# New Unionville Home Society

## GOVERNANCE AND NOMINATING COMMITTEE MEETING

## AGENDA

**MONDAY, APRIL 8, 2019**
**6:00 – 7:30pm**
**Union Villa Conference Room**
**4300 Highway 7**
**Unionville, ON**

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|---|---|
| **Committee Members:** | Julie Chapman, Paul Cousens, Glenn Crosby, Dan Horchik (Chair), Christine Joe, Ted Madden, Gayle Whittamore |
| **New UHS Staff:** | Paul Nyhof (CEO), Julie Horne (CFO), Marieanna Mallen (Executive Assistant) |

| # | Agenda Item | Encl. | Lead | Time |
|---|---|---|---|---|
| 1. | Call to Order | | Dan Horchik | 6:00 – 6:05pm |
| 2. | Roll Call and Appointment of Committee Meeting Chair and Recording Secretary | | | |
| 3. | Confirmation of Quorum Present | | | |
| 4. | Confirmation of Proper Notice Given | | | |
| 5. | Declaration of Conflicts of Interest | | | |
| 6. | Approval of the Agenda | √ | | |
| 7. | Approval of Minutes – February 11, 2019 | √ | | |
| 8. | Business Arising | | | |
| | 8.1 Work Plan Review | √ | Committee | 6:05 – 6:10pm |
| 9. | New Business | | | |
| | 9.1 Policy and Procedure Review<br>9.1.1 Risk Management - Update<br>9.1.2 Whistleblower - Update | √ | Committee | 6:10 – 6:40 |
| 10. | Board Evaluations – Q3 Results | √ | Committee | 6:40 – 7:00 |
| 11. | Strategic Planning – verbal update | | Paul Nyhof | 7:00 – 7:30 |
| 12. | Adjournment/ Date and Time of Next meeting<br>Monday, May 13, 2019 6:00 - 7:30pm | | | 7:30pm |

# New Unionville Home Society

## GOVERNANCE AND NOMINATING COMMITTEE

## MINUTES

**MONDAY, FEBRUARY 11, 2019**
**6:00 pm**
**The Union Villa Conference Room**
**4300 Highway 7**
**Unionville, ON**

| | |
|---|---|
| **Committee Members Present:** | Julie Chapman, Paul Cousens, Glenn Crosby, Dan Horchik (Chair, via teleconference), Christine Joe, Ted Madden, Gayle Whittamore |
| **New UHS Staff:** | Paul Nyhof (CEO), Julie Horne (CFO), Marieanna Mallen (EA) |

1. **Call to Order**
   Gayle Whittamore called the meeting to order at 6:01pm.

2. **Roll Call and Appointments of Meeting Chair and Recording Secretary**
   A roll call was completed. Gayle Whittamore and Marieanna Mallen were appointed meeting Chair and Recording Secretary, respectively.

3. **Confirmation of Quorum Present**
   It was declared that a quorum of the Directors was present.

4. **Confirmation of Proper Notice Given**
   All of the Directors having been given proper notice of the meeting and being present or having waived notice, the meeting was declared to be regularly constituted in accordance with the by-laws of the Corporation.

5. **Declaration of Conflicts of Interest**
   No conflicts of interest were declared.

6. **Agenda**
   The Agenda was approved as presented.

7. **Approval of Minutes, January 7, 2019**

MOTION to approve the Minutes of January 7, 2019 as presented.

**Carried**

## 8. Business Arising

8.1 Work Plan Review

The Committee reviewed the updated Work Plan.

MOTION to receive the 2018/2019 Work Plan as presented.

**Carried**

## 9. New Business

9.1 Policy and Procedure Review

9.1.1 Code of Conduct

The Code of Conduct Policy No. 2024 was approved as presented.

9.2 Strategic Planning

Paul Nyhof distributed a one-page document containing an overview of a proposed strategic planning process for the coming months. The goal is to have a Strategic Plan in place by September 2019 that will run for a five-year cycle.

Paul will be conducting a SWOT analysis with members of the Senior Leadership Team and identify innovations in long-term care that would benefit UHS and NUHS. The directors of NUHS, UHS and the Foundation will be invited to a full-day strategic planning session targeted to be held in June 2019.

Paul has approached a consulting firm for their proposal with respect to: (1) acting as facilitator for the strategic planning session, and (2) assisting with preparation and finalization of a new Strategic Plan. The firm to be retained will arrange focus groups that will include representatives from external parties (York Region, LHIN and vendors) and internal groups (staff, volunteers, family members, residents, family council, Board directors). The firm will then facilitate a full-day strategic planning session. A date and location will be determined once the project has received NUHS Board approval.

After discussion, the Committee agreed that the NUHS Board has sole authority to approve the final Strategic Plan. The NUHS Board will invite directors of the UHS Board and the Foundation Board to be involved in the planning process. It is anticipated that the final Strategic Plan to be approved by the NUHS Board will be presented to the UHS Board and to the Foundation Board for endorsement.

Following approval of a new Strategic Plan, the Senior Leadership Team will develop a yearly operational plan to continuously guide the fulfillment of the Strategic Plan.

A full presentation of the Staff recommendation with respect to a strategic planning process including consulting costs will be presented to the NUHS Board via teleconference prior to the February 27 Board meetings. Once approved, the plan will be shared with the UHS and Foundation Boards.

## 10. Adjournment/Date and Time of Next Meeting

The Committee meeting was terminated at 6:39pm.

The next meeting is to be held on Monday, March 11, 2019.

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# Governance and Nominating Committee - Work Plan 2018-2019

| **SEPTEMBER Activity / Project** | ***Status / Notes*** |
|---|---|
| • Review previous year activities | *DONE* |
| • Discuss priorities for work plan | *DONE* |
| • Determine 2018/2019 meeting schedule | *DONE* |
| • Policy and Procedure – Review List – Annual | *DONE* |
| • Review Risk Management P & P | *DONE* |
| • Board Giving: Discussion (as per Nov 2017 mtg) | *DONE* |
| • Strategic Planning | *DONE* |
| • Quality Improvement Planning (as per March 18, 2017 mins) | *MOVED TO OCTOBER MTNG* |
| **OCTOBER - Activity / Project** | |
| • Work Plan Review | *DONE* |
| • Quality Improvement Planning (as per Sep 10, 2018 mtng) | *DONE* |
| • Policy and Procedure Review - Biennial | *DONE* |
| **November** – Activity /Project | |
| • Succession Planning | *DONE* |
| • Policy and Procedure Review List – Triennial | *DONE* |
| • Review Results of Board Evaluations | *DONE* |
| • Risk Management P&P – Update | *DONE* |
| **JANUARY - Activity / Project** | |
| • Review Results of Board Evaluations | *DONE* |
| • Notice to Boards to appoint rep for Nominating Task Force | *DONE* |
| • Risk Management P&P – Review | *DONE* |
| • Criminal Reference Check/Vulnerable Sector P&P Follow Up | *DONE* |
| • Whistleblower Policy Review (2) | *DONE* |
| • Policy Review – Triennial (cont.) | *DONE* |
| **FEBRUARY - Activity / Project** | ***Status / Notes*** |
| • Policy and Procedure Review List – Triennial (Cont) | *DONE* |
| • Strategic Planning | *DONE* |
| **MARCH - Activity / Project** | ***Status / Notes*** |
| • Appoint Nominating Task Force | *Mtng Postponed* |
| • Whistleblower Policy review | |
| • Risk Management P&P review | |
| • Review Results of Board Evaluations | |
| **APRIL - Activity / Project** | ***Status / Notes*** |
| • Nominating Task Force - Appointment | |
| • Whistleblower Policy Review | |
| • Risk Management Policy Review | |
| • Review Results of Board Evaluation | |
| • Strategic Planning Update | |
| **MAY - Activity / Project** | ***Status / Notes*** |
| • Nominating Task Force Report for Board approval | |
| • | |

| JUNE - Activity / Project | *Status / Notes* |
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| • | |

| NEW UNIONVILLE HOME SOCIETY | | POLICY AND PROCEDURE MANUAL | |
|---|---|---|---|
| Subject: | **Integrated Risk Management (IRM) Framework** | Policy No.: | **2032** |
| | | Last Reviewed: | **April 8, 2019** |
| Section: | **2000 – Governance** | First Approved: | **June 20, 2007** |
| Approved by: | **Board of Directors** | Total Pages: | **9** |
| External References: | *Integrated Risk Management for Healthcare Organizations, A Risk Resource Guide*, HIROC (Oct. 2014)<br>*Integrated Risk Management Implementation Guide*. Treasury Board Secretariat, Government of Canada (2012).<br>*A Framework for Board Oversight of Enterprise Risk*. CPA Canada (2012).<br>*ISO 31000 Risk Management – Principles and Guidelines.* International Standards Organization<br>*Enterprise Risk Management – Integrating Strategy and Performance, Executive Summary.* COSO (June 2017). | | |

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**PREAMBLE:**

New Unionville Home Society and its affiliated corporations (NUHS, the 'organization') are committed to establishing an organizational culture which ensures that risk management is an integral component of strategic planning, goals and initiatives plans, management information systems and work processes. The organization is committed to ensuring a safe environment for its residents/clients, their families and its staff, volunteers, and visitors.

The Treasury Board of Canada Secretariat defines Integrated Risk Management (IRM) as "a continuous, proactive, systematic approach to identifying, assessing, understanding, acting on, and communicating risk from an organization-wide aggregate perspective". It is the practice of planning, coordinating, executing and handling the activities of the organization in order to minimize the impact of risks on the organization. IRM extends the approach to incorporate not only the risks connected with unexpected losses, but also strategic, financial, and operational risks.

The Board of Directors have adopted this Integrated Risk Management Framework to address the full spectrum of risks and manage the combined impact of those risks.

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The NUHS Integrated Risk Management Program is the mechanism by which risks are identified and prioritized and appropriate plans are established to mitigate the impact of the risks. It shall serve as a means by which the organization can learn from its risks and incidents, using a continual quality improvement model. The program's primary goals are ensuring the achievement of desired outcomes and having reliable contingency plans in place to deal with the unexpected events that could put service delivery at risk.

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| Subject: | **Integrated Risk Management (IRM) Framework** | Policy No.: | **2032** |
|---|---|---|---|
| | | Last Reviewed: | April 8, 2019 |

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## POLICY:

Risk management is an integral part of the organization's objectives and plans. It will be an essential component of strategic planning, goals and initiatives plans, management information systems and work processes.

Risk management is the responsibility of all employees of the organization:

- Employees are trained in, and aware of, risk management at a level that enables them to fulfill their responsibilities in protecting others, themselves and the organization from risk.
- Supervisory and management staff will utilize an assessment framework to manage risk. In addition, by identifying and determining actions as part of a planning process and by ensuring staff within their area of control understand and fulfill their individual responsibility, they will minimize the level of risk to the organization.
- The Senior Leadership Team (SLT) will establish systems to provide supervisory and management staff with effective risk control mechanisms.
- The CEO and SLT, in collaboration with the Board, will establish the standard of risk management and audit compliance, and provide reports to the Board of Directors.

NUHS is committed to building increased awareness and a shared responsibility for risk management at all levels of the organization through an IRM program that includes:

i. Clearly defined accountabilities and responsibilities
ii. A framework to analyze risk
iii. A risk register of key organizational risks
iv. A Board reporting schedule

## PURPOSE:

The purpose of this Framework is to provide guidance to the Board of Directors and Chief Executive Officer (CEO) on the implementation of effective risk management practices at all levels of the organization. The Framework will encourage a consistent approach to risk management and support strategic priority setting, resource allocation, informed decisions with respect to risk tolerance and improved results.

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The organization has formed its risk management program to proactively pursue its risk management goals and objectives. The program addresses the requirements for accreditation by CARF International, the requirements of HIROC's Risk Assessment Checklists, and reflects and is aligned with the Mission Vision, and Strategic Priorities of the organization.

The goals and objectives of NUHS' risk management program include:

1. To avoid exposure to accidental loss by not undertaking functions, contracts, programs or activities where the potential loss is greater than the potential benefit to be derived from these undertakings;
2. To prevent loss by identifying loss exposures and implementing policies and procedures to reduce the risk of these losses occurring;
3. To control losses that do occur by:
    a. Assisting and supporting injured parties,
    b. Developing contingency plans for possible loss scenarios, and
    c. Properly documenting and investigating losses.
4. To raise the awareness of all management, employees, volunteers and residents/clients and family members concerning risk management within our organization.

## SCOPE AND RESPONSIBILITIES:

This policy applies to all NUHS activities. It forms part of the organization's governance framework and it applies to all employees, contractors and volunteers.

Every employee has a personal responsibility for risk management activities.

It is important to outline how the responsibility of each individual contributes to the lines of management accountability through to the Board of Directors.

There are 4 identifiable tiers:

5. Board of Directors
6. Chief Executive Officer and Senior Leadership Team
7. Managers and Supervisory Staff
8. Employees undertaking daily activities

### 1. Board of Directors

The Board of Directors has overall responsibility for the risk management framework, systems and activities of the organization. The Board receives a quarterly report and an annual assessment of how well significant risks are being controlled across the organization. These reports, along with sentinel events reports, assist the Board to monitor how well risks are being handled on the Board's behalf and to prioritize actions that are sensitive to the overall clinical, organizational and financial needs and circumstances faced by the organization.

### 2. Chief Executive Officer and Senior Leadership Team

The CEO, who delegates responsibility and action to the Senior Leadership Team (SLT), holds organizational management responsibility.

It is the responsibility of the CEO and the SLT to ensure that standards of risk management are applied at all levels across the organization and that controls and assurance mechanisms are in place to report to the Board of Directors. They will coordinate these mechanisms and through relevant committees will:

- Provide advice to supervisory and management staff on effective risk control mechanisms
- Establish standards of responsible risk management practices
- Monitor progress and arrange for audit of compliance with standards

The CEO and the SLT have the responsibility for advising on the allocation of resources, the coordination, overview and prioritization of risk management activities and regular reporting to the Board of Directors.

### 3. Managers and Supervisory Staff

Managers and Supervisory Staff shall:

- Ensure that effective communication strategies are employed to communicate risk management principles to all employees within their area of responsibility,
- Ensure that employees within their area of responsibility understand and carry out individual responsibility for the management of risks,
- Undertake appropriate risk assessments in order to identify key risks and generate prioritized action plans in order to minimize these risks,
- Utilize the outcomes of risk assessments as part of the planning process to aid in the planning and resourcing of risk minimization and management, and
- Ensure that the information captured by complaints, litigation and incident reporting is used as a means of continuous monitoring and review, leading to risk reduction in services.

### 4. Staff undertaking daily duties

Employees shall:

- Be responsible for reporting incidents, which are a key source of information for managers regarding the nature and level of adverse activity within their area of responsibility,
- Be required to participate in activities, which support NUHS's risk management philosophy,
- Make risk management part of their daily duties. Employees will be able to identify and assess risk, take action to reduce risks to an acceptable level and inform appropriate supervisory or management staff, and
- Appropriately use equipment and supplies, being considerate of safety and health issues.

## DEFINITIONS:

**Risk Management:** is a comprehensive, systematic process that assists decision-makers in identifying, analyzing, evaluating and treating all types of risks, both internal and external to the organization.

**Risk:** an event that could potentially happen and one or more causes and one or more consequences.

**Hazard:** a source of potential harm or damage (e.g., water on the floor, unwashed hands).

## PROCEDURES – IRM PROGRAM FRAMEWORK:

### NUHS' Risk Management Process


Confirm Strategic Objectives

The organization should consider and focus on its core strategic objectives and the associated risks that threatens achieving them. Whether explicitly or implicitly stated, there is likely a core set of objectives related to care, human resources, finance, leadership and governance, community engagement, information systems and technology, facilities, and regulatory compliance.

Identify Key Risks

The organization will next identify risks to its strategic objectives – that is, identify what can go wrong. NUHS uses incident reporting, complaints and litigation, accreditation and compliance inspection reports, staff concerns, and key performance indicators in as well as industry data to identify risks.

Assess Risks

NUHS utilizes a system for grading risks, which takes into account parameters that include impact on the organization and probability of occurrence. Whenever possible, in determining the risk exposure, reference will be made to national, authoritative, legal, and best knowledge standards/requirements. Assessing the impact and likelihood of risks is essential to the prioritization process.

During this assessment, the organization will focus on residual risk – risk that remains with mitigation strategies in place.

The organization shall develop and use a risk consequence scale that is sorts risk by domain (e.g., physical or psychological harm, disengaged staff, financial loss, business interruption, reputational loss, statutory non-compliance, and failed strategic inititiatives) and provides specific, incremental definitions for the scale of impact. Similarily, the risk likeliness scale shall articulate specific definitions. See Appendix A – HIROC Same Risk Assessment Scales.

Manage Risk

Any risks identified at unacceptably high levels require an evaluation of the current risk mitigation strategy for each risk. The evaluation should include an assessment of whether existing controls are still appropriate and if so, whether they are being employed consistently.

Where it is decided that a specific risk is not at a tolerable level and that existing controls are not adequate, the additional or alternative mitigation plans should be developed and accountability for their implementation assigned. Risk management options include:

1. Avoiding/eliminating the risk by deciding not to start or continue with the activity that gives rise to the risk;
2. Removing the hazard;
3. Reducing the likelihood;
4. Reducing the consequence (e.g., by utilizing early warning/detection systems);
5. Sharing the risk with another party or parties (e.g. contracts, insurance, etc.); and
6. Accepting/retaining the risk where the risk is regarded as one that NUHS can legitimately bear and is merely a part of doing business.

Report

The results of risk assessments shall be documented and summarized in reports to senior leadership and the Board of Directors. The organization shall develop and maintain a risk register that summarizes the results of the risk assessments.

Monitor and Review

The risk register shall be monitored and updated as new information about risks becomes available. It will also be used by the SLT and CEO when setting organizational priorities.

The organization shall annually review its IRM Program to determine how the framework, policy and process, and risk management plan can be improved.

## APPENDIX A – HIROC SAMPLE RISK ASSESSMENT SCALES

### Potential Impact Scale

| Dimension | Very Low | Low | Medium | High | Very High |
|---|---|---|---|---|---|
| Physical/ psychological harm | • Minimal harm, no/minimal intervention or treatment<br>• No time off work | • Minor harm or illness, minor intervention<br>• Time off work for <3 days<br>• Increase in LOS by 1-3 days | • Moderate harm, professional intervention<br>• Time off work for 4-14 days<br>• Increase in LOS by 4-15 days<br>• Small number of patients | • Major harm leading to long-term incapacity disability<br>• Time off work for >14 days<br>• Increase in LOS by >15 days<br>• Mismanagement of patient care with long-term effects | • Incident may lead to death<br>• Multiple permanent instances of harm, irreversible health effects<br>• Large number of patients |
| Disengaged staff/ physicians | • Low level of internal grievances | • Grievances occurring but not in large numbers | • Grievances show an increasing pattern<br>• Low staff morale | • Grievances are increasing and more pervasive<br>• Very low staff morale | • Grievances preoccupy the organization, arbitration and external review<br>• Loss of several key staff |
| Financial loss | • Small loss | • 1% of budget | • 1-2% of budget | • 2-5% of budget | • >5% of budget |
| Reputation with stakeholders (including: community, donor, media, gov't, public, partners) | • Rumours<br>• Potential stakeholder concern | • Local media coverage (short term)<br>• Elements of stakeholder expectation not being met | • Local media coverage (sustained)<br>• Short-term reduction in stakeholder confidence | • National media coverage (short-term)<br>• Potential for political involvement<br>• Longer-term reduction in stakeholder confidence | • National media coverage (sustained)<br>• Political intervention<br>• Sr. leader termination<br>• Long-term reduction in stakeholder confidence |
| Service/ business interruption | • Interruption of >1 hour | • Interruption of >8 hours | • Interruption of >1 day | • Interruption of >1 week | • Permanent loss of service or facility |
| Compliance | • Minor non-compliance statutory duty | • Single failure to meet external standards or follow protocol<br>• Recommendations to comply with external agency | • Repeated failures to meet external standards<br>• Orders issued, report required by external agency | • Multiple statutory breeches /non-compliance with external standards<br>• Prolonged inspection, significant findings<br>• Prosecution initiated for non-compliance | • Gross failure to meet standards<br>• Maximum fines<br>• Criminal code violation<br>• Impact on affiliation agreements |
| Business objectives/ projects | • Insignificant schedule delay | • Minor schedule delay<br>• Small number of objectives not met | • Moderate schedule delay<br>• Some objectives not met | • Significant schedule delay<br>• Key objectives not met | • Initiative not implemented<br>• Key objectives not met |

### Likelihood Scale

| Category | Very low | Low | Medium | High | Very high |
|---|---|---|---|---|---|
| Broad descriptors | • Will probably never occur/recur | • Do not expect it to happen/recur but it is possible | • Might happen or recur occasionally | • Will probably happen/recur | • Will undoubtedly happen/recur, possibly frequently |
| Time-frame | • Not expected to occur for years | • Expected to occur at least annually | • Expected to occur at least monthly | • Expected to occur at least weekly | • Expect to occur at least daily |
| Probability | • <0.1% | • 0.1-1% | • 1-10% | • 10-50% | • >50% |

Adapted from NPSA, 2008

| NEW UNIONVILLE HOME SOCIETY | POLICY AND PROCEDURE MANUAL |
|---|---|
| Subject: **Whistleblower** | Policy No.: **TBD** |
| | Last Reviewed: |
| Section: **General Policies** | First Approved: |
| Approved by: **Chief Executive Officer** | Total Pages: **8** |
| External References: | |

**PREAMBLE:**

This policy is part of the Organization's ongoing efforts to identify and respond to any conduct that may pose a risk of harm to residents or staff, or to the operation of the Organization. This policy reflects the strong whistle-blowing protections in the *Long-Term Care Organizations Act, 2007* (the "LTCHA"), and reporting under this policy will assist the Organization in meeting the requirements of the LTCHA in this, and other areas.

Section 26 of the LTCHA forbids retaliation, or threats of retaliation against a person for disclosing anything to an inspector or the Ministry of Health and Long-Term Care Director, or for giving evidence in a proceeding under the LTCHA, or during a coroner's inquest. Under section 26, staff members, officers, and directors cannot discourage these disclosures.

**PURPOSE:**

- To encourage and enable reporting within the Organization relating to breaches or suspected breaches of the Organization's policies, procedures or standards, and legislation that applies to the Organization;
- To ensure that there is no retaliation against those who make reports in good faith under this policy; and
- To ensure compliance with the reporting and whistle-blowing provisions of the LTCHA.
- To ensure compliance with the Organization's Code of Conduct above.



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## POLICY:

It is the policy of the Organization that any staff member, volunteer or board member who is aware of, or suspects any of the following must report it as soon as possible in accordance with the reporting procedures in this policy:

- Improper or incompetent treatment or care of a resident; or unlawful conduct that affects or may affect a resident.
- Abuse of a resident by anyone, or neglect of a resident by a staff member, volunteer or board member of the Organization. This includes misuse or misappropriation of resident property.
- Verbal complaints concerning resident care or operation of the Organization.
- Breach of the Organization's policies, standards, procedures or by-laws.
- All other areas where there is real, or potential harm, exposure to the organization, residents and ongoing operations.

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## DEFINITIONS:

**Wrongdoing**

A wrongdoing occurs if there is:

- Gross mismanagement*;
- An act or an omission that creates a substantial and specific danger to the life, health or safety of a person;
- The taking of a reprisal/retaliation against an employee;
- A willful deliberate violation of any government legislative act or regulation;
- A significant deliberate violation of any Organization policy.

**Gross mismanagement is defined as a deliberate act or an omission showing a reckless or willful disregard for the efficient management of significant Organization resources.*

**Retaliation:** Encompasses direct actions, omissions and threats.

- Evicting a resident;
- Subjecting a resident to discriminatory treatment;
- Imposing a penalty on any person;
- Intimidating, coercing or harassing any person.

**Reprisal:** Reprisal action taken against an employee/person who has made a disclosure of wrongdoing in good faith includes:

- A disciplinary measure such as staff dismissal, discipline and suspensions;

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- Intimidating, coercing or harassing a person;
- Demotion of the employee;
- Any measure that adversely affects the employment or working conditions of the employee, or;
- A threat to take any of the previously identified measures

**Staff Reporting and Mandatory/Immediate Reporting under the LTCHA**

Staff shall be aware that section 24(1) of the LTCHA requires certain persons to make immediate reports to the MOHLTC Director where there is a reasonable suspicion that certain conduct or events occurred or may occur. (Section 24(1) is set out in the Appendix to this policy and for clarification about who must report see section 105 of the LTCHA regulation, which is included in the Appendix). Staff should immediately report through this policy any conduct or events that may lead to a mandatory/immediate report under section 24(1). Staff should also understand that it is an offence under the LTCHA to discourage or suppress a section 24(1) report.

**No Retaliation or Discouragement of Reports**

The Organization will protect staff members, volunteers and board members from harassment, coercion, penalty or discipline in the context of the following:

- Reports in good faith under this policy, and
- Disclosure of anything to an inspector or the MOHLTC Director, or giving evidence in a proceeding under the LTCHA or during a coroner's inquest.
- Disclosure to any relevant law enforcement or regulating agency.

The Organization will protect a resident (and his or her family members, Substitute Decision Maker (SDM), and persons of importance) against any threats or discrimination in connection with the resident's disclosure of anything to an inspector or the MOHLTC Director, or his or her giving evidence in a proceeding under the LTCHA or during a coroner's inquest.

A resident will not be discharged from a long-term care home, threatened with discharge, or in any way be subjected to discriminatory treatment (i.e. any change or discontinuation of any service to or care of a resident or the threat of any such change or discontinuation), even if the resident or another person acted maliciously or in bad faith, and no family member of a resident, substitute decision-maker of a resident, or person of importance to a resident shall be threatened with the possibility of any of those being done to the resident.

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Staff members, volunteers and board members must not do anything to discourage any of the following:

1. Reports under this policy,
2. Mandatory/immediate reports under the LTCHA, and
3. Disclosures to an inspector or the MOHLTC Director, or the giving of evidence in a proceeding under the LTCHA or during a coroner's inquest.

A staff member, volunteer or board member who retaliates, threatens a resident, or discourages a report in breach of this policy shall be subject to disciplinary action, which may include termination or removal.

**Reporting in Good Faith**

In making a report under this policy, a person must not act maliciously or in bad faith. A person who makes a report maliciously or in bad faith may be subject to disciplinary action up to and including termination of employment, termination of placement or removal from his/her position.

Any staff members, volunteers, students, board members and any other party who reasonably believes that they are being asked to commit a wrongdoing, or who reasonably believes that a wrongdoing has been committed or is about to be committed, may disclose the matter immediately to their supervisor/manager, Director, CEO and/or the Human Resources Department.

No person, knowing that a document or object (including in electronic or digital format) is likely to be relevant to an investigation under this policy, shall:

- destroy, mutilate or alter the document or object;
- falsify the document or make a false document;
- conceal the document or object;
- direct, counsel or cause any person to do anything mentioned above in any manner;
- purpose to any person that they do anything mentioned in the above clauses in any manner.

In making a report under this policy, a person must not act maliciously or in bad faith. A person who makes a report maliciously or in bad faith may be subject to disciplinary action, which may include termination or removal.

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## PROCEDURE:

### A. Reporting

All disclosures must be made in written form (see Appendix A), unless there is imminent and serious danger.

The Home will process and respond to verbal and written complaints through its complaints policy/procedures.

All reports under this policy should be to a staff member's immediate supervisor or manager. Where an immediate supervisor is implicated, or where a staff member is uncomfortable reporting to their supervisor, the report should go to the next level of leadership (Senior Management) or CEO.

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Board members should report to the Chief Executive Officer and/or the Chair or President/Vice Present of the Board, where appropriate.

Reports concerning management staff members should be to the Chief Executive Officer (CEO); or if the report implicates the CEO, to the Board Chair.

Reports concerning conduct of professional staff or service providers (physicians and medical students, dentists, nurses in the extended class, Director of Care, supervisors) should be to the CEO.

A staff member, volunteer or board member who experiences any form of retaliation/reprisal before or after submitting a report should immediately inform their supervisor or a member of the management team; or in the case of a board member, the CEO, President/Vice Present of the Board.

### B. Investigation

The person receiving the report will forward it for investigation to the Human Resources (HR) Services. The HR will investigate and resolve the subject matter of the report. Where necessary, they will advise or involve members of senior management and/or the CEO.

Responsibility for investigation and resolution may be referred to senior management or the CEO if the complaint is regarding a member of Human Resources Services.

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Staff members are expected to cooperate during any investigation.

If feasible and appropriate, the Home will inform the individual who made the report about the results of an investigation and the steps taken to address the conduct in question within 10 days.

The CEO will be informed of the results of the investigation and will report on the matter to the Board if an infraction of this policy has occurred.

**C. Confidentiality**

The Organization will accept reports under this policy on an anonymous or confidential basis. The Organization's normal procedure will be to keep all reports confidential to the extent possible, subject to the need to conduct an effective investigation or to take action to comply with the LTCHA or other law. The Organization will not tolerate any attempt by a person or group to identify a person who submits a report in good faith on an anonymous or confidential basis.

**D. Staff Orientation and Training**

Staff members will receive orientation and annual re-training on the reporting obligations under the LTCHA, the Organization's internal procedures for reporting, and the whistle-blowing protections in the LTCHA.

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## APPENDIX A
## LTCHA MANDATORY/IMMEDIATE REPORTS

The first excerpt sets out the matters that must be immediately reported to the MOHLTC Director - section 24(1). The second excerpt sets out certain staff to which this requirement does not apply – section 105 of the regulation and the definition of "staff" from the LTCHA.

**Reporting certain matters to Director**

**24.** (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident.
3. Unlawful conduct that resulted in harm or a risk of harm to a resident.
4. Misuse or misappropriation of a resident's money.
5. Misuse or misappropriation of funding provided to a licensee under this Act or the *Local Health System Integration Act, 2006*. 2007, c. 8, ss. 24 (1), 195 (2).

**Non-application re certain staff**

**105.** Paragraph 4 of subsection 24 (5) of the Act does not apply to a staff member who,

(a) falls under clause (b) or (c) of the definition of "staff" in subsection 2 (1) of the Act;

(b) only provides occasional maintenance or repair services to the Organization; and

(c) does not provide direct care to residents. O. Reg. 79/10, s. 105.

"staff", in relation to a long-term care Organization, means persons who work at the Organization,

(a) as employees of the licensee,

(b) pursuant to a contract or agreement with the licensee, or

(c) pursuant to a contract or agreement between the licensee and an employment agency or other third party; ("personnel

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## APPENDIX B
## TABLE: MANDATORY REPORT

Types of Incidents that must be reported to immediate supervisor/manager and/or the Ministry of Health and Long Term Care:

| Type of Incident | Reporting Time Frame |
|---|---|
| Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident | Immediately upon becoming aware of the incident |
| Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident | Immediately upon becoming aware of the incident |
| Unlawful conduct that resulted in harm or a risk of harm to a resident | Immediately upon becoming aware of the incident |
| Misuse or misappropriation of a resident's money | Immediately upon becoming aware of the incident |
| Misuse or misappropriation of funding provided to a licensee under the LTCHA or the *Local Health System Integration Act, 2006*. | Immediately upon becoming aware of the incident |

NEW UNIONVILLE HOME SOCIETY

# Board Evaluation Results for 2018/2019 Q3 Meetings (February, 2019)

Prepared for the Governance and Nominating Committee

Monday, April 8, 2019

NEW UNIONVILLE HOME SOCIETY

## Response Rate

| | | | | |
|---|---|---|---|---|
| NUHS | 15 MEMBERS | 13 members in attendance<br>10 responses | 77% | ▲ |
| UHS | 6 MEMBERS | 5 members in attendance<br>3 responses | 60% | ■ |
| FDN | 8 MEMBERS | 6 members in attendance<br>3 responses | 50% | ■ |
| WG | 5 MEMBERS | 4 members in attendance<br>3 responses | 75% | ▲ |

Goal: 100%

● = 100%
▲ = 70 – 99%
■ = < 70%

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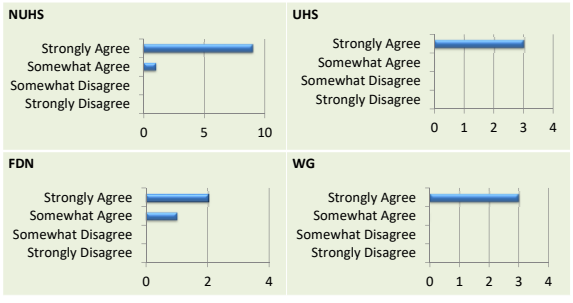
## Results – Focus

- **Q1:** The board focused on the important issues



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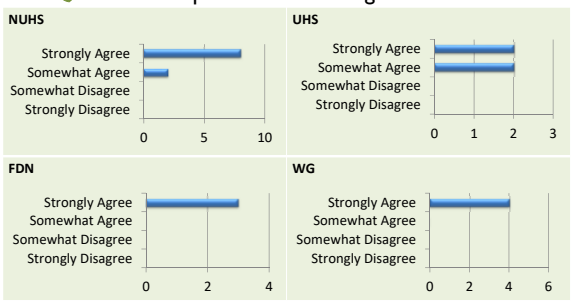
## Results – Focus (Cont.)

- **Q2:** The time spent at the meeting was of value

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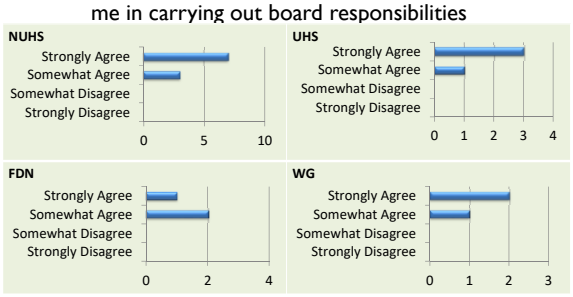
## Results – Learning

- **Q3:** The knowledge gained at this meeting will support me in carrying out board responsibilities

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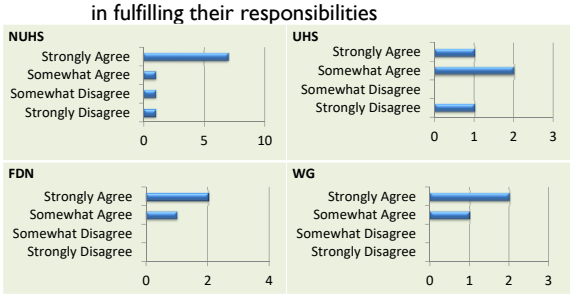
## Results – Learning (Cont.)

- **Q4:** The pre-circulated materials assisted the Directors in fulfilling their responsibilities



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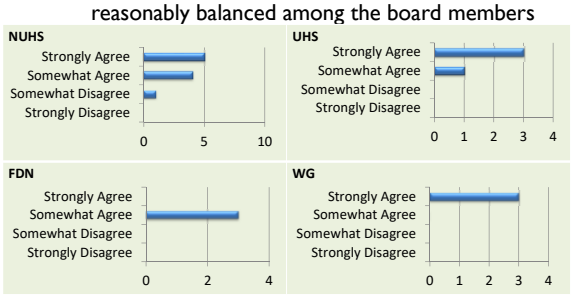
## Results – Discussion

- **Q5:** Discussion was meaningful, diverse and reasonably balanced among the board members

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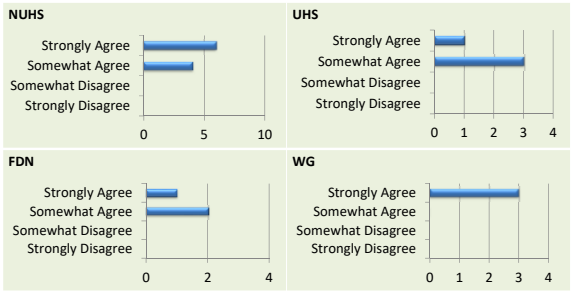
## Results – Discussion

- **Q6:** I was satisfied with the board meeting




NEW UNIONVILLE HOME SOCIETY

## Comments - NUHS

- Excellent materials and discussion , and milestone decision on the land deal.
- I would like the materials for the meeting to be circulated sooner.
- I realize that there has been significant change and projects at UHS, however in future we need to ensure that material is shared well in advance so the Directors have time to review. I agree with management's assessment that the dashboard performance report should be reviewed and streamlined to focus in on key areas the Board should be made aware of. As we go through strategic planning process, it should also align with the operational goals and targets developed from the strategic plan.

## Comments - NUHS

- While I appreciate the reason for some materials being circulated late, would appreciate receiving board package at least 48 hours before the meeting. Can we also indicate clearly on the agenda when an item is being presented for approval, similar to what is done with the minutes. Requested Approval of the 2019/20 budget was not clear to me from the agenda When people are calling in, need to make sure they are able to be part of the discussions. discussions gets dominated by those in the room as hard for those on the phone to just jump in and for the chair to know when they want to speak
- We spend too much time talking about materials we are provided ahead of time, when we could simply ask questions about what we might not understand or the presenter could highlight particularly important aspects of the material.

## Comments – UHS

- Lyndsey is the best...great to meet Paul again at the meeting...thanks to Paul, Julie, and Marieanna for everything that they do.
- I realize that there has been significant change and projects at UHS, however in future we need to ensure that material is shared well in advance so the Directors have time to review. I agree with management's assessment that the dashboard performance report should be reviewed and streamlined to focus in on key areas the Board should be made aware of. As we go through strategic planning process, it should also align with the operational goals and targets developed from the strategic plan.
- The board materials were not circulated in a timely manner.

## Comments – Foundation

- I was on the telephone for this meeting. Difficult to fully participate in this mode.
- I would appreciate numbering the pages and making reference to where we are when the presentations are being made....I find myself searching all over for what's being discussed.....I'm sure it's just me....thanks

NEW UNIONVILLE HOME SOCIETY

## Comments – Wyndham Gardens

- It would be appreciated if hand-out material is issued at least 3 working days before the meeting.
- Good discussion on those really important issues!