases where the perception of a conflict of interest or breach of duty may be harmful to the corporation notwithstanding that there has been compliance with the by-laws.

CONFLICT OF INTEREST

A director may be referred to the process outlined below in any of the following circumstances:

1. *Circumstances for Referral*
   Where any director believes that that director or another director:
   a) has breached his or her duties to the corporation;
   b) is in a position where there is a potential breach of duty to the corporation;
   c) is in a situation of actual or potential conflict of interest; or,
   d) has behaved or is likely to behave in a manner that is not consistent with the highest standards of public trust and integrity and such behaviour may have an adverse impact on the corporation.
2. *Process for Resolution*
   The matter shall be referred to the following process:
   a) Refer matter to Chair or where the issue may involve the Chair, to the Vice-Chair, with notice to CEO.
   b) Chair (or Vice-Chair as the case may be) may either (i) attempt to resolve the matter informally, or (ii) refer the matter to an *ad hoc* sub-committee of the Board established by the Chair which sub-committee shall report to the Board.
   c) If the matter cannot be informally resolved to the satisfaction of the Chair (or Vice-Chair as the case may be), the director referring the matter and the director involved, then the Chair shall refer the matter to the process in (b) above.

It is recognized that if a conflict, or other matter referred cannot be resolved to the satisfaction of the Board (by simple majority resolution) or if a breach of duty has occurred, a director may be asked to resign or may be subject to removal pursuant to the by-laws and the Corporations Act.

AMENDMENT

This policy may be amended by the Board.

SOURCE

OHA Guide to Good Governance, November 2005

SENSENBRENNER HOSPITAL
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POLICY NO.: 02-050
PAGE 1 of 1

ISSUED BY: BOARD OF DIRECTORS

APPROVED BY: BOARD CHAIR

MANUAL DISTRIBUTION: BOARD OF DIRECTORS, OH&S BULLETIN BOARD, HUMAN RESOURCES BULLETIN BOARD

CATEGORY: N/A

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(Gary Fortin, Board Chair)

ORIGINAL DATE OF ISSUE:
June 2, 2010

REVIEW/REVISION (YY/MM): R14/09

WORKPLACE VIOLENCE AND HARASSMENT

Sensenbrenner Hospital is committed to the prevention of workplace violence and will take whatever steps are reasonable to protect our employees, physicians, members of the Board of Directors, students, volunteers, patients/clients, visitors and contractors from workplace violence.

Workplace violence, intimidation, harassment, bullying and domestic violence in any form is unacceptable and will not be tolerated. Everyone is expected to uphold this policy and to work together collaboratively to prevent workplace violence.

There is a Workplace Violence and Harassment Prevention Program which includes measures and procedures to protect employees from workplace violence, a means of summoning immediate assistance and a process for employees to report incidents or raise concerns.

Sensenbrenner Hospital will ensure this policy and the supporting program are implemented and maintained and that all employees have the appropriate information and instruction to protect themselves from violence in the workplace.

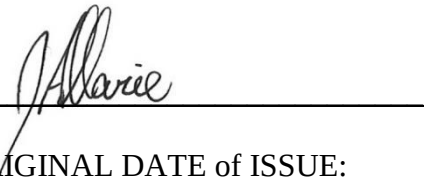
Managers/Supervisors are responsible for ensuring that measures and procedures are adhered to by employees and that employees have the information they need to protect themselves.

Every employee must work in compliance with this policy and the supporting program. Employees are encouraged to raise any concerns about workplace violence and shall report any violent incidents or threats to their Managers/Supervisors immediately. The Human Resources Policy No.: I-3-105 *'Workplace Violence and Harassment Prevention Policy and Program'* should be consulted whenever there are concerns about harassment in the workplace.

Managers/Supervisors shall investigate, deal with all incidents and complaints of workplace violence in a timely and fair manner, respecting the privacy of all concerned to the extent possible.

ISSUED BY: DIRECTOR

APPROVED BY: CHRO



ORIGINAL DATE of ISSUE:
June 20, 2007

MANUAL DISTRIBUTION: HUMAN RESOURCES, BOARD OF DIRECTORS (#02-055), MEDICAL/DENTAL STAFF (#21-010)

CATEGORY: STANDARDS OF CONDUCT

REVIEW/REVISION (YY/MM): R16/12, R17/04, R20/01

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
I. VIOLENCE AND HARASSMENT
II. SEXUAL VIOLENCE AND HARASSMENT
III. DOMESTIC VIOLENCE

POLICY STATEMENT

Sensenbrenner Hospital has zero tolerance for any form of abuse.

It is the responsibility of all stakeholders who provide, or are in receipt of services within, or associated with Sensenbrenner Hospital, to display appropriate conduct and behaviour which respects the dignity of all stakeholders. It is expected that all stakeholders shall comply with this policy.

PURPOSE

To provide support, safety and guidance to all stakeholders.

1. DEFINITIONS

I. Workplace Violence and Harassment

- "Workplace violence" means:
  a) the exercise of physical force by a person against a worker, in a workplace, that causes or could cause physical injury to the worker,
  b) an attempt to exercise physical injury force against a worker, in a workplace, that could cause physical injury to the worker,

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c) a statement or behaviour that is reasonable for a worker to interpret as a threat to exercise physical force against the worker, in a workplace, that could cause physical injury to the worker.

II. Workplace Sexual Harassment

- "Sexual harassment" as per the Occupational Health and Safety Act is defined as:
  a. "Engaging in a course of vexatious comment or conduct against a worker in a workplace because of sex, sexual orientation, gender identity or gender expression, where the course of comment or conduct is known or ought reasonably to be known to be unwelcome; or
  b. Making a sexual solicitation or advance where the person making the solicitation or advance is in a position to confer, grant or deny a benefit or advancement to the worker and the person knows or ought reasonably to know that the solicitation or advance is unwelcome." (1)

III. Domestic Violence

"As of June 15, 2010, the Ontario Occupational Health and Safety Act (the act) defines workplace violence as the exercise, attempted exercise, or threat to exercise physical force against a worker in a workplace that causes or could cause physical injury to the worker. Under the act, inappropriate behaviour in the workplace that does not risk a worker's physical well-being may also be considered harassment".

1.2 Stakeholders

Stakeholders include Volunteers, Students, members of the Board of Directors, Physicians, Employees, Patients/Clients, Visitors and Contractors.

1.3 Aggressor

An aggressor is a perpetrator of the violence or abuse.

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
I. VIOLENCE AND HARASSMENT
II. SEXUAL VIOLENCE AND HARASSMENT
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2. ROLES AND RESPONSIBILITIES

2.1 The Employer shall:

Ensure that measures and procedures in the Workplace Violence and Harassment Prevention Policy and Program are carried out. Management personnel are accountable for responding to and resolving complaints of any type of violence and/or harassment.
Ensure compliance by all who have a relationship with the organization, such as physicians, contractors, volunteers, refer to Item 1.2.
In consultation with the Joint Occupational Health & Safety Committee (JOH&SC), conducts a risk assessment as needed; establishes control measures; and provides training and education for all employees.
Integrate safe work practices into day-to-day operations.
Investigate all reports or threats of violence/harassment in a prompt, objective and sensitive manner and ensures an Incident Report, Administrative Policy No. I-3-95..\..\Administrative\Section I - Admin\Incident Report No. I-3-95.doc is completed promptly.
Report incidents of workplace violence and/or harassment to a manager or the occupational health nurse that will then inform the JOH&SC immediately in order that an accident investigation is promptly initiated. The CEO/or designate will review all workplace violence and/or harassment incidents and ensure appropriate actions were taken.
Ensure the Workplace Violence and Harassment Prevention Policy and Program is reviewed at least once a year.

2.2 The Manager/Supervisor shall:

Enforce this policy and monitors stakeholder compliance.
Identify and alert employee(s) to violent persons and hazardous situations.
Investigate all workplace violence and/or harassment incidents; reports on the Incident Report form, Administrative Policy No. I-3-95, Appendix 1; and contacts police as required.
Facilitate medical attention for employee(s) as required.
Debrief those involved in the incident either directly or indirectly.
Contact Human Resources to ensure the employee receives further counselling about his/her legal rights.

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
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Track and analyzes incidents for trending and prevention initiatives on a departmental basis.
Immediately report a death or critical injury to the MOL Inspector (See Appendix 1), the police (as required), JOH&SC representative and trade union and participates in the investigation with the JOH&SC.
Report the incident immediately to OHS, JOH&SC, police (if required), and notifies Senior Management on-call if incident occurs after hours.
Issue the Incident Report to OHS who will ensure the WSIB and the JOH&SC and trade union are notified appropriately within four days of the occurrence, in accordance with the OH&S Act.
Ensure the incident is investigated promptly and that measures are taken to safeguard employees/stakeholders and curtail the violence or harassment. There shall be no reprisal to an employee reporting an incident of violence or harassment in the workplace.

2.3 An Employee shall:

Participate in education and training programs so the employee can respond suitably to any incident of workplace violence and/or harassment.
Understand and comply with the violence and harassment prevention policies and related procedures.
Report all incidents or injuries of violence and/or harassment, threats of violence and/or harassment to her/his Manager or supervisor immediately by completing an Incident Report.
Contribute to risk assessments.
Seek support when confronted with violence and/or harassment or threats of violence.
Wear and utilize designated Personal Protective Equipment (PPE).
Seek medical attention if required from OHS and/or ER department.
Participate in a review of the workplace violence and harassment prevention program at least once a year.

2.4 The JOH&SC shall:

Be consulted about the development, establishment and implementation of violence prevention measures and procedures (the violence and harassment prevention program).

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
I. VIOLENCE AND HARASSMENT
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Make recommendations to the employer for developing, establishing and providing training in violence prevention measures and procedures.
Take part in reviewing the workplace violence and harassment prevention program, at least once a year.
Review reports of critical injury or death immediately upon being notified and actively participate in the investigation of the incident.
Within four days, review incident reports of injuries where an employee is disabled from performing his or her usual duties or requires medical attention as per the OH&S Act.

3. RISK ASSESSMENT

The employer shall assess the risks of workplace violence that may arise from the nature of the workplace, the type of work or the conditions of work as per Appendix 2, Workplace Violence and Harassment Risk Assessment Tool. The Risk Assessment shall be completed by each Manager and one of their respective employee's. The results of the risk assessment shall be communicated by the employer to the JOH&SC and a copy of this risk assessment will be provided to the JOH&SC. The employer shall assess the risk of workplace violence as often as is necessary to ensure that the related Workplace Violence and Harassment Prevention Policy and Program continue to protect the employees from workplace violence and/or Harassment. (Refer to Section 32.03 of the OH&S Act.)

4. PREVENTION AND EDUCATION

4.1 Strategies to Prevent Abuse:

a) Workplace Violence and Harassment Prevention Policy and Program and related policies and procedures are to be made known to all stakeholders by means of education programs, orientation programs, and patient/client pamphlets upon introduction of the patient/client to the Hospital.
b) Provide education sessions to all staff regarding Emergency Plan - *'Code White'*, Policy No. 01..\..\Emergency Plans\Code White\Code White Policy No. 01.doc
c) When required the OHN will prepare and initiate a Safe Plan

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
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d) Employees are offered PSA
e) A copy of the Workplace Violence and Harassment Policy will be posted on the JOH&SC Bulletin Board.
f) All employees are trained biennially with the CPI Non-Violent Crisis Intervention Program

4.2 Identifying the behaviours

a) Domestic violence behaviours (See Appendix 3)
b) Sexual Harassment (See Appendix 4)
c) Workplace Violence and/or Harassment (See Appendix 5)

5. PROCEDURE

5.1 Cognizant and Non-Cognizant Behaviour

5.1.1 Cognizant Behaviour

The aggressor who is not cognitively impaired is considered accountable for their actions.

In the situation where the aggressor is not cognitively impaired and the stakeholder is not the victim, it is expected that:

- the aggressor will be informed by the stakeholder that his/her behaviour is unacceptable and the aggressor will be asked to modify that behaviour.
- Emergency Plan - *'Code White'*, Policy No. 01 will be initiated if abusive behaviour continues.
- Employee and/or Physicians will be responsible for monitoring the aggressor's behaviour and informing the stakeholder of the consequences of continued inappropriate behaviour.
- Refer to item 16; Discharge of Offensive Patients/Clients.

5.1.2 Non-Cognizant Behaviour

An aggressor who is cognitively impaired is not accountable for their actions for reasons including, but not restricted to, post operative delirium, brain injury, psychosis, uncontrolled pain, or delirium tremens.

In situations where the aggressor is a patient/client and is judged to be cognitively impaired, it is expected that:

- the patient's/client's family will be informed by the Unit Manager or designate of their inappropriate behaviour and of the action taken to control such behaviour,
- the Unit Manager is responsible for investigating the abuse and making recommendations to control the behaviour in consultation with the physician; and
- measures to alleviate any agitation, chemical or otherwise, will be instituted as appropriate. Emergency Plan - *'Code White'* Policy No. 01 will be initiated.
- In situations where the aggressor is not a patient/client and is judged to be cognitively impaired, measures to alleviate any agitation will be instituted as appropriate. Emergency Plan - *'Code White'* Policy No. 01 will be initiated.

6. EMPLOYEE ASSAULT AND SEXUAL ASSAULT INTERVENTIONS

6.1 Employee Assault

Any individual who assaults another person may be charged under the Criminal Code of Canada.

All employees are entitled to the supports outlined in this policy regardless of whether charges are pursued or not.

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When Can Charges be Laid

Criminal charges may be laid in an employee abuse situation when:

a) threats are uttered;
b) an assault occurs;
c) an assault causing bodily harm occurs; and/or
d) forcible confinement occurs.

When "assault" is used in the rest of this policy it includes all of the above.

6.2 Employee Sexual Assault

a. If you believe you are the victim of sexual harassment, you should inform your department manager or the Director, HR. The first step is to immediately make your discomfort and disapproval known to the harasser.
The first step is to immediately ask the harasser to stop and inform the person that his/her behaviour is unwelcome. You must express your disapproval of their conduct.
b. It is very important to keep a written record of the alleged nature of the harassment with date(s), time(s), behaviour(s) and witness(es).
c. We will then request a written report from you of the complaint detailing the nature of the incident, the date(s), time(s), place(s), witness(es), and name of the alleged harasser. The Director, HR will investigate the matter, verify the facts and then request a meeting with the parties involved in an attempt to resolve this situation. All allegations of sexual harassment involve sensitive disclosures. The confidentiality of all concerned will be strictly maintained.

6.2.1 COMPLAINT PROCEDURE

1. If the employee chooses to make a formal complaint, a written statement should be forwarded as soon as possible to either the department head or the Director, HR. Again the written report is to include specific details such as the nature of the incident, the date(s), place(s), witness(es), name(s) of those involved and steps that were taken to informally resolve the issue.

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2. A formal complaint will authorize the Director, HR or his/her delegate, to release to the alleged harasser, a photocopy of the written complaint.
3. The person(s) named in the written complaint will be requested to reply in writing to the Director, HR within ten (10) working days after receiving the complaint
4. The Director, HR or his/her delegate will investigate the matter, verify the facts and meet individually with the parties involved in attempts to find an acceptable solution for all.
5. If a satisfactory solution is unable to be reached and the harassment continues, disciplinary action up to and including dismissal may occur. Alternatively, complaints will be dismissed if the staff member's complaint is found to be trivial, frivolous or made in bad faith and corrective action may be taken against the complainant. Knowingly making a false complaint will result in disciplinary action.
6. The Director, HR of his/her delegate will provide written results of the investigation and the suggested course of action to resolve the situation, to the complainant and the person named in the complaint.
7. A follow-up will be conducted by the Director, HR or his/her delegate within 3 months following the completion of the investigation.
8. If the matter is not resolved, the recommendation will be shared with and acted upon at the appropriate level of management.

6.2.2 THE APPEAL PROCEDURE

1. In the event the complainant or the person named in the complaint finds the resolution offered through this process to be unsatisfactory, he/she may submit a complaint to the Ontario Human Rights Commission. He/she may also submit a formal grievance under the appropriate collective agreement.

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
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6.2.3 RECORDS

1. Records of complaints including contents of meetings, interviews, results, of investigations and all other material related to the claim will be collected and maintained in a confidential file. Only letters of reprimand or discipline will be placed on an individual's personnel file.

7. PROCEDURES WHEN AN EMPLOYEE IS ASSAULTED AND/OR SEXUALLY ASSAULTED

7.1 When an employee is assaulted, the following procedure must be followed:

7.1.1 IMMEDIATELY INITIATE EMERGENCY PLAN - *'CODE WHITE'* POLICY NO. 01.

7.1.2 Notify the following individuals:

a) The employee's immediate Manager or designate;
b) Charge Nurse and attending physician;
c) Senior Management on-call (in off hours); and
d) Where applicable, union representative. The union representative is to be invited to provide assistance.

7.1.3 The Manager will review the incident and must call the police.

7.1.4 It is the Manager's or designate's responsibility to complete an Incident Report, Administrative Policy No. I-3-95, Appendix 1 and forward the report to the OHN immediately so that an accident investigation may be promptly initiated.

Names of witnesses and the request for a police investigation should be recorded on the Incident Report. It is imperative to include dates, time, locations, names of any potential witnesses, the approach of the aggressor, what was said and done.

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
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III. DOMESTIC VIOLENCE

7.1.5 During normal working hours, the Manager is responsible for coordinating meetings between employees and the police. In off hours, the Senior Management on-call shall be responsible for ensuring that steps 7.1 to 7.4 are completed.

7.1.6 If an employee has opted to contact the police directly, it is the responsibility of that employee to notify their Manager of the request prior to the police arriving on site. Should the police not lay any charge, the employee may be able to lay charges through the Justice of the Peace.

NOTE: Acute Care staff please refer to Appendix 1 for department specific guidelines.

8. EMPLOYEE SUPPORT AFTER ASSAULT

8.1 The Manager or designate will notify Human Resources in all cases of staff assault to an employee.

For serious injuries requiring immediate medical treatment, the employee should be taken directly to the Emergency Department.

When medical attention is sought by hospital employees, the OHN shall be notified and a Workplace Safety Insurance Board claim will be initiated.

If required, the affected employee may access the Critical Incident Stress Management (CISM) team as per the Human Resources Policy No. II-7-010 ..\..\..\Policy and Procedure Intranet Upload\Human Resources\Section II - Occupational Health Services\Critical Incident Diffusing Debriefing No. II-7-010.docx

'Critical Incident Deferring/Debriefing', to determine the need for a critical incident stress defusing/debriefing.

8.2 Compensation to Assaulted Employees

Employees are entitled to compensation for damaged personal items in an assault. Compensation will be assessed on an individual basis. Except in extraordinary circumstances, within one week of the reported incident the employee is responsible to submit a list of personal items that have been damaged to the Director of Human Resources.

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9. VISITORS ABUSING STAKEHOLDERS

9.1 Intervention:

a) Visitors do not have a right to be in the Hospital. Visitors are on the Hospital's premises at the Hospital's indulgence. If a visitor becomes aggressive or abusive, you may ask him or her to leave.
b) If the visitor refuses to leave, initiate Emergency Plan *'Code White'*, Policy No. 01.
c) Notice to prohibit aggressive visitors may be given orally or in writing. Notice to prohibit entry to the Hospital, or any parameters/conditions associated with permitted visits should be documented as per Appendix 6 Notice to Prohibit Entry Form.
d) It is the responsibility of the manager or designate under the direction of their respective Functional Director, to issue such notice. Approval must be given by the Functional Director or designate prior to presenting the visitor with the notice.

10. PROCEDURES FOR ASSAULTED STAKEHOLDERS OTHER THAN EMPLOYEES

When stakeholders other than employees are assaulted, the following procedure must be followed:

10.1 The employee will immediately initiate the Emergency Plan - *'Code White'* Policy No. 01. By initiating the Emergency Plan - *'Code White'* Policy No. 01, the Police department will be notified promptly.

10.2 Thereafter, the following individuals will be notified:

a) the Charge Nurse if applicable;
b) the department Manager or designate;
c) Senior Management; and if after hours;
d) Senior Management on-call.

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10.3 An Incident Report, Administrative Policy No.I-3-95, Appendix 1 will be completed by the Manager or designate.

10.4 Police will conduct their own investigation and remove the aggressor from the Hospital property in order to secure the facility.

12. RESTRAINING AGGRESSORS

12.1 Obtaining Injunctions and Restraint Orders

Where an aggressor threatens a particular employee, the Criminal Code allows for a "Surety to Keep the Peace", also called a "Peace Bond".

Essentially, obtaining a Peace Bond involves "laying of an information" and appearing before a Justice of the Peace or Provincial Court Judge. The Justice of the Peace or the Court must conclude there are reasonable and probable grounds for the individual's fears. Once the information is laid, the Justice of the Peace or Court would call the parties before him or her and decide whether to order that the defendant enter into a Peace Bond to keep the peace and be of good behaviour.

The Justice of the Peace or Court may also require that the defendant comply with any number of conditions that is considered desirable for keeping that peace. Options may include a deposit, and should the conditions of the Peace Bond be violated, the defendant would be required to forfeit the deposit.

The maximum duration of a Peace Bond is twelve months.

12.2 The Right to Restrain

Refer to Nursing Patient Care Policy No. III -r-24, *'The Use of Least Restraints'*..\..\Patient Care\The Use of Least Restraints No. III-r-24.doc

12.3 Police Involvement and the Right to Restrain

Where a situation escalates to the point that an employee can no longer control an aggressor, it is the obligation of the Manager/designate or Charge Nurse to request the assistance of the police. If the police refuse to assist they would be liable for the consequences of non attendance.

Where the police have been asked for assistance, the employees must not obstruct them. It would be the responsibility of the police to do what they think is necessary to protect the public.

13. SEARCH OF PATIENT/CLIENT BELONGINGS

If there is reasonable suspicion that the patient/client possesses the means to harm himself/herself or others a search may be justified.

Normally, searches may only be conducted with the patient's/client's consent. Where a voluntary patient/client refuses to allow a search of their possessions, the physician should be contacted to consider whether discharge would be appropriate. If the patient/client is detained under the Mental Health Act non-voluntarily and the health, safety and security of the patient/client or others is at risk, a search would be justified without the consent of the patient/client.

The search should take place in the presence of both the patient/client and a second staff person and be clearly documented in the patient's/client's chart.

If a patient/client refuses to allow a search of their possessions and the situation is threatening, the police should be notified immediately and the patient/client isolated, if possible, to avoid potential harm to other stakeholders. Each situation should be individually assessed according to the patient's/client's condition and the degree of risk.

14. WEAPONS

In the interest of the health, safety and security of stakeholders, weapons are not permitted in the Hospital.

Weapons are defined as, but not limited to, items such as guns, switchblades, martial arts weapons, etc.

WORKPLACE VIOLENCE AND HARASSMENT PREVENTION POLICY AND PROGRAM
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Procedure

When a weapon is found or surrendered, immediately notify police indicating that a weapon is involved.

If a weapon is surrendered, secure the weapon in a secure area until police arrives.

15. REFUSAL TO TREAT PATIENTS/CLIENTS

The Regulated Health Professions Act sets out professional standards for physicians, nurses and other disciplines of the health care team. However, the OH&S Act, Section 43(3)(b.1), states *"A worker may refuse to work or do particular work where he or she has reason to believe that workplace violence is likely to endanger himself or herself."* Refer to Human Resources Policy No.: III-1-120 *'Work Refusal'*..\..\..\Policy and Procedure Intranet Upload\Human Resources\Section III - Occupational Health and Safety\1. Occupational Health and Safety\Work Refusal No. III-1-120.docx

An employee of the hospital shall wear the designated PPE as directed by the employer. The Patient/Client Safety Committee will ensure an established identification process to identify violent patients/clients in order to safeguard hospital personnel and other stakeholders.

It is a contravention of standards of practice to discontinue professional services that are needed unless:

a) the patient/client requests the discontinuation,
b) alternative or replacement services are arranged,
c) the patient/client is given a reasonable opportunity to arrange alternative or replacement services, or
d) the caregiver is in an immediate serious risk and the patient/client is in no urgent need of care. Refer to *"Workplace Violence and Harassment: Decision Tree", Appendix 7* attached.

In common law, where a patient/client is being ignored by Hospital employees and a misadventure results, the staff involved, and by extension the Hospital, will have breached the duty of care owed to such patient/clients.

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16. DISCHARGE OF OFFENSIVE PATIENTS/CLIENTS

The Mental Health Act provides that a patient/client shall be discharged from a psychiatric facility when he or she is no longer in need of the observation, care and treatment. The Public Hospital Act (PHA) provides that where a patient/client is no longer in need of treatment in the Hospital, the attending physician shall order that the patient/client be discharged and communicate the order to the patient/client. The Hospital shall discharge the patient/client and the patient/client shall leave the Hospital on the date set out in the discharge order.

If there are medical reasons why the patient/client cannot be discharged or his admission refused because of offensive behaviour, the patient/client should be told that the Police will be called and the incident should be well documented. Documentation should include the basis for the employee's suspicions, the attempts made to secure the patient's/client's cooperation, the patient's/client's refusal and medical reason why the patient/client cannot be discharged or admitted. The Police should be contacted if there is a reasonable belief there is some danger.

17. CONFIDENTIALITY

In making a determination as to whether to breach the Hospital's statutory obligation for confidentiality, Hospital staff and physicians must decide whether or not disclosing information to the Police would result in serious harm to a specific individual or group of individuals. There is no need to provide clinical information or a diagnosis to the police officer unless it is important to the safety of the police officer.

EMPLOYEES COVERED UNDER A COLLECTIVE AGREEMENT REFER TO THE COLLECTIVE AGREEMENT.

RESOURCES:

[1] Health and Safety Act, http://www.occupationalhealthandsafetylaws.com/bill-132-new-sexual-violence-and-harassment-legislation , 2015

Ministry of Labour, Contact Center: https://www.labour.gov.on.ca/english/feedback/index.php#hsic

Occupational Health and Safety Council of Ontario (OHSCO) February 2010 - What employers need to know to help.

Occupational Health and Safety Council of Ontario (OHSCO) February 2010 - How to get help or support a colleague who may need help.

Ministry of Labour Health & Safety Contact Centre

Toll-free: 1-877-202-0008
TTY: 1-855-653-9260
Fax: 905-577-1316

- Call any time to report critical injuries, fatalities or work refusals.
- Call 8:30 a.m. – 5:00 p.m., Monday – Friday, for general inquiries about workplace health and safety.
- In an emergency, always call 911 immediately.

Revised: December 14, 2016

SENSENBRENNER HOSPITAL

WORKPLACE VIOLENCE AND HARASSMENT

ENVIRONMENTAL RISK ASSESSMENT TOOL

□ Sensenbrenner Hospital or □ Fauquier Health Centre

Department: _____ Date: _____

Manager/Supervisor: _____ Employee: _____

1. Parking Lot	**Yes**	**No**	**N/A**	**If no, please explain**
Are the entrances and exits well marked?	□	□	□	
Is the lot appropriately signed with security reminders (lock car, security patrolled)?	□	□	□	
Is the lighting sufficient?	□	□	□	
Does the lot have controlled entry?	□	□	□	
Have vehicles been stolen or vandalized on-site?	□	□	□	

2. Building Perimeters	**Yes**	**No**	**N/A**	**If no, please explain**
Is the workplace near any buildings or businesses that are at risk of violent crimes (bars, banks)?	□	□	□	
Do violent, criminal, intoxicated or drugged persons visit your building accidentally?	□	□	□	
Is your building located in a high crime area?	□	□	□	
Are there signs of vandalism?	□	□	□	
Is your building isolated from other buildings?	□	□	□	
Are there graffiti on the walls or buildings?	□	□	□	

2. Building Perimeters (Cont'd)	Yes	No	N/A	If no, please explain
Is the exterior of the building adequately lighted?	□	□	□	
Is the building entrance adequately lighted?	□	□	□	
If answer is no, please indicate location.				
Are garbage areas, external buildings or equipment that employees use: a) In an area with good visibility? b) Close to the main building with no potential hiding places? Do overgrown shrubs or landscaping provide a hiding place?	□ □ □ □	□ □ □ □	□ □ □ □	

3. Natural Surveillance	Yes	No	N/A	If no, please explain
Are there physical objects/structures that obstruct your view?	□	□	□	
If yes, could someone hide behind such objects?	□	□	□	
If so, where?				
What would make it easier to see? ! Transparent materials ! Mirrors ! Windows in doors ! Angled corners ! Less shrubbery ! Other	 □ □ □ □ □ □	 □ □ □ □ □ □	 □ □ □ □ □ □	

4. Stairwells and Exits	Yes	No	N/A	If no, please explain
Are stairwells and exits clearly marked, well lit, and controlled with locked doors that have panic bars to allow exit in an emergency?	□	□	□	
Do exit doors identify where they exit to?	□	□	□	
Are there places at the bottom of stairwells where someone could hide?	□	□	□	
Can lights be turned off in the stairwell?	□	□	□	
Is there more than one exit route?	□	□	□	
Do exit routes restrict the ability to escape an attacker?	□	□	□	
Do stairwell doors lock behind people during or after regular hours of operation?	□	□	□	

5. Access Control	Yes	No	N/A	If no, please explain
Is your building connected to other buildings through stairwells, elevators or hallways?	☐	☐	☐	
If yes, is there access control to your area?	☐	☐	☐	
Is there a system to alert employees to access by intruders?	☐	☐	☐	
Are offices and rooms signed in all areas?	☐	☐	☐	
Do you use keys or key cards to access areas?	☐	☐	☐	
Is there a system in place to minimize the distribution of keys or key cards?	☐	☐	☐	
Are locks replaced if keys are lost or stolen?	☐	☐	☐	

6. Security and Public Announcement (PA) System	Yes	No	N/A	If no, please explain
Is there a process to call for security assistance?	☐	☐	☐	
Is the security system tested monthly or annually?	☐	☐	☐	
Are there security guards or safety walking services at your location?	☐	☐	☐	
Where appropriate, have staff areas (e.g. emergency, reception) been equipped with Personal Security Alarms (PSA's)?	☐	☐	☐	

7. Reception	Yes	No	N/A	If no, please explain
Is the reception or nursing station identifiable and accessible? Can the people at these stations see incoming visitors?	☐ ☐	☐ ☐	☐ ☐	
Is the reception or nursing station visible to clients and visitors?	☐	☐	☐	
Is the reception or nursing station staffed at all times?	☐	☐	☐	
Can outsiders enter the ward or building if the reception or nursing station is not staffed?	☐	☐	☐	
Is the reception area or nursing station the first point of contact for visitors?	☐	☐	☐	
Is there a policy for receiving and identifying visitors?	☐	☐	☐	

7. Reception (Cont'd)	Yes	No	N/A	If no, please explain
Does the area function as a security screening area?	☐	☐	☐	
Does the reception or nursing station have an emergency call button?	☐	☐	☐	
If yes, are response procedures developed?	☐	☐	☐	
Could objects/tools/equipment in this area be used as weapons?	☐	☐	☐	

8. Signage	Yes	No	N/A	If no, please explain
Immediately inside the building/ward entrance, do signs identify where you are?	☐	☐	☐	
Are rules for visitors clearly signed?	☐	☐	☐	
Are exit signs posted?	☐	☐	☐	
Are the posted signs highly visible to all?	☐	☐	☐	
Are the hours of operation adequately posted?	☐	☐	☐	
Impression of overall signage: ☐ very poor ☐ poor ☐ satisfactory ☐ good ☐ very good				
_____ _____				

9. Lighting	Yes	No	N/A	If no, please explain
List areas where lighting was a concern, i.e., too dark or too bright during the inspection				
Is the lighting evenly spaced?	☐	☐	☐	
Are any lights out?	☐	☐	☐	
If yes, where?				

10. Movement Predictors	Yes	No	N/A	If no, please explain
How easy would it be for someone to predict staff patterns of movement? ☐ very easy ☐ somewhat easy ☐ no way of knowing				
Is an alternative, well-lit and frequently travelled route available?	☐	☐	☐	
Can you tell what is at the other end of each walkway or corridor?	☐	☐	☐	

10. Movement Predictors (Cont'd)	Yes	No	N/A	If no, please explain
If no, where?				
In walkways or corridors, are there alcoves or corners where someone could hide and wait for staff?	☐	☐	☐	
If yes, where?				

11. Elevators	Yes	No	N/A	If no, please explain
Do you have a full view of whether an elevator is occupied before entering?	☐	☐	☐	
Is there an emergency telephone or emergency call button in the elevator?	☐	☐	☐	
Is there a response procedure for elevator emergencies?	☐	☐	☐	

12. Washrooms	Yes	No	N/A	If no, please explain
Is public access to washrooms controlled?	☐	☐	☐	
Can the lights in the washroom be turned off?	☐	☐	☐	
Are washrooms inspected on a regular basis?	☐	☐	☐	
Do washrooms have emergency call buttons?	☐	☐	☐	

13. Interview Room	Yes	No	N/A	If no, please explain
Do you have a separate interview/meeting room?	☐	☐	☐	
If yes, is natural surveillance possible?	☐	☐	☐	
Is there an alarm system in this room?	☐	☐	☐	
Is the furniture arranged to allow for emergency exits?	☐	☐	☐	

14. Pharmacy/Medication Room/Treatment Room/Office	Yes	No	N/A	If no, please explain
Is there another way out for an emergency exit?	☐	☐	☐	
Are furniture/counters arranged to allow both visibility and protection of staff?	☐	☐	☐	
Do the width and height of the counter/desk provide an appropriate barrier between staff and the public?	☐	☐	☐	
Does the area have an alarm system?	☐	☐	☐	

14. Pharmacy/Medication Room/Treatment Room/Office (Cont'd)	Yes	No	N/A	If no, please explain
Do workers sometimes work alone?	□	□	□	
If so, do they know emergency alert procedures? (i.e. Code White)	□	□	□	
Is pharmacy staff required to handle cash?	□	□	□	

15. Waiting Areas	Yes	No	N/A	If no, please explain
Does the waiting area isolate patients/clients from staff and hinder communication with workers?	□	□	□	
Are there objects, tools or equipment that could be used as weapons?	□	□	□	

16. Files/Records	Yes	No	N/A	If no, please explain
Are confidential files/records kept in a locked room?	□	□	□	
Are file cabinets containing confidential records locked?	□	□	□	

17. Identification System for Clients and Visitors	Yes	No	N/A	If no, please explain
Have name tags, preferably with photo and no last name, been issued to staff?	□	□	□	
Have tags, preferably a different colour than those for staff, been issued to visitors?	□	□	□	
Is there a visitors' sign-in book to document who is entering and exiting the facility?	□	□	□	
Have clients with a history of violent behaviour been flagged in computers, charts and wristbands?	□	□	□	

18. Individual Offices	Yes	No	N/A	If no, please explain
Are certain employees at higher risk of violence?	□	□	□	
Has office furniture been arranged: ! To allow for a quick exit from the office? ! To maintain a safe distance between the staff and client?	 □ □	 □ □	 □ □	
Are objects that can be thrown or used as weapons minimized?	□	□	□	
Do these rooms have good natural surveillance (shatterproof glass in walls and doors)?	□	□	□	

19. Stairwells and Exits (Related to Individual Offices)	Yes	No	N/A	If no, please explain
Do exits identify where they lead to?	□	□	□	
Do stairwells contain places at the bottom where someone could hide?	□	□	□	
If yes, where?				
Is the lighting adequate?	□	□	□	
Can lights be turned off in the stairwell?	□	□	□	
Is there more than one exit route?	□	□	□	
Do any exit routes restrict your ability to get away?	□	□	□	
Do stairwell doors lock behind you?	□	□	□	

20. Possible Entrapment Sites	Yes	No	N/A	If no, please explain
Are there unoccupied rooms that should be locked?	□	□	□	
If yes, where?				
Are there small, well-defined areas where someone could be hidden from the view of others? ! Recessed doorways ! Unlocked storage areas ! Stairwells ! Elevators	 □ □ □ □	 □ □ □ □	 □ □ □ □	
Are there physical objects/structures that obstruct your view?	□	□	□	
If yes, could someone hide behind such objects? If so, where?	□	□	□	
What would make it easier to see? ! Transparent Material ! Mirrors ! Windows in doors ! Less shrubbery ! Other _____	 □ □ □ □ □	 □ □ □ □ □	 □ □ □ □ □	
Do members of the public approach staff from one entrance?	□	□	□	

21. Working Alone	Yes	No	N/A	If no, please explain
Has an emergency contact number been established for all hours of operation?	□	□	□	

21. Working Alone (Cont'd)	Yes	No	N/A	If no, please explain
Are emergency telephones located in key areas, accessible to all staff?	☐	☐	☐	
If no, where is access needed?				
Is there a designated Asafe room@ where employees can go during an emergency?	☐	☐	☐	
Does this room have a telephone and a door that can be locked from the inside?	☐	☐	☐	
At the time of the inspection, did any areas seem isolated?	☐	☐	☐	
If yes, which areas?				
In these isolated areas, is there a telephone or a sign directing you to emergency assistance?	☐	☐	☐	
In these isolated areas, how far is the nearest person who might hear calls for help?	☐	☐	☐	
Do you have alarms or PSA's (personal or stationary)?	☐	☐	☐	
Are the alarms or panic buttons easily accessible?	☐	☐	☐	
Do you periodically check the functioning of panic buttons or alarms?	☐	☐	☐	
Is it easy to predict when people will be around?	☐	☐	☐	

DK/LT/ctc
Prepared: May 14, 2010
Revised: December 14, 2016

Domestic Violence

Should employees identify the following behaviours:

Abuser	Victim
● He/she puts him/her down. ● He/she does all the talking and dominates the conversation. ● He/she checks up on his/her all the time, even at work. ● He/she suggest he/she is the victim and acts depressed. ● He/she tries to keep him/her away from family and friends. ● He/she acts as if he/she owns him/her. ● He/she lies and exaggerates to make himself/herself look good ● He/she believes he/she is superior and more important than others in his/her home.	● He/she is apologetic and makes excuses for the abuser, or sometimes becomes aggressive and angry. ● He/she is nervous when the abuser is nearby. ● He/she is sick more often and misses work. ● He/she tries to cover bruises. ● He/she makes excuses at the last minute when he/she cancels or postpones meetings with friends/ family members. ● He/she tries to avoid friends and family members on the street. ● He/she seems sad, lonely, withdrawn and afraid. ● He/she uses drugs or alcohol to cope.

Revised: December 14, 2016

Sexual harassment may include, but is not limited to:

Conduct which has the purpose or effect of interfering with an individual's job performance or creating an intimidating, hostile, or offensive work environment;

Unwelcome remarks, innuendos, or taunts about a person's sex, age, marital status, body, attire, personal relationships, sexual orientation, or experience;

The telling of sexist jokes causing embarrassment to an individual either privately or in front of co-workers;

The display of sexually offensive material including pornographic cartoons and pictures; and

Unwelcome sexual flirtations, advances, propositions, and physical contact such as touching, patting, pinching, and punching.

Revised: December 14, 2016

Workplace Violence and Harassment

- "Workplace harassment" means engaging in a course of vexatious comments or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome.
- Harassment: is any conduct, comment, gesture, contact or any other action that might be reasonably be known or ought to be known as eroding mutual trust and confidence and causes the person to believe their health and safety are at risk. It also includes behaviour that demeans, embarrasses, intimidates, humiliates, annoys, alarms or verbally abuses a person and that is known or would be expected to be unwelcome.
-
- Threat (verbal or written): is a communicated intent to inflict physical or other harm on any person or to property by some unlawful act.
- Physical Assault: is any physical force or threat of physical force to create fear and control another person. Some examples include: hitting, blocking, shoving, chocking, kicking, slapping, biting, or pulling hair; "caring" for the victim in an abusive way, threats of violence, and using a weapon or other objects to threaten, hurt or kill.
- Verbal/Emotional/Psychological Abuse: is a pattern of behaviour that makes a person feel worthless, flawed, unloved, or endangered. Like other forms of abuse it is based on power and control. Some examples include: swearing, put downs/name calling over a period of time, labelling the person as in a derogatory way such as stupid, crazy or irrational, acts of humiliation, extreme jealous behaviour, attacking the person's self-esteem in other ways.
- Workplace Bullying: repeated persistent negative acts towards one or more individuals, which involve a perceived power imbalance and creates a hostile work environment.

Revised: December 14, 2016

SENSENBRENNER HOSPITAL
HUMAN RESOURCES DEPARTMENT
Notice Prohibiting Entry

This Notice is being given to _____ under the Trespass to Property Act of Ontario and prohibits your entry on any portion of the grounds or buildings of or in the building of Sensenbrenner Hospital.

If you are seen on the grounds of The Sensenbrenner Hospital, you will be subject to immediate arrest and prosecution.

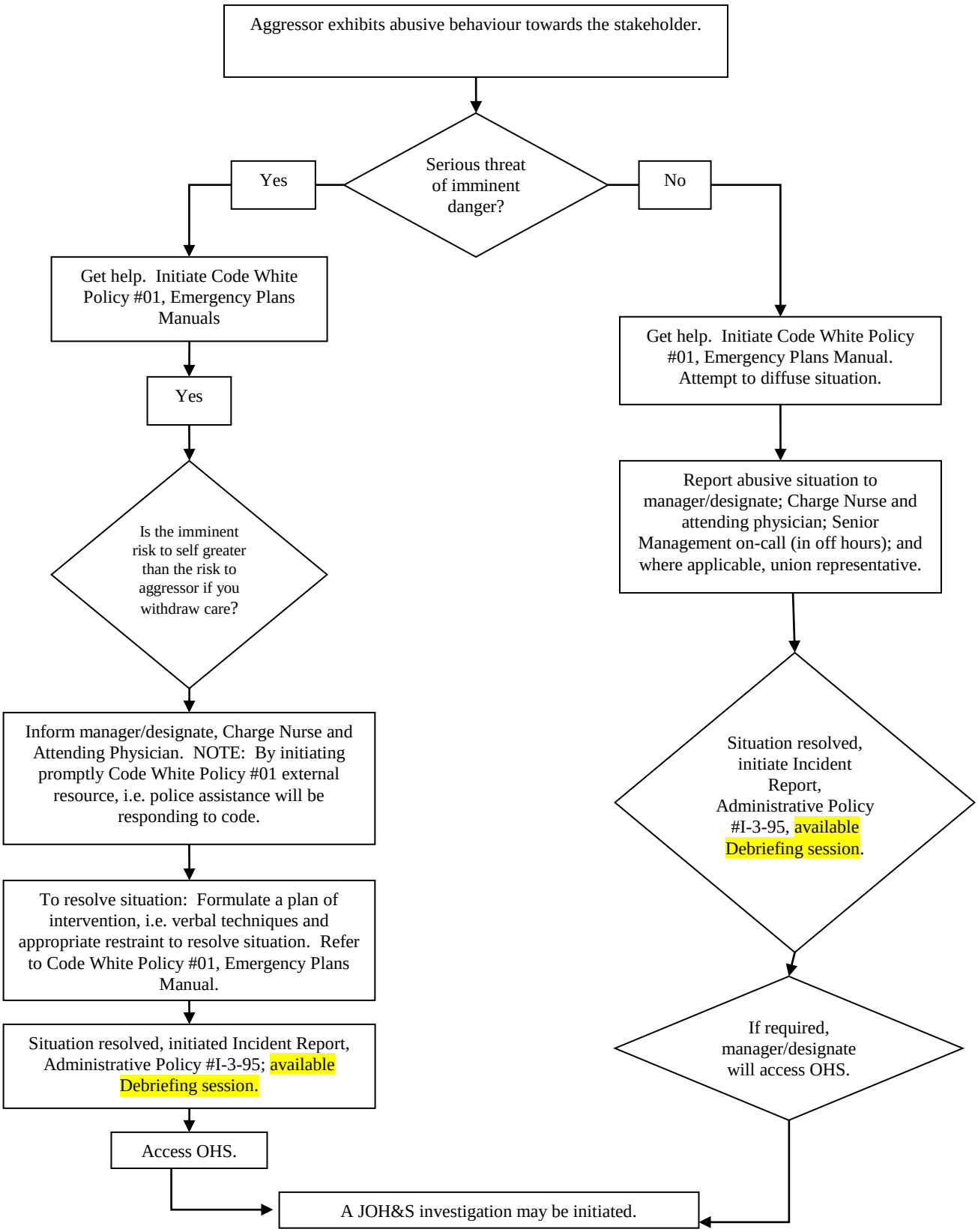
This Notice does not in any way take away your rights to medical attention at the Sensenbrenner Hospital. Therefore, should you have a doctor's appointment or require medical or Hospital Services, this Notice will not be enforced during your treatment.

Date Issued _____, _____ and effective for 30 days.

_____
Authorizing Signature
Chief Executive Officer or Functional Director

Revised: December 14, 2016

WORKPLACE VIOLENCE AND HARASSMENT DECISION TREE



Emergency Room (ER) Action Plan for Violent Situations

The Sensenbrenner Hospital ER action plan provides information on how to recognize potential violent behaviors factors or situations, what actions must be taken to reduce the potential for violence and how to obtain assistance.

In order to ensure staff safety, these guidelines must be followed:

1. Personal Security Alarm (PSA) are to be worn at all times.
2. The following doors in the ER department will be locked at all times. The door behind registration, the patient's/client's entrance door and the medication room.
3. After 23:00, the Paramedic will accompany the Registered Nurse (RN) to answer the ER door for patients/clients requesting services and remain with the RN in the department until the patient/client leaves the hospital. If the Paramedic is unavailable, a staff from Active Care Unit (ACU) will be responsible to assume this duty. At no time should the RN answer the ER door by themselves.
4. All patients/clients presenting to the ER department will be assessed for risk of violence via registration telephone and with a visual (see Violence/Aggressive Assessment checklist as a reference guide).
5. All patients/clients with history of violence/aggressive behavior will be "flagged" in CCIS and communicated to other health care team members when necessary, effective May 1, 2017.
6. Remember that any individuals showing signs of violent/aggressive behavior will not be given access to the ER department.
7. During any indication/signs of risk of violence/aggressive behavior, staff will attempt to deescalate the situation using Non Violent Communication Intervention (NVCI) skills.
8. Remember your body stance, how you are talking to the patient/client (volume, tone and rhythm). Don't sound condescending or impatient. Be alert at all times in case the patient's/client's behavior escalates.
9. You do not have to wait until a situation escalates to physical violence, you can activate a "Code White" at any time you feel you are in danger.
10. If individual's behavior continues to escalate, seek assistance from other co-workers. Ensure a Team Leader is designated, as only one person should speak with the individual. Continue to deescalate the situation by being supportive.
    - Other team members will assist by providing assistance as requested by Team Leader, or as observed.
    - Ask the person to leave the building. If the person does not agree to leave, seek assistance from your co-workers or supervisor. Remove yourself and others from the scene, if necessary. Advise other staff and have them leave the immediate area.
    - Assist with removing other patients/clients at risk from the area or stopping others from entering the area
    - Observe the area for safety concerns and if possible, address the concerns and/or remove any items which could be used as potential weapon.
    - If unable to control the situation, proceed with the following steps. Use employee 'safe room" (located in Medication Room in ER) for emergency situation and call 911 to get more assistance.
    - Remain in safe room until OPP assistance has arrived and have the situation under control.
11. Staff members should be instructed to limit physical intervention in altercations between patients/clients whenever possible, unless there are adequate numbers of staff of emergency response teams, and OPP assistance.

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(Mr. Gary Fortin, Board Chair)

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TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

1.0 PURPOSE

The purpose of the policy is:

- To set out rules and principles for the reimbursement of expenses to ensure fair and reasonable practices;
- To provide a framework of accountability to guide the effective oversight of hospital resources in the reimbursement of expenses; and
- To set the parameters for the public disclosure of information about expenses.

APPLICATION AND SCOPE

The policy sets out the rules for managing travel, meal and hospitality expenses for Sensenbrenner Hospital. They apply to:

- all employees
- all trustees
- all physicians

The following definitions apply for the purpose of the policy.

- *Claimant* refers to any person making a claim under the terms of the policy.
- *Approver* refers to the person with the authority to make approvals under the policy.
- *Chief Executive Officer (CEO)* refers to the hospital administrator.
- *Chair* refers to the person appointed as the Chair of the Board of Directors.
- *Employees* refers to employees.

The policy does not prevail over legislation or a collective agreement.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

2.0 PRINCIPLES

- Hospital dollars are used prudently and responsibly with a focus on accountability and transparency.
- Expenses for travel, meals and hospitality support hospital objectives.
- Plans for travel, meals, accommodation and hospitality are necessary and economical with due regard for health and safety.
- Legitimate authorized expenses incurred during the course of hospital business are reimbursed.
- Best practices are in place, including:
  - Prior approval to incur expenses is obtained.
  - Other options for meetings are always considered before travel is approved, including audio or video conferencing.

3.0 MANDATORY REQUIREMENTS – GENERAL

- Written approval is required for travel ***before*** any arrangements are made. Use the appropriate form.
- Alcohol cannot be claimed and will not be reimbursed as part of a travel or meal expense.
- Hospitality is provided only when the event involves people from outside the hospital. Functions involving only people who work for the hospital (all those covered by the policy) are not considered hospitality functions.
- Expenses for a group can only be claimed by the most senior person present.
- Information about expenses must be posted on the appropriate public websites for the following:
  - designated persons prescribed by regulation under the *Public Sector Expenses Review Act, 2009*.
- Good record-keeping practices must be maintained for verification and audit purposes.

Claimants must:

- obtain all appropriate approvals before incurring expenses; if no prior approval was obtained, then a written explanation must be submitted with the claim;
- submit original, itemized receipts with all claims (credit card slips are not sufficient). If there is not an itemized receipt, a written explanation must be submitted to explain why the receipt is unavailable and a description itemizing and confirming the expense must be provided;

- submit claims by the end of the quarter following the quarter in which the expense was incurred; a written explanation is required if not submitted within this timeframe;
- submit claims for expenses before leaving positions.

Approvers must:

- provide approval only for expenses that were necessarily incurred in the performance of hospital business;
- provide approval only for claims that include all appropriate documentation (e.g., original itemized receipts);
- not approve their own expenses.

Note that should there be a situation where there is an overpayment to a claimant, it is considered a debt owing to the hospital and must be repaid.

4.0 ACCOUNTABILITY FRAMEWORK

The policy sets out the approval authority for travel, meals and hospitality expenses.

4.1 Managerial Discretion

For the purpose of the policy, managerial discretion is the administrative authority to make decisions and choices with some degree of flexibility, while maintaining compliance with the policy. There is no discretion to depart from the principles and the mandatory requirements of the policy. All decisions should be taken very carefully.

When exercising discretion, the rationale must be documented and filed with the claim.

Approvers are accountable for their decisions, which must be:

- subject to good judgement and knowledge of the situation;
- exercised in appropriate circumstances; and
- comply with the principles and mandatory requirements set out in the policy.

When a situation arises and discretion needs to be exercised, approvers should consider whether the request is:

- able to stand up to scrutiny by the auditors and members of the public
- properly explained and documented
- fair and equitable
- reasonable
- appropriate

It is the responsibility of both the approver and the claimant to work out appropriate arrangements which would meet the test of being fair and equitable.

4.2 Public disclosure of Expenses

Information about expenses must be posted on the hospital websites for the following:

- designated persons prescribed by regulation under the *Public Sector Expenses Review Act, 2009*.

5.0 TRAVEL

The policy applies whenever travel is required.

For the purpose of the policy, travel does not refer to a person's regular commute to work – expenses related to a person's regular commute are not reimbursable.

5.1 When travel is a part of the job

There are some jobs where frequent travel is a requirement – part of the regular job duties.

On hiring, managers should ensure staff are aware of the policy and how it will affect their job. In these situations, approvers should meet with the employee to determine appropriate strategies (e.g. pre-approval for frequent or regular travel, when meals can be reimbursed, use of vehicles, etc.).

5.2 When travel occurs every now and then

In the majority of positions in the hospital, travel usually occurs irregularly on an as-needed basis; for example, to attend training, meetings, conferences or consultations; presenting the hospital at an event; etc. In some cases employees will be asked by their managers to travel, and in others, the request may come from the employee.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

5.3 Approvals for Travel

The following chart identifies the level for approvals for travel for everyone covered by the policy.

Level of Approval Required			
Role	**Travel in Ontario**	**Travel in Canada**	**Intercontinental Travel**
Chair	N/A	N/A	Board of Directors
Trustee	CEO	Chair	Board of Directors
Physician	CEO	Chair	Board of Directors
CEO	AAF&HS	Chair	Board of Directors
Employee	CEO	CEO	Board of Directors

5.4 Before Travelling

There is a process to follow for all people wishing to be reimbursed for travel expenses.

- As a best practice, obtain prior approval for any travel.
- Secure passports, visas, immunizations, medications, as appropriate before you travel.
- Consult with your approver to ensure that your travel arrangements include accommodation for any special needs.
- Until the time that loyalty points can be accumulated through the hospital corporate travel card, participation in frequent flyer or other loyalty programs is permitted provided that you:
- choose the most cost-effective accommodation or method of travel; and
- use the Administrative Assistant to book your method of travel.

Loyalty points can be redeemed at the user's discretion; however, they cannot be redeemed for cash by using the points for business purposes and then submitting a claim for reimbursement.

Insurance

Medical and Health Insurance

Eligible employees are covered under the employer's health insurance plans in the event of illness or injury. The cost of additional private medical/health insurance will not be reimbursed for travel within Canada.

Vehicle Insurance

If you rent a vehicle you should purchase the collision damage waiver coverage offered by the rental company. The insurance costs can be claimed as a travel expense.

Personal Vehicle

If you use your personal vehicle while on hospital business, the following apply:

- The vehicle must be insured at the vehicle owner's expense for personal motor vehicle liability.
- It is the driver/owner's responsibility to ensure that the motor vehicle insurance includes coverage for business use of the vehicle.
- The hospital will not reimburse the costs of insurance coverage for business use, physical damage or liability.
- The hospital is not responsible for reimbursing deductible amounts related to insurance overage.
- In the event of an accident, you will not be permitted to make a claim to the hospital for any resulting damages.

5.5 Transportation – How to Get There

Hospital employees should make travel reservations through the Administrative Assistant.

Airplane

Air travel is permitted if it is the most practical and economical way to travel.

Economy (coach) class is the standard option for ticket purchase. Travel in business class must have prior approval by the CEO, and may be considered in the following circumstances:

- on international flights; or
- on flights within Canada and the continental United States of America if related to the provision of reasonable accommodation (e.g., health reasons)

Train

Travel by train is permitted when it is the most practical and economic way to travel.

A coach class economy fare is the standard.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Vehicle

Choosing the Appropriate Vehicle

When road transportation is the most practical, economical way to travel, the order of preference is:

- rental vehicle;
- personal vehicle, if it is more economical than a rental vehicle.

If you travel frequently as part of your job, these arrangements should be made when you are hired.

Use of personal vehicle must be approved in advance. The hospital will assume no financial responsibility for the use of your own vehicle other than paying the kilometric rate.

Rental Vehicle

When renting a vehicle; a compact model or its equivalent is required. Any exceptions must be:

- documented and approved prior to the rental if possible; and
- guided by the principle that the rental vehicle is the most economical and practical size, taking into account the business purpose, number of occupants and safety (including weather) considerations.

Luxury and sports vehicles are prohibited.

To avoid higher gasoline charges, refuel your rental car before returning it.

Personal Vehicle

The hospital assumes no financial responsibility for personal vehicles. The hospital will, however, pay the kilometric rate if you are, with prior approval, using your own vehicle for hospital business.

If you will be driving more than 200 kilometres in a day, you should consider using a rental vehicle.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

If you are going to drive your personal vehicle for more than five days within a single calendar month – even if you are not exceeding 200 kilometres in a single day – you should consider lower cost options, such as vehicle rental or audio or video conferencing.

The approver must make a decision on the type of vehicle used for travel (personal or rental) based on the frequency of travel as well as the distance per trip. If a decision is made, with your approver, for you to continue using a personal vehicle, both your research and the rationale must be documented.

If using a personal vehicle, keep daily logs to track the business rate.

Accident Reporting

All accidents must be reported immediately to local law enforcement authorities and your immediate supervisor. In addition:

- If you are using a rental vehicle, advise the rental car agency and contact the travel card insurance provider to initiate a claim;
- If you are using a personal vehicle, advise your own insurer.

Reimbursement and Rates

Rates are based on kilometres
Rates may be established in a collective agreement, and, if they are not, the rates in the policy apply.

Expense claims must be submitted with distances calculated in kilometres.
Rate per kilometre is .454.

Parking and Tolls

Reimbursement is provided for necessary and reasonable expenditures on parking, as well as tolls for bridges, ferries and highways, when driving on hospital business.

Parking costs incurred in the office area as part of a regular commute to work will not be reimbursed.

There is no reimbursement for traffic or parking violations.

Taxis

Prior approval to use a taxi should be obtained whenever possible.

Taxis may be justified in cases where:

- group travel by cab is more economical than the total costs of having individuals travel separately by public transit or shuttle; or
- taking a cab allows you to meet an unusually tight schedule for meetings.

Taxis may not be used to commute to work or home except under exceptional circumstances; for instance:

- weather, health or safety conditions indicate it is the best, appropriate option; or
- transport of work-related baggage or parcels is required.

Public Transit

Local public transportation including hotel/airport shuttles should be used wherever possible.

5.6 Accommodation

In the normal conduct of business, reimbursement for overnight accommodation within your office area will be neither authorized nor approved. However, in emergency or highly unusual situations exceptions will be considered: For example:

- You are required to remain close to your office for periods long in excess of (your) standing working hours.
- Your services are deemed necessary (and approved accordingly) for the purposes of emergency or crisis management.

There will be no reimbursement for hotel suites, executive floors or concierge levels when travelling.

Reimbursement will be made for single accommodation in a standard room.

For extended stays at a single location, accommodation must be arranged with prior approval. This will take advantage of lower weekly or monthly rates. Penalties incurred for non-cancellation of guaranteed hotel reservations are the claimant’s responsibility and may be reimbursed only in an exceptional circumstance.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Private stays with friends or family are acceptable, and a cash payment or gift may be provided to the friends or family:

- A maximum of $30 per night is allowed for accommodation including any meals with friends or family, in lieu of commercial accommodation. Instead of a receipt, you must submit a written explanation describing the purpose of the trip, identifying the host and the number of days you stayed.
- The $30 value may be given in the form of a small gift (which must be accompanied by a receipt) or by cash or cheque.

Personal Care

If traveling on business for five consecutive days or more, reimbursement is allowed within reasonable limits for expenses such as:

- laundry
- dry cleaning
- hotel valet services (e.g., shirt pressing, suit steaming, shoe polishing, etc.)

Itemized receipts are required.

You will not be reimbursed for personal or recreational items (e.g., the toothbrush you forgot to bring from home, pay-per-view, or items from the mini-bar).

Tips/Gratuities

You may be reimbursed for reasonable gratuities for porter, hotel room services, and taxis. Keep a record of gratuities paid.

- Examples of reasonable amounts for gratuities include:
- 10%-15% on a restaurant meal
- 10% on a taxi fare
- $2-$5 for housekeeping for up to two nights in a hotel, up to $10 for a longer stay
- $2-$5 per bag for a porter

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Telecommunication

With prior approval, you may use your cell phone for business purposes when travelling. Speak with your approver to determine what is covered in your cell plan and how the hospital wishes to handle long distance or roaming charges.

Wherever possible, you are expected to use the least expensive means of communication, such as:

- calling cards; and
- internet access.

Use audio or video conferencing whenever possible, as an alternative to travel.

If you are away on hospital business, reimbursement will be made for:

- reasonable, necessary personal calls home for each night away; and
- additional business expenses such as:
  - business calls
  - emergency calls from air or rail phones
  - internet connections and computer access charges
  - facsimile transmissions
  - word processing and photocopying services
  - rental and transportation of necessary office equipment

6.0 MEALS

Rules

Alcohol cannot be claimed and will not be reimbursed as part of a travel or meal expense. There are no exceptions to this rule.

You may incur a meal expense when you are on hospital business and you:

- are away from the hospital area (i.e., at least 24 km) over a normal meal period; or
- have prior approval for the expense (e.g., a business meeting within the hospital area that must occur over lunch).

Reimbursement will not be provided for meals consumed at home or included in the cost of transportation, accommodation, seminars or conferences.

If you travel as a regular part of your job, your meals will not normally be reimbursed unless you have obtained prior approval.

Meal Allowances

Reimbursement for meal expenses is subject to the allowance set out in the chart below. These rates include taxes and gratuities.

Meals	**Maximum Amount**
Breakfast	$10.00
Lunch	$15.00
Dinner	$25.00

7.0 HOSPITALITY

What is "hospitality" for the purpose of the policy?

Hospitality is the provision of food, beverage, accommodation, transportation and other amenities at hospital expense to people who are not engaged in work for the hospital.

Rules

Functions involving only people who work for the hospital are not considered hospitality functions and cannot be reimbursed. This means that hospitality may never be offered solely for the benefit of anyone covered by the policy.

Hospitality may be extended in an economical and consistent manner when:

- it can facilitate hospital business; and
- it is considered desirable as a matter of courtesy or protocol.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Expenses that do not fit the definition of hospital hospitality will not be reimbursed. Examples of such expenses would be: office social events, retirement parties, and holiday lunches.

When hospitality is appropriate

Hospitality may be extended on behalf of the hospital when:

- engaging in discussion of official public matters with, or sponsoring formal conferences for:
  - representatives from governments;
  - the broader public sector;
  - business and industry;
  - public interest groups; or
  - labour groups;
  - providing people from national, international, or charitable organizations with an understanding or appreciation of Ontario and the workings of its hospitals;
  - honouring distinguished people for exceptional public service in Ontario;
  - conducting prestigious ceremonies for heads of state, government or distinguished guests from the private sector; and
  - other hospitality functions as approved by the CEO, providing they conform to the rules listed in this section of the policy.

Planning the event

- Choose the location
  - Use a hospital facility if there is one available and appropriate.
  - If a hospital facility is not available and another is chosen, the CEO must provide prior approval.
- Minimize costs where possible, but have due regard for the guests' status, the size of the party, and the intended business purpose.

Managing the guest list

- The host extending the invitation:
  - must document and justify the list of hospital representatives;
  - keep the number of hospital representatives to a minimum, limiting it to those who have a direct involvement in the business purpose of the event;
  - may include the partner of a host or hospital representative only when required by protocol;

- may reimburse expenses incurred by a partner, as a guest of the hospital hospitality with the following provisions:
- may be paid only on authorization by the CEO;
- may include costs for travel, event tickets or tours;
- must be paid directly to the partner concerned.
- For hospitality events where guests may include current or prospective vendors of record, approvers must:
  - obtain prior approval from senior management; and
  - avoid either the actual or perceived preferential treatment of any vendor.

Submitting the claim for reimbursement

- All expenses must be documented and include original itemized receipts.
- The claim must include event details regarding:
  - purpose;
  - date(s);
  - location;
  - type of hospitality (breakfast, lunch, dinner, reception, refreshments, etc.);
  - attendees.
- hospital attendees (all people and positions covered by this policy) listed by name
- other attendees listed by name and organization;
  - appropriate prior approvals.

Gift-Giving

Appropriate token gifts of appreciation, values up to $30, may be offered in exchange for gifts of service or expertise to people who are not engaged in work for the hospital. Gifts valued over $30 must have prior approval.

8.0 EXPENSES FOR CONSULTANTS AND OTHER CONTRACTORS

Consultants and other contractors will not be reimbursed for any hospitality, incidental or food expenses, including:

- Meals. snacks and beverages
- Gratuities
- Laundry or dry cleaning
- Valet services
- Dependant care
- Home management
- Personal telephone calls

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Claims for Reimbursement of Expenses

Reimbursement for allowable expenses under the policy can be claimed only when the contract with the hospital specifically allows for it.

9.0 RESPONSIBILITIES

Employees, Trustees and Physicians are responsible for:

- following the principles and rules set out in the policy,
- being aware of the conflict of interest rules that govern the hospital,
- being aware of any relevant statutes, directives, policies and guidelines.

Supervisors and Managers are responsible for:

- carrying out any delegated authorities and assigned tasks in accordance with the policy,
- exercising managerial discretion judiciously,
- ensuring there is an appropriate records retention system and that documents, including claims and approvals, are maintained and stored,
- ensuring staff are aware of the requirements of the policy,
- seeking timely direction when there are questions of application,
- taking appropriate action in the case of non-compliance.

CEO's (or Chair if appropriate) are responsible for:

- ensuring the policy principles and rules are implemented and monitored, including putting in place processes that support the policy,
- delegating approval authority to appropriate levels within the hospital,
- carrying out any delegated authorities and assigned tasks in accordance with the policy,
- ensuring consistent application of the policy (e.g. for all jobs requiring regular travel),
- ensuring that claims are fully documented by running regular spot checks,
- ensuring that all persons covered by the policy are aware of their responsibilities under the policy and of the appropriate conflict of interest rules.

TRAVEL, MEAL AND HOSPITALITY EXPENSES POLICY

Chairs are responsible for:

- ensuring all employees and appointees are made aware of their responsibilities under the policy,
- ensuring the policy is applied and monitored appropriately,
- ensuring that staff with delegated authority are able to effectively apply this policy.

10.0 DEFINITIONS

AAF&HS: Assistant Administrator, Finance & Hospital Services

Approver: A person with the authority to make approvals under this policy.

Chair: Someone appointed Chair of the Board of Directors.

Chief Executive Officer (CEO): The head of operations at the hospital.

Claimant: Anyone making a claim under the terms of this policy.

Consultants and Contractors: Individuals or entities under contract to the hospital providing consulting or other services.

Delegation of Authority: A written assignment by which a person who has a power, duty, function or responsibility under the policy authorizes another person (identified by name or by position title) to exercise the power, duty, function or responsibility.

Dependent: Someone who resides with the traveler on a full-time basis and relies on the traveler for care (e.g., a child or parent).

Employee: Individual employed by the hospital.

Hospitality: The provision of food, beverage, accommodation, transportation and other amenities at hospital expense to people who are not engaged in work for the hospital.

Itemized receipt: Original document identifying the vendor with the date and amount of each expense item paid by the claimant.

Office area: The area surrounding the regular workplace, with a perimeter of 24 km measured by the most direct, safe and practical route by road.

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INTEGRATION POLICY

Under section 24 of the Act, the Board of Directors ("Board") of Sensenbrenner Hospital commits the organization to build relationships and collaborate with the [North East Local Health Integration Network (the "NE LHIN"), other health service providers and the community to identify opportunities to integrate the services of the local health system for the purpose of providing appropriate, coordinated, effective and efficient services.

The Board, with the support of the Chief Executive Officer (CEO), will:

- be fully informed of the principles of health system integration, the organization's rights and obligations under the Act and the NE LHIN's integrated health service plan,
- designate a member(s) of the Board to collaborate with the NE LHIN and participate on behalf of the Board in all NE LHIN governance forums with health service providers and report back to the Board,
- annually review the Strategic Plan and revise it as necessary to ensure it addresses the integration requirements of the Act and respects key service integration principles and objectives pursued by the NE LHIN,
- provide direction to the CEO on the Board's expectations concerning the integration planning process and reflect this understanding in the CEO's performance agreement,
- annually consider and, if appropriate, approve specific voluntary integration initiatives, for consideration by the NE LHIN, as recommended by the CEO to advance the implementation of the Strategic Plan,

INTEGRATION POLICY

- establish a mechanism for dialogue with other health service provider board(s) and other persons and entities as required related to specific types of integration initiatives, and

- periodically monitor the performance of approved voluntary integration initiatives against defined indicators.

The Board delegates responsibility to the CEO to:

- provide for Board education concerning the Act and the NE LHIN's Integrated Health Service Plan (IHSP),

- provide regular updates on NE LHIN integration policy and activities,

- prepare an annual review and update of the Strategic Plan in relation to the NE LHIN IHSP and other voluntary integration initiatives,

- include specific performance objectives in his/her annual performance plan concerning collaborating with the NE LHIN, other health service providers (or other persons and entities) and the community toward the integration of services,

- collaborate with staff of related health service providers and the NE LHIN to identify opportunities to integrate the services of the local health system for the purpose of providing appropriate, coordinated, effective and efficient services and inform the Board of these activities,

- recommend specific voluntary integration initiatives for consideration and approval by the Board,

- identify performance indicators to monitor specific voluntary integration initiatives, and

- report to the Board periodically on the performance and outcomes of specific voluntary integration initiatives.

SENSENBRENNER HOSPITAL
BOARD OF DIRECTORS
POLICY & PROCEDURE MANUAL

POLICY NO.: 03-005
PAGE 1 of 1

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CHIEF EXECUTIVE OFFICER RECRUITMENT

POLICY

Pursuant to the Sensenbrenner Hospital By-laws:

> "41 (1) The Chief Executive Officer shall be appointed by the Board and may be Secretary, Treasurer, or Secretary-Treasurer of the Board of Directors."

PROCEDURE

1. Upon a vacancy occurring in the position of Chief Executive Officer an external search will be conducted utilizing appropriate media advertising.

2. As the position of Chief Executive Officer is designated under the French Language Services Act, 1986, any advertisements shall indicate "candidates must have the ability to provide services in French and English" as a required qualification. (See Administrative Policy No.: I-1-45.)

3. Advertisements will be published in conformance with respect to the French Language Services policy. (See Administrative Policy No.: I-1-40.)

4. Qualified applicants shall be considered through a formal interview process by a Selection Committee as established by the Executive Committee of the Board of Directors.

5. The Selection Committee will recommend the preferred applicant to the Board of Directors. The Board of Directors, in accordance with the by-laws, reserves final approval of the appointment.

6. The Selection Committee or a representative(s) thereof, will extend the formal offer of employment to the candidate approved by the Board of Directors.

SENSENBRENNER HOSPITAL
BOARD OF DIRECTORS
POLICY & PROCEDURE MANUAL

POLICY NO.: 03-020
PAGE 1 of 1

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COMMUNICATION OF LEGAL CLAIMS

POLICY

Any legal claims which name Sensenbrenner Hospital, as a defendant or co-defendant, will be brought to the attention of the Executive Committee of the Board of Directors.

PROCEDURE

1. Upon Sensenbrenner Hospital being served with a Statement of Claim the following details will be disclosed to the Executive Committee of the Board of Directors.
   i) the name of the claimant(s);
   ii) the nature of the claim;
   iii) the amount of damages being sought;
   iv) the existence of co-defendants.
2. Upon legal counsel filing a Statement of Defence on behalf of Sensenbrenner Hospital, the Executive Committee of the Board of Directors will be so advised.
3. On an annual basis the Evaluation of Claims requested of all legal counsel representing Sensenbrenner Hospital in conjunction with the annual audit will be circulated in their entirety to the Executive Committee of the Board of Directors.
4. The Chief Executive Officer and the Executive Committee are empowered to agree to settlement of any legal claims against Sensenbrenner Hospital on the basis of advice provided by legal counsel.

SENSENBRENNER HOSPITAL
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MANAGEMENT AND NON-ORGANIZED SALARIES

POLICY

Sensenbrenner Hospital will endeavour to maintain a competitive salary structure in order to recruit and retain staff.

PROCEDURE

1. The Chief Executive Officer (CEO) will review management and non-organized salaries and bring forth a recommendation to the Board of Directors for approval annually.
2. The Ontario Hospital Association (OHA) Salary Survey released in the fall of the year will be employed to compare the salaries in effect at Sensenbrenner Hospital, with the average of the mean maximum for hospitals with bedsize 50-99 and the mean maximum for hospitals with a budget size $10-25 million.
3. Other factors will be considered and clearly identified as part of the recommendation brought forth by the CEO.
4. The adjustments will be effective as of April 1 of the current year.

ISSUED BY: BOARD OF DIRECTORS

MANUAL DISTRIBUTION:
BOARD OF DIRECTORS

APPROVED BY: BOARD OF DIRECTORS

CATEGORY: N/A

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REVIEW/REVISION (YY/MM):

PERQUISITES DIRECTIVE:
BROADER PUBLIC SECTOR (BPS) ACCOUNTABILITY ACT, 2010

1.0 PURPOSE

The purpose of the policy is to establish rules on perquisites pursuant to directive under the Boarder Public Sector (BPS) Accountability Act, 2010, the 'Act'.

A perquisite refers to a privilege that is provided to an individual or to a group of individuals, provides a personal benefit, and is not generally available to others.

2.0 APPLICATION AND SCOPE

The rules apply to:
- All employees
- All trustees
- All physicians

The rules do not apply to:
- provisions of collective agreements
- insured benefits
- items generally available on a non-discriminatory basis for all or most employees (e.g. pension plans)
- health and safety requirements
- employment accommodations made for human rights and/or accessibility considerations
- expenses covered under Board of Directors Policy No.: 02-060, *'Travel, Meal and Hospitality Expenses'*

PERQUISITES DIRECTIVE:
BROADER PUBLIC SECTOR (BPS) ACCOUNTABILITY ACT, 2010

3.0 PRINCIPLES

The policy is based on three key principles.

a) Accountability
Sensenbrenner Hospital is accountable for the use of public funds. All expenditures support business objectives.

b) Transparency
Sensenbrenner Hospital is transparent to all stakeholders. The rules of perquisites are clear and easily understood.

c) Value for Money
Taxpayer dollars are used prudently and responsibly.

4.0 RULES

4.1 The following perquisites are not allowed under any circumstance:
- Club memberships for personal recreation or socializing purposes, such as fitness clubs, golf clubs or social clubs
- Seasons tickets to cultural or sporting events
- Clothing allowances not related to health and safety or special job requirements
- Access to private health clinics – medical services outside those provided by the provincial health care system or by the employer's group insured benefit plans
- Professional advisory services for personal matters, such as tax or estate planning.

These privileges cannot be provided by any means, including:
- An offer of employment letter, as a promise of a benefit,
- An employment contract, or
- A reimbursement of an expense.

4.2 Perquisites that are not related to business requirements are not allowed.

4.3 The approval authority for perquisites is retained by the Board of Directors.

4.4 Any and all expenditures are to be made in accordance with all other policies and procedures.

4.5 A perquisite is allowable only in limited and exceptional circumstances where it is to be a business related requirement for the effective performance of an individual's job.

4.6 Allowable perquisites will be made publicly available annually in summary on the Sensenbrenner Hospital website. Personal information will not be provided.

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BOARD OF DIRECTORS
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POLICY NO.: 04-010
PAGE 1 of 3

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(Mr. Gary Fortin, Board Chair)

ORIGINAL DATE OF ISSUE:
February 10, 2011 (Executive Committee)

REVIEW/REVISION (YY/MM): R16/03, R18/12, R19/08

QUALITY & RISK COMMITTEE (QC)

PURPOSE AND RESPONSIBILITIES

To monitor and report to the Board of Directors on quality issues and on the overall quality of services provided at Sensenbrenner Hospital

To analyze Patient Safety and Quality and Risk Management data and relay a brief overview of our current state to the Board of Directors

To consider and make recommendations to the Board of Directors regarding quality improvement initiatives, policies and allocation of resources

To ensure that best practice information supported by available scientific evidence is translated into materials that are distributed to employees providing services within the health care organization and to monitor the use of the material provided

To oversee the preparation of the Annual Quality Improvement Plans (QIP)

To carry out any other responsibilities provided in the regulations

QUALITY & RISK COMMITTEE (QC)

MEMBERSHIP

The membership composition and governance of the QC shall be provided for in the regulations and statutes. **The majority of the members of the QC must be voting members of the hospital Board of Directors**:

Voting Members:

- Board Executive Committee members (4)
- Medical Advisory Committee (MAC) member (Chief of Staff)
- Chief Executive Officer (CEO)
- Hospital staff member that does not belong to the College of Nurses of Ontario (CNO) or the College of Physicians and Surgeons (CP&SO) and is a member of a health profession within the meaning of the Regulated Health Professionals Act, 1991.

Ad-Hoc:

- Assistant Administrator, Nursing Services (AANS)
- Assistant Administrator, Finance & Hospital Services (AAF&HS)
- Director, Human Resources
- Such members as appointed by the Board of Directors

CHAIRPERSON

The Hospital Board shall appoint a voting member of the Hospital's Board of Directors to be Chair of the QC

QUORUM

A quorum is a simple majority of Board members present.

FREQUENCY OF MEETINGS

Members of the committee shall meet every 2 months, with the exception of July and August.

QUALITY & RISK COMMITTEE (QC)

AGENDA ITEMS

Reports
Quality Improvement Plan Update
Quality Improvement Plan - Development
Dashboard - Strategic Plan
Patient Related Incident Report
Annual FMEA Report
Utilization Rates and Stats Report
Risk Assessment Register
Patient Survey Feedback Report
Accreditation Report and Update
Patient Safety Audits Dashboard

Minutes
Medical Advisory Committee
Joint Advisory Committee
Professional Care Committee (PCC)
Joint Health and Safety Committee
Infection Prevention and Control (IPAC)
Medication Management Committee

MINUTES

Minutes will be recorded by the Administrative Assistant.

REFRENCE

As per Bill 46, Excellent Care for All Act, draft regulations of October 29, 2010.

SENSENBRENNER HOSPITAL
ADMINISTRATIVE
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POLICY NO.: I-1-20
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APPENDICES 1 & 2

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APPROVED BY: CEO

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PASTORAL CARE (#VI-1-010),

CATEGORY: ADMINISTRATIVE OVERVIEW

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April 1990

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SENSENBRENNER HOSPITAL STRATEGIC PLAN 2018-2023
MISSION/VISION/VALUES STATEMENTS

The Sensenbrenner Hospital Strategic Plan 2018-2023 has been prepared and includes the Mission, Vision, Values, goals and objectives of the organization.

HÔPITAL SENSENBRENNER HOSPITAL

Strategic Plan 2018-2023

Vision: (Future) **TOGETHER** For a Healthy Community

Mission Statement: (What we do) Providing quality and compassionate health care with our partners in our Northern Community.

Our Values: Integrity, Respect, Teamwork, Accountability and Professionalism

Our Priorities	Our Patients	Our People	Our Partners	Our Future
Our Goals	Patients and Care Teams Involved in Their Care	Our People Working Together to make a Difference in the Lives of Those We Serve	Partnerships to Ensure the Right Care, at the right Place, at the Right Time	Preparing Today for the Needs of Tomorrow
How we will get there	Smooth Transition to Community Care Patient and Family Engaged with Care Team Provide Safe and Appropriate Patient Care Understand Current Needs of the Community	Communication & Team Work Recruiting & Retaining an Engaged Workforce Healthy & Safe Work Environment Cultivating Skills & Growth	Stakeholder Collaboration to ensure efficient use of healthcare resources Efficient Communication Tools & Processes Between Health Care Providers and Community Partners to Ensure Access to Information in a Timely Manner	A Facility that Meets our Needs Balanced Budget Clean and Well Maintained Environment Clear and Available Policies Aware of Changing Community Needs A Foundation

Our Values

Integrity Is defined as the quality of being honest and having strong moral principles. To have integrity is to be honest, trustworthy and sincere and to have good work ethics, a positive mindset and pride in a job well done.

Some examples of Integrity are:

- Taking responsibility for your actions, admit when you have made a mistake and be open to learning from them;
- Reporting of incidents to avoid harm;
- Share needed information with team members; and
- Have the courage to stand up to negative or disrespectful behavior.

Respect Is defined as treating someone or something with kindness and care.

Some examples of Respect are:

- Greeting others in the Hospital;
- Treating others the way they would like to be treated;
- Being considerate of each other's time, space, feelings and privacy;
- Being polite with everyone, utilizing appropriate verbal and non-verbal cues when interacting with others;
- Respect is reciprocal, you must give respect to receive it;
- Taking the time to actively listen, without judgment;
- Avoid gossip and be respectful of others;
- Demonstrating these behaviors regardless of title or position.
- Share the information needed by our Patients/Clients to make informed decisions about their own Health Care

Accountability Is defined as the willingness to accept responsibility or account for one's actions.

Some examples of Accountability are:

- I am responsible for all that I do, my actions and my work performance;
- Communicate honestly and promptly (as soon as appropriate);
- Evolve with the organization; and
- Being self aware of your strengths and areas for improvement.

Teamwork Is defined as a group of people working together toward a common goal while creating a positive working environment and supporting each other.

Some examples of Teamwork are:

- Helping each other;
- Being open to ideas and feedback;
- "Pulling your weight";
- Recognize everyone's value; and
- Working together for a common goal, the Patient/Client.

Professionalism Is defined as an appearance, a language and an approach that leaves a positive impression always.

Some examples of Professionalism are:

- Engage everyone around you so they know they matter;
- Continuous improvement of your skills, knowledge and competence to do your job; and

Always be a part of the solution…refuse to "settle" and "complain".

ISSUED BY: NOMINATING COMMITTEE/ FLSAC/STRATEGIC PLANNING COMMITTEE/ BOARD OF DIRECTORS

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APPROVED BY: CEO

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May 1988

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NOMINATING COMMITTEE: FORMAT AND PROCEDURES

A. GENERAL

1. Minutes will be recorded of all committee meetings.
2. Names of volunteers and prospective Board members are to be placed on a master list and updated as required for committee reference. This list will be updated annually and distributed to committee members.
3. A file containing minutes, name lists, all correspondence, etc. is to be established, maintained and placed in the custody of the Chief Executive Officer for easy access by the committee.
4. Files are to remain confidential with accessibility limited to the committee.
5. Sensenbrenner Hospital will maintain bilingual representation on the Board of Directors.

B. PREPARATION FOR ANNUAL MEETING

1. The Nominating Committee Chair will be contacted by Administration on or about March 1st to schedule the Nominating Committee's first meeting.
2. The Nominating Committee will initiate its deliberations for the slate of nominees to be presented to the Annual Meeting by March 15th of each year.
3. Each incumbent Board member desiring to stand for re-election will be interviewed by the committee.
4. The committee will be guided by Sensenbrenner Hospital's By-Laws, Part I, Section 28, Clause 3 (Appendix 1) in assessing incumbent Board members.
5. In appraising each prospective candidate for an open position on the Board of Directors, the committee will be guided by the Corporation's By-Laws, Part I, Section 28, Clause 4 (Appendix 1).
6. All prospective candidates will be interviewed by the committee.
7. The committee will prepare its final report to the Board of Directors by May 1st each year and notify all candidates of its decision regarding the slate to be presented to the Annual Meeting.

NOMINATING COMMITTEE: FORMAT AND PROCEDURES

C. SELECTION OF NOMINEE TO REPLACE A DIRECTOR THAT RETIRES MID TERM

1. The committee will convene at the call of the Chair to consider prospective candidates for the vacancy.
2. The committee will be guided in its deliberations by Item 5, 6 and 7 in the preceding Section B.
3. At the conclusion of its deliberations, a recommendation will be prepared and submitted to the Board of Directors accompanied by a curriculum vitae of the nominee.

BY-LAW TIMEFRAME REQUIREMENTS FOR ANNUAL CORPORATION MEETING

January 1st	-	initiate advertising for prospective Board members
March 1st	-	schedule Nominating Committee meeting
March 15th	-	initiate deliberations
May 1st	-	final report to Board and notify all candidates of slate to be presented to the Annual Meeting
day 45	-	first advertisement for Annual Meeting
day 30	-	Secretary to receive written declaration of nomination by members
day 14	-	advertise Annual Meeting for two consecutive weeks
day 0	-	Annual Meeting

APPENDIX 1
(By-Law Excerpt)
(Board Policy No. 14-010)

28. NOMINATING COMMITTEE

(1) The Nominating Committee shall consist of:

(a) two Directors,

(b) two members of the Corporation who are not Directors; and

(c) the Chief Executive Officer without power to vote.

(2) The Nominating Committee shall:

(a) nominate persons for election to the Board to fill any vacancies on the Board; and

(b) nominate Directors for consideration by the Board for election as officers of the Board as defined in these by-laws.

(3) In selecting persons as nominees for election to the Board, the committee shall:

(a) endeavour to provide for broad community representation after considering the list of appointed and ex officio Directors;

(b) consider the names of all persons submitted in accordance with these by-laws;

(c) consider the potential contribution of any person nominated in relation to the function of hospitals generally in Ontario and the Corporation in particular in providing services to the community in accordance with the goals and the objectives of the Hospital;

(d) consider the person's:

(i) standing and reputation in the community; and
(ii) record of public service; and

(4) In selecting Directors for nomination for election or appointment as officers of the Board, the committee shall review participation and attendance at previous Board and committee meetings.

(5) The Nominating Committee shall perform such other duties as may be requested by the Board from time to time.

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BOARD OF DIRECTORS
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POLICY NO.: 18-005
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March 1986

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REMUNERATION: CHIEF OF STAFF

The hospital recognizes the invaluable service that the Chief of Staff provides. Therefore, the hospital will provide the Chief of Staff an annual stipend.

STIPEND

- $15,000
- payable June, September, December and March in quarterly installments

The hospital will also allow a per diem to the Chief of Staff associated with travel on hospital business (refer to Board of Directors Policy No.: 18-006).

SENSENBRENNER HOSPITAL
BOARD OF DIRECTORS
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POLICY NO.: 18-006/18-006
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CATEGORY: N/A

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February 1986

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REMUNERATION: PHYSICIANS

The hospital will allow a per diem to physicians travelling on hospital business, when at the request of Administration.

PER DIEM

Current approval level:

- $750 per day, plus other recognized expenses;
- payable upon submission of authorized travel expense statement;
- approval of Chief Executive Officer required, prior to departure.

The policy is subject to annual review and approval.